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

**Seventy-fourth Session**
**March 22, 2007**

The Joint Subcommittee on K-12/Human Services of the Senate Committee on Finance and the Assembly Committee on Ways and Means was called to order at 8:08 a.m. on Thursday, March 22, 2007. Chair Barbara K. Cegavske presided in Room 3137 of the Legislative Building, Carson City, Nevada. Exhibit A is the Agenda. Exhibit B is the Attendance Roster. All exhibits are available and on file in the Research Library of the Legislative Counsel Bureau.

**SENATE SUBCOMMITTEE MEMBERS PRESENT**:

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

**ASSEMBLY SUBCOMMITTEE MEMBERS PRESENT**:

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

**SUBCOMMITTEE MEMBERS ABSENT**:

Assemblywoman Barbara E. Buckley (Excused)

**STAFF MEMBERS PRESENT**:

Rick Combs, Program Analyst
Gary L. Ghiggeri, Senate Fiscal Analyst
Steven J. Abba, Principal Deputy Fiscal Analyst
Cynthia Clampitt, Committee Secretary

**OTHERS PRESENT**:

Charles Duarte, Administrator, Division of Health Care Financing, Department of Health and Human Services
Patrick Cates, Administrative Officer, Division of Health Care Financing and Policy, Department of Health and Human Services
Mary Wherry, Deputy Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services
Mary Keating, Administrator, Administrative Services Division, Department of Administration
Jon L. Sasser, Washoe Legal Services, Nevada Legal Services and Advocacy Chair for the Nevada Covering Kids and Families Coalition
Jan Gilbert, Progressive Leadership Alliance of Nevada

CHAIR CEGAVSKE:
I will open the hearing on budget account (B/A) 101-3178. The Committee would like you to discuss staffing increases and organizational changes. The *Executive Budget* makes requests for new investigative positions, caseload changes and rate increases.

First, explain and differentiate the role of the Employer-Sponsored Insurance (ESI) subsidy program as approved by the 2005 Legislature. Please compare the program to your anticipated role under the current proposal.

HUMAN SERVICES

HEALTH CARE FINANCING AND POLICY

HCF&P - Nevada Check-Up Program – Budget Page HCF&P-31 (Volume II)
Budget Account 101-3178

CHARLES DUARTE (Administrator, Division of Health Care Financing, Department of Health and Human Services):
When funding was allocated for a contractor to administer the ESI program, during negotiations with the potential vendor, it was determined our agency could deliver the same services at a lower cost if staffing was associated with the function. During the interim, it was decided the work would be completed in house rather than by contracting the work.

CHAIR CEGAVSKE:
Was a cost comparison done for this project?

MR. DUARTE:
Several cost comparisons were done and negotiated with the proposed vendor, Healthcare Management Systems (HMS). It became apparent their pricing structure was much higher than ours. The use of agency staff appeared to be more efficient and considerably less costly.

CHAIR CEGAVSKE:
Please share the cost comparisons with our staff.

MR. DUARTE:
We will provide the information for your staff.

CHAIR CEGAVSKE:
There were remaining funds allocated to contractor costs. Will the contract be continued? If so, explain what their ESI function would be and the length of time the contract would be necessary.

MR. DUARTE:
My administrative services officer will explain the funding issues and savings associated with providing the functions in house.

PATRICK CATES (Administrative Officer, Division of Health Care Financing and Policy, Department of Health and Human Services):
Is your question what functions the ESI program will continue to perform?

CHAIR CEGAVSKE:
A contractor has been employed. There are funds remaining in that provision. Do you plan to continue the contract?

MR. CATES:
The contractor will continue to work for the Division. They will be evaluating employers who provide health coverage for their employees and ensuring the health coverage offered to uninsured employees meets certain requirements. The ESI program is essentially a qualified-health plan. The contractor will also assist the agency in outreach activities.

CHAIR CEGAVSKE:
What is the balance remaining in the allocation for the contract? Please provide the information to our staff.

You are requesting a management analyst III position to manage and monitor the Health Insurance Flexibility and Accountability (HIFA) waiver. Are the functions of this position similar to the management analyst III approved during the 2005 Legislative Session?

MR. DUARTE:
The position is not the same. The staff position requested in the *Executive Budget* is for administration of the ESI program. That individual will provide the services originally intended under the contract.

