MINUTES OF THE
SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

Eightieth Session
February 11, 2019

The Senate Committee on Health and Human Services was called to order by Chair Julia Ratti at 4:03 p.m. on Monday, February 11, 2019, in Room 1214 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to Room 4412E of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Exhibit A is the Agenda. Exhibit B is the Attendance Roster. All exhibits are available and on file in the Research Library of the Legislative Counsel Bureau.

COMMITTEE MEMBERS PRESENT

Senator Julia Ratti, Chair
Senator Pat Spearman, Vice Chair
Senator Joyce Woodhouse
Senator Joseph P. Hardy
Senator Scott Hammond

STAFF MEMBERS PRESENT:

Megan Comlossy, Policy Analyst
Eric Robbins, Committee Counsel
Vickie Polzien, Committee Secretary

OTHERS PRESENT:

Steve Fisher, Administrator, Division of Welfare and Supportive Services, Department of Health and Human Services
Robert Thompson, Deputy Administrator, Division of Welfare and Supportive Services Department of Health and Human Services
Nova Murray, Deputy Administrator, Division of Welfare and Supportive Services, Department of Health and Human Services
Suzanne Bierman, Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services
Mark Krmpotic, Senate Fiscal Analyst, Fiscal Analysis Division, Legislative Counsel Bureau

Cathy Crocket, Senior Program Analyst, Fiscal Division, Legislative Counsel Bureau
Vivian Leal
Mylan Hawkins

STEVE FISHER (Administrator, Division of Welfare and Supportive Services, Department of Health and Human Services):
The Presentation on the Division of Welfare and Supportive Services (DWSS) (Exhibit C) covers the mission and vision of the DWSS, its goals, summary of operations, accomplishments, opportunities and challenges, as well as caseload and budget percentages.

The primary mission of the DWSS is to provide public assistance to all who qualify, and reasonable support for children with absentee parents. Page 4 of the presentation shows a summary of our positions; we have 2,100 positions within the DWSS. This slide is broken down by budget account; however, the budget accounts do align with our programs within the DWSS. Page 5 of the presentation describes our bill draft requests (BDR). We have three BDRs, all of which are Child Support Enforcement bills. One is a budget bill.

The first bill of the three bills is an insurance claims data matching bill allowing the Child Support Enforcement Program to identify, and if appropriate, seize assets of delinquent child support obligors. It is currently voluntary for insurance companies to enroll in this data matching process; this bill will make it mandatory for insurance companies to enroll.

Bill two relates to the suspension of recreational licenses, such as hunting or fishing licenses, for failure to comply with child support orders. This occurs today through the judicial or court ordered process. We would like to remove this from the court system making it an administrative process; for example, the suspension of a driver license.

Page 6 of Exhibit C shows a summary of our agency operations. We have the agency broken down into five operational areas. Director Whitley briefly touched on program outreach during his presentation last week. We have 30 case workers who are positioned in non-traditional locations where they provide eligibility services in locations such as detention centers, or in a hospital. We

have two public assistance programs which require work activities for those programs.

ROBERT THOMPSON (Deputy Administrator, Division of Welfare and Supportive Services, Department of Health and Human Services):
Page 7 of Exhibit C shows a visual of the three primary programs we provide through the DWSS. We service 736,000 unique individuals each month. The majority of our customers are receiving more than one program at a time; for example, Medicaid and the Supplemental Nutrition Assistance Program (SNAP). Medicaid serves all low-income Nevadans: children, pregnant women, nursing home residents, homeless, the temporary and permanently disabled, unemployed and through the Affordable Care Act, childless adults. The Temporary Assistance for Needy Families (TANF) welfare program provides cash assistance and over two-thirds of the 23,000 individuals receiving TANF are children. Half of those children are being raised by a nonparent relative such as a grandmother receiving a subsidy from us to assist in raising those grandchildren. The TANF program also has the employment and training component that Mr. Fisher spoke about. We engage approximately 5,000 individuals per month. The 736,000 individuals we serve are generated from approximately 58,000 applications per month. We touch up to 145,000 cases per month and we service approximately 60,000 telephone calls per month.

Page 8 describes our Energy Assistance Program. We service approximately 2,000 households per month with this program from two different funding sources. We focus that program on the elderly and disabled, providing assistance with their heating and cooling costs and, in some cases, upgrading their homes to become more energy efficient.

