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

Seventy-Fourth Session
March 7, 2007

The Assembly Committee on Ways and Means and the Senate Committee on Finance, Joint Subcommittee on K-12/Human Services was called to order by Chair Sheila Leslie at 8:12 a.m., on Wednesday, March 7, 2007, in Room 3137 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. Copies of the minutes, including the Agenda (Exhibit A), the Attendance Roster (Exhibit B), and other substantive exhibits are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at www.leg.state.nv.us/74th/committees/. In addition, copies of the audio record may be purchased through the Legislative Counsel Bureau's Publications Office (email: publications@lcb.state.nv.us; telephone: 775-684-6835).

ASSEMBLY COMMITTEE MEMBERS PRESENT:

Assemblywoman Sheila Leslie, Chair
Assemblywoman Barbara E. Buckley
Assemblyman Mo Denis
Assemblywoman Heidi S. Gansert
Assemblywoman Debbie Smith
Assemblywoman Valerie E. Weber

SENATE COMMITTEE MEMBERS PRESENT:

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

STAFF MEMBERS PRESENT:

Mark W. Stevens, Assembly Fiscal Analyst
Steve Abba, Principal Deputy Fiscal Analyst
Carol Thomsen, Committee Secretary
Connie Davis, Committee Secretary

Chairwoman Leslie indicated that the Subcommittee would commence with the budget presentation for the Division of Health Care Financing and Policy (HCF&P), Department of Health and Human Services (DHHS), Budget Account (BA) 3158.

HUMAN SERVICES
HCF&P—ADMINISTRATION (101-3158)
BUDGET PAGE HCF&P—1

Charles Duarte, Administrator, HCF&P, introduced himself, Mary Wherry, Deputy Administrator, and Patrick Cates, Administrative Services Officer 4 (ASO 4), to the Subcommittee. He referenced Exhibit C, "Budget Presentation to the Senate Finance/Assembly Ways & Means, Joint Subcommittee on K-12/Human Resources, FY 08–09," which had been presented to Subcommittee members. Mr. Duarte stated that rather than reviewing the presentation, he would like to address what the Subcommittee perceived as major issues within the budget.

Chairwoman Leslie asked Mr. Duarte to address Enhancement Unit 252 (E252), which requested ten new positions. She noted that the Division had provided Legislative Counsel Bureau (LCB) Fiscal Analysis Division staff with a priority list for the 42 new positions recommended division-wide, which would assist the Subcommittee when considering the requested positions.

Chairwoman Leslie stated that the Division had requested 42 positions division-wide, and BA 3158 included the request for 19 positions. She stated that E252 specifically requested ten positions under the fiscal management structure. Chairwoman Leslie asked Mr. Duarte to provide explanation for the ten positions requested in E252, beginning with the request for two auditor 2 positions and two auditor 3 positions.

Mr. Duarte explained that the auditor positions were being requested so that HCF&P could comply with the increased frequency of federal reviews and outside audits. A number of issues associated with payments to public entities had come to light, along with issues pertaining to reviews and audits of Division operations. Mr. Duarte said that currently there was only one auditor position within the Division, and that auditor was overburdened in the search for areas of financial risk. The duties of the requested auditor 2 and auditor 3 positions would include review of the Division's administrative and fiscal agent activities, and an administrative review of cost allocations, which was increasingly important.

Mr. Duarte explained that a number of partner agencies and other public entities included state funding in their budgets that was used by the Division. It was the responsibility of the Division to ensure that those funds were appropriately utilized through a certification of public expenditures (CPE) process. The requested auditor positions would also assist the Division in that regard.

The Division encountered frequent appeals in the area of reimbursement by providers, particularly institutional providers, and to review the cost data of the providers, the Division needed the additional audit staff. Mr. Duarte further explained that two audit positions would also be involved with rate review, as well as review of cost-based reimbursements to partner agencies and other public entities.

Mr. Duarte indicated that the Division had been audited by the Division of Internal Audits and the LCB Audit Division, which recommended that partner agencies be paid on a cost basis. In order to comply with that recommendation, the Division needed the auditor function to ensure that rates were appropriately set and that costs were justified.

Senator Cegavske stated that the Division currently had one auditor position that had been vacant since 2005, and she asked whether the Division wanted to retain that vacant position plus add two additional auditor positions.

Mr. Duarte stated that was correct. He explained that one of the problems the Division encountered in filling vacant positions within the fiscal management structure was the workload. When there were too few staff and too much work, staff members were often faced with a workload that was extensive and beyond their capabilities, which became very discouraging for incumbent staff. Mr. Duarte indicated that with appropriate staffing levels, the Division believed the workload could be assigned in a reasonable manner, thereby improving staff recruitment and retention.

Senator Cegavske voiced concern that since 2005 the Division had not been able to fill a vacant auditor position, and yet it was requesting two additional auditor positions for the upcoming biennium. She suggested that the Division remove two lower positions and replace those two lower positions with one auditor position, and then request one new auditor position, which would provide a total of four auditor positions including the current vacancy. Senator Cegavske indicated that after reviewing the vacancy list for the Division, it would make sense to use existing vacant positions that could be converted to auditor positions rather than adding new positions. She suggested that the Division consider that possibility.

Mr. Duarte advised the Subcommittee that the Division would certainly consider such action. He pointed out that two of the auditor positions were in the fiscal area, and two were in the area of rates and reimbursements. The auditors would be involved in very different tasks in each of those areas.

Senator Cegavske said she was simply looking for justification for the requested positions and, at the present time, she did not believe that the requested positions were needed by the Division without first considering other alternatives.

Chairwoman Leslie asked how the auditor positions and other requested positions in E252 fit with the additional requirements from the Centers for Medicare and Medicaid Services (CMS) pertaining to the CPE process.

Mr. Duarte explained that two auditor positions would be used to comply with the CMS requirement, while the remaining two auditor positions would be used in the Division's rate-setting process. He pointed out that the vacant auditor position was in the payment error rate measurement area, which was also a federally required function. That area reviewed payments made to providers and assured that those payments were appropriate. The vacancy had recently been reclassified to an auditor 2 position, and recruitment had been open since October 2006.

Chairwoman Leslie asked whether the Division felt the workload could be addressed with one new auditor position in each area rather than two.

Mr. Duarte replied that the workload had increased extensively over the past two years, particularly as new requirements were issued by the federal government. The Division was asked to provide greater and greater assurances about the proper use of public funds. Mr. Duarte noted that the State should take such action even when not mandated by the federal government, but with the increased federal scrutiny, it had become very important that the Division address that function to avoid the loss of federal funding.

Chairwoman Leslie asked whether the additional auditor positions would have helped the Division identify the administrative expenditures claimed on behalf of the Clark County School District that were not allowable and, consequently, would be refunded. Mr. Duarte confirmed that additional staff would have helped in that situation.

Chairwoman Leslie noted that the District was also requesting three budget analyst positions, which would be in addition to the six current analyst positions, for a total of nine budget analyst positions in the budget unit.

Mr. Duarte stated that the Division currently had one budget analyst in the fiscal budget area and the request was for three additional budget analyst positions.

Chairwoman Leslie explained that the six existing positions she referred to were assigned to the Division's budget unit. Two positions were assigned full-time responsibilities for contract monitoring of the Health Insurance Flexibility and Accountability (HIFA) waiver, and the four remaining positions were assigned other budget-related duties.

Mr. Duarte stated that the Division's request in E252 was for three budget analyst positions, and those positions would be assigned to the Accounting and Budget Unit. The duties of the budget analysts would include development of the biennial budget, tracking revenue and expenditures against budgeted authority, and ensuring compliance with federal and state statutes.

According to Mr. Duarte, E252 also requested an accountant 3 position and one grants and projects analyst position for the Accounting and Budget Unit, to comply with state and federal accounting requirements.

Chairwoman Leslie asked Mr. Duarte to provide justification for the request for three additional budget analysts in E252 to the Subcommittee.

Mr. Duarte advised the Subcommittee that those positions would track revenue and expenditures against budgeted authority. That function had been problematic for the Division because only one staff person currently tracked those expenditures.

Chairwoman Leslie noted that HCF&P included seven complex budgets, but she believed that the request for three budget analyst positions to oversee seven budgets was quite high, compared to other state agencies. The Subcommittee would like to have additional back-up information and justification for those positions. Mr. Duarte said he would be happy to provide that information.

According to Mr. Duarte, another issue facing the Division was when a small budget error was made it quickly translated into very large numbers because of the size of the budgets. For example, a 1 percent budget error could affect millions of dollars.

Assemblyman Denis referenced performance indicator number 5, "Percent of invoices/billings for which checks are issued within ten days of receipt," Exhibit C, page 20. The projected goal was 95 percent and the actual for FY 2006 was 71 percent, and he asked why the Division failed to reach the projected goal.

Patrick Cates, ASO 4, HCF&P, explained that the 71 percent was the result of staff hiring and turnover issues that produced insufficient full-time employees to meet the goal.

Chairwoman Leslie advised Mr. Duarte that the December sales tax projections were lower than predicted, and it appeared that the State would not have the revenue anticipated for the next biennium. The Legislature was not sure of the exact shortfall, but anticipated that it would be millions of dollars. Therefore, the Legislature was attempting to "stretch every dollar" to avoid full-blown cuts in balancing the budget over the upcoming biennium.

Mr. Duarte stated that he understood the issues. He believed that appropriate proactive oversight of the Division's budgets could potentially save money for the State.

Chairwoman Leslie acknowledged that the Division's budgets included cost-saving initiatives, but it was necessary for those cost savings to materialize. Mr. Duarte said that he understood.

Chairwoman Leslie referenced the request for one accountant 3 position and one journey-level accountant position. The Division was requesting two additional professional-level accounting positions, and she asked what accounting functions the new positions would be assigned to that were not currently being completed.

Mr. Cates reported that the current accountant position was charged with supervising most of the accounting functions of the Division. That position was devoted almost full-time to the preparation of federal reports, such as the CMS 64 and 21 reports for the Medicaid and Nevada Check-Up programs. Mr. Cates said those reports often included numerous revisions, and there were issues with how the reports were compiled. The Division conducted very limited review of those reports because of the time involved in preparation. Therefore, the reports were sent out at the last minute without adequate review.

Other areas of concern were reconciling the Division's federal grant funding and tracking federal draws. Mr. Cates explained that the current accountant position also handled those functions and was simply "spread too thin;" therefore, the functions were not being adequately addressed. By adding two positions, the Division could allow one accountant to prepare the federal reports, reconcile federal grant funding, and make sure that the Division used appropriate data. The accountant 3 position would serve as oversight and review the accounting functions of the Division. Mr. Cates said that with the additional full-time employees, a more adequate review of the accounting functions could be undertaken, such as review of training and cross training, and management review of the functions of lower-level accounting staff.

Chairwoman Leslie said that apparently the work was currently being completed, but the question was whether the reports contained errors. Mr. Cates explained that the completed reports contained numerous errors, and Division reviews were inadequate.

Chairwoman Leslie asked whether the accounting functions of the Division were similar to other state agencies. Mr. Cates said that was difficult to answer. A survey of state agencies would undoubtedly reveal that the Division was requesting more accounting staff that other entities. Mr. Cates believed, however, that the Division's budgets were more complex than those of other state entities.

Chairwoman Leslie asked for explanation of the request for a grants and projects analyst position. It appeared that HCF&P had fewer grants than other divisions within the Department of Health and Human Services (DHHS).

Mr. Cates explained that the position would be assigned the responsibility of compliance with grant requirements and reconciliations because the Division had difficulty tracking grant funds.

Chairwoman Leslie asked why the requested accounting positions could not address grant requirements and reconciliations.

Mr. Cates acknowledged that the accountant 3 position would provide some oversight in that area, but the existing accountant and the proposed accountant 1 position would focus on federal expenditure reporting. The grants and projects analyst would specifically focus on federal draws and the reconciliation of those draws. Mr. Cates explained that maintaining a record of the Medicaid portion of the draws was very complex, as was the Nevada Check-Up program.

Chairwoman Leslie asked whether the draws were performed electronically. Mr. Cates concurred that the draws were performed electronically, but there was a significant reconciliation process that was completed manually to ensure that the amounts were correct.

Chairwoman Leslie understood the importance of the work, but it appeared to be more of an accounting task rather than a grants and projects analyst task. Usually, that position would address program functions. She asked that the Division provide additional justification regarding the grants and projects analyst position.

Senator Cegavske asked for a comparison of vacancies to requested positions. The comparison also should show the duties of the vacant positions versus the duties of the requested positions. Mr. Duarte said he would provide the requested information to the Subcommittee.

Chairwoman Leslie referenced Enhancement Unit 253 (E253), which requested a new social services chief to decrease the span of supervisory control for the Chief of the Compliance Section. She asked Mr. Duarte to discuss the request.

