MINUTES OF THE JOINT MEETING
OF THE
ASSEMBLY COMMITTEE ON WAYS AND MEANS
AND THE
SENATE COMMITTEE ON FINANCE

Seventy-Seventh Session
April 12, 2013

A joint meeting of the Assembly Committee on Ways and Means and the Senate Committee on Finance was called to order by Chair Maggie Carlton at 8:13 a.m. on Friday, April 12, 2013, in Room 4100 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. Copies of the minutes, including the Agenda (Exhibit A), the Attendance Roster (Exhibit B), and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at nelis.leg.state.nv.us/77th2013. In addition, copies of the audio record may be purchased through the Legislative Counsel Bureau's Publications Office (email: publications@lcb.state.nv.us; telephone: 775-684-6835).

ASSEMBLY COMMITTEE MEMBERS PRESENT:

Assemblywoman Maggie Carlton, Chair
Assemblyman William C. Horne, Vice Chair
Assemblyman Paul Aizley
Assemblyman Paul Anderson
Assemblyman David P. Bobzien
Assemblyman Andy Eisen
Assemblywoman Lucy Flores
Assemblyman Tom Grady
Assemblyman John Hambrick
Assemblyman Cresent Hardy
Assemblyman Pat Hickey
Assemblywoman Marilyn K. Kirkpatrick
Assemblyman Randy Kirner
Assemblyman Michael Sprinkle

ASSEMBLY COMMITTEE MEMBERS EXCUSED

Assemblyman Joseph M. Hogan

SENATE COMMITTEE MEMBERS PRESENT:

Senator Debbie Smith, Chair
Senator Joyce Woodhouse, Vice Chair
Senator Moises (Mo) Denis
Senator David R. Parks
Senator Pete Goicoechea
Senator Ben Kieckhefer
Senator Michael Roberson

STAFF MEMBERS PRESENT:

Cindy Jones, Assembly Fiscal Analyst
Mark Krmpotic, Senate Fiscal Analyst
Jeffrey A. Ferguson, Senior Program Analyst
Heidi Sakelarios, Program Analyst
Anne Bowen, Committee Secretary
Cynthia Wyett, Committee Assistant

Heidi Sakelarios, Program Analyst, Fiscal Analysis Division, Legislative Counsel Bureau (LCB), said the first work session item was a Division of Health Care Financing and Policy (DHCFP) issue pertaining to the Federal Medical Assistance Percentage (FMAP). Ms. Sakelarios reminded the Committees that FMAP was the federal part of the Medicaid costs that were shared between the federal government and the state. The FMAP was calculated using a three-year average of the state per capita income compared to the national average.

Ms. Sakelarios explained that no state could receive an FMAP of less than 50 percent or more than 85 percent. The Executive Budget included a preliminary FMAP projection of 63.54 percent for fiscal year (FY) 2015. Recently, the Federal Funds Information for States (FFIS) published updated information on the projected FMAP rates for FY 2015: according to FFIS's projections, Nevada would receive an increase in its FMAP rate to 64.18 percent.

Ms. Sakelarios noted that the FMAP rate continued to be a projection until the fall of 2013 when the federal government released its final rates.

Ms. Sakelarios said the decision would be whether to approve the revised FMAP rate for FY 2015, which was projected to increase to a rate of 64.18 percent compared to 63.54 percent used in The Executive Budget, based on the revised information published by FFIS.

Senator Kieckhefer asked about the dollar figure of the increase and Ms. Sakelarios replied that based on the information received from the Division of Health Care Financing and Policy (DHCFP), it was not possible to separate out the difference attributed solely to the FMAP rate. The information received from the Division rolled together FMAP changes with caseload changes and cost per eligible revisions for Medicaid.

Assemblyman Eisen commented that the FFIS had been a reliable source over the years, and it was reasonable to use the projected rate of 64.18 percent in calculations for the biennium.

Ms. Sakelarios said the next item for the Committees' consideration was the revised caseload projections for Medicaid and Nevada Check Up. During each legislative session, the Division historically reran the caseload projections in March, taking advantage of more current data available, based on the actual caseload data through February.

The Governor's recommended budget projected the average monthly caseload for Medicaid resulting from historical or natural caseload growth as 313,388. The revised projection reduced the estimate to 310,943 per month, which was a decrease of 0.78 percent for FY 2014. Ms. Sakelarios said in FY 2015, the revised caseload reflected a reduction of 1.53 percent.

Ms. Sakelarios said according to the preliminary estimates provided to the Fiscal Analysis Division by the DHCFP, it appeared that the General Fund reduction for FY 2014 would total $2.2 million and for FY 2015, $8 million.

For decision unit Maintenance (M) 740 in budget account (BA) 3243, which was the implementation of the Affordable Care Act (ACA), the caseload projections were being reduced by 2.19 percent in FY 2014 and 2.78 percent in FY 2015. Decision unit M-741 included children currently eligible for Nevada Check Up who would become eligible for Medicaid because of the ACA. Ms. Sakelarios said that caseload was projected to increase by 0.03 percent in FY 2014 and by 0.97 percent in FY 2015. In decision unit Enhancement (E) 740, the expansion of Medicaid, the caseload was projected to decrease by 1.92 percent in FY 2014 and by 3.39 percent in FY 2015.

Assemblyman Sprinkle wondered what had led to the revised projections.

Ms. Sakelarios said that when The Executive Budget was prepared, the agency had actual caseload data through October of that calendar year. When caseload projections were revised in March, data was provided from October to February, and occasionally the actual caseload data affected projections for the upcoming months and years.

