MINUTES OF THE
SENATE COMMITTEE ON HUMAN RESOURCES AND EDUCATION

Seventy-fourth Session
February 12, 2007

The Senate Committee on Human Resources and Education was called to order by Vice Chair Barbara K. Cegavske at 1:34 p.m. on Monday February 12, 2007, in Room 2135 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to the Grant Sawyer State Office Building, Room 4401, 555 East Washington Avenue, Las Vegas, 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.

COMMITTEE MEMBERS PRESENT:

Senator Barbara K. Cegavske, Vice Chair
Senator Dennis Nolan
Senator Joseph J. Heck
Senator Valerie Wiener
Senator Steven A. Horsford
Senator Joyce Woodhouse

COMMITTEE MEMBERS ABSENT:

Senator Maurice E. Washington (Excused)

STAFF MEMBERS PRESENT:

Marsheilah D. Lyons, Committee Policy Analyst
Joe McCoy, Committee Policy Analyst
Sara Partida, Committee Counsel
Betty Ihfe, Committee Secretary

OTHERS PRESENT:

Charles Duarte, Administrator, 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
Jeff Weiler, Chief Financial Officer, Clark County School District

Patrick Cates, Administrative Officer IV, Division of Health Care Financing and Policy, Department of Health and Human Services
Connie McMullen, Chairman, Senior Services Strategic Plan Accountability Committee

VICE CHAIR CEGAVSKE:
Chair Washington is absent and excused. Today, we will hear an overview of Nevada Medicaid, a presentation of that budget and a presentation of the Committee Brief.

CHARLES DUARTE (Administrator, Division of Health Care Financing and Policy Department of Health and Human Services):
In this overview, I will focus on provisions related to mandatory and optional services in Medicaid coverage groups. I will comment on certain aspects of the budget and go over the direction we are headed in our overall program.

In the document, Medicaid and Nevada Check Up Overview (Exhibit C, original is on file in the Research Library), is a summary of the three major programs the Division of Health Care Financing and Policy administers. The first, Medicaid, provides health care to low-income families as well as aged, blind and disabled individuals. The second, Nevada Check Up, provides health coverage to low-income, uninsured children who are not eligible for Medicaid. The third program, Health Care Cost Containment, provides reports on hospital financial status, hospital community investments and collects fees from insurers which support the Legislative Committee on Health Care.

Medicaid is an optional medical federal-state partnership authorized under Title XIX of the Social Security Act. It was established nationally in 1965 and in Nevada in 1967. The oversight agencies are the federal Centers for Medicare and Medicaid Services (CMS). In Nevada, we cover all mandatory groups plus a few optional services. Our current caseload is 166,162 Nevadans.

Each recipient group must meet specific income and asset standards to qualify. The eligibility standards were set by Congress in the Welfare Reform Act effective July 16, 1996. An individual less than 21 years of age on Medicaid must be covered by both the mandatory and optional services. This federal entitlement is called Early and Periodic Screening, Diagnosis, and Treatment.

By utilizing other federal authorities, we cover services not covered in the traditional Medicaid program. Home- and community-based, long-term care services for individuals who would otherwise be in a nursing home or institutionalized are operated under waivers approved by the U.S. Secretary of Health and Human Services.

The Federal Medical Assistance Percentage (FMAP) defines the level of funding provided by the federal government to Nevada. It is based on the average household income in the state as compared to the rest of the nation. Basically, the FMAP goes down when incomes in the state go up. It is countercyclical to the general economic indicator of household incomes. We have seen a decline in our FMAP as a result of increases in the average household income in Nevada.

MR. DUARTE:
Besides federal funds and general funds from the State, we receive intergovernmental transfers from local government entities. These funds are used to pay subsidies to hospitals and to match federal funds for services that are required to be rendered by counties for institutionalized clients. Funding is also received from school districts.

To maximize federal revenues in supporting Nevada's health care infrastructure, we match those dollars in budgets of sister agencies in the Department. It is important to note there are no fee increases in those budgets.

Our largest Medicaid caseload is the Temporary Assistance for Needy Families (TANF) group. Most of these families are not on cash assistance, choosing to be only on medical assistance. Just under 50 percent of the expenditures are consumed by the Medical Assistance for the Aged, Blind and Disabled population. This group constitutes about 24 percent of our caseload and is the most costly-to-care-for population.

Nevada Check Up established under Title XXI of the Social Security Act in 1997 began in Nevada in 1998. It provides coverage for children from birth through 18 or those who have been uninsured for 6 months. While the families do not qualify for Medicaid, the services they receive under Nevada Check Up follow the Medicaid guidelines. We collect quarterly premiums ranging between $15 and $70 based on the family's income level. Our current caseload is 28,039 children with a budget of about $81 million in federal and state funds.

VICE CHAIR CEGAVSKE:
I have received a sample of the application used to apply for these funds. It is extensive. Is there assistance available to help people fill out the forms?