Mr. Duarte said the duties of the position would be responsibility and oversight of provider and recipient support services. The Division had added responsibilities in the Compliance Section, including third party liability recovery and oversight of the operation of third party, in-service providers. It had

become an issue of control, and the Division wanted to ensure that there was an appropriate level of supervision in the Compliance Section.

Chairwoman Leslie asked how many positions were included in the Compliance Section. Mr. Duarte responded that the supervisor in that section currently supervised six individuals.

Chairwoman Leslie noted that with the addition of a second supervisory position, the number of positions supervised would be lower. Mr. Duarte said the number of supervised staff would be reduced to three positions for each supervisor.

Chairwoman Leslie opined that the number supervised did not appear onerous. Mr. Duarte emphasized that the particular areas for which the supervisors would be responsible included a broad array of services.

Chairwoman Leslie advised Subcommittee members that an organizational chart of the Division was depicted on page 8 of Exhibit C, which indicated that each supervisor would supervise three lower positions. Mr. Duarte stated that was correct.

Chairwoman Leslie referenced E279, which requested one new information services specialist (ISS) position. She noted that there was a similar ISS position request included in the Medicaid budget (BA 3243) with slightly different responsibilities.

Mr. Duarte explained that the ISS 3 position requested in E279 would be responsible for providing programming support to the Division's numerous in-house applications that had been developed over the years. Those databases currently were in need of maintenance and would require enhancements. One of the most important applications was the database for the Nevada Check-Up program, which was utilized to maintain eligibility and enrollment information and needed to be upgraded. The proposal was that the ISS 3 position would be responsible, not only for the maintenance of the application, but also for the enhancement.

The Division had reviewed the possibility of using managed services agreements (MSAs) for maintenance of the in-house applications, but found that MSAs were more expensive than relying on an in-house position. Additionally, Mr. Duarte said the Division's applications included the document review manager, the security manager, the Internet and intranet systems, time-tracking and call-tracking systems, appeals-tracking systems for recipients and providers, and the Ticket to Work/Health Insurance for Work Advancement (HIWA) application. Mr. Duarte explained that the aforementioned applications were in need of maintenance and upgrades that the Division believed should be completed in-house. The Division believed that the ISS 3 position would be the most cost-effective way to provide the required maintenance and upgrades.

Assemblyman Denis asked how the Division was currently managing its in-house applications. Mr. Duarte replied that the Division utilized the services of a contractor to provide interim assistance, but an enhancement of the Nevada Check-Up database was not underway at the present time. The Division initiated the enhancement of that database in 2005, but because of cost overruns, further development and work on that database was discontinued. Mr. Duarte said the Division was very concerned because the application was aging and fragile and needed to be upgraded.

Mr. Denis noted that the Division was requesting two ISS 3 positions. Mr. Duarte explained that the ISS 3 position requested in E275 of the Medicaid budget (BA 3243) would be responsible for the Division's Decision Support System (DSS), which was part of the Medicaid claims payment system. Mr. Duarte stated that the DSS was a data warehouse and reporting application, and the ISS 3 position would ensure the integrity and quality of the data being released from that system. Quite often, program staff, fiscal staff, and outside parties requested data about Medicaid. The ISS 3 position would assist staff with designing and creating queries, would ensure that the correct data was accessed, and would ensure the integrity of the data. That data was used in reports and policy development, fiscal analysis, or other public purposes.

Mr. Denis asked how that function was currently being addressed by the Division. Mr. Duarte stated that no position was assigned that task at the present time. Staff handled the requests for Medicaid data, but were not specialists in the use of the DSS.

Mr. Duarte explained that the Chief of the Division's Information Technology Unit was attempting to provide maintenance on some applications on an ad hoc basis, but there was not sufficient time for the Chief to continue that maintenance along with his other duties.

Mr. Denis asked whether the Division could use one ISS 3 position to address both areas. Mr. Duarte explained that the positions were for two separate functions. The Division requested two positions based on the scope and volume of work for each position. The DSS queried from the Medicaid system, but the Division had not been able to do many of those queries, which was detrimental to the State. Mr. Duarte indicated that the Division anticipated receiving many requests for data from the Medicaid database, and the ISS 3 position would be extremely important in assuring that the database was sound.

Mr. Denis asked Mr. Duarte which ISS 3 position was most important to the Division, in the event the Legislature could not fund both positions. Mr. Duarte believed that the most important function was to ensure that the Division's in-house applications, particularly the Nevada Check-Up database, were properly maintained and updated, which would be assigned to the ISS 3 position requested in E275.

Chairwoman Leslie asked for information about the one-time General Fund appropriation of $567,939 for the relocation of the Las Vegas district office from the Belrose complex. She asked whether the Division had located a new site for the Las Vegas office, why the tenant improvement costs were so high, and why rent was being funded through a one-time appropriation.

Mr. Duarte reported that the new location for the Las Vegas office had not yet been identified. The tenant upgrades were estimates of what the Division believed it would cost to move the offices out of the current Belrose complex to a new location. Mr. Duarte was not sure why the rent was not broken out of the one-time General Fund allocation. Obviously, there were ongoing costs associated with the lease, and those costs should be identified separately.

Chairwoman Leslie asked when information would be available regarding a new site. Mr. Duarte said the Division had not started actively searching at the present time. Chairwoman Leslie commented that it was difficult for the

Legislature to budget without specific information about the relocation. Mr. Duarte said that he understood the difficulty.

Assemblyman Denis noted that the current location of the Las Vegas office was very accessible, and he asked whether the new location would be in close proximity to the Belrose complex. Mr. Duarte said the Division was not sure where the office would be located, but it wanted to be sure that the office was accessible to the clients. The Division would conduct a search to ensure that the location was close to the majority of its clients.

Mr. Denis hoped that the new location would remain as accessible to clients as the Belrose complex. Mr. Duarte said the Division understood the transportation concerns, and certainly wanted to locate the Nevada Check-Up staff in an area that would be close to client traffic and bus lines. He noted that clients did not travel to the Medicaid district office because staff provided oversight for home- and community-based waiver program clients.

Mr. Denis referenced the replacement of personal computers (PCs), and asked whether that would be from one-shot funding. Mr. Duarte stated that the request included both new and replacement equipment. Mr. Denis asked whether the equipment was for the new office, or whether there was a cycle for equipment replacement. Mr. Duarte explained that equipment was replaced on a regular cycle, but the request also included specialized equipment, including a color copier. He acknowledged that some equipment was associated with the relocation of the Las Vegas office because the Division was sharing equipment with the Division of Welfare and Support Services. Because the Division's Las Vegas office was relocating, new equipment would be needed.

Chairwoman Leslie pointed out that the Division would more than double the size of its Las Vegas office with the move, and she asked how many employees worked in that office.

Electing to respond the Chairwoman's inquiry was Mary Wherry, Deputy Director, HCF&P, who explained that there were 70 employees in the Division's Las Vegas office, which included two information technology staff members, plus the caseworkers.

Chairwoman Leslie asked the Division to prepare a better plan for the relocation of the Las Vegas office. The Legislature simply could not "write the Division a check" without knowing what the actual costs would be to relocate the office.

Ms. Wherry advised the Subcommittee that approximately nine months ago, staff in Las Vegas had looked at various locations to determine the cost of rent and to establish the costs for the office relocation, but the Division had not pursued an exact location because the funding for the move was uncertain. She noted that rent was included in the Division's base budget because the Division paid rent to the Welfare Division, which was probably more than the rent for a private sector office. The pricing in the budget was based on conversations with building owners regarding what changes might be needed, and the amount of space needed for the relocation.

Chairwoman Leslie noted that the budget contained a one-time funding request that included some specifics, but the Legislature needed details to justify the one-time General Fund appropriation.

Chairwoman Leslie stated that in addition to the cost of pay increases for all employees, the Division requested a two-grade salary increase for health care coordinator positions staffed by licensed nurses. The request does not include licensed social workers, and Chairwoman Leslie asked for clarification.

Mr. Duarte stated that the Division identified nurses as a much higher priority because of recruitment issues associated with those licensed positions, and as such, nurses were given priority across the DHHS.

Chairwoman Leslie asked whether the Division planned to hire nurses or social workers. Mr. Duarte explained that the health care coordinator classification series could be used for either licensed nurses or licensed social workers.

Chairwoman Leslie noted that, based on the statewide Personnel Department study, the social worker category had received an increase in pay because of turnover rates. She asked why that increase did not pertain to the positions within the Division.

Mr. Duarte explained that Enhancement Unit 814 (E814) supported a two-grade salary increase for health care coordinator positions staffed by licensed nurses.

Senator Mathews noted that E814 would not support a social worker as a substitute in the health care coordinator position, and she commented that quite often a licensed nurse was needed in those positions rather than a social worker. Mr. Duarte agreed that was often the case.

Senator Mathews asked whether either a licensed nurse or a licensed social worker could be classified as a health care coordinator.

Ms. Wherry explained that the Division's health care coordinator series primarily accommodated its caseworkers. The Division found that a mix of social workers and nurses provided a good balance. When social workers were on a case that might become medically complex, they often worked with the nurses to ensure that the client remained stable and able to remain in the home. Nurses could also function as case managers, and complete the same functions as those of a social worker. Ms. Wherry emphasized that only licensed nurses evaluated cases where a client was being added to a waiver program, assessed for the Katy Beckett program, or moved out of a nursing home environment. There were some health care coordinator positions that could be filled only by licensed nurses. For example, the Division had nurses who conducted reviews of nursing facilities. Those nurses had to understand the minimum information required for review, how to score the review, and how to assess the care of patients.

Ms. Wherry explained that the health care coordinator series was a very broad classification that was not only related to HCF&P, but was a scope and class series that went beyond the Division.

Senator Mathews remarked that she understood there were certain cases in which a nurse was needed rather than a social worker, but she was uncertain regarding how those positions could be interchangeable.

Chairwoman Leslie referenced the administrative expenditures in the amount of approximately $5.5 million claimed on behalf of the Clark County School District, which was disallowed based on the audit performed by the Office of Inspector General. The Subcommittee learned that the Division met

with representatives from the school district on February 21, 2007, and Chairwoman Leslie asked about the outcome of that meeting.

Mr. Duarte said that he, Mr. Cates, and Michael Willden, Director, DHHS, participated in a conference call with representatives from the Clark County School District on February 21, 2007. Mr. Duarte indicated that the school district was informed that CMS needed to be repaid by the end of the fiscal year, June 30, 2007, and that any payment plan that extended payments beyond the end of the fiscal year would be unacceptable. The Division would then be forced to seek legal means to recover those funds before the end of the fiscal year. If repayment was not received by that date, CMS would simply reduce the state's request for federal Title XIX allocations in the amount of the repayment.

Mr. Duarte reported that there had been no further communication with the school district with respect to a payment plan, and it was his intention to begin the process of applying negative balances to other claims presented by the district. At the very least, that would begin recovery of the funds.

Chairwoman Leslie pointed out that CMS would withhold Title XIX funds if payment was not received on the $5.5 million disallowance. Mr. Duarte stated that was correct.

Senator Cegavske asked whether additional audits had been conducted regarding the administrative expenditures claimed by the school district that were not allowed. Mr. Duarte explained that the Division had not conducted subsequent audits. However, the Division was scrutinizing claims submitted by the Clark County School District for administrative expenditures filed after calendar year 2004, which were outside the scope of the audit performed by the Office of Inspector General, prior to submitting those claims to CMS.

Senator Cegavske said her concern was that for calendar years 2003 and 2004 the expenditures that were not allowed totaled approximately $5.5 million, and another $3.4 million had been deferred by CMS after the audit period. Senator Cegavske asked whether there were additional monies that had to be repaid beyond those amounts.

Mr. Duarte explained that at the present time there were no additional expenditures; however, there had been the finding of a disallowance in the amount of $5.5 million associated with claims made during the 2003 and 2004 calendar years, which had not been repaid. Mr. Duarte indicated that there was an additional deferral of approximately $3.4 million, for which CMS had withheld Title XIX funds in 2006. Mr. Duarte stated that the school district had been asked to review the claims associated with the $3.4 million. Other claims had been submitted by the Clark County School District, and once the Division and CMS were assured that those claims were accurate, CMS would retain the funding for valid claims as repayment of the $5.5 million. It was hoped that the school district would eventually reach the status of positive cash flow from CMS.

Senator Cegavske asked whether repayment through valid claims was acceptable to CMS and the Division and whether the school district had resubmitted claims pertaining to the $3.4 million deferral.

Regarding the $3.4 million deferral, the Division was in agreement with CMS, and Mr. Duarte hoped that the school district understood the importance of

repaying the amount of the deferral to the Division. Mr. Duarte also hoped that the school district was aware that until the $5.5 million was repaid to CMS, the district would not receive further funding from CMS for its claims.

