MINUTES OF THE MEETING
OF THE
ASSEMBLY COMMITTEE ON HEALTH AND HUMAN SERVICES

Seventy-Eighth Session
February 20, 2015

The Committee on Health and Human Services was called to order by Chair James Oscarson at 1:33 p.m. on Friday, February 20, 2015, in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4401 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada and to High Tech Center, Great Basin College, 1500 College Parkway, Elko, Nevada. Copies of the minutes, including the Agenda (Exhibit A), the Attendance Roster (Exhibit B), and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at www.leg.state.nv.us/App/NELIS/REL/78th2015. In addition, copies of the audio or video of the meeting may be purchased, for personal use only, through the Legislative Counsel Bureau's Publications Office (email: publications@lcb.state.nv.us; telephone: 775-684-6835).

COMMITTEE MEMBERS PRESENT:

Assemblyman James Oscarson, Chair
Assemblywoman Robin L. Titus, Vice Chair
Assemblyman Nelson Araujo
Assemblywoman Teresa Benitez-Thompson
Assemblywoman Jill Dickman
Assemblyman David M. Gardner
Assemblyman John Hambrick
Assemblywoman Amber Joiner
Assemblyman Brent A. Jones
Assemblyman John Moore
Assemblywoman Ellen B. Spiegel
Assemblyman Michael C. Sprinkle
Assemblyman Tyrone Thompson
Assemblyman Glenn E. Trowbridge

COMMITTEE MEMBERS ABSENT:

None

GUEST LEGISLATORS PRESENT:

Assemblyman John Ellison, Assembly District No. 33

STAFF MEMBERS PRESENT:

Kirsten Coulombe, Committee Policy Analyst
Risa Lang, Committee Counsel
Nancy Weyhe, Committee Secretary
Jamie Tierney, Committee Assistant

OTHERS PRESENT:

Warner Whipple, Private Citizen, Elko, Nevada
Joseph L. Pollock, Program Manager, Environmental Health Section, Division of Public and Behavioral Health, Department of Health and Human Services
Laurie Squartsoff, Administrator, 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
Jan Prentice, Chief, Rates and Cost Containment, Division of Health Care Financing and Policy, Department of Health and Human Services
Bonnie Long, Administrative Services Officer III, Director's Office, Department of Health and Human Services
Jeff Fontaine, Executive Director, Nevada Association of Counties
Mary C. Walker, representing Carson City, Douglas County, Lyon County, and Storey County
Ken Retteroth, Division Director, Washoe County Social Services
Yolanda T. King, Chief Financial Officer, Department of Finance, Clark County

Chair Oscarson:
[Roll was taken. Committee rules and protocol were explained.] We have a work session today. I would like to ask our policy analyst, Ms. Coulombe, to take us through the bills. We will begin with Assembly Bill 99.

Kirsten Coulombe, Committee Policy Analyst:
The first bill on the work session is going to be Assembly Bill 99. This was heard last Friday, February 13, 2015. It was brought forth by Assemblyman Ellison.

Assembly Bill 99: Makes various changes relating to nonprofit camping programs for children. (BDR 40-53)

Kirsten Coulombe, Committee Policy Analyst:
[Ms. Coulombe read a description of the bill from the work session document (Exhibit C).] During the hearing there were no proposed amendments. Subsequent to that, there has been a proposed amendment, a mock-up. Chair Oscarson had directed Assemblyman Trowbridge to follow up on the amendment. Would the Chair like him to walk through the amendment?

Chair Oscarson:
Thank you, Assemblyman Trowbridge, for coordinating the efforts among all these people. There are a lot of people that were engaged in this. If you would read the amendment, we would appreciate it.

Assemblyman Trowbridge:
Without going into the background and history, I will get right to the meat of the matter. I think we have come up with some language that will correct the problem and not just address one specific facility for one particular type of group for one particular length of time. It is a much more encompassing and very clean piece of language. It addresses section 1. [Assemblyman Trowbridge read the proposed amendment from the mock-up (Exhibit D).]

That is the proposed new language. There was a camp that was being operated by the Lions Club International that got involved in a discussion about facilities that were covered under historical preservation rules, and it was okay under the U.S. Department of Agriculture's operating permit. But somehow someone interpreted it was in conflict with what we have, so we needed to specify that it did not address these types of issues. We are correcting it here, and it solves the problem. It is a minor issue but one that needs to be addressed. Last year we had to have the camp cancelled because of the dispute, but we wanted to get it resolved promptly so that people who are planning the camps can get about their business of providing the youth activities.

Chair Oscarson:
Thank you Assemblyman Trowbridge. We appreciate your efforts and those of Assemblywoman Benitez-Thompson and Assemblyman Sprinkle in being engaged in the process.

Assemblywoman Benitez-Thompson:
I wanted to make sure for the record that the language that Assemblyman Trowbridge suggested does keep the camps under the requirements of the U.S. Forest Service sanitation policies, which are quite extensive and are

important to this Committee. I think we found a good way to make sure that we have kids in camps that are safe, healthy, well run, and well maintained, and that we did not need the additional layer of state oversight.

Assemblywoman Titus:
Thank you for that clarification because that was the issue I had with this. Thank you for making sure that it continues as a safe and fun environment.

Assemblyman Sprinkle:
I have always been supportive of the concept behind this. I think there were some questions during the hearing on this bill; one of the comments that was made on the record had to do with our previous Attorney General and an opinion. I wanted to make clear on the record today that that opinion did not come from that office. I think that is an important fact to be made for the record today.

Chair Oscarson:
I agree and thank you for the clarification.