MR. DUARTE:
I think most of the packet you received is the program application for the Division of Welfare and Supportive Services (Welfare).

VICE CHAIR CEGAVSKE:
Nevada Check Up is on the front of the entire packet. How do people get the Nevada Check Up application?

MR. DUARTE:
The Nevada Check Up has a three-page application. We do have staff available in Las Vegas and Carson City plus telephone operators to assist people in filling out the form. The application is available from community health centers and hospitals. HealthInsight, an advocacy and outreach agency, and the grant funds from the Fund for a Healthy Nevada both provide continued support for outreach services and application assistance. The clients complete the form and mail it to our office.

VICE CHAIR CEGAVSKE:
I will let you decipher what I was sent because it looks as though it all flows together.

MARY WHERRY (Deputy Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services):
You were sent two applications. The first piece is the Nevada Check Up application and the rest are forms to apply for Medicaid.

VICE CHAIR CEGAVSKE:
Do they all have to be filled out to receive the benefits?

MR. DUARTE:
To apply for Nevada Check Up, just those few pages need to be completed. When applicants are assessed at a lower income level, they are referred to Medicaid. At that time, the more lengthy Medicaid application is sent from Welfare to the client. The application is used to simultaneously assess an

individual's eligibility for other federal benefits such as child care, food stamps, TANF and potential institutional eligibility.

VICE CHAIR CEGAVSKE:
With that clarification, I am satisfied that the Nevada Check Up application is not as overwhelming as it first seemed.

MR. DUARTE:
Assembly Bill No. 493 of the 73rd Session required the Director of Health and Human Services to apply for a Medicaid waiver for the Health Insurance Flexibility and Accountability (HIFA) initiative. A waiver gives states the flexibility to do things that otherwise would not be possible in a traditional Medicaid or State Children's Health Insurance Program (SCHIP) or Nevada Check Up program. One waiver covers pregnant women who have income above the current Medicaid level of 133 percent of poverty but no more than 185 percent of poverty. A new program, the Employer Sponsored Insurance Subsidy program, is called Nevada Check Up Plus (NCU-Plus). It provides a monthly subsidy up to $100 a month toward the cost of health insurance for that parent who cannot afford insurance and is employed by a small business employer. The employer must meet certain criteria and the employee's household income cannot be more than 200 percent of poverty.

SENATOR HECK:
For NCU-Plus, is it required for the children to be enrolled in Nevada Check Up?

MR. DUARTE:
The children do not have to be enrolled in either Nevada Check Up or Medicaid, but they do have to be eligible from an income perspective. If the parent applies to NCU-Plus and the children are not enrolled, it is an opportunity to determine if they are eligible for either Medicare or Nevada Check Up.

SENATOR HECK:
The goal is to enroll the children in one of the programs, if eligible.

MR. DUARTE:
That is correct.

SENATOR HORSFORD:
How does your department track the enrollment or participation in either of the HIFA waiver programs?

MR. DUARTE:
It is a federal reporting and tracking requirement that when individuals qualify for either component, they are given an aid code number and assigned a benefit plan. That information flows into our system so we can identify individuals specifically under these programs.

SENATOR HORSFORD:
How do we get the word out about NCU-Plus?

MR. DUARTE:
We interface through Welfare with the Department of Employment, Training and Rehabilitation to disseminate the information. Using our Nevada Check Up database concerning the employment of parents, we are in the process of mailing to 8,000 individuals advising them of the program. We also work with Covering Kids & Families for contacts. We have amended our contract with First Health Services Corporation to subcontract with Health Management Systems to check the eligibility of the employer's insurance offered and determine whether or not the employees have credible coverage.

VICE CHAIR CEGAVSKE:
Although we are the policy committee, I have asked Mr. Duarte to review portions of the budget because there are some issues that intertwine.

MR. DUARTE:
In the past two years, we have focused on several initiatives. In the stabilization of our claims payment system, payment on a clean bill is now sent within 10 days and 99 percent of claims are adjudicated within 30 days. In the pharmacy area, we have saved millions of dollars by improving generic utilization and putting maximum costs on the use of specific multi-source generic products. The recent increase in federal scrutiny and oversight is becoming a more important part of our budget and of our overall programming.

Under the tab, "Organization," page 3 of the Budget Presentation (Exhibit D, original is on file in the Research Library), the majority of positions being requested for the fiscal biennium are to address fiscal oversight and integrity of

the program, fraud and abuse detection, recovery of overpayments plus expanding the State recovery program.

SENATOR WIENER:
In breaking down the expenditures and creating greater efficiencies to avoid long-term, more expensive costs later, are preventative and early intervention measures built into your program?

MR. DUARTE:
Yes. I will introduce those initiatives later in this presentation. By including them, we expect to forestall the use of more expensive, higher-acuity care services.