Senator Cegavske again asked whether the method of repayment through valid claims was acceptable to CMS. Mr. Duarte answered that the payment method was acceptable to CMS.

Senator Cegavske noted that the school district stated it would resubmit some of the claims that were disallowed based on possible category errors or incorrect information.

Mr. Duarte explained that the $5.5 million discovered by the audit performed by the Office of Inspector General for the expenditures that were not allowed had been finalized, and the school district could not resubmit those invoices.

According to Mr. Duarte, two invoices in the amounts of $1.1 million and $2.3 million were involved in the $3.4 million deferral. The Division had resubmitted the $1.1 million invoice to CMS, and approximately $400,000 of those charges were deemed allowable by CMS, and that amount had been paid back to the Division. Mr. Duarte said that based on the experience with the first invoice, the Division anticipated that $800,000 to $1 million would be determined allowable by CMS for the second invoice and that amount would also be repaid to the Division. At that point, the remainder of the $3.4 million deferral would become a formal disallowance. The Clark County School District would then be required to repay the Division the remaining amount of the formal disallowance, because CMS had already withheld the $3.4 million from Title XIX funds. Mr. Duarte informed the Subcommittee that any future claims from the Clark County School District were suspended by CMS until the issue of the $5.5 million disallowance was completely resolved.

Senator Cegavske asked whether the Clark County School District was cooperating with the Division. Mr. Duarte replied that the school district had recently submitted data that would assist the Division in completing the revision of the $2.3 million invoice.

Chairwoman Leslie hoped that there was no resistance on the part of the Clark County School District, and she asked Mr. Duarte to advise the Subcommittee should the district balk at repayment. She pointed out that the violations that caused the problem were very obvious and flagrant, and she asked whether the underlying problems had been solved. She also asked whether there were other school districts involved.

Mr. Duarte said it was his sincere hope that the Clark County School District understood the findings by the Office of Inspector General. The school district had not disputed those findings, and Mr. Duarte assumed that the school district understood. Two other school districts had requested administrative expenditure claims, the Carson City School District and the Washoe County School District. However, the Division explained that it would not reestablish the program until the outstanding claims against the Clark County School District had been resolved. Mr. Duarte believed that the other school districts had been privy to the information regarding the audit and the problems with the claims.

Senator Cegavske referenced the performance indicators for BA 3158, and stated that she would like to have that information in a different format,

preferably one that contained numbers rather than percentages and was understandable. She asked that the Division work with either her or LCB staff to clarify those indicators.

Mr. Duarte said the Division was preparing a document that would be delivered to LCB Fiscal Analysis Division staff later in the week. That document provided the numerators and denominators associated with the percentages used in the performance indicators, so that legislators could clearly identify the information upon which the percentages were based.

Senator Cegavske said she was referring to whether the indicators pertained to Administration, or whether the subject matter could help the Subcommittee determine exactly what would occur in the budget. Mr. Duarte said he would be glad to work with LCB on that issue.

With no further questions or comments regarding BA 3158, Chairwoman Leslie closed the hearing, and opened the hearing on BA 3243.

HUMAN SERVICES
HCF&P—NEVADA MEDICAID, TITLE XIX (101-3243)
BUDGET PAGE HCF&P—13

Chairwoman Leslie asked about the General Fund shortfall in BA 3243. She noted that in January 2007 the Division advised LCB staff that the Disproportionate Share (DSH) payments for the Medicaid budget had been understated, which created a General Fund shortfall of approximately $9.6 million. She understood that the Division had determined a way to address that shortfall, and she asked Mr. Duarte for an explanation.

Mr. Duarte stated that the Division made an error in the amount necessary to pay hospitals under the DSH hospital program, and underfunded that program on the Medicaid payment side. The resolution to the shortfall involved working with the Division's actuary in setting reimbursements to health maintenance organizations (HMOs) to ascertain whether or not the Division could adjust its HMO inflation projections, which would affect Maintenance Unit 101 (M101). Mr. Duarte commented that the actuaries were able to identify the projections included in The Executive Budget that could be adjusted downward, resulting in a net savings that would address the shortfall and ensure that there was adequate funding for the DSH hospital program.

Chairwoman Leslie asked whether the Division's actuary agreed with reducing the inflation rate from 6.5 percent to 5.75 percent in FY 2007-08, and she asked what would happen in FY 2008-09. Mr. Duarte indicated that the actuary believed that the 6.5 percent was appropriate for FY 2008-09. The actuary believed it was too early to adjust that percentage. The other reason the Division was able to address the $9.6 million shortfall was because it was able to reduce its current fiscal year's inflation adjustment for HMO rates downward to 2.75 percent. Mr. Duarte said the downward adjustments had a compounding effect going into the next biennium, which helped the situation for FY 2008.

Chairwoman Leslie indicated that she understood what Mr. Duarte was saying, but the Legislature budgeted on a two-year cycle, and a decision would have to be made about the inflation rate for FY 2008-09. Mr. Duarte said he would talk to the Division's actuary again; however, past conversations indicated that the actuary felt the 6.5 inflation rate for FY 2008-09 was appropriate.

Chairwoman Leslie believed that the percentage should be revisited to ascertain whether further reductions in the inflation rate could be made in FY 2008-09. Mr. Duarte said he would be glad to review the inflation rate.

Chairwoman Leslie noted that the inflation rate recommended in The Executive Budget was higher than current medical inflation trends, which was why the Division was able to reduce the inflation rate for HMOs and address the General Fund shortfall. That rate adjustment reduced the costs for unit M101 by approximately $19.9 million.

Mr. Duarte said that increases within M101 dealt with pharmacy and a managed care program, Logisticare, which was the Division's transportation contractor. The Division worked diligently during early budget development to adjust its pharmacy inflation rate. Mr. Duarte believed that DHHS was using similar rates, which were based on the best available information. The Logisticare rate would have a relatively small impact on the budget, but Mr. Duarte said he could discuss the rates with the actuary to see whether there was room to maneuver on that inflation adjustment.

Chairwoman Leslie stated that the Subcommittee wanted to ensure that it had the best numbers when considering budgets, to compensate for the anticipated shortfall in the sales tax revenues. The Subcommittee had various ideas about how the State could provide more services to clients, but first it had to consider the shortfall. If the Division could save money by more accurately projecting medical inflation, that would assist the Subcommittee in its endeavors.

Mr. Duarte said the Division would be glad to attempt to adjust the projections downward, but he wanted to make sure that such action would not create a shortfall in the Division's budget.

Senator Mathews asked Mr. Duarte to discuss the physician rate increase and explain which physicians would receive the increase.

Mr. Duarte said the rate increase included in Enhancement Unit 425 (E425) affected not only physicians, but any licensed practitioner of the healing arts that billed the Division for services. That would include nurse practitioners, psychologists, and other providers. The rate increase would update the entire fee schedule for physician services. Mr. Duarte explained that there were several thousand procedures associated with the professional service fee schedule. The Division currently utilized a Medicare fee schedule based on the 2002 reimbursement rates. Mr. Duarte indicated that the Division proposed to significantly update the schedule and change the rates based on the 2007 Medicare fee schedule.

According to Mr. Duarte, there would be adjustments for specific code groupings, which would include groupings associated with services to individuals under the age of 21, and would affect surgery, obstetrics and gynecology, and radiology services. Those services were currently paid an enhanced rate for any individual under the age of 21. Mr. Duarte stated that the Division believed the overall upgrade would be budget-neutral to those specialties, and they would continue to bill an enhanced code for services provided to premature and low birthweight infants.

The net benefit of the proposed rate increase would be realized in the area of evaluation and management services. Mr. Duarte explained that those services

were rendered primarily at a physician's office. At the present time, those services were paid at 85 percent of the 2002 Medicare fee schedule. The Division proposed to increase that to 100 percent of the 2007 Medicare rate. Mr. Duarte indicated that the Division believed that more physicians in rural and northern Nevada would be willing to see more Medicaid patients in their offices and allow those patients to use the physician's office as their primary care physician. It was particularly important for individuals who were aged and disabled to have a primary care physician. Mr. Duarte said it was the hope of the Division that by increasing the reimbursement, particularly in the area of evaluation and management services, there would be more willingness on the part of providers to serve the Division's aged and disabled population, as well as mothers and children.

Senator Mathews said the pediatric group was of interest to her because of constituent concerns that pediatric groups had not had a raise in quite some time. She asked Mr. Duarte to explain the budget-neutral status, particularly for pediatric doctors.

Mr. Duarte stated that doctors providing basic pediatric care, which included community-based, primary care physicians, would realize a significant increase in reimbursement for office visits and medical procedures conducted in their offices. Mr. Duarte noted that the increase would be up to the 2007 Medicare rate. The Division believed that for the surgical and medical pediatric subspecialties, such as pediatric oncology, cardiology, and neurology, the rates would be budget-neutral. Mr. Duarte explained that many pediatric subspecialties provided services to extremely fragile and ill children and those doctors currently billed an enhanced code for services, which resulted in higher pay for services in pediatric subspecialties.

Senator Mathews referenced a constituent whose infant had undergone open heart surgery, and she asked for clarification of the term "budget-neutral." Mr. Duarte explained that surgeons currently received an enhanced rate for surgeries performed on children under the age of 21.

Senator Titus noted that the intent was to reimburse all physicians and medical professional providers with adjustments for place of service. She asked about doctors who did not maintain separate offices and whose practice was through a hospital.

Mr. Duarte said there was a separate fee schedule or adjustment for facility-based services, as opposed to community-based services, which was similar to the Medicare fee schedules.

Senator Titus asked whether those doctors would receive the enhanced reimbursement. Mr. Duarte replied that they would also receive the enhanced reimbursement.

Senator Titus pointed out that those doctors treated seriously ill children, and in many cases, they had not realized an increase in reimbursements. She asked whether those doctors would also fall into the increased reimbursement category. Mr. Duarte replied that the doctors who provided facility-based services for children under the age of 21 would be included in the increased reimbursement.

Assemblywoman Buckley believed that the Legislature had not taken sufficient action to keep pace with provider rate increases over the years, and the

proposal for discretionary rate increases in E425 appeared to be an attempt to try and make up for the years of neglect.

Ms. Buckley said she was worried about the sales tax figures for December, which were lower than projected, and the Legislature might have to address an unanticipated budget shortfall. Ms. Buckley asked what the Division perceived as the most important issues, and the area in which there was the greatest lack of access for current clients, should the Legislature determine that it was not able to approve the rate increase and was forced to prioritize budget items.

Mr. Duarte explained that the greatest issues affected the medical and surgical subspecialties. The Division had conducted surveys regarding access to care over the past two years, and it varied by region. In general, all medical and surgical subspecialties in which practitioners predominately served the aged and disabled populations were affected by the low reimbursement rates. Mr. Duarte said the Division saw greater impact in northern Nevada than in southern Nevada, but it was not isolated to northern or rural Nevada. In Clark County, the Division noted significant access issues in a number of clinical subspecialties.

Ms. Buckley asked Mr. Duarte to advise the Subcommittee how the Division would rank the discretionary rate increases requested in E425 in terms of budget priorities. Mr. Duarte said he would furnish that information to the Subcommittee. He noted that the provider rate increases were one of the highest priorities in the Division's budget, and he would like to see at least some of the increases retained in the budget. Mr. Duarte believed that the rates affected the Division's ability to better manage care in some of the other decision units.

Ms. Buckley said that she had no doubts that the Legislature would make progress on the budget shortfall, but she was asking where cuts might be made. Mr. Duarte said he would provide a list of the Division's budget priorities.

Ms. Buckley stated that the Subcommittee was aware that the aged and disabled category utilized the majority of the Medicaid budget, and the Subcommittee was hesitant to explore strict managed care because of possible cuts to the disabled community. The Legislature had always supported prevention and disease management as a way to help more individuals and, perhaps, cut costs so that additional funding was available for categories such as rate increases. Ms. Buckley asked what was included in the budget for better care management.

Mr. Duarte explained that there were two decision units in the budget associated with better care management. Care management and regional care coordination, E402, contained two parts. The Division would use its data systems to identify individuals who were high-risk, high-cost patients, primarily within the disabilities arena. These were not only high-cost patients, but individuals with conditions that were amenable to medical intervention that would improve the quality of life, while reducing the cost of care.

Mr. Duarte explained that the Division hoped to identify at least 4,000 individuals in the fee-for-service program who were high-risk, high-cost patients, and assign those patients to a care coordinator, such as a licensed professional nurse. The Division hoped to develop an appropriate care plan for those individuals through contract services and, most importantly, to assist the

primary provider in caring for the patient. Mr. Duarte remarked that quite often those patients arrived at a physician's office with multiple chronic conditions, which was the reason that many physicians refused to accept clients from the Division. It was very difficult to treat those individuals, particularly if they had a comorbidity of mental illness. A care coordinator could assist the physician and ensure that appropriate referrals and diagnostic procedures were being done, and make the individual's life easier in negotiating a very complex health care system.