Chair Carlton said she was going to take this opportunity to ask how recipients would be managed with the ACA. There had been some discussion about what the coverage between Medicaid and insurance was called and how that affected the projections.

Michael J. Willden, Director, Department of Health and Human Services, commented that eligibility for Medicaid would be based on the modified adjusted gross income (MAGI) rules and persons under 138 percent of federal poverty level (FPL) would be Medicaid-eligible. Persons above 138 percent of FPL could enter the Silver State Health Insurance Exchange marketplace and purchase insurance.

Mr. Willden stated that approximately 61 percent of Medicaid recipients were in managed care organizations. Projections indicated that the percentage of persons in managed care would increase from approximately 61 percent to the low- to mid-80 percent range. Mr. Willden said the "churn issue" was something that the agency was working on with the Silver State Health Insurance Exchange: if a person was Medicaid-eligible, there would be a one-year certification based on MAGI. Mr. Willden hoped to minimize churn and believed the simplified eligibility rules, the MAGI test, and the elimination of asset-testing should help streamline the process.

Chair Carlton asked whether there would be federal guidelines regarding "significant" change and how Medicaid recipients would be informed about what significant change was so they did not stay on Medicaid when they should not.

Mr. Willden explained there was a plus or minus 10 percent rule being discussed, and if a Medicaid recipient's income did not fluctuate by more than 10 percent, it would not be considered significant change. There had been ongoing rule-making processes and instructions from the federal government, but Mr. Willden did not have a specific federal definition of "significant change."

Steve Fisher, Deputy Administrator, Program and Field Operations, Division of Welfare and Supportive Services, DHHS, stated that if there was a significant difference between a recipient's MAGI and reported income, that would be a significant change.

Chair Carlton noted that Nevada had many seasonal workers, and she was concerned that a worker could make quite a bit of money for a few months, but then lose the income. She had concerns about how often a recipient's income would be evaluated and whether there would be an appeal process.

Mr. Fisher stated there was a one-year redetermination period. If a person was eligible for Medicaid, after one year the Division would redetermine that eligibility. However, if within that one year the recipient had a significant change in income, it was supposed to be reported, and at that point the Division could reassess the case. Mr. Fisher said seasonal workers, who sometimes worked and other times did not, posed a problem that the Division currently handled.

In response to a question from Chair Carlton, Mr. Fisher stated there was an appeal process for Medicaid recipients. Every eligibility determination required a notice to the recipient providing an outline of the recipient's rights, including the right to appeal a determination.

Mr. Willden explained that the appeals process contained three levels. The first level was to request a conference with the caseworker to mediate the situation, and if that was not satisfactory, the next step was to request a formal hearing before a hearing officer to adjudicate the difference. If the recipient was still not satisfied, he always had the right to appeal to district court.

Senator Kieckhefer wondered why there was going to be such a significant increase in managed care.

Mr. Willden replied that the increase was primarily related to the Medicaid expansion. Currently, managed care through Medicaid handled mostly families, while the aged, blind, and disabled were not in managed care organizations. The design for the expansion included a significant percentage of childless adults. Mr. Willden said that was primarily the cause of the increase in managed care caseload.

Mr. Willden commented that the Division had applied for the Section 1115 Demonstration Waiver from the federal government to continue to instill additional care-management principles into the Medicaid process. He noted that

by the end of the next biennium, projections showed 80 to 85 percent of recipients would be in managed care programs. He said he was referring to formal managed care assigned to Amerigroup or Health Plan of Nevada (HPN). Referring to the other 20 percent of recipients, Mr. Willden said the Division was attempting, through waiver processes, to apply additional care-management principles to those cases.

Senator Kieckhefer asked whether there was any indication where the waiver was in the federal process.

Mr. Willden said the Division had been working on the Section 1115 Demonstration Waiver for 18 months: Governor Sandoval had been in Washington D.C. in November 2012 and had attempted to get a decision. The latest letter from the Centers for Medicare and Medicaid Services (CMS), received three days ago, promised a July 1, 2013 decision.

Assemblyman Hickey remarked that there had been accounts in the press about delays in starting the ACA, and he assumed that was because states had bought in late, or had various other problems. He wondered whether Nevada, since it had opted in early with the Silver State Health Insurance Exchange (SSHIX), was going to be affected by possible delays in the implementation.

Mr. Willden said Nevada had made an early decision, and legislation was passed to create the Silver State Health Insurance Exchange. Mr. Willden stated that the SSHIX director, Jon Hager, and his staff were doing a wonderful job, and open enrollment would begin in October. The Division of Welfare and Supportive Services staff, with the SSHIX staff, were automating the eligibility engine and what Mr. Hager called the Business Operations Solution (BOS) system. Medicaid enrollment would begin in January 2014. While the state portion seemed to be moving smoothly, the federal part was moving slowly to provide some of the final rules. Mr. Willden said every week new rules were issued by the federal government. The other unknown was the federal hub, which was a significant interface between all states, Medicaid agencies and their exchanges, and the federal government to manage data. Mr. Willden said currently the federal hub had not been tested.

Mr. Willden summarized that there were substantial unknowns, but he believed the state was on the right path to completion of the program.

Assemblyman Aizley commented that it appeared there would be many new positions available and asked what the plans were for hiring for those positions.

