MINUTES OF THE
SENATE COMMITTEE ON FINANCE

Seventy-sixth Session
March 23, 2011

The Senate Committee on Finance was called to order by Chair Steven A. Horsford at 8:13 a.m. on Wednesday, March 23, 2011, in Room 2134 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to the Grant Sawyer State Office Building, Room 4412E, 555 East Washington Avenue, Las Vegas, Nevada. Exhibit A is the Agenda. Exhibit B is the Attendance Roster. All exhibits are available and on file in the Research Library of the Legislative Counsel Bureau.

COMMITTEE MEMBERS PRESENT:

Senator Steven A. Horsford, Chair
Senator Sheila Leslie, Vice Chair
Senator David R. Parks
Senator Moises (Mo) Denis
Senator Dean A. Rhoads
Senator Barbara K. Cegavske
Senator Ben Kieckhefer

STAFF MEMBERS PRESENT:

Rex Goodman, Principal Deputy Fiscal Analyst
Mark Krmpotic, Senate Fiscal Analyst
Madison Piazza, Committee Secretary

OTHERS PRESENT:

Charles Duarte, Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services
Renny Ashleman, Nevada Health Care Association
Charles Perry, President, Nevada Health Care Association
Daniel Mathis, CEO, Nevada Health Care Association
Andrew Clinger, Director, Department of Administration

CHAIR HORSFORD:
We will open the hearing on Senate Bill (S.B.) 54.

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

CHARLES DUARTE (Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services):
I have submitted my testimony (Exhibit C). Senate Bill 54 is known as the nursing home provider tax. This bill supports a decision unit in the *Executive Budget* that lowers the per diem rate paid to skilled nursing facility providers in the Medicaid program. It removes language that might be interpreted as restricting the State's ability to adjust nursing facility rates.

Nevada Revised Statutes (NRS) 422.3785 allows the creation of a Fund to Increase the Quality of Nursing Care, or the provider tax program. The language being deleted in section 4(a) states that the provider tax cannot be used to replace existing expenditures paid to nursing facilities. This language is ambiguous and open to the interpretation that NRS prohibits the State from lowering the rates paid to these providers. The language being deleted in sections 5(a) and (b) requires the State to restore rates to their 2003 level if the federal government prohibits use of provider tax funds to increase nursing facility rates. This language may be interpreted to mean the State cannot set appropriate rates based on current data and circumstances.

Senate Bill 54 has been submitted to clarify the intent of NRS 422.3785. The Governor's budget has attempted to reduce spending in a targeted manner in order to preserve essential services to Medicaid recipients. We understand that the issues associated with reducing reimbursements to any health care provider are serious and we know there are issues associated with potential access to care. We are willing to discuss options with providers and stakeholders that would provide equivalent savings to what is proposed in the Governor's budget. While we are willing to discuss alternatives, we want to make sure we do not harm other providers in an effort to save one group. The rate reduction proposed in the Governor's recommended budget is estimated to yield a State General Fund savings of $10,176,443 for the biennium.

There is a lot of controversy in the U.S. Court of Appeals for the Ninth Circuit. There has been much litigation, particularly in the State of California, regarding Medicaid reimbursement rates. The Ninth Circuit has made a decision that states and even the U.S. Solicitor General believe is incorrect. One particular case is going to the U.S. Supreme Court, primarily to look at the jurisdiction of a

provider suing the State. There are other issues and the Ninth Circuit has said that States must provide a study of access to care before they can reduce reimbursement rates. Unfortunately, the Courts did not provide any guidance as to what kind of access study has to be done. The Center for Medicaid and Medicare Services (CMS) has said it will come out with regulations for the states, telling them what kind of studies and benchmark reviews need to be done as a part of rate review. We do not know when that is going to be forthcoming, but have been told that draft regulations may be issued in April or May 2011, with a final regulation in the summer. We have data and have evaluated occupancy rates for nursing facilities. With approximately 80 percent occupancy statewide, 60 percent of licensed nursing home beds are occupied by Medicaid clients.

SENATOR LESLIE:
Since some of the rural hospitals have nursing homes to help fund the hospital, are you concerned that there will be an impact on those rural areas?