Mr. Duarte noted that E402 proposed to develop the care management system and assign care coordinators to high-risk, high-cost patients. Additionally, the system would identify children in residential treatment facilities who were diagnosed with serious emotional problems. The Division hoped to prevent the "revolving door" cycle for those children of entering and reentering residential treatment centers and psychiatric hospitals. The Division hoped to address that issue by providing services in the community under an assigned care coordinator, which would benefit the children and also reduce costs for the Division.

According to Mr. Duarte, E400 proposed to develop a managed care pilot program. That pilot program would involve a specialized HMO, or special needs plan, to work with many of the Division's disabled clients on an elective basis, in which the client could determine whether or not to participate in the HMO program. Mr. Duarte said the Division believed there might be some attraction to such a program because HMO plans often offered enhanced benefits, such as adult dental services, as way to recruit patients. Care coordination would also be provided to those patients, which would help improve quality of life, along with reducing costs for the Division.

Mr. Duarte reported that E400 and E402 would result in net savings, with care coordination providing a more immediate savings, and the managed care pilot program providing a savings within a 24-month period. The Division's actuary estimated that 24 months was the amount of time it would take to repay the "claims tail," which was the fee-for-service payments for claims received by the Division during the phase when patients were moved to managed care programs.

Ms. Buckley asked whether there were savings built into the budget based on those two programs. Mr. Duarte replied that there was a net savings for care coordination of $3.5 million in General Funds in E402. There would be a net savings of $2.7 million in the managed care initiative, E400. However, Mr. Duarte cautioned the Committee that funding for the claims tail was built into M101 and M200 in the amount of approximately $12 million. He pointed out that there would not be a significant net savings over the upcoming biennium, but the programs would result in future savings.

Ms. Buckley commented that she was trying to see the entire picture. She stated that placing children in residential treatment and hospital programs had been a pet peeve of hers for quite some time. If therapeutic foster homes could be located for those children, it would not only save money in the foster care budget, but would also save money in the Division's budget. Because no one paid attention and coordinated the care of those children, their lives were being ruined and the State was spending a significant amount of money for regional treatment centers, which was not necessary. Ms. Buckley hoped that progress could be made in the area of programs to assist children.

Mr. Duarte said that, if the budget proposal was approved, the Division hoped to improve the treatment options for children.

Chairwoman Leslie asked Mr. Duarte to work with LCB staff and provide additional options for consideration by the Subcommittee. She noted that doctors who practiced in the field of obstetrics and gynecology (OBGYN) were actually reimbursed at 128 percent, while other practitioners were reimbursed at a lower percentage. Mr. Duarte said that was correct.

Chairwoman Leslie said the proposed mandatory and discretionary provider rate increases would reimburse physicians and other medical professionals at 100 percent of the 2007 Medicare schedule. Mr. Duarte said that was correct.

Chairwoman Leslie believed that the Subcommittee should consider other options, such as reimbursement rates under the 100 percent level. She asked whether OBGYNs would be held harmless should the rates increase.

Mr. Duarte stated that the Division had not conducted a specific study on each subspecialty, but he believed that OBGYNs and other subspecialty groups would probably remain budget-neutral because they were currently reimbursed at 128 percent of the 2002 Medicare schedule. Therefore, a change of reimbursement to 100 percent of the 2007 Medicare schedule might provide at most a small net benefit to those subspecialty groups,

Chairwoman Leslie believed that the Subcommittee needed additional information regarding the proposed discretionary rate increases in E425. She asked that Mr. Duarte review the options with LCB staff and ensure that the request would not inadvertently harm any group of medical providers. Mr. Duarte stated that he would comply with that request.

Chairwoman Leslie referenced Maintenance Unit 200 (M200), Medicaid caseloads. The Division was using a new Medicaid Payments Projection (MPP) model, and the Chairwoman asked Mr. Duarte to explain the new model. She also wondered whether the Division had conducted comparative testing between the old MPP model and the new MPP model. Chairwoman Leslie asked how confident the Division was about the accuracy of the new model.

Mr. Cates commented that the Division had not run comparisons between the two MPP models. The old model was a series of spreadsheets developed by staff over the years, and the Division had documented evidence of the old model being highly inaccurate, particularly in calculating the cost for eligibility. The only staff member who was trained on the old model left the Division, but it had taken that staff person one month working behind closed doors to produce the projection.

Mr. Cates indicated that the Division ran a statistical test for reasonableness on the current MPP model, and manually calculated costs of caseloads and cost of inflation to ensure that that the calculations from the model appeared reasonable. The Division also contacted an economics professors at the University of Nevada, Reno (UNR), who peer-reviewed the work and found the methodology to be sound. Mr. Cates stated that the Division continued to review and analyze the new MPP model for accuracy.

Chairwoman Leslie noted that Medicaid projections would be run again in April 2007, and she asked whether the Division would track the results from the new model against the old model at that time. Mr. Cates said the Division did

not intend to conduct further tracking on the old model. It was a staffing issue because it took one trained staff member, who was no longer with the Division, one month to run the old model. Mr. Cates advised the Subcommittee that at the present time there were no trained staff members who could run the old MPP.

Chairwoman Leslie asked how many employees were trained on the new MPP model, and Mr. Cates replied the Division planned to train two additional staff members.

Chairwoman Leslie commended the Division for introducing saving initiatives in its budget, and she referenced E251, Medicaid Estate Recovery (MER). The Division proposed to add five new administrative assistant positions to the MER unit, and the average recovery per case was anticipated to be $1,200.

Mr. Duarte said the issue was not the amount recovered per case, but rather the caseload itself. In 2006 the Division identified 4,652 cases that could be reviewed, but the review was limited to only those individuals over 55 years of age, which reduced the number to 2,066. Of those 2,066 cases, the Division was only able to review 1,500 cases. Mr. Duarte said the number of cases reviewed fell from 4,652 to 1,500 because of the lack of staff. Estate recovery was an administrative function, and with the proposed five staff positions, the Division believed it could review the entire range of cases of deceased individuals who had recoverable assets that could be used to repay a portion of their medical costs. It was a matter of ensuring that the Division had a sufficient number of staff to conduct those case reviews.

Senator Cegavske asked how the Division was currently addressing that caseload. Mr. Duarte said that three staff members from the Compliance Unit were currently assigned to that caseload.

Chairwoman Leslie pointed out that in order to review additional cases, the Division needed additional staff. Mr. Duarte stated that was correct.

Senator Cegavske asked whether the requested positions were the same classification as the persons currently reviewing the caseload. Mr. Duarte replied that the positions were all administrative assistant positions.

Chairwoman Leslie referred to the fact that the average recovery was $1,200, and she hoped that the Division was not causing families additional grief in the recovery of those funds. The Chairwoman commented that there were undoubtedly cases in which the Division could appropriately recover more than $1,200, and she asked whether there was a way to prioritize the cases to determine the cases in which the Division might recover more than $1,200.

Mr. Duarte said he would have to consult with staff to determine whether there was a way, without additional personnel in place, to review cases and determine the potential for collecting more dollars from one case than another. Mr. Duarte agreed that that the average amount always appeared to be very small. He explained that the Division would often apply a lien to a client's home when there was a bona fide sale pending and there was no living spouse, and the opportunity for recovery in those cases was quite significant. He said he would discuss the issue with staff to ascertain whether there was opportunity to pre-screen the MER cases.

Chairwoman Leslie asked whether the Division currently screened cases. Mr. Duarte replied that the Division screened cases, but only those cases involving clients over the age of 55 because there was greater opportunity for recovery in those cases.

Senator Cegavske asked about the number of cases that the Division currently had under MER review. Mr. Duarte explained that each staff member maintained approximately 600 case files, and cases were opened and closed on an ongoing basis.

Senator Cegavske wondered whether each case handled by the existing three staff members had estates from which reimbursements could be made. Mr. Duarte replied that was correct. Mr. Duarte explained that there were many additional cases that the Division failed to review because of the lack of staff.

Chairwoman Leslie referenced Enhancement Unit 254 (E254), Surveillance and Utilization Review (SUR). The Executive Budget recommended seven new positions for the SUR Unit, and Chairwoman Leslie asked Mr. Duarte to explain the need for those positions.

Mr. Duarte explained that when the Division looked at several other states, it became apparent that programs of similar size, or slightly larger, than Nevada's Medicaid program, had very significant staffing components for the SUR teams. The SUR Unit was a mandatory federal service that involved retrospective review of claims payments, the identification of inappropriate payments and potential fraud, and also involved recovery. Mr. Duarte said one of the more important functions was actually provider education to ensure that inappropriate claims did not occur on an ongoing basis. The opportunity for recovery was significant, and Mr. Duarte noted that the federal Government Accountability Office (GAO) estimated that between 3 percent and 10 percent of Medicaid payments were fraudulent.

Mr. Duarte explained that the Division had been very conservative in the savings estimates provided in the budget, and it was simply a "numbers game" in terms of staffing. Currently, the Division had one team that reviewed claims, and those team members were often diverted to other duties, such as review of personal care agencies.

According to Mr. Duarte, the Division intended to create investigative teams to review a broad array of provider types. The teams would access data from the Decision Support System (DSS), which included quality information from which staff could review the relationships between providers and inappropriate billing by providers. Hopefully, staff could then identify opportunities for recovery and referral to the Medicaid Fraud Control Unit, which was the prosecutorial arm located in Attorney General's (AG's) Office.

Chairwoman Leslie stated that she fully agreed with the concept of identifying fraud, but she wondered how the number of seven new positions was determined as the optimum number of new staff.

Mr. Duarte explained that the Division had reviewed programs in other states that included significant staffing components, such as Georgia and New Hampshire, which both had programs similar in size to Nevada. He explained that New Hampshire had eight staff members that were organized into investigatory teams. The Division wanted to add two additional teams to the existing team, and add a supervisory position to the unit to oversee those

investigative teams. Mr. Duarte said the number of new positions were determined through comparison with programs in states of similar size to Nevada. He noted that New Hampshire and Georgia had been able to increase recoveries to a significant level through additional staff.

Chairwoman Leslie indicated that the positions appeared to be management analysts and auditors, and she asked whether staff needed medical knowledge or other training. Mr. Duarte said that the Division would work with LCB staff regarding the positions. Originally, the concept was designed to include a health care coordinator, which would be a licensed nurse who had medical knowledge. However, because the Division had experienced difficulty in recruiting nurses, it became an auditor position. Mr. Duarte pointed out that the positions of auditor and health coordinator would be budget-neutral, as they were the same grade levels.

Chairwoman Leslie asked whether there was a way to add staff on a smaller scale. Mr. Duarte noted that the Division planned to stagger the hire dates for the positions, and wanted to put one new team in place by October 2007, with the second team in place by March 2008. The Division could certainly look at the early success of the first team to ascertain whether a second team was justified. Mr. Duarte explained that quite often Medicaid fraud cases took a significant amount of time to investigate and review, and he did not want to limit the amount of time in which to judge the success or failure of the approach. He reiterated that the approach was used nationwide.

Senator Cegavske asked whether a SUR investigation took place after a claim and a complaint had been filed and whether there was any oversight when the claims were filed.

Mr. Duarte said there were four functions, the first being the post-payment review of claims, which was not based on complaints. The Division hoped to conduct post-payment review of claims on a wider scale. The current limited staff of the SUR Unit focused only on certain provider types.

Senator Cegavske asked whether additional staff would have helped identify the situation in the Clark County School District prior to submitting claims. Mr. Duarte replied that was correct. He noted that the problem in Clark County was with administrative claims, but there had also been problems with some of the school district's therapy service claims. The SUR Unit was involved in the review of those claims in 2001 and 2002.

Mr. Duarte stated that the second SUR function was verification of service. He explained that the Division sent out letters to clients to make sure that they were actually served.

Senator Cegavske asked whether that was an issue. Mr. Duarte said the Division often did not have sufficient staff to respond to all complaints relating to service verification. Quite often it was simply a misunderstanding between the patient and provider that led to a follow-up by the Division.

Mr. Duarte explained that another SUR function was review of ownership disclosure. That was when a provider applied or submitted a change in ownership. Ownership review was also done on an ongoing basis to ensure that the owner remained the same and that the Division had active documentation, which was mandatory.

Mr. Duarte said the final SUR activity was cooperation with the prosecutorial arm, which was the Medicaid Fraud Control Unit of the AG's Office. The Division cooperated with and referred information to the AG's Office.

In response to a question from Senator Cegavske concerning the Clark County School District case, Mr. Duarte said he could not discuss cases that had been referred to the AG's office.

Chairwoman Leslie referenced E277, Clinical Claims Editor, and asked Mr. Duarte to provide explanation of the software purchase.

