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

Seventy-Ninth Session
February 8, 2017

The Committee on Health and Human Services was called to order by Chairman Michael C. Sprinkle at 1:34 p.m. on Wednesday, February 8, 2017, in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4401 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. 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/79th2017.

COMMITTEE MEMBERS PRESENT:

Assemblyman Michael C. Sprinkle, Chairman
Assemblywoman Amber Joiner, Vice Chair
Assemblywoman Teresa Benitez-Thompson
Assemblyman Richard Carrillo
Assemblyman Chris Edwards
Assemblyman John Hambrick
Assemblyman William McCurdy II
Assemblywoman Brittney Miller
Assemblyman James Oscarson
Assemblyman Tyrone Thompson
Assemblywoman Robin L. Titus
Assemblyman Steve Yeager

COMMITTEE MEMBERS ABSENT:

None

GUEST LEGISLATORS PRESENT:

None

STAFF MEMBERS PRESENT:

Marsheilah Lyons, Committee Policy Analyst
Mike Morton, Committee Counsel
Kailey Taylor, Committee Secretary
Terry Horgan, Committee Secretary
Trinity Thom, Committee Assistant

OTHERS PRESENT:

Dena Schmidt, Deputy Director, Programs, Department of Health and Human Services
Naomi Lewis, Deputy Administrator, Program and Field Operations, Division of Welfare and Supportive Services, Department of Health and Human Services
Marta Jensen, Acting Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services
Shannon Sprout, Division of Health Care Financing and Policy, Department of Health and Human Services

Chairman Sprinkle:
[Roll was called.] Welcome to the 79th Session. We will now do introductions, and I will start with myself. I represent Assembly District No. 30, primarily the downtown parts of Sparks and a little portion of southeast Reno. This will be my third session on the Health and Human Services Committee. I do have a health-care background, so this is a real passion for me. I am honored to be chairing this Committee. As I look around at the Committee members, I am excited for the wealth of knowledge and experience you will hear. It gives me confidence that these people will do a great job vetting the difficult issues and even some fun issues. I will now turn it over to the Committee members, starting with my Vice Chair.

Assemblywoman Joiner:
I represent Assembly District No. 24, which is the core of Reno, from the university down to about Virginia Lake. I am thrilled to be on this Committee again. I was privileged to serve on it last session as well. My history with the Committee actually goes back a little bit farther. In 2009, I was sitting in Marsheilah's seat as the policy analyst when Debbie Smith was the chair of this Committee. Since then, professionally, I have worked in the Department of Health and Human Services and for the Nevada State Medical Association. Health-care policy is not only an area of professional interest to me, but also an area of passion. I am hoping that during this session, we can find ways to improve health in Nevada.

Assemblyman Carrillo:
I represent District No. 18 in southern Nevada, which is unincorporated Clark County and parts of Henderson. This is my fourth term and my second term on the Assembly Committee on Health and Human Services. My first time was in the 76th Session. It really opened my eyes to a lot of the stuff we deal with for the state. I am looking forward to assisting the people of Nevada. I might learn something from this Committee.

Assemblyman Oscarson:
I represent Assembly District No. 36. I am grateful to be here. This is my third term and my third time on the Assembly Committee on Health and Human Services. Chairman Sprinkle and I have had multiple conversations about last session versus this session and the bills we will have. I am grateful for his leadership and the way he approaches health care. I am looking forward to serving on this Committee.

Assemblyman Hambrick:
I have the privilege of representing Assembly District No. 2, which is the majority of Summerlin. I am very pleased to be on this Committee, not only because of the health aspect, but also because of the juvenile justice area of this Committee. I am the chairman of the Juvenile Justice Commission and, as many of you know, my passion is human trafficking. We will be touching on certain related issues. My wife is a breast cancer survivor, and I am a prostate cancer survivor. Again, I am very interested in the various issues that this Committee will be handling this session. I am very pleased that our Chairman has a background in health as the past Chairman did. It is going to be a fun session, and there will be many good things coming out of this Committee.

Assemblyman Edwards:
I represent the great Assembly District No. 19, which includes Mesquite, half of Moapa, a chunk of North Las Vegas, a piece of Henderson, and a chunk of Boulder City. This is my second session, and I am looking forward to working with everyone to resolve some problems for the people of Nevada.

Assemblyman Yeager:
Thank you, Mr. Chairman, and congratulations. We are all looking forward to a productive and hard-working committee. I represent Assembly District No. 9, which is in southwest Las Vegas. This is my first session as an elected official in the Legislature. I lobbied on behalf of the Office of the Clark County Public Defender the past two sessions. One of the areas of concern to me is the intersection of the criminal justice system and mental health. That is something that I have worked on in the past, and I look forward to continuing to work on that issue and everything else that comes in front of the Committee.

Assemblywoman Miller:
I represent Assembly District No. 5, which borders Summerlin and is primarily The Lakes area in Las Vegas. I do not have much health experience, but I did spend years in program administration and development in human services. I look forward to the opportunities we have and the things we can do to help Nevada grow.

Assemblyman McCurdy II:
I am the representative for Assembly District No. 6. I am very thankful to be on this Committee. I have worked around health care for a while now, and I am interested in participating in debate to make sure we keep Nevada residents safe.

Assemblywoman Titus:
I am from Assembly District No. 38, which is all of Churchill County and most of Lyon County. I was Vice Chair of this Committee last session. I am very much looking forward to working with the Chairman and his expertise. We were able to visit many times on health issues. I am a rural family practice physician; I still make house calls, I still see patients, and I even went to the office this morning. I am also the county health officer and a long-term care medical director, so I wear many hats, as most people do in rural areas. I am looking forward to working on this Committee and listening to everyone.

