MINUTES OF THE
JOINT SUBCOMMITTEE ON HUMAN SERVICES/CIPS
OF THE SENATE COMMITTEE ON FINANCE
AND THE ASSEMBLY COMMITTEE ON WAYS AND MEANS

Seventy-sixth Session
February 23, 2011

The Joint Subcommittee on Human Services/CIPS of the Senate Committee on Finance and the Assembly Committee on Ways and Means was called to order by Chair Sheila Leslie at 8:04 a.m. on Wednesday, February 23, 2011, in Room 3137 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to the Grant Sawyer State Office Building, Room 4412, 555 East Washington Avenue, Las Vegas, Nevada. Exhibit A is the Agenda. Exhibit B is the Attendance Roster. All exhibits are available and on file in the Research Library of the Legislative Counsel Bureau.

SENATE SUBCOMMITTEE MEMBERS PRESENT:

Senator Sheila Leslie, Chair
Senator Steven A. Horsford
Senator Barbara K. Cegavske

ASSEMBLY SUBCOMMITTEE MEMBERS PRESENT:

Assemblywoman April Mastroluca, Chair
Assemblywoman Debbie Smith, Vice Chair
Assemblyman David P. Bobzien
Assemblywoman Maggie Carlton
Assemblyman Pete Goicoechea
Assemblyman Cresent Hardy
Assemblyman Joseph M. Hogan

STAFF MEMBERS PRESENT:

Rick Combs, Assembly Fiscal Analyst
Mark Krmpotic, Senate Fiscal Analyst
Heidi Sakelarios, Program Analyst
Marian Williams, Committee Secretary

OTHERS PRESENT:

Charles Duarte, Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services
Lynn Carrigan, Chief Financial Officer, Division of Health Care Financing and Policy, Department of Health and Human Services
Mary Walker, Representative, Carson City, Douglas County, Lyon County and Storey County
Jeff Page, County Manager, Lyon County
Bobby Gordon, Assistant Director, Clark County Social Services, Clark County
Susan Rhoads, Long Term Care Supervisor, Clark County Social Services, Clark County
Kevin Schiller, Social Services Director, Department of Social Services, Washoe County
Jeff Fontaine, Executive Director, Nevada Association of Counties
Lawrence P. Matheis, Executive Director, Nevada State Medical Association
Bill Welch, President and CEO, Nevada Hospital Association
Kathy Silver, CEO, University Medical Center

CHAIR LESLIE:
Today, we will review the budget for the Division of Health Care Financing and Policy.

CHARLES DUARTE (Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services):
Before we get into a discussion of specific decision units for each budget, I would like to address the procurement of our take-over contract for our Medicaid Management Information Systems (MMIS). It is a large contract and we reprocured it with a total contract authority of about $176 million over a five-year period. The federal match for that contract is between 75 and 90 percent. There have been many questions as to how we procured the new contract and whether it reduced spending by the legislatively mandated 10 percent. We provided the Legislative Counsel Bureau Fiscal Division staff with information showing that we have reduced our projected contract spending over the five-year period. Our old contract with our previous vendor would have cost approximately $199 million over the five-year period, substantially more than our new contract which stands at about $176 million. The base bid that

we received from Hewlett Packard Enterprise Systems (HPES) was approximately $122 million. After nearly five months of negotiations with HPES, we tacked on some value-added services to that contract. Those services brought the total contract authority up to the present about $176 million. We negotiated additional engineering hours as a blended lump sum in order to meet the changes required by the Legislature, the Governor and the Affordable Care Act (ACA) over the next five years. Significant systems changes and programming initiatives will need to be undertaken during this time period and our negotiated lump sum engineering hours, which constitute the bulk of the value-added services in the contract, will enable us to accomplish this.

CHAIR LESLIE:
We will discuss this contract in greater detail when we get to the MMIS budget. Let us move on to budget account (B/A) 101-3158, the Administration budget of the Department of Health and Human Services (DHHS). Please discuss the federal mandates related to ACA. How will you manually calculate the rate increases for physicians as seen in decision unit M-501?

HUMAN SERVICES

HEALTH CARE FINANCING AND POLICY

HHS-HCF&P – Administration — Budget Page DHHS DHCFP-6 (Volume II)
Budget Account 101-3158

M-501 Mandates — Page DHHS DHCFP-10

MR. DUARTE:
Decision unit M-501 requests $11,117 in fiscal year (FY) 2012-2013 to help us determine what we need to pay physicians. Under ACA, primary care physicians will be reimbursed at 100 percent of the federal Medicare rate beginning in 2013. This will require us to increase reimbursements from the present level which is roughly 85 percent of the Medicare rate. The 15 percent difference between 85 percent and 100 percent will be covered 100 percent by federal funds. We must calculate how much we are going to spend on those claims and determine the incremental amount that will be reimbursed at 100 percent of

federal match versus the regular Medicaid match of approximately 50 percent. This decision unit will provide the contract support to enable us to do this.

CHAIR LESLIE:
Can these calculations be done through MMIS or do you need a separate contract?

MR. DUARTE:
It will be more cost effective to do these calculations manually as opposed to doing systems changes in MMIS.

CHAIR LESLIE:
Are these rate increases mandated by the federal government?

MR. DUARTE:
Yes. For calendar years 2013 and 2014, the rates will be 100 percent of the Medicare rate for primary care services for certain primary care providers. The enhanced federal match of 100 percent will go away after 2015. At that time we will have to make the decision as to whether we continue those rates.

CHAIR LESLIE:
Let us move on to the compliance with Community Living Assistance Services and Support (CLASS) Act provisions in decision unit M-502. Please explain what this is.

M-502 Mandates — Page DHHS DHCFP-10

MR. DUARTE:
This enhancement unit requests $25,000 to cover the cost of a survey of personal care providers. This survey is mandated by ACA and CLASS Act, which is a long-term care program. The CLASS Act is a voluntary, self-funded insurance program which allows current employees to enroll. The goal of this program is to have affordable premiums which will be paid through payroll deduction for participating employers. This program can be used to develop a long-term care benefit for current employees. By the end of March 2012 we must look at the ability of in-state agencies, primarily personal care agencies, to

serve as employers of personal care attendants who will serve the new population that will be seeking care.

CHAIR LESLIE:
Is CLASS Act voluntary, or are employees enrolled automatically?

MR. DUARTE:
My understanding is that employees are enrolled automatically and then must opt out of the program.

CHAIR LESLIE:
Has the federal government provided more detail on how this is going to work?

MR. DUARTE:
We do not have any more information at this time.

CHAIR LESLIE:
Please provide examples of who will be surveyed.

MR. DUARTE:
We will be surveying personal care agencies which provide supportive services in patients' homes. We are required to determine if these agencies will be capable of providing employment-related services for the individuals that they employ to perform in-home care.

CHAIR LESLIE:
Are they currently providing those services?

MR. DUARTE:
They are doing it currently, but there will be an additional number of individuals who may qualify as a result of CLASS Act. The survey will be investigating the capacity of the State agencies to do this work.

CHAIR LESLIE:
Will the survey show you where we are deficient and not able to meet demand?

MR. DUARTE:
That is my understanding.

CHAIR LESLIE:
Is the survey mandated by ACA?

MR. DUARTE:
Yes, it is.

SENATOR CEGAVSKE:
Was the survey drafted by the federal government or are you required to design your own?

MR. DUARTE:
We will be required to design and conduct the survey, although that may change once we get more guidance from the federal government.

SENATOR CEGAVSKE:
Do you already have a mechanism for evaluating these agencies?

MR. DUARTE:
Yes, we do.

SENATOR CEGAVSKE:
I would like to see the current survey you are using, along with the new survey which you are drafting.

CHAIR LESLIE:
Let us move on to decision unit M-503, which increases staffing related to provider support. In this line item, you are adding a social services program specialist III and a health care coordinator II. How have ACA mandates influenced your decision making process in adding these two new positions?

M-503 Mandates — Page DHHS DHCFP-11

MR. DUARTE:
On page 15 of your budget presentation handout (Exhibit C), you can see we are requesting two additional positions. One position will be in Provider Support and the other will be in Hearings. The Provider Support position is associated with enhanced requirements regarding provider enrollment, which is the front door for fraud and abuse prevention. The ACA creates new requirements to screen providers for ownership and ensure that providers disclose their ownership relationships with other companies before they enroll that company as a Medicaid provider. Additionally, we will be doing other screening activities, such as criminal background checks and business license checks. Although we are currently doing these screening activities, we would like to perform them in a more timely and complete manner.

The first position is associated with the new ACA requirements regarding provider enrollment. In December 2010, we completed 737 enrollment requests. We had 332 enrollments approved and we terminated 118 additional providers. As you can see by these numbers, we have an increasingly active provider enrollment unit and we anticipate these rates continuing.

The second position is related to our Hearings and Appeals Office. As required by both state and federal law, we allow providers and recipients to appeal negative decisions against them. Our goal is to resolve these hearing requests before they go to an administrative appeals judge. Last year, only 7 percent of our requests for appeal went before a judge. This position is being requested in anticipation of the growing number of appeals we will receive as a result of our fraud, waste and abuse prevention efforts. With additional audits and audit requirements, as well as oversight of providers, we are anticipating that we will have an increased number of appeal requests. This position will assist us in those efforts.

In 2010, we had 783 requests for appeals, 512 recipient appeals and 271 provider appeals, with only 7 percent of those going on to hearings before a judge. Our goal is to resolve these requests before they go before a judge.

CHAIR LESLIE:
Why is the Division anticipating increases in the demand for fair hearings, and how does the demand translate into additional workload?

MR. DUARTE:
Staff originally requested two positions in our Hearings and Appeals Office. We do not know exactly what the workload will be, but we will need this position just to handle our current workload, not to mention any increases.

CHAIR LESLIE:
If the U.S. Supreme Court determines that the health care reform law is unconstitutional, what impact would that ruling have on the need for these positions?

MR. DUARTE:
In this decision unit, the requirements of ACA for fraud, waste and abuse prevention are still appropriate for us to manage, maintain and utilize. We will continue our efforts and we hope that this will be approved irrespective of any decision by the U.S. Supreme Court regarding ACA. It is prudent for us to have these positions in place in order to continue our efforts around fraud, waste and abuse.

ASSEMBLYWOMAN CARLTON:
Please identify the groups who will be the subject of background checks.

MR. DUARTE:
We will be doing background checks on primary providers who are coming into the system. Whoever applies to be a direct care provider, whether they be physicians, personal care aids or nurse anesthetists, will be subject to these background checks. Business owners of companies will be reviewed as well.

ASSEMBLYWOMAN CARLTON:
Because these checks are both expensive and time consuming, will you accept background checks done for professional licensure status as well?

MR. DUARTE:
I will need to refer to the federal requirements and law to provide a definitive answer. Assuming we can be lenient with respect to the frequency of reviews, we will certainly take that suggestion into consideration.

SENATOR CEGAVSKE:
For all the new federal mandates we are dealing with today, could you explain the changes that are being required?