Assemblyman Moore:
Is the author in agreement with this amendment?

Chair Oscarson:
For the record, Assemblyman Ellison nodded his head. Is there any discussion from the Committee? [There was none.]

> ASSEMBLYWOMAN TITUS MOVED TO AMEND AND DO PASS ASSEMBLY BILL 99.
>
> ASSEMBLYWOMAN BENITEZ-THOMPSON SECONDED THE MOTION.
>
> THE MOTION PASSED UNANIMOUSLY.

Chair Oscarson:
I will open for public comment.

Warner Whipple, Private Citizen, Elko, NV:
I testified a week ago on this, and I would like to thank the Committee and Assemblyman Ellison for all the hard work that they did. I would just like to say thank you.

Assemblyman John Ellison, Assembly District No. 33:
I want to thank Assemblyman Trowbridge and everyone who worked on this. We pulled this together, Legal spent a lot of time, and my attaché made 30 calls. Thank you all for your hard work and concerns. Most of all, it is about our children and a facility that is second to none. It is beautiful, and it is a great, safe place for these children.

Joseph L. Pollock, Program Manager, Environmental Health Section, Division of Public and Behavioral Health, Department of Health and Human Services:
We are in support of the amendment, and we are glad this takes care of the issue. Thank you, Assemblyman Trowbridge, for working this through and coming up with a solution that works for everybody.

[Submitted but not discussed were a letter from the Elko County Board of Commissioners and an appraisal (Exhibit E).]

Chair Oscarson:
We will close the hearing on Assembly Bill 99. We will now hear Assembly Bill 29.

Kirsten Coulombe, Committee Policy Analyst:
Assembly Bill 29 was heard on February 11, 2015. It was brought forth by the Aging and Disabilities Services Division.

Assembly Bill 29: Revises provisions governing the care and treatment of persons with intellectual disabilities and related conditions. (BDR 39-324)

Kirsten Coulombe, Committee Policy Analyst:
[Ms. Coulombe read a description of the bill from the work session document (Exhibit F).] As the members may recall from testimony, this bill is a clean-up bill from when two divisions merged from the 2013 Session and this language was overlooked; it is adding that in where it is needed. There were no amendments proposed for this measure.

Chair Oscarson:
Are there questions from the Committee? [There were none.] Is there any discussion? [There was none.] Is there a motion?

ASSEMBLYMAN SPRINKLE MADE A MOTION TO DO PASS ASSEMBLY BILL 29.

ASSEMBLYWOMAN SPIEGEL SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

Chair Oscarson:
For the record, Assemblyman Trowbridge would you present the floor statement for Assembly Bill 99?

Assemblyman Trowbridge:
It will be my pleasure.

Chair Oscarson:
Assemblyman Sprinkle will do the floor statement for Assembly Bill 29. We will now have a presentation on Medicaid.

Laurie Squartsoff, Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services:
We are here to give a fairly full overview of the program not only in terms of how we started with federal regulation but also some of the details and the important components of our program as we continue to evolve.

Medicaid was authorized by Congress under Title XIX of the Social Security Act in 1965. [Ms. Squartsoff read from page 2, (Exhibit G).] Financing for the program does not account for the "countercyclical" nature of the program. That means that during economic downturns, Medicaid expands and state revenues shrink, reducing the capacity to afford increased enrollment. That is a challenge and the balance that we have to work on continuously.

Our general Medicaid rules include that there must be comparability of services across the state for beneficiaries, and that beneficiaries have free choice of providers. [Ms. Squartsoff read from page 3, (Exhibit G).] We have an assurance of transportation to medical services. Currently the contractor that we utilize is LogistiCare, and their role is to ensure that a beneficiary can get to that assigned appointment. There is a mechanism in place for transportation.

A key component to many of our programs is especially for children under our Early Periodic Screening, Diagnosis and Treatment (EPSDT) benefit. States are required to provide all medically necessary services to children under the age of 19. These services in some cases could be considered optional or non-covered benefits; and we have many rules in the national health care system, especially

with health care coverage for children and adults in low-income families, the elderly and persons with disabilities. [Ms. Squartsoff read from page 5, (Exhibit G).]

Medicaid is a publicly financed but not a government-run health care delivery system. [Ms. Squartsoff continued to read from page 4, (Exhibit G).]

Nationally, Medicaid and Children's Health Insurance Program (CHIP) cover more than one in three children. [Ms. Squartsoff continued to read from page 6, (Exhibit G).]

As you will likely hear throughout your career, there are differences in Medicaid programs; if you have seen one Medicaid program, you have seen one Medicaid program. They vary in each state. [Ms. Squartsoff continued to read from page 7 and page 8, (Exhibit G).]

Our division programs are under two different delivery service models. We have fee-for-service, where services are provided by an individual practitioner and reimbursed to that individual provider. We also utilize managed care for those beneficiaries who live in urban Washoe County and Clark County, and those individuals are managed through two managed care plans, Amerigroup and Health Plan of Nevada.

In addition, we have the Nevada Check Up program, which provides health care coverage to low-income, uninsured children who are not eligible for Medicaid. However, those services are provided on a fee-for-service basis through the managed care networks. [Ms. Squartsoff continued to read from page 9, (Exhibit G).]

Our program is overseen and our policies are coordinated with the federal government through the Medicaid state plan. The state plan is the collaborative effort between the state and the federal government to ensure that there is a clear description of what is covered under the program. We establish our own eligibility standards and have a memorandum of understanding which defines the type, amount, and scope of services, sets the rates for payments, and gives an overview of how our program is administered.