MR. DUARTE:
The rural hospitals have a bed type that is licensed as a distinct part of the hospital. Those types of nursing facility beds are not affected by this legislation which only affects freestanding nursing facilities.

SENATOR LESLIE:
Why did we establish the provider tax and what were the benefits to the State? Do you feel we are going back on an agreement we made with the nursing home industry?

MR. DUARTE:
The nursing home provider tax was implemented in 2003, after the State conducted a study with the nursing home industry in 2002. We were seeking to change the reimbursement method that had been in place for many years. As a result of that study, we determined that a reasonable rate needed to be paid. It was much higher than the base rate that we had established which was approximately $121 per bed day. In order to fund it, the nursing facility industry came to the Legislature in 2003 and presented legislation creating the provider tax fund, or the Fund to Increase the Quality of Nursing Care. That fund applied a fee across all freestanding nursing home beds, with the exception of Medicare beds. We were able to use that fee to augment reimbursement. Since 2003, rates have gone up by approximately 54 percent, so the current average rate is

about $187 per bed day. The match for the difference between our base rate of $121 and $187, or $66, comes from those provider fees which are distributed to facilities taking care of Medicaid patients.

The primary benefit to the State was that we did not have to come up with General Funds. We hope to work out some issues with the industry, in terms of how it is administered. We are incurring some expenses that require General Funds which were never intended for this program. We want to work with the industry to fix that methodology. The bottom line was that it helped us raise reimbursement rates to a level which is not only significantly higher than it was in 2002, but is also quite a bit higher than neighboring states.

SENATOR LESLIE:
If we drive rates down, I am worried that nursing homes will have to cut costs which could affect the quality of care. Are you concerned about that?

MR. DUARTE:
Yes, I am and have been for some time. We have created a "direct care floor" which establishes the bottom line at which direct nursing services need to be paid for out of our reimbursement. The Bureau of Health Care Quality and Compliances monitored problems with some of the facilities in Nevada. Despite significant increases in rates and establishing a direct care floor, there continue to be issues. Whether there will be more issues if we reduce the base rate by $20 per bed day, I cannot say. My hope is there will not, but it is possible that there may have to be some adjustments to labor costs. One of the things the industry discusses is that Nevada has one of the highest labor costs, primarily for nursing assistants, in the Western region. I am not sure if that is a supply-and-demand issue, but perhaps that is something the industry can look at as well. I do not want to tell them how to run their business, but we continue to be concerned about quality and hope to work with them on any issues related to this reduction.

SENATOR LESLIE:
If the additional 5 percent reduction results in services such as long-term care no longer being offered, is there enough capacity in rural Nevada? If some of the rural hospitals stop providing long-term care, there may not be an incentive for a private facility to develop that service in rural Nevada and these people may be forced to leave their community. Have we assessed that?

MR. DUARTE:
I want to make a distinction between the hospitals that are affected by the 5 percent rate reduction and those that are not. In rural Nevada, we have private hospitals, such as Banner Churchill Community Hospital and Northeastern Nevada Hospital and Medical Center. There are a number of private hospitals that would be affected by the rate reduction, but I do not think they have any "distinct part" beds, or nursing facility beds. I believe it is the public rural hospitals that have nursing beds. Those public hospitals are reimbursed on a cost basis. We reconcile with them at the end of the year and pay them their cost.

SENATOR LESLIE:
Those hospitals are operating on a thin margin right now. It is not just the 5 percent reduction and cash flow issue. Do we have a planning tool for determining the number of people likely to need long-term care in the rural areas and where they might go?

MR. DUARTE:
We would have to work with the industry. Much of this will be determined at some point in the future. Facility administrators are going to have to determine whether they can stay in business. You have been presented with information from a number of facilities saying they will close, primarily in urban areas. I think we have to wait to see what happens, because I am not sure that those actions will be taken. My assessments are what current business is happening in Nevada for Medicaid. If business was bad, 60 percent of the 80 percent occupancy rate would not be in nursing home beds.

SENATOR LESLIE:
I understand what you are saying, but if that happens, the people who will suffer are the vulnerable elderly who have to leave their community. I think it bears watching closely.

CHAIR HORSFORD:
Please provide a list of those rural facilities that may be impacted by this policy, by location.

