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

**Eighty-First Session**
**February 26, 2021**

The joint meeting of the Assembly Committee on Ways and Means and Senate Committee on Finance Subcommittees on Human Services was called to order by Chair Daniele Monroe-Moreno at 8:04 a.m. on Friday, February 26, 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.

## ASSEMBLY SUBCOMMITTEE MEMBERS PRESENT:

Assemblywoman Daniele Monroe-Moreno, Chair
Assemblywoman Teresa Benitez-Thompson, Vice Chair
Assemblywoman Maggie Carlton
Assemblyman Jason Frierson
Assemblyman Tom Roberts
Assemblywoman Robin L. Titus
Assemblywoman Jill Tolles
Assemblyman Howard Watts

## SENATE SUBCOMMITTEE MEMBERS PRESENT:

Senator Julia Ratti, Chair
Senator Nicole J. Cannizzaro
Senator Marilyn Dondero Loop
Senator Ben Kieckhefer
Senator Scott Hammond

## SUBCOMMITTEE MEMBERS ABSENT:

None

## GUEST LEGISLATORS PRESENT:

None

**STAFF MEMBERS PRESENT:**

Sarah Coffman, Assembly Fiscal Analyst
Alex Haartz, Principal Deputy Fiscal Analyst
Cathy Crocket, Senior Program Analyst
Mary O'Hair, Committee Manager
Anna Freeman, Committee Secretary
Bet Torres, Committee Assistant

**OTHERS PRESENT:**

Richard Whitley, Director, Department of Health and Human Services
Stacey Johnson, Deputy Director, Department of Health and Human Services
Suzanne Bierman, Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services
Melissa Laufer-Lewis, Administrative Services Officer IV, Division of Health Care Financing and Policy, Department of Health and Human Services
Phillip Burrell, Deputy Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services
Cody Phinney, Deputy Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services
DuAne Young, Deputy Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services
Sarah Lamb, Management Analyst IV, Division of Health Care Financing and Policy, Department of Health and Human Services
Steven Cohen, private citizen, Las Vegas, Nevada
Barry Gold, Director of Government Relations, AARP Nevada
Eddie Ableser, representing the Nevada Dental Association
Ted Nagel, private citizen, Douglas County, Nevada
Connie McMullen, representing the Personal Care Association of Nevada
Bill Welch, President and Chief Executive Officer, Nevada Hospital Association

**Chair Monroe-Moreno:**
[Meeting called to order. Roll was called. Rules and protocol were explained.] We will begin with Health and Human Services, Director's Office, budget account (BA) 628-3244.

**HEALTH AND HUMAN SERVICES**
**HEALTH AND HUMAN SERVICES - DIRECTOR'S OFFICE**
**HHS-DO - INDIGENT HOSPITAL CARE (628-3244)**
**BUDGET PAGE DHHS-DIRECTOR-54**

**Richard Whitley, Director, Department of Health and Human Services:**
Both budget accounts that I will be presenting today cover pass-through programs through the Division of Health Care Financing and Policy to make supplemental payments to hospitals. Budget Account 3244 [page 2, Exhibit C] is the Indigent Hospital Care program. This program was established to reimburse hospitals for care provided to uninsured persons. The Fund for Hospital Care to Indigent Persons (Fund) is administered by a Board of Trustees (the Board) appointed by the Governor. The Board includes four County Commissioners and one County Social Services Agency Director. The Counties seek reimbursement from the Fund for unpaid care provided in excess of $25,000. The Board may also transfer funds to the Division of Health Care Financing and Policy for supplemental payments to hospitals.

This budget account has two primary funding sources: ad valorem tax revenue, estimated to be approximately $17 million to $18 million each year, and unmet free care obligation, estimated to be approximately $26 million to $27 million for each year of the biennium [page 3].

Page 4 summarizes the four allowable uses of funds, as determined by the Board. Most of the funding is transferred to Medicaid to be used for supplemental payments. This is expected to be approximately $26.8 million in fiscal year (FY) 2022 and approximately $29.5 million in FY 2023 and will allow Medicaid to pay approximately $70 million in supplemental payments in FY 2022 and $81.5 million in supplemental payments in FY 2023 with the federal match.

This budget account has one significant decision unit [page 5]. Decision unit enhancement (E) 350 redirects revenue from the 1.5 cent ad valorem tax from hospital supplemental payments to the counties to offset their long-term care assessments. The Board voted for this change at their February 7, 2021 meeting. The Governor's recommended budget includes the reduction to hospital supplemental payments as follows: in FY 2022, from $101.5 million to $72 million and, in FY 2023, from $114.2 million to $81.5 million. The county match program also draws federal match, so we do not lose any federal match, it just shifts from one program to another.

**Senator Ratti:**
Is there a difference between the use of funding in the Governor's budget and what the Board has approved for the 2021-2023 biennium?

**Stacey Johnson, Deputy Director, Department of Health and Human Services:**
The only change is truing up the projections in FY 2021. We are estimating $6 million more. That will increase the carry forward to FY 2022. The primary reason for this is the ad valorem tax. We have a couple quarters of actuals now, so we are projecting approximately $2.4 million for that. We also have the actual amount of unmet free care, and that is expected to be approximately $1.6 million more. Typically, we budget approximately $1.5 million for traditional claims, but this year we did not receive any, so we have an extra $1.5 million. The Medicaid upper payment limit (UPL) offset is going to be approximately $600,000 less than originally anticipated. The Board moved at their meeting this month to split that $6 million total: 50 percent for hospital supplemental payments and 50 percent for the county offset. That is the primary difference between the Governor's recommended budget and what we see today.

**Senator Ratti:**
Will that stay static through this legislative session or will there be additional updates?

**Stacey Johnson:**
We do not anticipate any updates, but the second half of the year are still estimates. When we get actuals, that may fluctuate somewhat, at least in the ad valorem tax.

**Senator Ratti:**
Could you talk about what is driving the shift of funding in this budget from providing that nonfederal share in the Indigent Accident Fund to supporting supplemental payments for the counties?

**Richard Whitley:**
Our uninsured rate has greatly improved with the Affordable Care Act and the coverage that people have. We have less uncompensated care.