SENATOR WIENER:
Have we been collaborating with other states to create greater efficiencies in purchasing amounts of product that Nevada needs, rather than having to purchase the manufacturer's required minimum amounts?

MR. DUARTE:
Yes. We are one of ten states in a national Medicaid pooling initiative. We negotiate pricing with manufacturers which ties into our preferred drug list program. This has resulted in 2 million covered lives and over $2 billion in Medicaid drug spending. Within the Department of Health and Human Services, the Division of Mental Health and Developmental Services is part of a consortium that purchases drugs for their hospitals and clinics.

Over the next biennium, we are requesting over $1 billion in General Fund monies. The overall program is budgeted at $3.2 billion. The General Fund shares about one-third of the overall program. The rest comes from federal and local government funds. That break out is on page 4 under the tab, "Overview."

Under the tab, "Overview," page 10 of Exhibit D, the chart illustrates the decrease in Title XIX or Medicaid funding in the last biennium in our budget from over 51 percent to 48 percent. That is the result of Nevada's higher household incomes which impacts our declining federal-match rates.

SENATOR HORSFORD:
Can you provide trend data on the amount of declining federal match?

MR. DUARTE:
The impact for this biennium was approximately $10 million. We do have those figures over several bienniums and will provide those to you.

SENATOR HORSFORD:
Based on the trends from the past, do you have projections for the next 10 to 15 years?

MR. DUARTE:
The base set by Congress for the medical-payments, percentage-match rate is 50 percent. We are at 51 percent, so we can lose only 1 percent more under the current formula.

SENATOR HORSFORD:
If Congress decides not to reauthorize these programs at the current level, how will we maintain services?

MR. DUARTE:
It is unlikely Congress would lower the Medicaid match rate below 50 percent. While they can change the formula, they have not changed it in 40 years even in the most difficult economic times. At greater risk for limited funding through the reauthorization process may be the SCHIP which Congress is considering now.

Our caseload for this fiscal biennium did not hit budgeted targets in either Medicaid or Nevada Check Up. We have seen a flattening of caseload growth. Some factors contributing to this are the new federal requirements for citizenship documentation, individuals not following up on the application process, our State's rapid population growth and the increase in Nevada's household incomes.

Under the tab, "Demographics," page 20 of Exhibit D, our aging projections indicate the number of people over 65 will increase in Nevada more than any other state. Between the years 2000 and 2030, the aging population will go up 264 percent. There was a disproportionate increase of 157 percent in people with disabilities moving to Nevada as opposed to the rest of the nation between 1990 and 2000. On a per capita basis, Nevada spends less on Medicaid than any other state in the nation including the District of Columbia. This has been the same for eight of the last nine years.

SENATOR HECK:
Is that per capita for the entire population or per capita per enrollee? Does the robust economy in our State for the last eight years factor into the lower per capita payment?

MR. DUARTE:
It is per capita for the entire State population and the economy does impact it. Another reason is our eligibility standards. We maintain some of the lowest eligibility standards in the nation. We rank 47th in the nation when it comes to the percentage of the population we cover with Medicaid. The average across the nation is about 19 percent; we cover about 11 percent.

This bears more consideration when you start talking about the private sector and health coverage to employers. Think of the health care sector as a balloon that is ever-inflating. Employers and insurance companies squeeze one part of that balloon. Then Medicare and Medicaid squeeze another part of the balloon. The air in the balloon keeps getting shifted back and forth. Ultimately, people with employer-based coverage end up paying a premium tax associated with what they pay for health coverage. That can be as much as 10 percent of the premium because the cost of the uninsured has to be offset. When you think of the economics of this, you also have to think of the ramifications of reducing coverage in a public program and what that will mean not only to the uninsured but also to the employer-based coverage groups that are really paying for the uninsured's care.

A list of Budget Decision Units describing some of the related initiatives we want to undertake are summarized under the tab, "Budget Request," page 25 of Exhibit D. The first is the professional fee-schedule increase which links to our ability to make sure people have access to care. We conducted several provider surveys. We surveyed over 600 physicians in a variety of practices statewide. In general, across the State about 91 percent of physicians participate in Nevada Medicaid; 85 percent take new Medicaid patients and 90 percent continue to see their established patients. With substantially more physicians in southern Nevada, there are geographical distinctions and gaps in participation elsewhere. In the north and rural areas, only 71 percent of the physicians take Medicaid clients; 55 percent take new patients and 68 percent see established patients. Matching the 2007 Medicare fee schedule is an appropriate move in order to manage care and provide early intervention to high-cost services. Patients do need "medical homes" where their care is

coordinated. The care for the most high-cost patients we serve is provided by specialists and access to specialists statewide is a problem.