On page 11 (Exhibit G), you will see a chart with our mandatory and optional coverage groups. [Ms. Squartsoff continued to read from page 11, (Exhibit G).]

The chart on page 12 (Exhibit G) shows where the Medicaid eligibility is and the Federal Medical Assistance Percentages (FMAP), which is the federal match for our program. Currently our federal match is about 65 percent, so for every

dollar that is spent, 65 cents of that is federal funds and 35 cents is state funds. As you can see from this chart, we have coverage for children between the ages of zero and five. Our old eligibility standards prior to the implementation of the Affordable Care Act (ACA) is the bar that is in blue. The expansion with an increase up to 201 to 205 percent of federal poverty level is the coral color on this chart.

As we move to the right, we have the parents/caretakers. Historically those individuals had incomes up to 22 percent of federal poverty level, and now the parents and caretakers and childless adults between the ages of 19 and 64, with incomes up to 138 percent of federal poverty level, are covered.

On page 13 (Exhibit G), the chart shows historically what the number of Medicaid-eligible recipients were in the program. As of January 1, 2014, you will see that there is close to a straight line with our increase in enrollment. We went from 317,000 in round figures in January 2013 to the number referenced earlier of about 577,000 Nevadans covered currently.

In addition to our coverage, we also have mandatory and optional Medicaid services.

Assemblyman Jones:
Could you go back to that slide with the huge increase? Could you explain how that worked with the Affordable Care Act and how we took on the expansion of Medicaid so dramatically in 2014?

Laurie Squartsoff:
Effective January 1, 2014, the state made the decision to enroll in and participate in Medicaid expansion. That included those people who historically were not covered by Medicaid, including the childless adults, so people who previously were not covered by insurance or had not applied for Medicaid were now eligible. Starting January 1, through the Silver State Health Insurance Exchange and with the help of staff at the Division of Welfare and Supportive Services district offices, people were able to enroll. The original projections were that we would have about 147,000 people covered in that newly eligible population. The original projections were that it might take us two years for all those people to enroll in the program, but with the success of the Exchange, the "no wrong door" system for helping people gain access to Medicaid, they arrived. We had many applications that came through. We have an arrangement with the Division of Welfare and Supportive Services which takes care of the eligibility piece for Medicaid. Once a person is determined to be eligible, that information is rolled to us and we pick up the reimbursement for those medical services.

Assemblywoman Titus:
We have doubled our Medicaid-qualified applicants that have been accepted. What is the percent increase in the number of providers?

Laurie Squartsoff:
I do not have that information with me, but I would be happy to get that for you.

Chair Oscarson:
If you could get that to staff as soon as possible, we want to look at that. That is one of the adequacy issues that we have talked about in previous meetings.

Laurie Squartsoff:
On page 14 (Exhibit G), we look at the mandatory versus optional Medicaid services. [Ms. Squartsoff continued to read from page 14, (Exhibit G).]

Assemblywoman Titus:
Thank you for the list of things that you do reimburse, and I encourage you to consider adult podiatry. Right now Medicaid only reimburses for juvenile podiatry; but with this ever-increasing population of diabetic patients and patients with other chronic diseases that are now under Medicaid, they may need some other services.

Laurie Squartsoff:
I need to add a clarification to the chart on page 14 (Exhibit G). Under dental care, we do cover dental services, but it is for persons under the age of 21.

Medically necessary transportation includes both nonemergency and emergency transportation.

For our home and community-based programs, we have a 1915(c) program where we operate under three waivers. [Ms. Squartsoff continued to read from page 15, (Exhibit G).]

Medicaid has two delivery models wherever services are provided to our recipients. [Ms. Squartsoff continued to read from page 16, (Exhibit G).]

In 2011, the Legislature approved the budget for the development of a case management system for those high-need Medicaid recipients who receive their services under the fee-for-service model. Our Health Care Guidance Program received approval from Centers for Medicare and Medicaid Services (CMS) through a Section 1115 waiver, and those services are provided through

a contract with McKesson Health Solutions. [Ms. Squartsoff continued to read from page 17, (Exhibit G).]

The program helps recipients through the transitions from inpatient to outpatient care and follows up with them on their health care needs. It also assists physicians as a supportive tool to assist with follow-up for additional appointments with specialists, ensuring that patients are getting their prescriptions filled, ensuring that if there is a question about transportation that there is a care coordinator there to help facilitate those discussions so that we have better opportunities for patients to get to those appointments.

There are eight disease management interventions that are of particular importance for this program. [Ms. Squartsoff continued to read from page 18, (Exhibit G).]

Chair Oscarson:
On your care coordination program for those superutilizers that we talked about in the interim and that McKesson Health Solutions is providing now, do you have any preliminary numbers on how that is doing and the effect it is having on the process and programs?

Laurie Squartsoff:
We know that we have 39,000 lives that are being managed through and overseen by McKesson Health Solutions, but I can get the details from them and provide that to the Committee.

Assemblywoman Titus:
In particular, I would like to see the number of cases per case manager. Disease intervention is making sure that these clients and patients follow through, especially with these chronic diseases that end up being not only expensive to their health but also expensive to society. I would appreciate getting some numbers in that regard.

Laurie Squartsoff:
In addition to the receiving of the services and those people who are eligible for benefits, we have a fair hearing process for those services or for individuals if there are any questions regarding the requested services. [Ms. Squartsoff continued to read from page 19, (Exhibit G).]

The Medicaid/Nevada Check Up budgets are set biennially through the Legislature. [Ms. Squartsoff continued to read from page 20, (Exhibit G).]