**Senator Ratti:**
You do not anticipate any access-to-care issues from this reduction, correct?

**Richard Whitley:**
I do not.

**Chair Monroe-Moreno:**
Are there any other questions from the Subcommittee on this budget? [There were none.] We will move on to budget account (BA) 101-3260.

**HEALTH AND HUMAN SERVICES**
**HEALTH AND HUMAN SERVICES - DIRECTOR'S OFFICE**
**HHS-DO - UPL HOLDING ACCOUNT (101-3260)**
**BUDGET PAGE DHHS-DIRECTOR-57**

**Richard Whitley:**
Budget account 3260 is for the UPL program [page 6]. This is a pass-through account associated with the private hospital upper payment limit. Nevada Clinical Services, a nonprofit corporation, as part of their charity care initiative, assumes some of the department's contracted services. This creates a savings for the state which can be used to transfer to Medicaid for supplemental payments. Some of the funds are reverted to the State General Fund or to the Fund for a Healthy Nevada (FHN).

Page 7 shows the total amount of contracts and the amounts that will be reverted. We are projecting 46 contracts, which is approximately $12 million for each year. The budget includes transfers to Medicaid of approximately $9 million per year and reversion to the General Fund of approximately $3.1 million. With federal match, this allows Medicaid to generate approximately $23 million in supplemental payments. There are no major decision units in this budget. I would be happy to answer any questions.

**Assemblywoman Carlton:**
We have talked about this UPL holding account for a long time. It is a little complicated how it works. The money that we save by contracting some of these services out are then put into a fund that draws down more federal dollars. What is the match currently?

**Richard Whitley:**
The match is the Federal Medical Assistance Percentage (FMAP). We use that as a state share of funds for Centers for Medicare and Medicaid Services (CMS).

**Assemblywoman Carlton:**
As these contract services go on, have we identified who the nonprofits are? I believe it is one overarching nonprofit that contracts with providers to take care of some of these issues, is that correct?

**Richard Whitley:**
That is correct. The overarching nonprofit is Nevada Clinical Services. They, in turn, work with 46 contractors providing services to Nevadans.

**Assemblywoman Carlton:**
They receive money from the state to do this. Do they also receive money from providers to do this?

**Richard Whitley:**
No, they do not receive funding from the providers to manage it.

**Senator Kieckhefer:**
The southern Nevada Mobile Outreach Safety Team (MOST) is being added as one of the services being contracted out in this way and added to this holding account. Is there a new funding mechanism allowing that that was not available in the past? Why is that happening for the first time this session?

**Richard Whitley:**
We cannot use federal funding to get a match, but we can use FHN and the General Fund. There are 46 nonprofits that ordinarily would receive general funds, but Nevada Clinical Services (NCS) is serving as the funder to those agencies. We continue to review every opportunity for additional programs that may fit the criteria. We must run those by NCS. That change with MOST, using funds from FHN, has allowed us to utilize NCS.

**Senator Kieckhefer:**
It is the shift in funding source for MOST that has allowed them to come into this account, correct?

**Richard Whitley:**
That is correct.

**Assemblywoman Titus**:
Nevada Clinical Services is the overseer and the state contracts with them. Do they determine these subcontractors?

**Richard Whitley:**
No, these are identified agencies that the state would have ordinarily contracted to provide services to Nevadans. As part of their charity care initiative, NCS is providing it. As a result, we can use that funding as a match with CMS for Medicaid.

**Assemblywoman Titus**:
Must all the subcontractors be nonprofit?

**Richard Whitley:**
Yes. That is correct; they are all nonprofit.

**Assemblywoman Titus**:
Thank you for the clarity because I always have angst over contracting with for-profit organizations on federal and state dollars. I do not see the family home nurse program. Is that going to be on a separate budget?

**Richard Whitley:**
The home visitation program is proposed to be funded with TANF [Temporary Assistance for Needy Families] funding. We cannot use federal funding to hold up as a match back to the federal government with CMS.

**Assemblywoman Titus**:
It saves the state money to do these subcontracts, correct? Does it make better sense than hiring the personnel to operate these rural clinics, hotlines, and suicide intervention programs?

**Richard Whitley:**
Yes. It leverages the resource.

**Assemblywoman Tolles**:
We are increasing utilization of contracts with the MOST program but are decreasing with mental health placements, crisis intervention, psychiatric services, and community triage. Could you walk us through what that means when we see those decreases in those specific areas?

**Richard Whitley:**
There is not a reduction in the services, but we cannot leverage federal funds for a federal match. Because of the fiscal crisis we are in, we have leveraged federal funds that have a margin to be utilized in programs where possible to maximize those federal dollars. We cannot use those federal funds as a match for CMS. We can only use the General Fund and the Fund for a Healthy Nevada. We are not reducing those services but shifting funding streams. You will hear more about how those programs are supported when the Division of Public and Behavioral Health presents its budget in the upcoming weeks. It is not a reduction in services but a change in how they are funded to leverage these dollars.

**Assemblywoman Carlton:**
Assemblywoman Titus pointed out an important point. The state usually does not subcontract services like this. We have not had good luck with that in the past. The difference here is that Nevada Clinical Services donates part of the cost of doing this as a portion of their charity care. They are not in the business of doing this. It is a service they are providing to the state.

**Richard Whitley:**
That is correct. I would add that I know of no other nonprofit organization that would function in this role. Usually those intermediate agencies are for profit.

**Assemblyman Roberts**:
You had mentioned a $3 million reversion to the General Fund. Was that money used to further leverage federal dollars? Could it be used to further leverage federal dollars?

**Richard Whitley:**
Yes, any General Fund dollars could be used, when opportunities exist, to leverage federal dollars. I assure you that we have leveraged all the dollars that are available. This reversion into the General Fund does contribute back to the General Fund budget, including Medicaid.

**Assemblyman Roberts**:
If we did not revert that $3 million, would it be eligible for federal match? What would that typically be?

**Richard Whitley:**
It would be the FMAP, the federal match for the population being served by Medicaid, so it would depend on the service. If, for example, you wanted to add a service to Medicaid that costs $3.1 million, depending on what that service was and for what population, there would be a federal match that would be assigned to that. Again, I would highlight that we are reverting it to the General Fund and programs like Medicaid are then funded through that General Fund. It does come back around and has leverage capability. The significant point is that it does not stay in my budget in a discretionary way. Based on the budgeted Medicaid, we leverage as much funding as possible, then revert what is left over to the General Fund.