NOVA MURRAY (Deputy Administrator, Division of Welfare and Supportive Services, Department of Health and Human Services):
Projections for child care on page 9 of Exhibit C show a fairly small population, although you can see that number has been climbing. The Child Care and Development Fund (CCDF) program primarily provides child care subsidies to families receiving public assistance, or those transitioning from public assistance, and helps them obtain child care so they can work or attend training or educational programs. Eleven percent of our funding is used for quality for children, infants and toddlers. Currently we have five subgrantees that provide activities for our agency with the Children's Cabinet and the Urban League doing the eligibility activities. The Department of Education does our quality and

we subgrant for licensing activities with the Division of Public and Behavioral Health and Washoe County. In the next biennium the goals of the CCDF are strong fiscal monitoring, reducing financial burden on families, identifying gaps in our service, providing intervention through Child and Family Services and some flexibility in criteria for those who are homeless. We are also looking at suspension prevention for social and emotional intervention.

Additionally, we would like to mention the Child Support Program. This program is a partnership between the State and nine participating counties. We have 89,000 cases from which we collected $221 million in child support last year. We provide the five basic services and compete for incentives for similar programs to those in our area. Those programs include incentives for paternity establishment, support order establishment, and collections on current and arrears support. Additionally, cost effectiveness and the goals in the program for this biennium are the Child Support Replacement System and ensuring that system meets our requirements.

MR. THOMPSON:
As shown on page 10 of Exhibit C, over the last two years we have had significant accomplishments within the Division of Welfare and Supportive Services (DWSS) and it would not be possible without the hard work of our staff. Our accomplishments have occurred in three general areas; program improvements, customer service and efficiencies. Our Child Support Enforcement Program has moved from 25th in the nation to 13th; a huge accomplishment for the DWSS. We can attribute this to the integration of our Employment and Training Program and the One-Stop system in southern Nevada, as well as northern Nevada. Certainly our accomplishments in customer service and efficiencies played a significant role in our Supplemental Nutrition Assistance Program (SNAP) receiving a $1.5 million bonus. We were one of three states that received most improved for access. The four goals for the DWSS include improving customer access; creating opportunities for increased self-sufficiency; improving efficiencies through technology across the department; and seeking collaborative opportunities to enhance efficiencies, consistency and responsiveness to our customers. Page 12 describes the major initiatives for the next biennium. As Ms. Murray pointed out, the Child Support Replacement System is the number one initiative within the DWSS. This project replaces an antiquated child support enforcement system. This is a five year information technology project approved by the 2017 Legislature. We are back again this Session for additional funding for the next two years, and will be back

again next Session for an additional two years. Other initiatives include improving access to our Temporary Assistance for Needy Families program and improving access to our Child Care Program. We will also be improving the efficiency within our Energy Assistance Program by streamlining the business process.

Page 13 of Exhibit C lists the opportunities and challenges faced by the DWSS. We are taking a hard look at our policies for opportunities to possibly reduce the administrative burden to our customers. For example, we are taking a look at our SNAP certification process. Today if you have a household that does not have an elderly person in the home and you are eligible for SNAP, you must recertify every six months. We are looking to extend that to every 12 months in order to align with our Medicaid program. The Medicaid program dictates you recertify every 12 months. If you do have a household with an elderly or disabled individual, you recertify every 12 months. We want to extend that to every 24 months. In addition to that, once we roll out the 12 and 24 months, we can apply for a waiver to extend it to 36 months for households with an elderly person in the home. Through SNAP we currently load customer electronic benefit transfer (EBT) cards with their benefits and they are available on the first day of the month. This puts a heavy burden on the retailers. We are looking to distribute those benefits during the first ten days of the month rather than loading the cards for everyone on the first. We are also looking at relaxing resources within both the TANF and Medicaid programs; increasing some of those resource limits and other areas within these two programs.

I would like to give the Committee an update on suspending Medicaid eligibility for incarcerated individuals. We currently terminate services; however, we have made some changes to our eligibility technology to allow for suspending; we have yet to implement that. We have two areas we need to complete, one being the policy around when do we suspend services and for how long. Once that policy decision is made we may have to make minor adjustments to our technology to make that happen. Currently we are not notified by the detention centers when someone either enters or exits a facility. It would be nice to have an electronic process to let us know this information.

