MINUTES OF THE
LEGISLATIVE COMMISSION'S BUDGET SUBCOMMITTEE
Seventy-Eighth Session
January 21, 2015

The Legislative Commission's Budget Subcommittee was called to order by Chair Paul Anderson at 8:34 a.m. on January 21, 2015, in Room 4100 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. 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 video or audio record 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).

ASSEMBLY SUBCOMMITTEE MEMBERS PRESENT:

Assemblyman Paul Anderson, Chair
Assemblyman John Hambrick, Vice Chair
Assemblyman Derek Armstrong
Assemblywoman Teresa Benitez-Thompson
Assemblywoman Irene Bustamante Adams
Assemblywoman Maggie Carlton
Assemblywoman Jill Dickman
Assemblyman Chris Edwards
Assemblyman Pat Hickey
Assemblywoman Marilyn K. Kirkpatrick
Assemblyman Randy Kirner
Assemblyman James Oscarson
Assemblyman Michael Sprinkle
Assemblywoman Heidi Swank
Assemblywoman Robin Titus

SENATE SUBCOMMITTEE MEMBERS PRESENT

Senator Ben Kieckhefer, Chair
Senator Michael Roberson, Vice Chair
Senator Pete Goicoechea
Senator Mark Lipparelli
Senator David R. Parks
Senator Debbie Smith
Senator Joyce Woodhouse

STAFF MEMBERS PRESENT:

Cindy Jones, Assembly Fiscal Analyst
Mark Krmpotic, Senate Fiscal Analyst
Stephanie Day, Principal Deputy Fiscal Analyst
Alex Haartz, Principal Deputy Fiscal Analyst
Linda Blevins, Committee Secretary
Cynthia Wyett, Committee Assistant

Following call of the roll, Chair Anderson advised the Subcommittee that the purpose of the meeting was to hear an overview of the budgets for the Department of Health and Human Services. He instructed the Subcommittee that although questions were encouraged, there would be many opportunities for questions at the budget hearings during the 2015 Legislative Session.

Chair Anderson opened the meeting for public comment. There being none, Chair Anderson recognized Romaine Gilliland, Director, Department of Health and Human Services (DHHS).

Mr. Gilliland explained he had been the director since the summer of 2014, and he welcomed the opportunity to appear before the legislative body. He was accompanied by Dena Schmidt, Deputy Director, Programs; Bonnie Long, Administrative Services Officer, Director's Office; and Ellen Crecelius, Deputy Director, Fiscal Services.

Mr. Gilliland began his presentation on page 2 of Exhibit C, "DHHS Highlights—Pre-Session Budget Hearing, Budget Subcommittee," quoting, "The Department of Health and Human Services (DHHS) promotes the health and well-being of Nevadans through the delivery of essential services to ensure families are strengthened, public health is protected, and individuals achieve their highest level of self-sufficiency."

He further explained that DHHS consisted of the divisions of Aging and Disability Services, Child and Family Services, Health Care Financing and Policy, Public and Behavioral Health, and Welfare and Supportive Services. Mr. Gilliland then described the organizational chart on page 3 of the exhibit.

Directing the Subcommittee's attention to pages 4 and 5 of Exhibit C, Mr. Gilliland noted the State General Funds for the 2013-2015 biennium were $2,043,980,148 and for the 2015-2017 biennium, they were $2,179,031,863. The exhibit displayed the changes for various expenditure types over the 2013-2015 biennium. There was an increase in the "Caseload" category of $182,440,477 and a decrease in the "Other" category of $142,571,607. One of the areas where General Funds were reduced was the "newly eligible" with enhanced Affordable Care Act (ACA) Federal Medical Assistance Percentage (FMAP) and the behavioral health billings. Mr. Gilliland explained that an item previously funded with General Funds was now funded with a combination of federal funds and State General Funds, thus reducing the state's burden.

As shown on page 5, the Division of Health Care Financing and Policy (DHCFP) comprised the largest General Fund component of the Department, according to Mr. Gilliland. The DHCFP processed the Medicaid provider payments.

Revenues by division were shown on pages 6 and 7 of Exhibit C. The legislatively approved budget for the 2013-2015 biennium was $7,413,368,829. Mr. Gilliland noted the Governor's recommended budget for the 2015-2017 biennium was $9,566,464,616, and he noted that the change in the overall spending by type was positive in each category. The Governor had recommended an increase of nearly $1.2 billion for the 2015-2017 biennium. Funding sources for FY 2016 and 2017 were displayed on page 8.

The approximately $5.1 billion of federal funding represented 73 percent of the total DHHS expenditures, according to Mr. Gilliland. Page 7 displayed revenues by division for fiscal years (FY) 2016 and 2017. The General Fund share had decreased from 28 percent to 24 percent for DHHS.

The Federal Medical Assistance Percentage (FMAP) on page 9 displayed percentages for fiscal years 2003 through 2020. The projections for FY 2016 indicated the total FMAP at 64.79 percent and the "New Eligibles" FMAP for FY 2016 at 100 percent, but decreasing to 91.5 percent by FY 2020.

Mr. Gilliland remarked that while the administrator of each division in the Department would provide details of division activities, he would explain the key areas of focus for the Department. In his opinion, the key area of focus for the 2015-2017 biennium was the improved coordination of activities among the divisions. Mr. Gilliland had requested the Office of the Director to assist with bridging the gaps between the divisions. One significant item was the effective use of Medicaid eligibility in each division to limit the General Fund expenditures. The key areas Mr. Gilliland indicated were as follows:

- Timely, accurate, and cost-effective service delivery and case management.

- Behavioral health and wellness.

- Maximization of Medicaid federal fund participation, innovation, and optimization.

- Food security, such as the Supplemental Nutrition Assistance Program (SNAP) and the Special Supplemental Nutrition Program for Women, Infants and Children (WIC).

Mr. Gilliland advised the Subcommittee that page 12 of the exhibit revealed the accomplishments DHHS worked toward during the 2013-2015 biennium. The first accomplishment was the eligibility case processing and consisted of timeliness, process reengineering, lobby management, and call center enhancements. The goal was to maximize the efficiency of every eligibility caseworker to ensure DHHS could handle the increased caseload without significant staffing increases.

The next accomplishment, Mr. Gilliland explained, was the uninsured rate. He pointed out the mid-2013 uninsured rate was 23 percent, but the current rate was 11 percent. He said the lower rate was because of the combined effects of the Affordable Care Act (ACA) and the Medicaid expansion.

The third accomplishment was the Medicaid expansion, with a projected 147,000 newly eligible individuals. Mr. Gilliland reminded the Subcommittee members that they had previously heard the Medicaid expansion population was 160,000. It was his aim to connect the two numbers. Currently, the Medicaid expansion population was 160,000, he said, and he predicted that by the end of the 2015-2017 biennium the population would be 147,000. He anticipated the reduction would take place as the economy improved and more individuals moved above the poverty level. Additionally, ACA and expansion coverage had

increased services to Medicaid by approximately 300,000 Nevadans. In addition, enhanced behavioral health services had allowed DHHS to use Medicaid dollars for services previously funded with State General Funds.

Mr. Gilliland continued with the list of accomplishments, noting that managed care or timely appropriate health care was a concern for all Nevadans. Access to health care was being researched for methods for improvement. The DHHS was performing a more in-depth analysis of the health-care gap. For example, the Office of the Attorney General, from a federal perspective, had recognized the gap, noting that the number of physicians accepting Medicaid patients was unknown. It was necessary to perform a "secret shopper" study to determine whether the physicians were taking Medicaid patients, whether they were maxed out, and whether the physicians anticipated taking additional Medicaid patients later. Mr. Gilliland stated DHHS was moving forward on this analysis; unfortunately, the analysis would not be completed until about May 2015. However, he assured the Subcommittee it was high on the list of priorities for DHHS. It was important to bridge the gap of providers.

Mr. Gilliland moved to page 14 of the presentation and mentioned three major budget initiatives. The first initiative was for children with autism spectrum disorder (ASD). This would be referenced in the budget presentations of both the Aging and Disability Services Division (ADSD), which managed the Autism Treatment Assistance Program (ATAP), and applied behavioral analysis (ABA) under the Division of Health Care Financing and Policy (DHCFP). He hoped DHCFP would have the coverage for ABA services in place by January 2016. The major budget initiative increased spending by approximately $61.8 million in General Fund dollars, for a total overall spending for ASD of about $73 million.

The chart displayed on page 15 of Exhibit C showed the population increases for the ATAP. The gray area on the graph indicated the unserved population. Mr. Gilliland hoped that more children could be served with the funding requested in The Executive Budget.

Responding to a question from Senator Kieckhefer, Mr. Gilliland explained that with ATAP, a large percentage of the traditional client base was Medicaid-eligible. Accordingly, as the ABA was put into place through Medicaid, ADSD would receive a reimbursement for the Medicaid-eligible portion. He recalled that approximately 40 percent of the ADSD population used Medicaid. Whenever possible, ADSD would use Medicaid as a pay source. Waitlisted clients who were Medicaid-eligible would have access to services through ABA.

Mr. Gilliland further explained that a concern was not only the regulatory environment, but also the number of qualified providers. The funding request for the 2015-2017 biennial budget was phased-in consistent with when the provider community would be able to provide services.

Assemblywoman Titus asked for clarification of the requested budget amounts. Mr. Gilliland confirmed that the requested funds of approximately $73 million would serve about 1,879 children with ASD over the biennium.

Assemblywoman Carlton expressed her confusion over the number of waitlisted children. It appeared that the original number would have eliminated the waitlist; however, it now seemed that there would be a waitlist, but funds would be available to cover some of the waitlisted children.

Mr. Gilliland responded that the ATAP waitlist was anticipated to be 1,001 children. There would continue to be a waitlist. There would be two possibilities for services: one through the ATAP program in the ADSD to serve both Medicaid- and non-Medicaid-eligible children, and the other through ABA in the DHCFP for only Medicaid-eligible children.

Assemblyman Edwards noted that 30 percent of waitlisted children would not be receiving services, and he wondered what provisions would be made for those children.

Mr. Gilliland said the children would either receive services as individuals or not receive adequate services. While it was preferable to serve all of the children, there was neither sufficient funding nor the availability of services.

Assemblyman Edwards questioned what would be required to increase the number of providers so services could be available for all of the children. Mr. Gilliland did not have the numbers readily available, but the information would be provided to the Subcommittee later. Mr. Gilliland suggested the possibility of school-based services to allow children to receive some assistance through the educational environment.

Responding to Assemblywoman Kirkpatrick, Mr. Gilliland testified that approximately $28 million of the $73 million requested in The Executive Budget was coming from federal funds.

Continuing on page 16 of the presentation, Mr. Gilliland noted the major budget initiative for the Muri Stein Hospital and the expansion of the state forensic behavioral health services. During the 2013 Legislative Session, funds were

approved to remodel the Muri Stein Hospital to provide additional forensic behavioral health beds in southern Nevada. The remodel was scheduled to be completed in September 2015. The major budget initiative was for $20,703,121 to provide 154.02 full-time-equivalent (FTE) employees.

The third major budget initiative was shown on page 17 of Exhibit C. Mr. Gilliland detailed the pilot program to provide the most effective and appropriate services for children in foster care with severe behavioral and emotional problems within their own communities. Both the southern and northern pilot programs had been successful. Consequently, $13,205,911 was requested in The Executive Budget to fund ten FTE employees for the program.

Mr. Gilliland moved to page 19 of the presentation, noting the estimated number of Medicaid recipients at the end of the current biennium was 561,037. There was a forecasting change made recently that Mr. Gilliland explained. The DHHS reviewed the number of member months for which someone was eligible. When first applying for Medicaid, the applicant was eligible for Medicaid up to three months before that date for covered services. A backlog of applications combined with these "retro-months" overstated the number of reported Medicaid participants. The actual caseload peaked at approximately 565,000, with another 30,000 to 40,000 Medicaid-eligible who had yet to apply.

The Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF) were shown on pages 20 and 21 of Mr. Gilliland's presentation, which indicated a reduction in the TANF population. This would continue because there was a strengthening of the economy in the state.

Mr. Gilliland noted that page 23 provided an overview of the FTEs for DHHS. For FY 2015, there was a legislatively approved staffing level of 5,540, and there was a request for an additional 369 FTE for FY 2016. Approximately 146 of the positons requested were eligibility workers.

Assemblyman Kirner remarked that during the 2013 Legislative Session, approximately 420 FTE positions were approved to assist with the projected increase in enrollment into the Medicaid program because of the ACA. He questioned the status of those 420 positions.

Mr. Gilliland explained the 420 FTE positions had been hired and trained as projected. However, when considering all of the public assistance programs, such as SNAP, TANF, and Medicaid, increases were still occurring. During the

same period, the efficiency of SNAP was increased by 10 to 15 percent. The 146 FTE positions requested for the 2015-2017 biennium were a composite of both the increase in caseload and the reduction in needs by continued improvement in the processing procedures. Additionally, DHHS had increased call-center staff to improve the responsiveness to questions from the applicants. Call times had decreased from 15 minutes to 2 minutes. The call center had also implemented programs to allow callers to leave a number for a return call.

Mr. Gilliland believed another factor was the redetermination process that occurred every 6 to 12 months, depending on the program. During the summer of 2014, DHHS had reached a peak of 60,000 to 70,000 pending applications, which had been reduced to less than 20,000. A three-month deferral of the redetermination process had been requested from the federal government. As a result, the current process included a redetermination of the full population, slight increases in Medicaid, and a significant increase in SNAP. Mr. Gilliland thought that with the improvements, DHHS could limit the number of the requested increases of staff.

Chair Anderson noted that SNAP, TANF, and Medicaid were meant to be temporary programs, but enrollment continued to increase. He believed this was a symptom of a problem with SNAP and TANF; Medicaid could be a different problem. He suggested a thorough discussion later to develop a plan to help individuals get off these programs.

Mr. Gilliland responded that the mission of DHHS was to allow individuals to reach their highest level of self-sufficiency. That level was different for each individual. He was hopeful everyone could reach a level of not relying on public assistance. Although Nevada's economy had improved, the higher income levels had improved first, and the lower income levels lagged behind. Working in collaboration with the Department of Employment, Training and Rehabilitation (DETR) and the Division of Welfare and Supportive Services (DWSS), there needed to be a plan in place to meet the target audience. The amount of SNAP benefits decreased as the income level increased. The expanded Medicaid population anticipated at the beginning of the biennium, and the projected reduction from 160,000 to 147,000, were a direct reflection of an improved employment environment for the lower income population.

Chair Anderson thought helping individuals improve their education and employment status would make them become more self-sufficient and less reliant on public assistance.

Assemblywoman Kirkpatrick wondered whether Mr. Gilliland could provide a breakdown of the age groups being served. She believed many seniors were provided SNAP benefits.

Mr. Gilliland responded there were many dual eligibles with Medicaid, Medicare, and SNAP benefits and no future employment opportunities. Looking at self-sufficiency being the highest level for an individual, a person might always require some type of public assistance. However, the emphasis was to continue to try to get each individual to his or her personal highest level of self-sufficiency.