**Cathy Crocket:**
Mr. Whitley characterized it correctly. The excess funding reverts to the General Fund which then goes back to Medicaid or other state agencies. Similarly, the Fund for a Healthy Nevada is reallocated in future years to other services.

**Chair Monroe-Moreno:**
Are there any other questions from the Subcommittee? [There were none.] Next, we will have the Division of Health Care Financing and Policy, Prescription Drug Rebate, budget account (BA) 3245.

**HEALTH AND HUMAN SERVICES**
**HEALTH CARE FINANCING & POLICY**
**PRESCRIPTION DRUG REBATE (101-3245)**
**BUDGET PAGE DHHS-DHCFP-8**

**Suzanne Bierman, Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services:**
I would like to acknowledge that this has been a challenging and unprecedented time for the Division of Health Care Financing and Policy (the Division) staff, managing through much uncertainty related to COVID-19 and the corresponding budgetary crisis. I want to thank the staff present and all the Division staff for their long hours and hard work.

Page 2 and 3 [Exhibit D] provide information on the Division's mission and organizational chart. Page 4 is not a part of any of our decision units, but I wanted to provide an update on

Medicaid's caseload. We will talk about our caseload projections, but I wanted to highlight the significant caseload growth that we have had over the past year. You can see approximately a 20 percent growth to the largest caseloads that we have seen for Medicaid and the Children's Health Insurance Program (CHIP) [also referred to as Nevada Check Up]. Note that this is tied to the public health emergency and some additional enhanced federal funding that the Division is receiving through the Families First Coronavirus Response Act that has maintenance of effort eligibility requirements tied to it.

Page 5 provides an overview of the Division's recommendation for this biennium. The Division's overall funding recommendation is increasing 25 percent, approximately $2.4 billion over our current biennium's legislatively approved budget. The major changes here include caseload, inflation, changes related to the rate restorations that were made during the special session, and quite a lot of changes in the "Other" category due to the transfer of drug rebates into a standalone budget account, which is the first account we will discuss today.

Budget account 3245 is a new account [page 7]. It is a transfer of funds from the Medicaid account, for increased transparency of the drug rebate program. Revenue is over $300 million. There are two decision units for this account. Decision unit enhancement (E) 900 is the transfer from our Medicaid account into this standalone budget account. Decision unit E-501 aligns revenues and expenditures with the transfer.

**Assemblyman Watts:**
What is the anticipated time frame for evaluating drug rebate revenue projection methodologies?

**Melissa Laufer-Lewis, Administrative Services Officer IV, Division of Health Care Financing and Policy, Department of Health and Human Services:**
That is something that the Division began last biennium. We are continually monitoring several different projection methodologies. However, the methodology that remains most accurate is utilizing the five-year trend for rebates that the Division receives; that is what is included in the Governor's recommended budget.

**Chair Monroe-Moreno:**
Are there any other questions from the Subcommittee? [There were none.] We will move on to our next budget.

**HEALTH AND HUMAN SERVICES**
**HEALTH CARE FINANCING AND POLICY**
**HHS-HCF&P-INTERGOVERNMENTAL TRANSFER (101-3157)**
**BUDGET PAGE DHHS-DHCFP-10**

**Suzanne Bierman:**
Budget account (BA) 3157 collects payment from counties and public entities to pay for the nonfederal share of Medicaid supplemental programs; reduces the General Fund appropriations in support of the Disproportionate Share Hospital (DSH) payments that the Division makes to hospitals; and collects payments from counties, county hospital districts, and other public entities to support the upper payment limit (UPL) program [page 9]. Decision unit enhancement (E) 350 is the Fund for Hospital Care to Indigent Persons or Indigent Accident Fund (IAF) county Medicaid match program [page 10]. This decision unit proposes to divert a 1.5 cent tax revenue from the IAF supplemental payment program to assist counties with their recently increased obligations of the Medicaid match program for long-term care.

Decision unit E-352 recommends funding managed care organizations (MCOs) through a directed payment program [page 10]. This recommendation is a companion to decision unit E-352 in the Nevada Check Up budget account and decision unit E-352 in the Medicaid budget account. In 2016, the Centers for Medicare and Medicaid Services (CMS) issued information regarding the limitation and phaseout of this prior safety net program. Hospitals were facing a ten-year phaseout effective in 2017. As a result, the Division has been working with CMS and safety net providers to provide a more sustainable supplemental payment program. I wanted to provide some context on that decision unit.

Decision unit enhancement (E) 678 is the balance forward of the state net benefit (SNB) [page 10]. This recommendation balances forward the SNB into the Title XIX Medicaid Budget Account 3243 to offset General Fund appropriations for Medicaid expenditures. It is a companion to decision unit E-678 in budget account 3243. We are recommending this decision unit as a part of the Division's recommended budget reductions. We are currently projecting a General Fund surplus and seeking your approval to balance forward the SNB for FY 2021 to be used in FY 2022.

**Senator Dondero Loop:**
Could you describe the differences between the MCO enhanced payment program and the MCO directed payment program?

**Phillip Burrell, Deputy Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services:**
The primary difference between the two is the change in federal requirements for the previous program, the MCO enhanced program, to the requirements for the MCO directed payment program. In 2016, CMS released additional guidance to give us further direction

and understanding on how to proceed with this program. Through that, we worked with University Medical Center and Clark County to reprocess for the intergovernmental transfer (IGT) program to allow us to focus on this new program for directed payments that will allow us to be more in line with quality and directing services. It will allow us to give better focus and better updates on CMS requirements.

**Senator Dondero Loop:**
Could you confirm that reductions in the state Disproportionate Share Hospital (DSH) allotments have been delayed until October 1, 2023 and that this would provide the hospitals with additional DSH payments of $130 million over the 2021-2023 biennium?

**Phillip Burrell:**
Yes. The DSH payments are being pushed back to October 1, 2023. From the end of last year, the Consolidated Appropriations Act passed by Congress included the language for making this change happen.

