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

Eighty-First Session
February 15, 2021

The Committee on Health and Human Services was called to order by Chair Rochelle T. Nguyen at 1:33 p.m. on Monday, February 15, 2021, Online. 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/81st2021.

COMMITTEE MEMBERS PRESENT:

Assemblywoman Rochelle T. Nguyen, Chair
Assemblywoman Sarah Peters, Vice Chair
Assemblywoman Teresa Benitez-Thompson
Assemblywoman Annie Black
Assemblywoman Michelle Gorelow
Assemblyman Gregory T. Hafen II
Assemblywoman Lisa Krasner
Assemblyman Andy Matthews
Assemblyman David Orentlicher
Assemblywoman Shondra Summers-Armstrong
Assemblywoman Clara Thomas
Assemblywoman Robin L. Titus

COMMITTEE MEMBERS ABSENT:

None

GUEST LEGISLATORS PRESENT:

None

STAFF MEMBERS PRESENT:

Patrick Ashton, Committee Policy Analyst
Karly O'Krent, Committee Counsel
Abigail Lee, Committee Manager
Terry Horgan, Committee Secretary
Trinity Thom, Committee Assistant

OTHERS PRESENT:

Megan Freeman, Clinical and Policy Advisor on Children's Behavioral Health, Division of Child and Family Services, Department of Health and Human Services
Jacquelyn Kleinedler, Chair, Washoe County Children's Mental Health Consortium
Pamela Johnson, Chair, Rural Children's Mental Health Consortium
Dan Musgrove, Chair, Clark County Children's Mental Health Consortium
Suzanne Bierman, Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services
Robert Thompson, Deputy Administrator, Division of Welfare and Supportive Services, Department of Health and Human Services
Cody Phinney, Deputy Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services

Chair Nguyen:
[Roll was taken. Committee rules and protocol were explained.] Committee members, before we begin, please mute your microphone when you are not speaking to minimize any background noise. Also, please turn your camera on and leave it on during the entire committee hearing. Today, we have two overviews on Nevada's Children's Mental Health Consortia as well as an overview of Medicaid. We also have one bill hearing. We are asking that all public comment be kept to two minutes, so everyone interested in speaking can be accommodated and we can ensure we get through this agenda in a timely fashion. Additionally, we will limit the overall length of each public comment period to twenty minutes. Speakers are urged to avoid repetition of comments and may submit any additional comments in writing within 48 hours of the meeting adjournment. You may see Committee members looking at multiple screens or electronic devices. Please note that they are not trying to be disrespectful. We are all working in this virtual setting trying to refer to presentations or other written documents that we might have on various devices.

We will now move on to our first agenda item.

Megan Freeman, Clinical and Policy Advisor on Children's Behavioral Health, Division of Child and Family Services, Department of Health and Human Services:
Thank you for this opportunity to follow up on our presentation concerning children's mental health. Today, we are going to describe our children's mental health consortia in Nevada and how they shape our children's mental health system [Exhibit C]. I am going to provide a brief overview of how the consortia were established and how they function, then the chair of each consortium is going to take five minutes to describe its regional priorities and the recent impacts of the pandemic on its region.

Here [page 3] is a brief reminder of our agency vision and mission which we talked about in detail last week. As you know, Nevada has a bifurcated child welfare system. This means that in the urban counties, the county provides child welfare services, whereas in the rest of Nevada, the Division of Child and Family Services (DCFS) is responsible for child welfare

services. This structure was established by Assembly Bill 1 of the 17th Special Session in response to concerns about the previous structure of the child welfare system causing interruptions and delays in services and placements, as well as delays in permanency planning which would cause the child to remain in the child welfare system for longer than necessary, among other concerns. When this bifurcated system was established, the bill also required the establishment of independent groups that would assess and plan for the mental health needs of children in Nevada. These groups are the regional children's mental health consortia established for Clark and Washoe Counties and for rural Nevada [page 4, Exhibit C].

The consortia operate under system of core values and principles which we reviewed on Wednesday last week. They are family-driven and youth-guided, community-based, and culturally and linguistically appropriate. In 2010 and again in 2020, each consortium conducted a needs assessment in its region and submitted a ten-year strategic plan outlining the priorities for its region and the strategies that would be used to achieve its goals. Status updates are provided to the Director of the Department of Health and Human Services (DHHS) and to the Commission on Behavioral Health in odd-numbered years. In preparing the biennial budget request for the DHHS, the Director is required to consider the consortia's priorities and any request for budget allocations. The Director must report to the consortia which items from their priority list were included in the Department's request and explain the reasoning for any items that were not.

One of the features of a system of care approach is that youth and families are involved in every level of governance [page 5]. This includes the children's mental health consortia as the entities that drive the structure of our children's mental health system. Each consortium has a parent of a youth with behavioral health needs as a voting member, and typically, there are several more parents and caregivers in attendance at every meeting. There is time set aside at each meeting to hear parent concerns. In addition to individuals with much experience, each consortium consists of a representative from DCFS or from the Division of Public and Behavioral Health, depending on the region, Nevada Medicaid, the region's child welfare agency, the board of trustees of the school district, the local juvenile probation department, the local business community, a provider of mental health care, a provider of foster care, and a provider of substance use treatment. Each consortium holds a monthly public meeting, and some of the consortia have focus work groups that also meet monthly. Now I will turn it over to the Washoe County consortium to go over that region's priorities.

Jacquelyn Kleinedler, Chair, Washoe County Children's Mental Health Consortium:
In March 2020, the consortium finalized its current ten-year strategic plan as required by the *Nevada Revised Statutes* [Exhibit D]. We identified three overarching goals to guide our conversation, activities, advocacy, and our local and statewide data review strategies [page 6, Exhibit C]. In our effort to begin the path toward realization of our shared vision of equitable and compassionate mental health care for all, we established our first goal to address multiple ongoing and projected community needs in the coming years. We have started conversations around what increased access, decreased barriers, and least restrictive environments look like, and what it would take to make resources with these characteristics

available to youth. Achievement of this goal requires expansion of interrelated systems from private and public service agencies. For example, for our school district to succeed in its efforts to colocate services in their schools and increase collaboration with community partners, multiple local and state stakeholders must work together to provide the necessary resources to meet agreed-upon objectives.