VICE CHAIR CEGAVSKE:
We have found that specialty physicians say the high cost of their medical liability insurance prevents them from providing services in the lesser-served areas. Instead of being in business on their own, many are going into cooperative groups to offset the cost of their insurance. The Western Interstate Commission for Higher Education program is still in need of enhancement of their services, especially dental care in the rural areas. Is there anything we can do to get physicians into these areas?

MR. DUARTE:
An essential component to accomplish this should be to develop greater capacity within Nevada through graduate education and expansion of the medical residency programs.

The next initiative concerns Care Coordination Management. Many noninstitutionalized people in aged, blind and disabled programs and children in residential treatment centers with extended lengths of stay are left to fend for themselves. As it is complicated to get these special populations the care they need across the spectrum of service providers, we want to identify 4,000 of our highest-cost, highest-need clients and assign them a care coordinator. The care coordinator would be a professional person, usually a nurse. This professional would assist them in making and implementing a care plan. Their "medical home" physician would make referrals and be their follow-up component. This initiative would result in more appropriate placements.

VICE CHAIR CEGAVSKE:
Were you able to break down the $2.1 million cost for the 4,000 clients to a cost for each client and was it based on the highest level of care? Can you get that information to us?

MR. DUARTE:
They are primarily the noninstitutionalized aged and disabled with a focus on the disabled. The clients remain in the community, but go the emergency rooms or are admitted to hospitals which result in high utilization costs. I will get that information to you.

Another of our initiatives would provide an option to the aged and disabled recipients to allow them to enroll in a specialized managed-care program. We would target about 5,000 recipients who, on a voluntary basis, would elect to go into this program provided through one integrated health care company experienced in working with the Medicaid population. At this time, about 28 states offer a similar program.

VICE CHAIR CEGAVSKE:
Would you talk about the Fee for Service?

MR. DUARTE:
In a full-risk contract with a managed-care entity, you pay prospectively. That means you pay a premium for each person, each month, at the beginning of a month. The payment is based on actuarial calculations of what the cost of the care will be for that population. It may even be individualized for specific groups of diagnoses. For individuals moving from the full Fee-for-Service program, we would expect there would be a "tail." Tails are claims that providers submit after the date of service. We expect that tail to wind down after a three-month period. The tail is not in this decision unit; it is in another part of the budget. We have been conservative in our actuarial estimate of savings using 7.5-percent savings over fee for service. Some states have achieved 19-percent savings. We think we can achieve budget neutrality and cost savings in the future within 24 months.

SENATOR NOLAN:
What percentage of the eligible population do the 5,000 recipients represent? If you are successful, would you expect to expand the program?

MR. DUARTE:
It is about 20 percent of the eligible population. Yes, if we are successful, we would look to expand.

The next initiative we are going to implement concerns fiscal integrity and accountability. The federal Government Accountability Office, formerly the General Accounting Office, has identified Medicaid programs across the nation as high-risk. We have numerous audits underway and others will be undertaken to look at the fiscal integrity in the Medicaid program. We want to be proactive in providing the necessary oversight and guidance to people who are receiving federal funds. We want to make sure those funds are accessed and paid

appropriately. We do not want to have to pay back federal funds as we have had to do this biennium.

In order to achieve the accountability we seek, we are augmenting our accounting and auditing staff to enhance our fraud and abuse detection and our recovery services. We have the technology tools available, but lack adequate staff to utilize them. We have the opportunity to decrease inappropriate payments, increase recoveries of inappropriate overpayments plus recover estate dollars. Estate dollars are derived from the bona fide sale of a house when an individual has been institutionalized and there is no longer a need for the home by the community spouse, a child or adult disabled child. It is a federal requirement that a lien be put on the home, so the cost of care and assistance can be reimbursed, or partially reimbursed, to the State.

VICE CHAIR CEGAVSKE:
Is this the opportunity for us to discuss the audit and review completed in fiscal year (FY) 2006-2007?

MR. DUARTE:
Yes. Since 2000 or 2001, we have had a contract with the Clark County School District (CCSD) and have paid them for Medicaid administrative services. These are services they provide to help support outreach and enrollment activity throughout the school district. There is a methodology for identifying those costs and for paying them.

There was a federal audit by the Office of the Inspector General (OIG) on behalf of the CMS in 2005. Published on December 22, 2006, the audit identified approximately $5.7 million in disallowable costs that were paid to the CCSD. They had billed us for services and we had invoiced the federal government. We paid the school district only the federal dollars associated with those administrative services.

As a result of the OIG findings, we have been informed recently that CMS intends to take the $5.7 million out of our December, 2006 ending grant. This will have a significant impact on our budget if we do not get that immediately repaid by the school district. An option we have discussed with the school district was to offset that federal disallowance with future claims payments. However, because the school-based administrative claiming program has been put on hold by the CMS due to these problems, we have limited opportunity to

recoup the money from the school district. We are looking at other legal means to pursue those funds and we are in discussion now with the director. We will be talking with the school district about other means for us to immediately be repaid those funds. These are dollars that otherwise we will be paying back to the federal government from the State General Fund. These dollars would otherwise have been matched with federal money, so essentially doubled, and could have gone to the care of many individuals in the Medicaid program. That does say the school district does not have a need, they certainly do, but we also have a need in Medicaid for those dollars, and we need to get that repaid immediately.