Mr. Willden stated that most of the requested positions were in the Division of Welfare and Supportive Services budget. He said originally 450 positions had been requested, but that figure had been revised to approximately 410 positions. Mr. Willden said the Department was working with the Division of Human Resource Management to arrange the recruitments. The Department was also working with the Department of Employment, Training and Rehabilitation (DETR) and the local workforce boards to help identify and recruit new employees. It would be a significant challenge to bring that many employees into the Department. Additionally, the DHHS was a 5,000-person organization, which had an 8 percent to 10 percent vacancy rate every day. Mr. Willden said with the current 400 to 500 vacancies every day that were being recruited, and the 410 new positions requested, the Department would have to fill 700 to 800 positions quickly.

Chair Carlton asked whether there were any other questions from the members of the Committees and, seeing none, moved to Nevada Check Up.

Ms. Sakelarios explained the summary of the revised caseload projections and expenditure projections for Nevada Check Up. The M-200 decision unit, which was the standard caseload growth anticipated, reflected an increase of 2.77 percent in fiscal year (FY) 2014 and an increase of 4.02 percent in FY 2015. The caseload numbers reflected the average monthly caseload.

Ms. Sakelarios said the M-740 decision unit projected a reduction in the caseload of 5.21 percent in FY 2014 and 0.75 percent in FY 2015.

Decision unit M-741, concerned children currently eligible for Nevada Check Up who would become Medicaid-eligible. That caseload was projected to increase by 2.07 percent in FY 2014 and by 3.41 percent in FY 2015.

Ms. Sakelarios said when comparing the amounts included in The Executive Budget with revised expenditure projections for caseload, it appeared that there was a reduction of approximately $340,000 in FY 2014 and approximately $160,000 in FY 2015.

According to Ms. Sakelarios, the Fiscal Analysis Division received a formal budget amendment regarding the caseload changes; however, it was not received until April 8, 2013. She said current Fiscal Analysis Division estimates did not necessarily agree with that amendment.

Assemblyman Eisen said he understood there had not been time for the Fiscal Analysis Division staff to go through the budget amendment, but

wondered whether Mr. Willden had some idea of what the budget amendment was changing.

Mr. Willden stated there had been some "fine tuning" to get the final budget amendments in a formal, transmittable document, but it was his opinion that the numbers would not change significantly. There had been approximately $78 million worth of savings identified as well as approximately $75 million in proposed expenditures.

Chair Carlton asked for other questions from the Committees and, seeing none, moved on to the next discussion.

Ms. Sakelarios said the next item included for work session pertained to the Nevada Comprehensive Care Management Waiver, also called Section 1115 Demonstration Waiver by the federal government, which was discussed earlier. The Governor's recommended budget included three new positions that would be established effective October 1, 2013, to implement the waiver. As Mr. Willden had previously testified, the agency was still waiting for approval from the Centers for Medicare and Medicaid Services (CMS) for the waiver. Ms. Sakelarios said the decision to be made was whether to approve the Governor's recommendation to add three new positions to implement the waiver, recognizing that it had not yet been approved by CMS.

Ms. Sakelarios said the Governor's recommended budget proposed to establish a cost-sharing program with certain Medicaid recipients. In the Medicaid budget account (BA) 3243, there was a projected reduction to expenditures totaling $2 million in FY 2015. In the administration budget, (BA 3158), there were projected expenditures totaling $1.7 million in FY 2014. Ms. Sakelarios said the expenditures would be required to revise the Medicaid Management Information System (MMIS) to accommodate the start-up of the program in the second year of the biennium. The agency informed the members of Committees during the budget hearing that the projected expenditures for revising the MMIS to accommodate the new program would need to be updated, as those projections were outdated and had been prepared by a previous fiscal agent, not the fiscal agent for the current system.

The Fiscal Analysis Division had been informed that it would receive additional information from the Division by April 1, 2013. During the meeting on April 5, 2013, the Division indicated that no additional information was currently available. Ms. Sakelarios said the decision before the Committees was whether to approve the Governor's recommendation to implement a cost-sharing program for certain Medicaid clients, resulting in a reduction to

expenditures totaling $2 million in FY 2015, but an increase of expenditures of $1.7 million in FY 2014.

Chair Carlton asked whether cost-sharing for Medicaid recipients was still in effect and whether there had been any change in course.

Mr. Willden replied there had been a change in course. The original plan was to attempt to get through the regulations and policy analysis in FY 2013 and to consider automation issues in FY 2014 with the goal of establishing cost-sharing principles in FY 2015 and beyond.

Mr. Willden said that on January 14, 2013, the federal government had issued proposed rules, which were going to make it difficult to complete what the Department had originally set out to do. He said there would be significant challenges and did not believe the proposed cost-sharing could move forward until the state learned more about the final rules. Mr. Willden stated that current proposed rules would limit cost-sharing to households with incomes of 150 percent of the FPL or more, which would eliminate most Medicaid recipients in Nevada.

Assemblywoman Flores requested clarification of the term cost-sharing principles. She asked whether those principles were based on the federal poverty level or whether it was about trying to implement an across-the-board fee.

Mr. Willden stated that under the federal rules there were several cost-sharing principles: for example, one was enrollment fees or premiums. Currently, in the Nevada Check Up program, recipients paid a premium or an enrollment fee of $25 to $80 per quarter to enroll in the program. Mr. Willden said another example would be deductibles that a recipient paid for the service before Medicaid paid, similar to any insurance. While those examples were the types of cost-sharing the federal rules allowed, the problem was that some populations were not eligible, and additionally, the rules provided that cost-sharing could not exceed 5 percent of the client's or family's income. Mr. Willden said there was automation and tracking involved because the different cost-sharing principles could not overlap. There were populations, for instance Native American, to which cost-sharing principles could not be applied, and additionally, certain items could not be applied to children, nor could they be applied to certain services. Mr. Willden noted that cost-sharing principles had become very complicated, and while the federal government seemed to be in the process of simplifying the rules, the process was currently not very simple.