Assemblywoman Carlton commented that the individuals involved tended to run up against barriers, such as the minimum wage. While the minimum wages were low, individuals could still apply for services. In many cases, it was not that the individual had not reached his potential, but that the potential was not recognized in the paychecks.

Mr. Gilliland moved on to page 24 of Exhibit C, which reflected a chart of FTE positions by division for fiscal year (FY) 2008 through FY 2017. The number of DWSS staff was increased from 1,275 in FY 2008 to 1,943 in FY 2017. The eligible participants had more than doubled during this same period.

The chart on page 26 compared Medicaid recipients with and without the Affordable Care Act (ACA) expansion. Per Mr. Gilliland, without the ACA expansion, Nevada would have had 419,903 participants. However, with the ACA expansion, the participation increased to 561,037. This had a positive effect on the General Fund, especially in the area of behavioral health. The expanded population had a high demand for General Funded services but could receive the same services using a federal component.

One item to be discussed later would be the Rawson-Neal Mental Health Center in Las Vegas. The daily rate was historically a General Fund item, but for each patient who was eligible, a daily reimbursement was received from Medicaid.

Mr. Gilliland continued with page 27 of Exhibit C, which displayed two pie charts showing the estimated eligibility for coverage among uninsured Nevadans. The pie chart on the left displayed the numbers with ACA and Medicaid expansion, while the chart on the right showed numbers without the Medicaid expansion. The pie chart on the left of the page indicated 309,092 uninsured, or 11 percent of all Nevadans. Without the Medicaid

expansion, as indicated in the chart on the right, there would have been 586,898 uninsured, or 21 percent of all Nevadans.

Page 28 provided a pie chart with the estimated insurance status of all Nevadans as of October 2014. With a total Nevada population of 2,836,681, Medicaid clients totaled 558,934 or nearly 20 percent; uninsured individuals were 309,092, with Medicaid-eligible of about 35,000 to 40,000. Those eligible for the Silver State Health Insurance Exchange subsidized policy numbered about 90,000.

Senator Smith asked Mr. Gilliland to provide the Subcommittee with additional information on the employer or private insurance figures. She was curious to know how the numbers compared nationally and whether they had changed over the past decade. Mr. Gilliland agreed to provide the information.

Additionally, Assemblyman Kirner requested information regarding the number of employers who could opt out of providing insurance.

Mr. Gilliland responded that he would request the Division of Insurance of the Department of Business and Industry and the Silver State Health Insurance Exchange to provide the answers for Senator Smith and Assemblyman Kirner.

Mr. Gilliland completed his presentation, pointing out that the remaining pages of the exhibit were the overviews of the bill draft requests for DHHS and the summary of the requested budget for FY 2016 and FY 2017.

Senator Kieckhefer inquired how much long-term cost projection DHHS was doing. It appeared that the state had absorbed the expansion population, and significant growth was not anticipated in the near future. He was curious whether DHHS was aware of what the total cost run-out would be and what the fiscal effect would be on the General Fund.

Mr. Gilliland explained that DHHS was looking at long-term programs for optimizing federal participation in Medicaid beyond the federal-funding match arena. Other resources should be researched and developed. With the support of the National Governors Association, there was a grant being considered for Medicaid innovation, and there were several programs being considered that had longer-term effects. Additionally, other opportunities in the supportive services area were being reviewed for the aging population in Nevada to be provided alternate resources for greater community-based access. It was important to see how the expansion opportunities with Medicaid and federal-funding

programs would play out in future biennia, because they would be offset by the decreasing FMAP for the expanded population.

Mr. Gilliland also believed there were more opportunities from General Fund optimization than were in place at this time. Pilot programs should be undertaken in the next biennium to test developed methodology. Future opportunities should be reviewed for programs provided to Nevada citizens. The DHHS should consider other ways to reinvest the General Fund and expand opportunities in the public health and wellness environment.

Responding to Chair Anderson, Mr. Gilliland explained that as the economy improved, the general Federal Financial Participation (FFP) match, currently at approximately 65 percent, could be reduced. To maintain the same level of service without having a greater General Fund effect, the state would have to continue to seek ways to optimize the use of Medicaid for expanded services not covered at this time.

Chair Anderson said the equation and variables were complex, but he believed it would be beneficial for Mr. Gilliland to explain to the Subcommittee how the services for both the expanded and general populations would affect the General Fund as the economy continued to improve.

Mr. Gilliland agreed that it would be beneficial to look at the numbers from both a policy and a fiscal perspective. There might be policy matters to consider for future biennia that could have a favorable outcome.

Chair Anderson recognized Bonnie Long, Administrative Services Officer, Director's Office, Department of Health and Human Services (DHHS).

Ms. Long began her presentation with page 2 of Exhibit D, "DHHS Director's Office – Governor's Recommended Pre-Session Budget Hearing," noting that the mission statement was the same for the Office of the Director as for the entire DHHS. The organization chart displayed the directors, deputy directors, and programs under DHHS.

The programs and functions within the Office of the Director were shown on page 3 of the exhibit. Ms. Long explained that administration of Individuals with Disabilities Education Act (IDEA) Part C ensured compliance and provided oversight of eligibility determination, the availability of services, and the provision of those services, as well as supervision and monitoring of early intervention programs throughout the state.

Ms. Long moved to page 4, the summary by budget account, which showed the Office of the State Public Defender and the programs that fell under the Office of the Director. The proposed budget contained no significant budget initiatives or expansion of programs for the 2015-2017 biennium.

Page 5 of Exhibit D displayed a pie chart of the information shown on the previous page. Ms. Long noted the majority of the funding was shown in the "Other" category, which included the Office of the State Public Defender. The Director's Office budget included county fees, tobacco settlement money, slot machine taxes, the children's trust fund, a $.015 ad valorem tax assessment, and transfers from other agencies. The difference between the 2013-2015 and the 2015-2017 biennia was the removal of a tobacco pass-through account and a transfer of a $.01 ad valorem tax to the Division of Health Care Financing and Policy.

Ms. Long continued the presentation moving to page 6, the National Tobacco Master Settlement Agreement funds. The funds consisted of an annual payment based on the overall cigarette market and national inflation. Currently, Nevada received approximately 0.6 percent of the total settlement payment of over $7 billion. The table at the bottom of page 6 showed the breakdown of the annual payment, strategic contribution, and settlement credits. The DHHS received 60 percent of the remaining funds after the deductions shown. The Department worked closely with the Office of the State Treasurer in the disbursement of the funds. In 2018, Nevada would no longer receive the strategic contribution or settlement credits, which would result in a significant reduction of the DHHS annual payment.

According to Ms. Long, per *Nevada Revised Statutes* (NRS) 439.630, DHHS must consider recommendations from three advisory boards for allocation of the tobacco settlement funds. The boards must take into consideration the community needs, priorities based on surveys, and public hearings conducted statewide. The three boards were:

- Grants Management Advisory Committee
- Nevada Commission on Aging
- Nevada Commission on Services for Persons with Disabilities

The charts on page 8 of Exhibit D displayed the allocation breakdown of the tobacco settlement funds for FY 2016 and FY 2017. The appendix on page 24 of the exhibit contained the summary and NRS for each of the use categories.

Ms. Long stated that the chart on page 9 of the exhibit included $2,823,272 requested to be restored over the biennium.

One of the programs included in the tobacco funding was the Nevada 2-1-1 support to connect individuals with community services and resources and volunteer opportunities. Ms. Long said the requested amount was $730,000 each year of the biennium. Of that amount, $700,000 came from tobacco funds and $30,000 from the Division of Public and Behavioral Health, Maternal and Child Health Services. The DHHS requested an increase of $200,000 per year [included in the $700,000 noted above] for the 2-1-1 support. In addition, DHHS was requesting funding from the tobacco money for a part-time Nevada 2-1-1 coordinator. There was currently a contract employee in this position.

Assemblywoman Benitez-Thompson inquired whether there was a slight decrease in the tobacco settlement funds from FY 2016 to FY 2017 for disability grants.

Ms. Long replied that on page 24 there was a spreadsheet showing a breakdown of the requested amounts from FY 2014 through FY 2017.

Assemblywoman Benitez-Thompson commented that it appeared the same was true for the wellness grants. She wondered about the decisions to reduce these amounts or whether other grant opportunities might be available.

Ms. Long agreed, and she noted that the main portion of the grants was under the traumatic brain injury category as a result of attempts to maximize Medicaid; many of the use categories and programs had been slowly converted to Medicaid dollars.

Ms. Long continued, noting that page 11 covered the Social Services Block Grant as authorized by Title XX of the Social Security Act, as amended in 1981. The amount of this grant had been reduced slightly because of sequestration [automatic across-the-board cuts necessitated by the Budget Control Act of 2011], and adjustments had been made to the state agency grantees to offset the difference. She pointed out that pages 12 and 13 showed the breakdown by program and division.

The overview for the Fund for Hospital Care to Indigent Persons was shown on page 14. Ms. Long focused on the source of funding for this account, explaining that beginning in FY 2014, revenue from the supplemental ad valorem tax of $.01 was no longer received and tracked in this account,

but was deposited in the Division of Health Care Financing and Policy's Intergovernmental Transfer account.

Revenue projections for the $.015 ad valorem tax reflected an increase over the base amount of $11,627,930. In year one, the projection reflected an increase of $576,828 and in year two, a projected increase of $1,180,844. There were no projections for the unmet free-care obligation revenue, and the base amount was to remain at $1,270,803, because the amount paid to this account was based on the actual amount of each hospital's unmet obligation for the prior year.

Ms. Long noted that page 15 of Exhibit D, Indigent Hospital Care, explained that another funding source in the next biennium would be the $.01 ad valorem tax payments from prior years for one county in the amount of $500,000 each year of the biennium. The funding was not permanent and would end in FY 2018 when all past taxes had been paid. Additionally, the expenditures in this account would be expended as determined by the Board of Trustees. Potential uses of the funding could be to:

- Offset the county match program
- Make traditional indigent hospital care claims
- Increase supplemental payments by Medicaid

The Upper Payment Limit Holding (UPL) Account shown on page 16 was used to receive funding that would be transferred to the Division of Health Care Financing and Policy (DHCFP). Per Ms. Long, a percentage of the funds stayed in the account and was reverted to the General Fund at the close of the fiscal year. There was $1,250,000 converted in contracts to Nevada Clinical Services in FY 2014, resulting in $337,500 reverted to the General Fund. The projected amount to be reverted to the General Fund in FY 2015 was $1,212,380.

Ms. Long advised that pages 17, 18, and 19 outlined the requested enhancements for budget account (BA) 3150 and BA 3204 for the 2015-2017 biennium. In BA 3150, decision unit Enhancement (E) 275 addressed a change of funding for the tribal liaison position. In the past, the position was funded 100 percent by the Division of Public and Behavioral Health, Public Health Preparedness Program. The role of the position had shifted over the years and no longer worked mainly on public health preparedness coordination and outreach with the tribes in Nevada. The position was changed to benefit the entire DHHS.

Ms. Long explained that the Silver State Health Insurance Exchange had provided funding for four ombudsman positions to accommodate the influx of inquiries and complaints by the public as the ACA mandate was rolled out. The DHHS had identified funding sources that allowed it to retain three of the four ombudsman positions.

The DHHS Office of the Director was requesting 2.51 FTE positions. Ms. Long stated that one full-time information technology (IT) professional position was requested to provide support to the Office and six satellite offices. Additionally, DHHS was requesting a part-time Nevada 2-1-1 coordinator and one developmental specialist 4 position to provide assistance to programs in the early intervention system located in northern Nevada.

Ms. Long noted DHHS had one bill draft request (BDR) for the upcoming legislative session, as shown on page 20 of the exhibit. The BDR revised technical language relating to health information exchanges to remove language related to governance and allow DHHS to certify health information exchanges rather than operate a statewide health information exchange.

Pages 21-22 of Exhibit D listed budget accounts under the Office of the Director that had no enhancements or minor changes. Ms. Long explained that the Office of the State Public Defender represented indigent adults and juveniles accused of committing crimes in certain rural counties. The participating counties were Carson City, Eureka, Storey, and White Pine. The funding for the Office of the State Public Defender for the 2015-2017 biennium had not changed; it was split 19 percent General Fund and 81 percent county fees, with the exception of postconviction relief, which was 100 percent General Fund.

Ms. Long continued with a review of page 24, which was the tobacco settlement fund summary by various programs and amounts requested. The summary also showed the projected remaining cash at the close of the biennium. Pages 25 through 34 included a breakdown of the use categories for the tobacco settlement fund with corresponding *Nevada Revised Statutes*.

Pages 35, 36, and 37 were informational, displaying a flow chart of how the indigent hospital care and the supplemental payments, the unmet free-care obligation, and the private hospital program moved through the system. Ms. Long concluded her presentation, noting that pages 38 and 39 were informational only for the IDEA Part C program.

In response to Senator Kieckhefer, Ms. Long explained that the reserve for the tobacco funds was in the Office of the State Treasurer. The projected

remaining cash amounts were shown on page 24 of Exhibit D. The incoming funds would not sustain the program at the projected level of spending for the 2015-2017 biennium. The decline in the reserve was based on the shrinking revenue source and ongoing need.

Mr. Gilliland remarked that the key number to consider on page 24 of Exhibit D was $24,004,666, the remaining balance forward at the end of FY 2017. This indicated a significant drop in the fund.

Following a brief recess, Chair Anderson reconvened the meeting and recognized Laurie Squartsoff, Administrator, Division of Health Care Financing and Policy (DHCFP), Department of Health and Human Services (DHHS), also referred to as Nevada Medicaid. Accompanying Ms. Squartsoff were Betsy Aiello, Deputy Administrator, DHCFP, DHHS, and Leah C. Lamborn, Chief Financial Officer, DHCFP, DHHS. Ms. Squartsoff presented Exhibit E, "DHHS Division of Health Care Financing & Policy—Biennial Budget Pre-Session Presentation," to the Subcommittee.

Ms. Squartsoff directed the Subcommittee's attention to page 1 of the exhibit, which showed the mission statement for DHCFP. The mission was to purchase and provide quality health-care services to low-income Nevadans in the most efficient manner; promote equal access to health care at an affordable cost to the taxpayers of Nevada; restrain the growth of health-care costs; and review Medicaid and other state health-care programs to maximize potential federal revenue.

Moving to page 2, Ms. Squartsoff noted the role as a state agency was aligned with the Governor's priorities and performance-based budget core objective of health services. The programs and services covered by Nevada Medicaid helped Nevadans achieve optimum health, including physical, mental, and social well-being, through prevention and access to quality, affordable health care.

Page 3 displayed the organization chart for DHCFP. Ms. Squartsoff pointed out that there were three principal groups within the Division:

- The first group consisted of accounting, human resources, and rates and cost containment.

