MINUTES OF THE MEETING
OF THE
ASSEMBLY COMMITTEE ON WAYS AND MEANS
AND THE
SENATE COMMITTEE ON FINANCE
JOINT SUBCOMMITTEE ON HUMAN SERVICES AND
CAPITAL IMPROVEMENTS
Seventy-Fifth Session
May 11, 2009

The Assembly Committee on Ways and Means and the Senate Committee on Finance, Joint Subcommittee on Human Services and Capital Improvements was called to order by Chair Sheila Leslie at 8:09 a.m. on Monday, May 11, 2009, 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/75th2009/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
Assemblyman John Oceguera, Vice Chair
Assemblyman Morse Arberry Jr.
Assemblywoman Barbara E. Buckley
Assemblywoman Heidi S. Gansert
Assemblyman Joseph (Joe) P. Hardy
Assemblywoman Debbie Smith

SENATE COMMITTEE MEMBERS PRESENT:

Senator Bob Coffin, Chair
Senator Bernice Mathews
Senator William J. Raggio

THE FISCAL ANALYSIS DIVISION STAFF MEMBERS PRESENT:

Gary Ghiggeri, Senate Fiscal Analyst
Steve Abba, Principal Deputy Fiscal Analyst
Rick Combs, Senior Program Analyst
Janice Wright, Committee Secretary
Vickie Kieffer, Committee Assistant

Chair Leslie welcomed Rick Combs, Senior Program Analyst, Fiscal Analysis Division, and said the Subcommittee was glad he returned and looked well. She explained the Subcommittee would close budgets for the Department of Health and Human Services.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIGENT SUPPLEMENTAL ACCOUNT (628-3244)
BUDGET PAGE DHHS DIRECTOR'S OFFICE-28

Rick Combs, Senior Program Analyst, Fiscal Analysis Division, explained there were a couple of issues previously brought to the Subcommittee's attention during the budget hearings regarding the Indigent Supplemental Account (ISA), Budget Account (BA) 3244. The Governor recommended property tax receipts in BA 3244 of approximately $27.6 million for fiscal year (FY) 2010 and $27.9 million for FY 2011 based on the projected growth rates for the 75-cent property tax rate for the Distributive School Account (DSA). The property tax projections were declining, and the projection for BA 3244 had also been reduced based on the current projection for the 75-cent rate. The latest projections for the ISA were about $2.3 million less in FY 2010 and $4.7 million less in FY 2011. Based on these reductions of the property tax receipts, the Fiscal Analysis Division staff recommended a reduction of about $28,000 in FY 2010 and $79,000 in FY 2011 for the interest revenue earned.

Mr. Combs stated that the Governor's recommendation was to transfer the revenues generated in BA 3244 to the Division of Health Care Financing and Policy's Intergovernmental Transfer (IGT) Program account (BA 3157) as a means of offsetting General Funds in the Medicaid account (BA 3243). The reduced revenues created a General Fund need of approximately $7.1 million over the 2009-2011 biennium. The Fiscal Analysis Division staff recommended adjusting the revenues for BA 3244 based on the updated projections of property tax revenues and interest earnings.

> ASSEMBLYMAN OCEGUERA MOVED TO ADJUST THE REVENUES FOR BA 3244 BASED ON THE UPDATED PROJECTIONS OF PROPERTY TAX REVENUES AND INTEREST EARNINGS.
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> ASSEMBLYWOMAN SMITH SECONDED THE MOTION.
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> THE MOTION CARRIED. (Chair Arberry and Assemblywoman Buckley were not present for the vote.)

Mr. Combs said the major issue in BA 3244 was the use of property tax proceeds to offset General Fund need in the Medicaid program in decision unit Enhancement (E) 900. The Governor recommended transferring the property tax and interest receipts from BA 3244 to the IGT BA 3157 and then passing that revenue through to the Medicaid BA 3243, where the revenues would be used to offset General Fund. During the budget hearing conducted on January 26, 2009, representatives of local governments and hospitals testified that the loss of these property tax receipts to pay claims for hospital care would affect the counties. Mr. Combs said testimony had been provided indicating that hospitals would still be required to treat indigent patients, and the counties would still be required to reimburse the hospitals for the cost of treating those indigent persons.

Mr. Combs explained the American Recovery and Reinvestment Act of 2009 (ARRA) included a provision that prohibited states from receiving the increased Federal Medical Assistance Percentage (FMAP) rates if the state required political subdivisions to pay a greater percentage of the non-federal share of payments than the respective percentage required under the State Plan as of September 30, 2008. At the work session conducted on March 30, 2009, the Fiscal Analysis Division staff informed the Subcommittee that the Centers for

Medicare and Medicaid Services (CMS) indicated that Nevada's compliance with the ARRA provision may depend on whether the property tax receipts were considered county funds or state funds. If the funds were considered county funds, the counties would be required to pay a greater percentage of the non-federal share of payments than the respective percentage required under the State Plan as of September 30, 2008.

Mr. Combs said the Legislative Counsel determined the ARRA provision applied because Nevada required local governments to contribute toward the non-federal share of expenditures under the State Plan. Additionally, because the ISA was funded through two ad valorem taxes levied by the Board of County Commissioners of each county, and money from the ISA was used by the counties to reimburse the costs associated with providing medical care to indigent persons, the money was most appropriately considered county money. As a result, the use of the funds in the manner recommended by the Governor to offset General Funds in the Medicaid program would require the counties to pay a greater percentage of the non-federal share of Medicaid expenditures than the counties paid as of September 30, 2008. Using the funds in this manner could result in Nevada being unable to take advantage of the increased FMAP rates provided for in ARRA.

Mr. Combs said during the 25th Special Session conducted in December 2008, the Legislature approved the use of $25 million in funds from the Indigent Supplemental Account (BA 3244) in FY 2009 to offset General Fund revenue shortfalls. The funds were not required to be transferred through the Intergovernmental Transfer Program account for the purpose of expenditure as the non-federal share of Medicaid but were required to be transferred directly to the state General Fund to offset revenue shortfalls. Because the funds were not designated to pay the non-federal share of Medicaid expenditures, the FY 2009 transfer did not jeopardize Nevada's ability to take advantage of the increased FMAP rates provided for in ARRA. The Legislative Counsel indicated that the funds could be transferred to the General Fund again during the 2009-2011 biennium to ensure that the transfer of funds did not jeopardize Nevada's ability to take advantage of the ARRA FMAP provisions.

Mr. Combs said if the property tax receipts were not used to offset General Fund expenditures or were not transferred to the General Fund, the General Fund need resulting from the decreased projections of property tax receipts would increase from $7.1 million over the 2009-2011 biennium to $55.9 million over the 2009-2011 biennium.

Mr. Combs presented the following three options for the Subcommittee's consideration:

1. Do not approve the Governor's recommendation to transfer property tax receipts from the Indigent Supplemental Account to the Intergovernmental Transfer Program account to be used to offset General Funds in the Medicaid program, but approve the transfer of those receipts to the state General Fund as was approved during the 25th Special Session. If the Subcommittee chose this option, there would be a General Fund need of $7.1 million resulting from the decreased revenue projections for this account.

2. Do not approve the Governor's recommendation to transfer property tax receipts from the Indigent Supplemental Account to the Intergovernmental Transfer Program account, but approve the transfer of a portion but not all

of the receipts to the state General Fund. If the Subcommittee chose this option, the General Fund need of $7.1 million over the biennium would increase by the amount of the funds retained in this account for the payment of indigent medical claims.

3. Do not approve the Governor's recommendation to transfer property tax receipts from the Indigent Supplemental Account to the Intergovernmental Transfer Program account and leave the funding in this account for the current use of paying indigent medical claims. If the Subcommittee chose this option, the General Fund need of $7.1 million over the 2009-2011 biennium would increase to $55.9 million over the 2009-2011 biennium.

Chair Leslie said the Subcommittee had much discussion during the last three months about the funding. Based on the opinion of the Legislative Counsel, the funds must be transferred to the General Fund instead of to the Medicaid account.

Senator Coffin said he had a problem with the maneuver the Governor recommended because made it appear that if the Subcommittee disapproved of the Governor's recommendation, that the Subcommittee had created the General Fund need in the budget, when in fact the Governor had created the need in the budget. Senator Coffin said the Governor had created a problem for the citizens by stealing property tax from the local governments. Senator Coffin said the Governor had created problems on other occasions too.

Senator Coffin wondered how the Legislature would take the blame for the problem. Senator Coffin said the Legislature would require new tax money to try and balance the Governor's budget. Senator Coffin said the Governor had created a tax increase on the local governments and the citizens through the taking of their property tax. He did not like the idea. He was not one of those persons who would agree to support the Governor's recommendation even though he did not like it.

Chair Leslie asked whether Senator Coffin felt like coming up with $56 million to solve the problem. Senator Coffin confirmed he would find the funds. Chair Leslie said option 1 was to accept and transfer the money for the General Fund noting that because of the property tax reprojections, there still was a need of $7.1 million.

> SENATOR MATHEWS MOVED TO APPROVE OPTION 1, WHICH WAS TO NOT APPROVE THE GOVERNOR'S RECOMMENDATION TO TRANSFER PROPERTY TAX RECEIPTS FROM THE INDIGENT SUPPLEMENTAL ACCOUNT TO THE INTERGOVERNMENTAL TRANSFER ACCOUNT TO BE USED TO OFFSET GENERAL FUNDS IN THE MEDICAID PROGRAM, BUT APPROVE THE TRANSFER OF PROPERTY TAX RECEIPTS TO THE STATE GENERAL FUND AS WAS APPROVED DURING THE 25TH SPECIAL SESSION. THIS OPTION PROVIDED A GENERAL FUND NEED OF $7.1 MILLION RESULTING FROM THE DECREASED REVENUE PROJECTIONS FOR THIS ACCOUNT.
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> ASSEMBLYMAN OCEGUERA SECONDED THE MOTION.

Assemblyman Hardy said it seemed to him that the Subcommittee was choosing to increase the General Fund need, and it sounded like frustration speaking and not solution speaking. The Subcommittee would end up either way with about

a $60 million need because it was taking the funds from someone else's bank account. The Legislature could have a General Fund need, or the counties could have a need in taking care of the medical costs of indigent persons. He was frustrated but said he would support the motion.

Senator Raggio said based on the same reasoning as explained by Assemblyman Hardy, he would support the motion but indicated that the Subcommittee would have to find some way to alleviate the revenue loss to local governments. The local governments needed some kind of relief. Senator Raggio served notice that his support was based on doing something that alleviated the revenue loss to local governments.

Senator Mathews said all the Subcommittee members considered the option distasteful because they did not want to take funds from the counties. The solution was not pleasant for any of the members. Senator Mathews appreciated the positions of the two previous speakers, but she did not see any other way out of this problem. The Subcommittee had to do something.

Assemblywoman Buckley said she agreed with the previous speakers. When the state was $2.5 billion short, difficult choices were required. When this was heard in the Assembly Committee on Ways and Means, she asked Mr. Willden to work with Nevada Association of Counties (NACO) and the hospitals to see whether there were alternative solutions, but Mr. Willden could not find the money to resolve the problem. She spoke with Jeff Fontaine of NACO about some possible way to relieve the counties of liability. She still did not know whether that would yield any solutions. She was talking to the counties about a way to ameliorate the shortfalls and whether there was some way to allow counties to make up those funds. She was supportive of trying to come up with some solutions so the Legislature was not just shifting the burden. There was a limit to how much the Legislature could do with such a big shortfall. She would reluctantly support the motion.

THE MOTION CARRIED. (SENATOR COFFIN VOTED NO.) (Assemblyman Arberry was not present for the vote.)

Mr. Combs explained decision unit Enhancement (E) 665 recommended elimination of the transfer from this account to the Health Insurance Flexibility and Accountability (HIFA) Holding account (BA 3155) as a result of the recommendation to terminate the HIFA waiver program effective June 30, 2009. Based on the Legislative Counsel's indication that the funds from this account should not be transferred to the IGT account to offset General Funds in the Medicaid program, the Fiscal Analysis Division staff recommended retaining the transfer to the HIFA program in this account if the Subcommittee elected to continue the HIFA waiver program during the 2009-2011 biennium. The transfer was currently required by statute and could be accommodated under any of the three options presented. The transfer did not have a net effect on the General Fund and would allow the statute that was currently in place to remain in place. Therefore, the funds could be transferred without significant changes to the existing statute. It was Mr. Combs' understanding of the previous motion that the funds would be transferred to the General Fund only during the 2009-2011 biennium.

Mr. Combs explained decision unit E800 recommended eliminating the cost-allocation transfer from this account to the Department's Administration account (BA 3150) for administrative services provided by the staff of the Department of Health and Human Services (DHHS) Director's Office. Because

the Governor recommended transferring the revenues from this account to the IGT account (BA 3157), this account would be eliminated. If the account was maintained in its current form, a cost-allocation transfer to the DHHS Director's Office would be appropriate, but the amount of the transfer would depend on the Subcommittee's actions with respect to this account and the HIFA waiver program.

Mr. Combs requested the authority to work with the DHHS to determine the appropriate cost-allocation amount required for the DHHS Director's Office based on the Subcommittee's actions with regard to closing this account and the HIFA waiver accounts. If any funds were retained in this account for county claims, Mr. Combs would work with the DHHS to determine what amount the DHHS should receive for the work done in processing those claims. Mr. Combs said because of the Subcommittee's actions to transfer ISA funds to the General Fund, he discussed the cost-allocation requirement with the deputy director of the DHHS, who did not believe there was a need for any type of cost allocation as a result of transferring the money to the General Fund.

Mr. Combs pointed out he provided the Subcommittee some information requested at its work session regarding payments and receipts in this account in FY 2008.

Chair Leslie said it appeared the Subcommittee needed a motion to retain the transfer of the HIFA program for the 2009-2011 biennium and approve authority for the Fiscal Analysis Division staff to work with the DHHS to determine the appropriate cost-allocation amount required for the DHHS Director's Office based on the Subcommittee's actions with regard to closing this account and the HIFA waiver.

> SENATOR COFFIN MOVED TO CLOSE BA 628-3244 AND RETAIN THE TRANSFER OF THE HIFA PROGRAM FOR THE 2009-2011 BIENNIUM AND AUTHORIZE THE FISCAL ANALYSIS DIVISION STAFF TO WORK WITH THE DHHS TO DETERMINE THE APPROPRIATE COST-ALLOCATION AMOUNT REQUIRED FOR THE DHHS DIRECTOR'S OFFICE BASED ON THE SUBCOMMITTEE'S ACTIONS WITH REGARD TO CLOSING THIS ACCOUNT AND THE HIFA WAIVER.
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> ASSEMBLYWOMAN SMITH SECONDED THE MOTION.
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> THE MOTION CARRIED. (Assemblyman Arberry was not present for the vote.)
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> BUDGET CLOSED.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH CARE FINANCING AND POLICY
HCF&P-ADMINISTRATION (101-3158)
BUDGET PAGE DHCFP-6

Rick Combs, Senior Program Analyst, Fiscal Analysis Division, explained the major closing issues in Budget Account (BA) 3158 included funding for a new vendor to take over the Medicaid Management Information System (MMIS) and the transfer of administrative expenditures and positions from the Medicaid

account to this Division of Health Care Financing and Policy (DHCFP) Administration account (BA 3158).

The Governor recommended $1,051,532 in FY 2010 and $1,251,051 in FY 2011 to pay the cost to conduct the procurement process for a new vendor to take over the existing MMIS. Decision unit Enhancement (E) 588 was the Technology Investment Request (TIR) portion of the takeover of the MMIS. The decision unit included $709,537 in Title XIX funds in FY 2010 and $790,095 in Title XIX in FY 2011 to be transferred to the Department of Administration's Information Technology account (BA 1325). The General Fund match for the TIR portion of the project ($236,513 in FY 2010 and $263,365 in FY 2011) was recommended in the Information Technology Projects account. Decision unit E588 also included $26,370 in General Fund in FY 2010 and $49,398 in General Fund in FY 2011 to pay the costs of three positions to manage the project for the DHCFP.

Mr. Combs said the Division requested funding for the planning and the request for procurement (RFP) process. The Division had planned to start the process for developing a new MMIS; however, before The Executive Budget was completed, the Division decided to request a takeover of the existing MMIS. In June 2008, First Health Services Corporation (FHSC) notified the Division it was leaving the MMIS business market to concentrate on pharmacy management and healthcare utilization management and would not rebid the Nevada contract past its current term. The MMIS/fiscal agent contract with FHSC ended on September 30, 2012. Representatives of the Division indicated the decision to procure a vendor to take over the current MMIS was based on the risks associated with relying on the FHSC to continue to provide high-quality and affordable service throughout the remainder of the current contract until a new MMIS was implemented. While the FHSC had committed to extending its current contract as long as necessary to assist in the transition to a new vendor, the Division believed it was risky to rely on this commitment and believed the best option was to procure a vendor to take over MMIS as soon as practicable. Typically it took about five years to replace a MMIS, which would be approximately four years after the termination of the FHSC contract.

Mr. Combs said a risk identified by the Division was that FHSC costs had increased already in the first contract renegotiation. The Division was concerned that because Nevada was the sole remaining contract for MMIS service for FHSC, there would be no efficiencies created to keep the cost from increasing. Also, either party could terminate the contract with 180 days notice. The FHSC indicated it wanted to get out of the MMIS market, and the Division was worried that could happen anytime.

Mr. Combs said that at the February 18, 2009, Subcommittee hearing, the administrator indicated several vendors were interested in submitting RFPs to take over the existing MMIS. A request for proposal for the procurement vendor services had been issued. The proposal was contingent upon approval of funding by the Legislature. There were risks associated with the takeover. Mr. Combs said anytime the Division changed vendors, providers of Medicaid services could be affected in some negative manner through delays in payments. Much of the provider revenue was received through the Medicaid program. The administrator testified that although some disruptions were inevitable in a process like this, he believed the risks of delay in provider payments could be minimized through appropriate planning and testing, which was what the Division attempted to do through this process.