Assemblyman Sprinkle said that if the rules were so cumbersome for Nevada, he assumed the rules would also be cumbersome for almost any other state. He asked whether Mr. Willden had heard of any significant conversations or changes at the federal level that would occur in the next couple of years.

Mr. Willden explained that the federal government issued a set of proposed rules in January 2013. States and agencies or organizations that were concerned with those rules would all provide input, and then there would be another round of *Federal Register* discussion back and forth before the federal government issued a final set of regulations. Mr. Willden commented that cost-sharing was, in most cases, for higher-income families and Nevada was a lower-income state. Cost-sharing principles could not be used unless a state had significant numbers of eligible persons with income above 150 percent of the FPL. According to Mr. Willden, that would mean targeting Nevada's elderly and disabled. He said the agency would continue working with managed-care organizations on changing behavior and continue to work through the Section 1115 waiver and care-management principles.

Senator Kieckhefer asked whether eliminating the cost-sharing program would put almost $300,000 of General Fund dollars back into the budget, and Mr. Willden said that was correct.

Assemblyman Eisen commented that he was pleased to hear there would be a deferral in the decision on cost-sharing given the complexities so far. He opined that care should be taken with the way that cost-sharing principles were applied. The original proposal would have netted $300,000, but what concerned Assemblyman Eisen was the potential disincentive for patients to access care that was needed. He said he believed it was very important not to accept the fallacy that patients went to see the doctor because they wanted to, not because that was what was needed for healthcare.

Mr. Willden commented that the Department had two goals: better health outcomes and clients accessing the appropriate levels of care.

Chair Carlton stated that the Committees would probably not be discussing cost-sharing for Medicaid recipients again, and if there were any other questions, members could reach out to Fiscal Analysis Division staff or Mr. Willden.

Ms. Sakelarios noted that she had been contacted by the Division of Health Care Financing and Policy regarding the Intergovernmental Transfer (IGT) Program account (BA 3157). She was told there would be budget amendments

forthcoming, and as she moved through the account, she would try to indicate the issues that were subject to change because of a pending budget amendment. Ms. Sakelarios said that the official budget amendment had not been received by the Fiscal Analysis Division, and no analysis of the changes that were being recommended had been done.

Ms. Sakelarios said there were two issues in the Intergovernmental Transfer (IGT) Program account (BA 3157). The first item was that the Governor's recommended budget included IGT revenue from Clark County, which equaled 55 percent of the total supplemental payments for the Upper Payment Limit program. During the budget hearing, the agency indicated that Clark County had not yet signed a contractual agreement for the upcoming biennium and had not yet identified the percentage of its voluntary contribution. If Clark County's contract for the voluntary contribution came in at less than 55 percent, the state net benefit achieved through this account would be decreased, and the General Fund need in the Medicaid account (BA 3243) would be increased.

According to Ms. Sakelarios, the Division had indicated that as a part of the process of amending the State Plan for Medicaid to include the Upper Payment Limit program expansion, CMS had asked for revisions in the methodology used to calculate the program payment amounts. Based on revised methodology the agency was providing to CMS, it projected that the overall IGT payments would decrease during the upcoming biennium, which meant that the payments generated through the IGT account would also decrease. Based on the revisions, the agency was projecting a reduction to the state net benefit totaling approximately $1.9 million in FY 2014 and approximately $1.1 million in FY 2015.

Ms. Sakelarios stated that she believed the forthcoming budget amendment referenced earlier would recommend that Clark County's contribution be decreased from 55 percent to 52 percent of the supplemental payment amount for the Upper Payment Limit program.

Ms. Sakelarios said the decisions before the Committees included whether to approve the Governor's recommended budget for the IGT account, which included a voluntary contribution from Clark County equal to 55 percent of the Upper Payment Limit program payment amount. She noted that if the Governor's recommendation was approved, but Clark County agreed to continue the voluntary contribution at a lower rate, the state net benefit would be further reduced, and the effect of that action was currently unknown.

The second option would be to approve the IGT budget with the voluntary contribution from Clark County at a percentage less than 55 percent. The reduction suggested would lower the contribution to 52 percent, which would reduce the state net benefit by approximately $1.8 million in FY 2014 and $1.9 million in FY 2015.

Chair Carlton commented that she would like to do some numbers to truly understand. For FY 2014, Clark County was contributing $1.5 million and the return on the contribution was $157.6 million. She said Clark County gained $50 million on $100 million, a 50 percent increase on the money that it invested through the state, with the state's net benefit $42 million, based on the 55 percent rate. For the following year, FY 2015, the numbers would show an investment of $104 million with Clark County receiving $164 million and the state receiving $44 million from the agreement. Clark County was receiving a significant return on their dollar, but the state was also benefitting from that money. Chair Carlton believed the Committee members should keep those components in mind.

Senator Kieckhefer asked whether the budget had ever been closed without having an agreement in place.