- The second group was the policy team that oversaw policy for fee-for-service programs as reflected in the minimum coverage policy for the managed-care programs; the staff of the district offices located in

Carson City, Elko, Reno, and Las Vegas; and staff who monitored the grants and waiver programs.

- The third group had responsibility for maintaining the information technology and Medicaid Management Information System (MMIS) program and the program integrity and fiscal integrity activities.

In total, 277.51 full-time-equivalent (FTE) employees worked to ensure the operation of an efficient and effective program.

The priority of an educated and healthy citizenry was embraced by DHCFP through activities that included reimbursement for medical services. According to Ms. Squartsoff, approximately 80 percent of Nevada Medicaid beneficiaries received services through the managed-care model, and the health care guidance program provided coordination of medical and behavioral health services for those who received services paid on a fee-for-service basis.

Another activity of the DHCFP was to work toward meeting the goal of an efficient and responsive government. The service team regularly worked with providers across the state. Claims were reviewed for appropriate payment and on-site visits were often conducted. Cases of suspected provider fraud were referred to the Office of the Attorney General, and fraud and abuse by Medicaid recipients was handled by the Division of Welfare and Supportive Services.

Moving to page 5 of Exhibit E, Ms. Squartsoff noted the page showed the five budget accounts for Nevada Medicaid. The General Fund request was $566,599,145 for fiscal year (FY) 2016 and $631,971,942 for FY 2017.

The summary of agency funding sources for FY 2012 through FY 2017 on page 6 showed the increase in the size of the program. While there was an increase in General Fund dollars, Ms. Squartsoff explained there was an increasing percentage of federal funds used by the program. She asked the Subcommittee to note the changes for FY 2014 through FY 2017.

Page 7 showed the funding sources for FY 2014 base year. Federal funds accounted for 82 percent of administration of the program; 74 percent of the medical costs for Nevada Check Up were federal funds; and 67 percent of the Medicaid medical expenses were federal funds.

Ms. Squartsoff said that page 8 of the exhibit showed the changes for the 2015-2017 biennium. About 82 percent of the administrative costs continued to be federally funded. For Nevada Check Up medical services, there was an

increase from 74 percent to 93 percent federal funds. For Medicaid medical services, the increase was from 67 percent to 75 percent. She stated that it was important to note the reduction in General Funds needed for Nevada Check Up from 25 percent to 4 percent and for Medicaid medical from 26 percent to 18 percent.

The major budget initiative for children with autism spectrum disorder (ASD) was shown on page 9. Ms. Squartsoff pointed out that one of the Governor's major budget initiatives for the 2015-2017 biennium was for children with ASD. The DHHS had proposed a strategy to provide treatment for those children with ASD through programs offered from the Aging and Disability Services Division (ADSD) and Medicaid. The Autism Treatment Assistance Program (ATAP), overseen by ADSD, provided intensive behavioral treatment to children up to age 19. The DHCFP would submit a state plan amendment to provide reimbursement for applied behavioral analysis (ABA) therapy for children under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program. Of the approximately 6,000 children diagnosed with autism, about 30 percent of them were eligible for Medicaid, according to Ms. Squartsoff. The DHCFP requested funding to provide coverage for ABA services for those children beginning in January 2016.

In addition to the major budget initiative, DHCFP had two behavioral health services initiatives. The first, budget account (BA) 3243, was an increase to the reimbursement for inpatient psychiatric services provided by general acute care hospitals. Effective July 1, 2014, the rate was increased from $460 to $944 per day. The Centers for Medicare and Medicaid Services (CMS) prohibited reimbursement to freestanding inpatient psychiatric services provided to recipients between the ages of 22 and 64. Ms. Squartsoff explained that the general acute hospital rate increase allowed additional access to psychiatric beds and provided the ability for managed-care plans to provide inpatient psychiatric services to recipients of all ages in alternative settings, such as freestanding facilities. Federal approval of the in-lieu of services was based on the states' ability to demonstrate that services in alternative settings under the managed-care plan could be provided at a lower cost than in a general acute hospital under the fee-for-service model. In-lieu of services only applied to those recipients enrolled in a managed-care plan and not to the fee-for-service population. However, DHCFP continued to reimburse general acute care hospitals for psychiatric services for all ages, regardless of whether the beneficiary was enrolled in a managed-care or fee-for-service plan.

The other initiative was related to substance abuse. Ms. Squartsoff testified that BA 3243 was increased to expand substance abuse services to be in alignment with best practices of the American Society of Addiction Medicine (ASAM), expanded substance abuse service coverage, and the addition of licensed clinical drug and alcohol counselors and interns as service providers.

Ms. Squartsoff asked Ms. Lamborn to continue the presentation with an overview of the rate increases.

Leah C. Lamborn, Chief Financial Officer, Division of Health Care Financing and Policy, Department of Health and Human Services, began her presentation on page 11 of Exhibit E, noting that the budget request for FY 2017 included decision unit enhancement (E) 278, home health agencies. The budget increase aligned the reimbursement for nursing services to the therapy rates within this provider class. The DHCFP had been experiencing access to care problems for these services, and the General Fund request for this initiative was $3,000,529.

The request in decision unit E-279 was for a rate increase of about 5.7 percent overall for waiver services for individuals with intellectual disability. Additionally, the Division requested in decision unit E-275 a 2.5 percent rate increase in the aggregate for general acute care hospitals for inpatient services. This requested amount of General Fund dollars was $4,425,776.

Ms. Lamborn continued the presentation on page 12 of the exhibit. She explained that in September 2008, there was a reduction in the budget of reimbursement rates for the general acute care hospitals of about 5 percent overall. The reduction provided the state a savings of approximately $30 million per year in the 2015-2017 biennium.

Senate Bill No. 452 of the 77th Session (2013) was approved to authorize collection of a $.015 ad valorem tax for indigent hospital care to be reallocated for a new upper payment limit program for inpatient hospital services. The program was implemented in December 2014 and was retroactive to January 1, 2014. The supplemental payment had a potential to grow as revenue increased, and the Board of Trustees of the Fund for Hospital Care to Indigent Persons authorized an increase to the nonfederal share of the upper payment limit (UPL). Included as an increased reimbursement for acute care hospitals for inpatient services was the psychiatric rate previously discussed. This also applied to rehabilitation services provided within the general acute care hospital.

Ms. Lamborn noted that the base budget contained an adjustment to increase reimbursement for neonatal intensive care services.

Continuing on page 13 of Exhibit E, Ms. Lamborn explained that a proposed rate increase for physician services was requested in both FY 2016 and FY 2017. The change for physician services also covered physician assistants and advanced practice registered nurses. The change was approximately 10 percent overall in the biennium. Ms. Lamborn stated that reimbursement for the provider classes was complicated. The agency reimbursed for the services by using the Medicare 2002 value units and conversion factors. The requested change used Medicare 2014 values to bring the methodology up-to-date. Some procedure codes and services would increase and others would decrease. Page 13 showed the methodology for 2002 and the percentages paid for physicians, with various codes. Using the 2002 Medicare unit values, the state paid 100 percent, as seen in column two. For obstetrics, the payment was 128 percent of the 2002 values. The proposal for FY 2016, as seen in column three, was 95 percent reimbursement for surgery and 95 percent for obstetrics. In the final column, FY 2017 showed a slight increase with radiology increased from 90 percent to 94 percent.

Ms. Lamborn testified that at the present time, DHCFP was making a supplemental payment for primary care physicians, physician assistants, and advanced practice registered nurses. This was a program in which providers must be qualified and certified. Payment was being made to 1,344 qualifying providers within the three categories. The supplemental payment added a supplement to the base rate and brought it up to the 2014 Medicare rates. Medicare was considered the upper payment limit, and the maximum that could be paid was 100 percent of the Medicare rate. The proposed rate change allowed the Division to use the 2014 unit values rather than the outdated 2002 unit values for the providers and services listed on page 13 of the exhibit. This affected about 9,359 providers enrolled under the three provider groups. There were 2,712 providers enrolled in Nevada Medicaid that provided evaluation and management services, including primary care services.

According to Ms. Lamborn, as a result of using the 2002 unit values, the change to the 2014 unit values provided an increase to providers for evaluation and management services for which providers were billed when providing primary care services. However, there would be a decreased reimbursement for radiology services. In 2013, a rate increase for obstetric services was authorized by the Legislature, increasing reimbursement from 100 percent of the 2002 Medicare rate to 128 percent. Changing to the 2014 unit values was budget neutral for obstetric services and surgery. This was

the result of using the 2002 unit values based on cost, supply, and demand. It was important to review these rates periodically to stay up with the current market.

Assemblyman Edwards asked if a person was paid, for example, $128 for obstetrics in 2002 through 2014, whether that procedure would now be reimbursed at $95.

Ms. Lamborn replied that was not the case. For example, as shown on page 15, the base rate with 85 percent of the 2002 Medicare values was $44. The primary care increase for 2014 at 100 percent brought the base rate up to $75. Although the primary care physician rate increased, the supplemental payment decreased. The proposal for the FY 2016 budget was to pay 90 percent of the 2014 Medicare values, bringing the rate to $67, and to pay 95 percent of the 2014 values, or $71 for FY 2017. The values changed annually. It was a complicated process with the conversion factor and unit values.

Assemblyman Edwards responded that it appeared the base dollar was set in 2002 and the provider was paid a percentage of that. There had been an increase, but the proposal was to eliminate the increase and reduce the base. Ultimately, the doctor would be paid less.

Ms. Lamborn replied that some procedure codes increased and some decreased. The supplemental payment only applied to 1,344 providers, whereas this change applied to all 2,712 providers.

Assemblywoman Titus pointed out that the Medicare rate was not necessarily the physician's expenses, but the amount Medicare was willing to reimburse the provider.

Ms. Lamborn completed her presentation and requested that Laurie Squartsoff continue with the overview of Exhibit E.

Ms. Squartsoff requested that the Subcommittee turn to page 16 of Exhibit E. Included in the budget were requests to assist with the efficient operation of the program. In budget account (BA) 3158, staff positions were requested for the fiscal integrity audit unit for auditing of the fiscal agent contract. It was necessary for DHCFP to ensure proper oversight of expenditures through regular audits of the fiscal agent and other programs within the agency.

In addition, there were requests in BA 3243 for staff to perform surveillance and utilization reviews (SUR) for managed-care plans. Other than the fiscal agent contract, the contracts with the managed-care organizations were important to the Division budget. Because the Division had managed-care organizations encounter data, approval of additional staff allowed the Division the necessary workforce to oversee the SUR requirements for the contractors and generate additional SUR collections.

Ms. Squartsoff explained the asset verification system was a companion request to the one from the Division of Welfare and Supportive Services (DWSS) for an electronic financial system. The Centers for Medicare and Medicaid Services (CMS) required states to implement a system to identify assets that may not have been reported and reviewed when an eligibility determination was made for the aged, blind, and disabled Medicaid applicants.

Savings were anticipated, according to Ms. Squartsoff, with the personal care services utilization reduction. The benefit change was through an improved oversight of this particular program. Additionally, savings were projected with the improved management and coordination for high-cost, fee-for-service beneficiaries. It was noted that programs like the health care guidance program took time before outcomes and results would be realized.

Ms. Squartsoff discussed the reduction in expenditures for basic skills training that occurred from recent changes in the review of prior authorizations. The services were a benefit under the rehabilitation authority and must be medically necessary and meet all other rehabilitation criteria. Additional basic skills training savings were realized as an offset through the applied behavior analysis initiative.

The managed-care organization third-party liability required the Division to actively identify and pursue any credit balances that remained after a 12-month period for the managed-care enrollees. These initiatives were now conducted for the fee-for-service population.

Assemblywoman Benitez-Thompson asked whether there would be an opportunity at future hearings to learn more about the activities of the managed-care organizations and the services they were contracted to provide, how managed care "looks and feels," and the duties ascribed to managed care.

Ms. Squartsoff said that as stated earlier in the discussion, the fee-for-service Medicaid policy was the minimum standard for the managed-care plans.

The managed-care organizations had the capacity to provide additional services. Additional information would be provided at a later date.

Chair Anderson inquired whether with the increase in reimbursement there was any predictability relating to access to care and whether it was possible that more physicians would be accepting of those rates.

Ms. Squartsoff stated that would be addressed later in the presentation. She then directed attention to page 18 of the exhibit. The chart provided a comparison of the General Fund portion of the 2013-2015 Division of Health Care Financing and Policy (DHCFP) budget with the General Fund amount proposed for the 2015-2017 biennium budget. The net increase in General Fund was $95,235,847 after accounting for savings of $78,993,888 because of changes in the Federal Medical Assistance Percentage (FMAP).

The chart on page 19 was a representation of medical expenditures, operations expenses, fiscal agent costs, and other administrative costs, of which the majority were a pass-through of federal dollars to sister and state agencies for administrative services. Ms. Squartsoff pointed out that 94.37 percent of the budget was used for expenditures for medical services, and the administrative and fiscal agent expenditures were less than 4 percent.

Moving to page 20, Ms. Squartsoff explained decision unit E-550, a technology investment request. Nevada Medicaid completed the first two phases of the three-phase Medicaid Management Information System (MMIS) replacement project. The third phase included the release of the request for proposal (RFP), evaluation of the proposals, negotiation and award of the contract, and the start of solutions to ensure that the new system was compliant with Centers for Medicare and Medicaid Services (CMS) certification criteria. The MMIS in place at this time was in need of substantial improvements given the age of the system and the technology requirements needed to ensure an efficient business operation.

Page 21 outlined the mandatory staff proposals in Medicaid Administration, budget account 3158. Ms. Squartsoff stated that the Division was requesting 31 full-time-equivalent (FTE) positions to meet the needs of the program.

- Two positions would provide case management of the additional cases covered in the Home and Community-Based Services Waiver for Persons with Physical Disabilities.

- Seven positions were requested for the program integrity unit to work on surveillance and utilization reviews of medical claims, hearings, program integrity, and Health Insurance Portability and Accountability Act (HIPAA) of 1996 requirements.

Six district office staff were requested to meet the customer service and care coordination needs of the increasing number of Medicaid beneficiaries.

- Two staff positions were requested for the rates and cost-containment unit to accommodate increases in workload for the upper payment limit (UPL) supplemental payment programs, the newly required UPL demonstrations, and the recurring provider rate reviews.

- One FTE position was requested for the accounting and budget staff to track and analyze ACA-related expenditures and to ensure compliance with ACA reporting requirements.

- Three additional IT staff were requested to support the increased workload because of the ACA Medicaid expansion and the future design, development, and operational phase of the MMIS replacement project.

- Eight staff were requested to ensure the program was compliant with new federal rules related to the section 1915(i) state plan for home and community-based services.

- Two staff were requested to be dedicated to the Division behavioral intervention policy, specifically for applied behavior analysis. Those services were for children with autism spectrum disorder.

Ms. Squartsoff continued with the presentation on page 22, which outlined the enhancement requests in BA 3158 and also showed savings in BA 3158 and BA 3243 (Nevada Medicaid). There were ten FTE positions requested:

- One clinical policy staff who would provide contract oversight for utilization management and review of best practice delivery systems.