Mr. Combs said that on April 21, 2009, the Joint Subcommittee on General Government and Accountability approved the TIR portion of the MMIS takeover as recommended by the Governor. The question before the Subcommittee was whether it wished to approve the cost of the three new full-time-equivalent (FTE) positions recommended in decision unit E277, which included two business process analyst 2 positions that would begin October 1, 2009, in FY 2010 and a management analyst 3 position that would begin on July 1, 2010, in FY 2011. The business process analyst positions would define user requirements, participate in the development of the RFP, and test all system changes and enhancements to ensure proper functions as specified. The management analyst 3 position would perform project oversight, including the review of project deliverables, contract compliance, and responses to contractor requests for information.

Mr. Combs said the two MMISs would run simultaneously, and the existing system would continue to require the current levels of maintenance until the takeover system was completed, tested, and ready for use. In response to questions regarding the functions that would be performed by the two FTE positions once the takeover was completed, the Division indicated that the positions would examine the steps needed to comply with the federally imposed Medicaid Information Technology Architecture (MITA) initiative. The MITA initiative began in 2004 by CMS in response to the high costs of the MMIS projects. The initiative included moving toward systems with components that could be replaced individually without requiring entirely new systems. The Division also indicated that the new FTE positions could assist the agency in addressing interface issues and efforts to use automation to address audit findings to prevent overpayments, which would take place five years after the takeover was completed.

Mr. Combs said based on the actions of the Joint Subcommittee on General Government and Accountability with regard to the TIR portion of the takeover project and the information provided by the Division regarding the ongoing need for the three new FTE positions, the Fiscal Analysis Division staff recommended the approval of decision units E277 and E588 as recommended by the Governor.

Senator Raggio said he knew the Subcommittee had studied this issue and had no choice but to approve the decision units, but he still did not understand why it took five years for a typical replacement of an MMIS. He wondered whether it would take five years before the MMIS was in use once this process was begun. He knew the two systems would be run simultaneously. He wondered what took five years to get this type of a system in place. He understood there would be a subcontract with FHSC during this time but wondered what might happen if the FHSC did not agree with the subcontract terms.

Charles Duarte, Administrator, Division of Health Care Financing and Policy, responded the Division was allowing the takeover vendor five years for two reasons. One was the takeover vendor was investing in coming into Nevada and taking over an existing system. Mr. Duarte's intention was to try to keep the process budget-neutral from an operational cost standpoint. He said the Division believed the vendor would need a period of time in which to recoup its capital investment in this system.

Senator Raggio asked whether there was something in the existing system that the vendor could utilize or whether the vendor needed to design a whole new system. Mr. Duarte responded the new vendor was coming in to take over an

existing system, and over a five-year period, the vendor would be able to replace components of the system but would retain the core engine of the MMIS, which was the large claims-adjudication system.

Senator Raggio wondered what the anticipated length of the contract would be with the takeover vendor in the TIR. Mr. Duarte responded the length of the contract would be five years, and the contract was not to build the system but to operate it. In the interim the Division had the option or would design the option into the contract to allow the vendor to replace components of the system in a staged and phased manner so that the vendor did not create the kind of system disruption that occurred during a full-scale replacement of the entire system.

Senator Raggio asked how long the two systems would be running concurrently. Mr. Duarte responded that the plan was that after award of the contract, the vendor would run the existing system at least six months and would be copying the system over to a new hardware platform. The vendor would be running the new MMIS in the background to test the system.

Senator Raggio wondered whether during the time the vendor was running the system concurrently, the Division would be paying double the cost or more by paying two vendors. Mr. Duarte explained the Division would not be paying more. There would be a time when the Division would incur some increased costs, but his intention over the term of this takeover contract was to not exceed what the Division had budgeted operationally for the next two years as well as what it projected it would spend for operations in the next few years. For the entire five-year period, the project should be budget-neutral.

Senator Raggio said it was his understanding that the Division anticipated competitive bidding on the TIR. Mr. Duarte confirmed he had talked to the large vendors in the MMIS marketplace, and all of them expressed interest in potentially bidding on this project.

Senator Raggio wondered what might happen because the project would take five years to implement and the contract was only for five years. Mr. Duarte responded it would actually only take one year to implement a takeover, and then the vendor would run the MMIS and maintain it for four more years.

Senator Coffin questioned the FHSC stated purpose of leaving the MMIS market because the FHSC wanted to concentrate on pharmacy management and healthcare utilization management. He wondered whether that was really the reason. Mr. Duarte confirmed he believed the stated purpose of the FHSC was accurate and sincere. He said the Medicaid program was entering a phase in this particular segment of government-computer services for Medicaid systems that was going to require additional investment. There was new technology being developed that the federal government wanted vendors to adopt. The new technology would require an investment, and the FHSC did not want to expand its market share over the next five years like some of the other vendors. First Health Services Corporation was in a weak position, and Nevada was now its sole remaining contract for information technology (IT) systems. Its stated purpose was truthful because the FHSC wanted to focus on other aspects of the business and knew it would take a significant investment, which its parent company did not want to put forward to stay in the MMIS business.

Senator Coffin said the FHSC parent company was a huge company and it had capital. He just wanted to make sure that what the FHSC left behind was not a

problem that the Division could not foresee. Senator Coffin said that a new vendor coming in might possibly see things the Division did not recognize, and maybe those were the reasons the FHSC was leaving this contract.

Mr. Duarte said there were always problems with systems as large as this one. He was not satisfied with all aspects of this system but had not detected any unforeseen problems in the last five years. He said he was aware of the system's weaknesses and strengths and would be communicating those to the takeover vendor.

Assemblyman Hardy wondered whether there was anything that would preclude the Division from doing something new and different in three or four years when technology had improved over existing technology. It seemed to him that technology often got less expensive and more available every year, and it was almost impossible to predict the improvements in technology in five years.

Mr. Duarte answered that Assemblyman Hardy was correct, which was why Mr. Combs referenced this change. The federal government and states were moving to something called Service Oriented Architecture (SOA). In the Medicaid world, the technology was called the Medicaid Information Technology Architecture (MITA) initiative. Mr. Duarte suggested the Subcommittee consider the new technology as a "plug-and-play" system. He said large applications were going to be compartmentalized to allow the new technology to be more readily dropped into existing systems as replacements for certain components, whether it was a pharmacy-claims system or other aspects of a finance system.

Mr. Duarte said as the project proceeded through these five years, the Division would have the option to go out to bid or allow the takeover vendor to replace components of the system with newer technology, which he hoped would be in place for a significant period of time and replaced only when necessary. His plan was to adopt this plug-and-play strategy, which was consistent with the federal government and also with the direction of the Department of Information Technology's (DoIT) move toward SOA.

Chair Leslie explained the Joint Subcommittee on General Government and Accountability had already approved the TIR portion of the project. The question before this Subcommittee was to approve or not approve the three new positions. The Fiscal Analysis Division staff had recommended that the Subcommittee approve those three new FTE positions.

> ASSEMBLYMAN HARDY MOVED TO APPROVE THREE NEW FTE POSITIONS IN DECISION UNITS E277 AND E588.
>
> ASSEMBLYWOMAN GANSERT SECONDED THE MOTION.
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> THE MOTION CARRIED. (Chair Arberry and Assemblywoman Buckley were not present for the vote.)

Mr. Combs explained the Governor recommended transferring all administrative expenditures ($56.2 million in FY 2010 and $61.2 million in FY 2011) and all 151 positions from the Medicaid account (BA 3243) to this Administration account (BA 3158). The transfer would place all administrative costs for the Medicaid program in this account and would leave only the medical services costs in the Medicaid account (BA 3243). The Division indicated the transfer would simplify the CMS reporting requirements and its budgeting and

accounting processes. Because the Title XIX grants for medical services and administrative services were separate, the Division had to report and budget the costs for medical and administrative costs separately for the CMS. In many instances, the FMAP for administration differed from the FMAP for medical.

Mr. Combs said the Division indicated that moving all the Medicaid administrative costs to one account would simplify the manner in which the staff time was allocated among the various Division programs. Certain positions in the Medicaid account were currently allocated among various Division programs based on the time spent on each of those programs. In response to the Fiscal Analysis Division questions regarding the manner in which this transfer would assist with the allocation of costs among the Division's various programs, the Division indicated that it had issued a request for proposal (RFP) for a variety of services related to cost allocation and cost reporting based on new CMS cost-allocation requirements. The Division indicated that the CMS required the Division to review the cost-allocation plans of agencies that billed Medicaid for administrative costs whether or not those agencies had an approved Public Assistance Cost Allocation Plan. The CMS also required changes in cost-allocation and reporting requirements for government agencies that used certified public expenditures or cost-based rates. The Division indicated that having all administrative costs in one account would assist it in revising its internal cost-allocation methodology in a manner that comported with the CMS requirements. Although this was a significant change in the manner in which the Division was organized from a budgetary standpoint, the Fiscal Analysis Division staff had not identified any specific problems with the recommendation.

Mr. Combs said the Budget Division had submitted budget amendment 134 for this account to adjust the administrative revenue and expenditure transfers from the Medicaid account based on revised, caseload-driven administrative expenditures. The amendment also adjusted balance-forward revenue from FY 2009 to FY 2010 that was inadvertently left out of the transfer from the Medicaid account to this account. The amendment increased General Fund appropriations by $138,216 in FY 2010 and $128,456 in FY 2011. Although it appeared that there would be a General Fund reduction totaling $2,161,371 in FY 2010, the decrease in General Funds was the result of a technical adjustment in the Medicaid account (BA 3243). When administrative expenditures were transferred from the Medicaid account to this account in E901, balance-forward revenue totaling $2,299,587 from FY 2009 to FY 2010 was inadvertently left in the Medicaid account. The adjustments in each account would result in no net effect on the General Fund.

Mr. Combs said based on the information provided by the Division regarding the manner in which the recommendation would simplify the reporting, budgeting, and accounting processes of the agency, the recommendation as adjusted in budget amendment 134 appeared reasonable.

Chair Leslie said she believed the motion would be to approve the transfer of the administrative expenditures and positions from the Medicaid account BA 3243 to the Administrative account BA 3158 and budget amendment 134.

> SENATOR COFFIN MOVED TO APPROVE THE TRANSFER OF THE ADMINISTRATIVE EXPENDITURES AND POSITIONS FROM THE MEDICAID ACCOUNT BA 3243 TO THE ADMINISTRATIVE ACCOUNT BA 3158 AND APPROVE BUDGET AMENDMENT 134.

ASSEMBLYMAN OCEGUERA SECONDED THE MOTION.

THE MOTION CARRIED. (Assemblyman Arberry was not present for the vote.)

Mr. Combs explained decision unit Maintenance (M) 502 recommended $414,200 in FY 2010 and $215,100 in FY 2011 for increased auditing of hospitals that received Disproportionate Share Hospital (DSH) payments. The Division indicated that a new rule issued by CMS would increase audit requirements on those hospitals during the 2009-2011 biennium. The Governor recommended using contract auditors to comply with the new CMS requirements. The reason for the cost being approximately twice as much in the first year as compared to the second year was the Division was required to go back in time and complete audits for five previous fiscal years. During the current fiscal year, the Division would perform audits of two prior years, and in FY 2010 the Division would perform audits of two more prior years, and from then on, the Division would be caught up with the past audits and would perform an audit one year at a time. Mr. Combs said that based on the new CMS audit requirements cited by the Division, the recommendation appeared reasonable, and the Fiscal Analysis Division staff recommended approval of the decision unit M502 as recommended by the Governor.

Mr. Combs explained decision unit E720 recommended $22,000 ($11,000 in General Fund) in FY 2010 for the purchase of wireless radio towers for the Las Vegas and Reno district offices based on a recommendation from the Department of Information Technology (DoIT) to transfer data servers and supporting data to the DoIT Data Hosting Center. The radio towers would give the Division direct access to the Data Hosting Center as well as the necessary network bandwidth. The recommendation appeared reasonable, and the Fiscal Analysis Division staff recommended approval of the decision unit E720 as recommended by the Governor.

Mr. Combs explained three technical adjustments were recommended for this account. The transfer from the Medicaid account in decision unit E901 was amended by adding $7,859 to the Reserve for Resident Protection category based on the revenue budgeted for Civil Penalties in each year of the 2009-2011 biennium. Civil penalties were collected from nursing facilities by CMS for a violation of CMS regulations, and the state received the state share of the penalty based on the medical FMAP. The civil penalty revenues could only be used for the protection of nursing home residents if the state was required to temporarily take over the management of a nursing facility serving Medicaid recipients.

Mr. Combs said the FTE position count for FY 2010 was reduced by one position. The management analyst 3 position recommended in decision unit E277 had a start date of July 1, 2010, which was in FY 2011, but was reflected in the FTE position count as having been created in FY 2010. The adjustment reduced expenditures by $255 for assessments that were calculated based on the number of FTE positions in an account.

Mr. Combs explained the revenue allocation for the M100 decision unit in the Governor's recommended budget inappropriately balanced reductions in statewide cost allocations to the state General Fund. As a result, General Fund appropriations were reduced by $77,245 in FY 2010 and $73,415 in FY 2011 and should have been increased by $58,526 in FY 2010 and $62,355 in FY 2011. The Budget Division submitted budget amendment AGSW3158 to

correct the error. The budget amendment would increase General Fund appropriations for this account by $135,771 in FY 2010 and $135,770 in FY 2011. The adjustment would be made to this account when the statewide and AG cost allocations were made by the Fiscal Analysis Division staff.

SENATOR COFFIN MOVED TO CLOSE BA 101-3158 AS RECOMMENDED BY THE GOVERNOR FOR DECISION UNIT M502 AND E720, APPROVE BUDGET AMENDMENT AGSW3158, AND AUTHORIZE THE FISCAL ANALYSIS DIVISION STAFF TO MAKE ANY NECESSARY TECHNICAL ADJUSTMENTS.

ASSEMBLYMAN OCEGUERA SECONDED THE MOTION.

THE MOTION CARRIED. (Assemblyman Arberry was not present for the vote.)

BUDGET CLOSED.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH CARE FINANCING AND POLICY
HCF&P-NEVADA MEDICAID, TITLE XIX (101-3243)
BUDGET PAGE DHCFP-26

Rick Combs, Senior Program Analyst, Fiscal Analysis Division, explained the first major closing issue in Budget Account (BA) 3243 was the increase in Federal Medical Assistance Percentages (FMAP). The Executive Budget included General Fund reductions and corresponding increases in federal Title XIX funds totaling approximately $70.3 million in FY 2010 and $22.6 million in FY 2011 based on the assumption that Congress would approve a federal stimulus package that included a FMAP increase for Nevada. The budget recommendation was based on the assumption that the stimulus package would include a hold-harmless provision that increased the current FMAP for Nevada from 50 percent to the 52.64 percent in effect in Federal FY 2008 from January 1, 2009, through September 30, 2009. Additionally, the recommendation assumed that Nevada would benefit from a 58 percent FMAP for all of federal FY 2010 (October 1, 2009 – September 30, 2010). The recommendation included in The Executive Budget was based on the assumption that all of the Governor's proposed budget reduction measures could be implemented without jeopardizing Nevada's ability to receive the increased FMAP rate.

Mr. Combs referred to a table which compared the Governor Recommends FMAP to the ARRA FMAP. The table reflected a significant increase in the FMAP as compared to The Executive Budget. The Budget Division had submitted budget amendment 112 to incorporate the increased FMAP rates from ARRA into The Executive Budget. Rather than including the effect of the increased FMAP in a separate decision unit as was done in The Executive Budget for the Governor's projected FMAP increase, the amendment incorporated the adjusted FMAP rate increase provided for in ARRA across the various decision units in the budget and included other revenue and expenditure reductions resulting from Medicaid Payment Projection (MPP) adjustments and corrections to errors in The Executive Budget. As a result of the manner in which the budget amendment was constructed, the effect resulting from ARRA was not easily identified.

Mr. Combs said the Subcommittee should note that the General Fund reduction recommended in budget amendment 112 totaled $73.3 million in FY 2010 and $65.7 million in FY 2011. The FY 2010 amount was approximately $2.2 million less than the amount projected by the Division and provided to the Subcommittee during its prior hearings regarding ARRA. The FY 2011 General Fund reduction exceeded the amount projected by the Division and provided to the Subcommittee during its prior hearings by approximately $10.8 million. It appeared that these differences were primarily the result of technical adjustments and the inclusion of a new decision unit E415 to account for an additional FMAP increase unrelated to ARRA in FY 2011.

Mr. Combs explained the amendment decreased General Fund appropriations in the base budget by $134,311,606 in FY 2010 and by $67,237,158 in FY 2011. These decreases were fully attributable to the FMAP provision in ARRA. The total decrease in General Fund appropriations in the base budget was offset by the adjustment in the Intergovernmental Transfer (IGT) Program net state benefit resulting from the provision in ARRA that prohibited states from receiving the increased FMAP rates if the state required political subdivisions to pay a greater percentage of the non-federal share of payments than the respective percentage that was required under the Medicaid State Plan of September 30, 2008, and the ARRA provision that increased the ceilings for the disproportionate share hospital (DSH) program. The reduction in General Funds in the base budget was offset by the elimination of the General Fund reduction in E417 ($70.3 million in FY 2010 and $22.6 million in FY 2011). The base adjustments and the elimination of E417 resulted in a net General Fund reduction of $64 million in FY 2010 and $44.7 million in FY 2011.