As our discussion of goals took shape, we realized that primary, preventive support of families and caregivers in their naturally occurring and overlapping systems is necessary. Thus, our second goal is centered around activities that educate community stakeholders, including parents, about toxic stress, and about ways to buffer children, build resilience, and strengthen protective factors. The foundation of the second goal lies in the compelling research on adverse childhood experiences that documents future potential impacts of unmitigated toxic stress on children when they become adults and, potentially, parents themselves.

Our third goal embodies our shared value that children thrive when their family is thriving, and families thrive when their community is thriving. With this goal, we will set out to bridge systems and identify key community factors that enhance physical and emotional health, safety, and well-being. Each priority on this slide [page 7, Exhibit C] brings us a step closer to achieving all three long-term goals.

The challenges and opportunities of the COVID-19 pandemic continue to dominate our meetings, considerations, and discussions. We intentionally make space to hear the stories of members of our community and look for ways to amplify their voices in local and statewide advocacy. Through this process, we have come to understand that teachers and educators, some of the key adults who we rely upon to guide and teach our children, are themselves overwhelmed with the stressors and demands of educating during the pandemic. Many are experiencing what can be characterized as toxic stress. Thus, our attention has turned to advocacy for our educators. In late January, we penned a letter to the Superintendent of Public Instruction and the Director of the Department of Health and Human Services, requesting various forms of support, waiver, and relief. We believe that the adults who wrap love and support around our youth must also be supported.

Alongside this effort, we continue to examine ways to shore up care of children to address increased reports of anxiety and depression in our youth and to continue to fight against our ever-existing youth suicide epidemic. Though the pandemic has highlighted and intensified existing disparities in Washoe County around food, housing, and employment insecurity, it has also allowed a particularly unique opportunity for adults and young people in our community to understand the importance of mental health, and through their shared experiences, to decrease the stigma around accessing mental health care.

We hope to press on this momentum and keep the attention paid to mental health at the forefront. We hope to continue to normalize mental health needs and access to mental health care as a necessary function of overall well-being. In conclusion, I respectfully ask this

Committee to keep our children and families in mind as you continue to proceed through the 81st Session.

Pamela Johnson, Chair, Rural Children's Mental Health Consortium:
[Pamela Johnson supplied additional information not discussed Exhibit E]. I am the parent of a child with a serious emotional disturbance. He received treatment for approximately six years that was very expensive and confusing. As a nurse, I wanted to help others experiencing the same difficulty, so I decided to volunteer with the rural consortium. In the last two years, the consortium has had the highest meeting participation. We offered a virtual platform before the pandemic and we have representation from across rural Nevada.

The rural consortium has five goals I will briefly discuss [page 8, Exhibit C]. The most successful effort we have made is what we refer to as community discussions. Before the pandemic, we held two events, one in Winnemucca and one in Tonopah. We asked community participants about mental health efforts in their communities. They addressed their successes and challenges. Our goals were developed around community concerns.

Goal 1: The consortium members are participating in the DCFS Nevada System of Care Expansion Grant [Exhibit F]. The partnership is helping to improve and expand mental health services, specifically in rural communities. Some of these expansions include respite care, increased psychiatric services, and early childhood mental health services. We also work closely with peer support groups, including Youth MOVE Nevada, National Alliance on Mental Illness, and Parents Educating Parents, Inc.

Goal 2: There are limited providers in rural communities, and we facilitated partnerships such as with school social workers to promote early detection in schools. We have helped provide items to rural providers such as art supplies to carry out the goals of a youth's treatment plan.

Goal 3: We are supporting the expansion and continued funding of the rural Children's Mobile Crisis Response Team. The service is now 24/7 and is often the point of entry for youth and families. In fiscal year 2021, rural mobile crisis has had an 84.3 hospital diversion rate, meaning that 84.3 of the youth we had contact with were able to be stabilized in their home communities.

Goal 4: The consortium supported and joined the system of care in offering training to over 70 rural clinicians in becoming certified telehealth providers. We are also working on a plan to bring health equity training to rural communities.

Goal 5: The consortium has completed a memorandum of understanding with the Nevada System of Care to serve as a designated point of contact for youth, families, and other provider input. We are also working with behavioral health policy boards in the rural and frontier counties.

Regarding the impact of the pandemic, the severity of symptoms seems to have increased in 2020. Youth are reporting more lethal, violent, suicidal thoughts such as hanging, jumping into traffic, and firearms. This is possibly due to the increase in isolation, but due also to increased screen time during COVID-19 restrictions. Families are needing more intensive case management. They are struggling to provide the basic necessities such as food, clothing, and shelter, and these financial stressors are associated with COVID-19.

For youth needing to be hospitalized for safety, rural mobile crisis reports see longer wait times in emergency rooms. Perhaps one of the issues is COVID-19 testing before transporting. A rapid test may not always be available; it would sometimes take days for test results to came back so the youth could be transported.

Our state continues to see a shortage of acute psychiatric hospital beds, especially for youth between the ages of 5 and 15. Last week we had a ten-year-old who waited in the emergency room for days before a bed was available. Transportation continues to be an issue for rural families trying to access mental health services.

There are some strengths. We have collaborated with the suicide prevention and rural mobile crisis teams. They have partnered to provide rural families with gun locks, medication safes, and prescription disposal bags. Youth are getting outpatient services more quickly with the increase in telehealth providers. With more mental health services needing to be done via telehealth, Medicaid has enacted an expansion that allows mental health providers to be reimbursed for telehealth and phone-health services at the same rate as inpatient services. This expansion has helped mental health services in rural Nevada flourish during the pandemic. The consortium is hopeful this expansion will continue even after the pandemic.