VICE CHAIR CEGAVSKE:
As a policy committee, it is appropriate for us to delve into this issue and make some changes. When I spoke with the school district's representatives, they indicated that MAXIMUS, Incorporated was the group hired by the CCSD at the recommendation of your agency, is that correct?

MR. DUARTE:
No, that is not correct. While I was not here when MAXIMUS was mentioned as a possible federal revenue maximization vendor, I am aware that in 1988 or 1989, the Department entered into a contract with MAXIMUS to maximize federal revenue. School districts were permitted to participate, but were not required to do so, nor were the districts to inappropriately bill us, which I think is the crux of the matter.

VICE CHAIR CEGAVSKE:
We will get to that, but let us work our way through the first part of this. It is important that today we figure out where we are going from here. We are looking at a budget of close to $10 million total.

MR. DUARTE:
That is right. It is a lot of money, and we can ill-afford to float that.

VICE CHAIR CEGAVSKE:
In order for the school district to give back that money, are they looking at billing or continuing to bill for Medicaid dollars? Then, that money they would normally get reimbursed would stay with you, correct?

MR. DUARTE:
That would have been one possibility; however, we only get about $1 million a year in claims from the CCSD, so we would have to float that liability for five or more years.

VICE CHAIR CEGAVSKE:
How did we have a $5.5 million figure in FY 2003-2004?

MR. DUARTE:
We get about $1 million in claims a year for services, such as therapy services rendered by school-based practitioners, and we pay. Specifically, with respect to the administrative claims, those are not health care services. Those are administrative activities. Those claims and payment for those claims have been discontinued by the CMS. We are no longer getting federal money for those claims. We have over $3.2 million in claims which have been deferred and are waiting a formal disallowance.

VICE CHAIR CEGAVSKE:
Is that part of the $5.5 million?

MR. DUARTE:
Actually, it adds to the $5.5 million.

VICE CHAIR CEGAVSKE:
Is that the $3.4 million addition?

MR. DUARTE:
That is in addition to that.

VICE CHAIR CEGAVSKE:
You are saying it is $1 million a year and that is what I am unclear about. If it is $1 million a year and we have $5.5 million for FY 2003-2004 and $3.4 million for FY 2004-2005, what is that total?

MR. DUARTE:
Those are for subsequent quarters not found in the OIG audit. There are two revenue streams the school district receives from us. One has been through this Medicaid Administrative Claiming process. The second is for legitimate services they provide to children in the school district such as therapy services,

speech therapy and others. The administrative claiming revenue stream has been discontinued. It is the largest stream and that is what has been disallowed.

VICE CHAIR CEGAVSKE:
The CCSD fills out the information; they send it to your agency, and you send it on to the federal government for them for reimbursement, correct?

MR. DUARTE:
Yes.

VICE CHAIR CEGAVSKE:
Where was the oversight with your Division, your agency?

MR. DUARTE:
We did not have the audit staff to do that kind of oversight on these claims. We have one auditor in our Division who had other responsibilities, so in the budget for this biennium we are requesting additional audit staff. In terms of historical oversight, the responsibility does fall to the provider, and it is so indicated in the local agreement with the school district.

VICE CHAIR CEGAVSKE:
When this all started, the State had to come up with a plan. Your agency came up with how the plan is to be achieved, what qualifies and what does not. What happened?

MR. DUARTE:
They did not follow the plan.

VICE CHAIR CEGAVSKE:
The CCSD did not follow the plan?

MR. DUARTE:
I do not know who is to blame, whether it was their vendor or the school district. Our contract is with the school district.

VICE CHAIR CEGAVSKE:
Could there have been anything fraudulent that came from the agency?

MR. DUARTE:
Which agency do you mean?

VICE CHAIR CEGAVSKE:
From the group that was hired, the MAXIMUS? Was that talked about because I know they are no longer working for the State, correct?

MR. DUARTE:
That is correct.

VICE CHAIR CEGAVSKE:
They were let go because of these practices?

MR. DUARTE:
I do not believe they were directly related to these practices.

VICE CHAIR CEGAVSKE:
Are there other school districts out of the 17 in the same situation?

MR. DUARTE:
No, because we have discontinued administrative claiming. They do not have a contract with us. Before they got started, this issue came up and we put those contracts on hold.

VICE CHAIR CEGAVSKE:
This is very disheartening.

MR. DUARTE:
It is for us, too.

VICE CHAIR CEGAVSKE:
I understand. We will go to Las Vegas now for testimony.