**Assemblywoman Titus**:
My understanding is that MCO directed payments are provided to Medicaid participants and are associated with quality measures. This budget means that you are receiving more money because of the amount of people enrolled. I would like to see how much care was given. How much have patient interactions increased? My perception is that patient contacts, patient visits, patient hospitalizations have decreased. Could you provide clarity and some numbers of direct services to which this reimbursement is tied?

**Suzanne Bierman:**
We have utilization reports that we would be happy to provide to the Subcommittee. We saw a slight decline in utilization, on a per capita basis, between 2019 and 2020. We can follow up and provide the Subcommittee with that report and, if you would like information on utilization of specific services, we have that as well.

**Assemblywoman Titus**:
I am sure every member of the Subcommittee would like to see the utilization of direct services. Included in that report, since this is all about direct services, it would be important to know the increase in enrolled providers and reimbursement turnaround time. You mentioned there is no delay in access to care, but if these facilities close because they have not received payments, that will be a huge access-to-care issue. We need more details than just the number of enrollees.

**Assemblywoman Carlton:**
Along the line of Assemblywoman Titus's questioning, that is how managed care works. It is like a safety valve for the state that we funded along the lines of a per-member, per-month formula. Sometimes the provider or the facility does better, but it does protect the state. I think what we are talking about is how managed care works, and all it would take is a

couple of million-dollar babies to blow that formula out of the water. That was a big discussion point we had years ago as we moved to managed care. I think that needs to be part of the conversation also.

**Senator Kieckhefer:**
With the extension of the DSH program, there should be some extended benefit. Our staff indicates it is approximately $24.2 million over the biennium that is currently not incorporated into your budget recommendation. Do you agree with that number?

**Melissa Laufer-Lewis:**
Our staff is currently working with the recently extended postponement of the DSH reductions. We will require a reprojection of that program as well as the associated state net benefit (SNB). We will provide those updated figures with our caseload and FMAP updates next month.

**Senator Kieckhefer:**
We also understand that you are carrying forward approximately $2.4 million of SNB from FY 2020 that was not expended that will be available to us in the first year of the biennium. Is that included in your report?

**Melissa Laufer-Lewis:**
That is correct.

**Assemblywoman Carlton:**
When we were looking at these budgets, was the money that came from the federal government to help the hospitals part of these budget decisions?

**Suzanne Bierman:**
For the Division, the primary place we saw additional funding from the federal government was from the Families First Coronavirus Response Act. That is a 6.2 percentage point enhancement of the FMAP for the program that we have been receiving since 2020. In addition to that, the federal government also administered what is called a Provider Relief Fund, which is separate from the funding that came in to the Division; we provided outreach and education to a wide range of Medicaid providers to let them know that additional funding was available. We could follow up with the amount of money that came to Nevada through the Provider Relief Fund but the primary enhancement we have seen in our budget has been the enhanced FMAP through the Families First Coronavirus Response Act.

**Chair Monroe-Moreno:**
Getting that information would be helpful. If you could provide that to the Subcommittee, I would appreciate that. Are there any other questions from the Subcommittee on this budget? [There were none.] We will move on to our next budget.

**HEALTH AND HUMAN SERVICES**
**HEALTH CARE FINANCING & POLICY**
**HHS-HCF&P - HCF&P ADMINISTRATION (101-3158)**
**BUDGET PAGE DHHS-DHCFP-14**

**Suzanne Bierman:**
Budget account 3158 is the Medicaid administration account. This is the account that funds the administrative and operational aspects of the state's Medicaid program [page 11, Exhibit D]. Page 12 shows a graph related to waiver caseloads. We will talk about this more in the Medicaid medical budget when we get to it. There are some administrative costs associated with the increase in waiver caseloads, so we did want to provide this graph here. On this chart, the green section is anticipated caseload growth and the orange section is the additional caseload growth beyond that that is being recommended to comply with the Olmstead Decision and to ensure no one is waiting more than 90 days. Again, much of this is more applicable to the medical services budget, and we will talk about it then too, but I wanted to provide context as we discuss decision units related to waiver caseloads.

Page 13 shows the decision units that we are seeking to address the administrative costs related to the increase in waiver caseloads. These are things like quality reviews, processing eligibility for waivers, and compliance monitoring and oversight. Page 14 shows recommendations related to the waitlist reduction. Again, these amounts are the Division's administrative costs related to the waivers and these increased caseloads.

Page 15 shows two of our information technology (IT) initiatives. The first is related to interoperability. Medicaid providers have many different data systems. We are recommending funding for the administrative cost so that we can ensure the data systems talk to each other. From a consumer perspective, the federal government is requiring an application programming interface (API). Decision unit maintenance (M) 517 recommends funding to comply with that federal mandate. This has value to consumers in making data more accessible. Decision unit M-518 funds contracts for continued implementation of the state's electronic visit verification system (EVV). That is also a federal requirement that we are working to implement that allows the Division to automatically verify that Nevadans are receiving services that they are entitled to, specifically long-term care home- and community-based services.

Page 16 shows additional enhancements for health information technology funding. Decision unit enhancement (E) 225 recommends funding for a contract to move health data from electronic health records into a repository for care coordination and population health management. Decision unit E-226 is for the Medicaid management information system (MMIS) modernization project, something the Subcommittee has heard much about for some time. These are long IT projects in the works and massive undertakings for the state. I am happy to report the state has had a very successful MMIS modernization, and this is just the

last remaining piece of work relating to the state's MMIS modernization project. It is expected to be done in FY 2022.

Page 17 has decision units for administrative costs. Decision unit E-227 is for a medical loss ratio review study. The Division is seeking to hire a contractor to review managed care plan submissions related to their medical loss ratio. There is a federal requirement that managed care plans spend at least 85 percent of their net revenue on medical services. The Division is looking to fund a contractor to review those submissions. It is important because, if that 85 percent threshold is not met, a remittance is due to the state. Decision unit E-228 is seeking funding for a separate contract for a pharmacy benefits manager. Currently those services are provided through an overarching contract the state has with a fiscal intermediary, Gainwell Technologies. This decision unit will allow the Division to have more control over the benefits by having a direct contract with a pharmacy benefits manager. Decision unit E-229 is for Transformed Medicaid Statistical Information System (T-MSIS) data quality. This is a data initiative that has been important to our federal partners, the Centers for Medicare and Medicaid Services (CMS). It has been one of their long-standing priorities. It is also important for the Division because it allows us to improve our data quality, have more efficiency in our reporting, and have data that helps inform policy decision. We are seeking one new position to ensure that we continue meeting all our T-MSIS requirements and to improve our data quality going forward.