Mr. Duarte indicated that the clinical claims editor was a software application that would provide an array of almost one million different edits from which the Division could select. Those were pre-payment or pre-adjudication edits that would be applied to the Division's Medicaid Management Information System (MMIS). According to Mr. Duarte, the software would be the "front end" of the MMIS, and when claims were received, the Division could conduct an enhanced review of those claims to ensure that they contained correct information and that they included no incorrect billing activities. For example, the bundling and unbundling of laboratory diagnostic services was a significant issue for physician's offices, as well as clinical laboratories, and the clinical claims editor system would screen claims to ensure that the claims documentation was appropriate. Mr. Duarte said the program also was able to unbundle and re-bundle claims in a less costly manner.

Chairwoman Leslie asked whether the software would slow the provider claims process. Mr. Duarte said that it could initially slow claims adjudication, but only for those claims in which there was a lack of information or there was inappropriate billing activity, which would result in the claim being rejected by the system. Mr. Duarte explained that implementation of the system would be made through a phased, systematic approach to avoid upsetting the provider community. The Division would select specific provider categories and work with those providers in conducting "soft edits" rather than commencing with "hard edits."

Assemblyman Denis asked whether the clinical claims editor system was an off-the-shelf product. Mr. Duarte replied that was correct. He explained that it was an off-the-shelf product that was utilized by many Medicaid agencies, as well as commercial insurance companies.

Mr. Denis asked whether the system would be set up for the Division by the vendor. Mr. Duarte indicated that the vendor would work with the Division to determine what edits it would use during the soft edit phase. The Division would hold joint application and design sessions with vendor staff, and implementation by Division staff would require a significant time commitment of six to eight months.

Mr. Denis asked about the positions discussed earlier that would work with the Division's databases, and he wondered whether those positions could also work with the clinical claims editor system. Mr. Duarte stated that joint application design of the system would use almost all the Division's program staff, as well as its fiscal staff.

Mr. Denis asked about the maintenance of the system, and Mr. Duarte reported that the maintenance would be conducted by the commercial vendor who

installed the system. He indicated that the Division would utilize the request for proposal (RFP) process to select a vendor.

Chairwoman Leslie asked Mr. Duarte to address E400, Managed Care for the Aged, Blind, and Disabled. She noted that E400 required a state plan amendment, which would require approval of CMS. Mr. Duarte stated that was correct. Chairwoman Leslie pointed out that the Division had not been successful during the past two years in securing CMS approval in a timely manner.

Mr. Duarte agreed that CMS approval had been an issue in the past, but the Division hoped that the proposed amendment would not require extensive review. The managed care pilot program would be an optional program service offered by Division to recipients; it was not a mandatory program. Mr. Duarte noted that CMS might have greater concern over a mandatory managed care program, particularly for the aged and disabled population.

Chairwoman Leslie asked whether the Division had contacted CMS regarding the pilot program. Mr. Duarte replied that the Division had not contacted CMS. Chairwoman Leslie asked that the Division initiate contact with CMS to determine whether the pilot program would be acceptable. Mr. Duarte said he would contact CMS.

Chairwoman Leslie asked whether it was the Division's intent to use the current managed care networks that provided services to the Child Health Assurance Program (CHAP) and Temporary Assistance to Needy Families (TANF) program to facilitate the pilot program, or would the Division use the RFP process.

Mr. Duarte reported that the Division anticipated using the RFP process to search for a specialized managed care plan that dealt with the aged and disabled population. The providers for the CHAP and TANF programs might apply, and the Division would evaluate those providers the same as others regarding the criteria established during the RFP process. Mr. Duarte noted that providers would be required to meet special needs requirements to ensure they could provide the necessary care management and care coordination for the aged and disabled populations.

Chairwoman Leslie asked about the capitation rate structure and the possibility that the voluntary program would pre-select recipients who were not representative of the overall health problems of the disabled and aged populations.

Mr. Duarte said that might be an issue, and adverse selection would be the opposite of that situation. He indicated that the Division would attempt to manage the population of the pilot program. However, the pilot program was voluntary and the choice was made by the recipient not the provider. Mr. Duarte said the Division would also preclude active marketing of the program by the vendor.

Chairwoman Leslie asked how a client would determine which program would best serve their interests. Mr. Duarte replied that the Division would provide information to the client at the time of enrollment and to other clients in the community. It would be incumbent on the Division to provide information regarding the plan offering, as well as any enhanced benefits that clients might realize from the program. Mr. Duarte stated that the Division hoped there would be a reasonable selection of clients that were representative of the

overall population. The Division would attempt to structure its outreach and informational activities to provide a representative population, but it could not guarantee that the participants would not represent either an adverse or a relatively healthy population.

Chairwoman Leslie asked whether the actuary, after reviewing the pilot project, believed that the pilot project would generate a General Fund savings of approximately $2.5 million over the upcoming biennium. Mr. Duarte stated that was correct, and that amount was based on national data. Mr. Duarte explained that the actuary reviewed managed care initiatives for the aged and blind population throughout the nation, and the indication was that the savings ranged from 3 percent to 18 percent of the fee-for-service Medicaid costs. Mr. Duarte assured the Subcommittee that the Division was very conservative in its estimates of approximately 7.5 percent savings per year over the fee-for-service costs, and the Division's actuary agreed that the savings were reasonable.

Chairwoman Leslie noted that LCB staff might have more detailed questions as the Subcommittee worked through the budget, and Mr. Duarte stated that he would work with LCB staff.

Regarding E402, Care Management and Regional Care Coordination, Chairwoman Leslie noted that The Executive Budget estimated a General Fund savings of approximately $3.5 million in E402. The Subcommittee did not have sufficient detail regarding E402, and she asked Mr. Duarte for information regarding how the Division would target the recipients in the program, and how services would be managed to equal the General Fund savings.

Mr. Duarte stated that the Division used stratification criteria to develop the concept. The program was based on the experience of the Division's fiscal agents with other states, which did not mean that the Division would use the same stratification criteria to identify individuals for the program, but only that the criteria was used by the Division in the development of E402. According to Mr. Duarte, the establishment of a care management and regional care coordination program would be conducted through the RFP process, and the Division might modify the criteria for selection as it worked with the approved vendor.

Chairwoman Leslie asked whether the programs in other states had additional services available that would not be available in Nevada's program. Mr. Duarte pointed out that other states also struggled with access to care. He referenced programs such as those offered by Medicare and other state Medicaid agencies and pointed out that those programs usually paid the lowest provider rates in the state. The program would tie into the physician rate increases that were previously discussed, because in order to coordinate care, the client had to have a primary care physician.

Chairwoman Leslie asked what would occur if clients did not want their services managed. Mr. Duarte stated that clients would be offered the opportunity to opt out of the program.

Chairwoman Leslie believed that the Subcommittee needed additional details about the program, and Mr. Duarte stated that he would provide the requested information.

The final savings initiative was E403, Dental Benefits for Pregnant Women. Chairwoman Leslie asked what benefits would be available for women after the birth of a child.

Mr. Duarte said that E403 also included a quality-of-life issue. The Division could have a potential impact on full-term births by offering dental care, such as periodontal scaling and other preventative procedures to pregnant women. It was not simply a matter of saving money, but rather was a quality-of-life issue for the mother and infant.

Chairwoman Leslie said she was not questioning that women needed the service, but her point was that dental care was not offered to women who were not pregnant. Mr. Duarte said that was correct.

Senator Cegavske asked whether the Division used the services of the University of Nevada, Las Vegas (UNLV), School of Dental Medicine, not only for pregnant women, but also for other clients. The dental school at UNLV provided services, and she wondered whether the Division worked with the school in the establishment of programs, which would result in cost savings to the State.

Mr. Duarte said that the Division could talk with the dental school. He noted that the Division did a significant amount of work with the dental school, which provided services to the Division's HMO clients and also provided orthodontia care to children in Clark County.

Senator Cegavske asked whether dental school services could be extended to include pregnant women. Mr. Duarte explained that the dental school had access issues in terms of the ability to serve additional clients. The Division had been more successful in opening its Medicaid managed care plans to community dentists, particularly in Clark County, where the dentists were very interested in serving the Division's clients. The Division had been able to significantly increase dental care for children in the Nevada Check-Up program by opening the programs to private dentists rather than exclusively using the dental school. Mr. Duarte assured the Subcommittee that the Division would talk to the school about dental care for pregnant women, but he did not want to limit the Division's provider network of the dental school.

Senator Cegavske pointed out that use of the dental school would be another avenue that resulted in cost savings to the State. She pointed out that after a woman's baby was born the mother lost her dental coverage, and if a program was available through the dental school, new mothers might be able to continue their care.

Senator Cegavske asked about the total number of pregnant women served by the program. Mr. Duarte said the estimated number of pregnant women needing treatment for FY 2007 was 1,800. That number was based on percentages from studies by the American Academy of Periodontology.

Chairwoman Leslie said she was frustrated with the program because dental service would cease once a woman's child was born. She noted that the Division had addressed dental care for adult patients in its budget. However, at the present time, the only care available to Medicaid patients was emergency dental care. Mr. Duarte explained that emergency care was for adults and individuals over the age of 21, and institutionalized individuals also received some dental services.

Assemblywoman Gansert noted that the Health Access Washoe County (HAWC) clinic in northern Nevada provided dental services to adults. Mr. Duarte stated that the HAWC clinic was a federally-qualified health center that served not only Medicaid clients, but other clients without insurance using a sliding fee scale. Mr. Duarte believed that the dental chairs at the HAWC clinic were full because of the significant demand for services.

Mrs. Gansert asked whether a similar clinic existed in other areas of the State. Mr. Duarte replied that the Nevada Health Centers, Inc. had a number of clinics throughout Nevada. Nevada Health Centers was limited in the number of dental patients that could be served, but it did provide dental care to Medicaid clients and uninsured clients using a sliding fee scale.

Mrs. Gansert said it appeared there was access to dental care, but the Division was targeting only pregnant woman in E403 for a General Funds savings over the biennium. Mr. Duarte advised Mrs. Gansert that the Northern Nevada Dental Society operated a free care program, in which volunteer dentists provided free services. The Society received referrals from the northern Nevada area and served a significant number of children.

Chairwoman Leslie commented that she had been present at the HAWC clinic on dental care day, and she was surprised by the number of persons served. The Washoe County Drug Court program often referred persons who were addicted to methamphetamine to the HAWC clinic. Chairwoman Leslie pointed out that it was often very difficult for some persons to find dental care in the "real world." Northern Nevada was very grateful for the HAWC clinic and other charitable programs that provided dental care, but it simply was not enough.

Senator Cegavske asked whether there were charges or co-payments for pregnant women for dental care under E403. Mr. Duarte said there would be no copayments or other charges under E403, and pregnant women would receive standard Medicaid dental benefits.

Senator Cegavske asked whether that was for routine care and check-ups. Mr. Duarte stated that was correct. The Division was attempting to provide periodontal care to pregnant women and such care would include a screening process between dentists and periodontists. The benefits would be realized when pregnant women received gum care because the prevention of gum infection could lead to a significant reduction in pre-term births.

Senator Cegavske asked how many of the pregnant women in the program would receive dental care. Mr. Duarte estimated that approximately 186 women would receive dental care. The Division further anticipated that dental care would lead to an additional 15 percent of the 186 women carrying their baby to term. That was sufficient for the Division to realize a significant savings. Mr. Duarte said the Division was very conservative on the utilization rates and on the success rate under E403. There would also be other activities in cases in which women were at-risk for pre-term births through case managers. Mr. Duarte said the Division anticipated that through the case managers, pregnant women with gum disease would be referred to periodontists.

Senator Cegavske asked how long pregnant women would receive dental care. Mr. Duarte pointed that it would depend on when a woman applied for Medicaid, which usually occurred toward the end of their second trimester.

The studies on the benefit of preventative dental care included women during all phases of pregnancy, so providing dental services as late as the third trimester had been successful in ensuring full-term births.

Senator Cegavske said she was asking how long it would take a pregnant woman to actually receive services. Mr. Duarte said it would probably be a matter of weeks. The Welfare Division maintained a 45-day standard for review of eligibility, but the benefits offered in E403 usually had a 10-day eligibility review.

Chairwoman Leslie referenced the new initiatives to expand coverage and services included in The Executive Budget. The first was E404, the Health Insurance for Work Advancement program (HIWA), and the recommendation was to eliminate the unearned income limit. She asked Mr. Duarte why that unearned income limit had been such an impediment for the program.

Mr. Duarte explained that the unearned income limit at the present time was $699, and there was a very small gap between what people were currently earning under Supplemental Security Income (SSI) and that limit. That left a very small population that potentially would be eligible to retain their Medicaid benefits and return to work. The Division believed that by eliminating the unearned income limit, it could target a much larger population of potential eligibles who wanted to return to work, but also needed to retain their Medicaid benefits. Chairwoman Leslie commented that the Legislature wanted the program to be utilized.