JEFF WEILER (Chief Financial Officer, Clark County School District):

> I didn't have anything specifically prepared. I was here to respond if you had questions or comments that you wanted me to make specifically. I will say that we have done a very exhaustive review of our claiming process. At the time these claims were made, going

> back to 2001, we believed, and again I am fairly new here, too, I started in September, so I wasn't around in those days, but having looked into it, we did submit claims in accordance with what we thought were the guidelines. It wasn't until this federal review that Mr. Duarte mentioned that we were aware there were some problems with our claiming. That was in 2005, September, I believe. We immediately made some adjustments in our processes and even some staffing changes. And then, shortly thereafter, discontinued our relationship with the vendor you've mentioned, MAXIMUS, and put 'em [*sic*] on notice that per the agreement we had with them, that we will seek repayment of the fees that were paid to them upon such an event that is turned out happening where we're required to repay the funds to the State and all that. So that's where we are right now.

VICE CHAIR CEGAVSKE:
You are saying that the school district is responsible for not following the plan? In talking with the auditors this last week in the Senate Committee on Finance, they said they are continuing with that investigation. They are trying to work out who is liable in this. Are there things you are not able to talk about today to help us?

MR. WEILER:

> No,—We did, again as I said, we followed the guidelines as we understood them, and submitted the claims again via our vendor, MAXIMUS, through the State to the federal government. The reimbursement came back and again, it wasn't until they started their review in 2005, meaning the federal CMS folks or the Office of Inspector General, that we were aware that there were any problems with what we had submitted. And, of course, immediately we made changes once we knew that. And I am not aware of what, beyond what came out in the official report in December, what additional steps they might be doing.

VICE CHAIR CEGAVSKE:
Can you tell me how you are going to pay back the State and how soon that is going to happen?

MR. WEILER:

> Well, in fact, we have a meeting, I believe later this week, or a conference call, with Mr. Duarte and I am sure that is one of the things we will talk about. It will be very challenging for us much the same as what Mr. Duarte mentioned about the State's part of this as well. It will be very difficult for us as this is a lot of the services we get reimbursement for under this, even though it is administrative, are things that we typically would have to be doing anyhow with our medically fragile students under other federal guidelines that we have to operate. So, we will have to make adjustments and, you know, it'll have to come from somewhere. So, but again, we will comply with whatever agreements we have, both with the State and certainly comply with the review that the federal government has conducted. It will be very challenging to do that for us.

VICE CHAIR CEGAVSKE:
Does the school district think they have a handle on what is allowable now and what is not?

MR. WEILER:

> Yes, I believe we do. And we've gone, again, through a very extensive process of reviewing everything. We've looked at the specific findings in the report issued by the federal government, and yes, I believe we do.

VICE CHAIR CEGAVSKE:
You said there has been a change of administration over this. There is not the confidence in the people that were there, so they are no longer in those positions? Are they still working for the school district though?

MR. WEILER:
"They are still in the district, yes, but they are not involved with this particular process."

VICE CHAIR CEGAVSKE:
What kind of confidence can you give us that the $10 million, or is it more than $10 million, will be repaid to the State?

MR. DUARTE:

> Actually the repayment from them is, right now, is $5.7 million. And there is the potential for additional monies as I mentioned, but those are, I was saying though, if they, if that $5.7 million were to be retained by the State in the Medicaid program, I could match it with federal money because I have to repay with State General Fund, so their debt to us is only $5.7 million at this time.

VICE CHAIR CEGAVSKE:
Is that for the FY 2003-2004? Are there more funds in the next year? I am accumulating the amounts. I am talking about all of it.

PATRICK CATES (Administrative Officer IV, Division of Health Care Financing and Policy, Department of Health and Human Services):

> I just want to clarify the $3.4 million from the deferral; those were for claims after the OIG audit period.—Those funds were actually—taken by CMS last State fiscal year. So, in terms of a budgetary shortfall for us in this year, the $3.4 million was already taken by the feds. What we've been doing is working with the school district to revise those invoices to satisfy CMS that they're legitimate. We've submitted one invoice to them that was originally approximately $1.1 million. Of that, we have some agreement from CMS that about $400,000 of it appears to be allowable. And there is, I think, one or two other invoices that we're currently working with the school district to resubmit. So, the $3.4 [million] is already taken from our budget last fiscal year. And we're trying to recoup some of that for the district before we settle up on how much is owed for the $3.4 million. So, the main concern for our budget is the $5.7 million from the OIG report.

SENATOR WIENER:
On the $5.7 million, is that a 1-for-1 match? At this point, have we lost double if we have no recovery? Have we lost the money and lost the match?

MR. DUARTE:
"It is 51 percent federal match. Sorry, Mr. Cates just corrected that administratively, we only get 50 percent, so it is 1-for-1."

SENATOR HECK:
Was there any inclination that services billed for were not performed?