It is our hope that this overview of our efforts demonstrates the importance of providing children's mental health services in all areas of the state. Rural areas are challenging, but the lessons of the community discussion events demonstrate the pride each community takes in their efforts with other stakeholders to provide children with the needed health care in their own communities.

Dan Musgrove, Chair, Clark County Children's Mental Health Consortium:
[Dan Musgrove submitted additional information not discussed Exhibit G]. I have been working on mental health issues locally and with the state Legislature for over 20 years. I would like to call your attention to this slide, which is our strategic plan's overarching goals [page 9, Exhibit C]. There are six of them. In 2001, the Legislature created the local consortiums. There is also a statewide consortium I work with that includes the members of both Washoe County and the rural counties. Much of what you have already heard from Washoe and the rurals is happening in Clark County as well, but probably to a greater degree because of our larger population.

On this slide [page 10] is the progress being made on the top four priorities of the Clark County Consortium, and particularly on Nos. 3 and 4. There is a current investigation being conducted by the Civil Rights Division of the U.S. Department of Justice dealing with

whether the State of Nevada is unnecessarily relying on institutionalization to treat children with behavioral health conditions. When you look at our Items 3 and 4, those are issues we have seen for a number of years that we believe could have helped to deal with that issue. The benefit of these consortiums lies in their membership, and it includes state agencies, county agencies, the school districts, and parents. All of them are tremendous advocates on behalf of children. But as we know, dealing with budgets and restrictions and sometimes just an inability to move the needle, sometimes things get out of hand, and I think we have an issue of over-hospitalization. Also, we do not have capacity here in the State of Nevada. We do not want children to have to access long-term treatment: we want to see wraparound care and mobile crisis teams—those are all items we hope would keep kids out of long-term residential treatment facilities. However, in Clark County, we do not have a lot of beds. The majority of beds are in Reno or out of state which does not help kids or families at all. As you can see in our Items 3 and 4, we need more service array options because we have not seen progress.

During the 2015 Session, Assembly Bill 307 of the 78th Session was passed in both houses and that attempted to address many of these issues. It was a pilot program that would have looked at the intensive care coordination services for children with behavioral health needs who reside in Clark and Washoe Counties. The funding, however, was never there, so A.B. 307 of the 78th Session never was implemented or tried. Maybe we would have seen some help in those areas. It is all about having a complete service array to help children and families.

Another thing the Chair wanted us to talk about was the impact of COVID-19. We already have a stress system that has an impact on youth and families. These children have experienced everything: fear, grief, loss of loved ones, anxiety about COVID-19, the issues of their own family finances, dealing with online learning, the isolation, the disrupted relationships. Imagine children with disabilities and mental health needs having to deal with the additional burdens of remote learning as parents and their caregivers attempt to meet their needs in a home setting, in the absence of having a lot of the necessary supports and services they normally would have.

We have received lots of testimony from parents and mental health professionals about the methods schools are using to hold kids accountable, and it is harmful to these students. We see reports that schools are being punitive in the online environment. Students are already experiencing stress and anxiety about lower or failing grades, but they are receiving warnings that they might be retained; they are getting tired of uncomfortable screen time and threats of class failure, and threats of not even graduating.

We in Clark County have recognized the extreme challenges faced by the children and we believe you have to work on strategic and sustained planning efforts to help develop more systems of care for these children especially. The effects of the pandemic will be long-lasting, especially in the absence of adequate service array, so the mental health of children and their families needs to be prioritized. And, above all else, compassion and understanding

are needed so students and families feel supported, rather than punished, for this situation that is not within their control.

Chair Nguyen:
When I asked the children's mental health consortia to present, I asked them to highlight some of the key issues and priorities for their regions. Are there any questions?

Assemblywoman Summers-Armstrong:
Ms. Johnson, could you send your rural consortium's list of goals, please?

Pamela Johnson:
Absolutely, we can do that.

Assemblywoman Summers-Armstrong:
May I have some specifics about some of what you all reported? When you are speaking of increases in suicidal thoughts, are these children who are already receiving services in your consortiums or are these new children who are now seeking help? Who is collecting and tracking this data?

Pamela Johnson:
It is all the things you have mentioned—they are new, they are children in service, and they are also family members. We get the information from suicide prevention centers and mobile crisis units.

Assemblywoman Summers-Armstrong:
Is there a standard vetting procedure for this data, this intake? I hear about the increases, but I want to be sure we are gathering this data in a manner that is quantifiable so we can refer to it with confidence. Then we would be able to find resources and act on it because we have data that has been collected in a manner that is consistent with some kind of metric that is accepted in the industry.

Jacqueline Kleinedler:
One of the problems we see is the scattered approach to data collection about the topic of increased reports of anxiety, depression, and suicidal thoughts among youth. One of the ways the consortium is addressing this is to pull from multiple data sources. We ask different agencies in our community that work directly with youth. We invite them to give presentations. For example, the Human Services Agency of Washoe County gives presentations, The Children's Cabinet gives presentations, and Quest Counseling and Consulting gives presentations. We ask the school district to attend meetings, and they share information with us.

To my knowledge, there is no standardized mechanism for collecting data. There is also a lag between when the data is collected and presented and when we are able to formulate a response to that information. Your question about data is important and an area where we

could use a lot of support in figuring out how to track, how to report, and how to respond to the trends we see.

