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
March 25, 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 8:07 a.m. on Friday, March 25, 2011, in Room 3137 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to the Grant Sawyer State Office Building, Room 4406, 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
Jackie Cheney, Committee Secretary

OTHERS PRESENT:

Lynn Carrigan, Administrative Services Officer, Division of Health Care Financing and Policy, Department of Health and Human Services
Elizabeth Aiello, Deputy Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services
Charles Duarte, Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services
Brian M. Patchett, President and Chief Executive Officer, Easter Seals Southern Nevada
Mark Inouye
Renny Ashleman, Nevada Health Care Association

CHAIR LESLIE:
We will begin with the budget accounts that fund medical services under the Health Insurance Flexibility and Accountability (HIFA) waiver. The major issue is the elimination of the waiver program.

LYNN CARRIGAN (Administrative Services Officer, Division of Health Care Financing and Policy, Department of Health and Human Services):
Please refer to page 4 of the DHHS Division of Health Care Financing and Policy (DHCFP) biennial budget, (Exhibit C).

Budget account 101-3247 funds medical services under the HIFA waiver. The HIFA waiver uses State Children's Health Insurance Program funds under Title XVI of the Social Security Act to provide medical insurance coverage to pregnant women whose income is between 133 percent and 185 percent of the federal poverty level. This account also provides a monthly subsidy to help pay for qualifying medical insurance premiums for employees of small businesses whose income is below 200 percent of the federal poverty level. Currently, there are 150 pregnant women and 10 employees receiving assistance under this program. The HIFA program is capped at 150 pregnant women.

HUMAN SERVICES

HEALTH CARE FINANCING AND POLICY

HHS-HCF&P – HIFA Medical — Budget Page DHHS DHCFP-49 (Volume II)
Budget Account 101-3247

The Agency plans to terminate the HIFA waiver program when it expires on November 30, 2011. A termination plan has been submitted to the Centers for Medicare and Medicaid Services (CMS) for approval. This plan allows for the continuation of services to all the women currently enrolled in the program through two months postpartum.

CHAIR LESLIE:
What happens to the pregnant women with income between 133 percent and 185 percent of poverty who cannot get help after the program ends?

MS. CARRIGAN:
The Agency has no plan to cover this group. The private sector offers some services and federally qualified health clinics have medical services available on a sliding fee scale.

CHAIR LESLIE:
After this program closes, will the pregnant women who contact your agency be referred to alternative sources for help?

ELIZABETH AIELLO (Deputy Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services):
In the exit plan to CMS, all the current recipients will get a letter explaining the closure of the program and where they can go for help. New applicants and inquiries will be referred to Access to Healthcare and Nevada 2-1-1 in an effort to lead them to the available resources.

CHAIR LESLIE:
How did clients find the existing program?

MS. AIELLO:
The pregnant women became eligible for the HIFA program through the trickle-down Medicaid eligibility determination that occurs through the DHHS Division of Welfare and Supportive Services application process. The employees

requesting help with their health insurance premiums apply directly to our agency.

CHAIR LESLIE:
What are the options for the childless adults who have been getting help with their health insurance premiums?

MS. AIELLO:
Currently, there are only ten people receiving help with their health insurance premiums. The program restrictions regarding the size of the employer, the type of insurance and the applicant's income has made it difficult for people to qualify. Everyone receiving assistance will be notified six months in advance about the closure of the program. There is no alternative help until health care reform is enacted. These individuals have private insurance. They pay their premium and the Agency reimburses them for a portion of their premium. After the program ends, they will have to decide if they are able to continue their insurance without a subsidy.

CHAIR LESLIE:
Please review B/A 101-3155, the HIFA holding account.

HHS-HCF&P – HIFA Holding Account — Budget Page DHHS DHCFP-1 (Volume II)
Budget Account 101-3155

MS. CARRIGAN:
The HIFA holding account provides the State share of funding for all HIFA medical and administrative expenses. It is funded in equal parts by a transfer from the Indigent Accident Fund and a General Fund appropriation. At the end of the year, any remaining funds are reverted equally back to the Indigent Accident Fund and the General Fund. There is enough funding in the HIFA holding account to provide the State share funding for pregnant women through November 2011. Additionally, there will be some monies to cover claims that are incurred, but not recorded, at the time the program terminates. Refer to Pages 4 and 5 of Exhibit C.

CHAIR LESLIE:
Next we will consider B/A 101-3157, the Intergovernmental Transfer Program. Please begin by explaining how the intergovernmental transfer program works.