- Two IT staff to provide advanced technical skills to support the changes proposed in the fiscal agent system and internal system requirements.

- Four program integrity staff to identify provider fraud, waste, and abuse including those with managed-care claims, producing associated General Fund savings of $320,068 in FY 2016 and $316,533 in FY 2017.

- Three fiscal integrity staff for fiscal agent oversight to ensure proper claim data adjustments and to comply with new audit requirements, producing associated General Fund savings of $167,930 in FY 2016 and again in FY 2017.

Page 23 of Exhibit E provided an overview of total staff administering the Medicaid program for the state. There were 277.51 FTE positions in FY 2014. With the transfer of the Waiver for Independent Nevadans (WIN) staff from DHCFP to the Aging and Disability Services Division (ADSD), there would be a total of 291.51 FTE if the requested new positions were funded. The staff was tasked with overseeing and coordinating the policy and payment for care of nearly 577,000 Nevadans.

Ms. Squartsoff moved on to page 24 of Exhibit E, which detailed the transfer of staff in the WIN program from DHCFP to ADSD. The ADSD currently provided the oversight for other home and community-based services waiver programs. The request would transfer existing and newly requested management staff for the WIN program to ensure consistency within the three waiver programs.

Page 25 of the exhibit showed the Medicaid cost by budget category. The table on the left side of the chart identified the differences in category 11 with the ACA-enhanced Federal Medical Assistance Percentage (FMAP), category 13 for the newly eligible beneficiaries FMAP, and all other FMAP categories. The average monthly cost per eligible for categories 11 and 13 was based on six months of data. The beneficiaries in category 14, medical assistance for the aged, blind, and disabled, had an average cost per eligible of $873, while beneficiaries in category 12, Temporary Assistance for Needy Families (TANF) and Child Health Assurance Program (CHAP) population, had an average cost per eligible of $215.

Senator Kieckhefer asked whether there was a long-term lack of access to care that drove up the cost per eligible for the newly eligible versus the TANF/CHAP population.

Leah C. Lamborn, Chief Financial Officer, DHCFP, DHHS, responded that demand for the newly eligible affected the cost in the TANF/CHAP population.

Senator Kieckhefer speculated that individuals who had not had health care for an extended length of time and now had insurance might have created the delay. Ms. Lamborn agreed that was the cause, and the cost per eligible should drop.

Ms. Squartsoff agreed and further explained that patients who had access to health care might not have been the healthy uninsured as originally predicted and were coming into the health care system with more complicated medical conditions and required services at a higher cost. The Division anticipated changes over the course of time.

Ms. Squartsoff noted page 26 identified normal caseload growth. Medicaid caseload was projected to increase from 520,648 at the end of FY 2014 to 565,244 at the end of FY 2017, an increase of 8.57 percent.

Waiver caseload growth required 317 new slots consisting of 51 WIN slots, 93 slots for Individuals with Intellectual Disabilities (IID) waiver, and 173 slots for the Home and Community-Based Waiver (HCBW) program. As of August 2014, there were 513 persons on the waitlist for the HCBW program.

Page 27 showed the number of Medicaid-eligible who were projected to be covered by the program [557,479].

Ms. Squartsoff went on to explain that page 28 of Exhibit E showed the caseload change for Nevada Check Up [non Medicaid children's health insurance], which was projected to decrease from 23,655 at the end of FY 2014 to 13,974 at the end of FY 2017. There were corresponding reductions projected in General Funds of $892,507 in FY 2016 and $154,039 in FY 2017. Federal funding for Nevada Check Up was pending reauthorization by the U.S. Congress. If it was not reauthorized, the grant would not be awarded beyond federal fiscal year (FFY) 2015. Projections showed enough funding in the FFY 2015 grant to cover the program through FFY 2016. However, there was a maintenance of effort requirement through FFY 2019, which would require CMS-approved recipients to be moved to the Medicaid program through increase to 200 percent of the federal poverty level for children through FFY 2019.

The projected changes shown on the chart on page 29 were for the Nevada Check Up caseload.

Leah C. Lamborn, Chief Financial Officer, DHHS, DHCFP, continued the presentation on page 30 of Exhibit E. She presented an overview of budget account (BA) 3157, the Intergovernmental Transfer (IGT) account. This account collected all IGT for pass-through to BA 3243 and other budget accounts to pay for expenditures. The IGT account collected voluntary contributions from counties to support upper payment limit (UPL) payments to providers for graduate medical education, inpatient and outpatient hospital services, and mental health services, among others. The UPL program provided supplemental payments to certain providers to fill the gap between what Medicaid paid and the maximum Medicare reimbursement.

Certain voluntary contributions from Clark County and those for graduate medical education and public UPL inpatient and outpatient programs for hospital services produced a net state benefit. For example, if the supplemental payment was $100 and the FMAP rate was 65 percent, the nonfederal share would be 35 percent. The counties would provide a voluntary contribution of 50 percent of the total payment, or $50. The federal share was $65 and the nonfederal share was $35. The state would retain the difference between the $35 and the $50 received from the counties. That $15 difference was called a voluntary contribution and a state net benefit. The state net benefit was used to offset State General Fund for Medicaid medical expenditures for the aged, blind, and disabled.

The disproportionate share hospital (DSH) program, which was mandatory, had a different state net benefit. The IGT was paid at approximately 70 percent of the total DSH payments.

Ms. Lamborn explained that programs were also funded through other intergovernmental transfers for the nonfederal share that provided no state net benefit, including University of Nevada School of Medicine supplemental payments for mental health services, school-district reimbursements, private collaborative funds, and Supplemental Account for Medical Assistance to Indigent Persons revenues. Budget account (BA) 3157 also held a reserve of $2 million to help the counties pay matches. Matches were approved under the county match program, usually for the institutionalized or the home and community-based services waiver. The counties were required to apply for these funds. Additionally, there was a reserve of $5.2 million maintained in the IGT account to provide protection for the state if the program should be terminated.

The budget also included an anticipated balance forward from FY 2015 to FY 2016 of $18,125,991. The amount was budgeted to offset General Funds in BA 3243, Nevada Medicaid, Title XIX, for the aged, blind, and disabled medical expenditures. The total net benefit budgeted was $43,221,692 for FY 2016 and $41,570,714 for FY 2017. The base year yielded a state net benefit of about $34.6 million.

Ms. Lamborn moved to page 31 of Exhibit E, noting that the chart displayed programs that had a state net benefit. The DSH program showed a total paid out of $78,410,431 in hospital payments, with a federal share of $50,802,118. The state received IGT funding of $55,242,510. Of that amount, the state share was $27,608,313, leaving a state net benefit of $27,634,197 to be retained to offset General Funds. Other programs listed in the center of the chart had no state net benefit, but the Division used the IGT as the nonfederal share to support supplemental payments to providers. The bottom set of figures showed that the University Medical Center (UMC) of Southern Nevada was the largest beneficiary of these programs. The highest payments were from Clark County, with the IGT account and UMC receiving the most benefit.

Ms. Lamborn continued on page 32, which displayed BA 3160, Increased Quality of Nursing Care, and the provider tax program. The DHCFP projected a provider tax of $29,928,628 for FY 2016 and $30,215,942 for FY 2017. The projected total computable supplemental payment of $84,157,647 included federal match funds. In FY 2017, the supplemental payment was projected to be $86,214,263. Providers were taxed at the maximum allowable rate of 6 percent.

The request for a supplemental appropriation in BA 3243 was shown on page 33 of the exhibit. Ms. Lamborn explained the DHCFP anticipated a shortfall in FY 2015, creating a request of $527,872 for General Funds.

Ms. Lamborn turned the presentation back over to Laurie Squartsoff, Administrator, Division of Health Care Financing and Policy (DHCFP), Department of Health and Human Services (DHHS).

Ms. Squartsoff directed the Subcommittee's attention to the bill draft request (BDR) summary on page 34 of Exhibit E. The DHCFP had three non-budget-related bills for the 2015 Legislative Session. The first was Assembly Bill 41, which would, in part, change requirements of the Board of Trustees of the Fund for Hospital Care to Indigent Persons and would allow the agency to balance forward any remaining funds not used. The second,

Assembly Bill 87, would revise *Nevada Revised Statutes* (NRS) 689A and NRS Chapter 689B to identify all commercial insurance payers by business type and enable Medicaid to collect the total third-party liability available. The third bill was Senate Bill 14, which was a revision to NRS 422.4035 to decrease the minimum number of members of the Pharmacy and Therapeutics Committee and to change requirements for committee membership.

Page 35 of the exhibit was addressed by Ms. Squartsoff. In response to an earlier question from Chair Anderson regarding DHCFP challenges, Ms. Squartsoff explained that access to care was a major problem for the Division. Proposals to address the access problem included the following:

- Implement telehealth expansion; geographical restrictions would be eliminated.
- Use advanced practice registered nurses.
- Provide physician forums with fee-for-service (FFS) and managed-care organization (MCO) processes.
- Align prior authorization between FFS and MCO.
- Develop health care guidance program for high-need FFS recipients.
- Increase the inpatient rate for psychiatric services.
- Implement an "in lieu of" service option for MCO.
- Complete the access to care analysis and implement a secret shopper component.
- Request provider rate increases.

Page 36 of Exhibit E addressed additional challenges facing Nevada. The DHCFP was waiting to hear from Congress regarding the Nevada Check Up reauthorization. The Division was also challenged with the opportunity to improve program management. There was a technology investment request to replace the outdated Medicaid Management Information System (MMIS) and peripheral systems and a need for additional staff to handle the current workload caused by the Medicaid expansion.

Ms. Squartsoff thanked the Subcommittee for its time and said she welcomed any questions.

There being no questions or comments, Chair Anderson recognized Steve Fisher, Administrator, Division of Welfare and Supportive Services (DWSS), Department of Health and Human Services (DHHS).

Mr. Fisher was accompanied by Sue Smith, Deputy Administrator, Administrative Services, DWSS, DHHS, and Naomi Lewis, Deputy Administrator, Program and Field Operations, DWSS, DHHS. Mr. Fisher presented Exhibit F, "DHHS Division of Welfare and Supportive Services 2015-2017 Governor Recommended Budget." He began with the mission statement for DWSS as seen on page 1 of the exhibit.

Mr. Fisher noted the Division had two primary functional areas. The first was program and field operations. The primary responsibility in this area was to improve the lives of low-income Nevadans by providing temporary assistance to meet basic needs. Assistance consisted of the provision of cash grants, increased access to nutritious foods, access to quality childcare, employment and training services, energy and medical assistance, and securing reasonable support for children with absentee parents.

The second functional area was administrative services, which provided services necessary for the internal administration of the Division. There were six primary programs administered under program and field operations

Page 4 of Exhibit F highlighted the strategic priorities in the Division. Mr. Fisher pointed out four specific areas of focus for the next biennium, including program integrity, creating opportunities for increased self-sufficiency for clients of DWSS, customer service, and seeking collaborative opportunities for DWSS operations. These four priorities were keys to success for the DWSS programs.

Mr. Fisher noted six activities were shown on page 5 of the exhibit, along with a brief description of the purpose for the activities.

The Governor's recommended budget by funding source for fiscal year (FY) 2016 and FY 2017 was shown on page 6 of the exhibit. The sources shown were General Fund, federal funds, and other funds. Mr. Fisher noted the sources did not include Supplemental Nutrition Assistance Program (SNAP) benefits of $527,560,395 and child support collection and disbursement of $209,085,052.

Mr. Fisher explained that the chart on page 7 provided an overview of the full-time-equivalent (FTE) positions. He stated that additional eligibility staff was needed for the welfare field services area. The budget request was for 79 FTE positions in FY 2016 and an additional 60 FTE positions in FY 2017. He pointed out that the energy assistance program operated with 25 temporary employees, and he wanted to convert the temporary staff to 9 FTE and 16 intermittent FTE positions. This would improve the timeliness and maintain a trained workforce in the program.

The Temporary Assistance for Needy Families (TANF) cash caseload projections were shown on page 8. Mr. Fisher highlighted the marked growth after 2011 when the economy had a downturn. The recession starting in 2007 caused a substantial growth in caseload. The TANF cash caseload had been declining recently because of expanded employment. When the economy improved, individuals were able to leave the TANF program.

Senator Kieckhefer commented that a decline was anticipated in the 2013-2015 biennium, but it appeared the projections were not correct. He was curious to know how this problem was handled. Mr. Fisher responded that the projections were based on the caseload information at the time.

Senator Kieckhefer asked whether the caseload methodology had changed for the caseload projections. Mr. Fisher replied that the methodology had not changed.

Assemblywoman Benitez-Thompson was curious to know whether the number of positions requested would be adequate to reduce the length of time to process the SNAP applications. She was aware there were federal mandates regarding the processing time.

Mr. Fisher explained that many factors had to be considered. Because of the significant changes that occurred over the past two years, such as the increase in FTEs, technology improvements, the Affordable Care Act (ACA), and so forth, DWSS was in need of stabilization over the next few years. He was confident that the staffing request was adequate when combined with improvements in the technology and business processes.

Assemblywoman Benitez-Thompson asked what the response had been to the concerns from the U.S. Department of Agriculture (USDA) with regard to the timeliness for SNAP application processing.

Mr. Fisher stated DWSS was under a corrective action status because the processing time was less than 90 to 95 percent. A corrective action plan had been prepared and submitted to the USDA Food and Nutrition Service (FNS). The DWSS was required to report monthly to FNS on the timeliness, and there had been a significant improvement in timeliness over the past year. Referring to the chart on page 16 of Exhibit F, Mr. Fisher noted timeliness had improved by about 11 percentage points from October 2013 to October 2014. An interim timeliness goal of 85 percent was achieved in October 2014, but that needed to be sustained through February 2015. Additionally, DWSS hoped to reach 95 percent by October 2015. This was also true for SNAP expedited processing as seen on page 17 of Exhibit F.

Mr. Fisher requested the Subcommittee revisit a question regarding the methodology, because Ellen Crecelius, Deputy Director, Fiscal Services, DHHS, was now available.

Ms. Crecelius explained that in the past, the projections had been prepared based on total numbers for the caseload. The methodology had been changed to use individual-level data. This allowed for review of data for individual clients and for monitoring the length of time individuals stayed on the program when they met certain characteristics. She believed this was a more accurate method, and the new projections were based on this format. With the health care reform, DWSS did not expect to see more TANF clients; however, as persons applied for Medicaid, they also came into the TANF program.

Mr. Fisher moved to page 9 of Exhibit F, the sources and uses of funds for the TANF program.

Mr. Fisher noted that as a state with high unemployment rates and a high SNAP caseload rate, Nevada was eligible for contingency funds. The funding surplus line showed deficits from FY 2014 through FY 2017; based on projections, the Division was confident that the deficit would decrease over the biennium.

Page 10 showed a graphic representation of the TANF block grant reserves data listed on page 9. The reserve history on page 10 began in FY 2004 and continued through FY 2017.