Mr. Willden responded that budgets had been closed without a contract with Clark County, and last session budgets were closed based on a 60 percent UPL voluntary contribution rate. An agreement for a contract for FY 2012 was signed, but there was no agreement for FY 2013. Mr. Willden said during the last biennium, Clark County had filed a lawsuit, and the settlement reduced the UPL-related voluntary contribution rate from 60 percent to 56 percent, which reduced the General Fund in the current biennium. The Executive Budget was built for FY 2014 and FY 2015 at a 55 percent contribution rate. Mr. Willden stated the contracts for FY 2014 and FY 2015 were written at the 55 percent voluntary contribution rate and had been sent to Clark County. He recalled that at the Clark County Commission's March 2013 meeting, members voted to reject those contracts. Currently, the state did not have a contract for FY 2014 or FY 2015. Mr. Willden said the Governor had authorized him to work with Clark County fiscal staff to see whether an agreement could be reached for a 52 percent contribution rate. The state was receiving an 8 percentage point increase in FMAP, and the Governor believed it was fair to decrease Clark County's contribution rate by 8 percentage points, from 60 percent to 52 percent.

Mr. Willden said as Fiscal Analysis staff had indicated, there were two items in the UPL, calculations that would cost money over and above

The Executive Budget submittal. First, was the case-mix acuity, which would cause a $3 million decrease to the General Fund over the biennium, and the second was lowering the contribution rate from the 55 percent budgeted to the 52 percent under the amendment, which would cost the state an additional $5 million in General Fund. Mr. Willden emphasized that it had to be a voluntary contribution or the program would not work, and the county would lose its benefit and the state would lose its benefit.

Mr. Willden indicated the UPL contribution rate was one discussion and the Disproportionate Share Hospital (payments from the federal government to match Medicaid costs) (DSH) contribution rate was another. He said currently there was no offer on the table, and there was no pending budget amendment for the DSH.

In response to a question from Senator Kieckhefer about state allocations for DSH, Mr. Willden explained that the national DSH pool was approximately $11 billion and would reduce over the next six years to approximately $6 billion. The budget was built based on a proportionate ratio, which meant that if the national pool was reduced by a percentage, Nevada's DSH pool would also be reduced.

Chair Carlton requested that Ms. Sakelarios present the next budget discussion.

Ms. Sakelarios said the next budget discussion point pertained to the supplemental payment for skilled nursing facilities. During the budget hearing on March 25, 2013, the Division of Health Care Financing and Policy (DHCFP) indicated that during the current biennium, $2.50 per bed-day of General Fund expenditures were being contributed to the supplemental payments for skilled nursing facilities. The $2.50 contribution was the result of a settlement agreement reached between the skilled nursing facilities and the state to avoid litigation. The agreement would expire on June 30, 2013; therefore, General Funds would not be needed in the upcoming biennium.

According to Ms. Sakelarios, the DHCFP indicated that reducing the $2.50 expenditure in the upcoming biennium was one of the items included in the forthcoming budget amendments. The decision originally before the Committees was whether to remove the $2.50 per bed-day General Fund contribution to the supplemental payment amount for skilled nursing facilities as included in the Governor's recommended budget. The removal of the contribution would result in a General Fund savings of approximately $2.5 million in each year of the biennium.

In response to a question from Assemblyman Horne, Mr. Willden explained that the Medicaid program paid long-term care facilities for Medicaid-eligible residents. The Nevada Health Care Association brought a lawsuit, which was settled out of court, and the state agreed to contribute an extra $2.50 more on the payment rate through June 30, 2013. Mr. Willden said the current budget was built with the state continuing to make that $2.50 payment, and when the mistake was discovered, a budget amendment was written to reverse that $2.50 payment. It was not the state's intent to pay the additional $2.50 once the settlement ended on June 30, 2013. As Fiscal Analysis Division staff indicated, that was a savings to the General Fund of $2.5 million per year. Mr. Willden said the Nevada Health Care Association requested (1) that the $2.50 per day, per bed remain in the budget, and (2) that the support be raised to $11, instead of $2.50. The pending amendment coming would deny the request for $11 and reverse the $2.50.

Chair Carlton recalled that the Nevada Health Care Association claimed that without the $2.50 per bed, per day, and even without the requested $11, it would be difficult to place Medicaid patients in skilled nursing facilities because more beds would be allotted to the Medicare side rather than the Medicaid side to balance out the costs.

Mr. Willden explained that in skilled nursing facilities there were basically three types of patients: Medicaid paid patients, Medicare paid patients, and privately paid patients. In skilled nursing facilities Medicare paid short-term, but substantially better on a daily rate than Medicaid. There was some cost shifting that went on within skilled nursing facilities to meet the overall cost of care and the bottom line. Mr. Willden said the presentation by the Nevada Health Care Association maintained that with the ACA and through sequestration [the across-the-board cuts necessitated by the Budget Control Act of 2011] the Medicare reimbursements were being decreased. Those payments would be decreasing a couple of percentage points per year over the next three or four years. The concern was that if Medicare reimbursements decreased and the state eliminated the $2.50 support per day in Medicaid that the bottom line was being affected on both sides. The skilled nursing facilities were going to have a reduced revenue source from both Medicaid and Medicare.

Assemblyman Sprinkle commented that the Nevada Health Care Association had presented its concern very strongly at the budget hearing, and it appeared that the Department had taken a position with the proposed amendment. He wondered whether Mr. Willden wanted the opportunity to explain the Department's position.

Mr. Willden said that while he was not prepared to go into detail, the Department had a certain vision of what the Medicaid rate payments should be a couple of years ago. The state settled the litigation by the Nevada Health Care Association with a $2.50 bonus payment. The litigation settlement would end June 30, 2013, and the Department did not believe it was further obligated.

Senator Kieckhefer asked whether it was difficult placing Medicaid patients into a skilled nursing care facility because of space constraints.