HHS-HCF&P – Intergovernmental Transfer Program — Budget Page DHHS DHCFP-3 (Volume II)
Budget Account 101-3157

CHARLES DUARTE (Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services):
The Intergovernmental Transfer (IGT) account collects payments from local governmental entities to support three programs: Disproportionate Share Hospitals, Upper Payment Limit (UPL), and University of Nevada School of Medicine supplemental payments. These funds are collected in the IGT budget and are used as State matching funds for Medicaid reducing the need for General Funds for these programs.

Funds are received from the University of Nevada School of Medicine, Disproportionate Share Hospitals and from counties to support supplemental payments to nonstate owned public hospitals. These entities provide the State match funds and we, in turn, provide them with the federal funds received for medical services they provide to Medicaid recipients. All these funds flow through the IGT account in B/A 101-3157.

The UPL program provides payments to county-owned hospitals. Federal Medicaid law allows states the option to make supplemental payments to qualifying county or municipal hospitals up to the Medicare UPL. The intent is to preserve access to inpatient hospitals for needy individuals by reimbursing qualifying hospitals for uncompensated or undercompensated care. Pursuant to interlocal agreements, counties make IGT payments to this budget to be used as State matching funds for the UPL payments to their hospitals. Excess IGT payments are used to offset General Fund appropriations for other Medicaid expenditures.

CHAIR LESLIE:
Please explain the plan for expanding the UPL to outpatient services in public hospitals.

MS. CARRIGAN:
Decision unit E-699 introduces outpatient public hospital UPL supplemental payments. Please refer to page 7 of Exhibit C.

E-699 Budget Reductions — Page DHHS DHCFP-4

Medicare allows higher payments than Medicaid to medical providers. The CMS allows States to make supplemental payments to medical providers for the gap between the Medicaid and Medicare payment amounts.

As previously mentioned, we currently have one UPL program for public inpatient hospitals. The Agency has a pending State Plan amendment with CMS to expand this to include public hospitals for outpatient services. Both the State and hospitals will benefit.

CHAIR LESLIE:
What is the likelihood that CMS will approve this State Plan amendment?

MS. CARRIGAN:
It is expected the State Plan amendment will be approved.

CHAIR LESLIE:
When is it expected to be approved? I thought CMS had some problems in the past with how states were doing UPL.

MS. CARRIGAN:
The CMS have had concerns about supplemental payment programs in general. However, our experience is they have been receptive. Nevada has not had any difficulties with our public inpatient UPL program which uses a fairly conservative calculation method.

The Agency has submitted a State Plan amendment changing the methodology for paying the inpatient UPL payments. This will expand the public inpatient program from approximately $41 million to approximately $56 million. The impact of this is illustrated on the bottom of page 7 in Exhibit C. Typically, the State charges the local government paying the State's share a percentage of the

total payment, yielding a net benefit to the State. This also results in a tremendous benefit to the facilities and providers.

CHAIR LESLIE:
What is the net benefit to the State if the proposed provision for expanding the UPL to include outpatient services is approved?

MS. CARRIGAN:
The net benefit is approximately $5.5 million for the 2011-2013 biennium.

CHAIR LESLIE:
Will a budget amendment be forthcoming?

MS. CARRIGAN:
The new Federal Medical Assistance Percentages (FMAP) projection has increased. Additionally, the Agency just completed a new caseload projection. The entire Nevada Check Up budget must be redone. This will also impact the IGT account. The Agency will have the draft budget amendment, including the impact on the General Fund, completed next week.

MR. DUARTE:
This is good news. The caseload, however, is declining which reduces the amount of federal dollars. Overall, there will be a 1.6 percent increase in the FMAP for federal fiscal year 2012-2013. The gross benefit to the State has not been calculated. The overall net impact will be based on the increased FMAP, reduced caseload and average cost per individual. The end result will be increased dollars to the State.

CHAIR LESLIE:
When will this information be available?

MS. CARRIGAN:
This will be calculated by the end of business on Wednesday of next week. The Agency is meeting with the Legislative Fiscal Staff and Budget Office Staff next Thursday.

CHAIR LESLIE:
There has been some discussion regarding expanding the UPL program to private hospitals. Is this being done?