MR. DUARTE:
We will do that. The Department of Health and Human Services (DHHS) has done a good job of providing alternatives to nursing facility care, primarily with

home- and community-based services. We have managed to keep our facility census to 3,000 Medicaid clients since 2002. We will be stretched given the budget reductions, basically holding the current home- and community-based program static. We have staff and trained personnel and are available to work with the industry to find alternatives, assuming some people can be placed in the community. Oftentimes, it is difficult for long-term residents to be placed back in the community. Facilities cannot just close and abandon clients; they must provide a placement plan that is safe and reasonable for clients before they can discharge them. If that were to occur, we would be happy to work with the industry.

RENNY ASHLEMAN (Nevada Health Care Association):
I have submitted a memo to Charles Perry from Joseph Lubarsky, President, Eljay, LLC (Exhibit D) and a memorandum to Charles Perry from Lionel Sawyer & Collins (Exhibit E). Quality of care is a great concern to all of us. We are currently working with DHHS to hold a series of seminars that address the types of violations of quality of care that most frequently occur. This is a new program which started on March 17, 2011. Because of our turnover, this will be a repeated series. When we first adopted the provider tax, the quality of care issues diminished significantly and allowed for the hiring of more personnel. We have not had a raise, so to speak, since 2003. Medical inflation has impacted our ability to keep personnel and the quality of care is not as good now as it once was. We are working actively with the Division of Health Care Financing and Policy to see what can be done in that regard.

We have provided you with considerable detail. The losses in the industry due to this reduction will be significant. The bottom line is that few of our facilities are currently profitable. With these reductions, there is nowhere to go. If you are going to reduce costs by staff reduction, the average impact to the facility will be a reduction of 15 percent of the full-time employees of a facility's workforce. This will have adverse impacts. There are only so many things that can be done to react to these problems. They could close the facility. Currently, between two and five facilities have informed us that they intend to close. They can slow admission by insisting people have a pay source before they are admitted. Currently they admit the people and qualify them as they go along. At any given time, approximately 10 percent of the occupants are in the qualification process. I have been involved in the "slow admissions" process. It is expensive for the hospitals and can be expensive for the State. The estimated $10 million savings might end up being lost because it is more expensive to

keep a person in a hospital than in a nursing home. The losses this would generate would be about $500,000 per facility on average. Some facilities would lose approximately $1.5 million.

The rural hospital beds may get their costs, but we have not received our cost, even with the provider tax. Some facilities are cheaper to run than others and approximately 16 percent are able to make money on that rate while the rest do not. They make it up with their private pay and Medicare.

Exhibit E is a legal brief. The appeal that Mr. Duarte spoke about will not take up what is called the "subsidy issue." The subsidy issue is how you go about creating a reimbursement study that passes the Ninth Circuit's scrutiny. If the U.S. Supreme Court rules adversely to the providers, we would have to go to State court. We could still rely on the Ninth Circuit's discussion of the issues and its interpretation of the law. The brief shows that we are confident that the State has not, as of yet, conducted the studies to justify this cut. Unfortunately, you cannot do the study retroactively. Once you have announced you are going to do this for budgetary reasons, you cannot go back. We are comfortable with the result of the lawsuit which makes trying to save about $10 million and costing us about $23 million even more questionable.

CHAIR HORSFORD:
I would like to review two items. First, please highlight the impact to those facilities that are already marginal and what this would do to them. Second, the Ninth Circuit case is troubling and I do not want to do anything that would put the State at risk of a lawsuit with other states. I would like to give Mr. Duarte a chance to respond to that further.

MR. ASHLEMAN:
Our studies show a substantial number of our facilities are being subsidized nationally or regionally. Some are relying on reserves or cash infusions from local owners. Up to now, others have been all right, but the studies we have show that they are currently in dire straits.

California is not the only state that has been involved in the Ninth Circuit case. Others, including Oregon, are also involved. I disagree that the Ninth Circuit has not provided guidelines. While they may not have provided specific guidelines for what does work, they have provided guidelines for what does not work. It is clear that what the State of Nevada is doing currently does not work. They did

not make this cut after doing a study to find out they did not need to provide this service, they made the cut for budgetary reasons. It is our opinion that the U.S. Supreme Court will not take up this issue on appeal. It is accurate that the federal government is studying the issue and trying to issue its own guidelines. We are not sure what this will do to the Ninth Circuit decision.