Assemblyman Thompson:
I am the Assembly member in Assembly District No. 17. I represent the city that I was born and raised in, a different part of the city, but in the city of North Las Vegas. I am serving my third term. Most of you might know that I was appointed in 2013, so I served the last 40 days, and I have always served on the Assembly Committee on Health and Human Services. I actually served on four committees for those 40 days. I am glad to have only three this time. My background is mainly in the health, human, and community services areas. I am really looking forward to this because we have a plethora of issues and I see our diverse Committee with a lot of expertise.

Assemblywoman Benitez-Thompson:
I represent Assembly District No. 27, which is old northwest Reno, new northwest Reno, Panther Valley, Sun Valley, and parts of Golden Valley. It is very much a working class district. This is my fourth session, and each session I have had the honor of sitting on this Committee. I believe good things happen in this Committee, and it was one of my favorites. I am so happy to be here.

Chairman Sprinkle:
I cannot help but reiterate what a phenomenal crew we have on this Committee. I am excited about the work we are going to do. I also wanted to reiterate one thing that Assemblyman Oscarson said. First, I want to thank him for all of the outstanding work he did last legislative session. He and I worked closely together then, and even in these last few weeks, we have been working very closely on several of the bills we are going to be hearing this session. I certainly welcome his input, as with everyone on this Committee, because that is how we will get things done. Finally, Assemblywoman Joiner, I am thankful that you are going to be my Vice Chair, and I look forward to working with you and all of your experience.

With that being said, I would be remiss if I did not talk about our outstanding staff that is going to be helping me every step of the way to get through the next 118 days. I would like to start with our committee legal counsel this session, Mike Morton. He is Senior Deputy Legislative Counsel for the Legislative Counsel Bureau (LCB). This is his second session, and his law degree is concentrated in health law. Prior to moving to Nevada, Mike worked in the Missouri Senate. Thank you very much, Mike, for being here.

Our committee policy analyst is Marsheilah Lyons. Many of us know Marsheilah well. I cannot even tell you how grateful I am to have her sitting by my side. This is her ninth session. During the interim, she staffed the Legislative Committee on Senior Citizens, Veterans and Adults with Special Needs, as well as the Subcommittee to Conduct a Study of Postacute Care. While this is her first time staffing the Assembly Committee on Health and Human Services, she staffed the Senate Committee on Health and Human Services for seven of her eight prior sessions. Marsheilah also lives in my neighborhood and our sons played football together. We have known each other for quite a while.

Our committee manager is Sara Wainwright. While this is her first session working for the Assembly, she is not new to the legislative process. During the 2013 Legislative Session, Sara interned as a lobbyist with Marlene Lockard. In addition, during the 2013-2014 Interim, she interned as a research assistant for Elisa Cafferata. Sara brings to her position experience she gained working for nonprofits such as the American Lung Association and other social service organizations. She is currently working on her master's degree in public administration and policy. When I do not hold her captive here, she enjoys participating in hobbies related to art, golf, and dog agility.

Our committee secretaries are Terry Horgan and Kailey Taylor. They will be alternating coverage of our meetings. Terry has worked a number of regular sessions and two special sessions in a variety of positions. She enjoys working with the Assembly Committee on Health and Human Services because health is important and interesting. In addition, it is her family's focus with a number of health-care providers in her family.

This is Kailey's first session. She is very excited to be on the Assembly Committee on Health and Human Services. Kailey worked for the Nevada State Immunization Program prior to taking on this job, and she has a background in public health. She is looking forward to learning more about how policies are developed and offering her skills as a committee secretary.

Finally, I want to recognize Maria de la Luz Aguayo, our research secretary who will be working with Marsheilah. This is her third session with LCB and her first session as a research secretary. She is very excited to be in her new role this session. Truly, we want to thank this entire staff for the work that is coming and for the work that they have already done. We would not have been able to get this started without you.

Now, we have a little bit of business to take care of. We need to review and approve the committee policies (Exhibit C). Members should be able to view these on the Nevada Electronic Legislative Information System (NELIS). Hopefully, we will be adopting these policies very shortly. Number one, it is the intention of this Committee that members create an atmosphere of courtesy, professionalism, and respect to all individuals testifying. It is also the expectation that persons appearing before the Committee will show equal respect to its members. I will say that I believe very strongly in this and, if this is not adhered to, I will be very quick to cut people off.

In accordance with Assembly Standing Rule No. 54, exhibits for hearings, including proposed amendments, must be submitted electronically to the committee manager by no later than 1:30 p.m., two business days prior to the meeting (unless the Chairman approves otherwise), and include the contact information (phone and e-mail address) of the person providing the exhibit. This is not meant to make life more difficult. This is truly meant to make my staff's lives easier.

The Chairman reserves the right to reschedule matters if exhibits are not provided in advance.

Requests for equipment (laptop, projection screen, et cetera) to make presentations must be submitted to the committee manager no later than 1:30 p.m. two business days prior to the meeting, unless the Chairman approves otherwise. The presenter must bring the electronic file to the meeting room on a PC-compatible USB flash drive no later than 15 minutes prior to the meeting's posted start time.

When possible, Committee hearings may be videoconferenced to the Grant Sawyer State Office Building in Las Vegas; however, requests for videoconferencing should be directed to the Chairman as early as possible, but no later than three business days prior to the meeting. We do compete with other committees for this privilege, so please do follow through with that.

