MINUTES OF THE MEETING OF THE ASSEMBLY COMMITTEE ON WAYS AND MEANS AND SENATE COMMITTEE ON FINANCE SUBCOMMITTEES ON HUMAN SERVICES

Eighteth Session
March 1, 2019

The joint meeting of the Assembly Committee on Ways and Means and Senate Committee on Finance Subcommittees on Human Services was called to order by Chair Michael C. Sprinkle at 8:07 a.m. on Friday, March 1, 2019, in Room 3137 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4412 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/80th2019.

ASSEMBLY SUBCOMMITTEE MEMBERS PRESENT:

Assemblyman Michael C. Sprinkle, Chair
Assemblywoman Maggie Carlton, Vice Chair
Assemblyman Jason Frierson
Assemblywoman Dina Neal
Assemblywoman Ellen B. Spiegel
Assemblyman Tyrone Thompson
Assemblywoman Robin L. Titus

SENATE SUBCOMMITTEE MEMBERS PRESENT:

Senator Moises Denis, Chair
Senator Joyce Woodhouse, Vice Chair
Senator Kelvin Atkinson
Senator Ben Kieckhefer
Senator James A. Settelmeyer

SUBCOMMITTEE MEMBERS EXCUSED:

Assemblyman John Hambrick

STAFF MEMBERS PRESENT:

Sarah Coffman, Principal Deputy Fiscal Analyst
Cathy Crocket, Senior Program Analyst

Janice Wright, Committee Secretary
Lisa McAlister, Committee Assistant

After a call of the roll, Chair Sprinkle reminded the audience to silence electronic devices and reviewed the rules of the Subcommittees. He opened public comment.

Senate Bill 174: Makes various changes relating to services provided to persons with autism spectrum disorders. (BDR S-680)

Mathew Snell, Private Citizen, Reno, Nevada, and Shannon Thurman, Private Citizen, Reno, Nevada testified in support of Senate Bill (S.B.) 174 and the increase in the budget for special needs children. Mr. Snell stated their daughter Joy had not received services for the last three years. He indicated they contacted Sierra Regional Center (SRC) and received advice to post flyers themselves at the University of Nevada, Reno (UNR) to find a student who would help them provide care for Joy. Mr. Snell noted he was a father and a business owner. He did not believe it was his job to find college kids who were untrained to provide care for Joy. The daily rate paid of $29 per hour went to the agency that provided the caregiver. The caregiver only received $9 per hour. A salary of $9 per hour with no fuel reimbursement before taxes was insufficient to attract qualified individuals. It was not a job he wanted, nor a job that anybody wanted. A person would make a better living with benefits being a Walmart greeter or working at a Burger King restaurant. All of Joy's caregivers left because of poor pay, and Joy was regressing every day.

Mr. Snell stated that Joy developed emotional bonds with her caregivers. When a caregiver left, it broke his heart and they had to start over. He was advised to give up his guardianship of Joy so that his wife Shannon, who was trained in Applied Behavioral Analysis (ABA), could teach Joy. Then the state would take control of a child with no voice. He said the funding did not work, because the $29 per hour was really only $9. There was a breakdown between paying the caregiver and the agency taking the money. The rate should be increased, plain and simple. During the 79th Session (2017), Mr. Snell had testified that this was a problem that the children and the rest of the community would inherit. The children with special needs would not disappear or wake up one day and be fine. They needed services. Joy's regression was obvious. He asked whether the legislators were aware that a $9 per hour job with no fuel reimbursement was not worth anyone's time. Every day he tried to do the best he could for the children and the community. He was stopped by a system that said, "Go find help yourself." He understood that money was scarce, but it was being wasted. The current system did not work.

Shannon Thurman testified that her daughter Joy could not come today to testify. Ms. Thurman believed that the best way to ensure that services were never taken away from Joy was through the Medicaid waiver. The Medicaid waiver worked as opposed to the Autism Treatment Assistance Program (ATAP). But Ms. Thurman had to interview about eight to nine different agencies with the maximum pay of $9 per hour for those individuals.

Then she had to train the caregivers because they were not trained. There was no oversight. When she went to the SRC for help, she was advised to give up her guardianship of her 19-year-old daughter. Once children reach 18 years of age they do not receive services. There was no program for Joy. Ms. Thurman understood that the funds were needed to pay for early intervention services, but she wondered what happened to all the children who aged out of the system. Those older children might get a job on a production line and be watched and paid for what they produced. If they produced 10 percent, then they would be paid 10 percent of minimum wage or 25 cents per hour. That was disability slave labor. She did not know how that was legal to do to someone with a disability, but it happened.

Ms. Thurman explained that Nevada offered no other option because it lacked job carving [job carving was the act of analyzing work duties performed in a given job and identifying specific tasks that might be assigned to an employee with severe disabilities]. What Ms. Thurman had done every day was fight, learn, teach, and that took time away from her family as a whole. Unfortunately, her other daughter did not receive much of her time or attention because everything she did in her day-to-day life was to find services for Joy or teach someone to provide services.

Ms. Thurman stated that Nevada was last in the national rankings for health and human services and education. Joy had regressed so much, and Ms. Thurman contemplated pulling Joy out of school to homeschool her. For the past two years, Ms. Thurman had been ill and had brain surgery. She was sick all the time and unable to provide all the care for Joy herself. She would appreciate raising the rate to $12 per hour or more. A salary of $29 per hour was paid to the agency but the caregiver only received $9 per hour with no fuel reimbursement. Given the choice, she would rather work at McDonalds or Starbucks. No one was coming to give Joy services. Joy had been on the waiver for three years, and she had not had one person come to the house for services. Anything that could be done for disabled children should be done. She did not want to see anyone else regress to the state where Joy was now. Joy was unable to speak now because she had regressed from her skills two years ago.

Jennifer Jeans, representing the Legal Aid Center of Southern Nevada, Washoe Legal Services, Volunteer Attorneys for Rural Nevadans, and the Southern Nevada Senior Law Program, testified that those agencies had been involved with state budgets for more than 30 years and represented individuals with disabilities, seniors, and low-income Nevadans who relied on Medicaid to meet their basic health needs. She thanked the Governor for including some very important items in his budget that she hoped the Legislature would approve. Those included:

- Reducing individuals on the intellectual disability waitlist beyond 90 days in budget account (BA) 3243. Decision unit Maintenance (M) 510 added 346 slots.

- Reducing individuals on the Frail Elderly waiver waitlist beyond 90 days in BA 3243. Decision unit M-511 added 339 slots.

- Reducing individuals on the Physically Disabled waiver waitlist beyond 90 days in BA 3243. Decision unit M-512 added 147 slots.

- Funding Medicaid caseload growth in BA 3243, decision unit M-200.

- Providing funding for Medicaid 1915(I) Home and Community-based services including housing support for mentally ill homeless in BA 3243, decision unit Enhancement (E) 232. Sustaining growth in the continuum of care to improve health outcomes through Certified Community Behavioral Health Clinics in BA 3243, decision unit E-238.

- Increasing various provider rates throughout the Medicaid budget.

Ms. Jeans suggested the following two items should be added to the budget:

- A rate increase from $31.31 per hour to $43 per hour for registered behavioral technicians (RBTs) upon approval of a state plan amendment to be effective no later than January 1, 2020, recommended in Senate Bill 174 [Senate Bill 174: Makes various changes relating to services provided to persons with autism spectrum disorders. (S-680)]. The RBTs are paid by Medicaid in the Autism Treatment Assistance Program for applied behavioral analysis services to children with autism. The proposed rate increase is supported by the Autism Commission.

- Funding for 24/7 mental health stabilization services in Washoe and Clark Counties as proposed in Assembly Bill 66. [Assembly Bill 66: Provides for the establishment of crisis stabilization centers in certain counties. (BDR 39-486)]

Ms. Jeans continued that her one area of potential concern was whether there were plans to explore managed care for the aged, blind, and disabled populations. Any movement in that direction should require managed care organizations (MCO) to demonstrate that they were doing a good job handling children with autism and persons with mental illness. There was little public data on the success of MCOs with that population. She looked forward to working with the Legislature on the budgets and offered to provide any information that the Subcommittees might request.

Marc Tedoff, Ph.D., BCBA, LBA, testified from Las Vegas and read the following letter into the record:

> Good morning. My name is Dr. Tedoff. I am the owner of Applied Behavior Analysis Institute. We have been serving the autism community in Las Vegas

since 2011. Currently we serve 62 families. Of those families, 41 are funded by Medicaid. However, we are now in the process of migrating a majority of our caseload to children funded by private insurance. There are two main reasons for our initiating this migration. The first, and most salient reason, is purely economic. Other funding sources we work with have an hourly reimbursement rate for RBTs at or close to $50.00 per hour, whereas Medicaid only reimburses about $31.00 per hour. Thus, providing services for children funded by those sources is a far more attractive prospect for our practice. The second reason we are looking to reduce the Medicaid caseload is administrative. The main problem we have in administering the Medicaid-funded cases is trying to obtain reimbursement for services rendered. Last year we lost $5,000 from Medicaid-funded cases. There are a variety of technical reasons for the denials we receive, some of which often seem to make little to no sense. In one egregious instance we were denied $2,000 in claims because the prior authorization to provide services was completed incorrectly. The mistake in the request for prior authorization to provide services was not noted by Medicaid when they approved it but was noted after we provided services and attempted to get reimbursed for those services. I'm sure you will understand that it is very difficult to do business with an entity that promises payment and breaks that promise after services are rendered because of a minor technicality. We would very much like to continue providing research-based treatment for children with autism that are funded by Medicaid. We will only be able to continue to do so if reimbursement rates for RBTs are adjusted so they are more in alignment with the usual and customary reimbursement rates for RBTs available from other local funding sources, and administration of this Medicaid program is streamlined so that it is easily navigated with minimal difficulties.

The next person to testify from Las Vegas was Yeni Trujillo, Private Citizen, Las Vegas, Nevada, who read the following letter into the record:

My name is Yeni Trujillo and I am a single mother of four beautiful children. The two oldest children Christian and Joshua are 14 and 13 and have autism. The children have been on a waitlist for close to two years now. My children are older and require after-school hours, the timeframe that is most difficult to find a provider for.