MR. DUARTE:
Certainly.

CHAIR LESLIE:
We will now discuss enhancement unit M-505 which also deals with increased staffing related to ACA mandates. This decision unit includes two full time positions: one social services chief I and one social services program specialist II, who will oversee the expansion of eligibility categories for Medicaid and benefit requirements for these new categories.

M-505 Mandates — Page DHHS DHCFP-11

MR. DUARTE:
On page 16 of Exhibit C, you will see a general explanation of why these two positions are being requested. This request is associated with requirements of ACA and is mandated for the creation of new benefit plans for individuals not currently eligible for Medicaid, but will become eligible under the new Medicaid expansion. The expansion is designed to cover individuals between our current eligibility standards and 138 percent of the federal poverty level. This expansion will require us to develop new benefit plans, which must be similar to the federal Public Employee Benefit Board Program, the State Public Employee Benefits Program or the largest health maintenance organization (HMO). These benchmarks are very different from the services provided under current Medicaid law.

We will also need to align these plans with the potential plans that will be offered as qualified health programs through the health insurance exchange (HIE), which goes online in calendar year 2014. Going forward, we will be creating benefit packages akin to commercial insurance, meeting certain benchmark standards and align with HIE. The newly eligible individuals will probably move back and forth between qualified exchange plans and this particular benefit offered through Medicaid. It will benefit both the Division and

the recipients to ensure that there is continuity of benefits between the two programs.

CHAIR LESLIE:
Will this be a stand-alone unit? Do you have an organizational chart that can show us how these pieces fit together? Also, why do we need a social services chief I here?

MR. DUARTE:
On page 2 of Exhibit C, an organizational chart shows where these new positions will fit into our larger organizational structure. My position is the administrator in the center box. Beneath my position is the administrative services officer (ASO) IV, Lynn Carrigan, and the deputy administrator, Betsy Aiello. Enhancement unit M-501 will fall under Ms. Carrigan's position in the Rates/Cost Containment box as an ASO III. Enhancement unit M-502 will fall under myself in the Compliance box as an SSC III. Compliance includes our Surveillance and Utilization Review System (SURS), which is our investigative arm for providers, as well as hearings, appeals and several other programs. Finally, enhancement unit M-505 will fall under Ms. Aiello's position in the box labeled Program Services as an SSC III. Most of our medical policy development is done under Program Services.

M-505 Mandates — Page DHHS DHCFP-11

CHAIR LESLIE:
Could you provide a new organizational chart that shows only where the new positions will be located?

MR. DUARTE:
Yes, we will get that to you.

CHAIR LESLIE:
Why do we need a social services chief I if the unit does not stand alone?

MR. DUARTE:
The social services chief I is being requested because of the level of activity and the level of expertise needed to design the new benefit plans. This area,

commercial medical policy, is one that we have not worked in extensively in the past. The new hire will need to have specific expertise in that area, not necessarily Medicaid expertise.

CHAIR LESLIE:
Are we going to be able to attract someone with the expertise we need at the salary we are going to pay?

MR. DUARTE:
We have had some difficulties in hiring this classification of specialists, particularly if they require a clinical license. If we cannot recruit or retain individuals, we may have to look at contract services as another option.

CHAIR LESLIE:
If ACA is deemed to be unconstitutional, what would the impact be on these positions?

MR. DUARTE:
These positions would be eliminated if ACA were ruled unconstitutional. This request is specified in the budget for health care reform-related activities.

CHAIR LESLIE:
When would these positions begin?

MR. DUARTE:
These positions will take effect on October 1, 2011.

CHAIR LESLIE:
Let us continue to decision unit E-680, which requests increased staffing related to ACA mandates for Medicaid and Nevada Check Up programs. Are you requesting seven new positions and a reclassification?

E-680 New Revenue or Expenditure Offsets — Page DHHS DHCFP-16

MR. DUARTE:
On page 14 of Exhibit C, there is a description of E-680. This enhancement unit is also associated with savings in B/A 101-3243.

HHS-HCF&P – Nevada Medicaid Title XIX, — Budget Page DHHS DHCFP-33 (Volume II)
Budget Account 101-3243

MR. DUARTE:
The net savings between this enhancement unit and B/A 101-3243 is about $6.3 million over the biennium. We are requesting three audit positions and four SURS positions. These positions are specific to the activities of fraud, waste and abuse prevention and detection. In 2005, we requested additional staff in our SURS program to step up our investigations into potential fraud and waste. In both 2007 and 2009 we were given additional staff as well. We have augmented our activities using existing positions. The individuals in those existing positions have been responsible for conducting audit and review activities. Individuals in numerous positions within the Agency are assisting in the reviews of providers and program services.

In 2006, we had seven individuals performing these activities. Since that time, we have more broadly defined program integrity and compliance to include things such as provider enrollment and audits. Currently, we have approximately 29 full-time equivalent (FTE) positions who are involved in an array of program integrity activities. A majority of those 29 FTEs are existing personnel. We have added ten FTEs over the last two biennia, mostly in the areas of audit and SURS. We are requesting seven FTEs in order to continue and expand the scope of these programs.

Our audit staff will also be doing more risk-based audit reviews. Currently, they do comprehensive audits of our systems, of eligibility and of the Payment Error Rate Measurement (PERM). The PERM is done every three years with the help of my staff, my audit team and staff from the Division of Welfare and Support Services. In addition, the audit team is doing provider reviews, where they examine all 52 of our provider types. In these audits, they examine 15 to 100 claims in order to determine whether there are issues with our claim system or our policies. Following this review, they make recommendations for corrective action. All of this leads to cost avoidance, which is difficult to calculate, but we know exists.

In SURS, we have increased our activities and recoupment. It is important to realize that recoupment in and of itself is not the best measure of fraud, waste and abuse activity. We have examined many hot topic issues, such as personal care attendants, durable medical equipment and other provider types where we have seen notable abuse across the Nation. These reviews do not necessarily yield a high level of dollar recoupment but they do create a prevention and cost avoidance mentality which reduces potential waste. We have also focused on not moving immediately to recoupment. We try to resolve issues without the need for an administrative judge, as we do not want to take back so much money as to close down a provider.

Many of our activities in SURS are now related to education. If there is a possibility of fraud, we refer those to the Medicaid Fraud Control Unit. We have increased from approximately seven investigations in 2006 to over 700 preliminary investigations in 2009. We did comprehensive evaluations and reviews of 659 providers in 2009, many of which were referred to the Medicaid Fraud Control Unit. We have stepped up our activities, and this decision unit will help us to continue that level of work.

CHAIR LESLIE:
How did you determine that you needed five new positions in SURS?

MR. DUARTE:
We have designated activities for each of the new positions. We are requesting a Management Analyst (MA) II to complete some data analysis, three MA I positions to look at additional data and to utilize a new tool in our MMIS takeover called J-Search. This tool is a federally certified data mining tool that will enable us to delve into data more completely and spend less time doing data analysis. The four positions will be involved in this data mining, which will result in referrals to other investigators for preliminary investigations. We are also requesting an administrative assistant III to help support the unit.

CHAIR LESLIE:
What performance indicators can the Division provide to demonstrate the efforts of its existing staff in reducing fraud and abuse? What impact would the positions have on these efforts?

MR. DUARTE:
We do not have performance indicators to demonstrate reductions in fraud and abuse. The indicators for these new positions will be dependent on the types of reviews they are conducting and what areas we direct the investigations. I would need to check with staff to determine and identify the current performance indicators with respect to caseloads.

CHAIR LESLIE:
Please explain how you intend to measure the performance of these new positions. Also, have the fiscal agent costs been reduced in the Governor's budget during the upcoming biennium to accommodate for the audit activities that will now be performed by the auditor III position?

MR. DUARTE:
The job of the auditor III will be to oversee the fiscal agent. We will be doing much more comprehensive audits of our contractors. This particular position will be involved in audit oversight for the contract with HPES. This position will ensure that the fiscal and contract performance of HPES is in line with the contract itself. The auditor will determine if sanctions need to be levied based on the performance of HPES. We will have other staff who will be doing risk-based audits of our managed care contracts and our other large contracts. Because the HPES contract will be our largest administrative contract, it will need the additional oversight of the auditor III.

CHAIR LESLIE:
So this auditor is focused on the fiscal agent?

MR. DUARTE:
Yes, this auditor is focused on oversight of the fiscal agent.

CHAIR LESLIE:
That was not clear. Please provide additional information regarding the tasks this auditor will be performing compared to the others.

MR. DUARTE:
I will provide that information for the Committee's review.

CHAIR LESLIE:
What are the ACA time frames for the implementation of the various fraud prevention activities?

MR. DUARTE:
The activities associated with SURS in decision unit E-680 involve oversight of Recovery Audit Contractors (RACs). While the RACs have been involved in the Medicare program for some time, they are now being expanded to Medicaid which will be required to contract with these vendors. The RACs are incentive-based auditors and independent contractors who will be evaluating claims from institutional providers, as well as any other provider we include in their scope of service. The ACA originally required that these audits begin January 1, 2011, however, the federal government issued guidance requesting that states delay proposal requests until the federal government issues further guidance. We are anticipating new guidelines in May. The other activities, which involve reducing improper payments to vendors and health care providers, will begin as soon as we have the staff to do so. We believe that this work is prudent for us to do, regardless whether of the ACA mandate is constitutional.

CHAIR LESLIE:
Will we be able to compete with the private sector in hiring individuals for these positions?

MR. DUARTE:
I do not believe we will have any trouble recruiting employees for these positions. We are requesting some contract dollars as a part of this decision unit in order to expand some of the risk-based audit reviews, particularly of our managed care organizations, and to assist our staff with those reviews.

CHAIR LESLIE:
What is the correlation between the projected General Fund savings and the approval of these seven new positions?

MR. DUARTE:
The correlation is primarily associated with the work of our RACs.

LYNN CARRIGAN (Chief Financial Officer, Division of Health Care Financing and Policy, Department of Health and Human Services):
The RACs projection was based upon Medicare's experience with recovery audits. We used a 12 percent commission rate along with the PERM error rate to determine the percentage of recoveries we could expect, and then netted that out. In terms of SURS recovery, we projected those by staff member. We assumed that each staff member would yield a certain amount of recoveries, based on 2009 numbers.

CHAIR LESLIE:
Have you provided that methodology to Staff?

MS. CARRIGAN:
Yes, but we will make sure that they have it.

CHAIR LESLIE:
Let us move on to decision unit E-410, which deals with increased staffing related to Health Information Technology (HIT) mandates. Are you requesting two auditor positions here?

E-410 Access to Health Care and Health Insurance — Page DHHS DHCFP-13

MR. DUARTE:
Yes, we are requesting two auditors for our Audit Unit. They will directly report to me. On Page 17 of Exhibit C, you will see that this is not a requirement of ACA, but it is required under the American Recovery and Reinvestment Act (ARRA) of 2009 and the Health Information Technology for Economic and Clinical Health Act. As a part of ARRA, the State was given the opportunity to provide Medicaid providers, both eligible professionals and hospitals who meet certain criteria, with incentive payments associated with the "meaningful use" of electronic health records. The definition of "meaningful use" becomes more specific with each year through 2016. In the next biennium, we should be able to pass approximately $38 million in federal funds each year to eligible health care providers.