Members of the Committee are expected to report promptly at the designated hour for Committee meetings and to notify the Chairman in advance if they must leave a Committee meeting for an extended period of time. I do want to talk about this briefly. We have four individuals on this Committee who are also on the Assembly Committee on Education. That committee meets right after us. One of these members is our Education Chairman, Assemblyman Thompson. I want the Committee to know that I understand there will be conflicts, and so I will be working diligently with Chairman Thompson so that we can coordinate between the two committees to avoid a conflict on a day when one of the larger issues may be heard by this Committee. If there are conflicts with bill scheduling, please let me know in order to minimize any disruption to the Committee's hearings.

Finally, lobbyists and members of the public shall not be permitted on the dais before, during, or after Committee meetings. This is something that I feel strongly about. I understand that you all have reasons to talk to Committee members and that is not a problem at all; I would just ask that you get their attention and take it away from the dais to have those conversations. I feel strongly about this and will be strictly adhering to it.

I have one other introduction: Trinity Thom is our committee assistant, and we are certainly happy to have her on board with the team as well.

I will now take a motion to adopt the policies unless anyone has any questions.

ASSEMBLYMAN EDWARDS MOVED TO ADOPT COMMITTEE POLICIES.

ASSEMBLYWOMAN BENITEZ-THOMPSON SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

We all live and die by our cell phones, but please make sure you silence them as well as any other electronic equipment. We would prefer not to hear the noises when an alert comes in. Anybody wishing to testify should sign in at the table by the door. If you have a business card, be sure to give that to the committee secretary; it is helpful to have your name accurately in the minutes.

Before beginning to testify, please speak clearly, and state your name and affiliation for the record. Be sure to hit the mic button.

We will now go over the Committee Policy Brief.

Marsheilah Lyons, Chief Principal Research Analyst, Legislative Counsel Bureau:
Our role is as nonpartisan staff and, with that, we will not be advocating for or opposing any policies that come before this body. We are here to provide you with any information and research you might need in order to process the bills that are before you. If any individual member has a question, you can reach out to me and we will get answers back to you. If there is any direction that comes from the Chairman that relates to the entire Committee, we will respond to that and prepare that as well.

I will briefly go over the Committee Policy Brief (Exhibit D) that you have before you. Many of you have already heard the deadlines on page 2, but it includes a schedule of the session deadlines. April 14 is the deadline for the first committee house passage. This is very important. All of the committees will be busy around that time getting bills processed so that they get out of the committee and to the floor. The number of measures the Committee considered during the 2015 Legislative Session was 82 bills. That should give you an idea of how busy this Committee will be. We expect to work under the direction of the Chairman to process bills throughout the session so that we do not get bogged down. We will work with him to coordinate that and coordinate with the other chairs.

I also included an outline of legislative subjects that typically fall within the Committee's jurisdiction on pages 3 and 4. They are all health and human services-related topics. We encourage you to look at some of the reports and things that are included in the Committee Policy Brief. If you look it up on NELIS, you will see that there are links to many of the interim committee bulletins. Some of those will be coming out in the next couple of weeks. The mental health regionalization bulletin is already available. We encourage you to look at that. If you are interested in copies of any of these, give me a call so that I can get that to you. Otherwise, most of them will be available online. Policy and program reports are good

for a general overview of information on a topic or subject; we encourage you to look at those as well. You might be interested in some legislative audits and statutory reports as well. A list of some of those is included in the brief.

Two of the pieces of the brief that tend to be most helpful to members of the Committee are the appendices. The first one is contact information. That includes contact information for most of the agencies and organizations that will be testifying before this body. That may be something for you to hold on to if you have a question for these agencies. The other helpful piece of information in here is Appendix B, which lists common health care acronyms. The only committee that has more acronyms is Education. Please do not go through an entire hearing not knowing what an acronym stands for. Get the Chairman's attention in order to get that clarified. Not only will you make some of your colleagues happy, you will also make the secretaries very happy.

Assemblyman Oscarson:
I would like to remind the Committee that Ms. Lyons served on the Senate Committee on Health and Human Services for a significant period with Senator Hardy.

Chairman Sprinkle:
There are many acronyms. I will have the testifiers explain what those are too.

At this point, we are ready for our presentation. I have asked for a presentation on Medicaid. This Committee should be very familiar with Medicaid; there could potentially be many issues coming before us. I have asked the Department of Health and Human Services to give us Medicaid 101.

Dena Schmidt, Deputy Director, Programs, Department of Health and Human Services:
Today we are here to teach you about the key features of Medicaid and to give you an understanding of what the Medicaid program is: the history, the eligibility process, some information about the policies and budgets, and information on the managed care versus fee-for-service models. Those are our two delivery models.

Naomi Lewis, Deputy Administrator, Program and Field Operations, Division of Welfare and Supportive Services, Department of Health and Human Services:
I want to go over what Medicaid is. It is an optional program authorized by the Social Security Act of 1965 which states can elect to provide. Title XIX of the Social Security Act provides health-care insurance to low-income Nevadans. It was originally authorized in 1965. Title XXI is the Children's Health Insurance Program (CHIP) which provides health-care coverage to low-income, uninsured children who are not eligible for Medicaid. It was not authorized until 1997. Slides 4 and 5 (Exhibit E) provide you with a detailed timeline of events in the progression of Medicaid and later, CHIP, from 1965 to 2012. Over time, the program has greatly evolved and grown via legislation to better and more comprehensively meet the public's health-care needs. It is not one law that defines Medicaid in its entirety. Subsequent legislation has thought to build upon the program. For example,

in 1982 they added the home- and community-based waiver. In 1987, they added continuous coverage for the first full year for babies born to a Medicaid-eligible mom. In 2000, they added the Breast and Cervical Cancer Treatment and Prevention Program, and in 2010, they added the ability for states to cover adults without dependent children in the home. These are just some of the highlights.