CHAIR CEGAVSKE:
The description of the requested position is similar to the position authorized in the 2005 Legislative Session.

MR. CATES:
The management analyst III, approved in 2005, was required to produce the fiscal reporting for the HIFA waiver. Extensive federal reporting is required in terms of demonstrating allotment neutrality and ensuring fiscal aspects of the waiver are managed appropriately. As we completed the process of obtaining Centers for Medicare and Medicaid Services (CMS) approval, we discovered a large research component in the HIFA waiver of which we were not previously aware. This requires asserting and testing hypotheses, gathering extensive data and conducting extensive programmatic analysis. Those duties were not originally envisioned in the previous budget requests.

The currently requested management analyst III would perform those reporting and analysis requirements.

CHAIR LESLIE:
It would be helpful if the agency could prepare a simple matrix for the Committee indicating the duties of the six positions requested and the duties of the contractor. We are concerned functions may be duplicated in the ongoing contract and new duties associated with the requested management analyst III.

CHAIR CEGAVSKE:
We will now consider decision unit M-507. It contains the request for a new investigative position.

M-507 Mandates – Page HCF&P-34

You have indicated you are requesting positions in both the north and south ends of the State to investigate fraud and abuse issues. The agency already provides that function within a unit of the Division of Welfare and Supportive Services (WSS). Why does the agency feel additional staff is needed in this budget?

MR. DUARTE:
The WSS Division has an investigative unit established to combat recipient fraud within the Medicaid program. They currently have a full caseload. Occasionally, the investigators have been willing and able to accept a particularly blatant case within this budget. The investigators have completed two investigations over a several-year period. It is apparent the Nevada Check Up program needs to conduct its own investigations. There is likely a significant caseload to justify the two requested investigator positions.

CHAIR CEGAVSKE:
How many cases are anticipated?

MR. DUARTE:
The number of cases depends on percentages. It is possible 3 or 4 percent of the population is involved in some type of fraudulent activity and misrepresentation in their application and use of Nevada Check Up funds. That should be sufficient to ensure a caseload for the two requested investigator positions. Rather than continuing to depend on the WSS Division, which can only accept an occasional case, we must take a more proactive approach.

CHAIR CEGAVSKE:
Are two full-time equivalent positions warranted?

MR. DUARTE:
Yes, they are. Ms. Mary Wherry, Deputy Administrator, can provide further justification.

CHAIR CEGAVSKE:
Has the CMS cited the Division for not having an investigator within the provisions of the Nevada Check Up program?

MARY WHERRY (Deputy Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services):
We have not been cited, but we are not in compliance with the State or federal plans for program integrity within the State Children's Health Insurance Program (SCHIP). The *U.S. Code of Federal Regulations* (C.F.R.) Title 42, Part 457.915, describes the requirements for fraud detection and investigation. We have not been in compliance with those requirements.

While the program has undergone a maturing process, we have focused heavily on outreach and enrollment. During the most recent federal review, issues were raised requiring the startup program, such as timely and appropriate disenrollment and whether clients had qualified for Medicaid. We were

conducting presumptive eligibility to ensure their coverage until Medicaid initiated.

As the programs have grown, we anticipate there will be increased focus on whether or not we are in compliance with who was covered under the program. We have loose income and asset criteria for the Nevada Check Up program. We have encountered a number of situations where families may own $500,000 homes and have tried to enroll their children in the Program. We do not have sufficient staff to properly evaluate whether the records provided with applications are accurate.

From the perspective of volume, we have not had time to make a count of the number of clients signed on; we have just been processing applications.

CHAIR CEGAVSKE:
Would investigations be done randomly?

MS. WHERRY:
An investigative process has not been developed as yet.

CHAIR CEGAVSKE:
Would it be different from what is being done in the WSS Division?

MS. WHERRY:
It would be somewhat the same process. Some cases would be a matter of investigating the geographic location of the clients through zip codes. That is a first indicator of what their socioeconomic status might be versus what they have stated in their application.

There are many individuals who own small businesses. We want to ensure their children have access to health care, but we do not want to inappropriately subsidize them if they have other resources to purchase a commercial product.

SENATOR MATHEWS:
Do you have any idea of how many applicants may be perpetrating fraud?