Assemblywoman Summers-Armstrong:
I spoke with an organization not long ago about this issue. They told me they use Centers for Disease Control and Prevention (CDC) data. Have you considered adopting that metric, that process, so that each of the organizations that are reporting to your consortium are using the same standards? That way we would have something consistent to refer to. We are hearing conflicting things. I am a brand new legislator; I am learning every day; but I am hearing data from one hand and then the other on an issue that is this serious and requires action. People from different perspectives are putting forth their data and if it is not consistently collected, I do not know if that data is being presented in a manner that is for the individual or the organization's benefit, or if it is for the benefit of all. I want the data I receive to be consistent, so I know how this is affecting everyone, not an organization or institute that has a motive—except that they care about the kids. That is what I am concerned about.

Megan Freeman:
There is a survey taken here in Nevada called the "Youth Risk Behavior Survey" that is conducted using the CDC criteria. It is conducted by the University of Nevada, Reno, and in 2019 every Nevada middle and high school participated in that survey. That is an amazing source of data. I do not know whether any other places try to survey every eligible youth in a state. They will start data collection on the 2021 survey in the fall. It was scheduled for the spring, but was pushed back due to the pandemic. I would be happy to make sure you have a copy of some of the recent findings from that survey.

I also want to talk about data from different agencies, including children's mobile response. Usually that is data that is collected in the course of routine clinical care. Typically, that is collected in a different way for a different purpose than epidemiological data, like what is collected by the CDC, and so the questions will be asked in a slightly different way because it is done for a different purpose. There are complementary approaches, and we want to make sure to use both so we have a comprehensive understanding of the problem and how to address it.

Chair Nguyen:
If there is any additional information, please get that to Patrick Ashton so he can distribute it to the entire Committee.

Assemblywoman Titus:
Thank you for your presentations. I appreciate all you are doing, all you are trying to do, and the challenges ahead of you. I want to make sure all the consortiums, Washoe, rural, and Clark, are communicating with the other mental health consortiums so that we are not operating in silos. I have not heard of any joint ventures. I would like to know that you are communicating with the other behavioral health care boards, the other mental health boards, and not living in separate silos.

Dan Musgrove:
I can speak on behalf of Clark and some of the other consortiums. As you know, we are advocates for children and we have a responsibility to prepare these reports. We provide them to both the Commission on Behavioral Health as well as to Director Whitley of the DHHS. Two other members of the Clark consortium and I also serve on the Clark County Regional Behavioral Health Policy Board. A number of the other regional policy boards have ceded the work on children to the consortiums, and we report what we are doing to the regional behavioral health policy boards. That way, they are not doing the same work we are doing. We do have a statewide children's consortium where we all come together. You are absolutely right. We want to make sure there are no silos and all of us are working off the same sheet of music.

Assemblywoman Titus:
I just want to make sure there is not duplication of effort because we have such a limited supply of funds and volunteers. We need to make sure we are all working together and that it is a joint venture for all Nevadans.

On the Washoe County consortium's presentation, they mentioned toxic stress. In my experience, we are getting away from those terms and using something called ACEs—adverse childhood experiences. Have we seen a resurgence of toxic stresses with the current COVID-19 pandemic, or is that still something that has morphed into this more general term for adverse childhood experiences?

Jacquelyn Kleinedler:
Those two concepts are complementary. When we are describing toxic stress in our ten-year plan and in our forward goals, what we are talking about is the stressors children face that are chronic, ongoing, and that require buffering, resiliency factors, or protective factors to be introduced in order to prevent that toxic stress from creating long-term effects for that child.

When we talk about adverse childhood experiences, we are referring specifically to the standardized or the most normative ACE screening tool. That has been used in research as the correlative factor for ongoing problems for adults ranging from health to mental health to substance use to parenting issues.

Assemblywoman Titus:
For Committee members who may not know, the toxic stress rankings came out in around 2010 and involve positive stresses, tolerable stresses, and toxic stresses. Right now, I think

Assemblywoman Gorelow:
I have a question regarding the limited number of beds we have for the children. What happens if the children have to be hospitalized? Where do they go once we run out of those beds?

Megan Freeman:
Occasionally, they have to stay in the emergency room or a medical hospital, and sometimes they do go out of state.

Assemblywoman Gorelow:
Do you have an estimate of how many children are being sent out of state, and by out of state, are we talking about Arizona, California, or Utah, or are they going to Kansas or Texas?

Megan Freeman:
Typically, whoever places the youth tries to keep them as close to home as possible. Many youth do go to Utah and Arizona. We have that data publicly available, and we can get that to you to make sure you have all the information in detail.

Chair Nguyen:
Thank you for your presentations. If any Committee members have any follow-up questions, comments, or concerns, please follow up with our individual speakers. With that, I will move on to our next presentation—an overview of Medicaid.

Suzanne Bierman, Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services:
Thank you for the opportunity to present a very high-level overview of Nevada Medicaid and its relationship to the Division of Welfare and Supportive Services (DWSS). Today, we will be presenting an overview of Medicaid, how it works, the eligibility process, how it is delivered, a description of some of the benefits and services that are provided, how the federal and state programs work together, and how that works out for Nevadans, the state, hospitals, doctors, and others [page 2, Exhibit H].

Medicaid is the state's largest insurer and provides significant funding for hospitals, Federally Qualified Health Centers, nursing homes, and many other health care providers.

Robert Thompson, Deputy Administrator, Division of Welfare and Supportive Services, Department of Health and Human Services:
This is a joint presentation because DWSS operates the application and eligibility side of Nevada Medicaid for thousands of Nevadans a year [page 3]. Once a person is found eligible, we transmit that data, and our partners at Nevada Medicaid take over.

Suzanne Bierman:
The Division of Health Care Financing and Policy (DHCFP) is payor. We currently are serving over 810,000 Nevadans, a significant increase from pre-COVID-19 days. Medicaid is a health insurance program. It provides coverage for low-income children and adults, seniors, and people with disabilities. In challenging economic times, Medicaid provides temporary help for people who lose their jobs or become too sick to work. All Nevadans who meet eligibility requirements are guaranteed coverage under Medicaid.