The total Medicaid recipient caseload graph was depicted on page 11 of Exhibit F. In October 2013, DWSS was providing medical coverage to over 300,000 clients. According to Mr. Fisher, in 2015 DWSS was providing coverage to over 558,000 persons. This increase was a result of the

Affordable Care Act (ACA) and the Governor's decision to expand Medicaid. The result was a reduction in the uninsured rate from 23 percent to 11 percent of the population. The majority of those individuals were Medicaid recipients. A smaller percentage had received insurance through the Silver State Health Insurance Exchange.

The graph on page 12 illustrated the SNAP caseload growth. The healthy growth rate shown on the graph was attributed to an increase in individuals signing up for Medicaid as a result of ACA. Many of these individuals did not know they were eligible for SNAP until signing up for Medicaid. There were outreach efforts, education, and collaboration contributing to the growth rate for SNAP.

Moving to page 13 of Exhibit F, Mr. Fisher explained the chart showed the economic benefits of SNAP to Nevada. Per the United States Department of Agriculture Economic Research Service, every $5 in SNAP benefits generated $9 in economic activity, resulting in a $1.80 benefit for the state for each $1 of spending. The chart displayed the total benefits for the state since FFY 2009.

Chair Anderson inquired about the "ripple effect" of the $1.80 on the economy and whether the chart showed a measure of the effect.

Mr. Fisher replied that there was no accounting for removing the $1.80 from the economy. Chair Anderson wanted to ensure that the complete picture of the effects on the economy of the $1.80 was shown.

Mr. Fisher continued the presentation with page 14 of Exhibit F showing the SNAP participation rate. This was based on the 2011 participation rate, which was the most current data available from the USDA. The eligible unserved population was approximately 35 percent of the eligible population. According to Mr. Fisher, one in six Nevadans of all ages did not have access to enough food to maintain an active and healthy lifestyle. The outreach programs through trusted and community partners helped register individuals who were in need of assistance. The trusted partners ran a demonstration project that included interviews with individuals as well as registration for services. Additionally, 29 education programs for budgeting, healthy food choices, and related subjects were ongoing in the state.

Moving to page 15, the SNAP active error rate, Mr. Fisher explained the chart showed quality of services. For example, if errors were made on a SNAP case that resulted in miscalculation of the dollar amount, those errors were tracked to measure the quality of service. The chart displayed a green line

at 6 percent for 2013 through 2015 that highlighted an error rate above which resulted in a sanction. The goal was to have the error rate at 3 percent or less. A rate above 3 percent indicated a "corrective action state." A rate over 6 percent put the state into a "sanction." Based on projections, Nevada would have an error rate of 7 to 8 percent. Mr. Fisher believed the error rate could be attributed to the rapid caseload growth, combined with new staff. He advised the Subcommittee that the DWSS was in the process of submitting a corrective action plan to improve quality of service over the next year.

Chair Anderson requested additional information. Mr. Fisher stated the error rate was over the threshold and the state was sanctioned; however, he was not certain how the sanction amounts were determined.

Chair Anderson asked whether the state was required to pay back the federal funds that it had received. Mr. Fisher explained that if a sanction was $100, for example, $50 would be reinvested into the program and the remaining $50 would revert to the federal government.

Senator Smith requested additional information on the history of the baseline rate for SNAP.

Naomi Lewis, Deputy Administrator, Program and Field Operations, Division of Welfare and Supportive Services (DWSS), Department of Health and Human Services (DHHS), stated that eligibility for the food stamp program was historically set at 130 percent of the federal poverty level, but it had been increased to 200 percent of the federal poverty level.

Senator Smith asked how long the 130 percent rate had been in effect. Ms. Lewis believed that had always been the rate.

Senator Smith pointed out that the state had adjusted for the recession but generally, this was about those persons who made less money or were unemployed for extended periods rather than the state wanting to add more people to the rolls. Ms. Lewis agreed.

Assemblywoman Titus asked whether the six-day delay in processing SNAP applications was statewide or driven by each county. She commented that when someone was hungry, a six-day wait was considerable. Additionally she asked whether the Meals on Wheels program was included in SNAP.

Mr. Fisher responded that the Division tracked processing time for applications for each county office throughout the state. In answer to the second half of the question, Meals on Wheels was not included in SNAP.

In response to Assemblyman Oscarson's question regarding the length of time a person stayed on SNAP and TANF, Mr. Fisher was not aware of a report available with that information. Mr. Fisher stated that the TANF cash program was tracked because an individual could only receive benefits for 60 months. However, he was not aware of similar reporting for SNAP or Medicaid.

Chair Anderson inquired whether the Subcommittee had questions regarding pages 16 and 17 of the exhibit. There being no questions or comments, he requested that Mr. Fisher continue with page 18 of Exhibit F.

The chart on page 18 reported the aged and blind Supplemental Security Income (SSI) and adult group-care facility populations since FY 2006 and projections for FY 2015 through FY 2017. This state supplemental assistance program was funded 100 percent with General Fund dollars. Mr. Fisher pointed out that the aged SSI population was growing steadily. The adult group-care facility and the blind SSI populations had been growing much more slowly through the years. A payment was provided to individuals in these categories. The aged SSI recipient received $36.40, in addition to the federal SSI payment. The blind SSI recipient received $109.30 in addition to the federal SSI payment. Adults in the group-care facilities received an additional $391.

Page 19 displayed a graph showing childcare assistance. The DWSS was serving over 5,000 children. The data for the TANF New Employees of Nevada (NEON) children were shown in blue on the chart. The green at-risk populations included those children who were receiving childcare assistance but whose families were not on TANF, even though income-eligible.

Senator Kieckhefer asked whether the data regarding children on the at-risk waitlist would be in green on the chart, but they were not getting served. He wondered why the state would serve discretionary before at-risk if there was an income threshold.

Mr. Fisher responded that was not the case, even though it appeared that way in the chart on page 19.

Senator Kieckhefer asked whether all the children below the red line on the chart were getting served. Mr. Fisher explained the red line showed the number of cases that were legislatively approved.

Senator Kieckhefer wondered how the state could serve more children than were legislatively approved. Mr. Fisher remarked that there was a surplus in the childcare account, which was a federally funded program.

Mr. Fisher continued with page 20 of Exhibit F, which described the caseload growth for TANF, SNAP, and Medicaid recipients. The caseload-staffing standard was based on the number of cases per full-time-equivalent (FTE) employee. During the 2013 Legislative Session, DWSS used 280 cases per FTE employee as the base. Because of the success of program initiatives, the ratio was increased to 317:1. The Division had experienced multiple changes on multiple fronts, including policy, technology, caseload growth, business processes, and waivers. He believed a period of stabilization was necessary to more accurately calculate the long-term staffing needs. Therefore, the Division was deferring requests for 120 staff and one large office to a future biennium.

In reviewing the caseloads, Assemblywoman Benitez-Thompson believed that the 317:1 ratio was too high to accomplish all of the goals necessary to stay on budget and in compliance with federal guidelines. Mr. Fisher was confident that timeliness and quality could be improved with the additional staff requested in the budget. Additionally, there had been many improvements made in productivity tools, such as document imaging and the lobby management system.

Assemblywoman Benitez-Thompson commented that the Division should be efficient, because there was no room for error in the budget. Mr. Fisher agreed.

Assemblywoman Kirkpatrick hoped that Mr. Fisher would return to the budget hearings with a plan regarding the workforce. If the Division budget was approved with new positions, DWSS must have a plan to fill those positions. She agreed with Assemblywoman Benitez-Thompson that the ratio of 317:1 was too high to provide efficient service.

Mr. Fisher agreed to supply a plan when he returned for budget hearings. He was aware this would be a key component.

Assemblywoman Carlton understood the efficiencies as shown on paper, but because of the issue with SNAP and the U.S. Department of Agriculture (USDA), she needed to know what actions were being taken to avoid possible sanctions.

Mr. Fisher was developing a corrective action plan in collaboration with the USDA Food and Nutrition Service to focus on quality and timeliness. Both of those plans applied to SNAP.

Assemblyman Kirner questioned whether Mr. Fisher's proposed staffing needs took into account the possibility of reversing the furloughs for state employees. He wondered what the ratio would be if furloughs were not reversed. Assemblyman Kirner requested that Mr. Fisher provide more information on employee responsibilities. He wanted more information on the responsibilities of the requested FTE positions and why they were necessary.

Mr. Fisher responded that the initial ratio was 310:1 and without the furloughs the ratio increased to 317:1. He would provide additional information to the Subcommittee on the responsibilities of the positions.

Chair Anderson agreed that the corrective action plans and efficiencies were an important component of the proposed budget and additional information was needed. Mr. Fisher agreed and would supply the information.

Senator Lipparelli was concerned that there was data missing, but he concurred with his colleagues that it was difficult to know what the ratios should be because they were not aware of the requirements for processing applicants. He asked Mr. Fisher to provide additional information when he returned to testify at the budget hearings.

Mr. Fisher continued on page 21 of Exhibit F, remarking that this page was a continuation of page 20. The page showed the year-over-year growth for the child development program, the energy assistance program, and the aged, blind, and adult group-care facility program.

On page 22, Mr. Fisher noted highlights of the programs. He recommended accessing the DWSS Fact Book through the "A to Z" link on the Division's home page for additional information.

Page 23 was an overview of the staffing and infrastructure through FY 2015. Mr. Fisher noted that over the past two years, the Division was able to fill 410 field staff positions; however, as of December 30, 2014, there were 6 field staff vacancies. Additionally, four offices in the Las Vegas area had been leased, with one office in negotiation and one more office that needed to be acquired. The staffing ratio used to determine the 410 staff was a 280:1 cases-to-staff ratio. Because of the successful initiatives,

the productivity had increased from a caseload ratio of 168:1 to 317:1 over the course of 7 years.

Assemblywoman Bustamante Adams asked whether the two additional offices would be located in northern or southern Nevada. Mr. Fisher responded that the two additional offices would be in Las Vegas, as approved in the last legislative session.

Mr. Fisher continued the presentation, moving to page 24 of Exhibit F. The initiatives he had previously referenced were shown on this page and included:

- A supported state-based marketplace. That was a significant achievement.

- Call center expansion and voice response unit. Call wait-times reduced from 30 minutes to under 2 minutes.

- Document imaging, virtual caseload. Cases could be worked anywhere in the state.

- Business process reengineering. Previously, two of every ten clients were served on one-touch service. This was increased so that seven of every ten clients received one-touch service.

- A lobby management task management system. All work was tracked statewide and work could be shifted to other offices as necessary.

- A correspondence solution system. This solution would provide improved communication with clients.

- Phone payment options for the child support enforcement program. Payments could be made with a credit card over the phone.

Mr. Fisher noted the child support program case responsibilities for each county were outlined on page 25 of Exhibit F.

Pages 26-28 of the presentation listed the program initiatives, including:

- Request additional staff, along with two small offices.

- Stabilize the organization; improve timeliness, quality, and integrity; and strengthen employment and training programs.

- Strengthen investigation and recovery efforts through technology, education, and collaboration.

- Maintain a trained workforce through the conversion of 25 temporary contracted staff to 16 state intermittent positions and 9 permanent positions.

- Implement requirements of the Child Care and Development Block Grant Act that was reauthorized by Congress in 2014. The law included a number of new state requirements, such as background checks for all providers, new minimum health and safety requirements, and quality rating and improvement systems.

The overview of the Medicaid asset verification system mandate on page 29 indicated there were about 80,500 active Medicaid aged, blind, and disabled cases in Nevada. Mr. Fisher noted that about 35,640 of those were required to participate in the Medicaid asset verification system, which amounted to an approximate annual cost of $254 million in Medicaid charges. Using a conservative 5 percent recovery rate, the state would realize an estimated savings of $4.375 million for the General Fund.

Page 30 listed BA 3228 decision unit Enhancement (E) 228. The DWSS maintained a number of servers and storage area networks to manage digital information. There was a network drive assigned to each employee. The same file could be stored multiple times throughout the Division. This enhancement would consolidate the documents into one central location and reduce storage to streamline the organization. This system would also provide electronic routing for paperwork, significantly reducing the use of paper.

Mr. Fisher moved to page 31, which described BA 3233 decision unit E-720 for a lobby management system in ten additional offices. To support the new business processes, a lobby management system had been deployed in ten of the DWSS district offices, which provided statewide capability to see how busy the offices were at any time.

Page 32 of Exhibit F described the technology investment in decision unit E-550 in BA 3238, Child Support Enforcement Program, to upgrade the current collection and disbursement system. The system was used to collect and post cash, checks, and money orders. Mr. Fisher explained these payments were distributed to the custodial parent. There was a 48-hour turnaround time, and the present system was antiquated and had no support available.

Page 33 described the technology investment in decision unit E-552 for replacement of the DWSS automated processing system for the Child Support Enforcement Program. A feasibility study to identify the best alternative for meeting the automation needs was to be completed in 2016. Once the study was complete, DWSS could solicit vendors to submit proposals for a new system.

Mr. Fisher explained that page 34 of Exhibit F provided a list of the bills submitted to the Legislature. Assembly Bill 13 would revise provisions governing support enforcement to ensure compliance with federal law. Assembly Bill 73 would revise language to change the reporting period for the Energy Assistance Program. The change would allow the Division the flexibility to maximize both federal and Universal Energy Charge funds to maintain a stable year-round program.

Mr. Fisher concluded his presentation and invited comments or questions from the Subcommittee.

Senator Kieckhefer referred to page 9 of the presentation regarding the TANF block grant. It appeared that in FY 2016, there would be $15.8 million and $7.6 million spent on administrative services and systems. This seemed a high percentage spent on a limited resource. He asked whether this was a level of expenditure that the state had developed over time. Additionally, it appeared the state had run out the structural imbalance of available funding and expenses. According to the chart, the remaining grant at the end of FY 2017 would be about $500,000. He asked whether Mr. Fisher had a plan of action.

Mr. Fisher responded that the administrative services and systems costs included any modifications to the eligibility system, for example. The eligibility and program support was the cost for the staff to process eligibility determinations for TANF. He agreed the expenses must be scrutinized and administrative costs should be reduced where possible.

Senator Kieckhefer asked whether this was a level of administrative costs expected by the USDA Food and Nutrition Service (FNS) or whether it was consistent with the percentage of overall available resources that went toward administration in other states.

Mr. Fisher was not aware of the percentages used by other states, but he would research their programs. By focusing attention on employment and training and looking forward to an improving economy, the TANF caseload was decreasing. Employment opportunities were increasing and providing a better indication of where TANF was heading. He was confident the TANF caseload would be reduced, and if so, the deficit shown on page 9 of the exhibit would be reduced.

Chair Anderson asked whether there were any comments or questions. There were none. Chair Anderson advised Mr. Fisher that at a future date, he would like to discuss the mission statement "enabling Nevada families, the disabled, and elderly to achieve their highest levels of self-sufficiency." He was curious to learn how this was measured and who determined whether the state was successful in helping individuals reach their highest levels of self-sufficiency.