CHARLES PERRY (President, Nevada Health Care Association):
I would like to address the rate methodology that Mr. Duarte spoke about. When the new rate methodology was discussed, the Nevada Health Care Association hired a nationally known consultant, Joe Lubarsky, to work with us on the development of the rate methodology. He represented BDO Seidman and is highly qualified and recognized as a national authority on skilled nursing facility reimbursement. Mr. Lubarsky is also very knowledgeable on provider taxes as a certified public accountant. Since that time, Mr. Lubarsky and the State's consultants, Meyers and Stoffard, have developed a long-standing professional relationship. When Mr. Lubarsky's numbers are presented, they are generally accepted by the State as being accurate and correct. Every year, Mr. Lubarsky provides a study on Medicaid reimbursement to the American Health Care Association. Every state's Medicaid rates are examined for adequacy to determine whether there is a deficit in the reimbursement relative to cost. The latest figures we have from Mr. Lubarsky go back to 2010. At the time that he did this study, the proposal to reduce rates by $20 per bed day was not on the table. At that time, the nursing home industry, in aggregate, was losing approximately $11,903,803 a year. If you add a reduction of $20 per bed day to that number, it will bury some facilities. The facilities will not be able to operate and care for Medicaid patients with that deficit.

We do not want to turn people away; it does not meet with our mission. The only legitimate reason for denying a person admission is if you cannot meet the needs of the individual. Courts have held that the facility enters into an implied contract with an individual when agreeing to admit them, stating that they have the ability and will be able to meet the needs of that individual in that facility. If facilities do not have the financial resources, they will not be able to meet the needs of several patients.

The facilities do not want to close their doors, but if the State does not have the money to provide, the facilities will not have any other options.

DANIEL MATHIS (CEO, Nevada Health Care Association):
I would like to give you the perspective of an operator. As of a little over a year ago, I have had nine buildings in multiple states. The process the providers must go through once the rates are set is to review the revenue and decide how their building will move forward. Some buildings with a higher Medicare census may be able to survive, but a majority of the buildings that have mostly Medicaid clients will lose the ability to stay in compliance. In order to make the 15 percent staffing cuts that would be required, facilities will no longer be in compliance which is a risk that many providers are not willing to take. They will try to bring in other pay sources, but without the labor it will be very difficult. Through the Quality First educational series, we are working on compliance with Wendy Simmons, Chief of the Bureau of Health Care and Quality Compliance. We are trying to reduce the number of tags in each skilled nursing facility. Working with providers, if they have a reduction in their reimbursement, that transfers into a reduction in labor. If that is the case, the facility will have to make a decision to either try to stay in compliance with fewer people, or they may decide that the risk is too large and may limit access or change the use of those beds.

CHAIR HORSFORD:
Has the industry evaluated what the overall impact of closing facilities or shifting beds to another purpose would be? Since we do not have adequate capacity now, what would happen if facilities and/or beds were closed?

MR. MATHIS:
Nursing home admission has changed over the years because the average length of stay is much shorter. The effect would be to limit the admissions to a facility which would create a backup of Medicaid clients in acute care waiting for discharge to a nursing home. It would disrupt the flow of continuum care.

CHAIR HORSFORD:
I am looking for more empirical data. What is the current bed occupancy rate? If some of these facilities closed, what corresponding impact would that have in the industry?

MR. PERRY:
Although Mr. Duarte mentioned 80 percent occupancy, we do not agree with that number and I do not think the numbers indicate that. Vacancies in our facilities are due to a shortage of personnel because of the lack of interest in the

field of work and that causes facilities to reduce their capacity. Skilled nursing facilities are the relief for the acute care hospitals. Every payer of hospital care, from Medicare to smaller providers, puts pressure on the hospitals to get patients into a lower level of care as soon as they possibly can. Lower level of care only means that it costs less to keep the patient in a skilled nursing or rehab facility than in the hospital. If the hospitals cannot get those patients out, then they are backed up in the hospital which affects the entire community. The Hospital Association is also looking into this. I do not know if we have empirical studies, but we have reviewed it from an operational standpoint. We are not willing to take the risk of being unable to provide the care that somebody needs. It leads to legal risk and citations from the State and federal government, both of which can have financial implications and can lead to a loss of reputation in the communities.