On page 18, we have the decision units related to the certified community behavioral health centers (CCBHCs). Decision unit E-350 recommends contracts to assist with rate setting of quality incentive payments. This will help us improve our quality and ensure that the rates that are funding these critical CCBHCs are adequate and on the mark. Decision unit E-351 seeks to fund actuary costs to restore the 6 percent rate reduction that was made during the 31st Special Session, to have some actuarial help with the managed care component of our program, and to have the technical support needed to update our cost to manage care.

Decision unit E-800 funds revenue adjustments associated with transfers to multiple state agencies such as the Division of Welfare and Supportive Services, which does Medicaid determinations [page 19]. It funds the work to ensure we have appropriate cost allocation plans in place.

Page 20 outlines the position changes that the Division is seeking during this biennium. Decision unit E-400 and decision unit E-901 are clinical transfers from the Division of Public and Behavioral Health (DPBH) to the Division of Health Care Financing and Policy (DHCFP). Decision unit E-900 relates to quality assurance efforts, transferring three positions from DHCFP to the Aging and Disability Services Division (ADSD).

Page 21 provides a high-level summary of the positions just mentioned. The overall effect is that the Division would have one less position due to those transfers.

**Senator Ratti:**
My questions are focused on the medical and professional personnel. I am grateful that we have found a sustainable funding source for the dental health officer, but I want to dig into any consequences, intentional or unintentional, that may come from moving them. Is there any effect on the oral health program by shifting this out of DPBH and into DHCFP?

**Cody Phinney, Deputy Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services:**
The work of Medicaid is largely improving access and improving the quality of health care as we moved into the Affordable Care Act era. In order to have that work for us, it is helpful for us to have expertise like a dental health officer who can inform our policy and ensure that the policy we have is clinically sound, make sure that the partnerships that we are building, for example with our managed care partners and our dental benefits administrators, are directed at the most effective clinical services. We have had success in aligning the benefits that we currently provide with updated clinical practice in working with the dental health officer currently. The benefit of that, as we serve the 25 percent of the population that is with us now, spreads to the rest of the community. Because we have an improved network for Medicaid, it improves the network more broadly. From my perspective, having worked on both sides, we are seeing a lot of overall benefit that will continue from what the oral health program had started years ago. It will continue through and benefit, largely the Medicaid population, but also the entire network of access to oral health care in the community.

**Senator Ratti:**
This position has been appointed in the past by DPBH; I think that might be in the statute. Do you see a need to shift that to DHCFP?

**Cody Phinney:**
It was our intent, in not asking for a change in that statute, to collaborate with our sister agency, DPBH. We perceive that can be done successfully whether that appointment is made by DHCFP or DPBH. We are happy to work with that if this body sees fit.

**Senator Ratti:**
I have similar questions on the Medicaid pharmacy advisor position. How does that help Medicaid?

**DuAne Young, Deputy Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services:**
In the same vein as Ms. Phinney pointed out, the pharmacy advisor, managing 25 percent of the population, is going to help drive the initiatives for where the Department wants to go in managing the price of high cost drugs. It will manage both the oversight of the fee-for-service program and managed care. We will be talking later about our pharmacy benefits manager (PBM) contract and moving to a combined contract with the AIDS Drug Assistance Program for DPBH. That will not only increase the state's buying power but use

Medicaid as the force and the core to drive the mission throughout the state. I look at other state models, such as Ohio, where they have a combined PBM for many of the state's functions and move that beyond the state. Moving the pharmacy advisor position to Medicaid just makes sense because that is where you will have the most powerful drive for the combined purchasing power of the drugs where the state's roadmap wants to be.

**Senator Ratti:**
How would the Medicaid pharmacy advisor complement the Drug Use Review (DUR) Board and the Silver State Scripts Board (SSSB)?

**DuAne Young:**
The senior pharmacy advisor serves as the clinical portion for the staff of the DHCFP. The DUR Board sets the utilization criteria for FDA [Food and Drug Administration] approved drugs and the SSSB considers which drugs are preferred. Senate Bill (S.B.) 378 of the 80th Session (2019) allowed us to discuss cost for the first time but that is secondary to the clinical criteria. Even though our fiscal agent and their sub vendor have clinical expertise, the PBM is there to guide the clinical direction of the policy and to help the deputy administrator and the chief over pharmacy make the best decisions and ensure that the clinical criteria is at its highest standard; not only taking cost into consideration, but doing what is right for all Nevadans.

**Senator Ratti:**
With the state dental health officer position, or any of these clinical positions, are we confident that it is a 75 percent/25 percent match as opposed to 50/50?

**Suzanne Bierman:**
We confirmed with both the Attorney General's Office and CMS. There is a federal regulation that allows the Division to collect clinical match which is paid at a 75 percent federally funded rate for both the dental position and the pharmacist position.

**Assemblywoman Carlton:**
My questions focus on the pharmacy benefits manager contract. At the Interim Finance Committee (IFC) meeting in December, we had conversation about a carveout and the effect that that would have on the State General Fund. I would like to have something on the record about the agency's intent on the carveout prescription drug benefit for managed care because it will have a significant effect on the General Fund. Could you address that?

**Suzanne Bierman:**
We heard the message of this body loud and clear. We are working to analyze and evaluate the overall effect of that policy option. We are collecting more information, and we realize that it has significant effects outside of the Division on the state's budget in terms of premium tax revenue. We commit that we will not be moving forward in the short term without additional consultation and analysis.

**Assemblywoman Carlton:**
What is the time frame on that? I am a little concerned about the word "consultation." Something could happen, and we may not be in control of the horizontal. Could you elaborate on the time frame and consultation part?

**Suzanne Bierman:**
Previously, there had been language to carve that benefit out of managed care earlier in this next request for proposal. We put the brakes on that. Again, we are not moving forward with the carveout at this time. I will need to follow up with the Fiscal Analysis Division regarding the timeline for that additional analysis. It is not our intent to move forward with that at this time. We want to provide more information related to the effect that will have on the state premium tax and other factors.