Nevada Medicaid functions in many ways like commercial insurance. We enroll providers, process and pay claims, provide oversight of provider billing, and monitor utilization and management, just to name a few activities. The Division currently has a little over 300 employees.

This is a slide we often use [page 4, Exhibit H]. We think it is important and provides a high-level overview of some of the impacts of the program for Nevadans. As I mentioned, we have seen such an increase in our enrollment that Nevada Medicaid now covers one in four Nevadans. When I did this presentation two years ago, that figure was one in five.

Nevada Medicaid makes up a large percentage of the state budget at nearly 30 percent of state expenditures. We cover a lot. Sixty percent of the births in the state are covered by Medicaid, and it is also the single largest payor of nursing home care and long-term services. I want to note that Nevada Medicaid covers services that are not always covered by other commercial insurance programs or even Medicare. Back to the point about Nevada Medicaid being the primary payor for long-term care services, that is because many other commercial insurance programs and, outside of a certain day limitation, Medicare, do not reimburse for those services. So this is just another way Medicaid serves as a safety net for the state.

Our enrollment has definitely changed due to the public health emergency in the COVID-19 pandemic. I will spend some time on this slide, which is prepandemic, but it points out that Nevada has a higher rate of uninsured than the average across the United States [page 5]. While we note that this has changed during the pandemic, I think it is important to note that, historically, Nevada has had a higher rate of uninsured compared to the rest of the nation.

This slide shows our current Medicaid caseload as of January 2021 and the trends over the course of the last year [page 6]. You can see that uptick due to the COVID-19 public health emergency, and you can see that we have continued to see increases in our enrollment, but not at as such a steep rate as earlier in 2020.

These sorts of increases in the Medicaid program as the economy worsens are not surprising. Medicaid is what is called a counter-cyclical program. That means when the economy worsens, its caseload goes up. We are certainly seeing that here, and it is an expected trend in Medicaid programs as states face tough economic times.

A piece of federal legislation passed in early 2020 has some implications for our caseload, and that is the Families First Coronavirus Response Act (FFCRA), which has brought some additional federal funding to the state. However, along with that has come maintenance of effort requirements for eligibility. That requires continuous Medicaid eligibility during the time of the public health emergency. We expect to see these types of trends continue as the economy worsens. Another contributing factor to our increasing caseload is due to that requirement of the Families First Coronavirus Response Act. Almost half of our recipients are parents and children, then adults, and about 20 percent are in other eligibility categories, including individuals with disabilities.

Robert Thompson:
Information on the next few slides shows how Nevadans access Medicaid. They apply to Medicaid through processes within DWSS [page 7]. You might wonder why there are two different state divisions that administer Medicaid. It is common in other states to see one state agency that handles both the eligibility determinations for the public, and that works for the payors; however, in Nevada, DWSS does more than just determine eligibility for Medicaid. Nevada is somewhat unique in our approach to administering Medicaid. Often in states where Medicaid is a single agency, there are other, separate agencies for social services that serve similar populations. In other states, a person in need would be required to travel to one government office or agency to apply for food assistance such as Supplemental Nutrition Assistance Program (SNAP) and the Temporary Assistance for Needy Families (TANF), which is welfare, and then travel to another agency to apply for Medicaid. In the early 1990s, Nevada integrated these systems to remove the administrative burden from the public and put the burden on the state to provide one streamlined process to access multiple benefits to persons or families who need it.

In Nevada, we have organized our access so that several other major social services programs can be accessed at the same entry point. These other programs include SNAP, TANF, our energy assistance program, and our child care development program. In addition to administering these programs, the Division is the state-level child support enforcement authority, and we have provided administrative support to the homeless housing board commission. This was done in an effort to create a one-stop shop for persons in need. While many people receiving Medicaid, SNAP, and TANF can and do work, for those who are not employed, the Division administers workforce development programs to create pathways for people so they can improve their potential and contribute to their communities. For individuals on SNAP, the workforce program is called SNAP Employment and Training, or you may hear us refer to it as SNAP E&T. For individuals on TANF, the workforce development is called New Employees in Nevada, also referred to as NEON.

You might imagine that, with the additional programming features and the complexity of Medicaid's financial employment obligations, it became necessary to divide the duties for Medicaid and its two different divisions. That change was made by the Nevada Legislature in the 1990s.

There are two ways to apply for Medicaid [page 8]. The first way is through referrals, and the majority of our referrals come from Nevada Health Link, also referred to as the health exchange. Nevada Health Link reviews all marketplace applications because if anyone applying for coverage may be eligible for Medicaid or Nevada Check Up, depending on income limits, and if an applicant appears to be eligible for Medicaid, the application is referred to us for processing with no additional application required from the person applying. These applicants then receive correspondence about their case from us. The reason there is no additional and separate application required is because the Patient Protection and Affordable Care Act (ACA) required a streamlined application process for Medicaid coverage.

Another referral system is for hospitals to apply on behalf of a patient, and a hospital can get benefits through what is known as hospital presumptive eligibility. This method does require people to follow through with an additional regular application if they want to maintain their coverage. There are additional quality control measures that the welfare division puts in place to make sure those claims are being paid appropriately and are not fraudulent.

Customers can also apply directly with us. We refer to this as click-in, call-in, mail-in, or come-in. We encourage all our customers to apply online through Access Nevada. It is the most efficient system for them and us. But customers can also verbally apply over the phone to our call center. A lot of people do not know that. With Medicaid, we have an approved waiver for the person to verbally apply and verbally sign the application over the phone. There may be additional paperwork to do, but that initial application can be done verbally.

We receive applications via mail or through our drop boxes, and the final method is in person, which, obviously, was pre-COVID-19. Either in our DWSS offices or as part of growing outreach initiatives, we have set up many access points that are nontraditional such as in homeless shelters, family court, community centers, and, in some cases, even in detention centers. We plan to reactivate those, post-COVID-19.