Assemblyman Thompson:
I have a question on page 19 (Exhibit G) about the fair hearings. Set the stage for us for what a fair hearing looks like; who does the client present to? Is it a table discussion? Is it very formalized? What is the process with that?

Laurie Squartsoff:
The process starts with the notice that goes to the beneficiary, and they can request that hearing. The meeting is scheduled with our hearing staff within the division and a time is set for that opportunity—whether it is by phone or face-to-face. We start with a hearing prep meeting, a meeting before we get to the hearing so that we can identify what those issues are and if there is an opportunity to resolve the issue before we get to a hearing, then staff work with either the individual or with the provider to get those questions resolved. If that is not satisfactory, then the hearing is coordinated through the Department of Administration, and we have an administrative law judge (ALJ) who oversees those hearings. Then the ALJ takes the information from both sides, makes that decision, and that information is transferred to either the beneficiary or to the provider.

Our managed care plans also have an appeals process, so it is across the board whether you get your services fee-for-service or managed care.

Assemblyman Thompson:
Several years ago, I worked at the Division of Welfare and Supportive Services. Are people allowed to have authorized representatives? Not necessarily a lawyer, but sometimes people may not have the competency level to maneuver themselves. For example, if they receive a notice and they do not know what it means, but they do know what it means when they do not get the services the following month. Are people on the front end and intake allowed to have an authorized representative such as a relative, a neighbor, someone that can be their advocate and help them navigate through this process?

Elizabeth Aiello, Deputy Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services:
Yes, they are allowed to do that, and our hearing notices have information on the pro bono law services so if they do want to access some of those, they can. That usually is farther along in the process, but it is definitely up to the individual.

Assemblyman Jones:
Regarding the budget and recognizing that this is not a money committee, I want to have a broad understanding of what we have here on page 20

(Exhibit G). The budget is $5 billion for fiscal year (FY) 2014–2015, and then it is proposed to go to $7 billion in FY 2016-2017. That budget equals almost our entire budget. The federal government is paying 65 percent of that and we are paying 35 percent, is that how that works?

Laurie Squartsoff:
For most of Medicaid beneficiaries that is correct; that is the FMAP. For the newly eligible, the FMAP is 100 percent, and it gradually decreases through 2020.

Assemblyman Jones:
When you say FMAP, you mean that FMAP is paying for it?

Laurie Squartsoff:
Yes, FMAP is paying for it.

Assemblyman Jones:
Because we had that big jump with that 200 percent of the poverty level figure almost doubling, the federal government is paying 100 percent of that right now, but over the next few years, it is going to drop off to where you said in 2020 and where we are paying 100 percent?

Laurie Squartsoff:
No. There is a gradual decrease over the next several years. It is on page 21 (Exhibit G). There is a gradual reduction in the federal funding for those newly eligible individuals, and then when we get to 2020, we stay at 90 percent.

Assemblyman Jones:
Then in 2020 we are only paying 10 percent for that new 200 percent, which is almost 300,000 people? That is it?

Laurie Squartsoff:
That is correct.

Continuing to page 21 (Exhibit G), Federal Financial Participation (FFP) is provided to the state and allows for the reimbursement for those medical services. [Ms. Squartsoff continued to read from page 21, (Exhibit G).]

There is other funding that Medicaid provides, especially for our other state agencies. [Ms. Squartsoff continued to read from page 22 and page 23, (Exhibit G).]

We continue to increase federal revenue for Nevada, especially through a program such as the county match program. [Ms. Squartsoff continued to read from page 24, (Exhibit G).]

There are some additional details about the disproportionate share hospital (DSH), the upper payment limit, and the nursing facility quality improvement tax included for you on page 25 (Exhibit G). I would be happy to take any questions, and we can ensure that we provide you with additional details.

The Nevada Check Up program was authorized by Congress in 1997 as Title XXI of the Social Security Act. [Ms. Squartsoff continued to read from page 26 and 27, (Exhibit G).]

On page 28 (Exhibit G), we show how the caseload for Nevada Check Up has changed over the course of the last year and a half. The numbers have reduced from what was projected earlier, from 24,000 to 25,000 children covered under Nevada Check Up, to our January 2015 projection of 19,672.

Assemblywoman Titus:
To back up a little bit to the statement that if they apply it does not affect their immigration status [page 27, (Exhibit G)]; this is not just limited to citizens?

Elizabeth Aiello:
Children who are legal in the country for five years can also apply, so they do not need to be citizens; but a lot of times children may be born here but their parents are not citizens or not legal. The child is a citizen and a lot of times there are parents that are a little bit nervous about applying, so that is where that statement originated. No one looks at the immigration status if the child is a citizen or is legally in the country for five years.

Assemblyman Moore:
What exactly is medically indigent? Is it just an indigent person? How are you medically indigent versus being indigent?

Laurie Squartsoff:
I understand the question, and I will get the answer back to you so we can have the additional clarification.

Assemblywoman Spiegel:
Back to slide 21 (Exhibit G), when we talk about Medicaid funding and the newly eligibles, is that just from when the ACA went into effect and those people are the "newly eligibles" forever, or does that also include people who become newly eligible in, for example, 2018, 2019, 2020, and down the road?

Laurie Squartsoff:
The definition of newly eligibles is those who were eligible as of the implementation of the Affordable Care Act of January 2013. There may be people who will enroll in the program who, based on their decision, have chosen not to enroll; but if they are between the ages of 19 and 64 and meet the definition and the income requirements, then they would fall into that category of newly eligible.

Elizabeth Aiello:
I want to expand a bit because people who would have been eligible prior to January 1, 2014, but had their eligibility determination after January 1, 2014, are considered in our prior program and have the 65/35 match. The ones that have the 100 percent match are only those that meet the new category of eligibility.