Ms. Wherry said the Division considered whether changes to the program could be addressed administratively based on caseload volume because the funding had been budgeted by the 2005 Session. However, the Division was hesitant to override an intent that was not supported legislatively. The Division based its projections on national experience since 1999 when the Ticket to Work Act was passed. Ms. Wherry indicated that the Division under-projected the number of people it believed would access HIWA, based on the total number of people in Nevada currently collecting SSI or Supplemental Security Disability Income (SSDI) benefits, and the percentage that could potentially apply based on national averages. Ms. Wherry stated that nationally, HIWA was a very under-utilized program that had not met with the success expected by Congress.

Chairwoman Leslie asked whether other states were taking the same approach of eliminating the unearned income limit. Ms. Wherry indicated that many states did not have an unearned income requirement, and many states had disregards other than income. She pointed out that Nevada had a very generous disregard package, but the biggest problem was the unearned income limit.

Chairwoman Leslie referred to E408, for persons with traumatic brain injury and physical disabilities, which was included in The Executive Budget and would commence in the second year of the biennium. She asked what information was used in determining the number of recommended slots.

Mr. Duarte said the information was supplied by from the Division's community service providers. The Division asked the providers what the caseload would be if the Division added residential habilitation and behavioral adult daycare services to the traumatic brain injury waiver. The response from the providers

was that 45 slots could be developed, 30 for residential habilitation and 15 for adult daycare services.

Chairwoman Leslie asked whether the Division anticipated savings from returning out-of-state patients to Nevada. Mr. Duarte replied that the Division did not calculate any savings associated with E408. Chairwoman Leslie asked Mr. Duarte whether that might be a possibility. Mr. Duarte believed that the Division was paying fairly low rates for its current out-of-state placements. There were many reasons to bring people closer to home, but Mr. Duarte did not believe there would be budget savings associated with returning patients to Nevada.

Chairwoman Leslie noted that there might not be a budget savings, but for many people, the program would make a huge difference. Mr. Duarte explained that many persons currently housed out-of-state were at the institutional level of care, and E408 addressed a community-based program.

Regarding E405, Children Aging out of Foster Care, Chairwoman Leslie noted that The Executive Budget recommended approximately $202,000 over the biennium to continue providing Medicaid coverage to those young adults from 18 to 21 years of age who had left foster care. She asked whether the funding would continue to be included in the budget as an ongoing expense. Mr. Duarte replied that was correct.

Mr. Duarte explained that the 2005 Legislature had authored a Letter of Intent for the provision to sunset, and suggested that the Division return to the 2007 Legislature and request the funding through an enhancement unit.

Chairwoman Leslie asked whether children were taking advantage of the program. Mr. Duarte explained that county social service agencies and the Division of Child and Family Services (DCFS) had been working on the program for some time. He was not aware of how the program was being promoted, but DCFS was trying to ensure that caseworkers were aware of the program and were informing their clients. Mr. Duarte stated there were only 51 clients currently in the program, and he assumed that it was being underutilized because there were many more children aging out of foster care. Past fiscal projections were based on a much larger number of children aging out of the system.

Assemblywoman Buckley asked whether the State had considered an automatic enrollment program because the children were already on Medicaid. Mr. Duarte said the Division could certainly look at that as an option for the program.

Chairwoman Leslie agreed that auto-enrollment was a very good idea. Mr. Duarte advised the Subcommittee that there would be a cost associated with auto-enrollment, and Chairwoman Leslie asked him to determine the cost and report back to the Subcommittee.

Chairwoman Leslie referenced the positions requested in E255 and E275 and noted that LCB staff would discuss those positions with the Division. Regarding the social services chief requested in E410, Chairwoman Leslie asked for additional information to support that request.

Mr. Duarte commented that the Division's responsibilities for oversight of the State's home-based and community-based Medicaid waiver programs had increased. The Division utilized staff from the physical disabilities program to

provide oversight, which placed a burden on that program's staff. Mr. Duarte said increased federal responsibilities had also been passed down to the State. He indicated that Ms. Wherry could address the E410 request for staff.

Chairwoman Leslie asked whether the positions were only for the physically disabled waiver or for all waiver programs. Ms. Wherry replied that three staff positions applied to all waiver programs and two staff positions applied to the physically disabled waiver program.

Ms. Wherry explained that the Division had conducted a time study based on how many hours it took to conduct an annual review for the five waiver programs. The Division was responsible for conducting an annual review, such as program and fiscal reviews, and responsible for generating a CMS-372 report for the federal government that proved cost neutrality. In addition, the federal government had added a new requirement for an evidentiary response for every waiver. Ms. Wherry noted that as waiver programs came up for renewal, there was a very intense review, above the level of the annual review, of every process that took place in the waiver program. Ms. Wherry said that included the process for determining eligibility, the process for connecting a client to services, and the process for clients to maintain services and remain out of institutional care. Ms. Wherry explained that corrective action plans were usually the result of those extremely intensive reviews.

Ms. Wherry noted that corrective action plans could also result from each annual review. The Division recently cancelled the annual review of the WIN waiver because the Division had not addressed the corrective action plans from the last three waiver reviews. Ms. Wherry emphasized that the Division simply did not have sufficient resources. She noted that each time a waiver was renewed CMS came out with a new waiver template, which included requirements for quality strategies that the states were expected to initiate and continue to monitor, while continuing to report to CMS.

Chairwoman Leslie asked that the Division provide the specifics to LCB staff, so that the Subcommittee could make a better judgment about adding four positions along with a chief position in E410. The Subcommittee needed to see the relationship between the federal requirements and the need for the additional positions to accommodate those requirements. Ms. Wherry stated that she would provide the requested information.

Chairwoman Leslie put the Division on notice that the Subcommittee was very concerned about the change in the Division's policy on training. It appeared that the Division was considering payment for continuing education for professional staff with State funding, and there was a long-standing legislative policy against that action. Chairwoman Leslie stated that the Subcommittee did not want to set a precedent by allowing the Division to take such action and thereby create a significant statewide impact. She asked why the Division requested state funding for training.

Mr. Duarte explained that the Division believed that training and registration costs for continuing education courses for professional staff required as part of maintaining their licenses or certifications was an important retention and recruitment strategy, particularly for licensed professionals. The requirement to have those persons retain their own certification at their own cost was an impediment, particularly when other state agencies and the private sector paid those costs for employees. Mr. Duarte said the Division believed it would be beneficial, in the long-term, for recruitment and retention.

Chairwoman Leslie stated that the Subcommittee would require very specific information regarding E252 pertaining to training and payment of continuing education costs for professional staff. That information should include which positions and classifications would fall under the provision, and what the benefit would be for the State before the request went forward.

With no further testimony to come before the Subcommittee regarding BA 3243, Nevada Medicaid, the Chairwoman declared the hearing closed.

Chairwoman Leslie opened the public testimony portion of the Agenda regarding BA 3158, HCF&P and BA 3243, Nevada Medicaid. The Chairwoman recognized Judge Doherty.

Frances Doherty, District Judge, Second Judicial District Court, Family Division, introduced herself to the Subcommittee. Judge Doherty stated that she would discuss the challenges facing the Family Court with respect primarily to elderly individuals who were declared wards of the court. The court recognized that the problem affected individuals who were suffering from dementia or related behavioral challenges that were not specifically categorized as mental illness and, therefore, were not able to access services through the various mental health entities.

Judge Doherty noted that as a district court judge, her responsibility under the guardianship law was to approve the placement of individuals who were wards of the Second Judicial District Court. Of course, those wards did not physically appear before the court many times because of their health challenges. The court had the responsibility of determining the type of placement for the individual, and whether that placement was appropriate and in the person's best interest.

Judge Doherty said that everyone recognized the need to keep family members at home and under the care of family, and that challenges were greater for those individuals who did not have access to either a home with caring relatives or a facility that was able to address their health care needs. Many persons acted out behaviorally and suffered from dementia or dementia-like health problems. Judge Doherty stated that Nevada maintained a list of between 80 to 100 individuals who, at any given point in time, were transferred to out-of-state placements because they could not be cared for at home.

According to Judge Doherty, there were cases in which she had to approve placements for individuals in Louisiana, Massachusetts, Idaho, Utah, and Texas. The State maintained no realistic connection to those individuals and did not know whether or not their needs were being met, other than through the efforts of people who had the responsibility to attempt to check on the those individuals.

Judge Doherty opined that guardians, relatives, and wards were disconnected. The court today, as it did one year ago today, had wards that died while in out-of-state placements, and those wards were disconnected from family, home, and friends, and were ultimately buried in the state in which they died. Judge Doherty believed that individuals were being moved to out-of-state programs, who could otherwise be cared for in Nevada, and the court had attempted to develop solutions in that regard.

Judge Doherty referenced a case in which the individual, Curtis, died one year ago while in an out-of-state placement. Curtis was a ward of the Second Judicial District Court, and after his death, Judge Doherty created a task force to address the needs of elderly individuals who were placed in out-of-state facilities, along with others placed out-of-state based on untreated mental health conditions. The task force included members from guardian services, members from the community, members from the Senior Law Project, representatives from skilled nursing facilities, and members from advocacy groups, many of whom had strategized, not only during the past year, but for the past ten years, about the issue.

Judge Doherty said there was a menu of options with which the court hoped the Legislature could assist, and members of the task force would address the various areas. Judge Doherty introduced Ernie Nielsen, attorney from the Washoe County Senior Law Project, who served many of the clients identified in the court's work.

Mr. Nielsen explained that he would briefly review the five areas that were the focus of the task force. The task force realized that a combination of effort was needed to end the tide of out-of-state placements. There were 80 to 100 Medicaid-funded cases in out-of-state placements, and probably many other out-of-state placements funded by family members.

Mr. Nielsen noted that the first issue addressed by the task force was review of a mechanism similar to the Program of Assertive Community Treatment (PACT) utilized by the Division of Mental Health and Developmental Services, in which a team of persons would be involved with the client as the client transitioned from acute care to long-term care. Utilizing such a mechanism would allow the team to provide pertinent information to the receiving skilled nursing facility about a particular client, and would also increase the facility's skills with behaviorally challenged clients.

Mr. Nielsen estimated the proposed PACT team model would cost approximately $350,000 per year. The task force believed that PACT teams were an essential part of its overall strategy.

Secondly, Mr. Nielsen said, the task force had been in contact with a number of skilled nursing facilities in Nevada and the rest of the country, seeking to discover what it would take for facilities to build, lease, or develop additional capacity as regional nursing home facilities for clients with behavioral issues. Mr. Nielsen explained that the additional capacity could facilitate transfer of clients that nursing homes felt unable to deal with because of their behavioral issues. The task force believed existing nursing homes would be more willing to accept elderly residents if there was an alternative available should clients present challenges that went beyond the capabilities of nursing home staff.

Chairwoman Leslie asked whether the aforementioned five areas addressed by the task force were included in written format as an exhibit. Judge Doherty said no, but offered the following explanation of the five recommended areas for improved services developed by the task force.

1. Increase the payment rate for skilled nursing home facilities to address and assist behaviorally challenged individuals. The appropriate higher rate had been identified and would allow the court to utilize in-state facilities.
2. Provide funding to support two PACT teams to intervene with providers and assist them with the placement of behaviorally challenged individuals

in facilities. Those teams would train staff and interact with the ward of the court and maintain a presence at the facility until the ward's behavior had been controlled. Many times the clients sent out of state by the court were stabilized but were unable to return to Nevada. Stabilization of the behavior was a key component and a luxury not accessible to the court at the present time. It was hoped the PACT teams would assist in that endeavor.

3. Identify waiver programs for individuals who could eventually transition to group home placements. The court needed a Nevada Medicaid waiver to access the funding for a group home environment for those individuals.
4. Provide one-shot funding to recruit entities to address the need for transitional and acute care. For approximately ten years, the court had been attempting to recruit institutions to provide transitional and acute care for individuals whose behavioral challenges had escalated. The court did not have access to facilities to stabilize the behavior of those individuals.
5. Create state-recognized care facilities for elderly patients who become wards of the court through the Division of Mental Health and Developmental Services. Currently, the Division did not provide services to wards of the court who suffered from dementia. Therefore, clients who were declared wards of the court often ended up in jails or hospitals, or were placed out-of-state when Nevada's skilled facilities could not accommodate those wards.

Chairwoman Leslie thanked Judge Doherty for providing the frame work and asked her to expand on the fourth issue.

Judge Doherty stated that approximately ten years ago, long before the existence of the task force, efforts were made to recruit facilities that were skilled in the area of working with behaviorally challenged individuals, particularly the elderly. At that time, not many institutions inquired about the possibility of building a facility in Nevada to address the needs of behaviorally challenged individuals. Judge Doherty indicated that Nevada needed some type of incentive program to recruit those types of institutions.