On slide 6, there is a representation on how Medicare is a federally operated program and how Medicaid is a state program. Medicare covers individuals 65 and over, individuals who have renal failure, and individuals who have been disabled for two years. Medicaid covers low-income individuals in the states. They do have an overlap, and they do complement one another in providing home health.

Slide 7 explains how Medicaid plays many vital roles in the national health-care system. It promotes partnerships for an overall health-care system for all stages of life. It reduces the number of uninsured individuals, it improves access to care, and it provides an essential supplement to individuals with Medicare. Medicaid provides vital support to nursing homes, and it is the largest source of financing for nursing homes and community-based, long-term care. It is the largest source of funding for the safety net providers, health centers, and public hospitals. It represents the largest source of federal funds to states and fuels economic activity.

The counties have the state contract with the federal government in order to provide long-term care services. The counties pay for a portion of the care, and the federal government pays for a portion of the care. As a result, the state does not have to pay for any portion of that care.

Slide 8 highlights the fact that Medicaid is unique from state to state. There are no two states with the same program. The states that accept federal monies to provide Medicaid coverage have to provide a minimum of 13 covered services, for example, inpatient hospital care. States can elect to provide more than the minimum required services, for example, dental.

Each state develops a contract with the Department of Health and Human Services as part of its state plan and then submits it to the federal government for review and approval. If the plan is approved, we receive a certain amount of federal dollars to fund the program. The states provide the remainder of the funding, often referred to as the Federal Medical Assistance Percentage (FMAP). Medicaid works the same regardless of which state you are in. For example, California calls its program Medi-Cal. What Medicaid means is that it is a medical care coverage program for people receiving assistance from a state health program. Because there are variables in state options and there are state dollars involved, the coverage does not transfer from one state to another, but it has the same governing rules. Some ways you may have heard Medicaid referred to as are the Katie Beckett Eligibility Option, Nevada Medicaid, or CHIP; it has many names but all of them are Medicaid. We are accountable for the federal dollars we spend on the Medicaid benefits, and we undergo quality control to make sure we are providing correct benefits to the individuals who qualify and we are not denying individuals who should be eligible.

In proposing a state plan, states have two options to choose from. They can choose to provide medical need-based coverage or they can choose to provide category-based coverage. Nevada chose to be a categorically needy state with a narrow focus on categories of population. The first criteria that we look at in determining eligibility would be whether a person fits into one of the categories that we offer. Examples of this are aged, blind, disabled, children, and pregnant women. The remaining criteria for eligibility would be looked at after that. When a state chooses to be a categorically needy state, there are some mandatory categories and some optional categories.

On slide 9, I go into who is eligible under the categories that we offer. The mandatory groups are children, pregnant women, parent caretakers, Supplemental Security Income recipients, and certain qualified Medicare beneficiaries. The childless adults you see on the slide are actually an optional group. There are 66 eligibility programs in Nevada. As outlined in the timeline, Medicaid has become very complex because there have been additions to the regulations over the last 50 years. We evaluate the 66 eligibility programs for Medicaid. The agency always starts with the largest, so we evaluate coverage for the whole family and then we work our way through all 66 programs before we deny anyone.

On slide 10, I explain how to apply for Medicaid. We have expanded the business model to offer multiple ways and ways that will work best for our customers so that they can choose to access the program by an online application, a fax, or mail-in application. We have a call center, or people can visit their local district office. We also have the Supplemental Nutrition Assistance Program (SNAP) Outreach partners, food banks, and social service entities throughout the community who help us gather applications and bring them back to the agency. We have also started working through targeted partnerships. We are working with 20 criminal justice partnerships in the community. We have 12 medical partnerships in the community and 7 social service partnerships. We are placing an eligibility worker in the environment where the individual is accessing services in order to work with them in gathering their information and gaining coverage while they are there. We are working with Women, Infants, and Children (WIC) in Lovelock, so we are sending an eligibility worker there to enroll individuals while they are applying for WIC. We have eligibility workers in the Reno Sparks Tribal Health Center and The Harbor juvenile assessment center in Las Vegas enrolling individuals. There are many more, but we are working to reach individuals in their environments to target enrollment.

Slide 11 discusses the one single application for all insurance affordability programs. That includes the Silver State Health Insurance Exchange (or the Federally Facilitated Marketplace) and Medicaid. The idea was that populations are healthier when they have available insurance. Our goal was to keep them insured once they are insured by one program. The model is designed to minimize the churn for the agency and create the least amount of duplicate effort for the individual. One set of data is shared amongst multiple agencies. An example would be, those who came to us, applied for Medicaid, and we captured all of their information and approved them for Medicaid. If their circumstances change in the future, maybe they go to work or their wages increase and they are no longer eligible for Medicaid, we take their data and share it with the Silver State Health Insurance

Exchange so that they can enroll them in advanced premium tax credits and/or a qualified health plan if they qualify. That works in the reverse as well. If they started with a qualified health plan through the Silver State Health Insurance Exchange and they become eligible for Medicaid, their data is shipped to us. Once they are covered, we keep them covered. We try not to end that coverage unless they do not qualify in any of those places.