Assemblyman Moore:
With regard to the immigration status, if you cannot ask someone or do not ask that question, how do you determine if the children are citizens? How do we assure that they are citizens that are receiving care funded by taxpayers?

Elizabeth Aiello:
They do have to show citizenship documentation and/or legal documentation for the child, but it may not affect the family's immigration status. For the person for whom we are determining eligibility, information has to be provided. This will be a better question for the Division of Welfare and Supportive Services because we contract eligibility determinations to them interlocally. However, a lot of that is done electronically with some of the new systems reaching out to the federal hub.

Assemblyman Jones:
This happens often in these presentations, phrases like, "200 percent of federal poverty level," or "five times minimum wage," so what exactly is the amount right now that is 200 percent of federal poverty level for a CHP or for children's Medicaid to happen? Or eligibility?

Elizabeth Aiello:
Welfare just got 2015 data a week or two ago. You can see the 2014 Federal Poverty Guidelines on page 12 (Exhibit G), so that would give you a general idea. Of course, it is different as the household size changes or increases.

Assemblyman Jones:
So the 200 percent would be $23,340 for Household Size 1?

Elizabeth Aiello:
Yes.

Laurie Squartsoff:
Some of the other activities that we do within the Division of Health Care Financing and Policy (DHCFP) that are grant funded, we have a program called the Money Follows the Person. It is a $9.9 million grant from the years 2011 to 2016 with a no-cost extension through 2019. We have our Medicaid Incentives for the Prevention of Chronic Diseases Model working primarily with children with diabetes. [Ms. Squartsoff continued to read from page 29, (Exhibit G).]

Assemblywoman Titus:
You mentioned that you had this grant for diabetes; can you tell me what the interventions are and how you are using that grant in particular? What programs did you look at to help with the problems with diabetes?

Elizabeth Aiello:
The Medicaid Incentives for Prevention of Chronic Disease are not specifically just diabetes, and we have five entities that are partners with the grant. They include the Children's Heart Center which enrolled the lion's share, both our managed care programs, Health Plan of Nevada and Amerigroup, and the University Medical Center Lied Clinic prior to closing was a partner in that, and they had a few people enrolled. The YMCA of Southern Nevada enrolled one person, so we probably will not get a lot of statistics there.

There is a program called ChipRewards, and it is specific to Medicaid programs in the country. A lot of us have incentives to do some preventions because we get decreases in our own insurance packages, but in Medicaid there is not a premium or copay. The idea is when people are concerned about where their next meal is, different things within the world incentivize people to get health care coverage. People earn points, and it is a study. We are done enrolling people as of last December, and that study data will crank out; but it is a ChipRewards system where people can get things off the Internet. They earn things not just for going to the program but for making milestones like decreasing obesity, body mass index, or different things like that, and then maintaining it over time.

Assemblywoman Titus:
I am interested in looking at some incentive programs to make sure the patients are their best advocates for their own health, and I would like to talk to you more about that particular program. How much money did you invest in that program? How much money was that grant?

Elizabeth Aiello:
This grant was $3.5 million for a study. Through CHP, it buys people rewards, but it is a study. It is federal funds that we were awarded the grant from the Centers for Medicare and Medicaid Services (CMS). It was one of the grants available under health care reform.

Assemblywoman Titus:
How much of that $3.5 million went to direct patient programs versus administrative costs?

Elizabeth Aiello:
The grant is for research and demonstration. People are getting that the individuals do not get a huge payment. The money went to incentives and then to pay for the research. We are still in process; the end is in December 2015, and all the research has to be finalized, so I cannot tell you how much actually went out in incentives. A lot of it would be whether people actually made their goals and used the incentives and those types of things. We are still in process with all of that.

Assemblywoman Titus:
If you can provide to this Committee, and certainly to me, the number of patients that were actually involved.

Elizabeth Aiello:
We get regular updates so I will get those handouts to you.

Assemblyman Trowbridge:
I have received information from other sources about some of these wellness programs that are offered by insurance companies, and they simply are not working. They provide incentives to people to achieve certain goals—weight loss, workout, study guides, these types of things. However, the program costs more to market than the number of participants that are derived. It is a good idea that simply has not worked yet, but I look forward to seeing the same data you send Assemblywoman Titus, and maybe she can explain it to me.

Assemblyman Thompson:
I am so excited that the Medicaid expansion has been and continues to be a success for our community, and I want to say on the record for any of those service providers, those community-based organizations, those navigators that put in the hard work, thank you so much because it helps so many people. My question is on the activities and grants: tell me a little more about the Money Follows the Person program.

Elizabeth Aiello:
The Money Follows the Person program is actually a program where individuals who are in an institution are assisted to get back into community living. The idea is you would pay less in the community than you would in the institution to support the same individual. If someone has been in an institution, and an institution might be a nursing facility or an Intermediate Care Facility for the Mentally Retarded for intellectual disabilities, and if they are in a setting for 10 or 11 months, a lot of times they have lost their home because they cannot pay rent while they are in an institution. They sometimes lose their furniture and everything, so how do they get out, especially if they have to pay when Medicaid is funding their patient liability to cover the institution costs and they have just a small match that is for personal needs. The Money Follows the Person program is a demonstration grant where we go into nursing facilities and help staff identify long-term residents who would like to leave the facility. It helps fund some of the infrastructure to get them out. It may pay for the first month's rent on an apartment or pay for some utilities to help get people out of the nursing facility.