All of our programs are federal programs administered by the State, so we face challenges with our federal partners. Our programs are under continuing resolution, so we are unsure whether we will receive funding or if funding will continue. The federal shutdown created angst for us as well.

SUZANNE BIERMAN (Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services):
I will be reviewing the presentation on the Division of Health Care Financing and Policy (DHCFP) for you (Exhibit D).

While the DHCFP is primarily a payer of services, our overall goal is to improve the health of Nevadans. While we administer the Nevada State Medicaid and Nevada Check Up Program (CHIP), we are cognizant of the role of other social determinants of health and want our efforts to ultimately result in a healthier population. Approximately 680,000, or nearly 1 in 5 Nevadans receive their healthcare coverage through Medicaid and CHIP programs. That breaks down to approximately 650,000 individuals on the Medicaid program with an additional 30,000 children on the Check Up Program. Nevada Medicaid is a large payer of all births in this State covering about 65 percent of births, and nationally the largest payer of behavioral health services and health care in Nevada. We have a large role in financing health care and are cognizant of the important social determinants. The DHCFP wants to work with our partners to ensure access to care providing services in a sufficient manner, and reviewing Medicaid and other programs to maximize federal revenue coming to Nevada.

Our goals include ensuring the care we provide is cost efficient and effective, and we engage in program integrity efforts to make sure the services we provide are medically necessary. We are committed to ensuring appropriate managed care oversight and building the home and community based service delivery model. While we understand institutional care services are important for a segment of the population, we want to ensure there is a robust array of alternatives to that setting.

The first item related to the DHCFP operations shows that Medicaid is a federal and State partnership so we work closely with the Centers for Medicare and Medicaid Services. Medicaid is administered jointly by the State and federal government, whereas Medicare is a federal program. Nevada uses two primary service delivery models. We have a Managed Care System in the urban areas with about 72 percent of the overall population served by managed care companies. The remaining 28 percent are served through the Fee for Service program, which means Medicaid directly reimburses providers for those services. This is divided by the geography of the State with Managed Care Organizations (MCOs) operating in urban areas and Fee for Service programs

operating in Nevada rural areas. Medicaid does provide some services that other commercial insurers and the Medicare program do not typically provide. One example is Long-Term Care services. Medicaid also provides non-emergency medical transportation.

The Medicaid Management Information System (MMIS) is our primary IT System. It is outdated and overhauling this system has been a major undertaking; one that I am happy to report has gone smoothly and successfully. This system is used to pay claims and enroll providers and we expect system changes to be quicker, making for a more nimble system. Nevada is the first state to implement an MMIS and offer completely paperless claims.

We have expanded the number of managed care carriers in the State from two to three. We worked with our partners in the Division of Public and Behavioral Health to implement the Certified Community Behavioral Health Clinic model. Currently there are three sites in Nevada that are participating in that demonstration project. This provides for the integration of physical and behavioral health services, particularly those in rural areas that have not always had access to behavioral health and primary care services. One of the unique things about this model is that you can receive both services in one setting. We have been working on an initiative to ensure the services we provide are medically necessary and appropriate.

The 1115 Demonstration Waiver for the Certified Community Behavioral Health Clinics currently has three clinics. We are hoping to grow that number to 10 clinics and are working with the Centers for Medicare and Medicaid Services to get authority to continue and increase that program. We are working on a 1915(i) State Plan Home and Community-Based Services plan that would allow Medicaid to pay for services for the chronically homeless. While Medicaid cannot pay for residential services or housing, it can provide assistance needed for individuals to find and keep housing. We have been working with the Nevada Hospital Association to develop a Hospital Provider Fee.