In 2010, Christian and Joshua started an in-home ABA [Applied Behavioral Analysis] treatment program with assistance from the Autism Treatment Assistance Program known as ATAP. This was when ATAP policy included a parent-driven model to fund 25 hours of 1:1 therapy per week. I hired interventionists from the community, received supervision from a well-known ABA company, set up two rooms in my house, scheduled my weekly

treatment hours, and managed each child's budgets. Both children flourished in their programs. Having interventionists treat Christian and Joshua allowed me to focus on the twins schooling as I was a teacher.

The children are also Medicaid recipients which makes speaking in front of you today that much more difficult. When Medicaid started treating kids with autism, children like Christian and Joshua lost their ATAP funding and lost their treatment providers. The agency I had been working with did not accept the RBT reimbursement rate offered by Medicaid. It was a very scary time for me as the supports that allowed all my children to flourish were taken away and there was no replacement. The children lost all treatment the first months of 2017, over two years ago.

The kids were put on a waitlist and occasionally other ABA agencies would call and say they had an opening. I would interview them and the only services they offered were center-based, which was impossible. I cannot afford to pay for a sitter while I wait for the children receiving treatment at a center. Last month I received a call from a BCBA [board certified behavioral analyst] who stated they could provide in-home services. The BCBA did an assessment at the beginning of January but I haven't heard from them since. My children continue to wait for treatment. I fear the story is like so many others, an availability of a BCBA willing to visit for a few hours a month, but not provide weekly treatment hours delivered by an RBT [registered behavioral technician] because of limited staff.

Joshua is reaching puberty and has started hitting and screaming. I feel like I am losing him back to autism. It feels like he is regressing and I'm scared. He needs daily treatment hours.

The ATAP was a wonderful program and I am so grateful to them for helping the kids. But the transition from ATAP to Medicaid resulted in families like me losing their child's necessary treatment program. I watched ABA work. I watched the kids go from tantrumming and not talking to behaving, talking, and doing well in school. I ask legislators to please ensure there are enough providers enrolled in Medicaid to provide the treatment hours the children and others with autism need to progress. I believe increasing the reimbursement rate would be an incentive to increase the number of providers in Nevada. Please support S.B. 174. Thank you.

Sincerely,
Yeni Trujillo
6157 Ethel May Street
Las Vegas, Nevada 89108

The next person to testify from Las Vegas was Lynda Tache, Private Citizen, Las Vegas, Nevada. She read the following letter into the record:

> Good morning,
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> For the record my name is Lynda Tache. I serve as the current Insurance and Funding [Subcommittee] Chair for the Commission on Autism Spectrum Disorders and I am the parent of a 17 year old with autism, ADHD, and a learning disability, named Grant. I am also the Founder of Grant a Gift Autism Foundation, in honor of my son, which partnered with the UNLV School of Medicine to create the UNLV Medicine Ackerman Autism Center and have been involved with Nevada autism legislation since 2007, where it all began. I am here today to let the committee know how important behavior therapy, or ABA services, are for families in Nevada and how important it is to properly fund those services so providers could participate in delivering those services to our underserved Medicaid population. Medicaid families need and deserve the same opportunities for their children that those with means, insurance, and autism treatment assistance funding have. And currently they are not. The funding is there, but many providers are not able to participate because the registered behavior technician or RBT rate is too low.
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> - In the 2015-17 Biennium, most of the money appropriated to the Division of Health Care Financing and Policy (DHCFP) by the 2015 Legislature went unspent on ABA. For the biennium only some $2.3 million of the appropriated $42 million was spent by "fee for service" Medicaid. The caseload was 186 kids in June 2017. DHCFP provided no information regarding children served by Medicaid Managed Care Organizations (MCOs).
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> - The funding subcommittee of the autism commission recently heard directly from the three companies that have the managed care contracts, and while we estimate that they should be servicing over 2,000 kids, it appears they have only served 30 since the contracts began. The companies, although they have an obligation to provide an adequate network, also voiced frustrations at their inability to get providers.
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> - Nevada has one of the lowest RBT reimbursement rates, at $30.30. The national average is $48. That's what we're asking for. All states around Nevada have a higher rate. Florida has a similar autism treatment network and no state income tax and has a $48 dollar rate. The Tricare military rate in Nevada has a $52 RBT rate, so we

feel confident that this $48 number would be approved federally by CMS.

- The Project Director of the Autism Insurance Resource Center UMass Medical School, Shriver Center, provided information that Massachusetts had the same problem of providers not participating in ABA Medicaid services due to low rates for a position similar to the RBT position. They produced and passed legislation in 2015 to raise the rate, and more providers participated to serve more children.

Thank you for your time and for hearing our testimony, and please support raising the RBT rate in S.B. 174 this session so all Medicaid families can have access to critical autism treatment and care.

Michelle Scott-Lewing, Private Citizen, testified from Carson City. She said she was a mother to two children on the autism spectrum. She was President for the Autism Coalition of Nevada. She said this was her fourth legislative session in ten years. She assumed that all the members of the Subcommittees had done some research regarding autism and understood the definition of autism and what it was all about. One of the classic hallmarks was repetitive behavior. She said we repeat ourselves and talk about the same things every two years. She saw the same faces every two years, the same families, and the same discussion. That meant the state did not make the progress needed. Two years ago she talked about the critical need for early intervention services and diagnostic therapies for children with autism. She talked about brain plasticity and the opportunity to move a child from a diagnosis of low functioning autism to high-functioning autism. A child needed access to rigorous therapeutic interventions similar to physical therapy needed for a broken bone. Rigorous physical therapy was necessary to ensure the bone became a useful part of the body again. That was how critical it was for children to receive rigorous therapy for brain plasticity to make progress with autism. She talked about taking $29 per hour and tossing it straight out the window because it was not enough. All the benefits were lost if children with autism failed to receive consistent rigorous therapy from the same therapists so there was no stress or anxiety and the children could learn. It was a reset every time you started over with a new therapist. All the money spent on the previous therapist was wasted because you had to start over again. The goal was to retain those therapists to consistently work with that same child and make progress. She knew $48 per hour sounded like a lot of money. It might sound like a lot because Nevada currently paid $29, but $48 was the national average rate. Some states paid a higher rate than $48 and had better outcomes. Those states were doing well moving hundreds of children off of waitlists into therapy and through the process. But Nevada ranked 50th in mental health. That was not a good place to be. Now was an opportunity to change that and move Nevada out of that position. Autism occurred in 1 out of 59 children. Two years ago the autism population was less, and she could only imagine what it would be two years from now. The Centers for Disease Control and Prevention based the rate of 1 out of 59 children with autism spectrum disorder on 2014 data. The numbers may have

increased since that study. Nevada served over 7,500 individuals with autism spectrum disorder; however, she knew the true numbers might be higher because there were waitlists.

Jared Busker, Associate Director, Children's Advocacy Alliance, presented Exhibit C, a document titled "Policy Brief: Health 2019, 12-Month Continuous Coverage." He asked the Subcommittees to include funding in the Medicaid budget to provide 12 months of continuous care for children who were enrolled in that program.

The next person to testify from Carson City was Kerri Milyko, Ph.D., BCBA-D, LBA, Managing Partner, Senior Consultant, The Learning Consultants, who read the following testimony into the record:

> My name is Dr. Kerri Milyko. I am a Licensed Behavioral Analyst and a Board Certified Behavior Analyst at the doctoral level. I am also a co-owner of The Learning Consultants, a behavioral services agency in Sparks that I am representing today.
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> I appreciate the opportunity to come before you and discuss reimbursement rates for Medicaid services in our state. The organization has served as a Medicaid provider for almost two years now. The mission is to serve the needs of the community, and when we opened our doors, 100 percent of our caseload were children insured through Medicaid. However, in the past year we were forced to drastically reduce that number to 20 percent of our caseload due to the embarrassingly low reimbursement rates for behavioral services (one of the lowest in the nation). Given the extraordinary need for services in this state, we were further dismayed to learn that with the transition to category 1 CPT [current procedural terminology] codes in January, we would be expected to deliver the same high-quality care to our clients, for an even lower rate.
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> Let me explain: imagine that you own a restaurant. You really love your work and feeding the people who come in. You are able to make a living and even set a little money aside by charging your customers a bit more than it costs you to purchase, prepare, and serve the food. Then, one day, all of your customers come to you and say from now on they will only pay you for the time it takes to deliver the food to the table. All of the other work is still required to produce the meal; it just will not be paid for anymore. That is what has happened for behavioral services. All of the work that is essential to a child's progress, but occurs away from that child, such as data analysis and intervention program updates, is expected to be "bundled" with the direct service. However, this change in expectations did not come with an equal change in reimbursement rates to account for the parts of the service that cannot be billed for. Essentially, we must only charge for delivery without

> accounting for everything else that is involved. Put in quantitative terms—every hour of direct service delivery by an RBT to a child requires at least 10 minutes of the LBA's time in order to ensure the service is high-quality and effective. However, we are only reimbursed for the RBT's time. And the reimbursement rate of $31.28 per hour for that RBT's time does not even cover our cost of employing that RBT.
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> The same thing had happened for all of the adaptive behavior services CPT codes. And it is for this reason that behavioral service providers are increasingly choosing to reduce their participation as Medicaid providers. It is the reason that we are forced to further reduce the number of clients on our caseload who are insured through Medicaid while our board considers terminating the contract altogether. It is for this reason the already significant need and long waitlists will continue to grow. And ultimately, it is those children and families who most need this intervention that will suffer. It is only by increasing the rates for these services to a level that at minimum addresses the cost of providing them, that children in Nevada diagnosed with autism and dependent on Medicaid coverage will be able to access these services.
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> My partners and I are proud to be serving our community. We believe that every child and family deserves high-quality care. Our young clients are depending on you, and we very much look forward to a positive resolution.