The positions requested in decision unit E-410 will ensure that the federal money is being appropriately spent. The ARRA outlines that the program will run

through 2021. Eligible providers can begin the program as late as 2016 and can receive payments for up to six years, through 2021. We intend to get the program up and running by late summer 2011, starting with one position and adding another later on. The auditors will be required to ensure that the providers are being reimbursed for the purchase and operational use of electronic health records. These systems must be certified and the providers must use them in a way that is in accordance with ARRA regulation. Providers will be required to eventually use these systems to translate health information to other providers. This data transfer will include both claims and clinical data.

CHAIR LESLIE:
It appears that incentive payments are available through Medicare and Medicaid. If providers serve both populations, can they receive incentive payments for both?

MR. DUARTE:
Eligible professionals, defined as certain types of physicians, pediatricians, certified nurse midwives, nurse practitioners, and physicians assistants, will have to choose whether they will receive the Medicare or Medicaid incentive. Hospitals can elect to receive both incentives and the base payment to hospitals from Medicaid is approximately $2 million. Many facilities are counting on these funds to augment the development costs of electronic health records and health information exchanges.

CHAIR LESLIE:
Is one incentive more advantageous than the other for eligible professionals?

MR. DUARTE:
A federal grant was awarded to HealthInsight to establish regional exchange centers. HealthInsight is providing guidance and technical support to professionals in Utah and Nevada. They will assist medical professionals in the transition and use of electronic medical records. My staff has also been speaking with providers regarding this transition.

The main criteria for choosing the Medicare or Medicaid incentive is based on a provider's patient panel. For example, if you are a pediatrician and you have a high volume of Medicaid patients, it will behoove you to chose the Medicaid

option. Providers will choose one or the other depending on their patient panel and specialty.

CHAIR LESLIE:
Who decides the level of the incentive payment? Will our staff determine the payment amount?

MR. DUARTE:
The general requirements are provided in federal regulation. However, we are required to audit providers in order to determine if they meet federal requirements. Essentially, we will be reimbursing them for the purchase of a certified electronic health record system, up to the value of $21,500. Providers are also eligible for up to $8,500 a year in operational support if they use their systems appropriately. There will be caps on what we will pay the providers.

CHAIR LESLIE:
Will these two positions certify a provider's eligibility for the pass-through funding? Will a provider receive the incentive payment before or after they purchase the system?

MR. DUARTE:
Providers will apply to the federal government for these funds. The federal government will input the provider data into a master database at the Centers for Medicare and Medicaid Services. We will receive a download from that database of the providers in Nevada. Our auditors will ensure that providers who have applied for the reimbursement for the purchase of these systems actually have the systems in place and are using them appropriately. Our role is to verify this usage in order for the provider to receive federal payment. We will also be required to periodically check in with providers to ensure that they are meeting the meaningful use requirements established in federal regulations. These auditors will be doing claims-based administrative audits, but they will be going out into the field as well.

CHAIR LESLIE:
Will two positions be enough to meet such a workload?

MR. DUARTE:
Two positions will be enough. Also, this is an activity that will ramp up over time.

CHAIR LESLIE:
In this decision unit, you are requesting the addition of 13 new FTE positions which are linked to the implementation of health care reform mandates. Will the need for these positions continue indefinitely or will it be eliminated once the State has implemented the requirements of ACA?

MR. DUARTE:
With respect for the positions requested in decision unit M-503 of B/A 101-3158, I do not see the need going away after the implementation. Those activities will continue based on the expected volume of provider enrollment and hearings. Assuming that ACA is not overturned, the positions in decision unit M-505 will remain after implementation because benchmark coverage will continue to be a part of the Medicaid program for the foreseeable future. The positions associated with decision unit E-680 are simply prudent to have because of their role in reducing fraud, waste and abuse. Finally, the positions in decision unit E-410 of B/A 101-3158 will be needed through 2021. However, with these positions, there will be a decline in workload at some point which we may be able to handle electronically.

CHAIR LESLIE:
Can you work with our Staff to prioritize these positions based on need?

MR. DUARTE:
Yes.

CHAIR LESLIE:
Let us move on to decision unit E-570 of B/A 101-3158, the technology investment request.

E-570 Technology Invest, Access to Health Care — Page DHHS DHCFP-13

MR. DUARTE:
This is a technology improvement request associated with a federal mandate under the Health Insurance Portability and Accountability Act of 1997 (HIPAA). We are being required to begin using a new type of disease classification for noting diagnoses on a claim form. The current system is called the International Statistical Classification of Diseases and Related Health Problems Version 9 (ICD-9) and it is currently in broad use across the Nation on claim forms. When a provider sees a patient, they pick a diagnosis and puts it on a claim form using the ICD-9 code book. The new mandate under HIPAA will require us to use the new ICD-10 code book, which will further breakdown the classification of diagnosis and diseases into a much more detailed level. There are two benefits to this new system. For providers, it allows them to bill more specifically and enhance their reimbursement. For payers, it will allow them to review claims more completely, in order to determine that they are paying for an appropriate service for an appropriate diagnosis. For example, under ICD-9 if you fractured your leg, the doctor would only be able to describe which bone was fractured. Under ICD-10, the doctor would be able to describe which bone was fractured, along with the type of fracture involved. The complexity of the procedures will be more available to payers with the new code system. Our systems need to be updated in order to accommodate this new classification scheme. We are requesting approximately $1 million over the next biennium to complete this federal mandate. We are required to complete the planning and development of the new system by 2013. We need the funds now in order to meet the federal guidelines for implementation of the system change.

CHAIR LESLIE:
The Technology Investment Request (TIR) identifies the total cost as approximately $11 million, but the Governor's recommended budget recommends funding only about $10.3 million of these costs during the 2011-2013 biennium. Please explain the difference between the costs estimated in TIR and the Governor's recommended budget.

MR. DUARTE:
I do not know what the difference is between the Governor's request and the $11 million cost. All expenditures will be in the next biennium, so I do not know why there is a difference.

CHAIR LESLIE:
Does TIR budget include future maintenance costs?

MR. DUARTE:
Future maintenance costs were not calculated in this budget. I do not believe there will be significant maintenance costs beyond what we are already paying. Once the system is loaded, it will simply be a matter of routine maintenance rather than special maintenance activities.

CHAIR LESLIE:
Does our MMIS stand alone? Is there any opportunity to collaborate on similar projects with other states who are using the same type of system?

MR. DUARTE:
Our current system is only shared by one state, and that state is no longer contracting with our current provider, Magellan Health Services. We are the only remaining Magellan state in the Nation. The take-over contract with HPES will move Nevada into a group of 22 other states using this fiscal agent.

CHAIR LESLIE:
Would you describe our system as antiquated?

MR. DUARTE:
Our system will remain unique for some time. It is outdated. Our strategy with the take-over contract is to allow us to examine opportunities over the next five years to reprocure subsystems. We are looking at a service-oriented architecture system, which is very similar to plug-and-play technology. These subsystems will allow us to install new technology without changing our major claims engine, MMIS. Over the next five years, we will be examining opportunities to reprocure components and avoid the problems we would run into by replacing such a large system in total.

CHAIR LESLIE:
This is a considerable investment in an antiquated system. We must not pursue the incorrect choice.

MR. DUARTE:
There are not a lot of development costs associated with this transfer. We will just be maintaining the current system. There are some value added services from HPES and we will have the opportunity to create greater efficiencies in our system. I do not believe that we will be sinking a lot of development dollars into the system. Our goal will be to look at new technology and new tools as they come online over the next five years.

CHAIR LESLIE:
Please explain the correlation between not implementing this project and losing Medicaid providers. What is the likelihood of losing providers?

MR. DUARTE:
The system change associated with ICD-10 will affect providers across the Nation. If we maintain a unique claims system and unique billing rules, it will create an administrative burden for the physicians' practices and hospitals, which will result in additional costs for them. Those costs will be factored into the providers' decision-making process when they consider participating in Medicaid. We want to ensure we are consistent with the rest of the Nation and that we are not adding a cost burden to these providers.

CHAIR LESLIE:
If we do not implement these changes, will the increased costs associated with our antiquated system cause us to lose providers?

MR. DUARTE:
Correct.

CHAIR LESLIE:
Do you have any evidence of that?

MR. DUARTE:
I am basing my response on theory. I have run clinical practices myself and I have first-hand experience. When we encountered a payer with a unique claims processing system, we decided whether to work with the payer on the basis of how much it would cost our business to file the claims and get paid.

CHAIR LESLIE:
What steps have you taken to help providers accommodate to the new system? Will they need additional training?

MR. DUARTE:
We will be conducting training as this system change becomes operational. Providers are also familiarizing themselves with the upcoming changes in regards to ICD-10. This system will not be unique to Medicaid, and because of this many providers are becoming familiar with these tools. The transition to ICD-10 is also part of the upgrades many offices will undergo as they transition to electronic health records. Many of the systems currently in use are capable of upgrading to ICD-10. As providers continue to adopt electronic health records and HIT, the ICD-10 codes will be built into the new systems.

ASSEMBLYMAN BOBZIEN:
In order to adopt the upgrades that will be required for ICD-10, are you required to rework the core data structure and schema for the whole system? Would you consider these dramatic upgrades to the core of the application?

MR. DUARTE:
Yes, we are making changes to the core programming of MMIS. Once these changes are made, we will be consistent with the requirements of the industry and we will be able to communicate with other health care systems. The changes made to our core programming will also benefit the installation of new subsystems as we procure them. This is a change we would have to make whether we were buying a completely new system or simply maintaining our previous one.

CHAIR LESLIE:
Please explain how an avoidance of penalties can be considered a “return on investment.”

MR. DUARTE:
We have been informed that we risk the possibility of losing enhanced federal funding for the operation of our current MMIS. We receive 90 percent of our funding for development costs from the federal government. We also receive 75 percent of the cost of routine operations from federal resources. The federal

government has been willing to work with every state on this matter. We are not the only state struggling to meet the time frame and requirements for ICD-10. Because of this, I do not believe that sanctions would be imposed as it would be counterintuitive to the large goal of moving forward.

CHAIR LESLIE:
What procedures have been established by the Agency to ensure penalties are not imposed?

MR. DUARTE:
We have a team in place to help us move forward in planning and development activities. We are preparing an Advanced Planning Document to request enhanced federal funding for these activities. From a federal perspective, it is also important that we are presenting this issue to the Joint Subcommittee. We have made it clear to the federal government that this new system is part of the Governor's budget.

CHAIR LESLIE:
Can the Division provide an update on the new contractor and any plans to update or acquire a new MMIS?