Assemblyman Thompson:
You used the word institution, so follow my logic on this: does that cover a person that may have gone into prison? Often Medicaid pays for their services, and a lot of things happen if they are in the institution for 10 months or a few years. The challenge we have is when they are discharged, they have nothing. If the money follows the person, would this be an example of the Money Follows the Person program? We always have those struggles when people are discharged from prison; they are homeless or at risk of homelessness. It would be great to know that money is following some of these people so when they are coming back to our communities, as you said, they have that one month's rent.

Elizabeth Aiello:
That would be a situation where that needs to happen, but the federal grant covers nursing facilities and intermediate care facilities for intellectually disabled. Medicaid cannot pay the medical expenses for someone when they are incarcerated in a correctional facility; that is one of the base Medicaid rules.

My editorial feelings are because the state has paid for them before Medicaid was enacted in the 1960s, they did not want to take federal funding, but I do not know 100 percent. That is what I have been told anecdotally. Medicaid does not pay for people's medical expenses while they are incarcerated.

Assemblyman Thompson:
If they were on Medicaid prior to being incarcerated, would it not help them then?

Elizabeth Aiello:
It is a good idea, I think it is needed, and it would help them; but it is not allowable under the grant.

Laurie Squartsoff:
On page 30 (Exhibit G), we talk about our major budget initiative. Applied Behavior Analysis is a program we are working on for children with autism spectrum disorder, and this chart is intended to give you a high-level overview of where we are with this project. I have another chart, if it would be requested, that provides you with more specific details on the dates as we move forward. Looking at the program in April 2014, we developed a budget concept paper for Applied Behavior Analysis. We have obtained information from the two states that started the program once the federal government made the decision that the program would be mandatory. We got information from Louisiana and Washington. We continue to work with, and our staff has been exemplary with, having public workshops to make sure that we have all of our stakeholders involved in this process. We are continuing to move forward with our internal clearance process and our state plan amendments. Currently our projected time frame for this policy to go into effect is January 2016, and that is pending CMS approval for the project and legislative approval for the funding for the program.

One of the questions that regularly comes up deals with access to care. When the number of Nevadans with health care coverage increases and the statewide access to a provider pool of health care providers remains the same, access to health care becomes a statewide issue. It is more than just a Medicaid issue [page 31, (Exhibit G).] The good news is that we have been able to reduce our uninsured rate in the state from 23 percent to 11 percent so more people are getting needed care; but we continue to explore the opportunities for people to continue to get services where there are gaps of resources. We are currently involved with a secret shopper program with our external quality review organization to assess the access to care for services. That program has started, and we expect that we will have the results of that study in May. We will be able to provide some additional information for you that will more fully address not only where we have providers but where we may have providers who are currently Medicaid providers but who may or may not be accepting new beneficiaries under their programs.

Chair Oscarson:
As you get that information, even if it is not complete, whatever you can provide to the Committee as far as what you are finding out would be very helpful. We get pushed for time because the session ends in June, and the Interim Committee on Health Care will keep up with you getting that information, but whatever you get this Committee would be greatly appreciated.

Assemblyman Araujo:
Medicaid is a huge issue for the residents of my district. If I were to come to you in order to get services as a constituent, how long would I be looking at from inception all the way to the end when I would receive that formal letter approving me for Medicaid services?

Laurie Squartsoff:
Because our eligibility decisions are made through the Division of Welfare and Supportive Services, I will defer to them for the answer; but I would be happy to ask the question of them.

The question continues—what has Medicaid done to address the issue of access to care? We have made several policy changes in the last year to help with this process, including the expansion of our telehealth policy; historically we have had a geographic restriction where the services were only available in rural Nevada. We have eliminated those geographical restrictions on the originating site so it can be anywhere in the state. [Continued to read from page 32, (Exhibit G).]

Medicaid does provide quality services through our provider network for families and individuals with low incomes and limited resources, and we appreciate the opportunity to provide an overview of the program to you.

Chair Oscarson:
Are there any questions? [There were none.] We will now open the hearing on Assembly Bill 41.

Assembly Bill 41: Revises provisions relating to funding for indigent care. (BDR 38-327)

Jan Prentice, Chief, Rates and Cost Containment, Division of Health Care Financing and Policy, Department of Health and Human Services:
I will give an overview of Assembly Bill 41. We are proposing this bill because it clarifies *Nevada Revised Statutes* (NRS) language and intent; it allows the board of trustees of the Fund for Hospital Care to Indigent Persons the discretion as to whom they may enter into an agreement with. It removes

language that allows hospitals to be assessed to pay for indigent care, thereby allowing the Division of Health Care Financing and Policy (DHCFP) to use those indigent care funds as the nonfederal share for supplemental payments. It allows funds to be balanced forward to be used for indigent care or as the nonfederal share for Medicaid supplement payments or enhanced rates. It also deletes obsolete sections of the NRS. There is no fiscal impact to these changes; it is basically a cleanup of prior changes in the previous legislative session.

Chair Oscarson:
It is just cleanup and allows you to not get your money swept. You can keep it and apply it to the supplemental payment fund for the hospitals and the indigent fees where we know the disproportionate share hospital (DSH) funds continue to be depleted and lowered. This will give you a little bit of a cushion to be able to pay them some additional if it is appropriate and needed, correct?

Jan Prentice:
It is actually the county's money, and that is why some of these changes needed to happen. Some of these funds are being directed toward DHCFP to pay supplemental payments, but it is county money that is overseen by the board of the fund.

Assemblyman Thompson:
Regarding section 1, subsection 5, lines 16-18, where you are asking for the money to be rolled over, you said so it does not revert to the State General Fund, but then I heard you say that it is the county's money, so I am trying to understand, whose money is it?