MR. DUARTE:
We do not. We have estimates that 3 or 4 percent of recipients may be committing fraud or at least misrepresenting their assets.

SENATOR MATHEWS:
Be aware, in Reno, the zip code is no indication of whether or not a person is committing fraud.

CHAIR CEGAVSKE:
Your request for investigators indicates one will be placed in northern Nevada and one will be placed in southern Nevada. I can imagine the southern investigator might be kept busy based on population. Would investigators be authorized to travel? For instance, if the southern investigator needed assistance, could the northern investigator be sent to assist?

MS. WHERRY:
That is correct. We estimated the northern-based investigator will likely travel approximately 1,600 miles monthly.

CHAIR CEGAVSKE:
Would you be sharing information with the WSS Division in their fraud and abuse cases? If a client did not qualify for one program, might they try for the other?

MS. WHERRY:
I am sure we would be working closely with the Medicaid Administration. We currently send them referrals and they do likewise.

Nevada is a large State, and it is difficult to have only one staff person assigned to an urban location having responsibility for rural and smaller population areas as well.

CHAIR CEGAVSKE:
The Committee is aware the caseload is greater than that identified in the *Executive Budget*. Are we to expect a budget adjustment related to caseload growth?

MR. DUARTE:
Currently, caseload is 28,775. We are expecting caseload growth to exceed 29,000 in April 2007. That already exceeds the projected annual caseload for fiscal year (FY) 2007-2008. It is a significant issue for the Division.

SENATOR CEGAVSKE:
There was a problem with the Nevada Operations Multi-Automated Data Systems (NOMADS). Has the problem been rectified?

MR. DUARTE:
There were three issues that affected the caseload accountability. One was the back-to-school campaign which resulted in an increase in applications. The second was a reduction in the number of disenrollments. We believe that is because of an obvious campaign we have initiated to ensure individuals pay their premiums on time.

SENATOR CEGAVSKE:
Were premiums not being paid?

MR. DUARTE:
There have been a large number of instances, in the last two years, of families who were disenrolled for not paying their premiums.

SENATOR CEGAVSKE:
Do you know the number of such cases?

MR. DUARTE:
We will provide the information to the Committee.

The third, and most significant reason for the apparent decrease in enrollments, was the interface problem between our Division, the WSS Division and the NOMADS. The WSS Division was sending referrals to our Division electronically for evaluation. In late summer or early fall, we noticed a significant decline in those referrals. We discovered a system problem with an eligibility filter that examines a case before it is referred. We are still working on the electronic problem. In the meantime, we have requested the WSS Division to send referrals through a manual paper process.

Significant increases have resulted from the manual referral process. It is somewhat early to say whether the increases will slow down. The number of referrals is fairly consistent at this time. There have been over 1,000 referrals monthly.

With respect to requesting a budget amendment, that is not our intent at this time. We are closely watching caseloads in the Medicaid program and we will inform the Committee staff if a budget amendment is anticipated.

CHAIR LESLIE:
If the caseload is already greater than the budget projections, are you anticipating an enrollment decrease?

MR. DUARTE:
No, we must find a way to generate the necessary General Funds to cover any gap as a result of the Nevada Check Up caseload growth. We will work closely with the Budget Division and Legislative staff as we develop Medicaid and Nevada Check Up caseload projections.

CHAIR LESLIE:
I am encouraged you have kept the Nevada Check Up enrollment growing. I am aware of the warnings you have developed to allow families to pay their premiums before they become disenrolled from the program. I want to make sure everything is done to ensure children are insured.

MR. DUARTE:
I agree.

CHAIR CEGAVSKE:
Please discuss the rate increases requested in decision units M-101 and E-425.

M-101 Inflation – Agency Specific – Page HCF&P-32

E-425 Enable, Motivate and Reward Self Sufficiency – Page HCF&P-37

You are projecting a 6.5-percent increase in the Medicaid program. There are other federal funds to consider as well.

MR. CATES:
There are different capitation rates for the Nevada Check Up program than those in the Medicaid program. We recently proposed a reduction in the rate used for managed care within the Medicaid Program. We are not recommending a similar reduction under the Nevada Check Up program. In calendar year 2007,

managed care rates were reduced for Medicaid but increased for the Nevada Check Up program. We believe the Nevada Check Up rate is appropriate.

We are evaluating both rates with our actuaries. New information was received yesterday.