MR. DUARTE:
We have procured a take-over vendor for our current contract for our MMIS. Our current system is being run by Magellan Health Services. Many have wondered if we were aggressive in our reprocurement of this contract and whether our new contract will save us dollars over its term. We have provided the LCB Staff with information that demonstrates our cost saving in the new contract. It would have been possible to extend our current contract with Magellan Health Services. Had we done that, using our current caseload projections, the contract would have cost us about $199 million over the next five years. The estimate for our new contract under HPES will cost us approximately $176 million over the next five years which is roughly 11 percent less than the previous contract.

We require each contractor to bid on a number of required services. This is known as the base bid and at approximately $122 million, HPES was well below every other contract vendor examined. Following that bid, we requested and

negotiated specific items, the largest of which was enhanced programming hours. We negotiated those additional hours because we anticipate significant system changes that we will need to make in order to comply with ACA. Our new contract also includes programming hours for ICD-10 and our fraud and abuse detection activities. We negotiated this bundle of hours at a blended, reduced rate as a part of our contract with HPES. The total HPES contract authority is approximately $176 million. The difference between the base bid of about $122 million and the total authority of $176 million is significant, but if we do not use all the programming hours, we will not pay for them. It would be imprudent of us, however, to eliminate those hours at this time simply to reduce the price of the contract. Because we do not know the new requirements we might face over the next five years, it is prudent to have this bundled, negotiated rate for additional contract hours in case we need them. Making ad hoc system changes will require us to revert to a higher, hourly based rate structure. The negotiated programming hours were negotiated at the start of the contract term, when we had the clout which enabled us to get the best value for the hours that we needed.

Under our current system, there is a two-year backlog on some of the system changes that we need. Some of these programming hours will be used to reduce the number of system change request orders currently on hold. Many of these changes will create efficiencies for fiscal and rates and program services staff. We believe we purchased a very valuable contract at a very good rate for the State.

SENATOR HORSFORD:
The Agency did a good job of negotiating the contract terms with HPES. With that said, I believe we need to increase transparency in the contract process. This includes how the terms of the contract are reached and how the specifics included in the terms come about. Your Division has very specific justifications for what you have done and how you have done it, but those reasons are not neither readily available nor transparent. We need to create awareness of your reasoning and the benefits it brings. We need to be as open as possible, so the public can understand our process. I understand this could be difficult during the negotiation itself, but once the negotiation is complete those terms need to be publicized.

I do not believe that you should have agreed to the full rate in the contract simply because you had the authority. The 26th Special Session ordered agencies to reduce contracts by 10 percent in order to reduce costs. This contract came up after those orders from the Legislature and the orders were not followed. You ignored the Legislative direction given by the 26th Special Session. If the contract simply cannot be reduced, then justify why it cannot. We are trying to balance the budget and large contracts like this are a big part of that balancing process. Why is it okay for the State to give out private contracts worth hundreds of millions of dollars over multiple years without seeing a cost savings? I hope that your insight into the coming changes will enable us to see a cost savings in this contract over time. I also hope that we will not have to use the full authority of the contract, because the goal is to reduce cost wherever possible.

CHAIR LESLIE:
Let us move on to decision unit M-101 of B/A 101-3158 which deals with mandatory rate increases for administrative services.

M-101 Agency Specific Inflation — Page DHHS DHCFP-8

MS. CARRIGAN:
We have included inflation in decision unit M-101. This inflation includes cost inflation for the MMIS contract and the physicians' contract, which deals with physicians who do disability determinations.

CHAIR LESLIE:
Are these rate increases mandatory?

MS. CARRIGAN:
Yes, the rate increases are part of our contracts.

CHAIR LESLIE:
What is the recommended amount of the increase?

MS. CARRIGAN:
I do not know. We are only looking at several thousand dollars for our physicians' contract. Most of this enhancement unit will go toward our MMIS

contract. We have accelerators in the contract that break this rate down. The main inflation accelerator is the Consumer Price Index.

CHAIR LESLIE:
Given the State's financial situation and the current economic conditions, is there any opportunity to renegotiate?

MR. DUARTE:
There is always opportunity, but there is no guarantee that the vendor will agree to a new contract term or an amendment to an existing contract term.

CHAIR LESLIE:
Let us move on to B/A 101-3243 which deals with Nevada Medicaid and Title XIX of the Social Security Act. Please address the decrease in the Federal Medical Assistance Percentage (FMAP). When do we find out about the enhanced FMAP rate? Is our estimate for FY 2012-2013 still accurate?

HHS-HCF&P – Nevada Medicaid Title XIX, — Budget Page DHHS DHCFP-33 (Volume II)
Budget Account 101-3243

MR. DUARTE:
We know FMAP for FY 2011-2012 and it is included in the Governor's budget at a 55.05 percent federal match rate. We are making an educated guess in determining the rate for FY 2012-2013, which we have put at 57.66 percent. We will know the specific rate for FY 2012-2013 in late March 2011. We will reevaluate the budget at that time. We are hoping that the household income rate averaged over the last three years will have decreased in Nevada compared to the rest of the Country. If this happens, we will receive a higher federal match and more federal dollars. Both decision units M-170 and M-171 deal with the FMAP rate.

M-170 Enhanced FMAP Expiration — Page DHHS DHCFP-35
M-171 Enhanced FMAP Expiration — Page DHHS DHCFP-35

Between these two decision units, we have a net of about $162 million in necessary revenue due to the expiration of the match.

CHAIR LESLIE:
Please keep our Staff informed on this issue. Let us move on to decision units M-200 and M-201, which deal with caseload growth.

M-200 Demographics/Caseload Changes — Page DHHS DHCFP-36
M-201 Demographics/Caseload Changes — Page DHHS DHCFP-36

MR. DUARTE:
On page 31 of Exhibit C, you can see our current and projected caseload growth. These projections are based on the recession-induced benefit needs of Nevadans coming into the Medicaid program. We are not anticipating a reduction in caseload. According to our projections, by the end of FY 2012-2013 we will have and additional 112,000 recipients on the program. In FY 2012-2013, caseloads will begin to flatten out and then start a slow decline. We will still see significant growth in this time period, however. The predominant demographic of these new cases will be families with children. These projections determined both decision units M-200 and M-201.

CHAIR LESLIE:
When will you be rerunning the Medicaid projection model?

MR. DUARTE:
We run the projections in late March or early April, depending on when we get our approved federal match rate for FY 2012-2013. At that point we will rerun our caseload projections and we will use which ever FMAP rate is given to us at that time.

CHAIR LESLIE:
Please include the Staff in all pertinent planning meetings held to discuss information used for the new projections. Let us move on to decision unit M-101, which deals with provider rate increase.

M-101 Agency Specific Inflation — Page DHHS DHCFP-34

MR. DUARTE:
This budget item reflects agency-specific inflation growth and deals with specific provider types, including our HMO contracts. We have been quite

aggressive when it comes to estimates of inflation with regards to our HMO contracts. These contracts are reviewed and updated on a calendar-year basis. Whether these rates come to fruition will be based on the certification of an independent actuary.

MS. CARRIGAN:
In decision unit M-101 we have budgeted for federally mandated rate increases. A small amount is included for hospice, Indian Health Services and federally qualified health centers. The big increases will be in Medicare buy-in. We pay the premiums for Part A and Part B Medicare recipients. The Part B premium has increased significantly over the past several years as a result of a federal law that does not allow us to increase the premium for people whose Medicare premiums are deducted from their Social Security checks who have not received cost-of-living increases. This means that the increase cost of Medicare is pushed off on to the premium payers who do not have their premium deducted from Social Security. Medicare Part B costs have gone up significantly and we are projecting an additional increase of $5 per person. For HMO premiums, we have projected a 0.30 percent rate increase for calendar year 2011. We have projected a 0.50 percent rate increase on HMO premiums for calendar years 2012 and 2013. We have eliminated pharmacy inflation because we have seen that the cost per eligible person has decreased. We have left inflation in the clawback payment because although we may not experience inflation, the federal government does experience inflation and they set the clawback premium.

MR. DUARTE:
Clawback refers to the amount of money we pay the federal government to help support Medicare Part D which is the Medicare Drug program for patients who have both Medicare and Medicaid benefits. The State is required to pay the clawback in support of the Part D benefits for these beneficiaries.

CHAIR LESLIE:
Is it reasonable to assume that the pharmacy costs will not increase over the 2011-2013 biennium?

MR. DUARTE:
We are comfortable with these projections because they are based on three years of work by our Program Services Unit, as well as our fiscal agent to manage cost. Some of this comfort is related to increasing rates of generic medication use. A lot of our comfort is related to our sound medical policy, which ensures we are paying for the appropriate drugs for the appropriate reason. We have had significant program management initiatives over the last three years which has culminated in a very low rate of growth in pharmacy spending in our Federal Insurance Contribution Act (FICA) services program.

CHAIR LESLIE:
If approved, will the rate reductions recommended for inpatient hospitals and nonprimary care providers and the flat rate recommended for pharmacy services mitigate the need for rate increases for HMOs?

MR. DUARTE:
It will create adjustments in HMO rates. We did take that into consideration when setting these aggressive rates. We will not know what impact the rate reductions might have on HMO expenditures until we get some utilization data.

CHAIR LESLIE:
Let us move on to the continued budget reduction measures seen in decision units M-160, E-327 and E-663 of B/A 101-3243.

M-160 Position Reductions Approved During Biennium — Page DHHS DHCFP-34
E-327 Deliver Public Services Directly and Efficiently — Page DHHS DHCFP-37
E-663 Program Reductions/Reductions to Services — Page DHHS DHCFP-40

MR. DUARTE:
Enhancement unit M-160 includes a number of budget reductions that have been in place since February 2010, some of which were approved during the 26th Special Session. On page 21 of Exhibit C, we have highlighted the specific changes that were made and the estimated savings that will continue into the next biennium. As you can see, we have implemented a new assessment for determining the use of personal care services. When someone requests personal care services a full functional assessment is conducted by a professional therapist. We have reduced anesthesia rates to that of the federal Medicare

program. We have also reduced our behavioral health rates for specific rehabilitation services which are used primarily by children, but also by adults. This includes basic skills services. Rather than having three tiers of services, we now have one tier for basic skills. All of these have resulted in an anticipated reduction of about $15 million over the next biennium.

CHAIR LESLIE:
Has there been any push back on these reductions or are you still comfortable with them?

MR. DUARTE:
The area of particular discomfort which has been an issue since before the 26th Special Session is around behavioral health. It is not necessarily the rate reduction which we implemented, but the utilization management criteria that we are currently using to manage the use of these services. Some of these services have been used to support children's supervision in treatment foster care programs and they have not been used for the clinical purposes for which they were intended. We have worked extensively with SURS investigators which has resulted in a reduction of our cost per eligible person in this category of child welfare by about $20 per person per month. The primary category we have received over the past six months has dealt with authorization regarding what providers have deemed necessary health services for children.

CHAIR LESLIE:
What is your plan going forward?