MR. DUARTE:

> I don't believe so, Senator Heck. I think the OIG audit details out some of the specific findings. And they were more related to claiming for services which—were probably rendered but not necessarily to a Medicaid population.

SENATOR HECK:
Did the OIG's report comment as to the validity of the plan? The issue is if there is not a problem with the plan, it is a problem with compliance with the plan, correct?

MR. DUARTE:
"It's the latter. It's a problem with the compliance with the plan."

VICE CHAIR CEGAVSKE:
Mr. Weiler, in talking with the auditor, they are still investigating the question that you asked. That is part of what the Audit Division is looking into as the Legislative Counsel Bureau (LCB) has been brought into this.

MR. CATES:

> Just to clarify the OIG audit. The term 'service' was used, and I just want to clarify, this isn't medical services. This is the administrative expenses. Like we have our own administrative expenses—

VICE CHAIR CEGAVSKE:
Would you name some of those? I would like this Committee to hear some of the things that were requested for reimbursement.

MR. CATES:

> Well, exactly what I was going to speak to. The very, the largest component that was disallowed was—debt service on capital projects. By far, the largest component clearly doesn't have anything to do with Medicaid outreach. All of the administrative claiming is the result of allocations and time studies. And it is supposed to capture the costs of school district staff trying to get people enrolled in Medicaid, is the bottom line. And, and the debt service was the most clear example of something that doesn't conform to that.

MR. WEILER:

> I—the—it wasn't so as was just mentioned; it wasn't services directly. It was and where the, as it turns out, the issues arise with [*sic*] was [*sic*] the basis that we calculated the reimbursement on. We included debt service and some capital costs that was not part of the agreement. Again, it was not an intentional thing—and, by any means but it was done.

VICE CHAIR CEGAVSKE:
It was creative.

MR. WEILER:

> Well, I can't speak to that but—I don't know, since I wasn't here at the time, I don't know, but I believe it was just a misunderstanding of the guidelines that we were operating under is really how I would characterize that.

VICE CHAIR CEGAVSKE:
Mr. Duarte, is there anything we need to do with the State plan to tighten up things when we are working with the school districts or with other entities on this issue? Do you have any safeguards in place? Have you changed anything you are doing?

MR. DUARTE:

> Yes. You know in specifically getting back to what Mr. Cates was saying, we've, we're making sure that they understand, number one, what is allowable as administrative costs and, number two, that there is appropriate documentation to support the claim. And, specifically as, as Patrick indicated—we need to make sure there is appropriate time studies and documentation of their direct and indirect costs, so that we can demonstrate to the satisfaction of the federal government that those claims are appropriate and that they are consistent.

SENATOR CEGAVSKE:
Were there no red flags? It is amazing to me we could be that far off and there would be no red flags to the State agency.

MR. DUARTE:
"Well, I, I have to say that we did not examine those claims in any level of detail. And we were assured that they were in compliance with the State Medicaid Administration Claiming Guide."

VICE CHAIR CEGAVSKE:
From now on, will you be doing more?

MR. DUARTE:
"We are a little more skeptical."

VICE CHAIR CEGAVSKE:
That is what I wanted to hear. Mr. Weiler, are there any other comments you want to make? You said there is going to be a conference call with the agency. Are you going to be working out how it is going to be repaid? And the next time we see you, will you have those details for the subcommittee?

MR. WEILER:
"Yes. That is our plan as of right now."

VICE CHAIR CEGAVSKE:
Mr. Weiler, I realize you were not responsible for what has happened, but it is now your responsibility to fix it. We will be looking forward to that.

MR. WEILER:
"I take that very seriously. And we'll make sure that we do everything we can and to cooperate and make right on all this."

VICE CHAIR CEGAVSKE:
It was important that we get this all out because we have only had it piecemeal in the other committee.

MR. DUARTE:
In the Budget Presentation, under tab "Budget Request," page 35 of Exhibit D, there is a listing of the other program initiatives we plan to implement. Studies for the Dental Benefits to Pregnant Women initiative show the impact of proper preventive dental care in bringing a birth to full term. With this care, significant reductions in preterm births result. Other states offer this benefit because it makes fiscal sense and because it is the right thing to do from a quality-of-care perspective.

There are several other decision units on page 35 of Exhibit D that I will highlight. One is eliminating the unearned income limit for our Health Insurance for Work Advancement program. This would increase the number of disabled Nevadans who want to go back to work and retain their Medicaid benefits. We have a low enrollment in this. These individuals still need the personal assistance services provided by Medicaid to enable them to return to work.

The Aging Out of Foster Care program was funded for just this current biennium. We are putting general funds in our budget to continue this program, so foster children up to the age of 21 can continue to receive Medicaid if they need it.

Another decision unit concerns Traumatic Brain Injury services. Adding $1 million would provide residential rehabilitation and behavioral adult day-care services. Without these services, many of these individuals would probably be institutionalized.