**Assemblywoman Carlton:**
When you say, "at this time," do you mean this biennium? Is the goal to not have a discussion through this biennium then possibly discuss it as a change in the next Legislative session?

**Suzanne Bierman:**
Yes, that is our goal. There is no intention to move forward this biennium with projects not included in our budget recommendation.

**Assemblywoman Carlton:**
Medicaid does have the opportunity to change how they do things through CMS. I think this is a big policy shift that could have some implications of which everyone should be aware. It may be the right decision in the future, but we need to have that data in order to make that decision.

**Senator Hammond:**
Ms. Bierman, we have had much discussion about PBMs and the transmission of drugs from manufacturer to seller to buyer and the importance of transparency. In how you envision the PBM working for the state, do you see them being asked to adhere to all the transparency regulations and laws that we have passed? How transparent will their work be to the general public?

**Suzanne Bierman:**
What is being proposed here is a direct contract for the Medicaid fee-for-service population. With a PBM, we think there will be more transparency because currently those services are handled through a larger contract that then subcontracts to a PBM. By moving to a direct contract, the Division will have greater transparency into the workings of the PBM. The goal is to have increased transparency, and we would certainly require any of our vendors to comply with state and federal laws.

**Assemblyman Watts:**
Have any programmatic efficiencies been identified since the electronic visit verification (EVV) system was deployed?

**DuAne Young:**
We have not identified any systemic changes from this policy. Nevada was a leader and one of the first states to implement EVV, so my team has presented at several national conferences. What we found was general trepidation; many people believe the government is tracking them and some facilities are willing to give variances to longtime staff and provider caregivers who are hesitant about using technology. We have slowly been troubleshooting and diving into these cases. Once we have more systemic data, we will be able to look at policy changes. I think the intent of EVV is to prove that the services are happening. We are not seeing large amounts of fraud currently. There are no major active investigations in those. This is what we want to see from this program; that people are getting the services they say they are getting.

**Assemblyman Watts:**
I also have a question about decision unit M-517. What is the status of implementing the application programming interfaces and associated technologies?

**Phillip Burrell:**
We are in the implementation process now. We expect to go live on or before July 1, 2021.

**Assemblyman Watts:**
I also have a question about decision unit E-225, the health information exchange (HIE). Would the agency move forward with these projects if donations are not obtained to meet the nonfederal share of the costs?

**Phillip Burrell:**
This decision unit relates to our HIE program, HealtHIE Nevada. As part of the program, it is required that we receive CMS approval. It is currently in review. If the approval process is unsuccessful, we will not move forward.

**Assemblyman Watts:**
I would like some clarification regarding the modernization project in decision unit E-226. Is the project expected to be completed in FY 2022?

**Phillip Burrell:**
Yes. The modernization work with the systems enhancement is complete. This is the final contract for this project. We are wrapping up the postimplementation step of project management.

**Assemblywoman Benitez-Thompson:**
My question is with the new data quality position—the business process analyst. It looks like we are currently in compliance with federal requirements, but we also have data quality issues waiting to be resolved. Would the addition of this position ensure that those data quality issues are completely resolved? Could you give us some insight into what those quality issues are? Are they reconciliations in billing or coding in MCOs versus fee-for-service?

**Phillip Burrell:**
Yes, the position is part of the team effort to improve data quality in T-MSIS. We are continuing to work with updated information for CMS federal guidance on support for data quality and the submission of federal reporting. This position will be part of the data team that manages the reports and requests that are needed to fulfill for our federal requirements. [unintelligible]

**Assemblywoman Benitez-Thompson:**
We are having some sound issues. We may need some written follow-up on what the data quality issues are because we rely on utilization, claims, and expenditure data to make decisions. It would be helpful for the Subcommittee to understand what those quality issues are and what the projected outcomes are of adding the business process analyst position.

**Assemblywoman Carlton:**
The Medicaid management information system was initiated in 2007. It has not been easy, but we have seen other technology requests not go this well. It looks like it will be done in 2022, which is fantastic. I want to congratulate you for getting this huge project completed.

**Chair Monroe-Moreno:**
Are there any questions from the Subcommittee on this budget? [There were none.] We will proceed to our next budget.

**HEALTH AND HUMAN SERVICES**
**HEALTH CARE FINANCING & POLICY**
**HHS-HCF&P - INCREASED QUALITY OF NURSING CARE (101-3160)**
**BUDGET PAGE DHHS-DHCFP-29**

**Suzanne Bierman:**
Budget account 3160 is the increased quality of nursing care, also known as the skilled nursing facility provider fee [page 22, Exhibit D]. The goal is to improve long-term nursing care. This is funded by provider fee revenue. We have decision unit maintenance (M) 150 but there are no caseload changes.

**Senator Dondero Loop:**
What is causing the accumulation of the excess reserves in this budget?

**Sarah Lamb, Management Analyst IV, Division of Health Care Financing and Policy, Department of Health and Human Services:**
There is not generally a reserve, but this account continues to collect funds throughout the year, which can cross over fiscal years. Once we have finished collecting funds, we reconcile if any providers have overpaid any taxes. The program continues to operate throughout the year so there is not really a reserve in the traditional sense.

**Senator Dondero Loop:**
Is there a way to maintain that budget at that $900,000 level or below?

**Sarah Lamb:**
We do not allow the reserve to exceed $900,000 but it is unlikely there will ever be $900,000 because we continue to collect throughout the year. As we have enough in the account to transfer the nonfederal share of payments to BA 3243, we do that. There is no point during the year, due to the nature of the program, that it will ever be at $900,000.

**Chair Monroe-Moreno:**
Are there any questions from the Subcommittee on this budget? [There were none.] We will proceed to our next budget.

**HEALTH AND HUMAN SERVICES**
**HEALTH CARE FINANCING & POLICY**
**HHS-HCF&P - NEVADA CHECK UP PROGRAM (101-3178)**
**BUDGET PAGE DHHS-DHCFP-31**

**Suzanne Bierman:**
Budget account 3178 is the Nevada Check Up program, which is what we call the Children's Health Insurance Program (CHIP) here in the state of Nevada [page 23]. It provides coverage for thousands of low-income, uninsured children who are not eligible for Medicaid. This program covers a slightly higher income population than Medicaid. Decision unit maintenance (M) 101 is related to agency-specific inflation. We are recommending projected rate increases for capitated payments and fee-for-service expenditures for a variety of services such as federally qualified health centers, rural health centers, pharmacy, and hospice [page 24, Exhibit D].