CHAIR LESLIE:
I would ask the Division to work with our staff. If there was a significant decrease in the rate for one program, I would expect to see some kind of reduction in the other.

MR. DUARTE:
Historically, we have seen a significant difference in utilization between the two programs, particularly in the dental plan. There is greater utilization in the Nevada Check Up program than in the Medicaid program. As noted, new information will be provided to the Committee staff.

CHAIR CEGAVSKE:
Funding for a customer satisfaction survey is requested to satisfy the CMS requirements. How were previous surveys funded?

MR. DUARTE:
We have not previously conducted a customer satisfaction survey on the Nevada Check Up program. We are proposing such a survey to meet the external quality-review organization requirements.

CHAIR CEGAVSKE:
Will performance indicators be provided for conduct of the survey process?

MR. DUARTE:
Yes, those will be provided.

CHAIR CEGAVSKE:
I will now close B/A 101-1378 and open the hearing on B/A 101-3157.

HCF&P - Intergovernmental Transfer Program – Budget Page HCF&P-49
(Volume II)
Budget Account 101-3157

This budget covers a program at the University of Nevada, Las Vegas (UNLV), School of Medicine. Did the CMS approve this program?

MR. CATES:
We have not received final approval from the CMS for the State Plan Amendment at the UNLV, School of Medicine. We are in negotiations.

CHAIR CEGAVSKE:
Do you have an expectation of when approval might be received?

MR. CATES:
We have provided responses to their questions. They are bound by a 90-day time frame for response. We can get back to staff with the exact status of the 90-day timetable.

CHAIR CEGAVSKE:
Please explain the Inter-Governmental Transfer (IGT) payments and the Disproportionate Share Hospital (DSH) payments to the hospitals.

MR. CATES:
We collect IGTs from the counties. Most is collected from Clark County. These fees are collected in support of DSH payments. Those payments are made to hospitals that serve indigents, uninsured and in situations where costs are not covered by the Medicaid program. The majority of the funds are distributed to the University Medical Center (UMC) in Las Vegas, but a variety of other hospitals statewide also receive funds.

SENATOR RAGGIO:
Does the financial situation at the UMC have an impact on this program? Were any federal concerns expressed as to whether or not the funds were being used appropriately?

MR. DUARTE:
No concerns have been expressed to our Division. We are concerned about the extent of loss being announced by the UMC. They are an essential provider for our programs.

SENATOR RAGGIO:
The UMC is the primary recipient and reason for this fund, are they not?

MR. DUARTE:
That is correct.

CHAIR CEGAVSKE:
We were notified a fraud case is under investigation.

SENATOR RAGGIO:
My concern was whether or not the UMC situation had any impact on the Division's collection and receipt of funds in this budget account. Approximately 50 percent of the funding is provided through a federal program. I would assume they would have concerns regarding the proper utilization of the funds.

MR. DUARTE:
We understand the concern. We have been waiting to initiate a meeting with the administration at the UMC. We plan to discuss their continued ability to provide us with IGT funds. At this point, there has been no indication of a problem. There has been no concern communicated from the CMS.

CHAIR CEGAVSKE:
I will now close the hearing on B/A 101-3157 and open the hearing on B/A 101-3160.

HCF&P - Increased Quality of Nursing Care – Budget Page HCF&P-51
(Volume II)
Budget Account 101-3160

Please discuss the provider tax rate. It is increasing from $2.58 a bed to $3.69 in FY 2008-2009. The reimbursement rate for FY 2007-2008 is $161.08 and $159.98 in FY 2008-2009. The average bed-day rate is $121.66.

MR. DUARTE:
The tax to improve the quality of nursing-home care is set by statute. It allows the Division to collect fees from nursing homes up to 6 percent of their gross revenues. Federal law has changed requiring the Division to reduce the percentage in statute and practice to 5.5 percent. We estimate that will have an impact of approximately a $4.4 million on the overall availability of funds to pay nursing-home facilities. It will result in an overall reduction in the average payment to nursing-home facilities on a per-bed-day basis.

The $121-per-bed-day rate cited by the Chair is what we consider the base rate. That rate is not considered a part of the provider tax. No new General Funds have been added to nursing-facility care. Instead, we have provided increased reimbursement through the provider tax program, which is industry supported. The only changes being made are to be in compliance with federal policy.