MR. DUARTE:
Going forward, we have a policy in place allowing providers to request up to two hours of basic skills training a day without prior authorization. It still must be medically necessary and is subject to retroactive review. We are keeping a tight rein on the inappropriate use of these services, particularly in situations where the child's diagnosis is not consistent with basic skills and psychological social rehabilitation or if the child is not improving. These services are intended to augment clinical therapy, and often they are used as replacement for clinical therapy.

CHAIR LESLIE:
Is this an issue of training providers on how to use these services and bill them correctly?

MR. DUARTE:
Some of it has been a training issue. Over the last eight months, we have worked extensively with providers so that they understand that these are clinical services and they must have a clinical justification. Additionally, as a rehabilitative service, the child must show progress. There are numerous case studies showing that these children are not improving despite the number of services provided. We have a lot of education on the appropriate use of these services and how to bill for them. This basically comes down to treatment, foster care and supervision. We do not pay for room and board in Medicaid. We pay for medical services. The question is how do we support this care model appropriately and make sure there is enough money for child supervision.

CHAIR LESLIE:
We should speak at another time about putting together a different type of model for those treatment facilities because it is not working. The providers are frustrated and the children are not getting the care they need, which is the most important part. Decision Unit E-327 continues the Expanded Preferred Drug List (PDL). Will you continue to use this? If the sunset provision is removed, will this become permanent?

MR. DUARTE:
Decision unit E-327 anticipates the elimination of the sunset provision of our PDL for certain drug classes, particularly the atypical and typical anti-psychotic medications. We have agreed to use Senate Bill 97 as the vehicle for eliminating that sunset. We have requested that this bill go forward in order to achieve the savings on PDL.

SENATE BILL 97: Removes the prospective expiration of certain provisions governing the list of preferred prescription drugs to be used for the Medicaid program. (BDR S-940)

ASSEMBLYWOMAN CARLTON:
Was there any discussion on the Assembly Health and Human Services Committee to move the sunset out in order to make sure there are not any future problems?

MR. DUARTE:
There was no discussion at the hearing regarding moving the sunset. Subsequent to that meeting, we received a request to extend the sunset to June 30, 2015. We do not support moving the sunset. It has taken four sessions to get where we are today. Over the last five years, we have proven that we can manage an approved drug list safely. We manage a lot of drugs for patients, many of which have significant health-related requirements. We do not expect to see an adverse situation develop with respect to antipsychotic and anticonvulsant medication. It would be difficult to move the sunset out and having to face that battle again would be difficult.

We provided a quarters' worth of data to the Assembly Health and Human Services Committee that indicates we have had no denials of requests for nonpreferred products associated with this class of drugs. There have been 307 requests to the Magellan Pharmacy call center, we have approved 229 requests from physicians who showed justification for a nonapproved product, 57 agreed to a change in therapy from a preferred product, and we had 20 requests for information. The experience has been positive and we feel it will continue to be positive. Providers understand how the process works and how to get the correct care for their patients.

ASSEMBLYWOMAN CARLTON:
I am concerned that we have only been doing this for one quarter. That is too short a time frame for a snapshot.

SENATOR CEGAVSKE:
What about the patients' needs? The physicians know the medication and know their patients. When a doctor is forced to switch from a medication they know to a generic they do not know, it may require several attempts to find the right drug at the right dosage. This ends up being more expensive than the original prescription. This is a big concern for foster children, whom we should not be using as guinea pigs to determine which medications do and do not work.

CHAIR LESLIE:
Let us move on to the new budget reduction measures and decision unit E-640 which reduces rates by 15 percent for home and community-based services for the frail elderly, adult group care and disability waivers. Please discuss this decision unit in light of the Olmstead decision and the risk of litigation.

E-640 Budget Reductions — Page DHHS DHCFP-38

MR. DUARTE:
Decision unit E-640 request reductions in specific home- and community-based services. There was an error in calculating the cost savings associated with this unit. Two service areas were erroneously included in that 15 percent reduction. Specifically, we eliminated revenue for case management services that the Division of Aging Services directly supplies. We will be filing a budget amendment to correct the error.

CHAIR LESLIE:
Roughly, what is the new figure?

MR. DUARTE:
The ballpark number for case management is $116,000 in FY 2011-2012 and $109,000 for FY 2012-2013, a combined total of $225,000 over the biennium. Additionally, we reduced enhanced personal care rates for recipients on the physical disability waiver. That was not our intent and we need to reverse it. The net for that over the biennium is approximately $230,000 in General Fund savings. To reverse these two issues, there will be a General Fund savings of approximately $455,000 over the biennium. This change will reduce the net savings shown in this decision unit from about $1.7 million to about $1.3 million over the biennium.

CHAIR LESLIE:
That is bad news for the budget, but will it help with the Olmstead issue?

MR. DUARTE:
The rate issue will not have an Olmstead implication. There are other issues, however, that may have such an implication, but that will depend greatly on the provider community and the impact it has on the recipients.

CHAIR LESLIE:
If people go out of business because of the rate reduction, will that affect access and be an Olmstead issue?

MR. DUARTE:
It could be a potential implication. The question at hand is whether these rate changes will cause providers to go out of business. Many of our providers provide a host of other services, including personal care. At this time, we are not anticipating a lot of fallout from these provider groups.

CHAIR LESLIE:
Let us move on to decision units E-650 and E-690, which recommend reducing General Fund appropriations by reducing per diem rates for Skilled Nursing Facilities (SNF).

E-650 Program Limits or Rate Reductions — Page DHHS DHCFP-38
E-690 Budget Reductions — Page DHHS DHCFP-42

MR. DUARTE:
Decision unit E-650 requests a rate reduction of $20 per day for SNF. This will affect approximately 44 in-state providers. There is a bill associated with this line item.

SENATE BILL 54: Revises provisions governing the Fund to Increase the Quality of Nursing Care. (BDR 38-444)

This bill has been requested to be referred out of the Senate Committee on Health and Human Services and over to the Senate Committee on Finance.

CHAIR LESLIE:
Please discuss the per diem rate increases SNF has realized over the past nine years and whether Nevada's reimbursement rates, if reduced, will remain competitive when compared to the Western states.

MR. DUARTE:
Prior to 2003, Nevada was paying six levels of care for nursing home services. In 2003, we engaged with the industry to change our payment method to a

standard rate methodology. This new methodology made adjustments for patient need, or patient acuity. At the same time, the industry sponsored a bill for a provider tax, which accessed a fee on free-standing, skilled nursing facility beds excluding certain bed types. Those fees were provided to the State and used as part of a federal match for payment for Medicaid clients. Prior to the implementation of the provider tax, our base rate was approximately $122 a day. Over the last seven years, our base rate has increased by approximately 54 percent. A portion of that increase was funded by the fees paid by the facilities, but it is a significant increase. If you exclude those fees from the increase, we still see a raise in our base rate of approximately 30 percent. Oregon and Idaho are the two other states in the Western region who pay more than Nevada. It is difficult for us to compare ourselves to other states, because some states have provider taxes of their own and different pay structures. Nevada is still in the middle of the pack in terms of reimbursement, relative to states in the Western region.

CHAIR LESLIE:
Do you believe any SNF would be in financial danger if the per diem rate reduction were enacted as recommended?

MR. DUARTE:
That is a question for the facilities themselves, but I am not concerned about that issue at this point. It is a matter of supply and demand. In terms of supply, we currently have excess licensed bed capacity of 20 percent. Occupancy rates vary from facility to facility, but Medicaid makes up about 60 percent of occupied beds. We are a significant portion of that industry. We are the largest payer of long-term care services for the industry.

These facilities will have to make the decision to fill fewer beds, at a higher price, or to fill more beds while offering some of them at a discounted price. That will be determined by the industry and by the providers themselves.

CHAIR LESLIE:
Do other payers typically match the Medicaid rate? If we drop our rates, are other payers going to drop theirs as well?

MR. DUARTE:
I am not sure. Private pay rates are higher than Medicaid rates.

CHAIR LESLIE:
Let us move on to decision unit E-695 of B/A 101-3243, which recommends reducing General Fund appropriations by reducing rates for Intermediate Care Facilities for the Mentally Retarded and Developmentally Disabled (ICF/MR).

E-695 Budget Reductions — Page DHHS DHCFP-44

MR. DUARTE:
The Division is requesting a reduction in rates for ICF/MR for nonpediatric beds by 15 percent. There are seven facilities in-state and three out-of-state that would be affected. This also affects home health providers, so two provider types are rolled up into this decision unit.

CHAIR LESLIE:
Please discuss the amount of flexibility or latitude the Division needs to negotiate each facility's rate reduction.

MR. DUARTE:
Our proposal is a 15 percent reduction. When a patient has a mixed bag of diagnoses and issues, such as severe medical conditions in conjunction with being developmentally disabled, we look at those cases individually for recipients.

CHAIR LESLIE:
If the Division is authorized a certain amount of flexibility to negotiate rate reductions, how would the negotiated individual rate reductions compare to the legislatively authorized rate reductions?

MR. DUARTE:
I believe that the 15 percent rate reduction will be applied fairly evenly with the exception of pediatric services which are exempt. Pediatric services are specially negotiated. The same goes for out-of-state services. We always look in-state to see if we can take care of the needs of Nevadans, but quite often specialized services are only available out-of-state and those must be negotiated.

CHAIR LESLIE:
Let us move on to decision unit E-696, which recommends reducing General Fund appropriations by reducing reimbursement rates for laboratory, pathology, clinical and radiology services by 15 percent. Do you think there will be any access issues if this reduction is approved?

E-696 Budget Reductions — Page DHHS DHCFP-45

MR. DUARTE:
We do not foresee any access problems with respect to these providers.

CHAIR LESLIE:
Let us move on to decision unit E-666, which recommends reducing General Fund appropriations by eliminating nonmedical vision services for adults aged 21 years and older. Can you explain the definition of nonmedical vision services? Will we still cover eye exams? Will patients be able to get lenses and frames if they are medically necessary?

E-666 Program Reductions/Reductions to Services — Page DHHS DHCFP-40

MR. DUARTE:
Decision unit E-666 eliminates payment for eyeglasses and other appliances. Even if there is a medical justification, we will not pay for the eyeglasses. We will continue to pay for medical eye exams, but not for the appliances.

CHAIR LESLIE:
Will an individual who cannot afford to purchase eyeglasses now have to depend on charity or go without?

MR. DUARTE:
Yes, that is correct.

SENATOR CEGAVSKE:
There are many organizations who provide eyeglasses for children, such as the Lions Club. Do you work with them in referring clients to those organizations so they can get help?

MR. DUARTE:
We work with those organizations, but this decision unit only affects adults. We are not eliminating eyeglass for children. Under federal law, there is a special set of rules that requires us to pay for most things, including eyeglasses for individuals under 21 years of age.

SENATOR CEGAVSKE:
I believe the Shriners and the Lions Club have some adult programs.

MR. DUARTE:
We work very closely with Shriners and their services both in and out of state.

CHAIR LESLIE:
Charity will not be able to accommodate the 7,833 patients this will affect. Will there be people who need glasses who will not be able to get them?