Once DWSS has received the application for assistance, we have to evaluate the household circumstances to determine if they are eligible [page 9, Exhibit H]. Medicaid is approved at no cost, while Nevada Check Up has quarterly premiums. The primary eligibility determinations look at gross income, citizenship, household composition, residency, and, in some cases depending on the program being applied for, we have to look at their resources and assets. Those are primary eligibility reasons; there are multiple factors in eligibility. This slide also includes a snapshot of eligible income categories. Taking a household of one for example, if we were looking at a single adult without children, not pregnant, and not disabled, if that person's income level fell within 138 percent of poverty, so as long as the individual is making under $1,483 a month, that person would be eligible for Medicaid.

A second example could be a single parent with two children—so a household of three. Because there are children in the home, we would look at 205 percent of poverty, so that family could have up to $3,752 of gross monthly income and remain eligible for Medicaid assistance and that 205 percent is for Nevada Check Up. At this point, our agency would approve the case, transmit the data to Nevada Medicaid, and they would take over the case from there. They would issue the Medicaid cards and would become the enroller and the payor.

Suzanne Bierman:
As was mentioned, once DWSS has approved an application for Medicaid, DHCFP begins the Medicaid enrollment process. Nevada Medicaid uses two different service delivery models—managed care and fee-for-service [page 10]. Managed care is the primary model, covering 72 percent of the recipients in the state. It is available in the urban counties of Clark and Washoe, and to all eligibility groups except for the aged, blind, and disabled. Nevada Medicaid currently contracts with three managed care organizations (MCOs) to

provide care under this model. Individuals can choose among these three organizations as part of their eligibility application process, and the selected managed care organization will then provide a welcome packet with information about insurance coverage to the Nevada Medicaid member. In the instance that a recipient does not choose among the three MCOs, there is a process for auto-assigning those members to one of the three MCO plans.

Fee-for-service is the other service delivery model that is used by Nevada Medicaid. In this model, DHCFP performs many of the same functions and activities as a commercial insurance plan would, such as provider enrollment and claims processing. Fee-for-service covers Nevadans in rural areas and the aged, blind, and disabled population.

On this slide, we have an overview of some of the benefits and services provided by Nevada Medicaid [page 11]. This is not the full list and is just for illustrative purposes and to describe one element of the federal-state framework. The program, of course, is jointly administered between the state and the federal government, and certain services are mandatory and must be provided by all states. Other services are optional. The mandatory/optional service set up in the Medicaid program accounts for one of the reasons you see variation in Medicaid programs across states. As I said, this is not a full list, but I wanted to note this mandatory/optional distinction.

Nevada Medicaid does provide comprehensive coverage for children. The benefit for children is what we refer to as EPSDT, which is early and periodic screening, diagnostic, and treatment services. For the Medicaid expansion adults, Nevada Medicaid does cover the ten essential health benefits. Those are the same benefits that the ACA required to be covered by Nevada Health Link, so there is some continuity of coverage as individuals have changes in their income and may transition from Medicaid to exchange coverage or vice versa. In addition to those benefits, Medicaid also provides coverage for some services and benefits that other commercial insurers typically do not cover. An example of that is nonemergency medical transportation and long-term care. There is also a link here to the Centers for Medicare and Medicaid Services (CMS) website for the full listing of mandatory and optional services.

We often get questions concerning why Medicaid had not paid for a particular service, so I wanted to go over the four high-level requirements for Medicaid reimbursement [page 12]. When Medicaid pays for services for Medicaid-eligible and enrolled individuals, only providers who are enrolled in Medicaid will be reimbursed. Also, it must be a Medicaid-covered service, which goes back to that optional list. Is this a service that is included in Medicaid's benefit package? Last, is the service medically necessary?

I want to talk about the program's overall authority and how it is jointly administered between the federal and state governments [page 13, Exhibit H]. The federal agency with whom we work closely to administer this program is CMS. To qualify for federal matching funds, states must operate their Medicaid program in accordance with federal law and must file a state plan and state plan amendment with CMS. The state plan is basically the contract between the state and the federal government that describes how the state administers its

Medicaid program. It outlines the state rules and operating protocols for program administration. It is the primary authority that governs Medicaid services. However, waivers are also available to states when they need additional flexibility beyond what is available in state plan authority to design their programs.

As an example, Nevada has three program waivers which are 1915(c) home- and community-based waivers that allow Nevada to offer home- and community-based services as an alternative to care in facilities. These waivers allow the state to impose limits on program enrollment that are otherwise not allowable under state plan authority. Those are jointly operated by the Aging and Disability Services Division with oversight responsibility by DHCFP.

In addition to program waivers there are also options for research and demonstration waivers, often referred to as Section 1115 waivers. These waivers allow states to test program features that are otherwise not provided for or allowed under federal Medicaid law. These Section 1115 research and demonstration waivers must advance the objectives of the Medicaid program and are subject to stringent budget neutrality requirements that require actuarial analysis. They are generally approved for five years. If you think of this as a continuum between the standard and something that would be more of an exception to the general rule, you have state plan and then program waivers, and then there are Section 1115 research and demonstration waivers when the state needs to work with the federal government to try to design a program to meet state needs in a new and innovative way.

Here is a little information about how the program is jointly administered [page 14]. The federal government pays for the majority of the cost of the Medicaid program in Nevada. Medicaid is typically the single largest source of federal aid to the states. The federal government matches state Medicaid spending on an open-ended basis. The diagram here demonstrates how this works with the fee-for-service model where the federal government and the state pay providers. In the managed care model, the funding comes from the state and federal government to the MCOs, and those organizations then pay the providers.