Jan Prentice:
It is the indigent care funds, and it is regulated by the board of the fund, so some of the money is directed towards DHCFP to supplement the state's share. What happened before was that it was decided by the board how to use that money that was left, but it was previously swept. This allows it to be rolled over, and it can have multiple uses. They can use it to pay indigent claims to the hospitals; they can direct more of it to DHCFP to pay supplemental payments or to even enhance rates. It gives more options.

Assemblyman Thompson:
In 2014, how much money was left over? Are we looking at thousands of dollars? What are we looking at?

Jan Prentice:
I do not have that information, but I know there are county representatives here that might have some indication of that leftover funding. All I am aware of is how much was sent to DHCFP to be used in the supplemental payment program.

Assemblyman Sprinkle:
Since it does not look like this bill is going to be diverted over to a money committee because there is no impact, could you come up with a number as to how much money was involved, even just last year or last biennium? It looks like it is a 50/50 split if I look at statute, but for that money that reverted back to General Fund, I think it is important for us to know how much of that is not going to be in the General Fund any longer. Normally I would ask this question in Ways and Means, but it does not look like this bill will be going there.

Section 2, subsection 1, talks about changing who has the oversight for necessary contracts. I wonder why these contracts are necessary for the implementation of this. Secondly, why is there this desire to remove it from the oversight of the Office of the Governor?

Jan Prentice:
The original way it was set up was that the contracts would be between DHCFP and the county to use these funds. When we did the state plan amendment and went to CMS, their requirements are that DHCFP cannot direct these funds and we cannot enter into the contract. The contracts have to be between the board and the counties, so that is why the change is needed in this language.

Bonnie Long, Administrative Services Officer III, Director's Office, Department of Health and Human Services:
In the last couple of years, we have been able to work with the board of trustees for this account, and we have been able to pay out claims at the end of the year so that there was no money remaining that could have been swept. Last year was about $1.5 million and the year before that was about $500,000.

Chair Oscarson:
You paid claims specifically for indigent care? So you did not have any money left?

Jeff Fontaine, Executive Director, Nevada Association of Counties:
I would like to give a little history behind the funds so everybody understands what it is. What we are talking about here is one and a half cents in property tax levy that was requested by the counties in conjunction with the hospitals about 25 years ago. The purpose of that property tax levy was to pay claims

for the medically indigent who otherwise would have no ability to pay their hospital bills and who needed hospital care as a result of an automobile or motor vehicle crash.

Because of NRS Chapter 428, the counties are financially liable for the medically indigent. We had situations in some of the rural counties where we had motor vehicle crashes where three or four individuals were injured and needed hospital care and were indigent. The counties received a bill from the hospital that they could not pay, and so this was put in place as a catastrophic fund to help pay those claims.

It worked very well for many, many years, and then in 2008 the fund was swept to help the state balance its budget. It was swept for approximately five years, and the last biennium the Governor recommended and the Legislature approved the return of the fund to the counties. With that, the counties, the hospitals, and the Department of Health and Human Services all agreed that because of the Affordable Care Act and somewhat of a diminishing need, at least that we could perceive at the time for this type of fund, that we should take a look at utilizing those funds for different purposes, including using it to leverage additional federal Medicaid dollars. Through the hard work of the Department of Health and Human Services, we have been able to do that.

We were also able to set aside a certain amount of funds, and this was done in cooperation with the hospitals for counties to utilize to help them offset the growing liability for their nonfederal share of Medicaid to pay for long-term nursing home care. That was a result of an increased assessment to the counties for that cost as well. That is what happened and the board for the Fund for Hospital Care to Indigent Persons did decide to put into reserve $2 million in fiscal year 2014 for the purpose of helping individual counties who were having a difficult time paying that assessment. The reason that is important is because every county has to participate in that program or else we do not have a program. For those counties that are having financial difficulties this is an important program, and so that was done. The purpose of this "carry forward" or ability to carry forward is to help counties meet their long-term obligations so we have a long-term care Medicaid program.

Assemblywoman Benitez-Thompson:
My understanding of the testimony over the past couple of sessions on the indigent care fund is that it was so needed in counties that were in dire financial straits that I cannot imagine that there is a penny left over at the end of the year and that the fund is not completely expended. That is how I feel the conversations went over the past couple of sessions—what a hardship it was. Talk to me about how you acquire reserves and maybe a little more about that

$2 million number. How did you come up with that as an appropriate reserve amount, and then what happens if these reserves grow? I would never have thought you would have the ability to grow or retain reserves in the big financial picture.

Jeff Fontaine:
It is true, we did ask for the ability to have a set-aside to help counties meet their financial obligation. We did get a late start in getting Senate Bill No. 452 of the 77th Session, the enabling legislation, underway. It was a complete revamp of the use of that fund and deciding what the requirements would be to do the state plan amendment for Medicaid so that we could get the additional Federal Medicaid dollars and how much we would need to do that.

It took the better part of a year just to get CMS to approve our state plan amendment, so it was a little late in getting implemented and determining how much we could set aside for the counties. Once we determined that, then we had to go out and actually develop guidance that the counties had to meet in order to even qualify for those funds. What we did not want to do is just to say, "We have $2 million. First come, first served, you get what we have." We wanted to make sure we put into place some strict requirements in order to be eligible to receive those funds. For example, that you had to implement your full indigent property tax levy, you had to be spending all of those revenues on indigent services before you could even qualify to receive those funds. That part of it we pretty much have in place.