SENATOR RAGGIO:
The long-term care facilities will obviously receive lower reimbursement. Without the provider tax situation, it would be far worse.

MR. DUARTE:
That is correct. Without the provider tax formula, things would be much worse.

SENATOR RAGGIO:
Our information was the rate was $121 before the provider tax implementation. Is the industry aware of the necessity for the tax?

MR. DUARTE:
Yes, the industry is aware of the situation.

SENATOR RAGGIO:
Apparently, some in the industry did not understand. During the 2005 Legislature, I received several letters expressing concern about a tax being imposed.

MR. DUARTE:
I recall the letters. That situation has been corrected.

CHAIR CEGAVSKE:
I will close the hearing on B/A 101-3160 and open the hearing on B/A 101-3247.

HCF&P - HIFA Medical – Budget Page HCF&P-42 (Volume II)
Budget Account 101-3247

Please discuss the program level and the limits and flexibility through the CMS to manage and control the costs of the caseload under the HIFA waiver. Please explain the delays in receiving the CMS approval, caseloads for pregnant women and the ESI coverage.

MR. DUARTE:
The process of acquiring the CMS approval took nearly ten months. We worked closely with them and received final approval in November 2006, with an allowed start date of December 1, 2006. We began accepting applications from pregnant women with incomes between 133 percent and 185 percent of the federal poverty level.

CHAIR CEGAVSKE:
Your projected applications of 624 pregnant women and 175 ESI applications came up short. The program currently has only 27 pregnant women and 2 ESI participants.

MR. DUARTE:
The program is just getting off the ground. The start was delayed awaiting final CMS approval. There are now just over 31 pregnant women and 2 children born through this program. There are also two ESI recipients.

The ESI component is just beginning. In the last week, 7,200 letters describing the opportunities were sent to potential households.

CHAIR CEGAVSKE:
How did you determine which households should receive the letters?

MR. DUARTE:
We used the Nevada Check Up database to generate the letters. We also sent information about this program to all the Chambers of Commerce and a number of other employer organizations.

CHAIR CEGAVSKE:
Did you send letters to insurance brokers?

MR. DUARTE:
One thing to keep in mind about the ESI program is most employers' open-enrollment periods for their health plans are in May and June for programs beginning in July. Qualifying for the ESI does not qualify an individual to become a member of an employer health plan. We anticipate the caseload will be greater after most employers hold their open-enrollment periods.

CHAIR CEGAVSKE:
Should the projections be reconsidered?

MR. DUARTE:
We are in the process of reviewing the projections at this time and the information was sent last night to the Budget Division and the Legislative Counsel Bureau (LCB) staff.

CHAIR CEGAVSKE:
Staff indicates the information has been received.

Small businesses and methods to get them involved in such programs were discussed in another hearing yesterday. As a former small-business owner, it was difficult for us. We paid our employees more than minimum wage. Some employees did not want health coverage; they preferred additional salary. It was difficult to find a health program for employees who desired the coverage. Have you had feedback from small businesses about the pros and cons of this plan?

MR. DUARTE:
During the last Legislative Session and the interim discussions, the growing cost of health-care premiums to employers was identified as a major difficulty. It is particularly difficult for small businesses. This program makes it easier for the employee to receive group coverage. It is more attractive to the employers if a large number of their employees are covered under the ESI. The program would pick up those persons who might not otherwise qualify for coverage with a $100 subsidy.

It does not address the issue you raised of young adults who feel they do not need health coverage.

CHAIR CEGAVSKE:
For individuals in the age group from 25 to 35, who have been taken off their parents' health-care policy after college, it becomes difficult to purchase health insurance they can afford.

MR. DUARTE:
I used to sell long-term care insurance and it was always affordable in that age range, but individuals could seldom be convinced to spend even $15 monthly on premiums.

The first employer that contacted the Division ultimately decided to offer health coverage through this program. Hopefully, more of those kinds of stories will come forward.

CHAIR CEGAVSKE:
Is dental coverage included in the plan? Often, small businesses offer health coverage without dental provisions because dental coverage is so expensive.

MR. DUARTE:
That is correct. However, only emergency dental coverage is offered. It is the same coverage available to adult Medicaid recipients.