One of the key challenges for the DHCFP has been changes in the federal match rate. These are challenges that have been anticipated and included in our budget. Under the Affordable Care Act (ACA), a couple of eligibility categories received enhanced funding for a period of time. One of those in particular is the newly eligible adults or the State's Medicaid expansion program. While Nevada will always, unless statutes change, receive an enhanced match rate of

90 percent, that rate has tapered over the last couple of years, starting at 100 percent federally matched for three years. By the time we get to fiscal year (FY) 2021, it will be at 90 percent where it stays thereafter; each year that match rate has dropped some. We will top out at the federal government paying 90 percent of the cost of services for that eligibility group. Similarly, under the ACA, there was enhanced match rates for the Children's Health Insurance Program and Nevada benefited from an enhanced match rate for a number of years. By FY 2022 it will return to its non-enhanced standard rate, and by FY 2021 it is back to 78 percent. While small percentages may not look like much when you talk about a Medicaid budget, changes in small percentage points have very large financial ramifications. Additional non-state funding is needed due to the planned and anticipated decreases in the federal match rate and the States general match rate. When the economy does improve, the State match rate goes down; the State has to pay more and the federal government pays less. We will also anticipate changes in the federal match rate for non-enhanced eligibility groups, resulting in increases for our need for non-federal funding.

We also have challenges related to access. There are health professional shortage areas in all counties of the State. Nevada Medicaid does struggle with access issues, and while those issues impact Medicaid, they are not specific to Medicaid. We are looking forward to opportunities to address those issues. Some particular projects have been underway to help us address these access issues. We see particular areas of shortage around applied behavioral analysis and a lack of behavioral step down facilities in Nevada. Nevada Medicaid is working to fill those gaps by developing new service arrays to help address those issues. With the lack of step down facilities, and an overall lack of providers in the rural and frontier areas, we are working on a partial hospitalization program with some of the State's federally qualified health centers to fill the gap.

The total Medicaid caseload, which is nearing 700,000, is at 660,456 for 2019. The Nevada Check Up program has an additional 30,000 children enrolled in that program. The majority of our program enrollees are made up of the parents and children category at 47 percent with the next largest the newly eligible, or Medicaid expansion adults, at 32 percent. The next largest is the aged, blind and disabled at 12 percent. Although the parents and children had the most enrollees they are not the most expensive population. It is the aged, blind and

disabled that have a higher per person cost although they are not the bulk of our enrollees.

SENATOR SPEARMAN:
Per the graph on page 13, the aged, blind and disabled caseload category has the highest cost.

MS. BIERMAN:
Along with our waiver populations, yes, the aged, blind and disabled caseload category has the highest cost by caseload category. The waiver population would be those who would otherwise qualify for institutional levels of support, so you can see this category has the highest overall cost. By eligibility category it is the aged, blind and disabled, and then newly eligible adults and children have a much lower per person cost.

MARK KRMPOTIC (Senate Fiscal Analyst, Fiscal Analysis Division, Legislative Counsel Bureau):
When we look at funding levels in State government we look at comparisons to what the Legislature approved in the previous biennium as a baseline measure. The handout provided for you reviews the highlights of the Department of Health and Human Services Budgets (Exhibit E). The total Governor's recommended budget, if you include all funding sources, General Fund, federal funds, etc., totals about $25.8 billion, with federal funds being the largest portion of that.

As shown in the chart on page 2, Health Care Financing and Policy, including Medicaid and Nevada Check Up programs, shows an increase of $398 million of the $527 million increase. You will also find the other divisions and organizational entities within the Department of Health and Human Services listed there in terms of General Fund increases. By far, Health Care Financing and Policy represents the largest General Fund portion of the increase in General Funds on the Governor's recommended budget.

CHAIR RATTI:
Is it fair to say that in aging and disability services the Governor is recommending we invest an extra $63 million this year, and for that $63 million, what we are able to accomplish are the bullet points you reviewed?

MR. KRMPOTIC:
I would characterize those as enhanced funding in the budget from the upcoming biennium.

CHAIR RATTI:
If we are speaking to the general public, we can state these are areas we are increasing or enhancing our effort.

MR. KRMPOTIC:
Correct.

Page 3 of the presentation covers the Division of Health Care and Financing Policy representing primarily a Medicaid program which Ms. Crocket will present to you.