The next person to testify from Las Vegas was Martha Estrada, Family Resource Specialist at Families for Effective Autism Treatment (FEAT). Ms. Estrada said that she was a parent of Rafael, a 15-year-old with autism, and while working for FEAT, she had heard from parents on a daily basis about how their child had been on a waitlist for ABA [Applied Behavioral Analysis] services because of a lack of providers. Some had been on a waitlist for over a year. As a parent, her son was now moving to a third ABA provider because of the quality of service provided by the previous providers. She believed increasing the reimbursement rate would increase the number of providers currently serving Las Vegas and perhaps increase the RBTs and the quality of service.

The next person to testify from Las Vegas was Mara Mason, representing Azure Behavioral Solutions. Ms. Mason testified that Azure was a new company in Nevada that began in October 2018. Azure provided behavioral therapy services to children in Las Vegas and the surrounding areas. The biggest challenge had been hiring and retaining registered behavioral technicians (RBTs) because the reimbursement rates were so low. She asked for support of Senate Bill 174 to improve the quality of care for the children in need in Las Vegas. She presented Exhibit D, a memo dated March 1, 2019, to the Assembly Committee on Ways and Means and the Senate Committee on Finance, Subcommittees on Human Services, authored

by her, representing Azure Behavioral Services, in support of Senate Bill 174 to increase the rates for Applied Behavioral Analysis in the Medicaid budgets.

The next person to testify from Las Vegas was Hilary Cline, Registered Behavioral Technician, Center for Autism and Related Disorders, who testified in support of Senate Bill 174 to allow providers in the area to continue to serve Nevada Medicaid clients. Low rates were a restriction on the providers who needed the time to provide quality services to the families. An additional strain on companies and the credentialed clinicians was the state requirement for RBTs to obtain state certification through the State Board of Health. That should be taken into consideration when considering the budgets.

Chair Sprinkle closed public comment. The first item on the agenda was the budget hearing for the Department of Health and Human Services.

HEALTH AND HUMAN SERVICES
HEALTH AND HUMAN SERVICES - DIRECTOR'S OFFICE
HHS-DO - UPL HOLDING ACCOUNT (101-3260)
BUDGET PAGE DHHS-DIRECTOR-20

Richard Whitley, M.S., Director, Department of Health and Human Services, presented Exhibit E, a copy of a PowerPoint titled "Department of Health and Human Services FY 2020-2021 [2019-2021] Budget Presentation, Director's Office–Budget Accounts 3260 and 3244, Director Richard Whitley," dated March 1, 2019. He stated that he would present budget account (BA) 3260 and BA 3244, and that both budgets provided pass-through funding to Medicaid and made supplemental payments to hospitals that are intended to supplement Medicaid rates below the upper payment limit (UPL) that was the Medicare rate. Those supplemental payments helped to offset the reimbursement provided by Medicaid.

The first budget he would address was BA 3260. The UPL Holding Account exists to allow various divisions within the Department of Health and Human Services to transfer savings associated with healthcare-related contract expenditures that were budgeted but not incurred to the budget in the Director's Office. The UPL Holding Account was associated with private hospitals. He referred to page 3 of Exhibit E that provided the contracts and amounts that would be reverted. He estimated that 42 contracts totaled about $14 million in each year. The budget included transfers to Medicaid of approximately $8 million per year and reversions between $5 million and $6 million per year. By including the federal match, Medicaid would be able to make approximately $27 million in supplemental payments.

Senator Denis asked for information about how the contracted services were identified that were anticipated to be provided by nonprofit organizations in the upcoming biennium.

Mr. Whitley responded that the Department reviewed any potential contract to ensure it met the specific criteria. The contract was also reviewed by the deputy attorney general and the

attorneys for Nevada clinical services to ensure the contract was appropriate. All contracts that were funded with State General Fund or the Fund for Healthy Nevada were subject to a strict review.

Senator Denis asked whether a contract with a nonprofit entity that met the criteria would automatically be approved.

Mr. Whitley replied that all contracts were reviewed in accordance with the requirements of the attorneys, the State Board of Examiners, and the state processes. The only contracts that were denied were contracts that failed to qualify.

Senator Denis asked how the Department ensured the quality of services provided by the nonprofit organizations.

Mr. Whitley responded that the Department received regular reports on the services that were provided under the contract. The contract deliverables were specified and monitored. The Department reviewed those reports and provided oversight and auditing to ensure that the proper level of service had been completed.

Senator Denis asked whether all the contracts were audited annually.

Mr. Whitley confirmed that the Department audited all of the contracts once a year to ensure that the appropriate services were provided. Mr. Whitley confirmed that the Department also quantified and verified that the services were delivered.

Chair Sprinkle said there were no more questions on this budget account and moved to the next budget account.

HEALTH AND HUMAN SERVICES
HEALTH AND HUMAN SERVICES - DIRECTOR'S OFFICE
HHS-DO - INDIGENT HOSPITAL CARE (628-3244)
BUDGET PAGE DHHS-DIRECTOR-44

Richard Whitley, M.S., Director, Department of Health and Human Services, presented Exhibit E, a copy of a PowerPoint titled "Department of Health and Human Services FY 2020-2021 [2019-2021] Budget Presentation, Director's Office–Budget Accounts 3260 and 3244, Director Richard Whitley," dated March 1, 2019. He stated that he would present budget account (BA) 3244 that was a pass-through budget account. The Indigent Hospital Care budget was established to reimburse hospitals for the care provided to indigent persons. The Fund for Hospital Care to Indigent Persons was administered by a Board of Trustees consisting of four county commissioners and one director of a county social services agency appointed by the Governor. Counties sought reimbursement or partial reimbursement from the Fund for unpaid charges in excess of $25,000. In addition, the Board might enter into an

agreement to transfer funds to the Division of Health Care Financing and Policy to provide the state share of certain Medicaid expenditures related to hospital care for supplemental payments to hospitals. He referred to page 5 of Exhibit E that provided details on indigent hospital care revenues. Budget account 3244 received two primary funding sources: the ad valorem tax that was estimated at $14 million per year, and the unmet free-care obligation that was estimated to be $22 million in each year. The unmet free-care obligation had grown as Nevada's uninsured rate had fallen. There were fewer individuals uninsured, and the hospitals were unable to meet the free-care obligation.

Mr. Whitley referred to page 6 of Exhibit E that listed the four major uses of funds determined by the Board of Trustees and included:

- Nevada Association of Counties contract for administration.
- Traditional indigent accident fund [fund for Hospital Care to Indigent Persons] claims.
- Offset county match.
- Transfer to Medicaid for supplemental payments. The transfer was projected at about $34 million in each year of the 2019-2021 biennium. Those funds allowed Medicaid to pay approximately $95 million in supplemental payments.

Chair Sprinkle said the targeted reserve was about $21.5 million, but the actual reserve would exceed that amount by $3.2 million in FY 2020 and $4.2 million in FY 2021 and asked for the agency's plan to use the reserve funds.

Stacey Johnson, Deputy Director, Fiscal Services, Department of Health and Human Services, responded that the goal was to maintain the reserve at a level equal to the unmet free-care that is received. Those funds were normally received late in the fiscal year in February or March. The Board did not usually consider those funds until the following fiscal year beginning in July because the amount was unknown. She agreed to work with the staff of the Fiscal Analysis Division, Legislative Counsel Bureau, to true up those figures. It was a timing problem rather than a need for the reserve.

Chair Sprinkle asked the Department to work with the Fiscal Analysis Division staff. There were no more questions on this budget account, and he moved to the next budget account.

HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING & POLICY
HHS-HCF&P - INTERGOVERNMENTAL TRANSFER PROGRAM (101-3157)
BUDGET PAGE DHHS-DHCFP-9

Suzanne Bierman, J.D., M.P.H., Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services, presented Exhibit F, a copy of a PowerPoint titled "State of Nevada Department of Health and Human Services 2020-2021 [2019-2021] Governor Recommends Budget, Division of Health Care Financing and Policy," dated March 1, 2019. She stated that she would present an overview of the budget. Details were shown on pages 1 through 6 of Exhibit F that presented the agency's mission, vision, goals, summary of agency operations, and organizational structure. Page 7 of Exhibit F presented the total Medicaid caseload and the caseload projections based on historical data, population growth, policy and program changes, and economic conditions. She pointed out that as Nevada's economy improved, the growth in the Medicaid caseload slowed.

Page 8 of Exhibit F provided the waiver slot projections including the base numbers, projected caseload growth, and waitlist reduction numbers. Check Up was the Children's Health Insurance program, and page 9 of the exhibit provided the Check Up caseload. The program anticipated caseload growth resulting from the improved economy because the program insured covered children at slightly higher income levels than Medicaid. Page 10 of Exhibit F presented an overview of DHCFP funding sources. While there were several funding streams, 71 percent of the Division's budget was funded with federal funds. The Division's legislatively approved budget increased by 15 percent from $8.3 billion in the 2017-2019 biennium to $9.5 billion in 2019-2021 biennium in The Executive Budget. Approximately $398 million was the State General Fund increase over the prior biennium and, of that amount, $120 million resulted from changes in the Federal Medical Assistance Percentage (FMAP). An additional $120 million resulted from caseload changes, $78 million from inflation, and $9 million from mandates. Other nonfederal funding sources included intergovernmental transfers, long-term care provider fee revenue, and county match reimbursements.

Page 11 of Exhibit F provided a summary of the five budget accounts of the Division. Ms. Bierman explained that budget account (BA) 3157 was the Intergovernmental Transfer Program (IGT). The IGT program collected funds from other governmental entities to provide the state share of certain Medicaid expenditures, thereby reducing the need for State General Fund appropriations. Funds collected in the IGT budget were transferred to the Medicaid, Check Up, and administration budgets to provide the state share of supplemental payment programs and related administrative costs. Page 15 of Exhibit F provided details of decision unit Enhancement (E) 277 for the Clark County voluntary contribution of 12.5 percent above the state share that aligned with the new interlocal agreement for the 2019-2021 biennium.

Assemblywoman Carlton said this budget account had always been confusing and contentious. The negotiations between Clark County and the Executive Branch regarding the contribution percentage had been difficult. It was nice to see the matter resolved. She wanted to understand the methodology used to reach agreement on the change in the contribution rate. She asked how the voluntary contribution rate of 47.5 percent was developed. She understood that in the past the contribution rate was about 50 percent. The percent change did not sound like much, but those 2 1/2 percentage points made a difference in the budget.