CHAIR CEGAVSKE:
Please discuss the U.S.C. Title XXI block grant funding. There was barely enough funding to take care of the program. Also, please discuss your five-year projections and how the tight caps will be managed.

MR. CATES:
We submitted a five-year budget to the CMS for the HIFA waiver. The intent was to demonstrate allotment neutrality and the amount of federal funding available under the SCHIP block grant. The projections submitted were intentionally slightly high. Five years is a long-projection cycle. The projection demonstrated that in the fifth year of the waiver, Nevada would be spending approximately $90 million for Nevada Check Up and the HIFA programs. We would be spending down the carryover allotments we have had from year to year. We are currently carrying forward approximately $100 million. By the end of the fifth year of the waiver, we projected we would have approximately $15 million remaining in rollovers. We are currently receiving allotments of approximately $41 million annually. The $15 million was a buffer. The object was to spend down the rollover. The U.S. Congress passed legislation to take a portion of the federal FY 2004-2005 allotment of $12.4 million away and distributed it to other states. That action wiped out most of the buffer we had anticipated. The projections assume generous caseload growth in both programs. We are conducting a new analysis, based on our current HIFA and Nevada Check Up caseload projections, to see whether or not there are additional funds remaining beyond what was indicated in the earlier analysis.

It also assumes Nevada will remain at the $41 million allotment level for the five years of the waiver. At this point, what Congress will do regarding the SCHIP allotments is anybody's guess. There are several members of Congress sponsoring measures to increase overall allotments to the states.

CHAIR CEGAVSKE:
Apparently, you provided your plan to the LCB staff yesterday. If staff has further questions, they will contact your agency.

MR. CATES:
For clarity, the information I forwarded to the LCB staff was the analysis we had sent with the $15 million HIFA waiver. We still owe staff an analysis based on our current projections which should be available next week.

CHAIR CEGAVSKE:
Do you know when next week?

MR. CATES:
We anticipate availability late next week. Caseload numbers should be available the first part of the week and it will take us until later in the week to compile an analysis.

MR. DUARTE:
A question was raised concerning management of the tighter caps. The HIFA waiver allows us to manage the caseload. The staff person assigned to the fiscal area will monitor caseloads and expenditure to enable us to project, in advance, whether we will encounter allotment or expenditures caps. In that

case, we may have to stop HIFA-waiver enrollment. Priority is given to children under the waiver.

CHAIR CEGAVSKE:
Does the coverage for pregnant women under the HIFA waiver eliminate the need for some claims that would otherwise have been paid from the Indigent Accident Account?

MR. DUARTE:
The Indigent Accident Account, B/A 628-3245, and the HIFA program cover two different groups. The original intent was that HIFA would include a catastrophic coverage component which would have been close to what is paid subsequently through the Indigent Accident Account. It was not included in the final HIFA waiver. Pregnancy claims do not fall under the Indigent Accident Account. Those funds are primarily intended for traumas and other kinds of catastrophic health events.

More broadly, the question is whether or not there is a net benefit to the hospitals for pregnancies that would otherwise be uncompensated. They are now being covered through the program.

I have provided the Committee with a document titled "State of Nevada Department of Health and Human Services, Division of Health Care Financing and Policy, Budget Presentation to Senate Finance/Assembly Ways and Means, Joint Subcommittee on K-12/Human Resources FY 08 – FY 09, March 22, 2007 (Exhibit C, original is on file in the Research Library).

CHAIR CEGAVSKE:
I hereby close the hearing on B/A 101-3247 and open the hearing on B/A 628-3244 and B/A 628-3245.

Indigent Supplemental Account – Budget Page ADMIN-25 (Volume I)
Budget Account 628-3244

Indigent Accident Account – Budget Page ADMIN-27 (Volume I)
Budget Account 628-3245

MARY KEATING (Administrator, Administrative Services Division, Department of Administration):
We are the custodians of B/A 628-3244 and B/A 628-3245. They are administered by the Board of Trustees of the Fund for Hospital Care to Indigent Persons and through a contract with the Nevada Association of Counties (NACO). The NACO administers day-to-day operations and my office administers the accounting functions.

Both accounts receive tax funds at 1 cent and 1.5-cent rates to pay for supplemental catastrophic expenses for our citizens and for indigent accidents. Most payments from the Indigent Accident Account are primarily remitted to hospital facilities for those involved in motor vehicle accidents throughout the State.