MR. DUARTE:
As part of the State Plan amendments for public hospitals, the Agency has a State Plan amendment in play that would expand the UPL program to include private hospitals. These UPL payments can be used to offset State expenditures in other State agencies such as The Division of Mental Health and Disability Services (MHDS). Offsetting the State expenditures frees up General Fund monies that can be transferred to DHCFP, matched with federal money, and paid back to private hospitals. Although somewhat complicated, this financing concept has been allowed in at least two states, Texas and Louisiana. With some modification, we believe it will be feasible in Nevada.

The CMS officials are reviewing this more cautiously than the State Plan amendment for UPL payments for outpatient services in public hospitals. The Agency has not completed a projection of the fiscal impact yet. It will largely depend on the level of costs private hospitals can assume from other State agencies by taking over some of their contracts.

CHAIR LESLIE:
Will this be decided before the end of the Legislative Session?

MR. DUARTE:
I am not anticipating having this completed before the end of the Session.

CHAIR LESLIE:
I am assuming the hospitals are interested because they would gain funds.

MR. DUARTE:
Yes, this change would be beneficial to both the hospitals and the State.

ASSEMBLYWOMAN CARLTON:
This is a somewhat complicated. Please explain in further detail.

MR. DUARTE:
The private hospitals will form a consortium or set up a private, not-for-profit corporation. The corporation will assume the payment of some of the State medical contracts. An example is the MHDS physician contracts. The hospitals would be picking up State expenditures which, in turn, frees up State funding in MHDS. If the Director of the Department of Health and Human Services (DHHS) has the authority to transfer funds between divisions, he could then take those dollars from MHDS, transfer them to the DHCFP and we could then use these funds as a State match for federal funding. We would pay back monies to the private hospitals as a supplemental payment similar to the payments now made to the University Medical Center (UMC). In the case of UMC, the county gives us the money and we return it to them in the form of a supplemental payment.

ASSEMBLYWOMAN CARLTON:
It sounds like this is all about leveraging funds.

MR. DUARTE:
Yes, this is about leveraging existing dollars to get additional federal matching funds.

ASSEMBLYWOMAN MASTROLUCA:
In B/A 101-3243, decision unit E-699, the Graduate Medical Education (GME) payment program at UMC is being restored. This program was eliminated in the last biennium. Why is it coming back?

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

E-699 Budget Reductions — Page DHHS DHCFP-47

MR. DUARTE:
The GME payment program under Medicaid has been revised over the last few decades. It was a fairly large program in the 1990s. During that time, the State made GME payments to UMC, Renown and Sunrise Hospitals for some of their full-time equivalent resident physician costs. The program was reduced in 2002 as part of a budget reduction proposal and was eliminated last biennium.

The GME payment program is back because Clark County and UMC requested the program be reestablished using county funds as a match in offsetting their teaching costs. This will bring in additional federal funds through the IGT account similar to other supplemental payment programs.

ASSEMBLYWOMAN MASTROLUCA:
When will the contractual agreements with the counties be fully executed?

MR. DUARTE:
I am unsure. I have only seen draft contractual agreements that have not yet been approved by the county commissions. The Agency has been working with them in good faith negotiations. The State Plan amendments are currently being processed through CMS.

ASSEMBLYWOMAN MASTROLUCA:
What is the approximate State net benefit?

MR. DUARTE:
This is shown on page 8 of Exhibit C under line item E699 GME. The State net benefit is about $2.6 million for the 2011-2013 biennium. The State net benefit for UMC is approximately $3.2 million.

CHAIR LESLIE:
Let us move on to B/A 101-3160.

HHS-HCF&P – Increased Quality of Nursing Care — Budget Page DHHS DHCFP-21 (Volume II)
Budget Account 101-3160

MS. CARRIGAN:
This account is used to collect fees from skilled nursing facilities to use as the State share of a rate enhancement. The Division annually determines the projected gross revenues for free-standing nursing facilities. This amount is divided by the number of projected bed days and is then multiplied by 5.5 percent to determine the amount of tax to be levied on the provider. The Division then collects this tax and determines how much federal match that tax can generate. Next, the Division calculates a per diem rate increase for the

skilled nursing facilities. The Division pays the rates out of B/A 101-3243 and then transfers the money from B/A 101-3160 to B/A 101-3243 in order to pay for the State's share of that rate enhancement.

CHAIR LESLIE:
Please explain to the Subcommittee how the litigation at the U.S. Court of Appeals for the Ninth Circuit may affect the rate reductions.