Budd Milazzo, Chief Financial Officer, Division of Health Care Financing and Policy, Department of Health and Human Services, responded that the current budget was built at 47.5 percent. There had been talk about whether it was budgeted at 47.5 percent or at 50 percent. The percentage was always decided after the budget was submitted. The agreement with Clark County in the three-year contract was 12.5 percent over the state share. In fiscal year (FY) 2020, the percentage was 48.3 percent and in FY 2021, the percentage was 47.8 percent because of changes in FMAP. He was not present during the negotiations with Clark County about how the percent changed from 47.5 percent and 50 percent. He understood it had been an ongoing discussion every year. The Division was finally able to obtain agreement on a three-year contract to ensure the rate of reimbursement.

Assemblywoman Carlton said the effect would be a reduction in state net benefit totaling slightly more than $31 million in the Medicaid budget as compared to the previous biennium.

Mr. Milazzo agreed, but replied there were two parts to the contract. The first part was a decision about the amount of reimbursement from the county that was state share plus 12.5 percent. The second part was FMAP reclaiming. When Medicaid made supplemental payments to the hospitals, the standard FMAP was used. The Affordable Care Act (ACA) changed the FMAP percentages for certain participants. After each year, Medicaid was allowed to determine the trued-up rate based on the eligibility group of participants and calculate what the actual FMAP should have been for each service that was provided. Medicaid then received money back from the federal government that was called FMAP reclaiming money. Historically, the Division had kept that money as state savings or state net benefit. During the negotiation, Clark County wanted all of the share back from the FMAP reclaiming. The parties agreed that Clark County would receive 87.5 percent of the FMAP reclaiming, and Medicaid would keep 12.5 percent. That accounted for the biggest difference between the 2017-2019 biennium and the 2019-2021 biennium.

Assemblywoman Carlton asked him to repeat that explanation. She understood that Clark County wanted to keep the whole amount.

Mr. Milazzo responded that Clark County wanted to keep 100 percent of the FMAP reclaiming credited to it. The negotiation resulted in Clark County receiving 87.5 percent of the FMAP reclaiming, and the state retained 12.5 percent of the FMAP reclaiming.

Assemblywoman Carlton asked how that compared with previous negotiations.

Mr. Milazzo said there were no previous negotiations in FMAP reclaiming. In previous years, Medicaid kept the FMAP reclaiming, and the FMAP reclaiming topic was not discussed until the most recent negotiation with Clark County. He was not present during earlier negotiations, but he believed that had not been part of the discussion at all.

Assemblywoman Carlton said she would double check her notes because she was unable to recall the specifics. She said the funding was confusing because of the way it all came together. She asked for an explanation of the total amount of money, how it was divided, the amount of the state net benefit, how much went to Clark County, and how much went to other places. Because of the change, the Legislature needed a total picture of how this process worked because of the $31 million effect. It was important for the Subcommittees to understand the funding.

Mr. Milazzo agreed to work with the Fiscal Analysis Division staff, Legislative Counsel Bureau.

Assemblywoman Carlton asked to receive an explanation about negotiations before the Subcommittees made budget decisions.

Assemblywoman Neal asked why Clark County wanted to retain 100 percent of the FMAP reclaiming, because it sounded selfish.

Mr. Milazzo responded that he was not part of the negotiation and was unsure. He suggested that when parties negotiated, one party started at one end and the other party started at the other end. Then the parties tried to meet somewhere near the middle. He suspected that the initial claim was Clark County wanted 100 percent, and negotiations began at that point.

Senator Kieckhefer asked whether the contract was executed.

Mr. Milazzo responded that the contract was on the agenda for the March meeting of the State Board of Examiners. It had been signed by Clark County.

Senator Kieckhefer said the state operated on a two-year budget cycle and questioned why a three-year contract was suggested.

Mr. Milazzo replied that generally the contracts were retroactive and commenced after a fiscal year had begun. The Division wanted the contract to cover fiscal year (FY) 2019, FY 2020, and FY 2021.

Senator Kieckhefer asked whether there was a difference between what was budgeted for the current year (FY 2019) and what the Division executed in the contract.

Mr. Milazzo responded that there was a difference, and he would identify it and provide the projected numbers for the Subcommittees.

Senator Kieckhefer asked whether it affected supplemental appropriations or other parts of the FY 2019 budgets.

Mr. Milazzo responded yes, and the numbers he discussed with the Fiscal Analysis Division staff included the contracted percentage of 47.5 percent. It had not changed any of the projections in the past several months. Those numbers were previously quantified and taken into consideration.

There were no other questions on this budget account, and Chair Sprinkle moved to budget account 3158.

HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING & POLICY
HHS-HCF&P - HCF&P ADMINISTRATION (101-3158)
BUDGET PAGE DHHS-DHCFP-12

Suzanne Bierman, J.D., M.P.H., Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services, presented Exhibit F, a copy of a PowerPoint titled "State of Nevada Department of Health and Human Services 2020-2021 [2019-2021] Governor Recommends Budget, Division of Health Care Financing and Policy," dated March 1, 2019. She said she would present an overview of budget account (BA) 3158, and details were shown on pages 16 through 24 of Exhibit F. Budget account 3158 paid for the administrative costs of the Division. She would present the major decision units. The first three decision units related to caseloads and only included administrative costs related to the programs such as fiscal agent costs. The medical costs were captured in other budgets.

Page 20 of Exhibit F outlined three decision units related to the three waivers programs: individuals with intellectual disabilities, frail elderly, and physically disabled. Those decision units only included the fiscal agent administrative costs associated with the waiver caseload increases. The medical costs were captured in other budget accounts. Ms. Bierman moved to page 21 of the exhibit that listed three decision units related to reducing the waiver waitlist for the same three waivers. Those decision units added waiver slots to comply with

the Olmstead mandate to eliminate the waitlist of clients who had been waiting more than 90 days for services. Those decision units included administrative costs related to those programs such as the fiscal agent costs and increases in caseloads. The medical costs were captured in other budgets.

Moving to page 22 of Exhibit F, Ms. Bierman stated that decision unit Maintenance (M) 501 related to the 21st Century Cures Act that required an electronic system to verify the provision of personal care services. The decision unit covered the maintenance and operation costs related to the project. Page 23 of Exhibit F listed decision unit Enhancement (E) 233 that was a recommendation for two full-time-equivalent (FTE) positions: an information security officer [IT professional] and a security access coordinator [IT technician]. Those two positions were needed to ensure the confidentiality of protected health and public information maintained by the Division. Decision unit E-245 added a public information office to facilitate the Division's media relations. The new position would handle the increasing requests for media interviews and ensure that the Division communicated effectively with stakeholders, providers, and individuals served by the programs.

Page 24 of Exhibit F included two decision units for initiatives. Decision unit E-226 enhanced program integrity activities of the Division and included nine new positions. Decision unit E-238 continued the growth in the continuum of care by expanding the certified community behavioral health clinic program by adding additional clinics and three new positions. Ms. Bierman said she would pause to answer any questions of the Subcommittees.

Assemblyman Thompson wanted a discussion about how the nine new positions would improve the integrity of the Medicaid program.

Cody L. Phinney, M.P.H., Deputy Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services, responded that decision unit E-226 included positions for surveillance utilization review and program enrollment. The positions were specific to expanding program capacity. Medicaid had a backlog of cases in the surveillance utilization review unit. It would benefit both the program and the providers to process those cases more quickly. Hearing and appeal rights were associated with actions related to surveillance utilization reviews. The Division needed to act on those cases quickly. The most important activity for staff in the surveillance utilization review unit was educating the providers about program rules. The Division needed to provide as much education as possible.

Assemblyman Thompson asked about the plan to eliminate the backlog with the addition of nine new positions.

Ms. Phinney said the Division worked to eliminate 78 current cases that were active but needed to move more quickly. The backlog was monitored weekly. The Division had 20 projects with multiple cases associated with them. Medicaid had projects that had not been enacted, and those projects should be completed. The goal was to expand areas of the program that could be monitored more closely.

Assemblyman Thompson wanted an explanation of the 78 cases in the backlog and why nine new positions were needed to address the backlog.

Ms. Phinney responded that the Division had 78 current active cases, and her concern about those current active cases was the ability to collect the information and move those through the process in a timely manner. She was worried about individuals waiting while the Division worked the active cases. The Division currently monitored 78 cases, and the nine new positions would allow the agency to expand its services. Medicaid was limited in the sections or the provider groups that it was able to monitor. The agency had some additional projects that were broad-based and should be completed to improve the quality of the services and achieve cost savings. Improvements could be made to resolve the system problems, prevent improper payments, and improve the quality of services.

Chair Sprinkle said it appeared that many of those new positions were targeted to investigate fraud, and he asked whether the basis of the recommendation for new positions was an increase in the suspicion of fraud.

Ms. Phinney replied that the positions would investigate improper payments. Medicaid looked at improper payments in a broader category than one would associate with the term. Some of those payments might result from a mistake, misunderstanding, or misinterpretation of the rules. The Division wanted to educate the providers. The portion attributable to fraud was quite small. Medicaid provided some newer services, and there was a need to educate the provider base and help the billing structures for those services. New positions would enable Medicaid to improve its education assistance and increase capacity. One small portion of the problems might be attributable to fraud and intentional misuse of the program. Some other state agencies assisted in fraud investigations. The larger problem was increasing education and preventative measures to ensure clear information was provided to individuals enrolling in the program. Medicaid needed to certify that individuals met appropriate background requirements to enroll in the programs. Policy changes needed to be well understood and clearly communicated to providers and clients based on the needs of the community.

Senator Denis asked about the two new full-time-equivalent (FTE) positions recommended in the information technology (IT) unit. One position was the information security officer for security efforts. The other position was the security access technician. Currently it appeared that one of the application staff performed those duties on a part-time basis.