MR. DUARTE:
With respect to the capacity issue, our data states that there is approximately 20 percent capacity of unoccupied licensed beds. That is self-reported data from the industry. If it is not accurate, I would be happy to work with the industry and the facilities that provide us that information to get more accurate data. What Mr. Perry spoke about is correct, but we do not know how many beds have been made unavailable due to staffing shortages or other reasons.

With respect to the Ninth Circuit case, I disagree with Mr. Ashleman that the Courts provided a roadmap for states to develop these access studies. We were well aware of these cases one year in advance of the development of our budget. The Ninth Circuit case does not only affect skilled nursing facilities, but it affects all provider rate adjustments in the states involved. That being said, if the Courts had provided a roadmap to the states, my colleagues and I would be doing those studies. All the states involved have been pleading with CMS to tell us what they believe is reasonable. Whether or not that meets the Courts' standards is unknown.

CHAIR HORSFORD:
Did you solicit an opinion from the Attorney General (AG) of this policy based on the issues in the Ninth Circuit?

MR. DUARTE:
Yes, I did.

CHAIR HORSFORD:
Why are they not here to defend you and provide perspective on this case? I would like to hear the legal aspect of this from those who have analyzed it from that perspective.

MR. DUARTE:
I would be happy to ask them to come in and speak to the issues. I am speaking from an operational standpoint.

CHAIR HORSFORD:
Did they give you formal opinion?

MR. DUARTE:
It was informal.

CHAIR HORSFORD:
Informal opinions can change. I need to hear from someone who has evaluated it and reviewed case law. This is a big issue and there are implications which involve more than just the State of Nevada. If the U.S. Supreme Court agrees with the Ninth Circuit, what will happen then?

MR. DUARTE:
All the states would be in the same predicament.

CHAIR HORSFORD:
We do not want to put ourselves there prematurely.

MR. DUARTE:
I will ask a representative from the AG's office to speak to the matter.

Finally, I would like to point out that skilled nursing facilities are not the only safety net for acute care medical hospitals. The Department has been able to keep our nursing home census for Medicaid clients flat, at 3,000 individuals, since 2002. That is predominantly because we have dramatically increased spending, not just in home- and community-based waiver programs, but also in other Medicaid services, especially personal-care attendant services. When I first started in this job, we were spending approximately $2 million a year on personal-care attendant services. We are now spending about $80 million a year. Many of those individuals would be in a nursing home if it were not for

those services. One of the problems rate reductions presents to states is that we have no alternatives for managing our budgets. That puts all the states in a bind because the alternatives that we do have are eliminating optional Medicaid services, such as personal care or pharmacy. There are not many that could create enough savings. The way the federal law is structured, services cannot be cut individually. They must all be eliminated or all be provided according to a legal standard called comparability in Medicaid law. The federal government has taken away much of the flexibility in managing Medicaid. When we evaluated our budgets, this was the least onerous option.

MR. PERRY:
To respond to Mr. Duarte's comment on average occupancy, I was not trying to cast doubt on his information. Facilities do self-report their occupancy to the Division every month. That information is online for everyone to see. It reports the occupancy of the facilities and all of the categories of patients we have in the facilities: Medicare, Medicaid, private pay and other. They report their data based on the number of licensed beds they have available. When you take beds out of service, you report it based on the licensed capacity of your building. Perhaps we need to indicate that we have taken beds out of service. They do not want to give up those beds, because giving up licensed beds means that they will eventually have to go back through the process of getting those beds reinstated. I do not think we are that far apart in what we are talking about. We are coming at it from two different angles.

CHAIR HORSFORD:
First, before any action is taken on this bill, I want to hear from the AG. If I do not hear from them, I will not process the bill. Second, I would like to ask the industry to meet with Mr. Duarte on the self-reporting issue. Third, I would like information on the facilities in the rural areas because I am concerned that if they go away, no care will be available. I would also like information on the urban facilities in regards to the nuance of licensed beds and what the reduction in capacity could be if the reduction of $20 per bed day were approved.