The other part of it is that this is a growing obligation for the counties; you know what the demographics are in this state as far as our aging population and those that are going to require these kinds of services for which the county is going to have to pay. We want to make sure that we do not find ourselves in a situation where we have a county that is unable to pay the Medicaid match assessment and the whole program collapses. We are trying to balance the need today versus what we think is going to be the need in the future.

Assemblyman Sprinkle:
I am looking at NRS 428.295, subsection 4, and it talks about when the counties are not able to meet their requirements. Does the board not have the ability to come to the Interim Finance Committee to help supplement this fund if it were to be the case that the counties can no longer meet their obligations?

Jeff Fontaine:
I do not believe that they would. They are not a state agency; they are an independent board that is appointed by the Governor.

Assemblyman Trowbridge:
Are any of these funds available to the counties for their indigent health care hospitals? If I read the paper correctly, I think that Clark County is anticipating a $70 million deficit this year.

Jeff Fontaine:
The short answer is yes, but it is a very complex system in order to get those funds to the county.

Assemblyman Trowbridge:
How will they get the funds that are allocated based upon need? Seventy million dollars is not a trifle.

Jan Prentice:
Yes, the program that we have for the indigent accident fund is based on their need. In answer to Assemblywoman Benitez-Thompson's question, it did take a year to get the state plan amendment through CMS, and one of the reasons why there was leftover funding is we had originally drafted the state plan to use all the funding available, and because we did not know what that was until it was collected, the CMS would not allow us to put a methodology in there. They wanted a hard number so we only could do the state plan for a certain set amount. We have to go back every two years, do a new state plan amendment, and let them know what funding is available. That carryover is going to be important to us too because we will know in advance how much is available for the next biennium for the supplemental payments.

Those supplemental payments do go directly to the hospitals, and I can get you the exact number and the distribution. We just started paying out the supplemental payments this year, so I can get you those exact numbers and which hospitals received those.

Chair Oscarson:
Any further questions? [There were none.] We will now take testimony in support of Assembly Bill 41.

Mary C. Walker, representing Carson City, Douglas County, Lyon County, and Storey County:
I have two counties, Carson City and Lyon County, who are two of the several that have problems making the county long-term care match program. I think what is important from a state perspective, this program is called the county long-term care program, and as Mr. Fontaine stated, $2 million was set aside to help the counties pay for these long-term care payments. It is called the county match program, but to me that is a misnomer. It is actually a state match

program that is funded by the counties. It is a Medicaid program and Medicaid, per the federal law, has to be for all counties; it has to be statewide. You cannot have a Medicaid program in one area of the state and not in another.

The situation that we have with this county match program is every year the counties, all 17 of them, have to sign a contract with the state of Nevada saying that they will levy these taxes and they will pay for this program. If you have one county that does not sign that agreement and does not make those payments, then you no longer have a state program and the federal monies are at risk because it is not a state program. Last session Michael J. Willden, Director, Department of Health and Human Services, gave testimony that it was approximately $50 million of federal funding that would be at risk if you had a county that could not continue with this program and did not sign the agreement. This $2 million that Mr. Fontaine stated was set aside is basically insurance, insurance that the state of Nevada does not lose the $50 million that goes to pay for long-term care in this county match program. That is how I would phrase it; it is very important not just for the counties but for the state of Nevada. Fifty million dollars to go for long-term care, that is a lot of elderly people being cared for.

Ken Retteroth, Division Director, Washoe County Social Services:
We want to go on the record in support of this bill and thank the department for bringing it forward.

Jeff Fontaine:
We support the bill as well.

Yolanda King, Chief Financial Officer, Department of Finance, Clark County:
For obvious reasons, we absolutely support the bill that has been presented to you and would ask your approval.

Assemblyman Jones:
Ms. King, who do you represent?

Yolanda T. King:
I represent Clark County.

Assemblywoman Benitez-Thompson:
I absolutely agree with what Mary Walker said, and I appreciate all the counties coming forward in support. As a legislator who served in the 2011 Session, there was nothing worse than realizing the different types of cuts that you had to make, especially being a member of Health and Human Services and realizing

that in the course of 24 hours we cut $48 million from mental health. All of it was rural mental health because we did not have the money to fund it. We went in and we started sweeping county dollars as well. We knew that was hard on you, but if the state does not have money for funding then we come after your accounts. What I sincerely hope is that just as you were advocating to us, you are going back to the citizens of your counties, especially the rural ones, to help them appreciate the need for more revenue in this state so we do not have to come get into your pockets.

Chair Oscarson:
Any testimony in opposition? [There was none.] Any testimony in neutral? [There was none.] Seeing no further testimony, I will close the hearing on Assembly Bill 41. I will now open the meeting for public comment. Is there anyone who would like to make any public comment? [There was no one.]

This meeting is adjourned [at 3:03 p.m.].

RESPECTFULLY SUBMITTED:

_____
Nancy Weyhe
Committee Secretary

APPROVED BY:

_____
Assemblyman James Oscarson, Chair

DATE: _____

EXHIBITS

Committee Name: Committee on Health and Human Services

Date: February 20, 2015 **Time of Meeting: 1:33 p.m.**

Bill	Exhibit	Witness / Agency	Description
	A		Agenda
	B		Attendance Roster
AB99	C	Kirsten Coulombe, Committee Policy Analyst	Work Session Document,
AB99	D	Kirsten Coulombe, Committee Policy Analyst	Proposed Amendment
AB99	E	Assemblyman Ellison	Elko Board of Commissioners Letter and Appraisal Packet
AB29	F	Kirsten Coulombe, Committee Policy Analyst	Work Session Document
	G	Laurie Squartsoff, Department of Health and Human Services	Medicaid Presentation