Following a brief recess, Chair Anderson reconvened the meeting at 1:34 p.m. and recognized Richard Whitley, Administrator, Division of Public and Behavioral Health (DPBH), Department of Health and Human Services (DHHS). Mr. Whitley was accompanied by Laura Freed, Deputy Administrator, DPBH, DHHS; Tracey Green, M.D., Chief Medical Officer, DPBH, DHHS; and Mark Winebarger, Administrative Services Officer, DPBH, DHHS.

Mr. Whitley introduced Exhibit G, "DHHS Division of Public and Behavioral Health—Legislative Commission's Budget Subcommittee Presentation, SFY 16/17," noting that the 2013 Legislature had approved the request to integrate the Health Division with the Division of Mental Health and Developmental Services, creating the Division of Public and Behavioral Health. Page 3 of the exhibit provided an organizational chart. The structure of the Division supported the primary functions, which were the direct delivery of clinical services, primarily mental health services, the funding of community services, and the regulation of services.

Moving to page 5 of Exhibit G, Mr. Whitley explained the Division goals as follows:

- Divisionwide
  - Complete integration of public and mental health.

- Clinical Services
  - Optimize federal funds through Medicaid expansion.
  - Adopt holistic approach to health of Nevadans.
  - Reduce the impact of substance abuse and mental illness for individuals, families, and the community.

- Community Services
  - Use population-based strategies to promote and protect health and wellness.
  - Administer programs and activities that provide community-based prevention and treatment through Substance Abuse Prevention and Treatment Agency (SAPTA), which includes managing the Substance Abuse Prevention and Treatment block grant.

- Regulatory Services
  - Protect the public by clarifying federal and state laws and assuring compliance.

Page 6 of Exhibit G showed the DPBH General Fund investment, comparing the legislatively approved budget for the 2013-2015 biennium and the Governor's recommended budget for the 2015-2017 biennium. Page 7 listed DPBH's budget accounts, and page 8 showed activities by budget account. Mr. Whitley moved to page 10 of the exhibit that listed the highlights for the Division.

Page 11 addressed the completion of the integration of public and mental health services. Most of the integration had been completed. The first stage was direct services; however, the budget contained final integrations related to administration. Settling the cost allocation included maximizing the federal funds for the cost of doing business. There was a cost-allocation plan for the direct services provided by the Division and an indirect-cost rate for the grants received.

Mr. Whitley explained that the budget highlights included the impact of the Affordable Care Act (ACA) on behavioral health. The effect of ACA, specifically the Medicaid expansion, was significant, because nearly 80 percent of clients served were enrolled in Medicaid. On page 13 of the exhibit, the chart showed the details of client growth because of Medicaid expansion from July 2013 to June 2015. Mr. Whitley believed the Division had been successful with client

eligibility because of integrated eligibility. For efficiency purposes, client welfare eligibility was performed in the clinics. This was the first step toward expanded Medicaid.

As shown on page 14, clients were covered by various types of Medicaid. Mr. Whitley explained that out of approximately 12,000 clients, nearly 50 percent were enrolled in managed-care Medicaid and 32 percent in fee-for-service Medicaid. Managed-care Medicaid served primarily the urban areas and fee-for-service Medicaid served the rural areas. Enrollment in managed care allowed the client to go to community providers, which was more applicable to urban areas. The network of behavioral health providers was inadequate in rural areas.

Mr. Whitley explained the chart on page 15 of Exhibit G was a summary of the budget presentation from the 2013 Legislative Session and the process DPBH intended to use to maximize Medicaid expansion. The General Fund request was reduced to make the program workable, and the service-delivery model was changed to provide reimbursable Medicaid services. There were different service-delivery models in different regions of the state. The state had to be brought into compliance so reimbursable services could be provided. The rates had to be set and a cost settlement established to recover costs from Medicaid. A process was developed for service authorization to work with managed care. The DPBH had relied primarily on the General Fund in the past, and no prior authorization was necessary for services.

Continuing, Mr. Whitley said that the final process involved case management. The state struggled with being the primary behavioral health services provider. There was an inadequate network of psychiatrists for eligible clients, and the DPBH contracted with a large number of professionals.

Mr. Whitley stated that DPBH often appeared at the Interim Finance Committee (IFC) to request a transfer of money from salaried personnel to contracted personnel to be able to hire psychiatrists and keep the medication clinics operating. There was a limited pool of psychiatrists, nurses, and social workers available for recruitment. Historically, the state had been the major service provider. Developing a network to balance the responsibility of the state and the growing capacity in the community was an important step.

According to Mr. Whitley, by developing a cost-allocation methodology, DPBH was saving approximately $7 million in General Fund dollars. The Legislature in the 2013 Legislative Session had approved positions to assist

with billing. The billing process was centralized to ensure services were reimbursable. The productivity of staff was monitored.

Moving to page 17 of Exhibit G, Mr. Whitley explained the major budget initiative was for the Muri Stein Hospital in Las Vegas. The Muri Stein Hospital on the campus of Southern Nevada Adult Mental Health Services (SNAMHS) stopped serving patients in 2009. Although the Stein Hospital building was empty, the administrator had kept the beds licensed. With renovations to increase the security level, forensic-type clients could be served at Stein Hospital, expediting service delivery and reducing transportation costs. The renovation was supported by the Capital Improvement Program (CIP) and was scheduled to be completed by September 2015. The major budget initiative as shown on page 18 of the exhibit was for salaries at the facility.

Approximately 74 percent of the clients referred to Lakes Crossing Center in Sparks, Nevada for forensic assessment were from southern Nevada. The county was responsible for transportation of those clients. Transportation was typically by air on a monthly basis. By adding 47 forensic beds in southern Nevada, clients would be served in their community, and transportation costs would be reduced.

Senator Kieckhefer noted the majority of the revenue was General Fund. He commented that when Department of Corrections inmates were transferred outside the facility and into a private hospital for 24 hours, they became Medicaid-eligible. He wanted to know whether the same was true for a forensic facility.

Mr. Whitley responded that a forensic facility was not the same as a corrections facility. The Stein Hospital was a licensed and certified hospital. Therefore, client services could only be billed to Medicaid if the client was eligible. However, fee-for-service Medicaid in a standalone psychiatric hospital could not be billed. If a client was disabled and eligible for Medicare or if the client was enrolled in managed care, the service could be billed. Lakes Crossing Center was licensed as a hospital, but was not certified by the Centers for Medicare and Medicaid Services (CMS). He was uncertain about client eligibility for inmates. He agreed that was a revenue source that should be maximized.

Assemblywoman Kirkpatrick stated that the Interim Behavioral Health and Wellness Council had spent considerable time discussing this topic. The DPBH was tasked with determining whether an inmate could be suspended rather than terminated from Medicaid benefits. She explained that many hours

were spent discussing how to save the state money and provide the services clients needed to avoid becoming repeat offenders.

Mr. Whitley agreed with Assemblywoman Kirkpatrick and clarified that the jailed clients had not been adjudicated and were not considered "inmates." The hospital was licensed and certified. Forensic units in other states were able to bill Medicaid, but Mr. Whitley stated, he did not know the eligibility guidelines. However, it was his intention to research how that eligibility was accomplished. The point raised by Assemblywoman Kirkpatrick regarding eligibility was significant. When individuals were arrested and released and their eligibility was terminated, it created a problem. A client could be released with only three days of medication. If the client was unable to get an appointment for 30 days, he was thrown into a negative cycle. According to Mr. Whitley, the Division was working with the Division of Welfare and Supportive Services to be able to suspend rather than terminate eligibility. However, through the forensic unit, the services would be reimbursable if the client was eligible.

Page 19 of Exhibit G provided highlights of the Interim Behavioral Health and Wellness Council. The initiatives were recommended by the Council and were in the budget to continue. Mr. Whitley acknowledged that the Division was seeking to maximize Medicaid reimbursement for some of the services listed. One of the most beneficial programs was the mobile-outreach program working in cooperation with law enforcement. The program was operational in Washoe County, Carson City, and Clark County. There were aspects of the program that could be reimbursed from Medicaid. The Division was continuing to research ways to provide the outreach in a manner that would be reimbursable. According to Mr. Whitley, many of the initiatives shown on page 19 were funded with National Tobacco Settlement dollars. The Division intended to maximize Medicaid reimbursement to sustain the program.

Mr. Whitley identified the Division responsibilities in three areas:

- Provide direct services
- Fund services
- Regulate services

On page 21 of Exhibit G, the clinical services budgets were organized geographically:

- Southern Nevada Adult Mental Health Services (SNAMHS) included both outpatients and the Rawson-Neal Hospital.

- Northern Nevada Adult Mental Health Services (NNAMHS) had one urban outpatient clinic and the Dini-Townsend Hospital.

- Rural Community Health Services (RCHS) incorporated 13 behavioral health centers, 13 community health clinics, and one collocated integrated care center.

Mr. Whitley explained that following the 2013 Legislative Session, the community-health nursing program and the behavioral health centers were integrated. The integration of public and behavioral health was better received in the rural areas. The state was the direct provider of public health services in rural Nevada and more than a safety-net provider. For the convenience of clients, the DPBH had a provider agreement with TRICARE for veterans in rural Nevada.

Mr. Whitley reiterated that Lakes Crossing Center was a mental health hospital. The 2013 Legislature approved a CIP project for renovations at the facility. The facility was licensed, but not CMS-certified, and Medicaid billing could not be done. Mr. Whitley hoped to have the facility CMS-certified to maximize the reimbursement.

A lawsuit was filed by the Office of the Clark County Public Defender for the delay in serving patients. There was limited bed capacity and limited transportation available and delays were unavoidable. The number of beds had been expanded in the Dini-Townsend Hospital by taking over two empty wings and renovating them for forensic services. This was a short-term fix until the Stein Hospital was opened as a forensic unit.

As shown on the pie charts on page 23 of Exhibit G, the clinical services funding remained dependent on General Fund dollars. Mr. Whitley said this was because of the hospitals and that outpatient services were receiving reimbursements. When the Social Security Act of 1965 was enacted, many clients were deinstitutionalized. At that time, there was an exclusion: Medicaid could not reimburse for patient stays in standalone psychiatric hospitals. Only Congress had the power to change the law.

Nevada had only three acute hospitals with behavioral health units. Another opened in December 2014 at the Valley Hospital Medical Center in Las Vegas. The only alternative was the state facility. The number of beds was adequate, but reimbursement for those beds was problematic. There was an immediate improvement in Las Vegas when the Centers for Medicare and Medicaid Services (CMS) approved managed care to contract with standalone psychiatric

hospitals. The freestanding psychiatric hospital took the managed-care clients, and Valley Hospital Medical Center took the fee-for-service Medicaid clients. Mr. Whitley said this was a nationwide problem.

Mr. Whitley explained that the bed capacity shown on page 24 of the exhibit indicated the two areas served by the DPBH: inpatient hospitalization and outpatient services. When Muri Stein Hospital opened in September 2015, Southern Nevada Adult Mental Health Services, including Rawson-Neal Hospital, would have 211 nonforensic beds and 47 forensic beds. All beds were under the hospital license and CMS certification for Rawson-Neal Hospital.

The Northern Nevada Adult Mental Health Services had a 30-bed occupancy rate in the Dini-Townsend Hospital in Sparks, Nevada. With Carson Tahoe Regional Medical Center having an acute hospital and West Hills Hospital, a freestanding hospital in Reno, Mr. Whitley was anxious to see whether there would be a positive change. Additionally, Lakes Crossing Center Hospital in Reno currently had 56 beds, with another 30 beds in the Dini-Townsend Annex.

There had been discussions with Carson Tahoe Health about capacity and with West Hills Hospital regarding managed-care clients. When the capacity was met in the community, nonforensic beds could be eliminated.

Moving to page 26 of Exhibit G, Mr. Whitley pointed out that caseload fluctuated in different categories. There was more capacity in Las Vegas, providing more choices for managed-care clients. There had been a decline in caseload as a result of freestanding psychiatric hospitals appropriately admitting and discharging clients, and thus being required to provide outpatient services. This had the positive effect of growing a system of care in Las Vegas for both inpatient and outpatient services.

The caseload for mental health court was lower in Las Vegas than in northern Nevada. Mr. Whitley acknowledged that standardizing services had been a struggle, since mental health court operated differently in northern Nevada and southern Nevada.

Some variables that made a difference were:

- Sentencing in mental health court in northern Nevada was 12 to 18 months versus three years in southern Nevada.

- The mental health court in northern Nevada was for both misdemeanor and felony crimes versus felony only in southern Nevada.

- The state was the sole provider in northern Nevada versus Mojave Mental Health Services in southern Nevada.

Page 27 showed the major maintenance items were basic facility upkeep.

Page 28 of Exhibit G provided an overview and mission statement for Community Health Services. Mr. Whitley explained these were traditional public health services provided in the urban areas by local health departments for programs such as childhood immunization, HIV, sexually transmitted diseases, tuberculosis testing and treatment, and the Special Supplemental Nutrition Program for Women, Infants and Children (WIC). In contrast to direct services, funding supported local organizations, including the health districts. Most of the funding in this budget came from competitive grants.

Highlighted on page 30 of Exhibit G was the Substance Abuse Prevention and Treatment Agency (SAPTA). Unlike mental health services, local agencies were funded to treat and prevent substance abuse. There was a requirement in the SAPT block grant for a 10 percent set-aside for prevention, but most of the emphasis was on treatment. Recalling the discussion on the Medicaid expansion, Mr. Whitley said that the substance abuse providers were held to the same expectations and logic regarding Medicaid eligibility. The difference was that when a service was provided, Medicaid was billed. By looking at page 33, the reduction in General Funds for SAPTA could be seen. The 20 treatment providers that traditionally received public dollars also billed Medicaid fee-for-service and managed-care, not unlike the state.

Mr. Whitley noted that many treatment providers were struggling to receive reimbursement through Medicaid. He offered to provide a list of the amount of time and effort expended by staff to train providers on how to bill for services, which included facilitating meetings for the providers to enroll in managed care. The Division worked closely with the treatment providers to ensure they maximized reimbursement by providing a higher level of service to meet the standards for managed care.

Mr. Whitley concluded his portion of the presentation.

Senator Parks was interested in learning more about the program, because many providers had contacted him regarding reimbursement. Often the provider received only 50 to 60 percent reimbursement of the submitted billing without benefit of an explanation. He was aware there were a limited number nonprofit providers, and he wanted to ensure they continued to provide services.

Laura Freed, Deputy Administrator, Division of Public and Behavioral Health, Department of Health and Human Services (DPBH), continued with the presentation of Exhibit G beginning on page 34. There were nine budget accounts considered regulatory by DHHS.

Page 35 displayed the total funding sources for the 2015-2017 biennium. Ms. Freed pointed out that the General Fund comprised about 1.7 percent of the total funding. The majority of the budgets received no General Fund support and operated from fees and transfers from other accounts.