MR. ASHLEMAN:
We will also see if the facilities will permit us to share the data on their individual financial situations with the Division. I did not mean to imply that Mr. Duarte had not made an effort to find out, I was simply saying that what they have done does not comply with what the Ninth Circuit has forbidden.

SENATOR LESLIE:
Mr. Duarte discussed the personal-care attendants and the home- and community-based waiver programs and how they have been trying to keep people in their homes whenever possible. Recalling our budget subcommittee hearing on aging, I know that the St. Mary's Regional Medical Center personal-care program has been eliminated and I do not know how we are going to replace that. I am concerned about the waiver program which is pretty flat. I would like a report regarding the capacity that we have to do that. I agree it is a great alternative, but I do not think the budget for the next biennium is set up to accomplish that. I am concerned with maintaining what we have now. If the nursing homes go out of business and have more people, I do not see how we will be able to absorb them with the budget we have.

CHAIR HORSFORD:
Once we receive responses on those requests, we will determine whether to bring that bill back. We will close the hearing on S.B. 54. We will open the hearing on S.B. 73.

SENATE BILL 73: Makes various changes concerning state financial administration. (BDR 31-427)

ANDREW CLINGER (Director, Department of Administration):
There are two primary issues in S.B. 73. The first issue is the ability of the Board of Examiners to delegate certain authority to a person designated by the clerk of the Board. The second issue deals with the criteria for the revisions of work programs and Interim Finance Committee (IFC) authority.

Sections 1 and 3 of the bill deal with the delegation authority of the clerk to designate a person to approve Stale Claims Account or statutory Contingency Fund requests. Section 1 specifically deals with stale claims and would allow the clerk of the Board to designate the authority to approve stale claims. Section 3 would allow the clerk of the Board to delegate certain authority for statutory contingency claims. As the clerk of the Board, I currently have the authority to delegate on contract approval under $10,000 and I have delegated that to four individuals who approve those contracts on my behalf. I would like the same authority for stale claims as well as statutory contingency claims. It has to do with the volume of work related to processing these two items.

Sections 2, 4 and 5 deal with the thresholds for approving work programs. Section 2 deals with the dollar thresholds. Section 4 deals with gifts and grants. Section 5 deals with block grants. Page 3, line 8 strikes out the current language that establishes the criteria for the approval of work programs. What we are asking for in place of that language starts on page 3, line 16. This is a joint recommendation from the Senate Fiscal Analyst, the Assembly Fiscal Analyst and me. We would come up with the criteria for approval of work programs and that criteria would then have to be approved by both the Board and IFC. This would give us some flexibility on dealing with changes. For example, a few years ago we had an AG opinion dealing with the thresholds on work program approval. One of the unintended consequences of that opinion is that we now send balance forward work programs to the IFC for approval. These are work programs that have already been approved in a previous year and the Agency is simply asking to balance that authority forward. Prior to the AG opinion, Staff and I had agreed that those did not require IFC approval. Based on the strict interpretation of the AG opinion, we now send those to IFC. If we were able to collectively identify the criteria for approval, with the Board and IFC approval, we could react quickly to those types of changes as opposed to waiting every two years for a recommended change.

Section 6 of this bill changes the criteria for approval when positions move from one occupational group to another. Section 6 eliminates the IFC approval requirement for moving positions from one occupational group to another. The logic behind this is the Department of Personnel reviews job functions and duties and makes a recommendation on the duties a person is actually performing based on the classified system we have in the State.

CHAIR HORSFORD:
What authority has currently been granted to the clerk to approve the payment of these Stale Claims Account and Contingency Fund allocations?

MR. CLINGER:
The clerk of the Board approves all Stale Claims and all Contingency Fund requests.

CHAIR HORSFORD:
Under this proposal, to whom would you delegate any or all of that authority?

MR. CLINGER:
I would delegate that authority to the four individuals to whom I have delegated authority for contracts under $10,000. They are my three supervising analysts as well as my deputy director.

CHAIR HORSFORD:
What is the rationale for this policy change at this time?