This slide shows something you will hear a lot about—FMAP, which is the federal medical assistance percentage [page 15]. This is additional information on the percentage of the overall Medicaid program that is paid for with federal funds. Across all the Division's services, the federal government is paying anywhere from 64 percent up to 92 percent of the costs. You can also see on this chart that two of the rows in this table show "with FFCRA." That is the federal legislation I mentioned earlier when talking about enrollment that has some implications related to maintenance of effort, requirements for eligibility, along with the enhanced funding you can see on the slide. I will also note that this enhanced funding under the Families First Coronavirus Response Act is tied to the time frame of the public health emergency, so Nevada Medicaid is getting enhanced federal funding throughout the public health emergency. It has to be updated quarterly whether or not the public health emergency will continue to be extended. The Biden Administration recently sent a letter to governors stating that it understood the need for predictability around the timing of the public health emergency and indicating its intention of continuing the public health emergency at

least through calendar year 2021. It also indicated that it would provide states with 60 days advance notice before termination of the public health emergency.

In summary, I want to note again that during this time of a global health pandemic, Nevadans are increasingly relying on Medicaid. It is the state's health insurance program for low-income Nevadans, and it is a safety net during tough economic times. Medicaid provides comprehensive coverage and financial protection for many Nevadans. We do this through partnership with the federal government and providers, and there are a number of additional resources on our website as listed on this slide [page 17].

Chair Nguyen:
Are there questions?

Assemblywoman Gorelow:
Going back to where you list the federal poverty levels for the Medicaid program [page 9, Exhibit H], are those poverty levels across all states? How do they compare to other states?

Robert Thompson:
Those poverty levels are provided by the federal government to all states and are based on federal poverty guidelines.

Assemblywoman Gorelow:
How are those amounts determined when someone is applying for eligibility?

Robert Thompson:
It depends on the program. For most programs, we take the current circumstances and project the future circumstances and determine what their income will be on a month-to-month basis. If a person was working this month, their income was stable, everything was normal, and they were making under a certain amount, we would approve them. If they go over this amount this month, but they have verification with them showing that their income has stopped, that they have recently lost a job, then we would project that the income had stopped. We are consistently looking at what the current circumstances are and what the future projected circumstances are. That is not true in some of the medical assistance rates or the aged, blind, or disabled programs. Some of those programs use actual income on a retroactive basis.

Assemblywoman Gorelow:
How often do you redetermine someone's eligibility?

Robert Thompson:
Pre-COVID-19, we determined eligibility annually for all our programs. Customers are required to report to us if there is a change in circumstances. If their income is to go up, they are required to report that, but we do touch base and do a full analysis at least once a year.

Assemblyman Matthews:
For a few months we have been trending up. Most economic indicators are starting to move in the right direction, and we are seeing state unemployment rates go down consistently month after month. Are there any internal projections about when and where those caseload numbers may finally peak? When may we see some movement in the other direction as things start to stabilize further in our economy?

Suzanne Bierman:
It is difficult to predict, and we do work closely with DHCFP's office of analytics. They work on predicting and projecting caseloads for the department. We have met with them recently to take into account the recent news from the Biden Administration that they do plan to continue extending the public health emergency throughout the course of this calendar year. For that reason, we think that we will continue to see pretty high caseloads through 2021. Certainly, all of the maintenance of effort for eligibility protections that come along with the FFCRA will be in place through that time period. So, we plan to see our current levels stay about where they are—the same steady increase, but not back to early 2020 rates. However, we do not anticipate seeing any dramatic decreases at least through the period of the public health emergency.

Assemblywoman Titus:
You continue to show increases in Medicaid applicants and potential recipients [page 6, Exhibit H]. My question is, where is the slide that shows that you have an increase in Medicaid providers?

Cody Phinney, Deputy Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services:
We have done some research on that for our provider enrollment unit. We are seeing some increase in providers and would be happy to send that data over to you. It was actually more encouraging than I expected it to be. As you know, people are losing their employment and therefore their health insurance, but we were not expecting that more providers would be coming here. I can only attribute it to the fact that there are more people whose costs are reimbursable by our program; therefore, perhaps, providers are interested in participating more fully.

Assemblywoman Titus:
I am sure the Chair and the whole Committee would like to see that too. I have frequently referred the increase in Medicaid applicants to "giving out more bus passes but no more buses," so it is great to hear that there may be a shift in the positive direction. I am also interested in access to care and how long are people waiting to get an appointment with a provider, so if you could send the Committee that data, we would like that too because it is all relevant.

Presumptive eligibility was mentioned and all the criteria for that [page 8]. I think I heard you say that citizenship was a criteria, even including presumptive eligibility?

Robert Thompson:
When I was listing the eligibility criteria, I was meaning the five main criteria that can impact eligibility. There are two dozen Medicaid programs we trickle down through, and citizenship impacts coverage type as we move through those. I did not mean to imply that citizenship would turn on or turn off full eligibility, but it is one of those things we evaluate, and it does impact the type of cases that we can approve.

Assemblywoman Titus:
One of my biggest concerns, and I think others share this concern, are disparities in health care and especially sometimes in the prenatal realm and pregnancy issues. When you mentioned that they could sign up over the phone, I am concerned about that access and wanting to make sure that that application process is bilingual. Do they have other interpreters? I want to make sure it is available to all the folks who truly need it and are eligible.

Robert Thompson:
Previously, we utilized case managers who were bilingual, and what we found was that we could not keep the call-wait times equal if we had too many callers who spoke Spanish and not enough agents that day. We have a very efficient internal translation team that can connect our case manager with the translation team that speaks Spanish at any time with no wait, so the waits are the same. We also have a contract with an outside agency that will connect with just about any language. Sometimes that has to be scheduled ahead of time.

Assemblywoman Titus:
Excellent. That is critical; thank you for making that happen. That is very encouraging.

Chair Nguyen:
When you are looking at the eligibility rates and income, how often do participants have to have that eligibility reassessed?