The amounts requested in the budgets are based on the Department of Taxation's estimated real property tax revenue. The information regarding the transfer to the HIFA Holding Account was provided by the Division of Health Care Financing and Policy.

CHAIR CEGAVSKE:
We need confirmation the authority provided in A.B. No. 493 of the 73rd Legislative Session has offset the loss of the property tax revenues being transferred from this account to the HIFA Holding Account.

MS. KEATING:
At this point, there has not been a decrease in the ability to make those payments. The Indigent Accident Account receives a 1.5-cent rate of tax revenue. In A.B. No. 493 of the 73rd Legislative Session, the way the two accounts are administered was changed. The bill has a sunset of June 30, 2007. The bill requires the two accounts to be consolidated.

CHAIR CEGAVSKE:
Why has that provision not been addressed?

MS. KEATING:
It has not been done because of accounting practices. We treat the two accounts as if they are accounted for together. If the sunset occurs, that provision would have to be reversed.

We do not envision this to be a problem. We anticipated working with the LCB staff in the closing of these two accounts to accommodate those provisions as well as any statutory changes that might occur in the current Legislative Session.

CHAIR CEGAVSKE:
Have you tracked the time allocated by the Administrative Services Division for the two accounts?

MS. KEATING:
These accounts consume minimal time compared to the more than 100 accounts administered by our office. There is only activity twice each year. The revenue is transferred directly from the counties to the Office of the Controller.

CHAIR LESLIE:
The question is in the HIFA Holding Account, budget account 101-3155. It appears that only $8,221 has been transferred to that account. Is the funding being transferred to the HIFA Holding Account as we envisioned during the 2005 Legislative Session?

HCF&P - HIFA Holding Account – Budget Page HCF&P-45 (Volume II)
Budget Account 101-3155

MS. KEATING:
I am not aware of any funding requested by the HIFA waiver administration that has not been transferred. A bill was received for the $8,000 and it has been

transferred. The language of A.B. No. 493 of the 73rd Legislative Session requires transfers to be made on a quarterly basis. The programs are just starting and funds may not be what were anticipated. We have asked the Division of Health Care Financing and Policy to provide billings on which we make the transfers.

CHAIR LESLIE:
Will everything be transferred by the end of this fiscal year?

MS. KEATING:
To the extent we are billed, transfers will be made.

CHAIR LESLIE:
You do not anticipate balancing forward any funding?

MS. KEATING:
We will balance forward in B/As 628-3244 and 628-3245 because other programs are also included.

CHAIR LESLIE:
I am only speaking to the HIFA Holding Account funds.

MS. KEATING:
I do not envision any balance forward in that account. The requests I have seen from the HIFA waiver are less than the total funding presently in the account. I envision transferring all requested funds by the end of the fiscal year.

CHAIR CEGAVSKE:
What about funds not being transferred into the HIFA account?

MS. KEATING:
My intent, when the books are closed at the end of the year, depending on any other statutory changes, is to consolidate the accounts in accordance with A.B. No. 493 of the 73rd Legislative Session resulting in a single account. Any funds which are not paid to the HIFA waiver and are not paid to the Indigent Supplemental Account will be balanced forward to FY 2007-2008.

This budget envisions expenditure of all funding. My office cannot predict the exact day all funds from all counties will be received, so there may be a slight balance forward.

CHAIR CEGAVSKE:
Is there further testimony on B/A 628-3245?

MS. KEATING:
That is one of the two accounts that will be consolidated and balanced forward into the one account.

CHAIR CEGAVSKE:
Are any problems anticipated with the transfer of the accounts to the Department of Health and Human Services?

MS. KEATING:
These accounts have been administered by the Department of Administration for many years. We are willing to continue; however, as a result of A.B. No. 493 of the 73rd Legislative Session, it is no longer logical for the accounts to be administered by our Department. We expect the remaining account to be allocated to the Department of Health and Human Services in the Authorizations Act and we would simply change the account number appropriately.

ASSEMBLYWOMAN GANSERT:
Please discuss A.B. No. 493 of the 73rd Legislative Session further. It is my recollection that expansion of the uses for those funds was rejected under the HIFA waiver. Was the policy changed at a later time? Were the parameters changed?