MR. DUARTE:
Yes, that is correct.

CHAIR LESLIE:
Let us move on to decision unit E-698 which recommends reducing General Fund appropriations by transferring financial responsibility for a portion of the Medicaid Aid for the Aged, Blind and Disabled (MAABD) institutional population and the waiver population to the County Match Program.

E-698 Budget Reductions — Page DHHS DHCFP-46

MR. DUARTE:
We discuss this request on page 26 of Exhibit C. This request will move a portion of the Medicaid population to the responsibility of the counties by amending *Nevada Revised Statutes* (NRS) 422.272. The County Match Program was originally conceived as a way of assisting counties to pay for indigent care services for individuals who needed intuitional care by providing the federal funds to the counties, and the counties themselves providing the State match for these services. The NRS defines this as individuals who have incomes below 156 percent of the Federal Benefit Rate for Supplemental Security Income (SSI), which equates to an income of approximately $1,051 a month. Currently, the

counties have responsibility to pay the State share of costs for institutional Medicaid recipients whose income falls between 156 percent and 300 percent of the Federal Benefit Rate (FBR) for SSI. They have no financial responsibility for waiver recipients. In order to receive federal matching funds, they must pay this difference and that is the limit of where we will provide federal matching funds. The counties have additional obligations for indigent care above $212 a month for individuals who qualify.

We are proposing to reduce the income criteria, which will increase the counties' obligation to pay for more people who meet the institutional care criteria for the County Match Program. We recommend that the rate be dropped to 132 percent in FY 2011-2012 and 124 percent in FY 2012-2013. This change will result in General Fund savings of approximately $37 million over the biennium.

On page 26 of Exhibit C, you have an estimate of the impact on each county based on current expenditure patterns in the current County Match Program. The chart you see is an estimate of what may happen and what their obligation may be under this requested change.

CHAIR LESLIE:
How many clients will be shifted from the State's financial responsibility to the counties' financial responsibility by reducing the FBR percentage for determining County Match Program eligibility and adding waiver clients?

MR. DUARTE:
I do not have that information in front of me, but we will get that to you.

CHAIR LESLIE:
Please describe the factors that were considered in determining how much to reduce the FBR percentage for county match eligibility versus MAABD eligibility.

MR. DUARTE:
We used many factors and it is rather complicated. We used overall restrictions on which subsidiaries of State government, i.e., counties, can contribute toward the operations of the Medicaid program under ACA. Under ARRA and ACA requirements were established that limited the counties' requirement for

contributing to the cost of the Medicaid program. Both ARRA and ACA set benchmarks under which we could force the counties to take on additional cost obligations. To come up with these numbers, we reviewed the requirements of ACA for capping county expenditures for Medicaid and then determined the level to which we could lower the income level in order to meet that cap. We had to take into consideration the aggregate contribution of the counties to the Medicaid program.

CHAIR LESLIE:
Were the counties included in this discussion? Did they have any input?

MR. DUARTE:
There was no direct communication from my office during the development of this enhancement unit. Director Willden did have some discussion with county officials, but not to this level of detail that we are discussing today.

CHAIR LESLIE:
Currently, NRS provides a mechanism for the State to assume the costs for the county match clients in certain situations if a county has expended property tax proceeds up to a specified level for costs associated with institutional care. This mechanism allows for the continuity of the County Match Program in those situations in which a county no longer has the financial resources to pay its obligations for clients in institutional care under the County Match Program. Will this mechanism be affected by the 15 percent cut?

MR. DUARTE:
The NRS places a general cap on how much counties can raise in ad valorem fees to assess real property values. Currently, that cap is at ten cents. The aggregate cap may have a constricting effect on our ability to increase county expenditures for this program. We have done some rough estimates on what the effect may be. There are potentially three counties in FY 2011-2012 and six counties in FY 2012-2013, all rural counties, that could be affected by this stop loss. We will have to examine these numbers more closely, and if there is an effect we will have to make adjustments. We believe that these adjustments will result in approximately $600,000 to $800,000 in General Fund expenditures each fiscal year.

CHAIR LESLIE:
We will need another budget amendment to fill the hole that will be created by the NRS provision.

MR. DUARTE:
Potentially, yes.

CHAIR LESLIE:
How long will it take for you to determine if you need a budget amendment?

MR. DUARTE:
We have an estimate now which is based on older tax information. We will provide our current figures to staff.

CHAIR LESLIE:
These holes are beginning to add up and we will need to look at these numbers sooner rather than later. Let us move on to decision unit M-160 which will continue the reduction to the rates paid for anesthesia services. Have you seen any access problems since this was implemented?

M-160 Position Reductions Approved During Biennium — Page DHHS DHCFP-34

MR. DUARTE:
We have received six requests for disenrollment from the Medicaid program, a number of which are providers that did not see a lot of Medicaid patients. We have spoken with many surgeons, particularly in Clark County, and have been told that there have not been any reported access issues. We are grateful for the continued services that these providers are giving our recipients.

CHAIR LESLIE:
What about providers in Reno? We had a lot of protests from providers in this area.

MR. DUARTE:
I have not heard of any access issues in Reno.

CHAIR LESLIE:
Let us move on to decision unit E-691 which recommends reducing General Fund appropriations by reducing the rates paid to nonprimary care physicians by 15 percent.

E-691 Budget Reductions — Page DHHS DHCFP-42

MR. DUARTE:
Decision unit E-691 will lead to approximately $7.5 million in savings over the next biennium. This decision is not targeted at nonprimary care physicians, but at a range of services that are not considered primary care services. Any physician who provides an evaluation of management service, primarily office visits, will continue to receive the same rates we are currently paying. This will affect other areas such as surgery, radiology and obstetrics. It does not affect anesthesia rates.

CHAIR LESLIE:
How did the Division determine the procedure codes that would and would not be targeted for the 15 percent rate reduction?

MR. DUARTE:
There were two considerations. The first consideration was that primary care services are the largest area of services that Medicaid pays for, and is thus the most critical access area in terms of professional service. Office visits are the first entry point for patients who need primary care. The other issue deals with ACA and the increase in rates. The ACA established a benchmark date for us, after which we cannot reduce primary care rates. If we reduce primary care rates after the benchmark, ACA will not pay the difference between what we pay and what we are required to pay under Medicare. If we do not decrease these rates now, but do so later, the State will see an increased obligation to pay for rate increases for primary care services in FY 2012-2013 and FY 2013-2014.

CHAIR LESLIE:
How will the Division ensure providers do not alter their billing practices and charge Medicaid for procedures not affected by the rate reductions proposed?

MR. DUARTE:
I do not believe that physicians will change their codes in order to receive extra revenue. We do have systems in place that review inappropriate utilization of codes. I am not worried about that issue.

CHAIR LESLIE:
Is the medical community aware of how this will affect billing?

MR. DUARTE:
Mr. Matheis, the Executive Director of the Nevada State Medical Association, and his members are well aware of these changes. Other physician groups are also aware of these changes and have contacted the Division to ask questions. We have not promoted these changes yet and will not do so until a final decision is made.

CHAIR LESLIE:
Let us move on to decision unit E-693 which recommends reducing General Fund appropriations by reducing the rates paid for physician assistants, nurse midwives and nurse practitioners by 15 percent. Will this create any access issues that you are aware of?

E-693 Budget Reductions — Page DHHS DHCFP-43

MR. DUARTE:
This will not create any access issues. These rates are tied to physician services, so reducing physician rates necessitates reducing these rates as well.

CHAIR LESLIE:
Let us move on to decision unit E-694 which recommends reducing General Fund appropriations by reducing the rates paid for dental services, durable medical equipment (DME) and disposable medical supplies by 25 percent.

E-694 Budget Reductions — Page DHHS DHCFP-44

MR. DUARTE:
These reductions are predicated on two different things. With respect to dental services, our managed care plans have been successful in negotiating much

lower reimbursement rates that are well below what Medicaid is currently paying. I believe there will be some effect on access, but the measure will be whether it reduces access beyond what is available for all Nevadans in the geographic area. The decision regarding DME dealt with supply and demand. We have a significant number of DME providers and believe that because of the number of providers contracted with Medicaid that we can reduce their reimbursements and still maintain reasonable access.

CHAIR LESLIE:
Is this an equitable alignment? Temporary Assistance for Needy Families and Child Health Assurance Program clients participate in the Medicaid managed care program and may have less costly dental needs than aged and disabled clients who are not enrolled in managed care.

MR. DUARTE:
This is not necessarily the case. Individuals under FICA, who are predominantly the aged and disabled, are not eligible for Medicaid dental benefits except for pain and palliation care, which is extraction and infection control.

CHAIR LESLIE:
Are the aged and disabled not currently getting dental work?

MR. DUARTE:
Correct, they do not currently receive dental work.

CHAIR LESLIE:
Does the Agency anticipate the proposed rate reduction for dental services will pose a potential access problem for Medicaid clients residing in rural areas?

MR. DUARTE:
Dental care in the rural areas has always been a problem. I am not sure how this reduction will affect access in specific regions and it will be something we will monitor.

CHAIR LESLIE:
How will you monitor it?

MR. DUARTE:
We will monitor the number of phone calls and complaints we receive.

CHAIR LESLIE:
How will we fix it at that point?

MR. DUARTE:
We will need to transport those patients to an area where services are available, which could increase some of our costs. Those transportation costs will need to be weighed against the costs associated with this entire budget reduction.

CHAIR LESLIE:
Let us move on to decision unit E-651 which recommends reducing General Fund appropriations by reducing the rates paid to inpatient hospitals, inpatient psychiatric facilities and specialty inpatient hospitals by 5 percent. Can you please review the history of rate reductions in this area?

E-651 Program Limits or Rate Reductions — Page DHHS DHCFP-39

MR. DUARTE:
Hospitals that provide inpatient services to Medicaid recipients in our FICA service program have not seen a significant increase in Medicaid reimbursements in the last decade. While adjustments have been made to the rates we pay for different bed types, there has not been an across the board increase. The last time we affected rates was in September 2008, when we implemented a five percent rate reduction consistent with the budget reduction proposals at that time. During the 26th Special Session, there was a hearing on a similar proposal but it was not considered by the Legislature at that time.

CHAIR LESLIE:
What potential impact will the proposed rate reduction have on the financial viability of hospital providers?

MR. DUARTE:
I will allow the industry to speak to that point in particular. I believe that it will affect revenue. Many of these initiatives affect lives and livelihoods. There will

be an impact on the scope of services hospitals will be able to provide. There will also be a shift of costs to other payers.

CHAIR LESLIE:
Are client access problems anticipated?

MR. DUARTE:
I do not anticipate access problems here, but I will let the industry speak to that.

CHAIR LESLIE:
Let us move on to decision unit E-692 which recommends reducing General Fund appropriations by reducing the rates paid to outpatient hospitals by 15 percent.