Mr. Combs explained ARRA included the maintenance of effort (MOE) requirement that prohibited states from receiving an increase in its FMAP rate if eligibility standards, methodologies, or procedures under its Medicaid state plan were more restrictive than the eligibility standards, methodologies, or procedures in effect on July 1, 2008. Based on this provision, decision unit E665 must be eliminated from the legislatively approved budget for the state to receive the increased FMAP under ARRA, because the provision would make eligibility standards more restrictive than the standards in effect on July 1, 2008. Budget amendment 112 eliminated the decision unit based on the ARRA requirements. The Fiscal Analysis Division staff recommended approval of the base budget adjustments and the elimination of decision units E417 and E655 as recommended in budget amendment 112.

> SENATOR COFFIN MOVED TO APPROVE THE BASE BUDGET ADJUSTMENTS AND THE ELIMINATION OF DECISION UNITS E417 AND E655 AS RECOMMENDED IN BUDGET AMENDMENT 112.
>
> ASSEMBLYWOMAN SMITH SECONDED THE MOTION.
>
> THE MOTION CARRIED. (Assemblyman Arberry was not present for the vote.)

Mr. Combs explained budget amendment 112 also included a new decision unit E415 that recommended General Fund reductions and corresponding increases in federal Title XIX funds totaling approximately $11.3 million in state FY 2011, based on the latest projection for Nevada's FMAP rate in federal FY 2011. The adjustment was based on the latest projection for Nevada's FMAP rate of 50 percent for the last half of FY 2011. The Governor's recommended budget

was based on a FMAP rate of 50 percent for the last half of FY 2011. The new projected FMAP for the last half of FY 2011 was 51.91 percent and would begin on January 1, 2011, after the recession adjustment period in ARRA ended. The increase in FMAP for the last half of FY 2011 was published in *Federal Funds Information for States* (FFIS), and the Division indicated that it was comfortable with the projection. The Fiscal Analysis Division staff recommended approval of decision unit E415 to reflect the latest projection of the FMAP rate for FY 2011 as recommended in budget amendment 112. The Fiscal Analysis Division staff requested authority to make any necessary technical adjustments to decision unit E415 resulting from the Subcommittee's actions with respect to other decision units in this account.

> ASSEMBLYMAN OCEGUERA MOVED TO APPROVE DECISION UNIT E415 TO REFLECT THE LATEST PROJECTION OF THE FMAP RATE FOR FY 2011, AS RECOMMENDED IN BUDGET AMENDMENT 112, AND TO AUTHORIZE THE FISCAL ANALYSIS DIVISION STAFF TO MAKE ANY NECESSARY TECHNICAL ADJUSTMENTS RESULTING FROM THE SUBCOMMITTEE'S ACTIONS WITH RESPECT TO OTHER DECISION UNITS IN THE ACCOUNT.
>
> ASSEMBLYWOMAN BUCKLEY SECONDED THE MOTION.
>
> THE MOTION CARRIED. (Assemblyman Arberry and Chair Leslie were not present for the vote.)

Mr. Combs explained the revised Medicaid Payment Projection (MPP) model was rerun by the Division to take into consideration the most recent caseload projections through January 2009, the cost-per-eligible (CPE) data, and mandatory inflation increases for pharmacy, managed care, and transportation services. This MPP information was generally used as a guide to make adjustments to the Medicaid budget as recommended by the Governor. Unlike previous biennia, the MPP adjustments recommended by the Division were included in a budget amendment 112, which included the increased FMAP resulting from ARRA, other adjustments required by ARRA, an increase in FMAP projected for the last half of FY 2011, and corrections for errors made in the Governor's recommended budget.

Mr. Combs said The Executive Budget recommended $36 million ($19 million in General Fund) in FY 2010 and $55.6 million ($28.7 million in General Fund) in FY 2011 for mandatory rate increases for providers. The Health Maintenance Organization (HMO) provider rates were recommended to increase by 4.7 percent in FY 2010 and 5 percent in FY 2011, and transportation services were recommended to increase by 5 percent in each fiscal year of the 2009-2011 biennium. The Governor did not recommend an inflationary increase in pharmacy rates for the 2009-2011 biennium. The updated MPP increased expenditures in the M101 decision unit by approximately $5.7 million in FY 2010 and $5.8 million in FY 2011. The increases were the result of an increase in HMO rates compared to the Governor's recommended budget. The expenditure increases resulting from the HMO rate increase were offset by a reduction in the inflation rates for non-emergency transportation as compared to the rates used in the Governor's recommended budget.

Mr. Combs explained the updated MPP reduced the projected rate of growth for HMO provider rates in FY 2010 from 4.7 percent to 2.9 percent and left the projected rate of growth unchanged from the Governor's recommended budget

at 5 percent in FY 2011. Although the growth rate in FY 2010 was reduced from the rate used in the Governor's recommended budget and the growth rate for FY 2011 was unchanged, the total capitation rate in each year of the biennium increased because the FY 2009 rate of growth used in the Governor's recommended budget was 1.7 percent, while the revised rate of growth used in the MPP was 6.8 percent. The Division staff indicated that the growth rate used in the Governor's recommended budget for FY 2009 was actuarially projected at around the same time the state was in negotiations with a new HMO provider to replace Anthem, which elected to terminate its contract with the state. Because the capitation rate was higher in 2009 than was projected at the time the Governor's budget was constructed, the capitation rates for FY 2010 and FY 2011 would be higher than projected in the Governor's budget, even though the growth rate for FY 2010 was projected to be less than the amount used in the Governor's budget.

Mr. Combs explained that the Division informed the Subcommittee during its hearing on February 19, 2009, that the 5 percent hospital rate reduction implemented in October 2008 was factored into the HMO rate increases for calendar year 2009, but the rate projections included in M101 for FY 2010 and FY 2011 were not updated for the additional 5 percent rate reduction recommended in decision unit E654. The Division indicated that the updated rates used in the MPP included the additional 5 percent reduction in hospital rates recommended in decision unit E654. If decision unit E654 was not approved, the expenditures in decision unit M101 would be increased from the level projected in the MPP.

Mr. Combs said the non-emergency transportation rates in the Governor's recommended budget were projected to increase 5 percent in each year of the 2009-2011 biennium. The updated actuarial projections provided in the MPP indicated that the rates would increase by 2.6 percent in FY 2010 and 4.9 percent in FY 2011.

Mr. Combs said the Governor did not recommend any pharmacy inflation. The Division indicated that although pharmacy rates were increased annually, the Medicaid program had not experienced an increase in pharmacy costs per eligible (CPE) because of reduced pharmacy utilization. He noted that pharmacy inflation totaling 5.7 percent per year was included in the agency request but was removed in the Governor's recommended budget. In response to questions from the Subcommittee regarding whether the Division was certain that sufficient funding would be available for pharmacy costs if an inflationary increase was not included in the budget, the Division indicated that the implementation of the National Drug Code (NDC) requirement had not only increased drug rebates for the state but also had decreased utilization of prescription drugs as well. The Division indicated that it did not anticipate increased expenditures for pharmaceuticals in the 2009-2011 biennium that would not be offset by decreased utilization.

Mr. Combs said the question for the Subcommittee was whether it wished to approve the latest MPP projections for rate increases, which increased Medicaid expenditures in decision unit M101 by approximately $11.6 million over the 2009-2011 biennium, as recommended in budget amendment 112.

SENATOR COFFIN MOVED TO APPROVE THE LATEST MPP PROJECTIONS FOR RATE INCREASES, WHICH INCREASED MEDICAID EXPENDITURES IN DECISION UNIT M101 BY

APPROXIMATELY $11.6 MILLION OVER THE 2009-2011 BIENNIUM, AS RECOMMENDED IN BUDGET AMENDMENT 112.

ASSEMBLYWOMAN BUCKLEY SECONDED THE MOTION.

THE MOTION CARRIED. (Senator Mathews was not present for the vote.)

Mr. Combs explained that at the February 18, 2009, Subcommittee hearing on the Medicaid account, the Administrator of the Division indicated that although the reimbursement rates for pediatric home-health service providers were not being reduced in the Governor's recommended budget, he was concerned that without a rate increase for these providers, recipients would be unable to access pediatric home-health services in Nevada during the 2009-2011 biennium. The agencies that provided pediatric home-health services retained specialized therapists and nursing staff to provide services for children with serious disabilities and medical needs in a home setting.

Mr. Combs said one of the largest pediatric home-health service provider agencies in southern Nevada elected to discontinue providing services for the Medicaid program last year, and the sole provider in northern Nevada had indicated that it would no longer serve Medicaid recipients. The Administrator indicated that the agencies that provided these services had not had a rate increase in over eight years and were unable to provide the services at the current rates. The services provided by these agencies included nursing, physical therapy, and occupational and speech therapy services.

Mr. Combs said because of the Department's concern about recipients being able to access pediatric home-health services during the 2009-2011 biennium, the Department included a proposal to provide an average 40 percent increase in the various rates paid for these services as its number 3 priority on its add-back list. The Division indicated that the General Funds necessary to implement the rate increase would total $478,107 in FY 2010 and $557,769 in FY 2011 using the latest projected FMAP rates.

Mr. Combs said during the work session conducted on March 30, 2009, the consensus of the Subcommittee was to approve the additional funding for the rate increase for providers of pediatric home-health services to ensure access to care statewide. The question before the Subcommittee was whether it wished to affirm its work session consensus to approve the additional General Funds totaling $478,107 in FY 2010 and $557,769 in FY 2011 to increase the rates for providers of pediatric home-health services.

Assemblywoman Smith said it had been some time since the Subcommittee had heard the pediatric home-health services issue, and she wanted to make sure the physical therapy services were provided in the home. She recalled testimony from several therapists during the prior hearing. Mr. Combs answered that all the physical therapy services were provided in the home.

SENATOR COFFIN MOVED TO AFFIRM ITS WORK SESSION CONSENSUS TO APPROVE THE ADDITIONAL GENERAL FUNDS TOTALING $478,107 IN FY 2010 AND $557,769 IN FY 2011 TO INCREASE THE RATES FOR PROVIDERS OF PEDIATRIC HOME-HEALTH SERVICES.

ASSEMBLYWOMAN SMITH SECONDED THE MOTION.

THE MOTION CARRIED. (Assemblywoman Buckley and Senator Mathews were not present for the vote.)

Mr. Combs explained the next issues were caseload growth and cost-per-eligible (CPE) reductions that resulted from the MPP. Caseloads were trending slightly higher than the caseload projections included in The Executive Budget. The Child Health Assurance Program (CHAP) population had increased significantly. Compared to the caseload projections used in the Governor's recommended budget, the CHAP caseload was projected to increase in the new MPP by 5,763 recipients per month for FY 2010 and 10,313 recipients per month for FY 2011. The TANF caseloads were projected to decrease slightly in FY 2010 and by 10,600 recipients in FY 2011 from the projections used in the Governor's recommended budget.

Mr. Combs referred to a table which showed a comparison of overall caseload projections. He noted the increase would be 5,490 more CHAP cases in FY 2010 and 1,884 more cases in FY 2011. He said although overall caseloads were projected to increase slightly over the caseloads recommended in the Governor's budget, the updated MPP reduced expenditures in decision unit M200 by approximately $6.7 million in FY 2010 and $14.3 million in FY 2011. The reduction in expenditures was primarily because the latest MPP projected a decrease in the CPE rate for the TANF-eligible group. The CPE used in the Governor's recommended budget was heavily affected by FY 2008 expenditures that were not paid until July 2008 (FY 2009) because of insufficient funding available at the end of FY 2008. The Division recognized that the additional payments in July 2008 had inappropriately been factored into the CPE projections for the 2009-2011 biennium when the MPP was updated.

Mr. Combs said the Fiscal Analysis Division staff had reviewed the caseload projections and CPE adjustments with the DHCFP staff, and it appeared the projections were reasonable. The trend of increasing CHAP caseloads was of some concern, but the updated projections in the MPP had been adjusted in an effort to address that CHAP increase.

Mr. Combs said the question before the Subcommittee was whether it wished to approve the latest MPP caseload and CPE projections, which reduced Medicaid expenditures in decision unit M200 by approximately $21 million over the 2009-2011 biennium, as recommended in budget amendment 112.

SENATOR COFFIN MOVED TO APPROVE THE LATEST MPP CASELOAD AND CPE PROJECTIONS, WHICH REDUCED MEDICAID EXPENDITURES IN DECISION UNIT M200 BY APPROXIMATELY $21 MILLION OVER THE 2009-2011 BIENNIUM, AS RECOMMENDED IN BUDGET AMENDMENT 112.

ASSEMBLYMAN OCEGUERA SECONDED THE MOTION.

THE MOTION CARRIED. (Assemblywoman Buckley and Senator Mathews were not present for the vote.)

Mr. Combs explained two informational items that the Subcommittee had adjusted in other Subcommittee hearings. The first item was the Senior Services Program within the Aging Services Division. Mr. Combs had listed the incorrect number of waiver slots in the closing document and said the correct information was that the Subcommittee approved the addition of 239 CHIP waiver slots, 146 Waiver-for-Elderly-in-Adult-Residential-Care (WEARC) slots,

and 9 assisted-living slots for the 2009-2011 biennium. The General Fund match for these three waiver programs was included in the Medicaid budget. The General Fund portion of the costs in this account for adding these waiver slots was $753,920 in FY 2010 and $2,283,976 in FY 2011 above the amount required to fund the waiver programs in the revised MPP. The Department's add-back list (priority number 4) indicated that the General Fund cost for adding slots to the Aging Services Division waiver would total $3,067,048 in FY 2010 and $3,713,508 in FY 2011. Mr. Combs said it appeared that this cost was for a significantly higher number of waiver slots than were approved by the Subcommittee because the cost projection was based on funding all of the slots at the beginning of the biennium rather than phasing the slots in over the biennium, which was the typical manner in which waiver slots were filled and funded.

Mr. Combs said he would make the adjustments to increase the revenue and expenditure authority necessary to add those additional waiver slots for the Aging Services Division. The Department had included in its add-back list (priority number 6) a proposal to ensure that the funding in this account was sufficient to serve the wait-list for the Home and Community Based Services waiver administered by the Division of Mental Health and Developmental Services (MHDS). The Department projected that General Funds totaling $655,960 in FY 2010 and $472,859 in FY 2011 must be added to the Governor's recommended budget to serve the MHDS waiver wait-list. When compared to the expenditures for the waiver program as projected in the new MPP, the General Fund add-back required to serve the wait-list for the waiver program would total $136,658 in FY 2010 and $459,803 in FY 2011. During the closing for the MHDS account, the Subcommittee indicated it did not wish to add General Fund for this purpose and directed the Fiscal Analysis Division staff to work with the Department to determine what adjustments should be made to either the Medicaid budget or the MHDS budget or both to serve as many waiver slots as possible without adding any additional General Fund. The Fiscal Analysis Division staff would work on budget adjustments to ensure the Subcommittee's request was reflected in the budget recommendation.

Mr. Combs said the next major issue was the budget reduction measures recommended by the Governor, and the first measure was the continued elimination of payments to hospitals for graduate medical education (GME). The Governor recommended eliminating GME payments and reducing expenditures by $820,429 in each year of the 2009-2011 biennium. The projected savings to the General Fund from eliminating GME payments in The Executive Budget was $410,215 in each fiscal year of the 2009-2011 biennium. That savings was reduced in the amended budget and would now total $295,929 in FY 2010 and $353,113 in FY 2011 because of the increased FMAP rate. The question before the Subcommittee was whether it wished to approve the Governor's recommendation to continue the elimination of payments to hospitals for GME during the 2009-2011 biennium.

> SENATOR COFFIN MOVED TO APPROVE THE GOVERNOR'S RECOMMENDATION TO CONTINUE THE ELIMINATION OF PAYMENTS TO HOSPITALS FOR GRADUATE MEDICAL EDUCATION DURING THE 2009-2011 BIENNIUM.
>
> ASSEMBLYWOMAN SMITH SECONDED THE MOTION.
>
> THE MOTION CARRIED. (Senator Mathews was not present for the vote.)

Mr. Combs said the next item was the continued elimination of pediatric and obstetric rate enhancements. The Governor recommended reducing expenditures by $8,066,012 in FY 2010 and $8,505,759 in FY 2011 by eliminating pediatric and obstetric rate enhancements for physicians. Prior to September 1, 2008, physicians in the Medicaid and Check-Up programs received an enhanced rate for obstetrics services and for certain procedures performed on recipients under 21 years of age. The rate enhancements were eliminated in response to revenue shortfalls in the 2007-2009 biennium. Prior to September 1, 2008, the rates paid for pediatric surgical services were 170 percent of the 2002 Medicare facility-based rate, while the rates paid for pediatric radiology services were 120 percent of the facility-based rate. The rates paid for pediatric medicine services were 120 percent of the 2002 Medicare non-facility-based rate, while obstetric rates were 128 percent of the non-facility-based rate. All of these services were now being reimbursed at 100 percent of the 2002 Medicare rate. Based on the new FMAP rates resulting from ARRA and the latest MPP, the General Fund cost savings in this budget and the Check-Up budget resulting from this budget reduction measure was reduced to $2,550,368 in FY 2010 and $3,138,816 in FY 2011.

Mr. Combs said the Division indicated that while the rates for these services were reduced, the rates were still higher than the reimbursements paid for office visits, which were currently reimbursed at 85 percent of the 2002 Medicare fee schedule. Extensive public testimony was provided during the Budget Subcommittee and Joint Subcommittee hearings regarding this budget reduction measure. Several groups offering specialized physical therapy services for children had expressed concern with the reduced rates, and several pediatric physician groups had indicated an unwillingness to continue seeing Medicaid patients unless enhanced rates were restored. The Division indicated that Medicaid's physician rates still compared favorably to 2007 Medicare rates and the reimbursement rates paid in other western states. The Division had not as yet seen an increase in requests for authorization for out-of-state services resulting from the rate reductions.