CATHY CROCKET (Senior Program Analyst, Fiscal Division, Legislative Counsel Bureau):
The Division of Health Care Financing and Policy Program (DHCFP) has been fairly dynamic in recent years with the implementation of the Affordable Care Act (ACA). In fiscal year (FY) 2013, the Medicaid caseload was about 300,000 and the total budget was $2 billion per year of which approximately $500,000 was General Fund. By FY 2021 the caseload is projected to be about 677,000. The total budget for that year is recommended to be $5 billion, and of that, about $1 billion would be General Fund. The Medicaid and Nevada Check Up programs, which are administered by the DHCFP, make up a significant portion of the State budget. In the upcoming biennium they would make up about 33 percent of the total State budget at $9.5 billion over the biennium, and would comprise approximately 20 percent of the State total General Fund expenditure of $1.8 billion. They would contribute about 64 percent of the total federal funds in the State budget at $6.8 billion of the $10 billion total over the biennium. The DHCFP does account for about 75 percent of the total and about 60 percent of the General Fund expenditure for the Department of Health and Human Services (DHHS) budget.

The costs of Medicaid are generally driven by the number of people served and the cost of serving each person. That varies as the population of the State grows larger. As the economy improves, the increases may be lower. We are projecting an increase for the upcoming biennium even though the economy is

doing relatively well, and the cost per person of providing services varies based on trends and utilization.

Sources of funding include federal funds received from the federal government which are known as Title XIX (Social Security Act) funding and Title XXI (State Children's Health Insurance Program) funds. Local governments do contribute funding to the programs and there is provider tax on long-term care facilities, as well as General Fund appropriations. Federal funds comprise approximately 71 percent of the DHCFP overall budget providing for a portion of medical services and administrative costs. Ms. Bierman mentioned Federal Medical Assistance Percentage (FMAP) rates; this is the rate at which the federal government provides funding to the State. General Fund and other sources, such as county contributions, would comprise the rest of medical service and administrative costs.

FMAP rates are based on eligibility categories; for example, the newly eligible have a certain matching rate where children have a different matching rate. Although FMAP rates do vary over time, that does not affect the total overall rate, but shifts the cost among the federal government and the State. The standard FMAP rate, which covers most eligibility groups, is determined annually and is based on the per capita income of the State relative to other states. If our State is doing relatively well compared to other states, our FMAP rate would drop requiring the State to contribute more funding. If it is not doing as well, the FMAP rate would rise and the State would contribute less funding. Currently the FMAP rate is approximately 65 percent, which means the federal government would contribute 65 percent and the State would contribute the remaining 35 percent for the standard FMAP rate. There is the newly eligible FMAP rate which covers the Medicaid expansion population, the ACA population which started at 100 percent of federal funds when first implemented in 2014, scaled down slowly until it reaches a floor of 90 percent in FY 2021. There is now a temporary increase in effect for the Nevada Check Up program that will be sunsetting in FY 2021, decreasing the FMAP rate from 98 percent to 78 percent federal funds in FY 2021.

Local governments do provide a good portion of funding for a number of supplemental payment programs which are designed to provide enhanced Medicaid reimbursement for certain service providers. They also provide the FMAP match for certain participants who are in facilities or on waiver programs, known as the County Match Program. The local government contribution

amounts to approximately $375 million over the upcoming biennium which would comprise about 3.9 percent of the budget.

The DHCFP operates several supplemental payment programs which are supported by the local government. Supplemental payments will provide $765 million over the upcoming biennium with an additional reimbursement primarily to hospitals. Local governments do benefit through these programs by contributing the State share of expenditures. They are able to place additional funds back into those communities providing the local government with a benefit of approximately $430 million over the upcoming biennium. The State does receive a benefit by generating $98 million through these programs which act as a reduction in General Funds to the budget.

One of the two more significant supplemental payment programs is the Disproportionate Share Hospital program, also referred to as DSH, designed to reimburse hospitals for uncompensated care provided. This is a federal allotment specified annually by the federal government. In FY 2020-2021, the supplemental payments to hospitals would be about $74 million in FY 2020, and $62 million in FY 2021. The primary beneficiary of this program is the University Medical Center in Las Vegas. In FY 2018 they received about 88 percent of these total supplement payments. There is a provision in the ACA and subsequent legislation which will result in these supplemental payments reducing significantly. There is a $44 billion decrease scheduled over six years which will start in FY 2020, having a significant impact on the State and those supplemental payments.