Sandie Ruybalid, Information Technology Manager 2, Chief of Information Services, Division of Health Care Financing and Policy, Department of Health and Human Services, responded that the information officer's current responsibilities included other duties as assigned part-time, in addition to application development, but that was not a best practice. She wanted to fill the position with a dedicated information security officer to establish and manage policy. The second position would assist with background checks, access control, and other duties.

Senator Denis asked whether there was a current backlog or was work delayed because one part-time person tried to develop policy and manage the other work.

Ms. Ruybalid replied that she did not have the specific figures, but largely the systems were outsourced. Contract vendors often brought new staff to work on various projects, and those new staff were required to complete fingerprint-based background checks. It was beneficial to perform those background checks more quickly to get the staff working on projects and completing tasks.

Senator Denis understood that funding was recommended to modernize several existing applications including the document management system, Check Up premium invoicing and payment tracking system, Medicaid management information system issue tracking, Medicaid estate recovery case management, and time tracking. He asked whether those systems should be updated or replaced.

Ms. Ruybalid responded that the Division did not want to replace those systems. The oldest application was developed in-house in 2004. There had been many security and business changes to those applications, and the agency had a small IT development team. Her goal was to refresh the applications in a short amount of time. A refresh would make the applications easier to maintain for state staff without adding state staff positions to do that work.

Senator Denis thought she would use existing applications staff, but one of those positions would now be freed up because the person would not have to do information security work.

Ms. Ruybalid confirmed that Senator Denis was correct.

Senator Denis asked whether she thought that all the updates that were planned would be completed in the 2019-2021 biennium, or take longer than that.

Ms. Ruybalid replied that her goal was the work would be completed in the 2019-2021 biennium, but projects often extended beyond the original goal.

Senator Denis thought she would not be doing any customized programming but would use existing or off-the-shelf products.

Ms. Ruybalid confirmed that Senator Denis's understanding was correct.

Senator Denis said the base budget included health information technology projects that the agency pursued including the Nevada Health Data Network and the statewide master provider directory. He asked for details of those technology efforts.

Valerie Hoffman, Chief Information Technology Manager, Office of Health Information Technology, Department of Health and Human Services, responded that for the past year she had overseen the Health Information Technology program. A health information technology roadmap was completed. Some of the items Senator Denis mentioned were on that roadmap. She was in the process of moving the program back to Medicaid and would work with them on that transition. She would look at the 18 initiatives that were outlined in the roadmap and select the ones to move forward. Some projects had sufficient funding and would be completed by June 30, 2019. These included projects with the health information exchange, Healthy Nevada, to connect several of the underserved facilities and other connection projects for the Southern Nevada Health District, the University of Nevada, Reno, School of Medicine, and Washoe County Health District.

Senator Denis asked whether those projects were the ones that she was working on during the current biennium.

Ms. Hoffman confirmed that those projects were the ones she was working on for the 2019-2021 biennium.

Senator Denis said there was a 10 percent match required to receive federal money and asked how the agency would pay for the projects.

Ms. Hoffman replied that there was money in the existing DHCFP budget to cover the 10 percent for those health information exchange connections for underserved facilities. Washoe County Health District, UNR School of Medicine, and Southern Nevada Health District all had provided the 10 percent match. She was in the process of moving that money into the Division's budget to allow those payments to be made when those projects were completed.

Senator Denis asked whether she anticipated there would be ongoing costs with those projects.

Ms. Hoffman responded that no ongoing costs would be in the agency's budget because each entity was responsible for its own maintenance and operations for those connections. The agency provided the 10 percent match required to fund the planning, design, development, and integration into the health information exchange connections.

Senator Denis understood that the agency was giving the local entities a jump start into the health information exchange connections, but they had to maintain the connections.

Ms. Hoffman confirmed Senator Denis's understanding was correct.

Assemblywoman Titus asked about decision unit E-245 which recommended a new public information officer (PIO) position. She understood that the administrator and the two deputy administrators currently responded to inquiries. The new position would cost $162,275 for the biennium. She asked whether the new PIO position would assume the inquiry and media duties that the deputies had been performing and would allow the deputy administrators to reallocate their time. She wanted to ensure that all personnel fulfilled their duties. She asked for job descriptions for the positions. She also asked for justification for the PIO position, noting there were only 23 inquiries in 2011 and 110 inquiries in fiscal year 2018.

Ms. Bierman responded that the number of requests for media interviews had increased as Medicaid had grown. She thought the agency averaged one inquiry per week during her job tenure. The growing size and profile of Medicaid generated more interest and additional requests. Various individuals in the Division and Department had handled those requests in the past. The Department had a chief public information officer. She needed a position in the Division to streamline the process and be the point of contact instead of dividing all those activities among various staff. In addition to media requests for interviews, the Division was often asked to make presentations and conduct outreach to providers. Medicaid needed one centralized person to address those activities because the demand had increased.

Assemblywoman Titus asked for a job description for the new PIO position and the other positions that had previously performed the duties.

Ms. Bierman replied that she had previously submitted the job descriptions to the Fiscal Analysis Division staff but would provide additional information as requested.

Assemblywoman Neal asked for details of the activities and accomplishments of the housing coordinator position during the 2017-2019 biennium. She wondered how the housing coordinator assisted the Division in meeting its statutory responsibilities.

DuAne Young, Deputy Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services, responded that the housing coordinator was funded through the Money Follows the Person (MFP) grant. The purpose of this position was to transition individuals out of institutions and to increase the availability of community-based living options for those eligible for one of the three waivers. The position studied a cross-section of individuals who were eligible for the three waivers. Those individuals would be moved into the community housing to make them sustainable in the community. The position looked across the three waivers for the applicants best suited to move into housing. The position had an average caseload of 31 individuals and had been

successful. Certain waiver groups cost more. Part of the duties of the position was to identify the resources the waiver client had to move into the community and then evaluate the true need.

Assemblywoman Neal asked about the partners in the community that assisted with the process.

Mr. Young replied that the Division partnered with sister agencies including the Aging and Disability Services Division, Department of Health and Human Services, and community partners. Each district office had focused coordinators who worked with those facilities that housed the waiver clients. Regular assessments were conducted on those clients who were eligible for housing. Medicaid worked with the case managers through the Aging and Disability Services Division to place the clients.

Assemblywoman Carlton wanted to discuss the Section 1115(a) [Social Security Act] demonstration waiver in decision unit E-238. She asked how the Division determined what positions were needed to support the demonstration waiver and whether the Division recruited and hired those positions before the demonstration waiver was approved.

Stephanie Woodard, Psy.D., Medical Epidemiologist, Division of Public and Behavioral Health, Department of Health and Human Services, responded that the positions identified for the support of the certified community behavioral health clinics were based on past experience of Medicaid administering a Section 1115(a) demonstration waiver. The Division focused much effort on oversight and monitoring the waivers to ensure compliance. Oversight of demonstration waivers included looking at data analytics to ensure that the agency monitored the progress and expenditures and maintained the fidelity of the overall program evaluation that was necessary for the continuous reporting to the Centers for Medicare and Medicaid Services (CMS).

Assemblywoman Carlton asked whether the new positions would be recruited and hired before approval of the waiver.

Ms. Woodward replied that she did not believe the positions would be hired before approval of the waiver was received.

Turning to decision unit E-490, Chair Sprinkle asked about the elimination of the three positions funded with the MFP grant and whether the agency had sufficient resources to continue its efforts to transition individuals from institutions to home and community-based settings.

Mr. Young responded that those three positions were strictly limited to administering the grant. The housing coordinator position would maintain the housing activities that the grant had funded.

Chair Sprinkle said the grant was coming to an end and asked whether there was sufficient funding for the housing work to continue.

Mr. Young replied that sufficient funding was available to continue those activities. The Division needed to retain the housing coordinator position to conduct those activities, but the activities would be maintained outside of the grant.

Moving to decision unit M-205, Senator Woodhouse asked about the effect on services provided to Katie Beckett participants when the staffing ratio exceeded the agency's target ratio of one staff per 60 cases.

Mr. Young replied that the Katie Beckett program had a current caseload of about 666 individuals. Insufficient staff for case management meant a lack of providing timely resources, coordination, and verification of financial participation. The Division would be unable to study the overall efficiency of the program to ensure it provided the families with the help they needed through the district offices.

There being no other questions on this budget, Chair Sprinkle moved to the next budget account.

HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING & POLICY
HHS-HCF&P - INCREASED QUALITY OF NURSING CARE (101-3160)
BUDGET PAGE DHHS-DHCFP-28

Suzanne Bierman, J.D., M.P.H., Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services, presented Exhibit F, a copy of a PowerPoint titled "State of Nevada Department of Health and Human Services 2020-2021 [2019-2021] Governor Recommends Budget, Division of Health Care Financing and Policy," dated March 1, 2019. She testified she would present an overview of budget account (BA) 3160. Details were shown on pages 25 through 27 of Exhibit F. Budget account 3160 was the Increased Quality of Nursing Care budget created by Assembly Bill (A.B.) 395 of the 72nd Session (2003). That bill instituted a methodology that required the Division of Health Care Financing and Policy to establish a provider tax program encompassing all freestanding, long-term care facilities in Nevada. The provider assessment was used to match federal funds and increase reimbursement thereby improving the quality of long-term care in Nevada. There were no major decision units in this budget account.

There being no questions about the budget account, Chair Sprinkle moved to the next budget account.

HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING & POLICY
HHS-HCF&P - NEVADA CHECK UP PROGRAM (101-3178)
BUDGET PAGE DHHS-DHCFP-30

Suzanne Bierman, J.D., M.P.H., Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services, presented Exhibit F, a copy of a PowerPoint titled "State of Nevada Department of Health and Human Services 2020-2021 [2019-2021] Governor Recommends Budget, Division of Health Care Financing and Policy," dated March 1, 2019. She testified she would present an overview of budget account (BA) 3178 which funded the Nevada Check Up program. Details were shown on pages 28 through 32 of Exhibit F. Decision unit Maintenance (M) 101 funded mandatory inflation increases related to pharmacy, hospice, federally qualified health centers, rural health centers, and Indian health centers. The Division anticipated a 7 percent increase in caseload from 27,406 in fiscal year (FY) 2018 to 29,219 in FY 2019. Decision unit M-200 recommended additional increases in caseload to 30,012 in FY 2020 and to 30,188 in FY 2021 for a combined 3.3 percent increase over FY 2019. Page 32 of Exhibit F listed two decision units. Decision unit Enhancement (E) 242 recommended an increase in pediatric intensive care unit rates of 15 percent. Decision unit E-230 recommended 25 percent increases in the daily rates for neonatal intensive care unit Level 2 through Level 4 services. Each of the recommended rate increases also had companion decision units in the Medicaid budget. She paused for questions.