Mr. Combs said the Department had not included the restoration of any portion of the enhanced rates on its list of top 16 priorities because of the Division's determination that Medicaid's physician rates still compared favorably to 2007 Medicare rates and the reimbursement rates paid in other western states. At the work session conducted on March 30, 2009, the Fiscal Analysis Division staff informed the Subcommittee that the Division had projected the General Fund cost was $934,343 in FY 2010 and $1,151,027 in FY 2011 to restore one-half of the rate enhancements in the 2009-2011 biennium in the Medicaid and Check-Up accounts. It was unclear from the information provided at that time that the projected cost was for restoring only one-half of the pediatric rate enhancements. The General Funds required to restore one-half of the pediatric and obstetric rate enhancements would be $1,278,271 in FY 2010 and $1,546,125 in FY 2011. The Division had ranked the partial restoration of the pediatric rates as its 24th priority. The Subcommittee did not reach consensus regarding this issue at the work session.

Mr. Combs provided the Subcommittee with four different options to consider based on the discussion that occurred at the work session and the Division's priorities on its add-back list. He said the General Fund add-back amounts were based on the most current FMAP, MPP, and uncapped Check-Up enrollments. The options were:

1. Approve the Governor's recommendations to continue the elimination of the pediatric and obstetric rate enhancements for physicians in the Medicaid and Check-Up programs.

2. Restore one-half of the pediatric and obstetric rate enhancements for physicians in the Medicaid and Check-Up programs. This option would result in the need to add General Funds totaling $1,278,271 in FY 2010 and $1,546,125 in FY 2011.

3. Restore one-half of the pediatric rate enhancements but do not restore the obstetric rate enhancements, reflecting the Division's 24th priority on its add-back list. This option would result in the need to add General Funds totaling $928,709 in FY 2010 and $1,123,409 in FY 2011.

4. Restore the total pediatric and obstetric rate enhancements for physicians in the Medicaid and Check-Up programs. This option would result in the need to add General Funds totaling $2,556,543 in FY 2010 and $3,092,251 in FY 2011.

Chair Leslie said the Subcommittee heard testimony about the enhanced rates and had discussion about whether the rates were sufficient to ensure access to services. The enhanced rates were not included in the Department's top 16 priorities for restoration, and the pediatric rates ranked 24th on the Division's priority list.

Assemblyman Hardy wondered whether option 3 would help the pediatric cardiovascular surgeons, pediatric orthopedic surgeons, and genetic clinics. He said option 3 might not fully restore the enhanced rates but might allow the physicians to continue serving Medicaid and Check-Up patients.

Chair Leslie said she understood the genetic clinics were funded in the Health Division's budget. Mr. Duarte confirmed that the enhanced rates did not affect the genetic clinics but increased reimbursements for hospital-based procedures for pediatric cardiologists, many of whom practiced in Las Vegas.

Assemblyman Hardy asked whether the enhanced rates affected the pediatric cardiovascular surgeons who testified before the Subcommittee, and Mr. Duarte confirmed the rates would affect those surgeons.

Chair Leslie wondered why the Division ranked the rates low on its list of priorities to restore, and the Department did not even include the rates on its list of top 16 priorities to restore. She said she was sympathetic to those surgeons and wanted to ensure children had access to necessary medical services. She asked Mr. Duarte to explain why the rates were such a low priority for the Division.

Mr. Duarte responded that a limited number of physicians were affected by the rates. The Subcommittee heard testimony from six physicians. The rates affected physical therapy groups, but children had significant access to physical therapy services through home-health or out-patient physical therapy practices. He said there were still specialists serving children. The Subcommittee heard from one pediatric cardiovascular surgeon who expressed concerns. Mr. Duarte said that surgeon had not stopped serving Medicaid patients for which Mr. Duarte was grateful. To a great extent, physicians continued to serve children as needed. Mr. Duarte received one letter from a pediatric urology group referring two adults patients back to the Division, and the Division would

case-manage those two patients. That letter reflected the first direct denial of service of which he was aware. The Division continued to find ways to serve children both through the HMOs and through the fee-for-service program.

Senator Coffin said he was impressed by the testimony from the physician who requested that the Subcommittee consider restoring enhanced rates. He understood the financial effect. The physician did not say or threaten he would deny service but indicated he was in business to pay off obligations like college loans and must bill for his time. Physicians might perform more simple procedures that could be completed more quickly. Senator Coffin thought that procedures that required more extensive work and coding would not be performed. It would not be worth a physician's time to perform complicated procedures without the enhanced rates. Complicated procedures for patients would be performed in Los Angeles, and the state would need to pay more then. For that reason, Senator Coffin thought option 3 would satisfy him, and he would be happy to make a motion that the Subcommittee adopt option 3 as its choice.

Chair Leslie said she wanted to see whether there was further discussion before she entertained a motion.

Assemblywoman Gansert said she looked at all of the unfortunate cuts the Subcommittee must make including the GME and rate enhancements, but the state did not have sufficient funds for all the needs. The Legislature asked for the Department's priority lists because of the funding deficits, and she supported relying on those lists.

Chair Leslie wondered whether Assemblywoman Gansert would prefer option 1. Assemblywoman Gansert confirmed option 1 was her choice. She said that while it was unfortunate, she thought option 1 was the better choice. She did not know that there was anything else the Legislature could do at this time. Chair Leslie said she agreed with Assemblywoman Gansert.

Senator Coffin said he took exception with statements that he heard time and time again about the state not having sufficient money. He said the Legislature had not tried to find the money. The Legislature had rhetorical discussions about whether or not it could find the money. But it really had not tried to find the money as yet. He thought it was premature to deny these kinds of requests which may not be agency requests but were from the public. He thought the members should follow their instincts. What was decided before the session was that the Legislature would determine what was necessary and then try to find the funds in the usual way to fund the services. Some votes on tax increases passed and some failed. The Legislature had not done any of that, although it had voted for a tax increase through the room taxes. Senator Coffin thought it was premature to say the Subcommittee could not afford enhanced rates and hated to use that as a reason to not approve them.

Chair Leslie said the reason she agreed with Assemblywoman Gansert was because she wanted to follow the Department and Division's recommendations of the priorities. The Department and the Division staff were the experts, and if they ranked this as a lower priority than other items that must be cut, she felt compelled to agree with the Department and Division.

ASSEMBLYMAN OCEGUERA MOVED TO APPROVE OPTION 1 TO CONTINUE THE ELIMINATION OF THE PEDIATRIC AND OBSTETRIC RATE ENHANCEMENTS FOR PHYSICIANS IN THE

MEDICAID AND CHECK-UP PROGRAMS AS RECOMMENDED BY THE GOVERNOR.

SENATOR MATHEWS SECONDED THE MOTION.

THE MOTION CARRIED. (SENATOR COFFIN AND ASSEMBLYMAN HARDY VOTED NO.)

Mr. Combs said decision unit Enhancement (E) 652 recommended continuing the reduction of the rates paid to inpatient hospitals, inpatient psychiatric facilities, and specialty/rehabilitation hospitals by 5 percent for both the Medicaid and Check-Up programs. The rates were reduced effective September 1, 2008, in response to budget shortfalls in the 2007-2009 biennium. The projected General Fund savings from the continuation of this budget reduction measure, based on the increased FMAP resulting from ARRA and the latest MPP, totaled $3,581,582 in FY 2010 and $4,410,783 in FY 2011. Decision unit E654 recommended an additional 5 percent reduction in the rates paid to inpatient hospitals, inpatient psychiatric facilities, and specialty/rehabilitation hospitals for the 2009-2011 biennium. This additional reduction would bring the overall reduction to 10 percent. The projected savings to the General Fund from the 10 percent reduction in rates would double to $7,163,164 in FY 2010 and $8,821,566 in FY 2011.

Mr. Combs said the Division testified that there was no compelling justification for reducing hospital reimbursement beyond the fact that it was a provider category responsible for a large percentage of overall Medicaid expenditures. At the Budget Subcommittee and the Joint Subcommittee hearings, the effect on hospitals from the various budget reduction measures recommended in The Executive Budget was discussed extensively. The Division provided information to the Subcommittee indicating that a 10 percent rate reduction in FY 2008 would reduce Medicaid payments to hospitals by $19.4 million. At the Budget Subcommittee hearing, it was noted that because HMOs and the counties used the Medicaid fee schedules, the effect to the hospitals could be much larger than the amount directly attributable to the Medicaid and Check-Up rate reductions. In response to questions regarding whether there was anything that could be done to obtain savings for the Medicaid program without affecting the rates paid by HMOs and the counties, the administrator of the Division indicated that changes to the reimbursement rates must be approved by CMS through the State Plan process, and he must be truthful about the amount of reimbursement to hospitals.

Mr. Combs said that during the work session conducted on March 30, 2009, the Subcommittee discussed the Department's number 8 priority on its add-back list to eliminate the additional 5 percent reduction in hospital reimbursement rates recommended by the Governor in decision unit E654 for the upcoming 2009-2011 biennium. The Department's add-back list indicated that the cost to eliminate the additional 5 percent rate decrease would require additional General Funds totaling $3,573,699 in FY 2010 and $4,401,169 in FY 2011 in the Medicaid and Check-Up budgets. In discussions with the Fiscal Analysis Division staff, the Division confirmed that the full 10 percent hospital rate reduction was considered by the actuary when HMO rate projections were updated for the MPP. As a result, a decision to eliminate the additional 5 percent increase would result in higher rates and additional General Fund costs in the Medicaid budget totaling $483,405 in FY 2010 and $1,225,042 in FY 2011. A decision to eliminate the additional 5 percent hospital rate reduction recommended by the Governor would result in the need to add

General Funds totaling $4,064,987 in FY 2010 and $5,635,825 in FY 2011, based on the increased FMAP resulting from ARRA and the latest MPP.

Chair Leslie said the Subcommittee was familiar with these hospital reductions and said there were two decisions to consider. The first decision was whether the Subcommittee wished to approve the Governor's recommendation in decision unit E652 to continue the current 5 percent reduction in hospital reimbursement rates. If the hospital rates were restored to the 2008 levels, General Funds totaling approximately $8.2 million in FY 2010 and $11.3 million in FY 2011 must be added to the Medicaid and Check-Up budgets.

Chair Leslie said the second decision was whether the Subcommittee wished to approve the Governor's recommendation to decrease hospital reimbursement rates by an additional 5 percent effective July 1, 2009. If the additional 5 percent reduction was not approved, General Funds totaling approximately $4.1 million in FY 2010 and $5.6 million in FY 2011 must be added to the Medicaid and Check-Up budgets.

Assemblywoman Buckley said she was concerned about the additional 5 percent reduction. She thought it was hard to fathom how the hospitals could survive an additional 5 percent reduction. She thought that the Subcommittee could accept the initial 5 percent reduction. But since the Subcommittee was trying not to cut children off of their health insurance, not cut pregnant women off of their health insurance, and not cut autistic children off of their treatment, she thought the best the Subcommittee could do was to not implement the further 5 percent reduction.

> ASSEMBLYWOMAN BUCKLEY MOVED TO APPROVE THE GOVERNOR'S RECOMMENDATION TO CONTINUE THE CURRENT 5 PERCENT REDUCTION IN HOSPITAL REIMBURSEMENT RATES IN DECISION UNIT E652 BUT TO REJECT THE GOVERNOR'S RECOMMENDATION TO DECREASE THE HOSPITAL REIMBURSEMENT RATES BY AN ADDITIONAL 5 PERCENT EFFECTIVE JULY 1, 2009.
>
> SENATOR COFFIN SECONDED THE MOTION.

Assemblywoman Gansert said she supported that motion. She thought the Subcommittee members were concerned about access to care. The members recognized that when they changed this rate schedule, the change affected other rate schedules as well. She thought it was important to restore the proposed additional 5 percent cut.

Senator Raggio said he also supported the motion. He thought this budget proposal materially affected the hospitals. He thought an additional 5 percent cut would not only be a disservice to the hospitals but also adversely affect the quality of services.

> THE MOTION CARRIED UNANIMOUSLY.

Mr. Combs said the next item was the elimination of HMO incentive payments. The current HMO contracts allowed for payments of up to $1 million in incentives for achieving certain health outcomes, based on performance standards agreed to by the HMOs. The projected savings to the General Fund from this budget reduction measure were $95,617 in FY 2010 and $114,094 in FY 2011 based on the increased FMAP resulting from ARRA. Based on the lack

of concerns regarding this recommendation during the Subcommittee hearings and the current revenue shortfalls, the Fiscal Analysis Division staff recommended approval of this decision unit as revised for the new FMAP resulting from ARRA.

ASSEMBLYWOMAN SMITH MOVED TO APPROVE DECISION UNIT E653 AS REVISED FOR THE NEW FMAP RESULTING FROM ARRA.

SENATOR COFFIN SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

Mr. Combs said the next item was the addition of drug categories to the Preferred Drug List (PDL) in decision unit E656. He explained the Governor recommended reducing expenditures by $2,864,380 in FY 2010 and by $3,160,762 in FY 2011 by removing statutory restrictions that prevented the Division from adding certain categories of drugs to the PDL. The recommendation would allow those recipients who were currently receiving a drug in one of those categories to continue to receive that drug, even if the drug was not designated as a preferred drug within that class of drugs. The projected savings to the General Fund from this budget reduction measure were $954,668 in FY 2010 and $1,242,733 in FY 2011 based on the increased FMAP resulting from ARRA and the latest MPP.

Mr. Combs said through the enactment of Assembly Bill No. 384 of the 72nd Session in 2003, the Legislature required the Department of Health and Human Services to develop a list of preferred prescription drugs for Medicaid recipients. The bill created a Pharmacy and Therapeutics Committee to designate a selection of effective preferred drugs for each therapeutic class that did not require prior authorization. The goal of the program was to provide clinically effective and safe drugs to Medicaid recipients at the best available price. The state received rebates on drugs that were designated as preferred from the manufacturers. The rebates lowered the total expenditures paid by Medicaid for the pharmacy program. Currently *Nevada Revised Statutes* (NRS) 422.4025 required the Division to exclude certain categories of drugs from the PDL. The categories of medications that must be excluded from the PDL pursuant to NRS 422.4025 were:

1. Atypical and typical antipsychotic medications prescribed for the treatment of mental illness.
2. Prescription drugs prescribed for the treatment of HIV or AIDS.
3. Anticonvulsant medications.
4. Antirejection medications for organ transplants.
5. Antidiabetic medications.
6. Antihemophilic medications.

Mr. Combs said the Division indicated during the Joint Subcommittee hearing that the bill draft request (BDR) required to implement this budget reduction measure would allow the inclusion on the PDL of atypical and typical antipsychotic medications prescribed for the treatment of mental illness, anticonvulsant medications, antirejection medications for organ transplants, and

antidiabetic medications that currently must be excluded from the PDL. The BDR would allow those recipients who were currently receiving a drug in one of those categories to continue to receive that drug even if it was not designated as a preferred drug within that class. The General Fund resulting savings totaled $954,668 in FY 2010 and $1,242,733 in FY 2011 based on the increased FMAP rate and the latest MPP.

All currently manufactured anticonvulsant, antirejection, and antidiabetic medications would be placed on the PDL, but drugs prescribed for the treatment of HIV or AIDS and antihemophilic medications were not included as part of the Division's proposal, because there were no supplemental rebates for those classes of drugs. Senate Bill (S.B.) 419, introduced on May 4, 2009, would implement this budget recommendation, except that the bill did not allow the inclusion of antirejection medications on the PDL. The Division indicated savings from including antirejection medications on the PDL was a small part of the projected savings from this decision unit, and the Division would not recommend any adjustments to the projections based on the continued exclusion of those drugs from the PDL.

Mr. Combs said that 37 of the 40 states that responded to a survey used a PDL, and 28 of those states included antipsychotic medications on their PDLs. Most of the savings generated by the Governor's recommendation would come from antipsychotic medications. The Administrator testified that the PDL had not resulted in recipients being unable to obtain needed medications, and safeguards were in place that provided a process for a physician to obtain a medication for a patient, even if it was not a preferred medication, when circumstances warranted. Such circumstances included any instance when a preferred drug was not effective for the patient.

Mr. Combs said the question before the Subcommittee was whether it wished to remove statutory restrictions that prevented the Division from adding certain categories of drugs to the preferred drug list. If the Governor's recommendation was approved, approval of S.B. 419 would also be necessary to implement the budget recommendation, and the Fiscal Analysis Division staff would include the bill on a list of legislation necessary to implement the legislatively approved budget.

Chair Leslie said that Senator Coffin indicated S.B. 419 was on the agenda of the Senate Committee on Finance for May 11, 2009. She stated she would be satisfied with the appropriate safeguards, but she thought the Subcommittee should take the budget issue separate from S.B. 419.

> ASSEMBLYWOMAN BUCKLEY MOVED TO APPROVE THE GOVERNOR'S RECOMMENDATION ON DECISION UNIT E656 TO REMOVE THE STATUTORY RESTRICTIONS THAT PREVENTED THE DIVISION FROM ADDING CERTAIN CATEGORIES OF DRUGS TO THE PREFERRED DRUG LIST AND INCLUDE PRECAUTIONS AND GUIDELINES OF THE HEALTH COMMITTEE AND OTHER MEASURES AND SAFEGUARDS.
>
> ASSEMBLYMAN HARDY SECONDED THE MOTION.

Senator Coffin said he could not support the motion because he had not heard the bill as yet. He would hear the bill in a few hours and would abstain on this motion. He did not know what the ramifications might be if the Subcommittee were to delay its action. He asked whether this was the last meeting.

Chair Leslie confirmed this would be the last meeting of the Subcommittee. Senator Coffin said he could not approve the Governor's recommendation even if it included grandfathering of the current patients until he had heard the bill.

Senator Raggio said he also would be voting no. He was concerned about the ability of patients with difficult problems to receive effective medications.