The Upper Payment Limit program is the second of the two more significant supplemental payment programs operated by the DHCFP. This program is also designed to preserve access to care and compensate for uncompensated care. This will allow hospitals to receive a higher level of reimbursements up to the Medicare rate, which is known as the Upper Payment Limit. Counties do provide transfers to Medicaid for these programs. The supplemental payments for these programs are budgeted to be $167 million over the upcoming biennium. There is a Long-Term Care Provider Tax in place, which I believe is 6 percent of net revenues, which is budgeted to be about $81 million over the upcoming biennium, or about 1 percent of the DHCFP budget. This is used as a match to provide enhanced reimbursement to these same facilities that pay the tax. This will generate approximately $220 million in supplemental payments over the upcoming biennium. If there are no other sources of funding available, General

Fund makes up the remaining, anticipated to be approximately 19 percent of the total budget, or $1.8 billion over the upcoming biennium.

There is an overall funding increase totaling $1.2 billion over the upcoming biennium, representing an increase of about 15 percent when compared to the funding for the previous biennium. Of that increase, federal funds are an approximate $816 million increase, representing a 14 percent increase. The General Fund increases about $397 million, representing a 28 percent increase from the last biennium. The overall increase is largely driven by utilization changes, earlier referred to as the cost per eligible, showing the cost of providing care to participants is increasing. There are also caseload increases and provider rate increases that drive the overall increase.

The caseload for Medicaid is projected to increase by about 1.5 percent per year from 650,000 people this year to approximately 677,000 by FY 2021. This would require additional funding totaling $139 million of which $51.8 million would be General Fund. There is also a caseload increase projected for the Nevada Check Up program requiring $5.2 million, of which $600,000 would be General Fund. That caseload of 30,000 children per month is projected to increase by about 4 percent.

The Governor is also recommending a supplemental appropriation to provide funding for a projected shortfall occurring in this fiscal year, recommended to be $14.5 million. The DHCFP typically requests a supplemental appropriation when costs exceed what it budgeted. In 2017, a supplemental appropriation of $5.8 million was approved; in 2015 no supplemental appropriation was needed. In 2013 the supplemental appropriation approved was $27 million.

Federal Medical Assistance Percentage (FMAP) rates vary, having a material impact on the amount of General Fund budgeted. As the rates decline, the State contributes more to operate the same program. Based on an analysis put together by the DHCFP, $132.6 million is associated with the FMAP rate changes projected over the upcoming biennium. Those rates are projected to be decreasing, and of that total increase, about $84 million of that is associated with the newly eligible population, the Medicaid expansion group. There are mandatory discretionary and provider rate increases required by the federal government, which the Governor has recommended primarily to increase access to care.

Mandatory rate increases are projected to cost $346 million, of which $78 million would be General Fund. Those would include managed care capitation rates, prescription drugs, and federally qualified health centers, which are required to have rate increases under federal law.

The Governor is recommending several discretionary rate increases, which are projected to cost $49 million over the upcoming biennium; approximately $12 million in General Fund.

Also recommended is an increase of 25 percent to the rate for neo-natal intensive care services, which would cost $25 million; $9 million in General Fund total. A 15 percent increase for pediatric intensive care services has been recommended, requiring $2.5 million total; $900,000 General Fund.

A 3.3 percent rate increase is recommended for personal care services at a cost of $6 million, of which $2 million would be General Fund.

An increase is recommended for supportive living arrangements services provided through the Aging and Disability Services Division (ADSD) requiring federal funds within Medicaid and General Funds of $15.2 million which are budgeted in the ADSD budget.

There are initiatives recommended to expand access to care in the recommended budget projected to cost $48.7 million, of which $9.9 million is General Fund. The first item relates to an expansion of Certified Community Behavioral Health Clinics budgeted at $38.9 million over the biennium; $8 million General Fund cost. The DHCFP is projecting this would provide services to 9,200 people per year. There are currently 3 clinics operating under a pilot program and DHCFP is proposing to expand that number to 10 under the 1115 Demonstration Waiver, which would allow the DHCFP to test coverage for a 5 year period. These clinics provide services targeted to behavioral health and substance use disorders. Services include 24 hour crisis outpatient mental health and substance use treatment, as well as case management and different recovery supports. I would note at the January 30th Interim Finance Committee meeting a work program was approved to allow the DHCFP to develop an application for this waiver. The target to have this completed by July 1, 2019.