Assemblywoman Spiegel asked for details of the assumptions used to project the caseload growth for the Check Up program in the 2019-2021 biennium.

Ellen Crecelius, Ph.D., Actuarial Economist, Division of Health Care Financing and Policy, Department of Health and Human Services, responded that the caseload projections were completed by the Director's Office analytics staff who took into account historical data, economic conditions, and population growth.

Assemblywoman Spiegel asked why the Check Up caseload was projected to increase by 4.9 percent in FY 2019 but only projected to increase 1.3 percent in FY 2021.

Ms. Crecelius replied that there had been substantial caseload growth in the Check Up program in fiscal year (FY) 2018. Historically, the Check Up caseload increased when the economy improved. Medicaid caseload did the opposite and evened out or decreased when the economy improved. Check Up caseload increased when the economy improved because clients had higher incomes and no longer qualified for Medicaid and enrolled in Check Up. Substantial caseload increases occurred in Check Up recently. The projections would be updated in March. She anticipated the updated caseload projections would reflect even more growth in the 2019-2021 biennium.

Senator Kieckhefer asked whether the increased Check Up caseload correlated with the decreased Federal Medical Assistance Percentage (FMAP) changes.

Ms. Crecelius replied that the FMAP was based on comparing the per capita personal income for Nevada with the rest of the nation. However, FMAP reflected a three-year lag. The economy might improve, but the FMAP would not adjust until several years later. The Check Up FMAP was higher than the FMAPs for other programs.

Senator Kieckhefer asked about a change in methodology used to project Medicaid caseload with current fiscal year numbers instead of the FY 2018 base. He asked whether the Division used the same methodology changes for Check Up or used the old methodology.

Ms. Crecelius replied that all of the Medicaid and Check Up caseload projections were estimated using the survival model methodology.

Senator Kieckhefer asked for an explanation of the survival model methodology.

Ms. Crecelius responded that the survival model was based on monthly estimates of how many clients came into a program as new enrollees and how long the existing clients would remain on the caseload. Some individuals with certain characteristics remained on the caseload longer than normal. Those estimates were combined to develop the total caseload projection. The models took into account historical data, program changes, economic conditions, and population growth.

Senator Kieckhefer understood there was consistency between how both caseloads were projected and was satisfied.

Assemblywoman Titus asked what the agency anticipated achieving with the recommended rate increases for certain neonatal intensive care unit and the pediatric intensive care unit services. She appreciated that the rate increases recommended by the Governor provided more funds for neonatal services. She also asked about the ratio between the rate increase and the actual cost. It was good to recommend a 15 and 25 percent rate increases, but she expressed concern that the rates still did not cover the costs.

Cody L. Phinney, Deputy Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services replied that the most fundamental goal of the agency was to maintain and possibly increase availability of services in the state. The Division was concerned because the geography in Nevada required some clients to travel long distances to access certain levels of care. The agency did not want individuals to travel even farther or be forced to travel out-of-state to receive services, but wanted to reduce travel as much as possible. The agency knew that Medicaid rates did not cover the total cost of care. Neonatal intensive care unit and pediatric intensive care unit services in particular were disproportionately affected by Medicaid because the program covered a large share of

births that required those higher levels of care. There was no offset that might be expected in other medical services where higher portions were covered by commercial insurance. The second consideration of the Division was the effect of Medicaid on those particular services. The last consideration was budgetary limitation and competing priorities. Medicaid looked at a range of options for those. Clearly the program could always improve access to services. The neonatal intensive care unit and the pediatric intensive care unit services were expensive services. Those were factors considered by the agency with the goal to ensure that those services were available.

Assemblywoman Carlton said one of the things that she had been concerned about was the population in the middle who were disenrolled from Medicaid but made too much income to qualify for the subsidy from the Affordable Care Act (ACA) through the health exchange. She expressed concerns about the increases in caseload for Check Up. She asked whether the numbers included the variable of how expensive health care coverage was especially in the rural areas that only had one provider that offered expensive coverage. She looked at the Check Up caseload and asked how the agency would determine whether more individuals enrolled in Check Up simply because they were unable to afford private insurance.

Kyra Morgan, State Biostatistician, Department of Health and Human Services, replied that she did not have that information, but she would follow up and provide the specifics that were used in the projection model for Check Up. The agency considered economic factors, but she would look at the model specifically and follow up with the details later regarding the expense of health-care coverage as one of the factors for consideration.

Assemblywoman Carlton said it was important for the Subcommittees to include the high cost of private insurance in its discussions, especially considering that 12 of Nevada's 17 counties only had one insurance provider available. That might be the reason the caseload of Check Up increased because it was cost shifting to the state rather than to the uninsured category.

Ms. Morgan added that she anticipated that as the economy improved and caseload for Medicaid leveled out, the Check Up caseload would probably increase.

Assemblywoman Carlton said some individuals made higher incomes and no longer qualified for Medicaid but were unable to afford private insurance, and that was the population the Subcommittees needed to address.

There being no further questions on this budget, Chair Sprinkle said the final budget on the agenda was Medicaid. He wanted to allow sufficient time for public comments so he would start the budget hearing, but at some point he would close the budget presentation and hear the remainder on another day.

HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING & POLICY
HHS-HCF&P - NEVADA MEDICAID, TITLE XIX (101-3243)
BUDGET PAGE DHHS-DHCFP-33

Suzanne Bierman, J.D., M.P.H., Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services, presented Exhibit F, a copy of a PowerPoint titled "State of Nevada Department of Health and Human Services 2020-2021 [2019-2021] Governor Recommends Budget, Division of Health Care Financing and Policy," dated March 1, 2019. She testified she would present an overview of budget account (BA) 3243 and details were shown on pages 33 through 54 of Exhibit F. The BA 3243 base budget included funding for medical services and capitation payments for Medicaid clients. The federal match for the Medicaid program varied based on eligibility groups as described on page 35 of Exhibit F. The budget received expenditure offsets such as drug rebates, recoveries, and recoupments that partially offset the costs of medical services.

Ms. Bierman said decision unit Maintenance (M) 101 related to agency-specific and mandatory inflationary increases for pharmacy, hospice, federally qualified health centers, rural health centers, and Indian health services. Page 36 of the exhibit outlined decision units that recommended funding for caseload increases. Page 37 of Exhibit F listed decision units that recommended funding to address increases in caseload for the three waivers: individuals with intellectual disabilities, frail elderly, and physically disabled. Decision unit M-201 increased the waiver caseload for individuals with intellectual disabilities, but the State General Funds for the waiver services were included in a budget account within the Aging and Disability Services Division, Department of Health and Human Services. The General Fund included in decision unit M-201 was for the nonfederal share of the state plan services.

Page 38 of Exhibit F outlined decision units for waitlist reductions and to increase slots for the three waivers: individuals with intellectual disabilities, frail elderly, and physically disabled. The decision units added waiver slots to eliminate the waitlist of clients who had been waiting for more than 90 days. These decision units were needed for the state to comply with the Olmstead mandate. Page 39 of Exhibit F provided two decision units to increase the rates for pediatric intensive care units and certain neonatal intensive care units. Those rate increases had companion decision units in the Check Up budget account (BA 3178) as discussed earlier and were designed to ensure that the services remained available in the state as required. Page 40 of Exhibit F listed decision units that recommended rate increases for personal care services and supported-living arrangements. Those recommended rate increases aligned with proposals from the Aging and Disabilities Services Division, Department of Health and Human Services, and the waiver programs. Those services were designed to support individuals in home and community-based settings to ensure that there were alternatives to institutional placements available. The recommended rate in decision unit E-234 for personal care services increased

from $4.25 per 15-minute service unit to $4.39 per 15-minute service unit. State General Fund for the supported-living arrangements was included in the budget for the Aging and Disabilities Services Division, Department of Health and Human Services.

Ms. Bierman turned to page 41 of Exhibit F that outlined two decision units that were discussed previously for the program integrity initiative and the certified community behavioral health clinics. Page 42 of Exhibit F described two decision units related to the psychiatric residential treatment facility initiative and the 1915(I) [Social Security Act] state plan option for supported housing for the homeless. The psychiatric residential treatment facility initiative supported the conversion of existing treatment home facilities into psychiatric residential treatment facilities. The State General Fund for the psychiatric residential treatment facilities was included in the budget of the Division of Child and Family Services, Department of Health and Human Services.

Ms. Bierman referred to page 43 of Exhibit F that listed decision units related to the Clark County voluntary contribution, the county match supplemental fund, and the county match increased contribution. Additional pages in Exhibit F included the appendix for reference. She concluded her presentation and would address any questions.

Chair Sprinkle thanked Ms. Bierman and said he would take questions beginning with decision unit M-200.

Assemblywoman Carlton asked the agency to explain why the actual Medicaid caseloads during the 2017-2019 biennium were lower than initially projected. She asked for an explanation of the caseload increase recommended for the 2019-2021 biennium.

Ellen Crecelius, Ph.D., Actuarial Economist, Division of Health Care Financing and Policy, Department of Health and Human Services, responded that the current caseloads were slightly lower than originally projected because the economy had improved more than originally projected when the budget was submitted. The Division relied on projections of employment from the Office of Finance, Office of the Governor, and those projections were entered into the caseload models.

Assemblywoman Carlton said the economy was still doing well, and Nevada had about 4 percent unemployment. She asked how those factors affected the caseload model.

Ms. Crecelius responded that one thing to keep in mind was that population growth was taken into account. As the economy performed better and the state continued to change, Nevada gained population coming in from other states. That increase added to the caseload levels. The caseload projections would be updated in March, and she anticipated that those caseloads might be a little lower based on the actuals seen since The Executive Budget was submitted.