MR. DUARTE:
The issue in the U.S. Court of Appeals for the Ninth Circuit concerns reductions and reimbursements states make through changes in their state plans. There have been a number of cases including *California Pharmacists v. Maxwell-Jolly*, where providers have sued states for rate reductions. The court has held that the state cannot move forward with provider rate reductions until it demonstrates certain findings. Those findings include things like cost analyses and access studies. With respect to where we are today as a State, it is my contention in talking to our attorneys that no action has been taken in Nevada that would lead to litigation. There could be a lawsuit if a decision is made to move forward with a rate reduction or if Nevada submits a State Plan change to reduce reimbursements. The fact that we have talked about this as part of a budget reduction is a bit problematic in terms of how the Ninth Circuit looks at rate reductions. If you like, a representative from the Office of the Attorney General (AG) will come and explain their view on this issue.

CHAIR LESLIE:
Do you need Senate Bill (S.B.) 54 to pass to accomplish this rate reduction?

SENATE BILL 54: Revises provisions governing the fund to increase the quality of Nursing Care. (BDR 38-44)

MR. DUARTE:
The Agency has been advised by legal council that passage of the bill is helpful for clarifying ambiguous language in the *Nevada Revised Statutes*. Senate Bill 54 has nothing to do with what has been going on in the U.S. Court of Appeals for the Ninth Circuit.

SENATOR HORSFORD:
There are three key issues that must be addressed regarding the proposed policy of reducing nursing home rates. First, we need a written opinion from the AG as to whether this creates a legal liability for the State. Second, there must be some analysis on the impact of reducing the nursing home rates, particularly in the rural facilities. This reduction may be significant enough to cause a reduction of bed units or may even force some facilities to close. If that occurs, what would the corresponding impact be on the local communities? In the rural areas, closing a facility could mean no service will be available in that area, and in the urban areas where more capacity is needed, this change could result in reduced capacity. Finally, it appears this is being done to meet a budget reduction target, not necessarily as good public policy.

CHAIR LESLIE:
Community-based programs and personal care attendants have historically been a safety net for helping elderly people stay in their own homes. If nursing homes close or reduce their beds, there will be a greater need for this type of help. As I recall, significant reductions have been proposed in community-based programs and personal care attendants. The Senate Committee on Finance has asked DHHS Director Mike Willden to assess this area.

MR. DUARTE:
It is my understanding Mr. Willden has prepared information on this to present during the next Work Session.

CHAIR LESLIE:
The last item on the agenda for discussion today is B/A 101-3178, the Nevada Check Up program. The Subcommittee is familiar with this program so we can start with the provider rate increases in decision unit M-101.

HHS-HCF&P – Nevada Check-Up Program — Budget Page DHHS DHCFP-23 (Volume II)
Budget Account 101-3178

M-101 Agency Specific Inflation — Page DHHS DHCFP-24

MS. CARRIGAN:
Refer to page 11 of Exhibit C. The primary increase in the Nevada Check Up budget is the projected 1.5 percent per year rate increase for the Health Maintenance Organization (HMO). This amount will increase even more in the budget amendment that is forthcoming. The primary reason for this increase is increased costs for dental coverage.

CHAIR LESLIE:
Is dental coverage required?

MS. CARRIGAN:
The CMS require us to pay an actuarially certifiable rate based on the actual expenditures of the HMO. While the actuary may be able to certify a range, it would be fairly narrow. We have worked with the actuaries in the Medicaid budget particularly, to put in certain trending assumptions with respect to reductions in expenditures such as utilization of the emergency room. For dental utilization in the Nevada Check Up to be actuarially sound, there had to be a rate increase as shown in this budget.

ASSEMBLYWOMAN CARLTON:
How many HMO contractors are there?

MS. CARRIGAN:
There are two statewide.

ASSEMBLYWOMAN CARLTON:
Are they paid the same utilization rate?

MS. CARRIGAN:
I do not know the answer to that. I will find out and report this information back to you.

CHAIR LESLIE:
Please discuss decision unit M-200. This is where most of the questions are.

M-200 Demographics/Caseload Changes — Page DHHS DHCFP-25

MR. DUARTE:
The Nevada Check Up caseload has been declining since 2007. The reasons vary, but the primary reason is associated with the downturn in the economy. Household income has been reducing, resulting in families who were eligible for this program to qualify for Medicaid. There has also been an outmigration of working families, particularly in Las Vegas. The Agency has seen a change in demographics in the population applying for this program as well as a decline in the total number of new applications. The Agency is projecting a nominal increase in the caseload for the next two years as shown on Page 12 of Exhibit C. An average of 22,042 individuals is projected for FY 2011-2012 and 22,944 for FY 2012-2013.