Page 25 is our first caseload slide. These projections were done by the Office of Analytics. It provides caseload forecasts using data from the Division of Welfare and Supportive Services. The projections are expected to be updated in March. In an uncertain and volatile time, it has been hard to predict caseloads, but this is what was put together at the end of last year. We use this information to determine the cost per eligible recipient and then budget medical expenditures.

Page 26 outlines the caseload increases in decision unit M-200 and decision unit M-201. It provides more detail for projected caseload for CHIP in these two decision units.

You will see companions to the decision units on page 27 in the Medicaid budget as well. Decision unit enhancement (E) 351 funds a restoration of the 6 percent rate reductions approved in the 31st Special Session this past summer. The Governor's recommended budget proposes restoring those rates effective October 1, 2021. Decision unit E-352 funds the managed care organization (MCO) directed payment program. This is a companion to decision unit E-352 in the IGT program in BA 3157.

Page 28 outlines two of the proposed service eliminations as part of the reductions due to the continued economic crisis. These are basic skills training services and psychosocial rehabilitation services. Decision units E-682 and E-684 outline those recommendations. Page 29 shows the third service we propose to eliminate: biofeedback and neurotherapy services [decision unit E-685].

**Senator Dondero Loop:**
Could you tell us why the caseload is lower than the legislatively approved budget from the 2019-2021 biennium?

**Suzanne Bierman:**
That is a trend that we expect to see as the economy worsens, given the differences in income thresholds for Medicaid and CHIP. It is not uncommon, when the economy gets worse, to transition from Check Up coverage to Medicaid coverage, which results in a reduction in use of the Check Up program and an increase in the Medicaid program. That may be one of the factors that explains that.

**Senator Dondero Loop:**
The Check Up caseload is projected to be 9.1 percent in 2022 but only projected to increase by 2.5 percent in 2023. Could you walk us through that?

**Suzanne Bierman:**
The assumption that goes into the caseload projections has a lot to do with timing in when the economy may improve. Again, as the economy gets better, you see increased usage in Check Up and when the economy is worse you see more usage in Medicaid. I think that reflects projected economic trends.

**Assemblywoman Tolles**:
These service eliminations are based on reduced utilization in 2020. Do we need to project that there may be a higher demand for these services in FY 2022 and FY 2023? Could you speak more about how we are using 2020 figures to estimate in FY 2022 and FY 2023?

**DuAne Young:**
With behavioral health services, there is a difference in that we did not see a sharp utilization decrease in overall behavioral health services. We saw a stabilization due to telehealth. Telehealth has always been promoted for behavioral health services. The federal allowance allowed for telephone services. Our policy has always allowed for telephone services for case management and crisis intervention incidents. We did see an increase in crisis intervention incidents as well as outpatient counseling. Outpatient counseling is what we wanted to see an increase in because this means clients are accessing clinically licensed staff for those higher-level interventions. In looking at 2019 data, these services have never been allowed by telehealth because they are not appropriate interventions for telehealth. As we migrated to those higher-level clinical services and have backfilled the needs in other areas, it is a proposed elimination of these services due to lower utilization, because they were unavailable by telehealth. Those higher-level services were available by telehealth and we did see people accessing them.

**Assemblywoman Tolles**:
By eliminating these three programs, we will save $233,632 from the State General Fund. We will also be leaving $679,046 of federal matching funds on the table. We are eliminating three programs that cannot be replaced by telehealth and have a direct effect on citizens, and we are leaving a significant amount of federal funding on the table for $233,632 worth of savings if we approve the elimination of these programs, is that correct?

**Suzanne Bierman:**
The proposal is to eliminate these three services. I defer to my team on the math. I ask that Mr. Young speak about some of the other services that we think can appropriately address the same and similar needs for the patients that we serve.

**DuAne Young:**
I want to clarify that those numbers are based on the Check Up budget. These decision units are mirrored in the Medicaid budget as well. You will see a greater savings to the General Fund. It is correct that we will forfeit that federal match but, as with Medicaid, as other services grow and we see funds shift to more outpatient, intensive outpatient, partial hospitalization, and crisis-utilized services, which are services provided by licensed and credentialed professionals, we will draw down more of the federal match dollars for those services.

**Assemblywoman Tolles**:
I hope we are able to get more people out of the Medicaid income bracket and into higher income brackets so they will not need so much assistance there but get them closer to being back up on their feet.

**Assemblywoman Titus**:
I would like to circle back on what Assemblywoman Tolles asked you about what you have chosen to eliminate. From my medical standpoint, there is no way telehealth can substitute basic skills training, psychosocial rehabilitation, or biofeedback and neurotherapy. There were 37 people in one program, 154 people in the second program, and 85 people in the third program. Are you telling us that you have decided to replace these services with telehealth? Also, you are using 2020 data of access to services; what was the data from 2019 and 2018? We know that 2020 was a point in time when people could not access this care. Our state is lacking in mental health programs. I do not see the justification in eliminating these programs. Could you clarify?

**DuAne Young:**
First, let me clarify that these services were not replaced by a phone call. These services have not been traditionally allowed, nor have they been allowed during the pandemic, via telehealth. The only exception was psychosocial rehabilitation for those under 18 in our specialized foster care population because any clinical intervention is better than no clinical intervention. There was higher utilization in 2019 when we were not in a pandemic and people were meeting face to face. Where we saw higher utilization in telehealth in 2020 was in our clinical counseling services. One of the exceptions we made as part of our 1135 waiver was to allow for group counseling via Zoom. This is not something we would have done before, but there were clinical articles that supported any evidence-based clinical intervention is better than no intervention at all. The complexities of the pandemic have affected higher acuity levels and more individuals in crisis. That meant more people reporting to our emergency rooms and more individuals needing access to higher levels of care.
The elimination of these programs is to push people into those higher levels of care by licensed clinical professionals. We want to see an increase in outpatient counseling. We want to see greater utilization of our certified community behavioral healthcare centers (CCBHCs). We want to see more utilization of these services. There are some individuals for which recovery may not always be possible. They need long-term maintenance services for behavioral health.