MR. CLINGER:
The rationale is the volume of work and signing claims. I literally have to go through a stack of claims and sign them. It does not seem like the most efficient use of my time. My staff reviews them and makes recommendations to me for approval, so I would simply be delegating this to a supervisory level allowing them to approve them.

CHAIR HORSFORD:
Section 6 of the bill removes the prohibition against certain agencies changing the position from one occupational group to another. How would that be handled, operationally?

MR. CLINGER:
Section 6 deals with the cases in which a change in funding is not required. If a change in funding is required, then we have to approve a work program. The intent in section 6 is that the State Department of Personnel reviews classification change requests from State agencies or from employees. Their recommendation is made on the basis of their review of the duties that the position is performing. Any changes from one occupational group to another are based on that review.

CHAIR HORSFORD:
I will close the hearing on S.B. 73.

Mr. Clinger, please provide responses on budget amendments.

MR. CLINGER:
We are processing budget amendments that do not have an impact on the General Fund. Budget amendments that have an impact on the General Fund require some sort of offset to pay for them if they are requesting an addition in

General Fund appropriations. I do not have a way to submit budget amendments and also identify a way to pay for them.

CHAIR HORSFORD:
Why are you not submitting budget amendments with cuts to other places?

MR. CLINGER:
We are waiting until we receive additional data on caseload. We should receive that data next week as well as information on the revised revenue forecast.

CHAIR HORSFORD:
Some of the amendments are innocuous and should not be holding up subcommittee review. We are being delayed due to the fact that your budget is not balanced and you are waiting for additional data.

MR. CLINGER:
I am happy to work with Fiscal Division Staff on submitting those budget amendments, knowing that we will not have an offset for them as of the time that we submit them, but that we will later on. It is not my intent to hold up the work sessions.

MARK KRMPOTIC (Senate Fiscal Analyst, Fiscal Analysis Division, Legislative Counsel Bureau):
We have work sessions beginning the week of March 28, 2011, to April 1, 2011, and the subcommittees will start closing budgets the first week of April 2011. Where some of these amendments may be more involved, it is important for the subcommittees to be aware of them and in some cases hold a hearing or discussions with the agency in cases where they might involve a more substantive change to the budget. Staff can work with Mr. Clinger to identify some of the outstanding budget amendments and to identify a timeline where we can get those prior to the hearings.

SENATOR DENIS:
I spoke with the director of the Department of Business and Industry regarding an ombudsman for minorities. He spoke about some cost allocations. Will there be a budget amendment for that?

MR. CLINGER:
We are working on that. That is an item we are committed to changing. I have not talked with Director Johnson since that hearing, but I will follow up with him.

SENATOR DENIS:
I want to make sure we get that budget amendment.

CHAIR HORSFORD:
At a minimum, we are going to get them, even though you cannot pay for them. In April 2011, when it is time to close the budgets, we will not be able to do that unless there is something we do not know about today. Waiting until May 2011 is not fair to the Legislative process, but you guys are persistent on that. At a minimum, we need to get amendments and make notations regarding the fact that you do not yet have a plan to pay for them.

MR. CLINGER:
We are happy to work with Staff to accommodate the timing of these closings and try to include these adjustments that need to be made.

MR. KRMPOTIC:
As of March 31, 2011, the subcommittees will have heard all of the budget accounts for the first time.

CHAIR HORSFORD:
There is still a lot of work to do. The subcommittees are critical to refining the key decision units. I will be meeting personally with each of the chairs of the subcommittees in advance and after the work sessions. Staff needs us to make these decisions so we are prepared to move the process to the next step. The further we delay decisions, the further we are from our goal of having a balanced budget by June 6, 2011.

Seeing no further business, we will adjourn at 9:24 a.m.

RESPECTFULLY SUBMITTED:

_____
Madison Piazza,
Committee Secretary

APPROVED BY:

_____
Senator Steven A. Horsford, Chair

DATE: _____

EXHIBITS			
Bill	**Exhibit**	**Witness / Agency**	**Description**
	A		Agenda
	B		Attendance Roster
SB54	C	Charles Duarte	Testimony
SB54	D	Renny Ashleman	Memo from Joseph Lubarsky, Eljay, LLC
SB54	E	Renny Ashleman	Memorandum from Lionel Sawyer & Collins