Robert Thompson:
When we approve a person for Medicaid, we notify them that if their income increases above a particular amount—and we give them the amount—they are required to notify us by the fifth of the following month of that change so we can reevaluate the case. Whether we hear from a customer or not, we are required to do a full, new, reconfirming application annually to verify all income and nonincome criteria to make sure the household still meets eligibility. So, at least once a year.

Chair Nguyen:
I have another question that comes from a constituent who is a provider. I have been watching him go through the process of applying to be approved by Medicaid as a provider. How long does that process usually take?

Cody Phinney:
The process to become a provider for Medicaid in Nevada is a little bit complex because of our two different delivery models. The mechanism Nevada uses to meet the regulations that require the state to monitor our providers is we have everyone enrolled in our Nevada Medicaid Program—so every provider who wants to be reimbursed for any services through our regular program, which is our fee-for-service enrollment. If the provider also wants to participate with our MCOs, then those MCOs do an additional credentialling process. Some states do that in a centralized way where it is one process. In Nevada, we have them separated.

The enrollment into our fee-for-service program is within five days once we get all the information that is needed by our contractor who does that. The managed care applications can take a little bit longer because those are a more in-depth credentialling process to make sure that standards beyond our fee-for-service program are also met. The whole process can take some significant time. Generally, it is within 90 days, but there are times when it takes longer than that.

Chair Nguyen:
I want to thank you all for presenting today. With that, I will close today's presentation and open the hearing on Assembly Bill 26.

Assembly Bill 26: Revises provisions governing programs of energy assistance. (BDR 58-298)

Robert Thompson, Deputy Administrator, Division of Welfare and Supportive Services, Department of Health and Human Services:
Thank you for allowing us to present Assembly Bill 26 which is housekeeping language that revises provisions governing programs of energy assistance. The energy assistance program provides a supplement to assist qualifying, low-income Nevadans for the costs of home energy. Nevada's energy assistance program has two funding sources, the Low Income Home Energy Assistance Program federal block grants and state revenue generated from Nevada's Universal Energy Charge (UEC). You may have seen a small tax added to your power bill. That tax comes to us to roll out for energy assistance. The energy assistance program year begins July 1, and applications are accepted through June 30. Applications are evaluated year-round, or until funding is exhausted.

Eligible households receive an annual one-time benefit customarily paid directly to their energy providers. Currently, *Nevada Revised Statutes* (NRS) 702.275 is vague regarding the UEC, specified reporting dates of funds received, allocations, and distributions. This vague wording has caused conflicts and confusion, as these reports are utilized to distribute any remaining UEC funds. These proposed changes were recommended by the Legislative Counsel Bureau to clarify and specify the dates listed in the NRS to ensure that UEC funds are distributed as intended in regulation and to remove any room for interpretation of previous language.

Chair Nguyen:
Do Committee members have any questions? It was very straightforward, so I do not see any questions. At this point, I will open up for testimony in support, opposition, and neutral on A.B. 26. To provide testimony, you must register online with the Legislative website. Registrants will receive a phone number, meeting ID, and instructions to join the meeting. Please remember to clearly state and spell your name and limit your testimony to two minutes. Staff will be timing each speaker to ensure everyone is given a fair opportunity to speak. We will begin testimony in support of A.B. 26. [There was no one.] Is there anyone on the line in opposition to A.B. 26? [There was no one.] Is there anyone in neutral? [There was no one.] Would you like to make any closing statements, Mr. Thompson?

Robert Thompson:
Thank you for letting us present this bill today.

Chair Nguyen:
At this time, I will close the hearing on Assembly Bill 26. Is there anyone in the queue for public comment? [There was no one in the queue.] At this time, I will close public comment. Are there any comments or concerns from Committee members? [There was no response.] That concludes our meeting for today. Meeting adjourned [at 3:08 p.m.].

RESPECTFULLY SUBMITTED:

_____
Terry Horgan
Committee Secretary

APPROVED BY:

_____
Assemblywoman Rochelle T. Nguyen, Chair

DATE: _____

EXHIBITS

Exhibit A is the Agenda.

Exhibit B is the Attendance Roster.

Exhibit C is a copy of a PowerPoint presentation titled "Assembly Committee on Health and Human Services, Overview of Children's Mental Health Consortia in Nevada," dated February 15, 2021, submitted by Megan Freeman, Clinical and Policy Advisor on Children's Behavioral Health, Division of Child and Family Services, Department of Health and Human Services, and presented by Megan Freeman; Jacquelyn Kleinedler, Chair, Washoe County Children's Mental Health Consortium; Pamela Johnson, Chair, Rural Children's Mental Health Consortium; and Dan Musgrove, Chair, Clark County Children's Mental Health Consortium.

Exhibit D is a document titled "2020-2029, Washoe County Children's Mental Health Consortium, Long-Term Plan," submitted by Jacquelyn Kleinedler, Chair, Washoe County Children's Mental Health Consortium.

Exhibit E is a document titled "Rural Children's Mental Health Consortium Long-Term Strategic Plan, 2020-2029," submitted by Pamela Johnson, Chair, Rural Children's Mental Health Consortium.

Exhibit F is a document titled "State of Nevada, Department of Health and Human Services, Division of Child and Family Services, Nevada System of Care Expansion Grant, 2019-2023, Strategic Plan," prepared by the Division of Child and Family Services, Department of Health and Human Services, and submitted by Pamela Johnson, Chair, Rural Children's Mental Health Consortium.

Exhibit G is a document titled "Clark County Children's Mental Health Consortium 10-Year Strategic Plan," submitted by Dan Musgrove, Chair, Clark County Children's Mental Health Consortium.

Exhibit H is a copy of a PowerPoint presentation titled "Assembly Committee on Health and Human Services Medicaid 101," dated February 15, 2021, presented by Suzanne Bierman, Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services, and Robert Thompson, Deputy Administrator, Division of Welfare and Supportive Services, Department of Health and Human Services.