Page 36 listed most of the regulated industries. Ms. Freed explained that the CMS-certified medical facilities were where health facility surveyors performed work for CMS. Federal reimbursement was received for those services. The state-licensed health facilities listed on page 36 were not CMS certified, although Medicaid could be billed. Among certified medical facilities over the past five fiscal years, there had been nearly 41 percent growth. Among state-licensed health facilities, the growth was about 66 percent. Ms. Freed noted that health care facilities had grown, despite the recession.

The Division also licensed dieticians, music therapists, medical laboratory personnel, emergency medical service providers, emergency medical technicians for counties other than Clark County, and medical marijuana establishments. Also regulated, but not shown on the chart, were doctors' offices that used various levels of sedation, as well as mammography machines and authorization of the personnel who used those machines.

Page 37 of Exhibit G provided an overview of the state's medical marijuana program. Ms. Freed discussed two programs regarding medical marijuana: patient registry and medical marijuana establishments (MMEs). Page 38 showed 8,055 total active patient cards and 487 primary caregiver cards. The total number of cardholders for fiscal year (FY) 2015 was projected to be 11,332, with a 44.7 percent projected growth to 16,396 cardholders in FY 2016. In FY 2017, the projected number increased 31.6 percent to 21,576. Ms. Freed explained that the numbers were included in the joint projection of the medical marijuana excise tax projection group, which was comprised of Legislative Counsel Bureau staff, DPBH staff, and Budget Division, Department of Administration, staff. She suggested that because the increase between December 2014 and January 2015 was about 400 cardholders, the projections should be reevaluated prior to budget closings.

Pages 39 and 40 of Exhibit G displayed the application processing times for the medical marijuana registry. According to Ms. Freed, there was a 30-day statutory limit included in *Nevada Revised Statutes* (NRS) 453A.210 for medical marijuana registry identification cards. The chart showed a spike which began in August 2014, coincident with the opening of the application window. There was another peak in October 2014, but the Division was currently below the statutory 30-day limit for both initial applications and renewal applications.

Moving to page 41 of the exhibit, Ms. Freed noted that the Cole Memorandum from the U.S. Department of Justice (DOJ) issued in August 2013 provided that as long as a strong regulatory system was in place, the federal government would leave enforcement of the medical marijuana regulations to state and local authorities. In a December 2014 Congressional spending bill, the Hinchey-Rohrabacher medical marijuana amendment barred the DOJ from spending on medical marijuana enforcement. While still a schedule I controlled substance per the federal Controlled Substances Act, Congress recognized that with 23 states allowing medical marijuana and 4 states allowing recreational marijuana, marijuana policy was becoming a state responsibility.

Ms. Freed explained that the medical marijuana establishment (MME) program issued 373 provisional certificates out of 519 applications received on November 3, 2014. The provisional certificates were issued individually, so multiestablishment facilities received only one certificate upon opening.

Page 43 showed 16 authorized state full-time-equivalent (FTE) positions to support the medical marijuana establishment program, as well as contract FTEs and software contractors to implement the final changes on the medical marijuana establishment agent card system. All employees and volunteers of the medical marijuana establishment must have an establishment agent card at a cost of $75 per year. The system was in beta testing.

A survey was sent to provisionally registered MMEs in November 2014. Of the 373 surveys mailed, only 45 responded. The breakdown of the responses was shown on page 44 of Exhibit G. It appeared that six of the labs were prepared to open by the end of February 2015. The cultivation and production establishments and dispensaries were eager to open by the end of April 2015.

As far as revenue was concerned, Ms. Freed previously referenced the marijuana excise tax projection group. In The Executive Budget, the total amount for FY 2015 was projected to be $128,000 and for FY 2016 nearly $1 million. For FY 2017, the projected total was nearly $1.5 million and included the total excise tax, the portion budgeted in the State Distributive

School Account, and 25 percent for the medical marijuana program, pursuant to NRS Chapter 372A. The projections supplied little money to run the program; therefore, the MME program would be supported by application and renewal fees.

Page 46 listed the bill draft requests (BDR) for the 2015 Legislative Session. Ms. Freed explained the BDRs were necessary to implement The Executive Budget. The first was a change in the definition of alcohol and drug abuse facilities licensed by the Bureau of Health Care Quality and Compliance (HCQC). Regardless of funding, the statute currently stated that only facilities certified by SAPTA could be inspected by HCQC. The change would allow any alcohol and drug abuse treatment facility to be licensed, inspected, and investigated, regardless of funding.

The second and third BDRs were a part of The Executive Budget for reimbursement purposes. There was an enhancement to certify a peer-support recovery organization as a health facility type. There was also an enhancement to certify community health workers so they could be certified as a Medicaid provider type.

Lastly, there was a recommendation for the counties to reimburse Lakes Crossing Center for extended client commitment up to ten years for residents from those counties.

Ms. Freed concluded her presentation.

Tracey Green, M.D., Chief Medical Officer, Division of Public and Behavioral Health (DPBH), Department of Health and Human Services (DHHS), began her presentation on page 47 of Exhibit G. Dr. Green explained that the DPBH was focusing on the continuum of medical care and maximizing Medicaid reimbursement. There was a gamut of psychiatrists, as well as physicians and nurse practitioners, who were state or contract staff. The DPBH was able to fill the majority of positions.

Dr. Green said that leadership positions were needed, and the budget request identified three leadership positions. The first position was the statewide psychiatric medical director. In previous budgets, this was a contract position, and DPBH was requesting a state position for the statewide psychiatric medical director. The other two positions were analogous to the chief medical officer. The positions were required because of the expanded population, combined with integration of health services and the need for dental services and dental oversight. According to Dr. Green, the two requested positions, the

State Dental Health Officer and the State Public Health Dental Hygienist, were authorized in *Nevada Revised Statutes*. In completing the compliment of health care, the state needed to enhance the dental oversight. Additionally, the proposed location of the two positions was near the School of Dental Medicine, University of Nevada, Las Vegas. Placing some leadership in southern Nevada had been successful, not only because of greater population, but also as seen with Chelsea Szklany, Deputy Division Administrator, Southern Nevada Adult Mental Health Services (SNAMHS), that seating administrative staff in southern Nevada was advantageous.

Dr. Green concluded her presentation and welcomed comments or questions.

Senator Kieckhefer questioned the scope of duties for the State Dental Health Officer and the State Hygienist. Dr. Green noted that the dental officer and the dental hygienist would establish an advisory council to receive community input to identify the gap in dental health services. Additionally, the duties would include the dental officer assessing the needs of Nevadans. For the purposes of DPBH, duties would involve working with Medicaid to review current reimbursable services, where services were being provided, and how to maximize the dental health services. When examining the field of dental health, it was about the dentists providing the dental services and the hygienists working on the prevention side of dental services. The state hygienist would oversee those prevention activities.

Assemblywoman Titus asked whether there would be a full-time psychiatrist reviewing the needs of the psychiatric component as opposed to seeing patients.

Dr. Green explained that the statewide psychiatric medical director had clinical hours and resident supervision. With the trend toward a forensic facility, it was hoped the state could recruit a forensic-trained, board-certified psychiatrist.

Assemblywoman Carlton recalled that the Legislature had approved a State Dental Health Officer position in the past, and she was curious whether that position was ever filled.

Mr. Whitley confirmed the position was approved but never filled.

Assemblywoman Carlton thought the same was true of the State Public Health Dental Hygienist position. She believed that position was approved in 2011, and the dental health officer had been approved in the early 2000s.

Mr. Whitley was uncertain about when the positions were approved. He agreed with Assemblywoman Carlton that the positions were not filled because there was no money in the budget.

Assemblyman Oscarson thanked Mr. Whitley for the comprehensive presentation. He asked Mr. Whitley to expand on bill draft request (BDR) 15A4061045 to implement a community health worker model in Nevada, as described on page 46 of Exhibit G. He was curious to know how that would benefit the state.

Mr. Whitley responded that BDR 15A4061042, to develop a peer support recovery organization, had been in the Medicaid state plan since 2005 but had never been used. One reason for this was the lack of certification. Many programs had to be licensed and certified to receive Medicaid reimbursement. The Bureau of Health Care Quality and Compliance served the dual role. The community health workers were not in the Medicaid state plan at this time. It was a CMS-approved service. The Division had been proactive and planned to authorize the service if the state Medicaid plan included this provider type in the future. Many states had moved to this process because of the inadequacy of a health network. The community health care worker was used to help clients navigate the system and to assist clients with chronic health conditions to take their medications when required or provide other ancillary services. It was an enhancement to the health care system. The intent was to be proactive and have the authority established because Medicaid could change the state plan through a public workshop process.

Assemblyman Oscarson questioned whether Mr. Whitley envisioned the community health care worker assisting clients to comply with the provider's orders to avoid being hospitalized or institutionalized.

Mr. Whitley responded that was a component. It was important to assist clients with behavioral health and chronic disease problems. The regulation would meet the same requirements of CMS for this provider type.

Ms. Freed explained that what distinguished community health workers in the Centers for Disease Control and Prevention (CDC) literature was residency in the communities they served. As residents, they were aware of the barriers, especially with chronic diseases such as diabetes. Numerous states had certification processes for community health workers.

Following a brief recess, Chair Anderson reconvened the meeting and recognized Jane Gruner, Administrator, Aging and Disability Services Division (ADSD), Department of Health and Human Services (DHHS). Ms. Gruner presented Exhibit H, "DHHS Aging and Disability Services Division Budget Presentation." Ms. Gruner read the following testimony into the record:

> Aging and Disability Services Division (ADSD), under the guidance and direction of DHHS, is a service delivery division that supports individuals across the lifespan. The Division is responsible for providing services to Nevada seniors, persons with physical disabilities, persons with intellectual disabilities and related conditions, and infants and toddlers with developmental and physical disabilities or special health care needs.
>
> Aging and Disability Services Division's mission is to ensure the provision of effective supports and services to meet the needs of individuals and families, helping them lead independent, meaningful, and dignified lives.
>
> Aging and Disability Services Division's organizational structure is found on page 2 of the handout (Exhibit H). The Division has a staff of 886 and provides services throughout Nevada. In addition, the Division contracts with community partners and individual service providers to deliver many of the direct services that we offer. The goal is for consumers to receive as many services within their own communities as possible.
>
> On page 4 of the handout, you will find Aging and Disability Services Division's top five strategic plan goals. During the 2013 Legislative Session, Assembly Bill No. 488 of the 77th Session (2013) transferred developmental services and early intervention into the existing ADSD. The newly integrated division is in collaboration with our consumers, our community partners. Community partners-at-large developed a strategic plan to guide the Division throughout the integration process.
>
> The strategic plan was utilized to guide our budget-building process. The top five strategic goals were to identify funding streams that support sustainable services; to adopt and implement a person-centered philosophy and planning process throughout the Division; [to] establish evidence-based service delivery systems that include key components of access, transportation,

and collaboration with our communities; to establish and report on criteria that demonstrate outcomes and efficiencies throughout the Division; and to develop a system to recruit and retain a skilled workforce.

On page 5 of your document, you will find a detailed description of the ADSD programs. They encompass early intervention, and early intervention identifies infants and toddlers who are at risk for or have a developmental delay. We support them with in-home services. Therapists go into the family's home and help the family learn how to help their child.

Developmental services provides or purchases services and support for individuals with a developmental delay or related condition. Those types of services include residential supports, jobs and day service supports, case management, nursing oversight, and quality assurance.

Disability services provides resources at the community level that assist people with severe disabilities and their families to live as independently as possible in an integrated setting. Those would include such services as the Autism Treatment Assistance Program, communication access program for the deaf and hard of hearing, and assistive technology for independent living.

Aging services provides services and support to older Nevadans and persons with disabilities most at risk in their communities. The service array includes residential service support, personal assistant services, and elder protective services. Elder protective services receives and investigates abuse and neglect.

Administrative and other services is a "catch all." We have advocate services and grants management, which include nutrition programs, transportation, and respite programs; pharmaceutical assistance; information management; and personnel support.

Julie Kotchevar, Deputy Administrator, Early Intervention Services and Operations, Aging and Disability Service Division, Department of Health and Human Services, continued the presentation of Exhibit H, listing the core functions shown on page 6. Page 7 contained a summary of the agency program activities. The ADSD budget was built around the programs listed and described on page 7.

Ms. Kotchevar noted that as a part of the integration plan, ADSD instituted an evidence-based service system. Revisions were made to the performance measures to ensure programs had meaningful measures of outcomes. The changes were shown on page 8 of the exhibit.

The funding requests were shown on page 9. They were broken down by General Fund, federal funds, and other funding, which included funds such as third-party liability insurance billed for infant and toddler programs and grants and intergovernmental transfers.

Moving to page 10, Ms. Kotchevar noted the funding requests were broken down by program. The largest funding request was for developmental services, and home and community-based services was second. These services were for seniors and persons with physical disabilities. The third highest funding was for early intervention services.

Page 11 showed the full-time-equivalent (FTE) breakdown by budget account. According to Ms. Kotchevar, the Division was receiving about 27.5 transfers, the majority coming from the Home- and Community-Based Waiver for Persons with Physical Disabilities program. There were 44 FTE positions resulting from caseload growth. The direct-service programs were governed by caseload. There were a few FTE positions shown as enhancement positions.

There was one major budget initiative for autism spectrum disorder (ASD). Ms. Kotchevar explained the Autism Treatment Assistance Program (ATAP) had been operating for several years. The budget included a major budget initiative between ADSD and the Division of Health Care Financing and Policy (DHCFP) to provide a combined solution for treating ASD.

Ms. Kotchevar had prepared the graph on page 13 showing the number of children diagnosed with ASD and the number of children projected to be served between ADSD and Medicaid combined. There were approximately 6,000 children in Nevada diagnosed with ASD.

Page 14 of Exhibit H described decision unit maintenance (M) 201, caseload growth for ATAP. Ms. Kotchevar said the projected caseload growth permitted an additional 264 children to receive services over the 2015-2017 biennium. In fiscal year (FY) 2017, approximately $2.2 million was to be held in reserve because of the concern with provider capacity.

Assemblyman Armstrong noted that on page 13 of the exhibit, the graph showed about 6,000 children diagnosed with ASD in 2014 and more than 7,000 children in 2017. He asked how the projection was determined.

Ms. Kotchevar stated the projections were performed by statisticians based on the projected population growth of children and the prevalence rate for ASD nationwide as determined by the Centers for Disease Control and Prevention (CDC). The prevalence rate would add about 2,000 additional children, but based on the U.S. Department of Education statistics, the number of children who actually had a diagnosis was lower than the CDC prevalence rate.

Senator Kieckhefer asked Ms. Kotchevar to discuss the number and types of providers contracted by ATAP.