Slide 12 shows eligibility based on poverty levels for the modified adjusted gross income groups. This is the adjusted gross income based off the tax returns plus a couple of minor add-ins or take-aways. The current eligibility federal poverty levels are on slide 12. It is 165 percent of the federal poverty level for a child aged 0 to 5 years, and it is 138 percent of the federal poverty level for a childless adult aged 19 to 65 years.

On slide 13 there are some unique rules to the Nevada Check Up program because it is under Title XXI. It does have some unique rules outside of Medicaid but does follow Medicaid rules for the most part. One difference is that we potentially charge a premium for the program, somewhere between $25 and $80 a month to participate. It is for children only and children who do not qualify for Medicaid. Right below that are the federal poverty limits that go along with the chart on slide 12. For example, the household size is four and they are applying as a pregnant woman at 165 percent of the federal poverty level. That is roughly $3,000 per month. When we make an eligibility determination, we look at non-financial information, income, resources, and expenses in some instances.

We have a verification plan, which the federal government approves. With that plan, we are required to verify everything electronically that we possibly can. We have interfaces with Social Security, the Department of Employment, Training and Rehabilitation, jails, and other electronic data sources. If we cannot get the information electronically, we ask the client to provide the information. We do have 45 days to make a determination but have an 8-day average processing rate. It was 52 days a couple of years ago. We are processing an average of 44 days sooner now, based on our current business model.

Slide 14 highlights the fact that we are an integrated agency and that we determine eligibility for multiple programs. We have found that there are multiple things that play into the world of health. We know that food, clothing, shelter, and education all play a role in health outcomes. This chart represents three of the programs we offer in our agency. Almost 373,000 are on SNAP and Medicaid, so we are assisting with food and medical coverage. In addition, 21,000 people are on SNAP, Medicaid, and Temporary Assistance for Needy Families (TANF).

Assemblywoman Titus:
It used to be 45 days to process and you have now lowered it to 8 days, correct?

Naomi Lewis:
The regulation says that the agency has 45 days to determine eligibility. Our current average processing days are at eight.

Assemblywoman Titus:
You mentioned that it had been longer. What was it a year ago?

Naomi Lewis:
When health-care reform first launched and we had an influx of applications, it was almost 71,000 applications. Our average processing time during that period was 52 days.

Assemblyman Yeager:
On the bottom of page 14, I noticed it explains that Medicaid counts include retroactive cases. Could you explain what that means, please?

Naomi Lewis:
One of the rules in Medicaid indicates that individuals can apply in the current month and they can apply for up to three prior months. In the counts, there are times where we have added from the past three months.

Marta Jensen, Acting Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services:
My section will talk about what people are eligible for and how we deliver that service to them. The Centers for Medicare and Medicaid Services (CMS) are our federal partners. They fund the majority of our programs through the Medicaid state plan. They set the standard of what is supposed to be included in a Medicaid plan to get approval. I have a list of the items, but I will give you some highlights. When we are talking about comparability, all of our Medicaid members, regardless of where they are in the state, if it is a Medicaid covered service and is medically necessary, can receive that service. In some cases, the service may or may not be available in the state in which they reside. We have access issues on a national perspective. Specifically in Nevada, we will pay for those services to be provided out of state. We also provide for transportation and other services such as the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit for individuals under the age of 21. They are eligible for additional services outside of the state plan, if it is medically necessary. We want to make sure that we get these young individuals the services they need so that they have better health in their adult years.

One of the other things that we are also required to do is to have appropriate utilization controls in place to make sure that we are looking for that fraud, waste, and abuse. We do have a prior authorization process as part of the utilization controls.

Slide 16 discusses the ten essential health benefits that are required to be provided by Medicaid, as well as every other health plan since the Affordable Care Act. It levels the playing field between health plans. This is important because as members transition between health plans, whether it is Medicaid or in the commercial market, they need to have a suite of

services available to them, and it is good for continuity of care. It makes sure that no matter what plan you go to, the service that you are receiving will be available at that next plan.

Slide 17 discusses the mandatory Medicaid-specific services for a plan to be approved by CMS. Some of them are physician services, family planning, federally qualified health centers, nurse midwife services, and a variety of services that are the basic requirements for a Medicaid program. Centers for Medicare and Medicaid Services also offers a list of optional benefits that the state can also receive approval to fund. On the right side of the slide are all of the things that Nevada has opted to cover. We have done that for various reasons, but the most important is that we feel that covering these services is good for our member base. It helps them stay healthy, and it keeps them on track. If you identify an issue early and cover that service, most likely it will stop that long-term, possibly chronic disease or horrific event that would cost more in the long run had they not had their prescriptions or diagnostic testing. These decisions were made several years ago, but we still believe they are the right thing for our member base.

Slide 18 discusses our service delivery models. Currently we have two: fee-for-service and managed care. In fee-for-service, individuals can receive service from any provider that is enrolled in Nevada Medicaid. They do not need referrals from a primary care physician and they are responsible for coordinating and managing their own care. The majority of our members are managed care customers. Managed care is a health organization that provides care coordination, patient education, and connects individuals with primary care physicians and specialists. They are also required to maintain that network of providers for the geographic areas that they serve. A Managed Care Organization (MCO) covers most of the services that are in the Medicaid state plan such as physician or hospital services, pharmacy, behavioral health, personal care, and therapies. Managed Care Organizations provide value-added benefits as well. They have a basic platform and then have the option to add additional services such as housing or adult dental services, which could benefit their member base. It is something that they believe would improve the health of their members. Some of the things we have chosen are Medicaid-covered services, such as emergency transportation, but we have chosen not to have managed care handle that. That is all run through the fee-for-service program. It is still offered to the managed care recipients; it is just run through a different delivery model. Our MCOs currently are in the two urban areas of Nevada, Clark County and in the Reno-Sparks area. Everything else is considered fee-for-service.