Leah Lamborn, Administrative Services Officer (ASO), Division of Health Care Financing and Policy (DHCFP), DHHS, stated that, currently, the average occupancy rate for nursing facilities was 80 percent: there were beds available.

Mr. Willden added that he had discussed the subject with some of the Nevada Health Care Association board members and the issue was clear: there were available beds in skilled nursing care facilities, but the Nevada Health Care Association believed Medicaid rates were not sufficient to meet their financial needs.

Chair Carlton requested the presentation regarding the Medicaid provider rate increases.

Ms. Sakelarios said it appeared that the Governor intended to submit a budget amendment recommending the restoration of provider rate reductions made during the 2011 Legislative session. While some preliminary information suggested that the recommendation would include General Funds totaling $11 million over the course of the biennium, the conversations with the agency had indicated that amount might be different. She said that was one of the issues that would be addressed in the forthcoming budget amendment. Preliminary information received on April 5, 2013, suggested the following rate increases were being considered:

- A 15 percent rate increase for free-standing ambulatory surgery centers
- A 15 percent rate increase for ambulance services
- A less than 1 percent rate increase for dental services

Ms. Sakelarios said the previously listed increases would, in essence, negate the rate reductions that were approved by the 2011 Legislature.

The additional rate restorations included:

- An approximate 6.86 percent rate increase for partial anesthesia services
- A 36 percent increase for nonprimary care obstetric services
- A 36 percent increase for pediatric surgical services

Ms. Sakelarios said it was her understanding that the 36 percent rate increases would establish rates that were equivalent to the rates that primary care providers were currently receiving through the ACA rate increases during the current biennium and into the next biennium.

According to Ms. Sakelarios, the decision before the Committees would be whether to approve General Fund savings for rate increases for Medicaid provider services during the upcoming biennium once expenditure projections and supporting documentation had been received.

Senator Smith commented that she was glad to see the increases for the providers because they were in a group that did not make choices about which patients were treated.

Chair Carlton noted the numbers were not hard and fast, and there would be changes.

Seeing no other questions or comments from the Committees, Chair Carlton asked for the next presentation.

Ms. Sakelarios said under existing law, for each fiscal year, each county board of commissioners was required to allocate money in its budget for medical assistance to indigent persons. The allocated money went to the county match program, which was used to assist with a portion of the costs for the Medical Aid for the Aged, Blind, and Disabled (MAABD) population, as well as the waiver population included in the county match program.

Senate Bill 3 was currently under review in the Legislature and would limit the amount allocated in the counties with populations less than 700,000 residents to 8 cents per $100 of assessed valuation of taxable property.

It was Ms. Sakelarios' understanding that the General Fund allocation necessary in the Medicaid budget because of the legislation might be included in the forthcoming budget amendments. There was a fiscal note submitted for S.B. 3, which indicated a General Fund increase of approximately $430,000 in each

year of the upcoming biennium. In subsequent conversations with the agency, the cost was estimated at approximately $600,000 per fiscal year.

The decision before the Committees would be whether to add General Funds totaling approximately $600,000 in each year of the biennium if the provisions of S.B. 3 were enacted.

Seeing no further questions from the Committees, Chair Carlton requested the next presentation.

Jeffrey A. Ferguson, Senior Program Analyst, Fiscal Analysis Division, Legislative Counsel Bureau, presented information regarding the Division of Welfare and Supportive Services. Mr. Ferguson said the main issue was the caseload-driven new positions and new field offices. He pointed out that the Governor's budget originally recommended 458 new positions for two budget accounts: 437 of the positions would go into the field services account, and 21 would go into the administration account. Within the two budget accounts were common decision units: decision unit Maintenance (M) 200 dealt with regular caseload increases; decision unit M-740 dealt with the implementation of the Affordable Care Act (ACA); and decision unit Enhancement (E) 740 dealt with the expansion of Medicaid.

Mr. Ferguson said in fiscal year (FY) 2014 there would be a total of 91 new positions that would start July 1, 2013, with 193 more added in August 2013. On July 1, 2014, there would be another 174 positions added. In addition, the budget recommended four new field offices, three of which were scheduled to open on July 1, 2013, with a fourth office to be opened on July 1, 2014.

The total cost for the positions in the new facilities was $18.6 million in FY 2014 and $29.2 million in FY 2015 for the positions and field offices in the two accounts. Mr. Ferguson noted that the costs were administrative costs and typically were funded 50 percent General Funds and 50 percent federal funds. The General Fund portion of those costs would be approximately $9.3 million in FY 2014 and approximately $14.6 million in FY 2015.

Mr. Ferguson recalled there had been considerable discussion during the budget hearing about how the agency could logistically hire all of these positions, bring them all on board, or in groups at the same time, and open three offices on July 1, 2013. As a result of testimony, the agency had taken certain steps as indicated below:

- Division personnel had been working with the Division of Human Resource Management to open recruitments, schedule testing, and produce hiring lists in advance of start dates.
- Division staff had been designated as members of a hiring panel and would schedule, interview, and make selections on new staff on a continuing basis.
- The Division had requested three additional positions for its personnel unit to handle the recruitment and processing of new hires.
- The Division had been working with the Southern Nevada Workforce Investment Board in to help identify and prepare potential applicants.

Mr. Ferguson pointed out that of the new positions, 243 positions were family service specialist (FSS) positions, and 79 would be administrative assistant 4 (AA4) positions. The positions were eligibility workers who were the frontline personnel who spoke with persons applying for Medicaid or for welfare services. He said there was also a discussion during the budget hearing that the FSS positions required a 12-week training academy before being placed in a field office, with the AA4 positions receiving a 4-week training period. All of the positions would be trained in Las Vegas. The FSS positions would be trained in what was called the Professional Development Center, which accommodated a maximum of 72 persons per academy. The AA4 training could accommodate 31 persons.