MS. KEATING:
A part of our suggestion to move the account to the Department of Health and Human Services was because it is the agency housing the experts on the HIFA waiver. It is my understanding three elements were requested by HIFA. Two elements were approved in December 2006.

RICK COMBS (Program Analyst, Fiscal Analysis Division, Legislative Counsel Bureau):
There were three elements to the waiver request. The CMS did not approve the catastrophic-event portion of the waiver request. The bill was drafted requiring the funds from the Indigent Supplemental Account to be transferred to the HIFA Holding Account. They were two separate issues within the bill. The catastrophic-event element was not approved in the HIFA waiver and it is the one element that would have had the most effect on the Indigent Supplemental Account.

ASSEMBLYWOMAN GANSERT:
Were those funds available for other uses? Did we not retain what was expected to be spent on that program?

MR. COMBS:
The transfer to the HIFA Holding Account for this year was supposed to be $4.2 million, and to date, only approximately $8,200 has been transferred. That was the Chair's question to Ms. Keating concerning what happens to the remaining funds if they are not completely transferred to the HIFA Holding Account. The answer is, it will balance forward and be available to be used for claims against the Indigent Supplemental Account for either a motor vehicle accident or other indigent situations once the two accounts are combined.

JON L. SASSER (Washoe Legal Services, Nevada Legal Services and Advocacy Chair for the Nevada Covering Kids and Families Coalition):
I have provided my written testimony (Exhibit D) for the Committee.

The largest issue in the Nevada Check Up program is under projection of the caseload volume. I worry when we have a program that underperforms for a period of time and we adjust caseload projections downward. Then, caseloads are adjusted reflecting an increase, but certain amounts of funding are lost. I am

delighted to hear Mr. Duarte testify they are requesting General Funds to replace the loss.

Looking at the last two years, Nevada Check Up has been averaging assistance to 3,000 fewer children monthly than what was projected in the 2005 Legislative Session. We had hoped to reach approximately 32,000 children monthly by the end of the biennium. As you heard, the number will likely reach 29,000 children at the end of next month.

To put that in perspective concerning policy goals, the federal funding and goal is to reach all children in Nevada whose families are in the income range of up to 200 percent of the federal poverty level. According to the Great Basin Primary Care Association, there has been an increase of nearly 100,000 uninsured people in the State between the year 2000 and today's date. It is particularly distressing that in the same six-year period the number of uninsured children and families between 100 percent and 200 percent of the poverty level, the Nevada Check Up coverage range, rose from 21,000 to 35,000. Approximately 26,000 children entered that target income category, and we enrolled approximately 12,000, or 44 percent of those eligible.

I had the pleasure of working with the Health Care Committee during the interim. We considered the uninsured individuals within the State. We decided the easiest approach was to attempt to get all those currently eligible for existing programs enrolled. That goal is slipping badly in the Nevada Check Up program. I encourage the Committee to adopt the increased caseload projections coming forward soon. It would be helpful if Assembly Bill (A.B.) 168 is passed.

**ASSEMBLY BILL 168**: Makes various changes concerning expanding health insurance to make health insurance available to more residents of Nevada. (BDR 38-1144)

I would note just saying we will cover 5,000 additional children does not make it happen. Additional efforts will need to be utilized.

CHAIR CEGAVSKE:
I appreciate the information you provided in Exhibit D.

JAN GILBERT (Progressive Leadership Alliance of Nevada):
I concur with Mr. Sasser's testimony. We must remember the Nevada Check Up is bringing in enhanced funding from the federal government. It is a savings for the State. It is an insurance program, not a handout. Individuals pay for coverage under the program.

Our uninsured percentages are increasing. The Great Basin Primary Care Association states, "Our people without health insurance have increased 17.1 percent."

We know these people are going somewhere for their health insurance. Unfortunately, they end up in our emergency rooms. The Division has done well in working through obstacles and the Alliance wants to support them and support families to receive the health care their children need.

CHAIR CEGAVSKE:
There being no further testimony to come before this subcommittee, the meeting is adjourned at 9:11 a.m.

RESPECTFULLY SUBMITTED:

_____
Cynthia Clampitt,
Committee Secretary

APPROVED BY:

_____
Senator Barbara K. Cegavske, Chair

DATE:_____

_____
Assemblywoman Sheila Leslie, Chair

DATE:_____