E-692 Budget Reductions — Page DHHS DHCFP-43

MR. DUARTE:
Decision unit E-692 requests a reduction to outpatient hospital service rates. Outpatient hospital services include same day procedures and diagnostic procedures performed in outpatient hospital centers. The anticipated savings is about $2.7 million. We anticipate that this will affect 38 in-state hospitals and a number of out-of-state providers, particularly those in regions near the State border. For in-state hospitals, it will continue to place pressure on services available through Nevada hospitals.

CHAIR LESLIE:
Please describe how the Division worked with outpatient hospital providers to structure the proposed reduction in a manner that will have the least impact on their financial ability to provide services.

MR. DUARTE:
Although we did not have a discussion with the outpatient hospitals with respect to these reductions, we are open to those discussion. If we do make changes to this, or any of these proposals, we will need to do so in a way that does not affect the overall savings associated with the Governor's budget. We

do not want to suggest that it would be appropriate to start taking revenue from others.

CHAIR LESLIE:
The theme of the budget is to take money from other people. The Governor's budget includes a recommendation to expand the Upper Payment Limit (UPL) program. Can you explain that?

MR. DUARTE:
Medicaid has many different financing mechanisms available to enhance federal revenue and we have taken advantage of many of those. There are two areas in which we have worked with the industry to increase hospital payments for Medicaid and these payments are associated with the UPL program. Essentially, Medicaid cannot pay more for a service than what the federal Medicare program pays, which is called UPL. For inpatient services at non-State government hospitals, such as the University Medical Center (UMC), we make a supplemental payment up to the Medicare reimbursement amount. This payment is funded by an intergovernmental transfer from the counties or the hospital district, not from the hospitals themselves. We receive a transfer of funds, which for Clark County is 60 percent of the total payment that the hospital receives. We use part of this intergovernmental transfer as a State match and then we pay the hospital the federal share. We are expanding that.

CHAIR LESLIE:
Are we expanding the UPL program for outpatient hospitals?

MR. DUARTE:
We are expanding it in three ways. The first way is that we are looking at using intergovernmental transfers in Clark County and hospital districts to supplement payments for outpatient hospital services for public hospitals. This will mitigate some of the rate reductions for outpatient services.

CHAIR LESLIE:
Please explain whether this expansion will happen and the level at which the rate reduction will be mitigated.

MR. DUARTE:
I cannot put a specific percentage on the mitigation. We have some estimates which we will talk about at a later hearing.

CHAIR LESLIE:
We do not need to discuss decision unit E-697. Let us move on to decision unit E-328 of B/A 101-3243 which recommends the restoration of subpoena power to the Director of the Department, allowing access to records to facilitate Medicaid Estate Recovery (MER) efforts by the Division.

E-697 Budget Reductions — Page DHHS DHCFP-45
E-328 Deliver Public Services Directly and Efficiently — Page DHHS DHCFP-38

MR. DUARTE:
Medicaid is required under federal law to run a MER program. Essentially, when an individual becomes qualified for Medicaid, they often have to spend down to get long-term care services. As part of that application process, they must acknowledge assets that can be used to contribute toward their cost of care and we have the right to use those assets. These assets include real property, cash and other assets. We do not go after the assets until two things happen. First, the recipient must expire. Second, the assets are not being utilized by a community spouse who is entitled to part of those assets or there is no dependent child using those assets. Most of the funds recovered through the MER program are associated with bona fide sales of real property. We have a lien established and we go after half of the estate, only up to the amount associated with the cost of care of the recipient. With respect to cash, recipients are allowed to keep up to $3,000.

When we were under the Division of Welfare and Supportive Services, we had subpoena authority to obtain bank records in order to establish whether or not a person had money in the bank in excess of the $3,000 allowable limit for cash. Last year, a national bank informed us that they will no longer honor those subpoenas because we are no longer under that Division. We attempted to use a general subpoena authority to get those records in order to recoup cash, but were unable to do so. We are requesting additional subpoena authority in order to pull in additional funds.

CHAIR LESLIE:
Have the costs associated with conducting recovery efforts been incorporated into the General Fund reduction amounts?

MR. DUARTE:
No, those costs already exist. There are no additional costs associated with this.

CHAIR LESLIE:
Decision unit E-680 of B/A 101-3243 recommends a General Fund reduction from recoveries resulting from the implementation of ACA-mandated program integrity activities. Our staff will be sending you questions regarding how you define the roughly $4 million in each year in savings.

We will start with the counties for public testimony.

MARY WALKER (Representative, Carson City, Douglas County, Lyon County and Storey County):
We are concerned with the 50-50 Medicaid match for long-term care. Under the current statute, the counties are allowed to enact an 11.5 cent tax, of which 2.5 cents has already been given to the state for the Indigent Accident Fund (IAF) Supplemental fund. Following that reduction, we only have 9 cents remaining. In the current law, the remainder goes to long-term care, but it stipulates that the county cannot pay more than its budget. If we retain that language, it will help us greatly. Under the Governor's proposal, we would have to pay the entire 11.5 cents to the State, plus dip into our General Fund appropriations. In many of our rural counties, we will then be faced with the decision of laying off police officers or keeping long-term care recipients in their beds. This is a terrible decision to have to make. Please consider retaining the budgetary cap so that rural counties will not have to make layoffs in order to keep elderly patients in long-term care.

CHAIR LESLIE:
Please work with Mr. Duarte to clarify that language.

JEFF PAGE (County Manager, Lyon County):
Lyon County encompasses about 2,013 square miles and has a population of approximately 55,000 people, which makes us the third-most populous county in the State. We also have the highest unemployment rate in the State and we are the third-most economically depressed county in the Nation. In our budget last year, we cut 15 percent of our FTE employees. Based on the numbers given to us today by DHHS, we will have to contribute about $565,000 toward Medicaid, which means eight deputy sheriff positions will be trimmed from our budget. We have already cut about $1.8 million from our budget due to a revenue shortfall and increases in health care benefits for public employees. We are also cutting our health care benefits so that we are in line with the State cuts. This additional burden will cut 8 positions out of the 77 we currently have, which is a lot of people in our county.

BOBBY GORDON (Assistant Director, Clark County Social Services, Clark County):
I have submitted written testimony (Exhibit D), but would like to make a few additional comments. Clark County has grave concerns with the Medicaid match program. When the Medicaid match program began in 1989, we had approximately 165 recipients, which totaled approximately $850,000, as the County's annual share. Today we have a monthly average of roughly 900 clients which equates to about $17 million a year. We are also concerned that Medicaid waiver clients are included in this program, as those clients have not been a prior consideration for us. The anticipated cost burden to the County is about $17 million, which is in addition to the approximately $17 million we currently pay. We have already incurred some of these costs with other program shifts, specifically the IAF Supplemental fund. In your deliberation of the budget, please consider the impact and consequences it will have on the counties.

SUSAN RHOADS (Long Term Care Supervisor, Clark County Social Services, Clark County):
I have been involved with Clark County in the long-term care arena since the inception of the County Match Program. When we initially started this program, we only had 165 eligible clients and less than $1 million in cost. Today, we have over 900 institutional clients and we are anticipating approximately 500 home- and community-based waiver clients with these new changes. These waiver clients are not included in the current terms of the existing interlocal agreement. There was no prior discussion with Clark County about whether we

will be able to incur the cost and care management load for those additional 500 clients. We believe that this figure of 500 clients is low, as we only had accurate numbers from one of the waiver programs.

CHAIR LESLIE:
Please provide any specific financial information you have regarding the estimated impact of the waiver program to our staff.

MS. RHOADS:
The additional impact of the waiver clients for the home- and community-based waivers will be approximately $6.5 million per year on top of the $17 million increase for the new institutional clients.

CHAIR LESLIE:
Please submit those numbers in writing so our staff can evaluate them.

MS. RHOADS:
Yes, I will do that.

KEVIN SCHILLER (Social Services Director, Department of Social Services, Washoe County):
We serve the indigent in our Health Care Assistance program with an operating budget of roughly $22 million. Services included in this program are hospital care, outpatient services, clinic visits, emergency room visits, adult protective services, group care, burial and cremation. Any hit we take with regard to these services will require a reprioritization of our mandated services and directly impact those clients. Specifically in the nursing home care world, the impact will be about $3.1 million in FY 2011-2012, and it will be about $3.6 million in FY 2012-2013. Our operating budget for the entirety of nursing home care is about $4.3 million, which serves about 350 to 400 clients. If you do the math, you can see the impact that this will have on the capacity of the program. We are going to see a significant shift in services around the indigent in an effort to provide diversion in costs. We have done several things to make our taxpayer dollars go further in relationship to serving these indigent clients. With this reduction, we will be forced to go backwards in terms of how we are wrapping services around those clients. This will ultimately cause us to spend less and see more expenses come in.

I would also like to highlight the IAF Supplemental fund sweep. Our main objection here is to note that hospitals have already taken reductions in relation to the indigent care that is continuing into the next biennium. Related to this are triage centers, outpatient counseling and residential program reductions. I cannot speak to the Medicaid budget without addressing these reductions as well. These services allow us to create diversion programs and cost savings for clients. Finally, I would like to discuss what Mr. Duarte highlighted which is treatment level foster care. This is a work in progress and needs to continue to be a work in progress. We are anticipating reductions in room and board payments to juvenile services clients, which will impact child welfare based on parents refusing custody in order to get treatment for their children. In addition, the ability of the Department and the juvenile justice system to meet the needs of sexual offenders from a rehabilitative standpoint will be challenging based on our current treatment level foster care system. That being said, as a county we understand that reductions are necessary. We are teaming up with other counties to see how we can best collaborate on these issues and come to a solution.

JEFF FONTAINE (Executive Director, Nevada Association of Counties):
The most expensive item on the list of cost shifts to counties in the Governor's budget is the County Match Program. The State's estimated cost of this shift is about $37 million and it will impact all 17 counties. We are thankful for the backstop in ARRA, because it appears that the intent is to shift as much cost to the counties as possible. Without the ARRA backstop, the impact would be much higher. We are very concerned about the counties' ability to pay for this. You have heard from Clark and Washoe Counties about the issues they are facing and the safety net services they are required to provide. Also, we have the specter of revenue diversions and other cost shifts in social services to counties, so it is important to remember that you cannot look at this particular item in isolation.

According to DHHS, the estimated cost to the counties is based on historical caseloads. This is an underestimate, because if you look at the demographics in this State and the graying population who have lost assets in this recession, you can see that they will need these services at increasing rates.

If the estimates are based on caseloads, we can look at places like Esmeralda County which currently serves one client. If they receive one additional client, it will double their caseload and will double the impact of this program. In Mineral County, the cost over the biennium is estimated to be $216,000. In White Pine County, the cost is estimated to be $428,000 over the same time period. Both counties are at the tax cap and cannot raise property taxes to pay for this service. Even if they did not have a tax cap in place and they needed to raise property taxes to pay for this impact, White Pine County would have to increase its tax rate by 17 cents and Mineral County would need to raise its tax rate by 22 cents. We understand this is a difficult decision, but we ask you to consider what the impact will be on the county.

CHAIR LESLIE:
Please leave your analysis with the Joint subcommittee. I would like that on the record.