Chair Leslie wondered whether the Department used a PDL for the Division of Mental Health and Developmental Services (MHDS) for antipsychotic medications and thought the Department was considering using a PDL for Medicaid as well.

Mike Willden, Director, Department of Health and Human Services, explained it was important to explain two words to the Subcommittee, a PDL versus an algorithm. He confirmed the Department used an algorithm in MHDS that was not a PDL but was an algorithm that physicians used to prescribe medications. In Medicaid, the program used a PDL that allowed it to obtain supplemental rebates from the federal agencies. In MHDS, the agency used an algorithm, which was a modified Texas medical algorithm.

Chair Leslie said in her reading lately about the atypical medications, the latest research was really interesting and showed that there was little difference between the more expensive drugs (the new antipsychotics) and the old drugs. She recognized that certain medications were effective for some persons only.

Mr. Willden confirmed that was his understanding as well. He emphasized that S.B. 419 addressed three groups of drugs including the typical and atypical antipsychotic drugs (which would be grandfathered), the anticonvulsants, and the antidiabetic drugs, which would all be included on the PDL, and physicians would be able to prescribe any one of those drugs. The only difference was that the Department could not get supplemental rebates now and would be able to get supplemental rebates under the PDL. He said no changes were being recommended for the other drugs listed.

Chair Leslie asked Mr. Duarte to explain how a person who needed a drug that was not on the PDL would be able to receive the drug.

Mr. Duarte explained the antipsychotic class of drugs included both atypical and typical antipsychotic medications. Those drugs would be grandfathered so there was no access problem for persons receiving their current medications. No one would be forced or transitioned to another medication product that was preferred. If there was a new patient that was going to begin treatment with an antipsychotic medication, that would be a different situation. The class of drugs was deemed equivalent, but the patient would receive the physician-prescribed medication. That physician would need to check to see which medication was preferred versus which medication was non-preferred for the typical and atypical antipsychotic class of drugs. For new patients the option would be for the patient to use the preferred drug. But the patient could use the non-preferred drug if the physician could show that the patient had not been clinically successful in using a preferred product. The big distinction between Medicaid PDLs and commercial PDLs was that Medicaid must provide all necessary medications. All Medicaid needed was that there be some clinical justification for use of a non-preferred product in the antipsychotic class of drugs.

Chair Leslie wondered whether the cost of not using a PDL for the drugs was about $1 million per year, and Mr. Duarte confirmed she was correct.

Assemblywoman Buckley wondered if a physician indicated circumstances required use of a non-preferred drug, whether the physician would be able to prescribe a non-preferred drug. Mr. Duarte confirmed she was correct. A patient would need to go through a prior-authorization process. Documentation was required to demonstrate that the patient was not successfully treated by a preferred drug product. There were other kinds of safety allowances that allowed a physician to prescribe a needed drug. If a physician knew the patient was allergic to a drug product, there were control mechanisms in the prior-authorization process to allow the physician access to a drug that a patient needed.

Assemblywoman Buckley wondered whether a physician could recommend a non-preferred drug based on other medications a patient used or other issues in the patient's medical history. Assemblywoman Buckley asked whether a physician could prescribe a non-preferred drug initially in those cases after prudently reviewing the medical circumstances.

Mr. Duarte confirmed Assemblywoman Buckley was correct. The authorization process that allowed for access to non-preferred products included allergies to all medications in the same class, contraindications with drug-to-drug interactions, or a history of unacceptable or toxic side-effects to the preferred medications, and there were other reasons as well. The provisions of S.B. 419 allowed Medicaid to move away from requiring two therapeutic failures of a preferred drug in that class to one therapeutic failure.

Senator Coffin said he was worried that the $2.2 million savings projected could be fictitious if physicians were allowed to appeal or prescribe a newer, more expensive medication. He worried that the Subcommittee might not be looking at realistic savings numbers.

Mr. Duarte said the Division was cautious in developing the fiscal note for S.B. 419 and used data from First Health Services Corporation (FHSC) based on work FHSC had done with PDLs in 12 other states. The fiscal note was based on the FHSC history in other states regarding the compliance rates by the physician population. For all the other drug classes on the PDL, Medicaid obtained about 90 percent compliance within the first six months. From the patterns the agency had seen, it was able to estimate the savings with a good degree of certainty.

Chair Leslie said she knew S.B. 419 would be heard this afternoon but believed the clarification was good information for the Subcommittee. She reminded the Subcommittee the motion before it was to approve the Governor's recommendation.

> THE MOTION CARRIED ON THE ASSEMBLY SIDE BUT FAILED ON THE SENATE SIDE WITH SENATOR RAGGIO AND SENATOR COFFIN VOTING NO AND SENATOR MATHEWS ABSTAINING.

Mr. Combs said the Governor recommended reducing expenditures by $10,999,426 in FY 2010 and $11,319,867 in FY 2011 by reducing the reimbursement for Personal Care Services (PCS) by 16.2 percent, from $4.63 per 15 minutes to $3.88 per 15 minutes. The hourly rate would be

reduced from $18.52 to $15.52. The Division indicated that there were approximately 85 personal care agencies enrolled as Medicaid providers in Nevada. The projected savings to the General Fund from this budget reduction measure was $3,852,826 in FY 2010 and $4,728,467 in FY 2011 based on the increased FMAP resulting from ARRA and the latest MPP.

Mr. Combs said the Division indicated that its decision to reduce the hourly rate by $3 per hour was based on a comparison of Nevada Medicaid's personal care reimbursement rate to the reimbursement rates in other states, which indicated that Nevada's rate was higher than the rates paid in any of the other states. Based on concerns expressed by providers and recipients of services, the Department included a proposal on its add-back list (priority number 4) to reduce the rates for the Medicaid and Aging Services Division programs by only one-half of the amount recommended by the Governor. At its work session conducted on March 26, 2009, the Subcommittee expressed support for the Department's proposal, which would set the hourly reimbursement rate for the 2009-2011 biennium at $17 per hour. The Division's latest projection of the General Fund need necessary to restore one-half of the PCS rate reduction recommended by the Governor was $1,558,880 in FY 2010 and $1,913,169 in FY 2011, based on the increased FMAP resulting from ARRA and the latest MPP. This was a reduction from the amount projected in the add-back list ($1,926,412 in FY 2010 and $2,364,233 in FY 2011). The Subcommittee approved the $17 reimbursement rate for the Aging Services Division when it closed that Division's budget.

> ASSEMBLYWOMAN SMITH MOVED TO APPROVE A RATE OF $17 PER HOUR TO CONFIRM ITS WORK SESSION CONSENSUS TO RESTORE ONE-HALF OF THE RATE REDUCTIONS FOR PERSONAL CARE SERVICES RECOMMENDED BY THE GOVERNOR.
>
> ASSEMBLYMAN HARDY SECONDED THE MOTION.
>
> THE MOTION CARRIED UNANIMOUSLY.

Mr. Combs said the next item was the continuation of limitations on personal care services in decision unit Enhancement (E) 660. The Governor recommended reducing expenditures by $9,830,469 in FY 2010 and $10,073,084 in FY 2011 by limiting personal care services for bathing, grooming, and dressing to one hour per day and eliminating personal care services for exercising entirely. The services were limited in September 2008 in response to budget shortfalls in the 2007-2009 biennium. The projected savings to the General Fund from the continuation of this budget reduction measure was $3,584,787 in FY 2010 and $4,399,510 in FY 2011 based on the increased FMAP resulting from ARRA and the latest MPP.

Mr. Combs said during the Joint Subcommittee hearing on February 18, 2009, the Administrator indicated that the Division adopted administrative provisions to ensure that persons who were at risk of being placed in an institution could receive additional hours of service to enable them to live independently. The Division indicated that it had approved additional services for approximately 40 recipients with special circumstances. In addition, the Division indicated that a caregiver must ensure that the most critical needs of a waiver client would be addressed, even if less-critical needs had to be delayed to ensure that the health of the client was not jeopardized.

Mr. Combs said the Administrator also indicated that the reports provided by personal care agencies to the Division did not reflect that the reduction in hours of PCS caused any significant increase to hospital or nursing home placements. The PCS agencies were required to report to the Division any occurrences of PCS recipients being placed in an institution. Although concern was expressed at the hearing that the effect of the reductions may be more evident after the reductions were in place for a longer period, the Division indicated that it would expect to see such effects within a month or two after the implementation of reduced hours.

Mr. Combs said the question before the Subcommittee was whether it wished to approve the Governor's recommendation to continue the limitation of personal care services for bathing, grooming, and dressing to one hour per day and the elimination of personal care services for exercise. If the Governor's recommendation was not approved, General Funds totaling approximately $3.6 million in FY 2010 and $4.4 million in FY 2011 must be added to the Medicaid budget, as adjusted for the revised FMAP and the MPP. If the Subcommittee voted to restore one-half of the hourly rate for PCS services in decision unit E657, the cost to restore this decision unit increased to approximately $3.9 million in FY 2010 and $4.8 million in FY 2011.

Chair Leslie said this issue dealt with continuing the limits on personal care services that was implemented during the current biennium.

> ASSEMBLYMAN OCEGUERA MOVED TO APPROVE THE GOVERNOR'S RECOMMENDATION ON DECISION UNIT E660.
>
> ASSEMBLYMAN ARBERRY SECONDED THE MOTION.

Senator Coffin said he had been concerned with the proposal limiting PCS hours since it was first proposed. The state had no money in the 2007-2009 biennium. At the time the Legislature decided to endorse the PCS proposal in December 2008, it had held no hearings on this subject. Now the Legislature had hearings on this proposal and had indications PCS caregivers would not be able to spend enough time with many of the clients. Senator Coffin said the Division used an example of an average person, but he wondered on what factors that calculation was based. Senator Coffin said he wondered what would happen to the person who was not average. Nobody was average, so there were half above and half below the average. Senator Coffin said some persons needed more time. He wondered how the Subcommittee could ensure that persons received the care needed.

Mr. Combs said the Division indicated that it had administrative provisions and a review process in place to allow recipients to petition for more PCS hours if needed. The Division granted additional hours to 40 recipients in danger of being placed in an institution.

Senator Coffin said he understood that. But he worried about the recipients and the limited amount of time provided for PCS. Senator Coffin said PCS recipients received a bath, which included a massage with the bath. If the recipients did not receive the massage, they got bedsores. The only person seeing these recipients sometimes was the personal care attendant (PCA). The PCA had to perform according to his or her contract. That caregiver may not understand until it was too late that this limited PCS time was going to allow bedsores to form. Senator Coffin worried there was not an independent party looking and watching to see whether recipients were okay. The PCA was the sole judge

and arbiter of whether or not that patient was going to need more care. Senator Coffin was worried that this PCS reduction was not satisfactory. He knew Senator Mathews had similar concerns and was unsure whether her concerns were resolved. He just was not satisfied with this reduction.

Senator Raggio said his questions were similar to Senator Coffin's questions. He was willing to support the recommendation of the Governor, but he also wanted to ask about an available administrative solution. These PCS recipients were particularly vulnerable. Senator Raggio's understanding was there were administrative solutions in place that would prevent a recipient from being placed in a confined setting or institution. He wondered about the effectiveness of those solutions. He asked about the length of time required to receive approval of additional PCS hours. Senator Raggio wanted some assurance that if a person needed additional PCS time, there was an effective appeal process that would quickly accommodate that person.

Chair Leslie said the entire Subcommittee shared Senator Raggio's concern. She asked Mr. Duarte to address Senator Raggio's concern and explain about the 40 recipients approved for the additional PCS hours.

Mr. Duarte said he understood the concerns. The administrative override was a temporary process put in place to deal with a period of time where the Division notified recipients of a reduction in PCS hours. The Division received appeals from numerous recipients about any possible reduction in the number of service hours they might receive. The administrative override was enacted to allow recipients to continue to receive PCS hours until they received a reevaluation and were allowed to go through an administrative hearing. Once the administrative hearing judge made a decision, the recipient could potentially lose some hours if they were not medically necessary.

Mr. Duarte said the question about risk to the individual was probably the most important. The risk was something that the Division had weighed and measured ever since and prior to the implementation of the PCS reduction. He thought the concern about the individual not receiving sufficient care, which might put them at risk of institutionalization, was a good question. But as Senator Coffin pointed out, in the contract a personal care attendant had a responsibility to report significant occurrences including things like bedsores so that the patient could be referred to receive appropriate medical attention and avoid institutionalization. The Division had protections in place including the training of PCAs and the contractual responsibilities of these agencies to assure that persons were not being put at risk of institutionalization.

Mr. Duarte said the Division tracked both self-reported data and data from the nursing facilities and hospitals regarding institutionalization of individuals who were currently receiving personal care services. The Division had not seen an increase since September in the number of nursing-facility admissions or hospital admissions associated with this group of recipients. The significant occurrence reports the Division received from the personal care agencies were consistent with past reports and did not suggest that there were individuals at risk of institutionalization because of a reduction of PCS hours. The Division monitored the PCS closely and believed that the reduction could go forward without creating any harm to recipients. A number of recipients were on wait-lists for home- and community-based waiver services. Increasing the slots in the 2009-2011 biennium would reduce wait-lists. The wait-lists were prioritized if recipients were at significant risk for institutionalization. The

Division had not seen a change in the indicators including nursing facility admissions or the significant occurrence reports from PCA agencies.

Senator Coffin said he would rely on Mr. Duarte's assurances and would support this change. Data could be bad or could be good. Senator Raggio wanted to receive periodic reporting to the Interim Finance Committee (IFC) to see a summary of the raw data so that the members could monitor the situation.

Chair Leslie agreed that was a good suggestion and asked Mr. Duarte to keep monitoring the data and advise the IFC every quarter. Mr. Duarte confirmed he would report regularly to IFC on this item.

THE MOTION CARRIED UNANIMOUSLY.

Mr. Combs explained the last major issue was the continued elimination of the non-medical vision services for adults in decision unit E661. The Governor recommended reducing expenditures by $1,267,052 in FY 2010 and $1,322,279 in FY 2011 by eliminating non-medical vision service for adult Medicaid recipients. The services were eliminated during September 2008 in response to budget shortfalls in the 2007-2009 biennium. The projected savings to the General Fund from the continuation of this budget reduction measure was $419,682 in FY 2010 and $516,858 in FY 2011 based on the increased FMAP resulting from ARRA and the latest MPP.

Mr. Combs said the Division indicated that coverage for ocular equipment and related supplies, including eyeglasses, frames, spectacles, and contact lenses for recipients who were 21 years of age and older was eliminated. Ocular services were still provided for persons under the age of 21, and adults were still covered for medical vision services. In response to a question from the Subcommittee regarding how Medicaid recipients received ocular services, the Administrator indicated that most recipients would probably not get their eyeglass prescriptions filled. The restoration of ocular services for adult Medicaid recipients was included in the Department's priority list of General Fund add-backs as priority number 15. At the work session conducted on March 30, 2009, members of the Subcommittee expressed support for restoring services during the 2009-2011 biennium.

Mr. Combs said the question before the Subcommittee was whether it wished to approve the Governor's recommendation to continue the elimination of non-medical vision services for adult Medicaid recipients or wished to restore those services as requested pursuant to priority number 15 on the Department's add-back list. If the Governor's recommendation was not approved, General Funds totaling $419,682 in FY 2010 and $516,858 in FY 2011 must be added to the Medicaid budget, as adjusted for the revised FMAP and the MPP.

SENATOR COFFIN MOVED TO NOT APPROVE THE GOVERNOR'S RECOMMENDATION IN DECISION UNIT E661 AND RESTORE THE VISION SERVICES AS REQUESTED PURSUANT TO PRIORITY NUMBER 15 ON THE DEPARTMENT'S ADD-BACK LIST.

ASSEMBLYWOMAN BUCKLEY SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

Mr. Combs explained the Governor recommended the continuation of six measures that were implemented during the 2007-2009 biennium to generate new revenues or to offset expenditures for the Medicaid program during the 2009-2011 biennium. Decision unit E680 recommended reducing expenditures by $1,128,103 in each year of the 2009-2011 biennium because of the scheduled installation of clinical claims editor software for the MMIS. The software identified claims that should be denied for such reasons as billing mutually exclusive procedure codes, using an assistant surgeon when not warranted, or unlisted procedures. During the 2007 Session, the Legislature approved approximately $1.4 million in funding to procure a clinical claims editor system. The General Fund savings was projected to be $439,418 in FY 2010 and $542,187 in FY 2011 based on the increased FMAP resulting from ARRA.

Mr. Combs said decision unit E681 recommended reducing expenditures by $351,540 in each year of the 2009-2011 biennium because of efforts by First Health Services Corporation to implement more efficient diabetic supply procurement practices. The supply procurement program used the First Health/Provider Synergies market share purchasing power in the Medicaid market to negotiate rebates for diabetic supplies paid for by the states that participated in the program. First Health/Provider Synergies had pharmacy contracts in over one-half of the states. The General Fund savings was projected to be $108,697 in FY 2010 and $142,258 in FY 2011 based on the increased FMAP resulting from ARRA.

Mr. Combs said decision unit E682 recommended reducing expenditures by $655,038 in FY 2010 and $722,816 in FY 2011 based on the implementation of polypharmacy criteria that prevented the prescription of multiple drugs in the same therapeutic class to the same recipient at the same time. The polypharmacy criteria were implemented on July 1, 2008. First Health projected that total savings (General Fund and Title XIX) would be $500,000 in FY 2008, if the criteria was in effect. The General Fund savings was projected to be $195,443 in FY 2010 and $240,696 in FY 2011. The projected savings were based on First Health's projected total savings of $500,000 for FY 2008, adjusted for projected caseload increases based on the latest MPP for FY 2009, FY 2010, and FY 2011 and the increased FMAP resulting from ARRA.