Senator Denis asked about the outcomes anticipated as a result of the recommended 25 percent rate increase for certain neonatal services.

Ms. Phinney responded that the neonatal intensive care unit (NICU) and pediatric intensive care (PICU) rates had been grouped together. The fundamental goal of the Division was to ensure that the services were available. Those services were disproportionately affected because Medicaid covered a large share of the population needing those services.

Senator Denis asked how the agency determined the recommended 25 percent rate increase was appropriate for certain neonatal intensive care unit services.
Ms. Phinney replied that the agency paid those rates on a per diem basis. A variety of levels of rate increases were studied, and discussions were held with the hospitals. The agency continued to look at the cost of intensive care services to get as close to the cost as possible while balancing with other demands. The recommendation realigned rates to more closely associate with the clinical levels of care rates that were provided in neonatal intensive care units. On an ongoing basis the Division would identify what was needed and how much it would cost for future consideration. The agency studied other payment methodologies in an effort to get closer to the best information available about those costs.

Senator Denis asked whether the agency sought a balance and how close it was to the target.

Ms. Phinney responded that a balance was difficult to achieve, and the agency could always acquire better cost information. It was hard to pinpoint accurate costs in healthcare in general. Medicaid rates were even lower than Medicare rates, but the agency was getting closer.

Assemblywoman Carlton said the term presumptive eligibility was discussed in the Legislature a long time ago. A mom might not be covered under Medicaid, but the minute the baby was born, the baby was covered under Medicaid. The moms did not receive the necessary prenatal care. She believed that if the Legislature correctly addressed presumptive eligibility, then not as many babies would need NICU and PICU services. She asked whether the growth in NICU and PICU services was due to population growth or other factors. She thought that perhaps something else was going on behind the scenes that the Legislature should address. She understood her concern was related to policy but said it was an important part of the discussion. Need versus population growth should be studied. Assemblywoman Carlton hoped access to NICU and PICU services would increase and asked whether the Division had studied other states that increased NICU and PICU rates to determine whether access actually increased. It was all about the access and not about the profit center for her. She understood that there was a need, and she was pleased the agency knew the cost because it had been difficult to ascertain the cost on certain services. In summary, she needed to know whether the recommended rate increases would increase access to care for the moms and the babies.

Ms. Phinney noted that Assemblywoman Carlton made an excellent point that preventative services would ensure healthy babies were born who did not need more NICU and PICU services. Medicaid was designed now so that those babies were eligible for services. The Division worked with the managed care organizations (MCOs) to ensure that babies were enrolled and had continuity in the same program from the moment they were born and even before birth. She would provide some more specific information on presumptive eligibility for the moms and how to enroll moms before the delivery.

Assemblywoman Carlton was unsure how the problem would be resolved and recalled that former Senator Sheila Leslie was involved. A certain population had been unable to access services because of their legal status. The hospitals were interested in presumptive eligibility because undocumented immigrants made up much of the population served. Healthier babies at birth was the goal. She asked for an update on the status of serving those moms.

Ms. Phinney replied that the program had some initiatives aimed at ensuring there was access to a substance use treatment program. That program would affect the population of moms because some of those infants were substance exposed. That was a big concern. The other initiatives blended with that problem. It was a challenge to compare hospital rates with other states. The Division studied how other states developed rates, how to improve the system, and what Medicaid could do to maintain those services and increase them when necessary.

Assemblywoman Carlton said one hospital corporation that bought substantial newspaper time and sent numerous emails regarding presumptive eligibility operated hospitals across the country. That national company might be a good resource for information about rates and the effect of rates on access.

Chair Sprinkle asked about the recommended 15 percent increase for PICU rates. He asked how Medicaid determined the recommended 15 percent reimbursement rate increase for PICU services was the appropriate rate to sustain or improve those units in the hospitals.

Ms. Phinney replied that the agency studied a range of rate increases to get as close to the true cost of those services as possible. The Division worked with the hospitals and the Nevada Hospital Association. More recent increases had been made in the PICU rates, and that change created the current difference between the NICU and PICU rates. Medicaid was closer to cost in the PICU rates than in the NICU rates, and the difference was evident. The program appeared to be maintaining the level of PICU service availability.

Chair Sprinkle asked whether the agency was confident or had received feedback that it could sustain the current level of service being provided.

Ms. Phinney responded that yes, the agency had the sense that those rates would maintain or increase the ability to provide those services.

Senator Kieckhefer assumed that NICU and PICU rates were not targeted to Medicare as many rates were. He asked whether there was an upper payment limit (UPL) associated with those services and whether the agency had a target level. He asked whether Medicaid evaluated provider costs as a component of the proposal and what standard the agency used to benchmark the rate.

Ms. Phinney replied that Medicaid looked at a number of things including billed charges, cost information, what other states paid, and how close the rates were to actual costs. Cost identification in healthcare was a broad problem. It was complex and difficult to agree on a methodology to allocate the physical structure of the hospital. The agency studied the actual cost of services, what specialties were needed, how to maintain capacity, and how close the rates were to actual costs. She would provide additional information to the Subcommittees.

Moving to decision unit E-234, Assemblywoman Neal asked how the personal care services provider rates were determined to be appropriate considering that the 2009 rate was $4.63 per 15 minutes of personal care service and the recommended rate was $4.39 per 15 minutes of personal care service.

DuAne Young, Deputy Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services, replied that the rate was recommended based on cost and did not meet the total cost of living. Personal care services were used the most by Medicaid clients and accounted for the biggest Medicaid expenditure. Any increase was magnified across the population and created a significant fiscal effect. The recommended rate was determined to be most amenable to the personal care providers with the least fiscal effect across the Medicaid budget because those were the largest services billed.

Assemblywoman Neal understood him to say it was better to use the rate recommended in The Executive Budget to find the services even though the higher 2009 rate was the rate that should be recommended.

Mr. Young did not disagree, and he stated that it would be beneficial to return to the 2009 rate. However, services had grown exponentially. The Affordable Care Act (ACA) created an increase in the caseload, and more services were provided. It would be ideal to return to the 2009 rate, but the agency chose to recommend an incremental increase from $4.25 to $4.39 per 15 minute service unit because of the growth in caseload.

Assemblywoman Neal said that in 2017 the agency believed it could charge an assessment to personal care service providers, but now it had become a challenge. She asked what happened between "I believe I could" and "now I cannot."

Mr. Young replied that he thought it was still "I believe I could." The provider fee program required more than 60 percent of the industry to agree. Personal care services was one of the

largest expenses for Medicaid and comprised the largest provider group. The agency needed to have the industry come together and had worked with the association over time to reach agreement. The Division had been convening sessions with the association, but the agreement had to reflect the will of the providers to enact.

Assemblywoman Neal said the agency's response begged the question of the quality of the services provided. The recommended rate seemed low in general, but the difference was significant. There was a problem with the quality of the personal care that was received. The recommended rate was lower than the rate in 2009, and the agency was unable to get agreement from the providers to offset the cost.

Mr. Young said the quality could be addressed in two separate questions. A 14 cent increase per quarter hour equaled 56 cents per hour and would probably not attract a higher quality of provider. The rate might encourage those who were dedicated and provided services to continue to provide those services in a high quality manner. The other way to ensure quality was through the electronic visit verification (EVV) that was addressed earlier. That program was enacted through the Cures Act [The Cures Act mandated that states require EVV for Medicaid-funded Personal Care Services and Home Health Care Services for in-home visits by a provider. The Cures Act was signed into law on December 13, 2016, and added the new subsection 1903(I) of the Social Security Act.]. The Cures Act helped agencies hold personal care staff accountable for what was done in the visit and the services that were provided and ensured those services aligned with the care plan of the individual. He did not think there was one silver bullet to improve the quality of the services. However, all of those efforts weaved together at least moved Medicaid to raise the standard and level of expectation of those services.

Assemblywoman Neal asked whether the Division had ever been audited on the quality of care received by clients.

Mr. Young replied that the agency had not received a specific audit in that area. Many states did not offer personal care services because the types of providers were so expansive and because there was concern about such a large group of providers enacting services through different milieus. He could not speculate on why the government passed that section of the Cures Act, but he believed that it was to ensure providers were held to specific standards through the electronic visit verification program. He did not want to presume there were quality problems other than those that were brought to his attention. But he knew Medicaid could always do better. The agency worked to provide higher quality services and enact procedures that were helpful, rather than harmful, for the services that were rendered.

Referring to decision units E-249 and E-250, Senator Woodhouse asked how the recommended rate increase for supported-living arrangements was anticipated to benefit those receiving services.

Mr. Young responded that supported living arrangement provider rates were reviewed in 2002, and a strategic plan was developed. The University of Nevada, Las Vegas (UNLV) developed another plan in 2014 to establish appropriate rates and to ensure a safety net for those vulnerable populations. The rate allowed them to provide competitive salaries, and employees remained on the job. Medicaid used those two studies and worked with the Aging and Disabilities Services Division (ADSD), Department of Health and Human Services, to align those rates. The ADSD previously notified the Interim Finance Committee (IFC) of a 5 percent rate increase in June 2018. The recommended rate increases would true up what ADSD previously presented to the IFC.

Chair Sprinkle asked whether a state plan amendment was required if the rate increase was approved.

Mr. Young replied that currently all of the rate adjustments required a state plan amendment. The Centers for Medicare and Medicaid Services (CMS) granted the Division latitude to run state plan amendments through CMS informally so the agency could receive timely feedback. Medicaid took advantage of that process. Typically, the window for state plan amendments had been about 90 days for review, but occasionally the CMS response was received in less time.

Moving to decision unit E-238, Assemblywoman Neal asked about the populations and conditions being targeted through the Section 1115 (a) demonstration project.

Stephanie Woodard, Psy.D., Medical Epidemiologist, Division of Public and Behavioral Health, Department of Health and Human Services, replied that within the certified community behavioral health clinics (CCBHCs), the Department aimed to serve the same populations that were served through the Section 223 demonstration program that established the CCBHCs. Those populations covered all age groups, including those individuals with serious mental illness, severe emotional disturbance, lower thresholds of severity and acuity for mental health problems, substance use disorders, and co-occurring mental health and substance use disorders.