Our current population is around 638,000 members. Prior to expanding the population in January 2014, we had 323,000 members. In this three-year period, we have doubled our population. The good news is that we have reduced our uninsured rate from 22 percent to 12 percent. An unexpected benefit was that through the education of this new insurance requirement and the programs that are available, we also had our traditional markets, which are our moms and children. We have seen a huge increase in all of our populations. We saw a huge increase in the expanded population, but we also saw it in the traditional population, which is the aged, blind, disabled, moms and kids. That is a good thing because more people are availing themselves of health care coverage and getting their health care needs met.

The chart on slide 19 shows the growth of the program. Our largest population still is our moms and children. Our second-largest population is our childless adults. Third largest is aged, blind, and disabled. The fourth largest is the newly eligible parent caretakers and fifth is others, which is our county match, waivers, and child welfare kids.

To further break down our population, slide 20 shows the breakdown of managed care versus fee-for-service. The majority of our members, 72 percent, are actually in managed care. Currently, we have two managed care plans. One is Amerigroup and the other is Health Plan of Nevada. With that, 59 percent are in Health Plan of Nevada, 41 percent are with Amerigroup, and 28 percent are in fee-for-service. That is all of our rural counties. When we talk about actual numbers, managed care has about 462,000 members and fee-for-service has about 175,000 members.

In the last session, we were asked to look into putting long-term support services into managed care. What our director decided at the time, was that rather than look at that population, we should look at managed care in its entirety. It has been in Nevada since around the early 2000s, but we have not looked at it from a wholistic perspective. In January of last year, we started having listening sessions across the state in all of the communities we were able to get to. We asked people to come forward and tell us their thoughts on the care that they were receiving and how they felt about managed care, if applicable. We found that there were many good comments as well as many concerns. We received information from our recipients, providers, legislative individuals, and anyone with an interest. Individuals have different concerns depending on who they are. If I were a member, my concerns would be different from those of a provider. We created smaller groups with provider associations. We met with anyone who wanted to meet with us. We went to their location, showed them what we were looking at, and asked them for their ideas. We received a plethora of information and ideas. We decided that we needed to hire a consultant to help us with this. Much information was gathered, but we needed an outside entity to come in and look at what we gathered, and also look at it from a national perspective in order to tell us what some of the other states are doing. If they are doing something well, we should consider that. It was a great opportunity for us to see what was available. The final report is due any day; we expect it by the end of the month. However, no decisions have been made at this point. We do have recommendations coming from the company, Navigant Consulting, Inc.

You will notice as we go through our budget presentations, we have not made a request related to changing the current service package. We have always had language in our contracts with our existing partners to expand into additional geographic areas or services, but we have never exercised that option. We now want to know what is available based on the recommendations from our consultant.

Slide 21 breaks down the managed care population by the member type, including Medicaid, Nevada Check Up, and so on, compared to the overall population and the newly eligible. There is a spike from January 14 through December 14 because we had a large increase in the newly eligible population because the majority of these individuals are in urban areas and that is where the delivery models are.

Slide 22 discusses access to care. This is a national topic currently, but I would like to discuss what is happening locally. Our member base has doubled, and our provider base has not. This creates an access problem. I cannot say that there is one particular entity responsible for addressing all of it. We have to work at this together from various levels, whether it is the education system, the regulators, the licensing boards, or reimbursement from a Medicaid perspective. We need to understand how to increase the entire pipeline of our workforce. If you get people educated in school, earning degrees, where do they go to get their internship? If I can reimburse at an intern rate, it is likely that they will stay in-state and continue to be a provider. We have to look at the whole pipeline of activity to make sure all of the right steps are in place in order to enhance our workforce. From a Medicaid or reimbursement program perspective, what can we do to help get more providers? Is that through an increased reimbursement? Is that through recognizing certain provider types to provide a service and provide them a reimbursement?

I am most proud of some of the things we have done as a division. This is not an all-inclusive list on slide 23. These are just the things that I think can resonate with you and your districts. We have implemented several programs. I am concerned about access in the rural areas because we do not have enough specialists in Nevada. We have expanded from a telemedicine perspective; we have opened up the geographic regions and the providers that can use telemedicine to reach their members.

We have also implemented a paramedicine program from last session. Regulations were passed to recognize that a certified emergency medical technician (EMT) could provide certain services within their communities. It can be urban or it can be rural. I have seen it as especially beneficial in Washoe County and in rural districts in Winnemucca. When people are discharged from a hospital, they get a pack of papers, go home, and sometimes they do not follow through with the instructions that they receive. The community paramedics can do community management by checking in on that patient, doing wound care, and providing immunizations. There are many services they can provide which will then prevent that individual from going back to the hospital or going to an urgent care center or another place where slots are needed for another member of the community. It is trying to make sure that the member gets well, stays well, and that there are available appointments for the rest of the members.

We have implemented the applied behavior analysis program, which is related to children on the autism spectrum. We have also expanded our reimbursements. We have now recognized and expanded the use of advanced practice registered nurses. We have increased the inpatient psychiatric rate, which will increase the number of beds that are available. You will see in our budgets that I have asked for additional funding for additional provider types—podiatrists and registered dietitians—to do that medication therapy. That allows those individuals who have those conditions to go to a recognized Medicaid provider and not rely on a primary care physician. This then allows primary care physicians to see other people in their practice. Again, we are trying to look at this from a wholistic point of view. We are trying to look at all of the things we can do to improve access. Again, reimbursement will bring additional providers in from a recruitment perspective. We have additional providers

in the state that may cap their eligibility for Medicaid recipients for whatever reason. We have some that do not want to take Medicaid because the administrative burden is difficult between enrollment, prior authorization, claims, and processing. We are looking at how to make it so that providers want to take Medicaid.