Mr. Combs explained decision unit E683 recommended reducing expenditures by $5,932,718 in FY 2010 and $6,546,588 in FY 2011 based on a projected increase in the receipt of rebates from physician-administered drugs during the 2009-2011 biennium. Because of a requirement in the federal Deficit Reduction Act, a National Drug Code (NDC) number was now required for all physician-administered drugs. Prior to the implementation of the NDC, the state received rebates only for physician-administered, brand-name drugs. The Division indicated that, beginning in FY 2009, the state began receiving rebates on physician-administered, generic drugs. The General Fund savings were projected to be $1,770,131 in FY 2010 and $2,179,996 in FY 2011. The projected savings were based on First Health's projected savings of $4,528,528 in FY 2008, adjusted for projected caseload increases based on the latest MPP for FY 2009, FY 2010, and FY 2011 and the increased FMAP resulting from ARRA.

Mr. Combs said decision unit E684 recommended reducing expenditures by $6 million in each year of the 2009-2011 biennium for projected savings resulting from a care-coordination contract entered into with APS Healthcare Midwest (APS). A clause in the APS contract required that the Division realize

savings of $4 million in FY 2009 and $6 million in FY 2010. The contract could be renewed for another two fiscal years (FY 2011 and FY 2012). Based on the current APS contract terms and the increased FMAP resulting from ARRA, the General Fund savings was projected to be $1,596,581 in FY 2010 and $2,215,868 in FY 2011.

Mr. Combs explained decision unit E685 recommended increasing County Reimbursement revenue and decreasing General Fund appropriations by $1,758,031 in FY 2010 and $1,791,226 in FY 2011, which was based on the decision made during the 2007-2009 biennium to charge the counties for Medicare Part D clawback payments for dual-eligibles (those eligible for Medicare and Medicaid) in the County Match aid category. When Medicare Part D was implemented on January 1, 2006, states that were responsible for 100 percent of the costs for prescription drugs for dual-eligibles were no longer required to cover prescription drug costs for those recipients, because the costs were covered under Medicare Part D. Because the states were no longer responsible for these costs, the Part D provisions required states to pass the savings on to the federal government in the form of a monthly clawback payment. Since the counties were responsible for 100 percent of the costs of dual-eligibles in the County Match aid category, it appeared that the counties should have been contributing toward the costs of the Medicare Part D clawback since its inception in 2006. As adjusted for revised caseload in the MPP, the General Fund savings was reduced to $1,685,395 in FY 2010 and increased to $1,820,817 in FY 2011.

Mr. Combs said he reviewed the six decision units recommended by the Governor to generate new revenues or offset expenditures for the Medicaid program during the 2009-2011 biennium. The Fiscal Analysis Division staff recommended approval of the six decision units, as adjusted in budget amendment 112 for both the FMAP rate and the latest MPP.

> ASSEMBLYWOMAN BUCKLEY MOVED TO APPROVE THE GOVERNOR'S RECOMMENDATION FOR DECISION UNITS E680, E681, E682, E683, E684, AND E685 AS ADJUSTED IN BUDGET AMENDMENT 112.
>
> ASSEMBLYMAN OCEGUERA SECONDED THE MOTION.
>
> THE MOTION CARRIED UNANIMOUSLY.

Mr. Combs explained decision unit E686 recommended transferring the property tax receipts projected for the Indigent Supplemental Account (BA 3244) to the Division's Intergovernmental Transfer Program account (BA 3157). The projected receipts of $27.8 million in FY 2010 and $28.1 million in FY 2011 would be used to offset General Funds in the same amount in the Medicaid program. At the 25th Special Session in December 2008, the Legislature approved the use of $25 million in funds from the Indigent Supplemental Account (BA 3244) in FY 2009 to offset General Fund revenue shortfalls. This decision unit would be eliminated as a result of the Subcommittee's previous actions on the Indigent Supplemental Account.

Mr. Combs said decision unit E800 recommended transfers to the DHHS agencies of $18.8 million in FY 2010 and $15.8 million in FY 2011 for Medicaid administrative and medical services costs, based on the Governor's recommended expenditure levels.

Mr. Combs said decision units E900 and E902 recommended transferring the General Fund portion of payments for Medicaid administration costs for the Aging Services Division's programs from this account to the Aging Services Division's Home and Community Based Programs account (BA 3146) and Aging Federal Programs and Administration account (BA 3151). The transfers totaled $2,236,945 in FY 2010 and $2,255,584 in FY 2011. The CMS directed Medicaid to alter the manner in which it accounted for federal Title XIX funds and the state funds used as match for those federal funds. The federal Title XIX portion of the Aging Services Division's administrative costs would remain in the Medicaid account and would be drawn down by the DHCFP and transferred to the Aging Services Division.

Mr. Combs said decision unit E901 recommended transferring all administrative expenditures ($56.2 million in FY 2010 and $61.2 million in FY 2011) and all 151 full-time-equivalents (FTE) positions from this account to the Division's Administration account (BA 3158). The transfer would place all administrative costs for the Medicaid program in the Administration account and would leave only medical services costs in this account.

Mr. Combs said the technical adjustments were similar to the adjustments the Subcommittee approved in the Administration account, and this was the other side of those adjustments. The first adjustment was the balance forward revenue from FY 2009 to FY 2010 which was inadvertently left in this account in The Executive Budget. Based on the recommendation to transfer administrative revenues and expenditures to the Administration account in E901, the balance forward revenues should have been transferred to the Administration account. The adjustment would result in a General Fund addition in this account totaling $2,299,587 but would also result in a corresponding decrease in General Fund need in the Administration account.

Mr. Combs said the next technical adjustment was for the base budget and decision unit E901. The $7,859 budgeted for Civil Penalties revenue in the base budget would be credited to the Reserve for Resident Protection expenditure category. Civil Penalties were collected from nursing facilities by CMS for the violation of CMS regulations, and the state received the state share of the fine based on the medical FMAP. The Civil Penalties revenues could only be used for the protection of nursing home residents if the state was required to temporarily take over the management of a nursing facility serving Medicaid recipients. A corresponding adjustment was required to the decision unit E901 to transfer the increased reserve amount to the Administration account.

Mr. Combs said the revenue allocation for decision unit M100 in the Governor's recommended budget inappropriately balanced reductions in statewide cost allocation to the state General Fund. As a result, General Fund appropriations were reduced by $122,182 in FY 2010 and $123,397 in FY 2011 but should have been reduced by only $80,553 in FY 2010 and $81,740 in FY 2011. The Budget Division had submitted budget amendment AGSW3243 to correct the error, and the budget amendment would increase General Fund appropriations for this account by $41,629 in FY 2010 and $41,657 in FY 2011. The adjustment would be made to this account when the statewide and AG cost allocations were made by the Fiscal Analysis Division staff.

Mr. Combs said the Fiscal Analysis Division staff requested authority to make all necessary technical adjustments for FMAP changes throughout the budget and to revise AG, Statewide, and sister agency cost allocations as appropriate. Because many of the budget reduction measures were related in some fashion,

the Fiscal Analysis Division staff requested authority to make any technical adjustments that resulted from decisions that were made by the Subcommittee that increased or reduced the savings in another related decision unit.

ASSEMBLYWOMAN BUCKLEY MOVED TO:

- CLOSE BA 101-3243.
- APPROVE DECISION UNITS E686, E800, E900, E902, AND E901 WITH TECHNICAL ADJUSTMENTS IN THE BASE BUDGET AND M100.
- AUTHORIZE FISCAL ANALYSIS DIVISION STAFF TO MAKE ALL NECESSARY TECHNICAL ADJUSTMENTS FOR FMAP CHANGES THROUGHOUT THE BUDGET AND TO REVISE AG, STATEWIDE, AND SISTER AGENCY COST ALLOCATIONS AS APPROPRIATE.
- AUTHORIZE FISCAL ANALYSIS DIVISION STAFF TO MAKE ANY TECHNICAL ADJUSTMENTS RESULTING FROM DECISIONS THAT INCREASED OR REDUCED THE SAVINGS IN ANOTHER RELATED DECISION UNIT.

SENATOR COFFIN SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

BUDGET CLOSED.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH CARE FINANCING AND POLICY
HCF&P-NEVADA CHECK-UP PROGRAM (101-3178)
BUDGET PAGE DHCFP-18

Rick Combs, Senior Program Analyst, Fiscal Analysis Division, explained the Budget Account (BA) 3178 covered the Nevada Check-Up program. He said the first major closing issue was the increased federal medical assistance percentage (FMAP) in budget amendment 135. Although the Check-Up program did not receive the FMAP increase provided for in the American Recovery and Reinvestment Act of 2009 (ARRA), the program received an increase anytime the regular FMAP rates for the Medicaid program increased. Based on the latest projections for FMAP in federal FY 2010 and federal FY 2011, the FMAP rates for the Check-Up program were projected to increase from the current rate of 65 percent to a blended FMAP rate of 65.08 percent in FY 2010 and 66.03 percent in FY 2011. Budget amendment 135 included a new decision unit Enhancement (E) 415 that recommended General Fund reductions and corresponding increases in Title XXI funds totaling $11,260 in FY 2010 and $359,500 in FY 2011 based on the latest projections for Nevada's FMAP rate in each year of the biennium. The Fiscal Analysis Division staff recommended approval of decision unit E415 to adjust for the latest projection of the FMAP rates for FY 2010 and FY 2011 as recommended in budget amendment 135.

SENATOR MATHEWS MOVED TO APPROVE DECISION UNIT E415 TO ADJUST FOR THE LATEST PROJECTION OF THE FMAP RATES FOR FY 2010 AND FY 2011 AS RECOMMENDED IN BUDGET AMENDMENT 135.

ASSEMBLYWOMAN BUCKLEY SECONDED THE MOTION.

THE MOTION CARRIED. (Senator Raggio was not present for the vote.)

Mr. Combs explained the second major closing issue was the provider rate increases. The Executive Budget recommended $5.5 million ($1.9 million General Funds) in FY 2010 and $7 million ($2.4 million General Funds) in FY 2011 for mandatory rate increases for providers. The Health Maintenance Organization (HMO) provider rates were recommended to increase by 3.8 percent in FY 2010 and 4.5 percent in FY 2011, and transportation services were recommended to receive a 5 percent rate increase for each fiscal year of the 2009-2011 biennium. The Governor recommended a 5.7 percent increase in pharmacy rates in each year of the 2009-2011 biennium, although the Governor did not recommend funding for pharmacy inflation for the Medicaid program.

Mr. Combs said the Division of Health Care Financing and Policy (DHCFP) indicated at its budget hearing that the inflation rate for pharmacy was included in error and would be eliminated through the submission of budget amendment 135, which not only eliminated the funding for pharmacy inflation to be consistent with the Medicaid budget but also revised the HMO and transportation inflation rates recommended by the Governor. The adjustments reduced expenditures in M101 by approximately $2.5 million in FY 2010 and $2.7 million in FY 2011.

Mr. Combs said although the Division indicated that the 5 percent hospital rate reduction implemented in October 2008 was factored into the HMO rate increases for calendar year 2009, the rate projections included in M101 for FY 2010 and FY 2011 were not updated for the recommendations included in the Governor's recommended budget, including the additional 5 percent rate reduction recommended in decision unit E654. The Division indicated at the hearing for the Medicaid account that it would provide updated rates under a scenario that included the additional 5 percent rate reduction in hospital rates and a scenario that did not include the additional 5 percent reduction in hospital rates. The Division indicated that the updated HMO rates provided by the actuary for the Check-Up program were reduced from the amount recommended in The Executive Budget. Mr. Combs referred to a table which compared the per-member, per-month (PMPM) rates used in The Executive Budget to the updated medical, dental, and total PMPM rates provided by the actuary based on the 5 percent reduction in hospital reimbursement rates approved in 2008. The Governor's recommended total PMPM rate was $117.67 for FY 2010 and the revised rate was $108.06. The Governor's recommended rate was $122.96 for FY 2010 and the revised rate was $112.90.

Mr. Combs said the actuary mistakenly had not included the reduction in capitation rates that would result if the additional 5 percent reduction in hospital rates recommended in decision unit E654 was approved. If the additional 5 percent hospital rate reduction recommended in E654 was approved, General Fund need in this account would be reduced by an additional $34,746 in FY 2010 and $34,747 in FY 2011.

Mr. Combs explained the latest actuarial projections also reduced the non-emergency transportation rates from the amount recommended in The Executive Budget. As with the Medicaid program, the updated actuarial projections indicated that the non-emergency transportation rates would increase by 2.6 percent in FY 2010 and 4.9 percent in FY 2011 compared to the 5 percent increase included in The Executive Budget. The revised mandatory rate increases reduced the General Fund appropriations required to fund this account by approximately $863,000 in FY 2010 and $918,000 in FY 2011. The revised rates appeared reasonable, and the Fiscal Analysis Division staff recommended approval.

> ASSEMBLYWOMAN BUCKLEY MOVED TO APPROVE THE REVISED RATES IN DECISION UNIT M101.
> ASSEMBLYWOMAN SMITH SECONDED THE MOTION.
>
> THE MOTION CARRIED. (Assemblyman Arberry was not present for the vote.)

Mr. Combs discussed the capping of Check-Up enrollment. He said The Executive Budget recommended capping enrollment in the Check-Up program at 25,000 recipients in each year of the 2009-2011 biennium. The recommendation to cap Check-Up enrollment reduced expenditures for the program in The Executive Budget by $4,650,824 ($1,523,949 of General Funds) in FY 2010 and $4,480,842 ($1,464,453 of General Funds) in FY 2011. The reduced expenditures represented the difference between the costs to fund the uncapped program in FY 2008 and the projected costs to fund the program at the capped enrollment in each year of the 2009-2011.

Mr. Combs explained the Department indicated that removing the enrollment cap from the Check-Up program was its number one priority for funding on its add-back list. Testimony was provided during the Budget Subcommittee and Joint Subcommittee hearings indicating that this budget reduction measure would result in harm to Nevada's children. Concern was expressed that capping the program during the current economic downturn eliminated an option for families that were struggling financially to ensure that their children were provided basic health services. The Department included on its add-back list General Funds totaling $612,508 in FY 2010 and $2,544,252 in FY 2011 to remove the enrollment cap. These costs were revised based on new caseload projections.

Mr. Combs said although the average monthly caseload for the program in FY 2008 was 29,077, the average monthly caseload for the program as of April 2009 was 22,437. The Division reported that although enrollment in the program was down, the number of applications received in FY 2008 was 4 percent higher than the number of applications received in FY 2007. The Division indicated at the January 26, 2009, Budget Subcommittee hearing that the enrollment in the program decreased even while applications were increasing primarily because there were vacancies in the Division's eligibility staff positions, and processing times were increasing because of new federal requirements. In a memorandum dated February 10, 2009, the Division indicated that there was a backlog of 3,304 applications pending review. The Division indicated that 12 family services specialist positions worked overtime to review applications, and they had reduced the processing time from 104 days as of December 31, 2008, to 78 days as of February 6, 2009. The Division later indicated that it had eliminated any backlog of applications and had reduced the processing time to less than 45 days.

Mr. Combs said the projected General Fund cost to remove the enrollment cap for the program was based on the Division's original projection of uncapped enrollment that was prepared in March 2009. Although the average enrollment for February 2009 was 22,535, the Division projected that enrollment in the program would be 24,839 in July 2009 (the first month of the 2009-2011 biennium). The Division further projected that enrollment would increase to an average monthly enrollment of 28,638 in FY 2010 and 32,551 in FY 2011, if enrollment was not capped as recommended by the Governor. The Division also indicated that a decision not to cap the Check-Up program would result in the need for four new family services specialist positions and a new administrative assistant position to support the additional caseload.

Mr. Combs said the Fiscal Analysis Division staff met with the Division to discuss the caseload projections submitted for the work session because enrollments had not increased significantly during the current fiscal year, even after eliminating the backlog of applications. The Division indicated that it believed enrollment would increase as the application processing time decreased and applications for the program increased. The Division continued to believe that the enrollment decrease during the current biennium was because of the Division's inability to process applications in a timely manner. The Division also believed that the current economic conditions appeared to be causing applicants and enrollees who were eligible for Check-Up to be eligible instead for the Medicaid program as part of the Child Health Assurance Program (CHAP) population.

Mr. Combs said based on the current enrollment in the Check-Up program, the Division had decreased its enrollment projections since the work session. The latest projections reduced the average monthly enrollment to 24,753 in FY 2010 and 31,035 in FY 2011. Although the projections for FY 2011 were still aggressive, the Division indicated that the FY 2008 enrollment levels, which peaked at 30,184, supported the contention that enrollment levels exceeding 30,000 were approachable during the upcoming biennium.

Mr. Combs said the CHAP population in the Medicaid program had increased significantly in recent months, and although it appeared that the updated Medicaid Payment Projection (MPP) had attempted to address the increasing caseload, it was unclear whether the increased enrollment would continue and, if so, when the growth would level off. The Division pointed out those uninsured children would end up in the CHAP program or in the Check-Up program depending on the income level of their parents. If the enrollment in the Medicaid CHAP population continued to increase, the Check-Up enrollments may not reach the latest enrollment projections; however, if the Medicaid CHAP enrollment leveled off or declined in FY 2011, the Division believed it was likely that the Check-Up enrollments would increase significantly as a result.

Mr. Combs noted that the Division had authority to transfer its General Fund appropriations between budget accounts and because of the uncertainty with regard to the economy and its effect on the CHAP and Check-Up enrollments, it appeared reasonable to fund the latest projected enrollments for the Check-Up program if the Subcommittee elected to uncap the Check-Up program. If enrollments did not meet the projections, it was likely that Medicaid CHAP recipients would increase accordingly. Such an increase in the CHAP population might result in the need for a transfer of funding from this account to the Medicaid account to fund the enrollment growth.