Chairwoman Leslie asked Mr. Nielsen to continue his presentation. Mr. Nielsen stated that his presentation was complete, and Mr. Perry would present testimony about the payment rates, which would cost approximately $3 million over the biennium. Mr. Nielsen indicated that the rates were on the list entitled "Items for Special Consideration," which depicted items not included in The Executive Budget.

Chairwoman Leslie asked whether rates were the only issue contained in the "Items for Special Consideration" list. Mr. Nielsen stated that was correct. Chairwoman Leslie asked whether that was the number one priority of the task force, and Mr. Nielsen stated that was correct.

Judge Doherty introduced Connie McMullen to the Subcommittee.

Ms. McMullen, Chairman, Senior Services Strategic Plan Accountability Committee (SPAC), informed the Subcommittee that she was present to testify in support of the proposed Enhancement Unit 428 (E428), Nursing Home Rates, on the "Items for Special Consideration" list (Exhibit D).

The strategic plan for seniors, which was completed in 2002, called for both integrated and segregated living options for Nevada seniors with Alzheimer's disease and related cognitive impairments. Ms. McMullen stated one goal was that by June 30, 2010, there would be no Nevada seniors with Alzheimer's disease living in out-of-state institutions. Five years later, Nevada still had the same number of seniors in out-of-state placements, and despite the efforts of Nevada Medicaid, the numbers remained the same. Ms. McMullen indicated that there had been no advancement in the strategic plan to resolve the issue.

Ms. McMullen commented that HCF&P provided funding to house seniors in out-of-state placements, and Mr. Duarte had commented earlier that it was actually less costly to place persons out-of-state. Ms. McMullen believed that if out-of-state placements were limited in the first place, that would be a benefit in the long run. Many decisions regarding out-of-state placements were made because Nevada nursing homes would not accept seniors who were behaviorally challenged.

In February 2003, HCF&P issued a RFP and received seven responses for senior care, but nothing came of those responses. Ms. McMullen indicated that the Division then created an incentive to entice providers, and in 2004 the proposed nursing home payment rate to support behavioral health, E428, was developed following a survey of approximately ten western states about their Medicaid reimbursement policy.

Ms. McMullen stated that the rate negotiated by Medicaid and the Nevada Health Care Association, along with other interested parties, was $261.29 per day in addition to the existing rate of $164 per day, for nursing home reimbursement in Nevada.

According to Ms. McMullen, in 2005 a state plan amendment that described rate settings for new free-standing nursing facilities was developed for behaviorally challenged elderly clients. In 2006 that state plan amendment was approved by the Centers for Medicare and Medicaid Services (CMS). Ms. McMullen said that a year later, the Task Force on Guardianship and Out-of-State Placements of the Second Judicial District Family Court convened. The prevailing concern of the task force was that the practice of out-of-state placement for elderly clients with behavioral challenges continued to grow, and the State moved further away from resolving the problem with each legislative session.

Ms. McMullen commented that Nevada nursing homes were losing the capacity to care for the elderly behaviorally challenged population, and was shifting that population to other states. Transitioning residents back or diverting residents from leaving became more and more costly, as it required the assistance of several agencies and many hours of staff work to bring residents back to Nevada, or to keep them from being placed out-of-state.

According to Ms. McMullen, there was currently no free-standing institution in northern Nevada that could provide care to elderly behaviorally challenged residents. Ms. McMullen explained that she testified from personal experience

because her behaviorally challenged father-in-law died in a nursing home in California, and it was "gut-wrenching" for the family.

Ms. McMullen indicated that funding for E428 was not included in The Executive Budget, but it was included on the list of "Items for Special Consideration." The court and task force would ask that the Subcommittee give the issue special consideration.

Chairwoman Leslie thanked Ms. McMullen for her testimony and indicated that the Subcommittee would ask LCB staff to review E428 prior to closure of the budget for HCF&P.

Kim Spoon informed the Subcommittee that she was a Private Professional Guardian in Nevada. Guardians were involved in the process because approximately 95 percent of the cases where persons were placed out-of-state involved a guardian, either a family guardian, a public guardian, or a private guardian. Ms. Spoon said her testimony would put a face on the persons that were being sent out-of-state. She referenced her written testimony (Exhibit E).

Ms. Spoon reported that there were anywhere from 70 to 100 persons residing in out-of-state facilities, and that number had remained consistent for many years. At the present time, according to Nevada Medicaid, 80 persons were placed out-of-state. Those were the only concrete numbers that could be verified, but it was well known that families often paid to send their elderly family members to out-of-state facilities, and the Veteran's Hospital also sent its severely ill psychiatric patients out-of-state.

Ms. Spoon said the three diagnoses that were most prevalent were: (1) dementia; (2) traumatic brain injury; and (3) chronic severe mental illness. All three areas dealt with cognitive deficits that could lead to behavioral challenges. Of those medical issues, dementia in the elderly was the most prevalent in terms of out-of-state placements. Ms. Spoon noted that the majority of the aforementioned Medicaid cases were demented, elderly patients. However, not all persons with dementia suffered from behavioral issues to the point that nursing homes believed their behavior was beyond the capacity of staff. The percentage of elderly patients who suffered behavioral problems was small.

According to Ms. Spoon, patients with cognitive impairments that were sent out-of-state had behavioral issues that put them or others in danger, and a major problem was paranoia. Some of the problems associated with paranoia were: the patient thought that others were stealing from them; the patient thought that others were trying to poison their medication or food; or the patient thought that others were conspiring to murder them. Ms. Spoon noted that there were very serious behavioral issues with paranoia that put others in harm. Often, patients suffering from paranoia refused the medications that would keep them calm, and usually, the paranoia was focused on the caregivers that were closest to them, particularly if the caregivers were family members.

Ms. Spoon explained that persons suffering from paranoia had little or no insight into their problems and often exhibited poor impulse control. They could, and often did, become verbally and physically aggressive and intimidating to others. Ms. Spoon stated that persons suffering from paranoia could throw items or push and hit care providers and other residents, which was a very real problem because other residents could suffer injuries such as a broken hip. Persons suffering from paranoia could find themselves in situations where their behavior

put them in danger of being hurt by others because of the inappropriateness of their actions.

Continuing, Ms. Spoon indicated that there had been several cases involving men between the ages of 50 and 60 who had experienced head injuries resulting in permanent brain damage and had been sent out-of-state because of the lack of facilities in Nevada. A brain injury in a younger person was even more complicated because of the vitality and physical aggressiveness of the person. The younger person was, therefore, more dangerous to the elderly population in nursing homes where both could reside because there were no other facilities available.

Ms. Spoon offered the following example, which encompassed many of the problems facing almost every individual sent out-of-state.

> In 2004 in northern Nevada an 81-year-old man who, with a diagnosis of dementia—Alzheimer's type, was living at home with his wife and adult son. According to his wife and the police report, he became upset about something and grabbed a knife, which he waved around. His wife, in an attempt to take the knife away from him, received a slight injury to her arm. The police were called and they arrested the 81-year-old man and took him to jail, where he remained for two months. He was charged with domestic battery with a deadly weapon, a felony. He was deemed incapable to stand trial, but the court would not release him to the community without a guardian, which was accomplished through a private guardian, and subsequently through the Washoe County Public Guardian's Office.
>
> From jail, the 81-year-old man was sent to the Veteran's Administration (VA) hospital to address his medical issues, and from the VA hospital he was sent to a behavioral unit in Idaho, which was the only facility that would accept him. The 81-year-old man was sent away from his wife and son, who did not have the funds or health to visit him on a regular basis. The Public Guardian's Office attempted to work with the public guardian and ombudsman in Idaho to assist in monitoring the case, but was unable to conduct a one-on-one visit more than once a year, providing funds were available.

Ms. Spoon said that she had updated the case with the Washoe County Public Guardian's Office and learned that the man had died while out-of-state and his wife was able to be with him at the time of death, which was usually not the case.

According to Ms. Spoon, the main concerns regarding out-of-state placements were:

1. Patients being forced from families, friends, and their area of residence.
2. The difficulty for family or guardians to monitor patients because of the lack of resources to make the necessary trips. Independent sources could aid in monitoring, but that would not take the place of family who knew their family member better than anyone, or guardians who were trained to perceive problem areas and rectify areas of risk.
3. Patients being forced into long-term placements in nursing homes because of financial or behavioral issues, when a specialized group home

might be more appropriate after the behavioral issues were dealt with. A less restrictive environment was very important and patients should not be made to remain in higher levels of care. Patients were often forced to remain in behavioral units or nursing homes because of the lack of alternatives.

4. Patient trauma caused by transfer to an out-of-state facility.

Ms. Spoon explained that Nevada did not have the staff and extended care facilities to handle elderly behaviorally challenged patients, it did not have the behavioral units to which patients could be sent, and it did not have specialized group homes for elderly patients who might be able to leave the behavioral units.

Regarding transfer trauma, Ms. Spoon stated that placement out-of-state caused a physical and emotional decline for many elderly persons because of such things as the loss of appetite and isolation from family or friends. It was difficult enough to move an elderly person from his home into a nursing home in the same area, but when that person was moved out-of-state, it was a much more difficult adjustment.

Ms. Spoon said that she could not provide documentation about out-of-state placements, but those involved in the process had reviewed many cases in which elderly behaviorally challenged persons were sent out-of-state, and within approximately six weeks, the person had died.

Chairwoman Leslie commented that the Subcommittee would certainly take whatever action it could during the 2007 Session, but she believed that a more appropriate place for an in-depth discussion and study would be before the interim Legislative Committee on Health Care. Chairwoman Leslie assured those testifying about the problems with the elderly population that the Subcommittee certainly agreed with the points being brought forward, and believed the issues deserved more attention. There would not be sufficient funding available for the Subcommittee to address the main issues of concern voiced by Ms. Spoon. Chairwoman Leslie pointed out that the problems did not occur instantly, and they would not be solved instantly. She asked everyone to keep that in mind.

Chairwoman Leslie noted that the Subcommittee was in receipt of Mr. Perry's written comments (Exhibit F), and she asked him to summarize those comments for the record.

Charles Perry, Executive Director, Chief Executive Officer (CEO), Nevada Health Care Association, indicated that he was a former owner and operator of nursing homes in Nevada and other states. The issues were more complicated than they appeared, and money was not necessarily the root of the problem. The problem was the method used by the Bureau of Licensure and Certification to inspect and survey nursing homes, particularly when a nursing home accepted elderly behaviorally challenged patients and did not have the ability to provide the appropriate care, which put the nursing home at risk.

Mr. Perry explained that the Bureau of Licensure and Certification, which was involved in the aforementioned task force, reviewed the issue and reported that the Bureau could not inspect nursing homes that accepted behaviorally challenged elderly patients into their general population differently than other nursing homes. That created a liability issue for those nursing homes if they accepted behaviorally challenged elderly patients.

Mr. Perry stated that the liability issue was that nursing homes put themselves at risk when they could not provide the care required to meet the regulatory requirements of state agencies. To avoid the problem, nursing homes did not accept such patients.

Chairwoman Leslie concurred and noted that Exhibit F indicated that NHCA supported enhanced Medicaid funding for behavioral care in skilled nursing facilities. She wondered whether Mr. Perry believed that enhanced funding would help address the nursing home problems.

Mr. Perry replied that, providing the other problems could be bridged, an enhanced rate for nursing homes to care for elderly behaviorally challenged patients would allow the homes to hire additional staff and provide additional training.

Chairwoman Leslie asked whether Mr. Perry felt the Subcommittee should consider E428, Nursing Home Rate, contained on the "Items for Special Consideration" list. Mr. Perry replied that he felt the Subcommittee should consider E428 because he believed that everything worked together. There was an interest and willingness on the part of regulatory agencies to become involved in the issue and help sort out the problem areas. Mr. Perry said it was ridiculous to send elderly patients out-of-state for placement when they could be cared for in Nevada.

Judge Doherty said that over the past year, the task force had addressed the issue with many providers, and the increased rate was a critical first step in addressing the problem. The Bureau of Licensure and Certification was an issue that would not necessarily require Legislative mandate for solution. She noted that the other areas of concern that had been raised were merely informational and could be discussed over the course of the next two years.

Chairwoman Leslie thanked Judge Doherty for her leadership and noted that there were many issues that needed consideration. The Subcommittee would review nursing home rates, and the Legislature would more thoroughly review some of the other issues during the interim.

Mr. Perry commented that the data used to calculate the $261 amount that was in addition to the regular daily rate was developed from 2004 data and might need to be revisited.