We are implementing a new modernized Medicaid Management Information System (MMIS), which will enhance provider experience into Medicaid through online provider enrollment, quicker prior authorizations, and quicker claims payment. We are also looking at centralized credentialing. Currently, a provider has to enroll with Medicaid, the fee-for-service program. Once they become enrolled and choose a managed care plan to enroll in, they will then become credentialed with that managed care plan.

I have two managed care plans. Effective July 1 of this year, we will have four plans. That will increase that need for credentialing. Is there something we can do one time so that the providers can be signed up and continue practicing?

Slide 24 discusses how we pay for this. This chart illustrates that our budget in fiscal year 2016 was $3.4 billion and 95.57 percent of that went to medical services. We have a 4.43 percent administration rate, which means that all of the pass-ons that would go to our sister agencies go through our fiscal agent contract, Hewlett-Packard, which processes all of our claims, enrolls our providers, and does the appeals. They handle the business side of Medicaid according to our state plan and our Medicaid rules. However, that does include their fee.

Slide 25 is a high-level description of the various categories of our population. Our largest population by expenditure is our newly eligible. We have approximately 212,000 newly eligible. We spent almost $1.1 billion on them. The average cost per eligible, cost per person, is around $429. The second category is our traditional Medicaid, moms and children. They are 29 percent of the caseload. We have approximately 313,000 members, and their average cost per eligible is $228. The third category is aged, blind, and disabled. They are 26 percent of our caseload. We have 72,000 members, and their average cost per eligible is $864 per person. Some of the services they receive are more costly. These include inpatient hospital stays, pharmacy, nursing facilities, personal care services, and physician services.

As we go through the budget process this session, you will see that I have asked for some additional funding in our community-based services in order to help with this overall cost. On slide 26, I will talk about the Federal Medical Assistance Percentage (FMAP), which is the amount of the federal match that we get. Typically, it is around 65 percent. They set this about once a year, but we adjust it three times a year. It was a lot easier before the Affordable Care Act (ACA), but once that came on board, it added an additional FMAP to the mix. For every dollar that is spent for the traditional Medicaid market, we get 65 cents back from the federal government as a match. The newly eligible who came on January 1, 2014, were funded at 100 percent federal match. You can see that by shifting that population from general into Medicaid, 100 percent of their expenses were paid by the federal government. Beginning in January of this year, that match has gone down to

95 percent, so the General Fund portion is 5 percent. This chart shows what we consider to be blended. It changes based on the category that you are in, whether it be newly eligible, standard fee-for-service, or managed care plan versus the time of year that the new FMAP comes in.

Assemblyman McCurdy II:
With the expansion of Medicaid and the increase in reimbursement rates, has there been a lot of Medicaid fraud? Have we been able to track that and see where it is that we can retain some of those funds that were fraudulently taken, especially in services that are provided?

Marta Jensen:
Within Medicaid, we have a surveillance and utilization review unit that looks at claims data. We receive various tips from the provider base or the population. We take any information from anyone who believes there is a problem, whether it is fraud, waste, or abuse. It is a very small unit with about 14 analysts right now. Through the ACA we also had a requirement to contract with a recovery audit contractor. Every state is required to contract with someone. We have secured a contract with Healthcare Management Systems (HMS) Holdings Corporation. They supplement what we are doing in our unit because they can take on a larger population. We will give them projects that we do not have the staffing or expertise to look at. We try to look at it from various angles. I do not have figures off the top of my head, but I can get that history.

Chairman Sprinkle:
There was a bill specifically dealing with this that was referred to the Assembly Committee on Judiciary (Assembly Bill 53). The optional benefits are available to all Medicaid recipients who are enrolled, is that correct? You do not look at the different categories and decide that some people get some benefits but that others are not eligible for? There are some exceptions. In the optional program, when you ask for approval, you can isolate it down to a certain population.

Dena Schmidt:
For some of the optional categories, we do opt in for certain services, just for waiver recipients. The recipients in the waiver category do get certain services that the rest of the population does not. Generally, your optional categories for the state plan itself are available to all members, but we can exclude those using waivers.

Assemblywoman Titus:
I am concerned about the managed care aspect of this. In my mind, managed care really is not about managed care, it is about managing money, sometimes to the detriment of the care. I want to be cautious about that expansion and how it affects the rural areas. Sometimes that model does not work when you do not have that access to care, providers, or services. Then you perhaps require them to go out of their communities if it is in a managed care plan. I am sure you are working with the rural health people to make sure that it is not to the detriment of the patient, and that it continues to manage the care and not just manage the money.

Marta Jensen:
I will say that our rural tour was very vocal. We received many comments about their concerns, and it was all taken into consideration.

Assemblyman Thompson:
On slide 18, regarding the Title XIX dollars, you specifically talk about Clark County and Washoe County. I just want to make sure that we are including all of the kids and all of the families. Where do the rural communities come into place?

Marta Jensen:
You want to know what the services are that are provided in the rural areas, is that correct?

Assemblyman Thompson:
That is correct. You were very specific about Title XIX.

Marta Jensen:
That would be the fee-for-service model. All of our rural counties and the rural areas of Clark County and Washoe County would be fee-for-service.