Mr. Ferguson said that in response to questions from Fiscal Analysis staff and from the Committees during the budget hearing, the Welfare Division had reconsidered how it would bring these positions on board and was devising a new hiring plan that was still under development. The hiring plan would bring on eligibility workers based on space available within the training academies, and those positions would be phased in through the course of the biennium. An initial class of approximately 48 positions would start the academy on July 8, 2013, and be ready to be placed in the field immediately after the 12-week training was finished. Similarly, subsequent academy classes would begin at strategic times with the participants in each academy having been hired just in time to begin the next available academy. Mr. Ferguson said the proposed plan would reduce the need for all three field offices in the FY 2014 budget to start on July 1, 2013. The agency indicated that the three offices could be phased in during September 2013, November 2013, and February 2014. The fourth would be phased in on July 1, 2014.

The Division indicated the proposed plan would allow them to continue to monitor the demand for services, measure effectiveness, and potentially modify the hiring plan to best meet the demand for the services and needs of the clients.

The Division had also communicated to Fiscal Analysis staff that it would like to be flexible in the size and location of the buildings requested and be allowed to customize some of those buildings. As it was originally discussed during the budget hearing, all welfare offices would offer the same services. Mr. Ferguson believed under the Division's new plan, employees would be distributed a little differently. An example the Division provided was having a designated facility that would deal with virtual processing, require less parking space, and perhaps be a less expensive building.

Mr. Ferguson said that in 2009, staff was distributed within the Division based on 168 cases per full-time equivalent (FTE). In the 2011 Session, that figure was raised to 268 cases per FTE because of the number of automated systems the Division started using. The staffing plan that was presented for the 2013 Legislature raised it to 280 cases per FTE, and the agency had indicated that the new eligibility engine would create approximately an 8 percent efficiency, and possibly a few more cases could be handled per FTE.

Mr. Ferguson said the Division testified that currently the staffing ratio was 306 cases per FTE, and there was discussion that number had created high turnover. The FSS positions had a turnover rate of 22.4 percent during 2012, and the Division believed the high number of cases had contributed to a decline in quality control standards for accuracy and timeliness.

Mr. Ferguson stated there had been some reprojections of caseloads. In addition to the Medicaid caseload, the Welfare Division also supported the Supplemental Nutrition Assistance Program (SNAP), and the Temporary Assistance for Needy Families (TANF) program. The ultimate result of the caseload reprojections was that 27 fewer positions were needed compared to the number used in The Executive Budget. All of those reductions were in the Field Services account, which was where the majority of the positions were located. The 21 positions that were initially recommended for the Administration account would not change.

According to Mr. Ferguson, the potential increase in federal funding for the eligibility process was a new subject for the Committees' consideration. In speaking with the agency, Fiscal Analysis staff had been informed there had been negotiations with the federal government to provide what was called

Medicaid-enhanced funding. Mr. Ferguson said the administration costs for the Field Services and Administration accounts were funded with 50 percent General Funds and 50 percent federal funds. The state was negotiating with the federal government for it to provide 75 percent of the funding and the state 25 percent of the funding.

If that funding scenario were to occur, it appeared that it would begin October 1, 2013. Mr. Ferguson said the funding change would apply to the entire Field Services and a portion of the Administration accounts. It would be a significant change in funding and would provide General Fund savings. The agency had provided Mr. Ferguson with an estimate of General Fund savings of approximately $6.7 million in FY 2014 and approximately $10.8 million in FY 2015.

Mr. Ferguson said the decisions that would need to be made by the Committees were whether to approve the fewer positions based on recent caseload projections, to stagger the hiring of the positions to more closely match the need for those positions and the space available in the training academies, and to phase in the facilities that were being requested.

In response to a question from Senator Kieckhefer, Mr. Ferguson said decision unit M-200 concerned general caseload increases. The Division believed there would be an immediate need to accommodate additional positions. The ACA would not be in full force until January 2014, and those new positions would have been hired on a "just-in-time basis" to attend the training academy, bringing them to speed for beginning work the first business day after January 1, 2014. Mr. Ferguson said the initial plan was to bring 91 positions on immediately, but the revised plan projected that the initial class would have 48 positions. Those persons would go into the training academy in September 2013, and the Division could monitor anticipated need and could adjust the hiring plan if necessary.

Assemblyman Kirner commented that he believed everyone recognized what a monumental task this was going to be, and any business or organization that tried to hire as many employees as projected was going to have fluctuations. He also believed that any latitude that could be given to the Department would be worthwhile. He said the only question he had was for the Fiscal Analysis Division staff about the 10 percent vacancy for the Division. He asked whether there were adjustments to the budget calculations in light of the addition of 400 plus positions and whether at any given time the Division usually had a 10 percent vacancy rate.

Mr. Ferguson said there were vacancy savings built into the personnel costs. He pointed out that while the training academies for FSS positions were able to accommodate 72 persons, the plan that the Division was considering would not fill all 72 new positions because of the current turnover and the need to also fill those vacancies.

Senator Smith said she appreciated the work Fiscal Analysis staff and the Division had accomplished. She said it appeared that everyone involved had worked hard to arrive at a realistic timeline and approach.

Chair Carlton asked whether background investigations, fingerprinting, school transcripts, and other requirements for employment with the Department had been taken into consideration before the big push to hire employees and send them through the academies.