Under tab, "BDRs & LOIs," pages 59 and 60 of Exhibit D, there is a list of the Bill Draft Requests and Letters of Intent from our Division.

VICE CHAIR CEGAVSKE:
After the Committee Brief overview, we will hold public comment.

MARSHEILAH D. LYONS (Committee Policy Analyst):
The document, Committee Brief Senate Committee on Human Resources and Education 74th Regular Session (Exhibit E, original is on file in the Research Library), reviews the jurisdiction of the Committee and defines this Committee's counterparts on the other side, the Assembly Committee on Health and Human Services Committee and the Assembly Committee on Education.

As the Policy Analyst for the human resources issues of this Committee, I will review those portions of the document, and Joe McCoy, the Committee Policy Analyst for Education, will review that portion of the brief. On page 14 of Exhibit E, under the Health and Human Services Policy Issues heading, in the 2005 Session, the Committee addressed a broad spectrum of issues listed. Next is a summary of many of the significant measures processed by this Committee. The chart on page 19 of Exhibit E shows a portion of this Committee's reports from the 2005 Session. More comprehensive reports and summaries are available at your request.

On the bottom of page 19 of Exhibit E, I draw your attention to the Legislative Committee on Health Care Bulletin (LCB Bulletin No. 07-20). This document is produced in the Research Division and is a summary of the work accomplished during the interim by the Legislative Committee on Health Care. During this particular interim, we had a contractor working with us who put together a health care strategic plan. We will be making that available to you soon.

Significant issues for this Session include access to health care, child welfare and substance-abuse addiction and treatment. We expect all these to be discussed and deliberated extensively. Some of the State and federal issues expected to be debated during this Session are listed on page 23 of Exhibit E.

JOE MCCOY (Committee Policy Analyst):
The Education Policy Issues begin on page 3 of Exhibit E. We have listed a number of important education issues from the 2005 Session. The issues are divided between Elementary and Secondary Education and Postsecondary or Higher Education headings. On page 6 of Exhibit E, we have included a list of bills that were unsuccessful in the last Session. On pages 6 through 9 of Exhibit E, a number of reports to be submitted to the Legislature are listed. Following that list is a summary of the work of the several Interim Legislative Education Committees.

Significant Issues for the 2007 Legislative Session are on pages 11 through 13 of Exhibit E. Some of those listed are funding, the Empowerment Schools Plan that Governor Jim Gibbons mentioned in his State of the State Address, all-day kindergarten, teacher incentive pay, career and technical education, and the Millennium Scholarship program.

Pages 24 through 28 of Exhibit E give contact information for education and for human resources. On the final page is the Schedule for Implementation of the 120-Day Session.

VICE CHAIR CEGAVSKE:
We will now hear public comment.

CONNIE MCMULLEN (Chairman, Senior Services Strategic Plan Accountability Committee):
On behalf of the Senior Services Strategic Plan Accountability Committee, I am speaking in favor of the Nursing Home Rate in the *Executive Budget* under Items for Special Consideration, Decision Unit E428. This is not budgeted in this Session and this is the third session we are advocating for it. As described in the handout (Exhibit F), this item affects seniors with co-occurring behavioral issues that are placed in nursing homes out of state. This priority in our strategic plan would bring seniors "home." Home means bringing these patients back to Nevada for care.

The capacity in the State's nursing homes for these end-of-life, traumatic brain issue or Alzheimer's patients, who demonstrate aggressive or combative behaviors, continues to be shifted to nursing homes out of state. The 80 to 100 seniors have remained a constant number for the past several years. The Behavioral Nursing Home rate has been negotiated between the Nevada Healthcare Association and Nevada Medicaid. This rate would provide an incentive to entice interested providers to care for this special population in Nevada. In order to accomplish this, funding is needed to increase capacity, for staff, their training and liability. We ask that you reconsider and support this request.

I am also here to support the Items for Special Consideration, Decision Unit E407 in the *Executive Budget* which would fund a Behavioral Health Provider Recruitment Contact. Mr. Duarte issued a Request for Proposal but no in-state

or out-of-state provider responded. With that component of the Behavioral Nursing Home rate, it might be possible to fill this essential position.

VICE CHAIR CEGAVSKE:
From a policy perspective, bringing these issues to this Committee is appropriate. I urge you to appear before the Senate Finance Committee when they meet on this issue.

MS. MCMULLEN:
I will. Count on it.

VICE CHAIR CEGAVSKE:
There being no other issues before us today, this meeting of the Senate Committee on Human Resources and Education will now adjourn at 3:24 p.m.

RESPECTFULLY SUBMITTED:

_____
Betty Ihfe,
Committee Secretary

APPROVED BY:

_____
Senator Barbara K. Cegavske, Vice Chair

DATE: _____