Assemblyman Thompson:
On slide 17, could you differentiate between primary care case management and targeted case management, which it says is limited?

Shannon Sprout, Division of Health Care Financing and Policy, Department of Health and Human Services:
With targeted case management, you have a carve-out from your managed care organization so it is only in your fee-for-service population. They are for nine target groups. For an example, your target group would be your juvenile justice population, parole and probation. Your non-severely emotionally disturbed is another target group. There are a number of target groups, which we have identified. Those services for targeted case management are specific to helping provide resources that are needed.

A primary care management model is about managing care coordination and the component of the recipient as a whole. For targeted case management you are looking at the nine target groups that occur in fee-for-service. Your primary care management model is a separate model that looks at the care management of the recipient.

Assemblyman Thompson:
Could you get the nine specific target groups and tell us who is the decision maker of those groups? Are you using the term "limited" because there are only nine or because you can only spend a certain amount of dollars for those nine categories?

Shannon Sprout:
When we are looking at the nine target groups, essentially we are looking at the juvenile parole, juvenile probation, non-severely emotionally disturbed, non-seriously mentally ill,

seriously mentally ill, seriously emotionally disturbed, and intellectual disabilities. They are limited in the number of hours. For all of your target groups, we currently cover up to 30 hours per month. There will be a change that becomes effective next month for the non-severely emotionally disturbed and the non-seriously mentally ill. It will be a titrated service package so they will receive ten hours in the first month and five hours for the following three months. Then any of the limited services, whether it is the thirty hours or ten, can all be overridden, as services are deemed necessary through a prior authorization.

Assemblyman Edwards:
What is the reimbursement rate for Medicaid, and what is the optimal rate across the country? Who reimburses the best?

Marta Jensen:
Every service has a different rate assigned to it. Is there a certain service you are looking for that I can explain?

Assemblyman Edwards:
Is there perhaps a range of all of the services?

Marta Jensen:
I can get that, but the difficult part is that there are 250,000 different rates set. There is quite a variation depending on what that service is. I do not have the information about the national rates, but it is all based upon that individual service. We look at the market and across the nation when we do our individual adjustments.

Dena Schmidt:
To close, I wanted to go over how to maximize Medicaid. Since the implementation of the ACA, we have looked at ways to implement Medicaid and transition State General Fund dollars to the Medicaid fund; for example, maybe our Division of Public and Behavioral Health, our Division of Child and Family Services, and our Division of Aging and Disability Services where we have traditionally been the provider, paying 100 percent of the State General Fund for certain services. We have been able to take those services and transition them to a Medicaid-billable service, allowing the state to save on the General Fund dollars associated with that. Where you would normally pay 100 percent of the General Fund, you bill Medicaid, and now you can pull down that 60 percent of the federal fund instead of 100 percent of the General Fund. As we go forward, you will see several initiatives coming before your Committee and the money committees on ways that we can look to maximize Medicaid, not only across our department and our direct service divisions, but also looking at all of our grant units. If we are granting out funds to the community for providers, if those are billable services, we are working with those entities to transition to a billable model in order to allow those funds to go further and serve more individuals. We are also exploring opportunities with our county and government entities. Many of you have been involved in some of those efforts where we use the cost allocation plan for federal and state entities to bring down the federal share as well as working with the universities.

Slide 28 shows you a General Fund savings in our behavioral health categories. The blue bar shows the amount of Medicaid expansion savings associated with behavioral health funds. Each year they are decreasing but you can see how much we have been able to save by transitioning State General Fund dollars over to the Medicaid-billable. We do not know what the ACA repeal reform will look like. We are going with the information we have, and we are building our information on that. Several of these initiatives allow us to continue this great work.

Lastly, we gave you an appendix (Slide 29, Exhibit E). There is some information about the acronyms (Slide 30, Exhibit E) as well as some of the eligibility categories and detailed information about several things you heard today. The most important is that there are district information health profiles (Exhibit F) for each of you with information about your particular district. It includes the number of individuals on the Medicaid, SNAP, and TANF programs in your district as well as various other health indicators.

Chairman Sprinkle:
Thank you for coming here and giving us this presentation. One of the difficult things is that oftentimes it is easy with a subject like this to be wrapped up in the money part of it. I am glad that you were able to give the presentation so that, as we are deciding policy issues, we will have that in the back of our minds.

Is there any public comment in Las Vegas? [There was none.] Is there any public comment in Carson City? [There was none.] The meeting is adjourned [at 2:56 p.m.].

RESPECTFULLY SUBMITTED:

_____
Kailey Taylor
Committee Secretary

APPROVED BY:

_____
Assemblyman Michael C. Sprinkle, Chairman

DATE: _____

EXHIBITS

Exhibit A is the Agenda.

Exhibit B is the Attendance Roster.

Exhibit C is the Committee Policies for the Assembly Committee on Health and Human Services for the 79th Regular Session, provided by Marsheilah Lyons, Committee Policy Analyst.

Exhibit D is the Committee Policy Brief for the Assembly Committee on Health and Human Services dated February 2017, provided by Marsheilah Lyons, Committee Policy Analyst.

Exhibit E is a PowerPoint presentation titled "Medicaid 101," dated February 8, 2017, presented by Dena Schmidt, Deputy Director, Programs, Department of Health and Human Services (DHHS) and other DHHS staff.

Exhibit F is a PowerPoint presentation titled, "2015 Health Profiles"–a profile for each Committee member's district provided by Dena Schmidt, Deputy Director, Programs, Department of Health and Human Services.