Michael J. Willden, Director, Department of Health and Human Services, said that generally the FSS employees did not require a college degree. While a college degree was helpful, experience mattered more. Also, FSS employees did not have to have the same background check as social workers. Mr. Willden said the Department could get fairly large lists of candidates through the Division of Human Resource Management. He said previously the Department had hired personnel using face-to-face interviewing and lots of "paper shuffling" and then entering data into automated systems. The Department wanted to be careful about finding staff who had automation skill sets to perform electronic processes. Mr. Willden said he did not want to interview prospective employees and then discover in the academies they did not have hard skill sets to do what was needed in the job. He said that work was ongoing with the employment partners, and he was not sure that background checks were a problem, and if high school transcripts were a problem, he had not heard about it.

Mr. Willden said the other group that the Department would be hiring in high numbers was the administrative support positions. In the past, the Department almost always hired mostly eligibility workers to perform the FSS function, but now it was hiring a new mix of high-end clerical assistants, and he believed the Department could recruit those persons, but again wanted to ensure they had the needed skill sets. Mr. Willden said the first goal was to get some of the current vacancies filled, because that had to balance with the vacancy savings rates built into the budgets. Staff indicated a 22 percent turnover in eligibility workers. Mr. Willden said it was a tough job, and the Division was constantly recruiting, teaching in the academies, and getting employees into the offices.

Chair Carlton asked about the mandatory English and Spanish proficiency requirement and wondered whether that was correct for the FSS position or whether she was misinformed.

Mr. Willden explained that not every employee was required to have both English and Spanish proficiency. The Division had Spanish-speaking units, and when clients arrived at the office lobbies their needs were identified, and they were routed to the correct workers. He acknowledged the Division needed a high percentage of Spanish-speaking workers, but not everyone was required to be bilingual.

In response to a question from Chair Carlton regarding fingerprinting, Mr. Willden said fingerprinting was required after hiring. A new employee that had to be fingerprinted for the position could work for a period of time before the fingerprinting and background checks were processed.

Assemblyman Aizley commented that he did not know what the Department's academies did or where they were, but the universities, through continuing education, provided certificate programs, and he asked whether any of those programs suited the needs of the Department.

Mr. Willden responded that the certificate programs would suit the Department's needs, but specifically an "academy" was a new worker academy. The academy programs taught the interviewing process, computer skills, mock interviews, Department policies and procedures, and automated systems.

Chair Carlton asked for questions from the Committees and seeing none requested the presentation on Child Assistance and Development, budget account (BA) 3267.

Jeffrey A. Ferguson, Senior Program Analyst, Fiscal Analysis Division, Legislative Counsel Bureau, said the last presentation for the work session was the Child Assistance and Development budget account. Fiscal Analysis staff had been informed that there would be a budget amendment that would place $2 million of General Funds in each fiscal year into the Child Assistance and Development account. Mr. Ferguson said that during the budget hearing there was discussion that the 2011 Legislature reduced General Funds in the account from $16.9 million in the 2009-2011 biennium to $5.2 million in the current biennium. The Governor's budget, as currently recommended, continued the $5.2 million over the next biennium, or $2.6 million each fiscal year. Mr. Ferguson said that was the minimum General Fund requirement to meet the

maintenance of effort (MOE) in the account and had led to some waiting lists for families and children who were seeking childcare.

Mr. Ferguson pointed out there were three populations that received childcare through this account. The Temporary Assistance for Needy Families (TANF) and New Employees of Nevada (NEON) covered individuals with families, and all children in that population would receive childcare. There was also the "at-risk" category, where a family was eligible to receive TANF, but had elected not to receive it at the current time. There was testimony that the at-risk category had a waiting list of approximately 1,178 children, within approximately 621 families. Mr. Ferguson said the third category consisted of what was referred to as the discretionary population: low income families that did not currently qualify for TANF, but as funds became available had, in the past, received some childcare subsidies.

Mr. Ferguson said the Division had provided Fiscal Analysis staff with information that indicated $2 million in each fiscal year would provide childcare services to approximately 436 children, or 229 families, in the at-risk category.

The decision that would need to be made would be whether to approve the Governor's forthcoming amendment to add $2 million of General Funds in each year into the Child Assistance and Development program.

Chair Carlton requested public comment.

Paula Berkley, representing Food Bank of Northern Nevada, said her organization strongly recommended the $2 million for childcare and also recommended flexibility in the new buildings for the Division of Welfare and Supportive Services. She explained that she had always wanted to have space in the welfare offices for the Food Bank to provide emergency food for clients before they could be signed up for services. Ms. Berkley anticipated that with the new Medicaid offerings, Supplemental Nutrition Assistance Program (SNAP) outreach would have additional pressures.

Barry Gold, representing AARP Nevada, commended the Governor, the Legislature, and Mike Willden and his staff for all the work that was being done to provide for the Medicaid expansion and ensure that it was implemented in a consumer friendly way to provide the necessary healthcare coverage to thousands of Nevadans all across the state.

Chair Carlton adjourned the meeting at 10:30 a.m.

RESPECTFULLY SUBMITTED:

_____
Anne Bowen
Committee Secretary

APPROVED BY:

_____
Assemblywoman Maggie Carlton, Chair

DATE: _____

_____
Senator Debbie Smith, Chair

DATE: _____

EXHIBITS

Committee Name: Committee on Ways and Means

Date: April 12, 2013 **Time of Meeting: 8:13 a.m.**

Bill	Exhibit	Witness / Agency	Description
	A		Agenda
	B		Attendance Roster