Mr. Combs said based on the Division's latest enrollment projections, the General Fund cost to uncap the Check-Up program would total approximately $2.8 million over the 2009-2011 biennium. These additional costs were offset by the reductions in General Fund costs resulting from budget amendment 136, which included provider rate reductions in Maintenance (M) 101, the increased FMAP, and an increase in the premium revenues that were understated in the Governor's recommended budget by $334,745 in each year of the 2009-2011 biennium. The budget amendment would decrease the General Fund required for the program over the 2009-2011 biennium by approximately $2 million based on the Governor's recommendation to cap the caseload at 25,000 in each year of the 2009-2011 biennium.

Mr. Combs referred to a table which compared the General Fund appropriation required to fund the Governor's recommended budget, the Governor's recommended budget as amended by budget amendment 136, and the proposal for uncapping the program based on the decreased enrollment projections. Mr. Combs explained that although the General Fund required to uncap the Check-Up program totaled $2.8 million over the 2009-2011 biennium, the increase from the Governor's recommended General Fund appropriation for the program totaled only $842,172 over the biennium. If the program remained capped, the capped enrollment could be funded with $2 million less in General Fund than recommended by the Governor.

Mr. Combs said based on the reduced enrollment projection, the number of new positions necessary to address the additional enrollment resulting from uncapping the program could be decreased from four family services specialist (FFS) 2 positions and an administrative assistant position to three FFS 2 positions and an administrative assistant position. The Division indicated that it did not want a backlog of applications to accumulate if the enrollment increased as projected, but the Division recognized that the positions would not need to be filled if the projections were overstated.

Mr. Combs said at the work session, the Subcommittee expressed its consensus that the Governor's recommendation to cap enrollment in the Check-Up program at 25,000 children should not be approved. The question before the Subcommittee was whether it wished to affirm its work session consensus to not approve the Governor's recommendation to cap enrollment in the Check-Up program. A decision to remove the cap would result in the need to add approximately $2.8 million in General Funds to the account based on budget amendment 136 but only $842,172 more than the appropriation originally included in the Governor's recommended budget. The decision would also add three new FSS 2 positions and an administrative assistant position to manage the additional projected caseload. Based on the unpredictability of the enrollment trends for this program, the Subcommittee may wish to direct the Division not to fill the new positions unless the enrollment level warranted the addition of the positions.

ASSEMBLYWOMAN BUCKLEY MOVED TO NOT APPROVE THE GOVERNOR'S RECOMMENDATION TO CAP ENROLLMENT IN THE CHECK-UP PROGRAM AND TO APPROVE THE FOUR NEW POSITIONS TO BE FILLED ONLY IF ENROLLMENTS IN THE PROGRAM SUPPORTED THE NEED FOR THE POSITIONS.

ASSEMBLYMAN OCEGUERA SECONDED THE MOTION.

THE MOTION CARRIED. (Assemblyman Arberry and Senator Mathews were not present for the vote.)

Mr. Combs said the last major item in this budget account was the continuation of the Check-Up program service reductions in decision unit E666. The Governor recommended reducing expenditures by $997,318 ($349,061 in General Funds) in each year of the 2009-2011 biennium based on the continuation of Check-Up program service reductions implemented during FY 2009. The service reductions included the elimination of orthodontia, certain vision services, and capping non-emergency dental services at $600 per year for Check-Up enrollees.

Mr. Combs explained the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) required states to include dental services as a benefit under the State Children's Health Insurance Program (SCHIP). The benefits provided must include services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions. As a result of this CHIPRA requirement, the Budget Division included in budget amendment 135 a recommendation to remove the cost savings from capping dental benefits at $600 per year. At the capped enrollment of 25,000 recommended by the Governor, the increase in General Fund required to restore full dental benefits totaled $200,522 in each year of the 2009-2011 biennium. Based on the CHIPRA requirement, the Fiscal Analysis Division staff recommended approval of the budget amendment to restore full dental benefits for Check-Up enrollees.

Mr. Combs said at the work session the Subcommittee also considered the Department's number 10 priority on its add-back list to restore the non-medical vision and orthodontia benefit reductions that were implemented during the 2007-2009 biennium. Although the add-back list indicated that General Funds totaling $357,565 would be required to restore the benefits, the latest caseload projections for uncapping enrollment in the program reduced the General Funds required to restore the benefits to $350,445 over the biennium. The Subcommittee expressed its support for restoring the vision and orthodontia benefits for Check-Up enrollees at its work session. The question before the Subcommittee was whether it wished to affirm its work session consensus to restore vision and orthodontia benefits for Check-Up enrollees and approve the budget amendment 135 to restore full dental benefits for Check-Up enrollees.

SENATOR COFFIN MOVED TO RESTORE VISION AND ORTHODONTIA BENEFITS FOR CHECK-UP ENROLLEES AND APPROVE THE BUDGET AMENDMENT 135 TO RESTORE FULL DENTAL BENEFITS FOR CHECK-UP ENROLLEES.

ASSEMBLYWOMAN BUCKLEY SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

Mr. Combs said another closing item was the elimination of four vacant positions in decision unit Maintenance (M) 160. The Governor recommended the elimination of four FTE positions that were not filled during the 2007-2009 biennium because of the decision to cap the Health Insurance Flexibility and Accountability (HIFA) waiver as a result of the General Fund revenue shortfall. The four positions included a management analyst 3, an administrative assistant 2, and two family services specialists (FSS) positions. The 74th Session in 2007 approved four new positions, the reclassification of

three existing positions, and the transfer of three existing FSS positions from the Division of Welfare and Supportive Services (DWSS) to the Check-Up program to provide the program resources to assume the eligibility and policy responsibilities for the Employer Sponsored Insurance (ESI) component of the HIFA waiver. When the HIFA waiver was originally approved by the 73rd Session in 2005, the Division intended to contract with a private vendor to perform a majority of the eligibility work related to the ESI program. However, when bids were solicited, it became apparent that it would be more cost-effective and less expensive for the Division to assume this responsibility.

Mr. Combs said the Governor recommended the elimination of the HIFA waiver program during the 2009-2011 biennium and elimination of four of the seven FTE positions. Based on the current and projected enrollment for the ESI component of the HIFA waiver program, the Division had agreed that the four positions recommended for elimination could be eliminated irrespective of the Subcommittee's decision regarding the Governor's recommendation to terminate the HIFA waiver program.

Mr. Combs said decision unit E665 recommended General Fund appropriations totaling $20,090 in each fiscal year of the 2009-2011 biennium to replace the state share of funds that were transferred from the HIFA Holding account to this account for the HIFA waiver administration costs. Based on the Subcommittee's decision on the HIFA waiver program, the Fiscal Analysis Division staff would make appropriate adjustments in this account for the upcoming 2009-2011 biennium. The General Funds in this account would be offset by funds transferred from the HIFA Holding account.

Mr. Combs said there were three budget reduction measures that affected this account as well as the Medicaid account and were identical to decision units that the Subcommittee decided in the Medicaid account. The first measure was decision unit E651 which eliminated the pediatric and obstetric rate enhancements for physicians. Decision unit E652 reduced the rates paid to inpatient hospitals, inpatient psychiatric facilities, and specialty/rehabilitation hospitals by 5 percent for both the Medicaid and Check-Up programs effective September 1, 2008. Decision unit E654 recommended reducing expenditures for the additional 5 percent reduction in the rates paid to inpatient hospitals, inpatient psychiatric facilities, and specialty/rehabilitation hospitals for both the Medicaid and Check-Up programs for the 2009-2011 biennium.

Mr. Combs said a technical adjustment was needed and explained budget amendment 135 should have included a $64,685 low-birthweight baby charge in each year of the 2009-2011 biennium that was partially responsible for the reduction in capitation rates addressed in the budget amendment. The cost was added in each year of the 2009-2011 biennium. The Fiscal Analysis Division staff requested authority to make all necessary technical adjustments for FMAP changes throughout the budget, statewide and AG cost allocations, and operational and equipment costs to support any new positions approved by the Subcommittee.

ASSEMBLYWOMAN BUCKLEY MOVED TO:

- CLOSE BA 101-3178.

- ELIMINATE FOUR POSITIONS AS RECOMMENDED IN DECISION UNIT M160

- AUTHORIZE THE FISCAL ANALYSIS DIVISION STAFF TO MAKE APPROPRIATE ADJUSTMENTS IN DECISION UNIT E665 FOR THE HIFA WAIVER.

- APPROVE THE BUDGET REDUCTION MEASURES FOR DECISION UNITS E651 AND E652.

- NOT APPROVE DECISION UNIT E654.

- APPROVE THE TECHNICAL ADJUSTMENTS IN BUDGET AMENDMENT 135.

- AUTHORIZE THE FISCAL ANALYSIS DIVISION STAFF TO MAKE ALL NECESSARY TECHNICAL ADJUSTMENTS FOR FMAP CHANGES THROUGHOUT THE BUDGET, STATEWIDE AND AG COST ALLOCATIONS, AND OPERATIONAL AND EQUIPMENT COSTS TO SUPPORT ANY NEW POSITIONS APPROVED BY THE SUBCOMMITTEE.

ASSEMBLYMAN OCEGUERA SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

BUDGET CLOSED.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH CARE FINANCING AND POLICY
HCF&P-HIFA MEDICAL (101-3247)
BUDGET PAGE DHCFP-44

Rick Combs, Senior Program Analyst, Fiscal Analysis Division, explained the Budget Account (BA) 3247 was for the Health Insurance Flexibility and Accountability (HIFA) waiver which was recommended for elimination in The Executive Budget. The HIFA waiver was eliminated primarily because the program must be discontinued to cap enrollment in the Check-Up program, but the Subcommittee decided not to cap enrollment in the Check-Up program. The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) included provisions that affected the HIFA waiver for pregnant women and adults. The CHIPRA provided states with a new option to cover pregnant women with State Children's Health Insurance Program (SCHIP) funds by submitting a state plan amendment, rather than through a waiver provision. However to choose that option, states must cover pregnant women in Medicaid up to at least 185 percent of the federal poverty level (FPL). Nevada currently only covered pregnant women in Medicaid up to 133 percent of the FPL. Coverage of adults with children would still be allowed, but beginning September 30, 2011, allowable spending under the HIFA waiver would be subject to a set-aside amount from a separate allotment and would be matched at the state's regular FMAP unless the state was able to prove it met certain coverage benchmarks for providing coverage to children. At the time of the work session, there was some concern that the HIFA waiver would be terminated under the CHIPRA on September 30, 2010, but the Administrator of the Division had since indicated that CMS had confirmed that the waiver could be continued until September 30, 2011 (the first quarter of FY 2012).

At the work session, the Subcommittee considered two options for continuing coverage for pregnant women between 133 percent and 185 percent of the federal poverty level (FPL) during the 2009-2011 biennium. Based on the CHIPRA requirements and the concerns expressed during the Subcommittee hearings about eliminating coverage for pregnant women between 133 percent and 185 percent of the FPL, the Department included on its add-back list (priority number 9) a proposal to retain the HIFA waiver program through September 30, 2010, and begin covering pregnant women up to 185 percent of FPL in the Medicaid program effective October 1, 2010. The Fiscal Analysis Division staff indicated during the work session that General Funds totaling approximately $220,000 in FY 2010 and $860,000 in FY 2011 must be added to fund the proposal.

Mr. Combs said the other option was retaining the HIFA waiver program in its current form throughout the 2009-2011 biennium. Currently, the program was capped at 200 pregnant women and 100 ESI recipients. Members of the Subcommittee expressed support for this option because of the enhanced FMAP rate for SCHIP as opposed to Medicaid. The Administrator noted during the work session that it would make sense to continue to cover pregnant women under the HIFA waiver as long as possible based on the enhanced FMAP rate for the HIFA waiver. Provisions of ARRA prevented Nevada from obtaining the increased FMAP rates for Medicaid for pregnant women between 133 percent and 185 percent of FPL during the recession adjustment period (October 1, 2008–December 31, 2010) because coverage of that group would be considered an enhancement of eligibility. The Fiscal Analysis Division staff indicated during the work session that the General Fund costs to continue the HIFA waiver program during the 2009-2011 biennium would be $220,451 in FY 2010 and $690,621 in FY 2011 based on the Division's calculations and the current enrollment caps for the program.

Mr. Combs said the Fiscal Analysis Division staff had worked with the agency to refine the projection of General Fund costs for retaining the current HIFA waiver program. The Division had indicated that the enhanced FMAP for the waiver was projected to increase from 65 percent to 65.08 percent in FY 2010 and to 66.03 percent in FY 2011. The revised projection of General Funds required to continue the program at the current capped enrollments was $149,797 in FY 2010 and $588,718 in FY 2011. To fund the Division's projections of caseload for pregnant women throughout the 2009-2011 biennium (an average of 189 women in FY 2010 and 227 women in FY 2011) would require additional General Funds of $78,690 over the 2009-2011 biennium. The Subcommittee should note that the General Funds required for FY 2010 were offset by the $399,717 recommended by the Governor's decision unit E666 to cover the medical costs of pregnant women enrolled at the time of program termination through two months postpartum.

Mr. Combs said the Subcommittee should note that the proceeds received from property tax levies that were currently transferred from the Indigent Supplemental Account (ISA) to support a portion of the HIFA waiver program costs were recommended to be transferred through the Intergovernmental Transfer (IGT) Program account to offset General Funds in the Medicaid program. The Subcommittee decided to uncap the program and eliminated the transfer of the property tax receipts to the IGT account, thus there would not be any additional General Fund effect, allowing the current statute to remain in place. The Fiscal Analysis Division staff recommended continuing the practice of funding one-half of the state share of the program through the transfer of the ISA if the Subcommittee decided to restore the HIFA waiver.

Mr. Combs said the question before the Subcommittee was whether it wished to approve the funding necessary to continue the HIFA waiver program throughout the 2009-2011 biennium. If the program was continued, the Subcommittee could either approve funding for the current capped enrollment for pregnant women ($738,515 in General Funds over the biennium) or approve sufficient funding to serve the Division's projected enrollment ($817,205 in General Funds over the biennium).

Mr. Combs said if the Subcommittee elected to continue the HIFA waiver program, adjustments would be needed in this account and three or four other Department accounts, depending on the Subcommittee's actions with respect to the Governor's recommended transfer of funds from the ISA (BA 3244). The Fiscal Analysis Division staff requested authority to make the necessary technical adjustments in those accounts based on the Subcommittee's actions with respect to the HIFA waiver program.

> ASSEMBLYWOMAN BUCKLEY MOVED TO CLOSE BA 101-3247 AND APPROVE THE CONTINUATION OF THE HIFA WAIVER FOR THE PROJECTED ENROLLMENT IN DECISION UNIT E665.
>
> ASSEMBLYWOMAN SMITH SECONDED THE MOTION.
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> THE MOTION CARRIED UNANIMOUSLY.
>
> BUDGET CLOSED.

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Mr. Combs clarified that decision unit E666 recommended General Funds of $399,717 in FY 2010 to cover the medical costs of pregnant women enrolled in the HIFA waiver program at the time of the program termination. The appropriation would allow women enrolled in the program on June 30, 2009, to continue their enrollment from delivery through two months postpartum. Based on the Subcommittee's decision to reestablish the program, those General Funds would be used to offset the costs of the program in the 2009-2011 biennium.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH CARE FINANCING AND POLICY
HCF&P-HIFA HOLDING ACCOUNT (101-3155)
BUDGET PAGE DHCFP-1

Rick Combs, Senior Program Analyst, Fiscal Analysis Division, explained the Budget Account (BA) 3155 contained no major closing issues and requested authority to make all the necessary technical adjustments to the HIFA Holding account based on the closing actions approved by the Subcommittee in the HIFA Medical account and the Indigent Supplemental Account. The HIFA Holding account received the state portion of funds for administering the HIFA waiver program through a transfer from the Indigent Supplemental Account (BA 3244) for one-half of the required funds and the General Fund for the other half of the required funds. Those funds were then transferred to the HIFA Medical account and matched with Title XXI funds.

> ASSEMBLYWOMAN BUCKLEY MOVED TO CLOSE BA 101-3155 AND AUTHORIZE THE FISCAL ANALYSIS DIVISION STAFF TO MAKE ALL NECESSARY TECHNICAL ADJUSTMENTS TO THE

HIFA HOLDING ACCOUNT BASED ON THE CLOSING ACTIONS APPROVED BY THE SUBCOMMITTEE IN THE HIFA MEDICAL ACCOUNT AND THE INDIGENT SUPPLEMENTAL ACCOUNT.

SENATOR COFFIN SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

BUDGET CLOSED.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH CARE FINANCING AND POLICY
HCF&P-INTERGOVERNMENTAL TRANSFER PROGRAM (101-3157)
BUDGET PAGE DHCFP-3

Rick Combs, Senior Program Analyst, Fiscal Analysis Division, explained the Budget Account (BA) 3157 for the Intergovernmental Transfer Program (IGT). The Executive Budget proposed to continue the Disproportionate Share Hospitals (DSH) program as designed and approved in Assembly Bill No. 297 of the 72nd Session in 2003. The Governor's budget envisioned that participating hospitals would receive payments of approximately $88 million for FY 2010 and $87.1 million for FY 2011, and the counties would benefit indirectly from those payments by approximately $26.2 million for FY 2010 and $25.9 million for FY 2011, when comparing the hospital DSH payments to the amount of the IGT payments. The Executive Budget estimated that the IGT payments for the DSH program would generate a benefit to the state of approximately $17.6 million for FY 2011.