CHAIR LESLIE:
I am still unclear why an increase is projected for the next two years when the caseload has been decreasing since 2007.

MS. CARRIGAN:
These caseload projections were done some time ago when the initial agency request budgets were done. A new caseload projection, which is considerably lower, will be shown in the upcoming budget amendment. The fee for service and HMO will be higher, but the FMAP is also higher. All things considered, the Agency is expecting a reduction of General Fund expenditures in the Nevada Check Up budget amendment.

CHAIR LESLIE:
Please talk about the elimination of the nonemergency transportation program, decision unit E-652.

E-652 Program Limits or Rate Reductions — Page DHHS DHCFP-27

MS. CARRIGAN:
Currently, Nevada Check Up recipients receive nonemergency transportation as a covered medical service. The federal government does not require this. It is required for Medicaid but not Nevada Check Up. There has been very little utilization. The Agency has been paying a 20 percent administrative fee to a transportation broker to fund the little utilization that exists. Also, the transportation policy was revised to require people who are capable of taking

public transportation to take public transportation. Virtually, all the Nevada Check Up recipients would qualify for this. Given the cost of the program, the benefits simply are not there.

CHAIR LESLIE:
I will read through some of the other budget reductions. Many have already been discussed in previous Medicaid budget hearings. Decision Unit M-160 pertains to reductions in the anesthesia rates approved by the 26th Special Session.

M-160 Position Reductions Approved During Biennium — Page DHHS DHCFP-25

Decision unit E-691 is a 15 percent rate reduction for nonprimary care physicians. This affects 4,149 in-state and 1,792 out-of state providers.

E-691 Budget Reductions — Page DHHS DHCFP-29

Decision unit E-692 is a 15 percent rate reduction for outpatient hospital rates. This affects 38 in-state and 343 out-of-state providers.

E-692 Budget Reductions — Page DHHS DHCFP-29

Decision unit E-693 reduces physician assistants and nurse practitioners rates by 15 percent which includes professional medical services provided by physician assistants and nurse practitioners.

E-693 Budget Reductions — Page DHHS DHCFP-30

Decision unit E-694 reduces rates for dental service, durable medical equipment and disposable medical supplies by 25 percent. This impacts 528 in-state and 33 out-of-state dental providers and 457 in-state and 52 out-of-state durable medical equipment and disposable medical supplies providers. The specific concern here is whether there will be dental access issues in rural Nevada, in particular, as a result of this reduction.

E-694 Budget Reductions — Page DHHS DHCFP-30

MR. DUARTE:
Rural access to dental services has been a long-standing issue. The Agency is available and willing to work with clients if there are problems in accessing dental care and is open to looking at ways to provide incentives for providing dental services in rural Nevada. While CMS may allow incentives, the proposal is to make a statewide reduction in dental services for now.

CHAIR LESLIE:
Please expound further regarding the possibility of a rural incentive.

MR. DUARTE:
In some cases, CMS will allow a rural deferential. Some consideration may be given if we submit a proposal.

CHAIR LESLIE:
Are you preparing an overall plan or analysis to address the access issue in rural Nevada for Check Up clients?

MR. DUARTE:
Although we are reviewing access statewide for all provider types, we are not doing anything specifically centered around dental services in rural Nevada.

CHAIR LESLIE:
Decision unit E-651 decreases inpatient, specialty and psychiatric hospital rates by 5 percent. This impacts 39 inpatient hospitals, 13 specialty hospitals and 7 psychiatric hospital providers. From your viewpoint, what is the impact of this change to the recipients?

E-651 Program Limits or Rate Reductions — Page DHHS DHCFP-26

MR. DUARTE:
The reduction is fairly nominal. The Agency does not anticipate any problems with respect to access to services. The majority of the children in the Nevada Check Up program are covered by HMO services. The HMO contract requires services to be available through their network of providers.

CHAIR LESLIE:
Decision unit E-697 reduces rates for ambulatory surgical centers, ambulances, and end-stage renal disease by 15 percent. This impacts 67 in-state and 7 out-of-state ambulatory surgical centers, 40 in-state and 38 out-of-state ambulance providers and 42 in-state end stage renal disease providers.

E-697 Budget Reductions — Page DHHS DHCFP-31

This enhancement unit was already covered in the previous Medicaid budget discussions.