Pat Elzy, Director of Legislative Affairs, Planned Parenthood Mar Monte, indicated that she represented Planned Parenthood Mar Monte of Reno, as well as Planned Parenthood of Southern Nevada. Together, the five Planned Parenthood Health Centers had served over 40,000 clients over the past year in Nevada. Ms. Elzy stated that Planned Parenthood centers had been providing services in Nevada for over 35 years. Ms. Elzy submitted a copy of her written comments, Exhibit G.

Ms. Elzy asked that the Subcommittee consider investigating the option of a Medicaid family-planning waiver. Twenty-five states had expanded eligibility for Medicaid coverage by securing a waiver from CMS. The programs reviewed by CMS proved to be cost-effective, with a savings to both the state and the federal government.

Currently, Ms. Elzy said, women in Nevada were eligible for Medicaid family planning and contraceptive services, providing they met certain requirements and were at 133 percent of poverty level. However, according to the 2006 Guttmacher Institute report, there were over 122,000 women in Nevada who were in need of family planning services, but were unable to afford those services. Ms. Elzy indicated that family planning was critical to the health and wellness of women and families. Half of the pregnancies in the United States were unintended, and the best way to prevent unintended pregnancies was to make sure that women had access to family-planning services.

According to Ms. Elzy, the federal/state match for a family-planning waiver was 90 percent federal/10 percent state, which meant that for every $1 the state spent, the federal government would pay $9. Ms. Elzy pointed out that funding for family planning was cost-effective and a common sense investment for Nevada.

Ms. Elzy commented that there was overwhelming public support for access to contraception. Family-planning programs allowed women to be responsible for preventing unintended pregnancies and their consequences. Ms. Elzy asked the Subcommittee to consider investigating a Medicaid family-planning waiver.

Chairwoman Leslie thanked Ms. Elzy for her testimony and commented that 10 percent state match to secure federal funding was very good. Chairwoman Leslie emphasized that 25 states currently had a Medicaid family-planning waiver. Chairwoman Leslie said that such a program would be a cost-savings initiative.

Jack Mayes, Executive Director, Nevada Disability Advocacy and Law Center, indicated that he was present on behalf of the Developmental Disabilities Council. The Council asked him to report that it strongly supported E404, HIWA expansion. Mr. Mayes said he also represented the Strategic Plan Accountability Committee (SPAC) for persons with disabilities, which strongly supported both the HIWA expansion and E408, the traumatic brain injury (TBI) enhancement.

Mr. Mayes noted that the two issues had been reviewed by the 2005 Legislature and were being heard again during the 2007 Legislature. Both the Developmental Disabilities Council and SPAC for persons with disabilities were happy that the issues were included in The Executive Budget and would ask that the Subcommittee approve the funding.

Mr. Mayes indicated that the Nevada Disability Advocacy and Law Center had done a significant amount of work with out-of-state placements of elderly persons, and he would be happy to share information. He noted that representatives had actually visited facilities in Utah, Idaho, and California.

Chairwoman Leslie asked whether Mr. Mayes was referring to Judge Doherty's task force and the issues facing elderly persons, and Mr. Mayes stated that was correct.

Paul Gowins introduced himself to the Subcommittee, and stated that he had been working with the groups that supported HIWA, which he believed was very important to the disabled community. Mr. Gowins stated that terms such as "underutilized" were commonly used in conjunction with HIWA, and he believed that HCF&P had identified the major issue regarding why the program had not been fully utilized.

Even though the Subcommittee apparently supported elimination of the unearned income limit from HIWA, sometimes program changes were overlooked in the overall budget picture. Mr. Gowins hoped that when the time came to close the budget for HCF&P that the issue of eliminating the unearned income limit from HIWA, which had caused the underutilization, would be approved. Mr. Gowins said that he had opposed the original structure of HIWA and hoped that the Legislature would show the wisdom to maintain a very viable program for persons with disabilities.

Chairwoman Leslie thanked Mr. Gowins for his comments, and stated that the Subcommittee would consider the disabled community's belief that the barrier to the program was the unearned income limit.

Jon Sasser informed the Subcommittee that he represented Washoe Legal Services, Nevada Legal Services, and the Washoe County Senior Law Project. He stated that he also served on the Strategic Plan Accountability Committee (SPAC) for persons with disabilities, and as the Advocacy Committee Chair of the Nevada Covering Kids and Families Coalition. Mr. Sasser indicated that he had provided a written copy of his testimony to the Subcommittee, Exhibit H.

Mr. Sasser reported that the interim Legislative Committee on Health Care discussed the high rate of uninsured persons in Nevada. To underscore that fact, a recent survey by the Great Basin Primary Care Association showed that since the year 2000, there was an increase of approximately 100,000 additional uninsured persons in Nevada, which represented a 25 percent increase since the year 2000.

Mr. Sasser noted that the interim Legislative Committee on Health Care determined that the reason Nevada had such a high uninsured rate was not because employers, both large and small, did not provide insurance at or above the national average, but rather that Nevada's public insurance programs, Nevada Check-Up and Medicaid, covered only half as many persons as other states covered with similar programs. Therefore, at least part of the solution to lowering the percentage of uninsured persons in Nevada was to increase participation in the public insurance programs.

At the same time that Nevada was trying to accomplish the public policy goal of lowering its uninsured rate, the Nevada Check-Up and Medicaid caseloads were less than projected. Mr. Sasser commented that the budgeted Medicaid caseload for FY 2007 was 193,227, but the actual caseload was estimated to be 170,373. The budgeted Medicaid caseload for Temporary Assistance to Needy Families (TANF) and Child Health Assurance Program (CHAP) in FY 2007 was 131,705, while the actual caseload was estimated to be 112,607.

Mr. Sasser noted that passage of A.B. 168 to expand health insurance would add new clients the Medicaid programs, but there would still be a net loss over the current biennium. There were undoubtedly a variety of reasons why the caseloads were down, and part of the problem could be attributed to the passage of the Deficit Reduction Act by Congress in February 2006. Mr. Sasser indicated that there was a possibility that some of those decisions would be reversed by Congress, which might increase the caseload numbers. A large part of the caseload came from the TANF/CHAP Medicaid programs. Mr. Sasser explained that there were two problems with those programs: (1) the Deficit Reduction Act and its impact on the programs; and (2) to qualify for either the TANF or CHAP programs, the income for a mother and two children, established in 1991, was a net income of $348 per month.

Mr. Sasser said that adoption of A.B. 168 would help the situation somewhat by adding 1,000 pregnant women to the Medicaid caseload. Mr. Sasser stated that he joined Mr. Gowins and Mr. Mayes in support of the initiatives in The Executive Budget concerning the HIWA and TBI programs.

Mr. Sasser stated that there were initiatives not included in The Executive Budget that SPAC hoped might be considered by the Legislature:

1. E334—provide services for autism in the developmental disabilities Medicaid waiver.
2. E405—Provide dental services for clients in all four waiver programs.
3. E406—Expand the Katie Beckett Medicaid option to allow kids with serious emotional disorders (SEDs), who met the criteria for psychiatric institutionalization, to be treated at home.

Mr. Sasser explained that under the *Olmstead Decision*, Nevada attempted to move persons from institutional care to community-based services. To comply with the *Olmstead Decision*, the goal was to make sure that persons did not remain on waiting lists for periods more than 90 days. The latest data concerning the Waiver for Independent Nevadans (WIN) program indicated that there were 115 persons on the waiting list, with an average wait of almost six months. Mr. Sasser said that the problem, according to Mr. Duarte, was not with funding slots in the WIN program, but rather with the retention and recruitment of case managers. Mr. Sasser indicated that he and Mr. Duarte had discussed the staff turnover in the program and the 14 vacant positions.

Mr. Sasser hoped that HCF&P would develop a plan to deal with the staff-turnover issue. Unless the staffing problems were addressed within the various waiver programs, the Legislature would continue funding services that were not being utilized, but were badly needed by the clients.

Chairwoman Leslie thanked Mr. Sasser for his testimony and his written comments (Exhibit H).

Bill Welch, President and CEO, Nevada Hospital Association (NHA), referenced Exhibit I entitled, "Prioritization of Hospital Budget Issues for Medicaid/Check Up," which had been presented to members.

Mr. Welch indicated that priority number one, hospital rates that approximated cost, concerned a rate increase for Medicaid patients. The issue was on the "Items for Special Consideration" list, but was not included in The Executive Budget. Currently, Mr. Welch said, hospitals were being reimbursed at approximately 79 percent of the cost to provide the care. That equated to almost $72 million in cost shift, which impacted other businesses in Nevada that paid for health insurance.

The NHA understood the budget and fiscal restraints facing the Legislature, and Mr. Welch explained that Exhibit I included two other options that would at least ensure that rates would not be reduced from the current amount. He emphasized that the increase in rates would bring Medicaid payments up to the current costs and, by the next biennium, reimbursement rates would once again be below the costs to provide care.

Chairwoman Leslie referenced the exhibit and asked whether the figures reflected the first, second, and third choices for rate increases. Mr. Welch replied that was correct.

Mr. Welch said the second NHA priority was the proposal that Nevada adopt a presumptive eligibility process for Medicaid patients who qualified for SSI benefits. The exhibit depicted the cost for such a process at $711,000 for FY 2008 and $9.6 million for FY 2009. The process would be available only to the disabled population, rather than all Medicaid recipients. Mr. Welch stated that NHA believed that presumptive eligibility would allow the Division to redirect a recipient's initial care to a more appropriate center other than hospital emergency rooms. As pointed out by Mr. Duarte, a number of patients used hospital emergency rooms as their primary medical care provider.

Mr. Welch said that because the Medicaid budget had been presented to the Subcommittee, the NHA would distribute written notification about its positions to legislators.

Chairwoman Leslie thanked Mr. Welch for his presentation.

George Ross, representing the Hospital Corporation of America (HCA) Healthcare, Sunrise Hospital, indicated that his testimony was about doctors known as pediatric intensivists. Those were doctors who manned pediatric intensive care units at five hospitals in Nevada and at other hospitals throughout the country. Mr. Ross said he was familiar with the doctors who handled pediatric intensive care at Sunrise Hospital in Las Vegas and Renown Regional Medical Center in Reno. Those doctors maintained no office or practice outside the hospital. Mr. Ross indicated that, based on prior testimony, his concern was whether such doctors would be included in the proposed provider rate increase.

Chairwoman Leslie advised Mr. Ross to check with Mr. Duarte after the meeting to ascertain whether those doctors would be included in the proposed rate increase. Mr. Ross said that he would check with Mr. Duarte.

According to Mr. Ross, because of the importance of pediatric intensivists to the healthcare of children in Nevada, there was a need for continued recruitment. The efficiency of the methods used by pediatric intensivists was well documented, and Mr. Ross said his request would be that with budget constraints, pediatric intensivists would receive a rate increase based on the importance of the care they provided to gravely ill children in Nevada. Mr. Ross commented that those doctors had not enjoyed a rate increase in approximately 11 years.

Chairwoman Leslie asked Mr. Duarte to check on that issue and report back to the Subcommittee.

Senator Cegavske believed that Mr. Duarte had answered in the affirmative to a question posed by Senator Mathews regarding whether or not pediatric doctors were included in the rate increase.

Ann Lynch, HCA Healthcare, Sunrise Hospital, commented that her concern was that pediatric intensivists were not specifically named in the proposed rate increase. That specialty included only approximately 22 doctors in the State. Ms. Lynch advised the Subcommittee that she was in possession of the necessary codes to discuss the specialty with Mr. Duarte.

According to Ms. Lynch, the use of pediatric intensivists represented a savings because when a child was in the care of a pediatric intensivist, the average length of hospital stay for a certain diagnosis was 1.7 days. However, if the child was under the care of a pediatrician not associated with the hospital, the average stay was 3.5 days. The reduced hospital stay represented a savings to Medicaid.

Chairwoman Leslie thanked Ms. Lynch for her testimony and asked whether there was further public testimony to come before the Subcommittee and, there being none, declared the hearing adjourned at 10:52 a.m.

RESPECTFULLY SUBMITTED:

_____
Carol Thomsen
Committee Secretary

APPROVED BY:

_____
Assemblywoman Sheila Leslie, Chair

DATE_____

_____
Senator Barbara K. Cegavske, Chair

DATE_____

Committee Name: Assembly Committee on Ways and Means/Senate Committee on Finance Joint Subcommittee on K-12/Human Services

Date: March 7, 2007 **Time of Meeting: 8:12 a.m.**

Bill	Exhibit	Witness / Agency	Description
***	A		Agenda
***	B		Sign-in Sheet
***	C	C. Duarte/HCF&P	Budget Presentation
***	D	Connie McMullen/SPAC	Written testimony
***	E	Kim Spoon/Professional Guardian	Written testimony
***	F	Charles Perry/Nevada Health Care	Written testimony
***	G	Pat Elzy/Planned Parenthood	Written testimony
***	H	Jon Sasser/SPAC	Written testimony
***	I	Bill Welch, NHA	Written Testimony