Ms. Kotchevar responded that there were two groups of providers. The professional providers were board-certified behavioral analysts or licensed psychologists who had behavioral training. The providers developed the behavior plan and supervised the paraprofessionals providing the in-home treatment. Typical applied behavior analysis (ABA) consisted of a treatment plan and, for a young child, 25 to 30 hours per week of in-home treatment. The professionals, the board-certified behavioral analysts who had a master's degree or above, or licensed psychologists developed the treatment plan and trained the paraprofessionals. The paraprofessionals were high-school graduates who had at least 40 hours of specific training and ongoing training by the professionals for in-home behavior intervention. Both had national certifications and a state license. One board-certified behavioral analyst could serve about 24 families. Current capacity at ATAP could serve the number of children projected, about 800. The number of board-certified behavioral analysts willing to serve only children, the number still in practice, and the effect of Medicaid involvement were unknown.

Assemblywoman Kirkpatrick was aware that Nevada provided limited ASD services. She requested that Ms. Kotchevar provide a list of children receiving services outside of Nevada. Assemblywoman Kirkpatrick was concerned that older children with ASD were not receiving appropriate services. She related a situation where a family moved to Texas so the child could receive the services needed. Additionally, Assemblywoman Kirkpatrick requested an overview of services available to older children diagnosed with ASD.

Assemblywoman Titus commented that children diagnosed with ASD frequently had multiple problems. In addition to behavioral services, the children often needed services such as occupational health, speech pathology, and physical therapy. She asked whether the Division only supported behavioral services or covered the other multiple problems that a child diagnosed with ASD might face.

Ms. Kotchevar replied that ATAP primarily provided behavioral therapy and was not an all-inclusive program. For example, all of the therapies were included in early intervention for infants and toddlers. However, services for children served by ATAP, were primarily behavioral therapy programs. There had been changes to Medicaid and other insurances that provided for other types of rehabilitative services. The Division worked with families to ensure they could access other available services.

Chair Anderson referred to page 13 of Exhibit H. He commented that there was a gap between the projected number of children diagnosed in FY 2017 and the number of children able to receive treatment. He asked whether the children in the gap would be covered by private insurance, families, and other services, or whether there would be a backlog of needed services.

Ms. Kotchevar anticipated that about 1,000 children would be waitlisted for ATAP services by the end of FY 2017. If services were not sought through the Division, there was no way to determine what other services were provided.

Page 15 of Exhibit H addressed caseload growth for the Office of the State Long-Term Care Ombudsman in decision unit M-200. Ms. Kotchevar explained that the ombudsman program advocated for residents of long-term care facilities. The goal was to improve quality of care and quality of life and to assist with mediation of disputes between residents and the facilities. She noted that this was the first legislative session that a legislatively established caseload was requested for this program. The caseload had grown significantly since the program was established. There were 7,170 cases in FY 2015 and 12,057 cases projected by FY 2017. The budget request was for six full-time-equivalent (FTE) intake staff to provide fast responses to complaints.

Page 16 of the exhibit addressed caseload growth for early intervention services. The budget request, according to Ms. Kotchevar, would provide services to an additional 193 children over the 2015-2017 biennium. Decision unit M-200 in this budget account also accounted for an increase in per-child therapy costs, since the program no longer had a waiting list for services.

The budget request included an additional 1.5 FTE intake staff and a transfer from DPBH for a dietician specializing in metabolic conditions.

Page 17 of the exhibit addressed caseload growth for the family preservation program located in the developmental services area. The program provided a monthly stipend to families of persons who had a significant or profound intellectual disability to assist with care allowing the family member to remain in the home. This caseload growth would permit an additional 41 families to participate in the program over the 2015-2017 biennium.

Page 18 of Exhibit H addressed caseload growth for community-based care services, including services for seniors and persons with physical disabilities. Ms. Kotchevar pointed out there were five programs that covered this area, including Community Service Options Program for the Elderly (COPE); Personal Assistance Services (PAS) and the Homemaker Program, which were financed with General Fund support; and the Home- and Community-Based Waiver (HCBW) for the Frail Elderly and the Waiver for Independent Nevadans (WIN) for persons with disabilities, which were partially Medicaid-funded.

Page 19 of the exhibit addressed caseload growth for developmental services in decision unit M-200. Developmental services provided or purchased services for persons with intellectual disabilities and related conditions. Ms. Kotchevar said there was a caseload increase for the Rural Regional Center, Sierra Regional Center, and Desert Regional Center. The Rural Regional Center had a significant growth rate.

Assemblywoman Benitez-Thompson referred to page 18 of the exhibit and noted the slot allocations for the HCBW program. She expressed concern that 513 seniors currently on the waitlist were low income and fragile enough to qualify for institutional care. She asked whether there was an estimate of how long a senior had to wait before receiving services.

In response, Ms. Kotchevar said that she did not have the information readily available, but she would provide it to Assemblywoman Benitez-Thompson.

Assemblywoman Benitez-Thompson asked whether the projected appropriations were enough to keep up with the increases of an aging population.

Ms. Kotchevar said there was significant growth in the number of aging citizens. This trend was factored in when projections were made. The turnover rate for this program was slightly higher than other programs because of the ages of the clients.

Senator Kieckhefer referenced page 19 (Exhibit H) and the caseload growth for developmental services. He wondered whether the caseload increases would adequately handle the waitlist during the 2015-2017 biennium.

Jane Gruner, Administrator, Aging and Disability Services Division (ADSD), Department of Health and Human Services (DHHS), said that the increase would not eliminate the waitlist.

Senator Kieckhefer asked whether there were projections available for the 2015-2017 biennium.

Ms. Kotchevar responded that the waitlist would not change because the caseload increases kept up with population increases. The waitlist would remain steady and would not decline.

Senator Parks referenced page 15 on which an increase of 68.1 percent in the caseload growth was indicated for the long-term care ombudsman program. He was curious to know what problems would cause a large increase and what kind of service demand was anticipated.

Ms. Kotchevar explained that increases were a result of providing services for all individuals, not only seniors, who were residents of long-term care facilities. When ombudsmen went into the communities, more inquiries were received as people discovered assistance was available. Types of conflicts were usually between resident preferences and quality of life. Conflicts between the family and the resident were common. The Division would assist with mediation of those problems.

Responding to Senator Parks, Ms. Gruner confirmed that group homes were included in the service.

Ms. Kotchevar directed attention to page 20 of the exhibit. The caseload growth for the assistive technology for independent living program in decision unit M-540 was outlined. This was considered a mandate because it helped the state comply with the Olmstead decision [*Olmstead v. L.C.* 527 U.S. 581 (1999)]. The Olmstead decision mandated that states serve persons with disabilities in the most integrated setting. The Independent Living Assistance Program performed home and vehicle modifications to allow individuals with disabilities to remain in their homes.

Ms. Kotchevar said that following the 2013 Legislative Session, the Division received a significant caseload increase; therefore, the increases shown for FY 2016 and FY 2017 were to adjust the budget in conjunction with the Consumer Price Index for purchases of goods and services.

Assemblywoman Titus opined that the Division was under-budgeted for the Independent Living Assistance Program. Ms. Kotchevar responded that the Division would be happy to accept additional funds.

Senator Smith asked Ms. Kotchevar whether veterans were served under this program. Ms. Kotchevar explained that although the program would serve veterans, the Division preferred to assist veterans in obtaining benefits through the U.S. Department of Veterans Affairs.

Senator Smith said there would be further discussion on the subject during the budget hearings.

Budget enhancements were shown on page 21 of the exhibit. Ms. Kotchevar pointed out that the most significant enhancement was decision unit E-250, provider rate adjustment for developmental services in FY 2017. The requested enhancement would increase the rates by 5.7 percent. This program was reimbursed below the Medicaid rate, and it had become difficult to provide services.

There were several enhancements to support commissions, boards, and taskforces to provide for members' travel costs, costs related to interpreters, and other meeting requirements. The Division needed the commissions, boards, and taskforces to assist with the development of the service system and to guide the process.

There was also a request for audiology equipment in decision unit E-718 in budget account (BA) 3208. Ms. Kotchevar explained that Early Intervention Services provided early hearing tests for infants and toddlers with hearing loss. The Division's audiology equipment had exceeded its lifespan and required replacement.

Ms. Kotchevar requested the Subcommittee also consider decision unit E-721 for mobile audiology screening equipment. This equipment would be new for the Division. Audiology screening was not available in rural Nevada, and the Division believed the purchase of the mobile equipment was justified.

Page 23 of Exhibit H outlined the technology investment needed for the Division. Ms. Kotchevar said that decision unit E-233 in BA 3151 was the Division's portion of the expansion of the Elko bandwidth. The other requests shown on page 23 were to maintain equipment based on the five-year replacement schedule.

Page 24 provided an overview of position transfers. The primary transfer was the Waiver for Independent Nevadans (WIN) program from DHCFP to ADSD. The transfers in decision units E-900 and E-901 in BA 3266 included the transfer of 29 staff from DHCFP to ADSD to provide fully integrated services.

Ms. Kotchevar moved to page 25 of Exhibit H, which provided information on decision unit M-425, deferred maintenance for state-owned buildings. In BA 3280 for the Sierra Regional Center, the concrete sidewalks at the building entrance posed a safety hazard and needed to be replaced. The Desert Regional Center proposed converting 200,000 square feet of lawn to desert landscaping to conserve water and reduce utility costs.

Ms. Kotchevar noted that one significant grant change was identified on page 26 of the exhibit. The Early Intervention Services (BA 3208) had pediatricians on staff since the creation of special children's clinics in the 1970s. Partial funding for these positions was moved from General Fund to the Maternal Child Health (MCH) block grant during the economic downturn. The MCH block grant eliminated coverage of these positions and the subgrant to ADSD. Decision units E-490 and E-491 in BA 3208 restored the positions to General Fund to maintain the vital services provided by the positions.

According to Ms. Kotchevar, the Division had one bill draft request to clarify language in the *Nevada Revised Statutes* following the integration of early intervention and developmental services into the Aging and Disability Services Division in the 2013 Legislative Session.

Page 28 focused on problems the Division would face during the next biennium. The primary focus was on population increases. Ms. Kotchevar said that in 2000, approximately 15.1 percent of Nevadans were aged 60 or older. By 2030, it was estimated that 25.2 percent of Nevada citizens would be 60 and older. Other problems facing the Division were:

- Growth in the incidence of Alzheimer's disease and other forms of dementia. About one in nine persons over age 65 had Alzheimer's disease. This had a major effect on the Division's service delivery system.

- Over 75 percent of individuals with intellectual disabilities resided with family members. More than 25 percent of family-care providers were over the age of 60. Nearly 38 percent of caregivers were between 41 and 59 years of age.

- One in 68 children was diagnosed with ASD. In Nevada, over 6,000 children had been diagnosed with ASD.

Ms. Kotchevar concluded the presentation for the Aging and Disability Services Division.

Assemblywoman Titus said that she believed that keeping disabled clients in their homes saved the state a considerable amount of money.

Assemblyman Oscarson inquired whether time spent by pediatricians and physicians could be reimbursed by some of the programs in DHHS.

Ms. Kotchevar responded that many pediatricians were reimbursed for services; however, Early Intervention Services was governed by the Individuals with Disabilities Education Act (IDEA) Part C, and the Division could not require families to permit the Division to bill their insurance. The Division asked for permission, but the services had to be provided regardless of whether the Division was allowed to bill private insurance.

Assemblyman Oscarson requested the percentage rate of families who allowed the Division to bill insurance on their behalf. Ms. Kotchevar said she would provide the information.

Chair Anderson opened the hearing for public comment.

Lisa Foster, representing Southern Nevada Association of Providers (SNAP), for people with developmental disabilities, read the following into the record:

> Good afternoon members of the budget Subcommittee. My name is Lisa Foster, and I'm here today representing SNAP, which is a consortium of providers for people with intellectual disabilities. On behalf of SNAP, I wanted to briefly state their appreciation for the inclusion of a Medicaid increase in Ms. Gruner's budget for year two of the biennium. For the SNAP members providing housing, supervision, transportation, and related services, Medicaid is the sole source of revenue, and there has not been an increase since 2006, even though the cost of serving these individuals has

> continued to increase. They are truly just making ends meet in their effort to provide stable and safe environments. SNAP has a concern, however, that the first year may be a very tough stretch for some of their members, so we will be having conversations with you as to how to make this work for the state and for these individuals. SNAP again appreciates the administration for hearing these providers' plea, and we look forward to working with the Legislature throughout the session on this budget issue.

Jeffrey Klein, Chairman, Nevada Commission on Aging Inc., Subcommittee Concerning Legislative Issues, and President/CEO, Nevada Senior Services, provided written testimony (Exhibit I) for the Subcommittee. Mr. Klein read the following into the record:

> The role of the legislative subcommittee is in large part to listen to Nevada's seniors, provide voice to the voiceless and our most vulnerable and fragile, and recommend/support policy initiatives on behalf of Nevada's seniors.
>
> Thank you to the Chairs, Vice Chairs, and members of the budget Subcommittee.

Mr. Klein commented that from personal experience, he appreciated the opportunity to work with Jane Gruner, Administrator, Aging and Disability Services Division; Laurie Squartsoff, Administrator, Division of Health Care Financing and Policy; Richard Whitley, Administrator, Division of Public and Behavioral Health; and Romaine Gilliland, Director, Department of Health and Human Services, to explore problems facing Nevada senior citizens.

Chair Anderson asked whether there were additional comments or questions. There being none, the meeting was adjourned at 3:25 p.m.

RESPECTFULLY SUBMITTED:

_____
Linda Blevins
Committee Secretary

APPROVED BY:

_____
Assemblyman Paul Anderson, Chair

DATE: _____

_____
Senator Ben Kieckhefer, Chair

DATE: _____

EXHIBITS

Committee Name: Legislative Commission's Budget Subcommittee

Date: January 21, 2015 **Time of Meeting: 8:34 a.m.**

Bill	Exhibit	Witness / Agency	Description
	A		Agenda
	B		Attendance Roster
	C	Romaine Gilliland, Director, Department of Health and Human Services (DHHS)	DHHS Highlights Pre-Session Budget Hearing Budget Subcommittee
	D	Bonnie Long, Administrative Services Officer, Director's Office, DHHS	DHHS Director's Office Governor's Recommended Pre-Session Budget Hearing
	E	Laurie Squartsoff, Administrator, Division of Health Care Financing and Policy, DHHS	DHHS Division of Health Care Financing & Policy Biennial Budget Pre-Session Presentation
	F	Steve H. Fisher, Administrator, Division of Welfare and Supportive Services, DHHS	DHHS Division of Welfare and Supportive Services 2015-2017 Governor Recommended Budget
	G	Richard Whitley, Administrator, Division of Public and Behavioral Health, DHHS	DHHS Division of Public & Behavioral Health Legislative Commission's Budget Subcommittee Presentation SFY 16/17
	H	Jane Gruner, Administrator, Aging and Disability Services Division, DHHS	DHHS Aging and Disability Services Division Budget Presentation
	I	Jeffrey Kline, Chairman, Nevada Commission on Aging Inc., Subcommittee Concerning Legislative Issues, and President/CEO, Nevada Senior Services	Written Testimony regarding Community-based service system