There is funding recommended to address housing instability through the 1915(i) State Home and Community-Based Services Plan, costing about $9.8 million; $1.9 million in General Fund. This is intended to address homelessness and provide support for those who are in chronic homeless situations.

An additional recommendation in the Governor's budget is to increase county support for what is referred to as the county match population, which would be a decrease in General Fund of $19 million over the upcoming biennium, replaced with the corresponding amount in funding contributed by the counties. This would be to revise the methodology for determining the funding split between the State and the counties for certain county match participants.

Additional General Funds of $31 million were recommended over the biennium to reduce Clark County's voluntary contribution in support of the supplemental payment programs mentioned earlier.

CHAIR RATTI:
Are we taking away $19.2 million from the counties and then giving them $31.1 million?

MS. CROCKET:
Essentially, yes. I will give a little background on the county match piece. In 2011, the Legislature approved assigning to counties the financial responsibility for some Medicaid participants, primarily certain waiver participants. By DHHS internal policy, they decided to cap the cost for those assessed to the counties at the 2013 level. Over time, as caseloads increase and the cost per person increases, the counties have not been contributing additional funds to cover the increased cost. The county match is recommended to true that, and have the counties pay the non-total, non-federal share for the people for who they contribute support. That would impact all counties throughout the State, whereas the Clark County voluntary contribution rate is based on negotiations between the DHCFP and Clark County, to settle on a rate which the county would voluntary contribute to these supplemental payment programs. Supplemental programs require counties to contribute voluntarily statewide; this is what Clark County has decided to contribute and the State has agreed to that.

CHAIR RATTI:
If I heard correctly, in the place where the cost to counties is going up, the $19.2 million will be spread across all counties. In the place where the costs are going down, only Clark County will benefit.

MS. CROCKET:
Yes, that is correct.

The final major recommendation relates to waiver slot increases. The DHCFP operates three waiver programs designed to keep people in home and community settings rather than institutions. These are operated by the Aging and Disability Services Division. The Governor is recommending $68.5 million total over the biennium, a $15.6 million General Fund increase. This will increase waiver slots by 27 percent from approximately 5,300 people in FY 2019 to 6,700 in FY 2021.

As there is an interest in understanding how policy bills that progress through this Committee might have an impact on the budget, I will review a couple of those bills.

SENATE BILL 115: Requires the State Plan for Medicaid to include coverage for donor breast milk. (BDR 38-560)

Senate Bill 115 has been referred to this Committee requiring Medicaid to include coverage for donor breast milk for certain infants, a policy decision to put something in statute to require the DHCFP to put that service in the State plan. The DHCFP fiscal note they submitted for that bill indicated the estimated cost would be $24.9 million, of which $8.8 million would be General Fund.

ASSEMBLY BILL 116: Provides for an actuarial study to determine the cost of revising certain Medicaid reimbursement rates. (BDR S-702)

There is also Assembly Bill 116 that has been referred to Assembly Health and Human Services. This would require the DHCFP to conduct an actuarial study to examine the cost of setting Medicaid rates equal to 98 percent of Medicare rates. The fiscal impact for that study would be $150,000 added to the DHCFP budget to fund.

ASSEMBLY BILL 122: Requires the Department of Health and Human Services to seek a federal waiver so that certain care for persons who are aged, inform or disabled may be included in the State Plan for Medicaid. (BDR 38-100)

Assembly Bill 122 introduced today and referred to Assembly Health and Human Services Division, would require the DHCFP to seek a waiver for certain adult day care and respite services. There is no fiscal note released for that as of today; however, we anticipate that will have a fiscal impact.

SENATOR HAMMOND:
Looking at the DHHS funds going for Medicaid reimbursement, it seemed to be going out to primarily one hospital. How do they determine this? Why not do it proportionately based on how many Medicaid patients a hospital has?

MS. CROCKET:
Standard Medicaid reimbursement for services is based on the services that the hospitals provide in regard to supplemental payments. There is a formula, an administrative code in statute that determines how that money is distributed. The DHCFP does not have leeway in how the money is distributed under the administrative code for the disproportionate share hospital, for which I referred to as the University Medical Center.

CHAIR RATTI:
When it comes to DHCFP, we are spending almost $400 million more, of which over a quarter of that is caseload growth and mandatory rate increases in which we do not have a choice. If we are going to maintain the same level of service with the mandatory increases from the federal government, is this money we are going to spend right off the bat?