Mr. Combs said after the submission of the Governor's recommended budget, the Centers for Medicare and Medicaid (CMS) published the preliminary FY 2009 ceilings for DSH payments to the states. In addition, the American Recovery and Reinvestment Act of 2009 (ARRA) included a further increase in DSH ceilings for all states totaling 2.5 percent in federal FY 2009 and federal FY 2010. The increased FMAP rates provided in ARRA did not apply to the DSH program. The increase in the DSH ceilings resulted in the need for adjustments in this account and in the Medicaid account (BA 3243). The adjustments would increase the DSH payments to qualifying hospitals by approximately $6.6 million in FY 2010 to $94.6 million and by approximately $8.1 million in FY 2011 to $95.2 million. The counties would receive an indirect benefit totaling $28.3 million in FY 2010 and $28.4 million in FY 2011. The benefit to the state would increase from $17.8 million to $19 million in FY 2010 and from $17.6 million to $19.2 million in FY 2011.

Mr. Combs said The Executive Budget also recommended continuing the Upper Payment Limit (UPL) program without change for the 2009-2011 biennium. Participating hospitals were projected to receive payments of approximately $30.1 million in FY 2010 and $31.4 million in FY 2011 in The Executive Budget. The net benefit to counties (hospital payments less IGT payments) was projected to be approximately $12.1 million for FY 2010 and $12.6 million for FY 2011. The estimated net benefit for the state was projected to be approximately $3 million for FY 2010 and $3.1 million for FY 2011.

Mr. Combs said ARRA included a provision that prohibited states from receiving the increased FMAP rates if the state required political subdivisions to pay a greater percentage of the non-federal share of payments than the respective percentage required under the Medicaid State Plan as of September 30, 2008. Since UPL payments were made to county-owned hospitals, the ARRA provision would increase the net benefit to counties by approximately $16.4 million in FY 2010 and $14.8 million in FY 2011 and decrease the net benefit to the state by $2.9 million in FY 2010 and $3 million in FY 2011.

Mr. Combs said The Executive Budget provided approximately $1.7 million in each fiscal year of the 2007-2009 biennium to pay the supplemental payments to University of Nevada School of Medicine (UNSOM) for the higher costs of providing medical services in a teaching environment. Because of the ARRA FMAP increase, the amount was reduced to approximately $1.3 million in FY 2010 and $1.5 million in FY 2011 based on the reduced state share for the program.

Mr. Combs said the budget expended all funding available for the 2009-2011 biennium, and no unobligated reserve would remain for cash-flow purposes or unforeseen expenditure needs in the Medicaid or Check-Up budgets.

Mr. Combs said decision unit E900 provided for the transfer from the Indigent Supplemental Account (BA 3244), which would be eliminated as a result of the Subcommittee's decision on that account.

Mr. Combs said budget amendment A00136 made the adjustments for the DSH, UPL, and UNSOM programs. The budget amendment also corrected a mistake that was made in the transfer from the Indigent Supplemental Account and was no longer necessary because of the decisions of the Subcommittee.

Mr. Combs said the Fiscal Analysis Division staff recommended closing the budget with the adjustments recommended in budget amendment A00136 for the DSH, UPL, and UNSOM programs.

Mr. Combs said a bill draft request was discussed during the hearings regarding the current methodology for distributing the DSH payments for qualifying hospitals. The Administrator indicated that the Nevada DSH provisions needed to be revised to comply with the new federal DSH regulations, which required an amendment to Nevada's State Plan. In the process of reviewing that State Plan amendment, the Division believed the CMS would determine that some of the current methodologies for distributing DSH payments to hospitals would result in the need to amend the methodology no later than June 30, 2010.

Mr. Combs said the Division's requested amendments to the current methodologies were included in Senate Bill 382, which was referred to the Senate Committee on Finance. On April 27, 2009, Senator Horsford and Senator Washington presented a proposed amendment to the bill that would repeal the current DSH distribution methodology effective June 30, 2010. Until then the Division would be required to work with stakeholders (counties and hospitals) to develop state regulations to revise the DSH distribution methodology in a manner that complied with federal regulations. Those regulations would be subject to review by the Interim Finance Committee and the Legislative Committee on Health Care and would be approved by the Legislative Commission. After the regulations were approved by the Legislative Commission, the State Plan amendment would be submitted to CMS for its approval. The proposed amendment did not reduce the net benefit

received by the state during the 2009-2011 biennium, but it would include a provision that required the Division to consider incrementally increasing state revenue for the Medicaid program in the future to enable the net benefit to be reduced.

> ASSEMBLYWOMAN BUCKLEY MOVED TO CLOSE BA 101-3157 WITH THE ADJUSTMENTS RECOMMENDED BY THE FISCAL ANALYSIS DIVISION STAFF IN BUDGET AMENDMENT A00136 FOR THE DSH, UPL, AND UNSOM PROGRAMS AND AUTHORIZE THE FISCAL ANALYSIS DIVISION STAFF TO MAKE ANY NECESSARY TECHNICAL ADJUSTMENTS.
>
> ASSEMBLYMAN OCEGUERA SECONDED THE MOTION.

Senator Raggio wondered how S.B. 382 would change the DSH program's administration or funding. Mr. Combs responded the bill would not change the current program's administration or funding, but it would change the DSH program in the future. His understanding was the state's net benefit from the program would not change, but the bill included a provision that would direct the Division to reduce the state's net benefit incrementally over future biennia. Mr. Combs said there would be a change to the future DSH payments, which would be increased based on the increased ceilings and the 2.5 percent increase in the budget. The UPL payments to the counties were being increased and the state share of the UNSOM payments was being decreased because of the FMAP increases in ARRA.

> THE MOTION CARRIED. (Assemblyman Arberry was not present for the vote.)
>
> BUDGET CLOSED.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH CARE FINANCING AND POLICY
HCF&P-INCREASED QUALITY OF NURSING CARE (101-3160)
BUDGET PAGE DHCFP-16

Rick Combs, Senior Program Analyst, Fiscal Analysis Division, explained the Budget Account (BA) 3160 and said The Executive Budget did not recommend any changes to the financing methodology for the nursing facility provider tax program in the upcoming biennium. The reduction in the provider tax rate implemented during FY 2008 reduced the pool of revenue available to match federal Title XIX funds, which, in turn, reduced the amount of funding used to increase reimbursement rates paid to long-term care facilities. Even with the rate reduction, long-term care facilities continued to receive a reimbursement rate that was significantly higher compared to the rates received prior to implementation of the provider tax program. The Division estimated long-term care facilities would receive an average per-bed-day reimbursement rate of $169.25 for FY 2010 and $169.35 for FY 2011, as compared to the $121.73 received prior to the provider tax program. The net increase (net of the tax) realized by nursing homes was $23.76 in FY 2010 and $24.19 in FY 2011.

Mr. Combs said in response to questions regarding whether the increased FMAP rate resulting from the American Recovery and Reinvestment Act of 2009 (ARRA) would have any effect on the provider tax program, the Division

indicated that NRS 422.3785 did not obligate the state to adjust skilled-nursing facility reimbursement to fully account for adjustments to federal financial participation rates. The Division indicated that although the funds from this account had to be used only to increase rates paid to nursing facilities and to administer the provider tax program, there was no requirement that any particular portion of federal financial participation must be used to compensate skilled-nursing facilities. As a result, the Division indicated that ARRA did not affect the provider tax program. The Fiscal Analysis Division staff recommended closing this account as recommended by the Governor.

Senator Raggio said his understanding was the collection of the provider tax resulted in the match, which then benefited the long-term care facilities. Mr. Combs confirmed that Senator Raggio was correct. The net benefit to the long-term facilities was $23.76 per bed-day in FY 2010 and $24.19 per bed-day in FY 2011.

Senator Raggio appreciated that clarification. He said some facilities thought the Legislature was causing the long-term care facilities to lose money, when in fact, just the opposite was true. The program allowed funds to be matched with federal dollars which provided a net benefit to the long-term care facilities.

> ASSEMBLYWOMAN BUCKLEY MOVED TO CLOSE BA 101-3160 AS RECOMMENDED BY THE GOVERNOR.
>
> ASSEMBLYMAN OCEGUERA SECONDED THE MOTION.
>
> THE MOTION CARRIED. (Assemblyman Arberry was not present for the vote.)
>
> BUDGET CLOSED.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH CARE FINANCING AND POLICY
HCF&P-NEVADA MEDICAID, TITLE XIX (101-3243)
BUDGET PAGE DHCFP-26

Chair Leslie said she wanted to discuss one issue on Budget Account (BA) 3243 dealing with the preferred drug list (PDL) in decision unit E656 again. The Subcommittee's motion on the PDL failed on the Senate side because the Senators wanted to hear S.B. 419 this afternoon. Her concern was the Subcommittee needed to close this budget today to give the Fiscal Analysis Division staff time to enter all the information into the computer budget program. She was familiar with this issue because she was the sponsor of the original bill Assembly Bill No. 384 of the 72nd Session in 2003, which she now argued against. She knew the feelings of many Senators. This was the third time the Department had tried to change the statute. It was her opinion that S.B. 419 would not be approved by the Senate. Her recommendation to the Assembly members of the Subcommittee was to make another motion and agree to add this money ($954,668 in FY 2010 and $1,242,733 in FY 2011) back to the budget.

Assemblywoman Buckley said if economic times were better she probably would not approve any of the reductions to the Medicaid budget, but the Legislature was trying to produce a "bare-bones" budget and only approve

essential items. Like many of the other items heard, there were many essential services, and if this matter was one that the Senate felt strongly about, she was willing to rescind her previous motion.

> ASSEMBLYWOMAN BUCKLEY MOVED TO RESCIND THE PRIOR MOTION ON DECISION UNIT E656 AND CLOSE BA 101-3243 WITHOUT THE GOVERNOR'S RECOMMENDATION ON DECISION UNIT E656.
>
> ASSEMBLYMAN OCEGUERA SECONDED THE MOTION.
>
> THE MOTION CARRIED WITH ONLY THE ASSEMBLY MEMBERS VOTING ON THIS MOTION.
>
> ASSEMBLYWOMAN BUCKLEY MOVED TO CLOSE BA 101-3243 WITHOUT THE GOVERNOR'S RECOMMENDATION ON DECISION UNIT E656.
>
> ASSEMBLYMAN OCEGUERA SECONDED THE MOTION.
>
> THE MOTION CARRIED UNANIMOUSLY.
>
> BUDGET CLOSED.

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Jeff Fontaine, Director, Nevada Association of Counties (NACO) said he wanted to ask for help for the counties that were now dealing with medical costs for indigents. The Subcommittee's actions to use the funds in the Indigent Supplemental Account (ISA), combined with the withdrawal of the ISA account of approximately $75 million at the prior Special Session in 2008, hurt the counties. Those ISA funds were originally to be used for Medicaid, and the increase in Medicaid from the ARRA funds would now be shifted to supplant General Fund dollars. The Legislature was not leveraging any additional money.

Mr. Fontaine appreciated the legislative discussion regarding how the use of the funds for state purposes would affect the counties. He also appreciated the Subcommittee's decision to support the Department's add-back list. His concern was NACO had not been part of the discussions about what was included on the add-back list. Now the counties would face a $75 million shortfall in the ISA, and the effect on the counties would be greater than a dollar-for-dollar effect. He projected that the University Medical Center (UMC) would experience a $40 million direct loss in funds from the depletion of the ISA over the next three years. He also projected another $150 million in additional liabilities for all counties because the ISA paid the costs for unbudgeted indigent medical expenses and settled those claims on a pro-rata share, ranging from 18 cents to 22 cents on the dollar.

Mr. Fontaine said counties would incur an additional $50 million in liabilities for indigent medical costs for Clark County and another $100 million in liabilities for indigent medical costs for other counties over a three-year period. He did not know how UMC would manage another $40 million loss in revenues. He did not know how rural counties would manage when an automobile accident occurred on one of their highways that sent uninsured persons to a hospital. A bill for $500,000 for Esmeralda County or Lincoln County would devastate the county because it would be 25 percent of the county's General Fund budget.

Mr. Fontaine said the counties needed the Subcommittee's help. The Legislature had eliminated a successful public-private partnership which had been in effect for over 25 years. The ISA had helped counties and hospitals address the enormous costs of treating the medically indigent in this state. Now the counties faced financial chaos. He was unsure what counties were going to do and needed the Legislature's help. He was willing to work with anyone to develop solutions to this financial problem.

Senator Raggio wondered whether the problem was because the liability was capped as a result of the limit on what ISA funding was available. Mr. Fontaine confirmed Senator Raggio was correct. Senator Raggio said because the state used the ISA funds, there was no effective cap on the amount of county liability that could ensue from indigent accident medical claims. Mr. Fontaine said the counties were responsible for the accident costs of the medically indigent, and he had verified that with Mr. Willden.

Senator Raggio said under existing ISA law there was an effective cap on the amount of county liability. Mr. Fontaine said when the ISA fund paid a claim, the county was held harmless so the ISA served as a stop-loss for counties. Senator Raggio asked whether it would help to place a cap on the amount of liability for counties based upon previous levels in the ISA even though the ISA fund was depleted. Mr. Fontaine confirmed a cap would help some counties but would not help rural hospitals. There were some counties that did not have the ability to generate money for the ISA because the counties' tax rate was at its maximum limit.

Senator Raggio said a large part of the future liability would be created because there was no effective cap. Senator Raggio thought that was something that should be addressed for all the counties.

Assemblywoman Buckley said the legislators did not like being in the position they were in. The Legislature was required to produce a balanced budget, and there would have to be some cuts made. She thought the Subcommittee realized that there would have to be some revenue raised, because it could not cut much from the shortfall in the state budget.

Assemblywoman Buckley said the Legislature did not approve the Governor's recommendation for an additional 5 percent cut to hospitals, did not approve the Governor's proposal to cut children off health insurance (because more children without health insurance would go to the hospitals for their care), and did not approve the Governor's recommendation to cut pregnant women off their care (because they would go to the hospitals and incur uncompensated care costs with higher risks because of a lack of prenatal care). She said she would like to reverse every one of the Governor's recommendations, but the Legislature did not have enough revenue to do so.

Assemblywoman Buckley said she agreed with Senator Raggio and would consider a proposal to create a stop-loss to assist the counties. She wanted to see draft language soon. She would be interested in any other suggestions to assist the counties because she wanted to help. The Legislature understood the plight of the counties and knew the situation was difficult. She was willing to receive draft language and listen to the counties concerns.

Senator Coffin said he was part of the team that created the ISA about 25 years ago. He never dreamed that the ISA would be stolen by the state for General Fund needs, and this was not how it was created or intended to be

used or why it was collected for the last 25 years. The ISA was originally created to help the small counties but had been expanded. He heard testimony in the Senate Taxation Committee that there was a county problem, and the Legislature wanted to protect the counties. The Legislature created the ISA to avoid bankruptcy of small hospitals and counties. Now the ISA had expanded to all counties.

Senator Coffin said he learned he could not bind a future legislature from actions it might see fit to take in time of financial exigency. The state use of the ISA had a "ring of moral uncertainty and discredit." He questioned why the state went to the counties for funds, and the answer he received was the counties had the money under the Willy Sutton rule. (A legend had resulted in the "Willie Sutton rule," used in activity-based costing (ABC) of management accounting. The law stipulated that ABC should be applied "where the money is," meaning where the highest costs are incurred.) That was not how the state should do things.

Senator Coffin said this problem was about taxes. It was about the nerve it took to raise taxes to provide for the general welfare. The Taxation Committees had a duty, but the ISA problem was in the Assembly Committee on Ways and Means. The state was facing a reckless policy by a Governor unwilling to face reality and unwilling to understand that things change. Promises made in the heat of a campaign sometimes had to be broken in the heat of reality. That was why Senator Coffin said he voted against the ISA swap. Having been involved in the ISA creation and modifications, he could not support it.

Bill Welch, Nevada Hospital Association, acknowledged the challenge the Subcommittee faced and the efforts it was making. He appreciated the comments he heard in consideration of the problems that the hospitals faced and the challenges to ensuring access to quality health care in this state. He appreciated the motion to not approve the second 5 percent hospital rate reduction. As he listened to the discussions about the ISA, he would not repeat his concerns because Mr. Fontaine had done an eloquent job in expressing those concerns.

Mr. Welch said the state continued to push down the responsibility and would keep driving it down until it was no longer a responsibility of the state. The responsibility had been pushed down to the county, and now the responsibility was pushed down to the hospitals. He hoped that the hospitals were part of any solution, and the solution was balanced and equitable for all parties. Otherwise this full burden would fall on the backs of the hospitals that were already hurting and ultimately on those few patients who paid the cost of health care services. That would be a catastrophic situation. He thanked the Subcommittee for the efforts it was making and its continued consideration. He said he was happy to be part of any discussions to develop an equitable solution to the funding issue.

Chair Leslie encouraged Mr. Welch to work with Mr. Fontaine to develop any realistic ideas as quickly as possible.

Connie McMullen, Chairman, Strategic Plan Accountability Committee, thanked the Subcommittee for all the fine work it had done to restore the PCS cuts, the compromise, the waivers, and all the efforts made to keep aged or disabled persons living independently and out of nursing homes.

Chair Leslie asked for any other public comments and there were none. There being no further business before the Subcommittee, she adjourned the meeting.

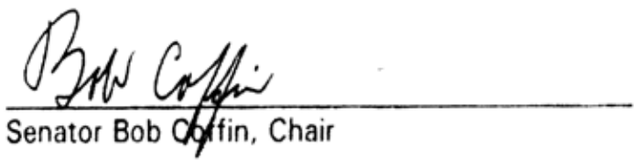
RESPECTFULLY SUBMITTED:

_____
Janice Wright
Committee Secretary

APPROVED BY:

Assemblywoman Sheila Leslie, Chair

DATE:_____



Senator Bob Coffin, Chair

DATE:_____

EXHIBITS

Committee Name: Assembly Committee on Ways and Means/Senate Committee on Finance Joint Subcommittee on Human Services/CIPS

Date: May 11, 2009 **Time of Meeting: 8:09 a.m.**

Bill	Exhibit	Witness / Agency	Description
	A		Agenda
	B		Sign-in Sheet