LAWRENCE P. MATHEIS (Executive Director, Nevada State Medical Association):
With 3,000 to 4,000 new Medicaid eligible people each month, the State has a significant problem. There may not be any good answers and Mr. Duarte's presentation indicated that he does not have many solutions that we will find acceptable. Many of the assumptions built into the presentation are similar to the assumptions made by the federal government, which has a similar problem with its flagship program, Medicare. This year, for the first time, the majority of people who have health coverage will have it through a government program because the baby boomers are moving into Medicare just as our unemployed are moving into Medicaid. The problem many of the administrative structures being put into place to ensure money is being spent correctly is that they are accompanied by further cuts to what is actually paid. Thus, we as providers must jump through more hoops to be paid less. The bottom line for both the federal and State government is that it is a new form of rationing. It is rationing by making it simply impossible to provide the services that are needed.

Two years ago, I raised the concern regarding the direction we are going with the State Medicaid program, which is the last formal coverage program. Below that program, we have a hodgepodge of nonprofit organizations, charities and others that try to fill the gaps created because there is nothing in the private sector and there is nothing else from government. My fear was that we were

creating a hollow Medicaid program and did not actually provide access to services. Mr. Duarte presented anecdotes indicating that he had not heard of access problems, but I have opposite anecdotal evidence. Surgeons are having trouble finding anesthesiologists for Medicaid patients and report having to reschedule a number of times in order to get surgeries done, particularly in pediatric cases. We have asked physicians in each of the major specialties whose practices serve Medicaid patients to look at what they are paid for routine services they provide and how the proposed cuts would affect their ability to deliver those services. We will present those numbers once we are finished collecting them. The proposed cuts will bring payments of specialized services below cost. These payments will be below market, below Medicare, below everything. We are not paying the Medicare rates, we are paying the 2002 Medicare fee schedule rates. For primary care physicians, this will be good, but they then have trouble referring patients on to other specialists. The most frequent codes that are billed are the evaluation and management codes, because they show which specialty and follow-up care a patient needs. If the follow-up and specialty care is not there because the specialist will not be paid, you have a primary care doctor trying to patch the system. You have the emergency departments becoming our primary care system if we are not careful or, at the very least, they become our specialty care system when the primary care system cannot handle the load. We have grave concerns that we are moving to a level of compensation that amounts to rationing by insufficient payment and that the lack of availability of care is going to become more noticeable. The hospitals are going to be the recipients of a growth in Medicaid services. As to why doctors do not leave Medicaid given these situations, many of them have hospital staff privileges and they will be referred out of the emergency room to treat Medicaid patients. Staying in the system keeps the option open even if they have to bill at insufficient rates. Practices themselves tend to be increasingly closed to new Medicaid patients.

CHAIR LESLIE:
Please prepare that data for the next Medicaid hearing.

BILL WELCH (President and CEO, Nevada Hospital Association):
I would like to provide a quick overview of Nevada's Medicaid story (Exhibit E). I would like to remind the Committee that Nevada's Medicaid program rates 48th in the Nation in terms of Medicaid enrollment per capita. This is a bit ironic when Nevada's unemployment rate is the highest in the Country. We also rank as one of the highest in the Nation in terms of uninsured populations.

CHAIR LESLIE:
Does Nevada rank 48th in terms of Medicaid enrollment per capita and 51st in Medicaid dollars spent per capita?

MR. WELCH:
Correct. Regarding the history of Medicaid, Mr. Duarte pointed out that the last rate increase was in 2001. The rate reductions we saw as a result of the 26th Special Session, combined with the proposed rate reductions, will take us back to the 1999 rates of reimbursement. If our costs were also reduced to that level, there would be no problem, but our costs have increased 50 percent over this same time period. Although this seems substantial, hospital costs nationally have been going up at an even higher rate. In 2004, you can see that there was an additional reduction, but that was not a reduction in Medicaid rates. In 2004, the State moved over to First Health and they changed systems. At that time the change in methodology caused us to take a reduction in rates for two years. In 2006, the State recognized this mistake and made an effort to make the payment shortfall whole by by raising rates approximately 2 percent. We had that enhancement for about 18 months.

The proposed rate reductions will bring us at or below the 1999 Medicaid reimbursement rates for hospitals through 2014. For 14 years, we will have been underfunded in the Medicaid programs. This will be on top of the IAF Supplemental sweep. We are not just taking the Medicaid cuts, but IAF cuts as well. These have a direct impact on our bottom line and cash flow. Those are real dollars that would have come in to offset our operating costs for caring for these patients. We have also spoken about reductions in other programs. The

individuals in those other programs will still need to receive health care. They will end up in our emergency rooms. They will receive care in our hospitals, which are the most costly centers where they could receive care. We, the hospitals, will absorb the cost for providing that care. We cannot sustain this.

On page 2 of Exhibit E, you can see the total expenditures for Medicaid hospital services in 2009, which totaled a little more than $443 million. Hospitals are funding 40 percent of Medicaid in this State by absorbing the cost of these recipients. This is nearly $180 million of the total cost. The federal government funded just over $168 million of our Medicaid costs and the State funded roughly $90 million of those costs. It should be highlighted that in the State's share, about $25 million was IAF Supplemental funds, which are really just hospital funds. In reality, hospitals are covering 46 percent of the cost of care for Medicaid recipients. The graph on the bottom of page 2 in Exhibit E shows the trends of where we are and where we are going in underfunded Medicaid liability. In 2010, we will see a shortfall of about $179 million. If all things remain the same, including caseload, the proposed cuts and inflation, we will be underfunding Medicaid by approximately $291 million a year in 2014.

On page 1 of Exhibit F, which is entitled "Condition Critical: Hospital Services to Patients in Jeopardy," you can see those who are at risk for losing access to service. As you can see, this is not just the Medicaid population. There is going to be an impact on access and there has been an impact on access as a result of the historical underfunding. We admit about 260,000 patients annually. Of those patients, approximately 21,000 are uninsured, 100,000 are Medicare and 45,000 are Medicaid. Many of them have no other option as to where they receive their care other than the hospital. We treat over 930,000 patients in our hospital emergency rooms annually. Of those, approximately 75,000 are uninsured, 355,00 are Medicare and 160,000 are Medicaid patients. As Mr. Matheis pointed out, you are seeing more and more of these populations move into our hospital emergency rooms, not only for emergency care, but for primary care as well. We are at risk as a result of growing uncompensated care costs due to the underfunding of Medicaid.

As you can see in Exhibit F, I have listed all the services that have closed since the fall of 2008. Only one of these has been reestablished, the Outpatient Oncology unit at UMC, which was reopened with private funds. At the current funding levels of these programs, more services will close unless we find a private donor. We are at risk of ending dialysis, obstetrics and oncology services with this underfunding, because these are the types of services that the uninsured, Medicaid and Medicare populations use at high rates. When we reduce or close these services, however, it is not just that population that suffers. It is all populations. On page two of Exhibit F you can see the calculations for the estimated $992 million in uncompensated care our hospitals will have to absorb in 2011. You can also see where we have gone from 2007 to 2009 regarding the payer mix of the uninsured, Medicaid and Medicare populations. While 36 percent of our population was insured in 2007, only 31 percent of patients are insured today. That may not sound like a large change, but it is a 10 percent shift in payer mix in a two-year period of time and we are continuing this downward trend. At some point in time, the overwhelming majority is going to be government funded programs that do not pay cost for the uninsured. The bottom line is that through 2010, the acute care hospitals are operating on average at a negative operating margin of 3.95 percent. Of our 33 hospitals, 2 out of 5 northern Nevada hospitals and 10 out of 13 hospitals in southern Nevada are operating at a loss. Also, 8 out of 15 rural hospitals are operating at a loss. We cannot continue to absorb these types of hits. We will not be able to continue these services. I do not know if any hospitals will ultimately close its doors, but there will be significant changes in the scope of services. We may see hospitals close as acute care facilities and refocus on a line of business where they can recoup the investment that they have made. They have to balance their budget as well.

KATHY SILVER (CEO, University Medical Center):
Page 1 of Exhibit G shows the effect of the original budget reductions that occurred in 2008. We went from Medicaid funding of about $74 million in FY 2007-2008 to about $45 million in FY 2009-2010. This constitutes an annual hit of $30 million to UMC's revenue line. Page 2 shows a direct correlation between UMC's operating loss between 2008 and 2010.

Page 3 shows that 55 percent of the patients who come into our hospital are either Medicaid, self-paying or "penders." This means that we have very little other business to shift these costs to. Only 15 percent of our cases have insurance and those would be the populations to which we would need to shift costs. At this percentage, however, it is simply not possible.

On page 4 you can see our payer mix trend. In this economy, people are deferring elective surgeries and things of that nature. Page 5 shows UMC Medicaid payments decreasing from 2006 to 2010, which is an average decrease of approximately $20 million a year. On page 6 you can see the UMC Medicaid payment per claim. In 2006 our average payment per claim under Medicaid was $6,721.32, in 2010 our average payment per claim for Medicaid was only $4,766.23. This is a combination of additional denials by Medicaid as well as Medicaid rate reductions. On page 7 you can see a summary of State funding of UMC. Medicaid reimbursements have declined steadily over the past four years, while the number of patients we have been serving has continued to increase. On page 8 you can see a combination of all the hospitals in southern Nevada. Most notably, you can see that in almost every case, Medicaid populations are increasing at every hospital. The exception is North Vista Hospital, which correlates with North Vista closing its labor and delivery unit in 2010. That business has been shifted to other hospital providers across the valley.

Page 9 shows that UMC is the largest Medicaid provider in the State. We are disproportionately affected by any of these changes in rate reductions. Finally, page 10 shows that the current proposals of rate decreases of 15 percent for outpatient treatment and a reduction of 5 percent for inpatient treatment would result in an additional about $6.3 million in revenue at UMC.

We are already seeing situations in which other hospitals are transferring patients to us because the specialty care those patients need is not available at their facility because the physician is no longer accepting Medicaid. This will continue to happen. I have grave concerns regarding how we are going to continue to treat these patients. The trickle-down effect of this will be that the physicians who serve our hospital will expect to have their subsidy increased to reflect that change in Medicaid reimbursement and the change in volume they will be seeing at our facility.

CHAIR LESLIE:
There being no further business before this Committee, we are adjourned at 10:59 am.

RESPECTFULLY SUBMITTED:

Marian Williams,
Committee Secretary

APPROVED BY:

Senator Sheila Leslie, Chair

DATE:

Assemblywoman April Mastroluca, Chair

DATE:

EXHIBITS			
Bill	**Exhibit**	**Witness / Agency**	**Description**
	A		Agenda
	B		Attendance Roster
	C	Charles Duarte	Health Care Financing and Policy, Biennial Budget
	D	Bobby Gordon	Written Testimony
	E	Bill Welch	Nevada's Medicaid Story
	F	Bill Welch	Condition Critical: Hospital Services to Patients in Jeopardy
	G	Kathy Silver	UMC Funding Reductions