Assemblywoman Neal asked about the anticipated outcomes of continuing and expanding CCBHCs in the state.

Ms. Woodard responded that the agency selected one of four options as a goal of the original demonstration program: to improve availability of access to and participation in a broad array of services. The Department intended to continue to adhere to that goal. The Department also used 21 quality measures that it was required to collect and report on that included follow-up after hospitalization, an emergency room visit, or initial engagement in treatment services.

Senator Kieckhefer wondered whether Medicaid had operated under a federal demonstration project but now would move into a state-based waiver. He asked whether there was any change in the program and what services would be provided when that change was made.

Ms. Woodard replied that Medicaid was reapplying for a Section 1115(a) demonstration waiver that was considered an extension of the current demonstration program and not a waiver. The agency did not intend to change any of the services that were currently available under the Section 223 demonstration program in the Section 1115(a) demonstration waiver.

Senator Kieckhefer questioned whether the goal related to access was to measure any new access or a shift from existing providers.

Ms. Woodard responded that the Department had studied data to attempt to determine the answer to that question. The agency was required to develop a rigorous evaluation plan to determine access to services as part of the current demonstration program. She stated that the number of providers that were participating under the Section 223 demonstration waiver in the three programs had grown exponentially. Many of those providers came from out-of-state so Nevada was not shifting resources from one geographic area to another. The other component studied was the waitlists. If any of the geographic areas had waitlists for similar services, the CCBHCs were prevented from creating a waitlist and were required to see individuals and initiate them in treatment within 10 days of the initial request for services.

Senator Kieckhefer said it was good that additional providers were coming in from out-of-state. He asked whether the agency had identified specific clinics that would meet eligibility for the program under an expansion and worked with them to get them enrolled so the program was operating as soon as possible.

Ms. Woodard replied that the agency ran a competitive request for application and selected six additional clinics to work with the program. Those clinics were supported at least in part through the mental health block grant to assist them with training and technical assistance. The grant also provided additional resources to ensure they had adequate staffing to continue to work toward certification criteria. The federal government dictated the certification criteria. The agency had provided training and technical assistance for the clinics and was in the process of doing preliminary site visits to provide intensive individualized on-site technical assistance and ongoing guidance. The plan was to conduct more formal site visits to determine whether the clinics met certification criteria late in the summer.

Chair Sprinkle understood that the services were going to be the same because this was an extension of the current demonstration project. He asked whether the additional seven facilities would all have to meet the same requirements as the original program.

Ms. Woodard confirmed that the clinics would all have to meet the certification criteria.

Chair Sprinkle asked for an update of the progress.

Ms. Woodard replied that at the Interim Finance Committee (IFC) meeting on January 30, 2019, the Division submitted a work program to move federal grant dollars to support a contract with a vendor to assist with writing the application. The application was about 95 percent complete. The agency met three times with the Centers for Medicare and Medicaid Services (CMS) and intended to hold weekly meetings as it completed some of the more difficult and challenging technical portions of the application. The target date was around the middle of March at the latest to begin the transparency process. Nevada was one of eight states funded through CMS to begin the demonstration program two years ago. All eight states had engaged CMS in either state plan amendments or a Section 1115(a) demonstration waiver application. The CMS worked diligently with each of the states recognizing that many states were under tight timelines to receive approval by July 1, 2019.

Chair Sprinkle appreciated the update. He recalled during the IFC meeting that he was concerned about the timeline. He asked what would happen if Nevada failed to receive the extension of the waiver and how would the appropriated funds be used.

Ms. Woodward replied that she was confident the waiver would be approved. She could not guarantee what that timeline might be. She knew CMS was motivated to avoid a significant gap in coverage for those states that were working with them on the Section 1115(a) demonstration waiver extensions.

Chair Sprinkle appreciated that the staff was optimistic in being able to move forward with the plan. He asked again about the use of the funds already appropriated for the extension.

Mr. Young replied that part of the demonstration waiver was to have a prospective payment system rate to accomplish all those services similar to what a federally qualified health center (FQHC) would bill. The program would revert back to a traditional billing under the Provider Type (PT) 17 Specialty 215 that was a Substance Abuse Prevention and Treatment Agency (SAPTA) certified clinic that had similar certification processes administered by the Division of Public and Behavioral Health, Department of Health and Human Services. If a gap occurred between the waiver approval and the extension of those funds through the Section 223 demonstration grant, Medicaid would revert to the PT 17-215 billing until the waiver was approved. Medicaid would then bill in that prospective payment system for that rate.

Chair Sprinkle said he was supportive of the efforts of the agency. He asked what kind of financial or other benefits Medicaid had seen by moving forward with those facilities. He asked whether the agency anticipated that any savings would result in other areas of Medicaid following the application of the Section 1115 (a) waiver.

Ms. Bierman responded that one of the unique elements of the particular demonstration waiver was that it allowed for the integration of physical and behavioral health services. Some of the population would receive primary care services that otherwise might not be available to them.

Chair Sprinkle said he was aware that the Senate had some other obligations, and he wanted to allow sufficient time for public comment. He tried his best to get through all the budgets today but was unable to complete them. He would hold the remainder of the budget until next Tuesday and finish the budget then. He opened public comment.

Tracy Brown-May, Director of Advocacy, Board, and Government Relations, Opportunity Village, testified from Las Vegas. She said Opportunity Village was an organization in Southern Nevada that provided services for individuals with intellectual and developmental disabilities. Children with autism needed services, and the need existed throughout Nevada not only for individuals with autism but also for those with intellectual and developmental disabilities. The Clark County School District identified more than 600 children between the ages of 18 and 21 years who were diagnosed with autism, intellectual disabilities, multiple impairments, or traumatic brain injuries and were preparing to age out of the school district.

Ms. Brown-May addressed the reimbursement rates in Nevada and the Medicaid intellectual disability waiver. While small rate increases had been realized over the last years, there had been no comprehensive study to ensure adequate rates for reimbursement. The waiver was currently in the process of renewal. It served individuals with intellectual and developmental disabilities seeking jobs and day-training services and supported-living arrangement services. She understood that the rates of reimbursement were included within the waiver renewal. Assembly Bill (A.B.) 108 of the 79th Session (2017) provided for a periodic review of reimbursement rates. To date, a study of jobs and day-training and supported-living arrangement rates had not been completed.

Providers of services regularly worked to improve the quality of services provided to the vulnerable population. Increasing the pay rates associated with direct-care service positions would improve the quality. Ms. Brown-May said it was important to work for the recognition of direct-care service as a job code by the U.S. Department of Labor. Proper reimbursement rates would attract quality care providers. Personal-care aides and direct-service providers were the individuals who provided the most intimate level of care to the vulnerable population. They deserved to be paid appropriately for the services they provided. She understood the intellectual disability waiver was currently under review by the Centers for Medicare and Medicaid Services (CMS), and a cost study was recommended before approval of that waiver. She asked for help in addressing the funding problem across Nevada. An amendment to the state plan would be required for providers to receive any type of rate increase. Jobs and day-training providers were currently reimbursed at the maximum allowable payment limit under the Medicaid state plan in Nevada. She believed that because those providers received the maximum allowable rate, no increase was recommended for

jobs and day-training providers while an increase was recommended for supported-living arrangements. The jobs and day-training provider rate increase of 5 percent that was approved at the Interim Finance Committee (IFC) meeting in June 2018 was finally realized. The 2002 recommended rate was based on the earlier study. The state could expect that a recommendation would be received from CMS following the completion of the 80th Session (2019). It was important that the Legislature know that providers expected a recommendation to increase the rates. The providers were prepared to consider ways to support the population in the interim. She appreciated the Subcommittees' time and consideration and thanked the Legislature for its support of Nevadans.

Shannon Thurman, Private Citizen, Reno, Nevada, testified that the rate increase would be good. Her concern was that her daughter Joy had been on the Medicaid waiver for some time without receiving services. She expressed concern that more families might qualify for the waiver but might not receive services either. She was on a waitlist for two years to get on the waiver. Joy also had a supported living arrangement to keep her out of a group home. When Joy turned 18, Sierra Regional Services fought Ms. Thurman to put Joy in a group home. She did not want to put her daughter in a group home. There was so much abuse that occurred in group homes. She needed help to get Joy active so she could become a functioning member of society. Joy was on an active waiver but was not receiving any services during the past three years. Ms. Thurman supported the rate increases because she assumed that no person wanted the job for $9 per hour with no reimbursement for fuel.

Chair Sprinkle said there were no further public comments and closed the public comment section of the hearing. Chair Sprinkle adjourned the meeting [10:25 a.m.].

RESPECTFULLY SUBMITTED:

_____
Janice Wright
Committee Secretary

APPROVED BY:

_____
Assemblywoman Maggie Carlton, Vice Chair

DATE: _____

_____
Senator Moises Denis, Chair

DATE: _____

EXHIBITS

Exhibit A is the Agenda.

Exhibit B is the Attendance Roster.

Exhibit C is a document titled "Policy Brief: Health 2019, 12-Month Continuous Coverage," presented by Jared Busker, Associate Director, Children's Advocacy Alliance.

Exhibit D is a memo dated March 1, 2019, to the Assembly Committee on Ways and Means and Senate Committee on Finance, Subcommittees on Human Services, authored and presented by Mara Mason, representing Azure Behavioral Services, in support of Senate Bill 174, increasing rates for Applied Behavioral Analysis and the Medicaid budgets.

Exhibit E is a copy of a PowerPoint titled "Department of Health and Human Services FY 2020-2021 [2019-2021] Budget Presentation, Director's Office–Budget Accounts 3260 and 3244, Director Richard Whitley," dated March 1, 2019, presented by Richard Whitley, M.S., Director, Department of Health and Human Services.

Exhibit F is a copy of a PowerPoint titled "State of Nevada Department of Health and Human Services 2020-2021 [2019-2021] Governor Recommends Budget, Division of Health Care Financing and Policy," dated March 1, 2019, presented by Suzanne Bierman, Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services.