MS. CROCKET:
Correct. If you look at the overall increase, I calculate about 80 percent of the total increase is to continue operating the same program as it is now with caseload increases and FMAP rate changes. I calculate about $321 million of the overall increase is not related to enhancements.

CHAIR RATTI:
So 20 percent is enhancements and items we are able to take a step forward with as a State. The larger rate increases are targeted toward Medicaid billable

expenses; NICU, service level agreements and new initiatives. Particularly the Certified Community Behavioral Health Care clinics and the 1915(i) State Plan Home and Community-Based Service waivers of behavioral health are getting an investment. The waiver slot increases in the Home and Community-Based waivers and the Frail Elderly are so we can reduce those waiting lists, is that correct?

MS. CROCKET:
Yes, that is correct.

MR. KRMPOTIC:
We have additional bullets, shown in Exhibit E, starting on page 4 of the handout, completing on page 5, relating to the remaining divisions of the Department of Health and Human Services, the Welfare and Supportive Services Division and the Division of Child and Family Services.

The money Committees will be deliberating on each of these recommendations and enhancements, and over the next three months they will likely change. Staff also work with the DHCFP to update the caseload projections that are included in the Governor's recommended budget to include more months of actual experience, including the most accurate and up-to-date caseload projections in the budget.

CHAIR RATTI:
Keeping an eye on caseload projections is big for the next three months. You made a comment about when the economy is doing better we would typically expect to see less caseload, less usage of some of our programs across the board, but we are not necessarily seeing that in this economy. Is that a new disconnect between economic prosperity and the amount of those needing services?

MR. KRMPOTIC:
I would say that in the Temporary Assistance for Needy Families (TANF) program you would see caseload decrease, not dramatically, but the trend has been downward; that is the Welfare Cash Assistance Program. In the Supplemental Nutrition Assistance Program (SNAP), I do not have those caseload projections with me; however, they would not necessarily impact the budget as SNAP benefits are paid directly from the federal government to the recipients. I believe those caseloads may have been leveling off. Ms. Crocket

also indicated the Medicaid caseloads have also leveled off. We are watching the caseloads in relation to the economy and there are increases in various areas and this is not always easy to explain.

CHAIR RATTI:
I am stunned each time I hear the statistic that 56 percent of the children born in Nevada are born on Medicaid. We all know the poverty level at which you have to live to qualify for Medicaid is relatively low. I believe it is helpful for us to keep in mind that during a time when we are seeing increased economic prosperity and wage growth, still in the State of Nevada, 56 percent is well over half of the children in Nevada born on Medicaid. That is a daunting number and probably an indicator of many other things.

SENATOR SPEARMAN:
I think Ms. Bierman reflected on social indicators and the connection it has, possibly as some of the wages and prosperities rise. We have looked at unaffordability of housing and we still have a growing wage gap. In my mind there are some social factors that are inextricably collocated with what we are trying to do with health care, particularly for children and our most vulnerable populations.

CHAIR RATTI:
I will open it up for public comment.

VIVIAN LEAL:
Written testimony read (Exhibit F).

MYLAN HAWKING:
Written testimony read (Exhibit G).

CHAIR RATTI:
Seeing no further comments, we are adjourned at 5:13 p.m.

RESPECTFULLY SUBMITTED:

Vickie Polzien,
Committee Secretary

APPROVED BY:

Senator Julia Ratti, Chair

DATE:

EXHIBIT SUMMARY				
Bill	**Exhibit / # of pages**		**Witness / Entity**	**Description**
	A	1		Agenda
	B	5		Attendance Roster
	C	14	Steve Fisher, Deputy Administrator, Program and Field Operations, Division of Welfare and Supportive Services, Department of Health and Human Services	Presentation on the Division of Welfare and Supportive Services
	D	15	Suzanne Biermann, Administrator, Division of Health Care Financing and Policy	Presentation on the Division of Health Care Financing and Policy
	E	5	Mark Krmpotic, Senate Fiscal Analyst, Fiscal Analysis Division, LCB	Description of Department of Health and Human Services Budgets
	F	2	Vivian Leal	Testimony
	G	2	Mylan Hawkins	Testimony