Please address decision unit E-681 regarding drug rebates.

E-681 New Revenue or Expenditure Offsets — Page DHHS DHCFP-29

MS. CARRIGAN:
Health care reform requires managed care organizations to get drug rebates and pass them through to the State. Currently, our managed care organizations do not do that. They negotiate discounts directly with the pharmaceutical companies. This change no longer allows them to get those up-front discounts. Although the Agency will get the drug rebates, we will have to increase HMO premiums to make up for the increased pharmaceutical costs HMOs will be experiencing.

CHAIR LESLIE:
There is not much we can say about this. We trust the Agency will negotiate the best possible rate in this area.

This concludes the Subcommittee's questions. We will now take public testimony starting with Las Vegas.

BRIAN M. PATCHETT (President and Chief Executive Officer, Easter Seals Southern Nevada):
I am here today specifically to discuss the reductions affecting those in supported living arrangements (SLA) and, in particular, intensive supported living arrangements. The magnitude of the reductions in services affecting this population is becoming increasingly apparent.

I can convey my concerns best by talking about the people we serve. Taylor is a child who was in a skilled nursing facility. She has sclerosis and significant behavior issues including self-abuse. Additionally, she has a seizure disorder and other intellectual disabilities. Until Taylor was placed in an intermediate care facility (ICF), she was unable to attend school. Taylor is now attending school, getting wonderful services and her self-abusive behaviors have reduced dramatically. When someone has the number of problems this young lady has had, there are not many options within the community to provide care. A 15 percent rate reduction may cause some of the SLAs and ICFs to close.

MARK INOUYE:
I am an ICF provider operating three facilities. In one location, we moved six children in wheelchairs directly out of a nursing home that was closing their children's wing into one of our ICF facilities. We take other clients with severe behavioral and health issues directly out of Desert Regional Center. These children are thriving in the ICF environment. The proposed 15 percent budget cut would severely hamper our ability to continue providing these services in the community.

RENNY ASHLEMAN (Nevada Health Care Association):
We may not agree with the State's view of the legal situation on rate reductions, but Mr. Duarte did a good job of summarizing the status of the lawsuit. I will not dwell on that, except to give you our opinion which may sound contradictory to our best interests. Please refer to our written analysis on the lawsuit (Exhibit D). If the State of Nevada is to undertake the reductions, the passage of S.B. 54 is needed to avoid adding another count to our lawsuit.

The largest concern is the impact on the nursing homes regarding access to care and quality of care. Please refer to the financial analysis of the impact of a $20 per patient day Medicaid rate reduction on nursing home providers in Nevada (Exhibit E).

Please refer to the summary showing the losses of 32 providers handling Medicaid (Exhibit F). Most of our facilities are currently losing money in handling Medicaid clients. This document does not show the overall loss to the nursing home, only the loss associated with Medicaid patients. As you can see, there was a shortfall in FY 2009-2010 before the rate reduction. After the rate

reduction, there will be extreme losses in many of the facilities. Some are over $1 million, some over $2 million, and at least one over $3 million. The total statewide loss is $27,881,863. This is not sustainable.

There are only a few things that can happen to deal with this kind of loss. The facility could close; some large facilities have indicated their intentions of closing. Rather than taking in pending Medicaid clients, facilities could slow the intake to wait for the Medicaid eligibility determination which makes it more difficult for the hospitals and increases costs to the State while the individuals are waiting in the hospital. Facilities may close beds. If there are any more reductions in available beds, there will be an access to care problem. Please refer to the hand-out, (Exhibit G), which gives information regarding current occupancy rates. The other thing that can be done is to reduce personnel costs by 15 percent which would affect quality of care and/or reduce the number of available beds because there would not be adequate staff to cover the beds.

In closing, please do not impose a Medicaid rate reduction on the nursing homes.

CHAIR LESLIE:
As there is no further business to come before the Subcommittee, this meeting is adjourned at 9:11 a.m.

RESPECTFULLY SUBMITTED:

Jackie Cheney,
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	Department of Health and Human Services, Division of Health Care Financing and Policy, Biennial Budget
	D	Renny Ashleman	Summary of U.S. Court of Appeals for the Ninth Circuit
	E	Renny Ashleman	Medicaid Rate Reductions Financial Analysis
	F	Renny Ashleman	Financial Impact to 32 Providers
	G	Renny Ashleman	Nursing Home Occupancy Rates