We have two alternative programs. We will discuss one later for children in specialized foster care, and as the 1959 state plan option that replaces these services, there is a policy not allowing these services to happen at the same time as those services in specialized foster care because those children have a specific need to work with the agency and the foster parents to stabilize those children through crisis stabilization and intensive in-home services. The other need is for those adults and children who are not able to recover, that cycle in and out of our hospitals and need support. These are rehabilitative mental health services that were never meant to be long-term services. We have long-term services and support.

What we have found with personal care services and home health services is that the populations of those that are seriously and consistently mentally ill have increased in

accessing those services. We find that those long-term services and support are more appropriate for helping this population with activities of daily living and their instrumental activities of daily living; helping them with that instead of putting them in rehabilitative behavioral health services where immediate recovery is not the goal, but stabilization and daily growth is.

**Assemblywoman Titus**:
You made a statement that you are eliminating these programs so that you can push people into higher level of care. I have some concerns. I would like to see outcome data. Do all these people need a higher level and extended care? That could be a discussion we have offline. I would still like to see the numbers of utilization from 2019. All the comments that you have made are in good faith to help people, but I would like to see your strategic plan in how these dots all fit together. I trust that you want to improve outcomes, but I want to see how that fits. Perhaps you could follow up with some information on the breakdown of where you are substituting or eliminating programs but extending other programs. I think it would help us to see what this truly is, not just this microvision of what we see. I appreciate what you are doing and that you are trying to improve the mental health of Nevadans, but I would like to see the other programs you are offering that will replace these eliminated programs.

**Senator Ratti:**
I think it is important to have context with CHIP and Medicaid. I want to acknowledge that there was a long list of Medicaid optional services that were on the table for budget cuts during the special session this past summer. As you were trying to address your budget cuts that were recommended by the Governor during this challenging financial time, you have worked to not have dental, prosthetics, or other significant Medicaid and CHIP funded programs on this list. There is good news in this budget that we do not see because it is not listed as a cut. I believe these are the optional Medicaid services that you are recommending as a cut to help meet the financial gap we have and because there are other places within the overall system of care that these needs can be addressed. Do we actively help the people currently in these programs navigate into new programs so that we know that they do not get lost?

**DuAne Young:**
Managed care has always had a warm handoff in transition to services. You will typically see lower utilization of these services in managed care than in fee-for-service. In fee-for-service, what we tried to do through the Governor's budget last year, through the expansion of the CCBHCs, is give people a behavioral health home, the same as they would with Federally Qualified Health Centers on the medical side: a place that looks to the care of the whole person, and links to that medical component as well. Yes, the transition is to link these recipients into those other services where they can receive services from clinical professionals but also link them into other services, like personal care services, if there is a need for assistance with those activities for daily living.

**Senator Ratti:**
If we were not in a challenging budget situation, would you be eliminating these services to achieve that strategic direction?

**DuAne Young:**
I think if we were not in a challenging budget situation, you would see a limiting and curtailing. You may remember, in the 2017 session, we brought in a budget initiative to lower this rate and cut some of the hours for some of these services. At that time, we had the impetus to have a replacement of services for children within specialized foster care. The Division has accomplished that. Regardless of the budget, you would have seen an impetus to curtail and shape some of these programs. I think that has been accelerated by the pandemic and the state's current budget situation. We do think this is ultimately the direction in which the state needs to move.

**Senator Ratti:**
In crisis stabilization specifically, but more broadly over the behavioral health system of care, we are doing a lot of work to ensure we are utilizing the workforce of peers. These are services that are often provided by peers. You referenced elevating people to a higher level of care with a licensed clinical professional. That is, of course, wonderful when available. We also recognize peers as a valuable workforce. If we eliminate this, are there other places where we are making sure peers are still part of the solution, knowing that we have a shortage of licensed clinical professionals and knowing that research is showing that peers can be an asset to a behavioral health journey?

**DuAne Young:**
While peers can perform these codes and enroll in Medicaid, there is a separate set of CPT [Current Procedural Terminology] codes that are utilized for peer support services as well as having peer support services integrated into our CCBHCs. We see the role of peers increasing. There is a certification process with regulations involved that support the clinical efficacy of the model of peers. The Division sees that. When we are speaking of certified professionals, we are speaking of peers as well. That is a model that continues to gain support and will not be affected as they have separate billing codes.

I want to clarify that these services can still be provided in the context of an outpatient therapy appointment or group therapy appointment. If a clinician finds it clinically appropriate to have a client do basic skills training, they can do that as part of the individualized treatment plan and perform those services within the context of psychotherapy. We are not eliminating or limiting the peer's or the clinical professional's ability to work with the client—we are just altering the service mechanism in which they occur.

**Chair Monroe-Moreno:**
Are there any other questions from the Subcommittee on this budget? [There were none.] We will move to our last budget of the day.

**HEALTH AND HUMAN SERVICES**
**HEALTH CARE FINANCING & POLICY**
**HHS-HCF&P - NEVADA MEDICAID, TITLE XIX (101-3243)**
**BUDGET PAGE DHHS-DHCFP-36**

**Suzanne Bierman:**
This is the account from which we pay for medical services for the Medicaid program, which covers one in four Nevadans [page 30, Exhibit D]. Decision unit maintenance (M) 101 is similar to what you saw in the CHIP account but is specific to the Medicaid program for agency-specific inflation for the same range of services we discussed in the Check Up budget [page 31].

These decision units fund caseload changes in the Medicaid program [page 33]. The projections are volatile and have some implications related to the public health emergency and how long it lasts. This caseload projection on page 32 was done in 2020 and will be updated in March. Decision unit M-200 and decision unit M-201 are the increases and decreases for caseload in this budget account.

Page 34 shows the medical costs associated with the increases in the three home- and community-based services waiver caseloads. Decision unit M-202 is for the increase in the waiver caseload for individuals with intellectual disabilities and related conditions. Decision unit M-203 is for the increase in the frail elderly waiver caseload. Decision unit M-204 is the recommended increase in waiver caseload for persons with physical disabilities.

The decision units on page 35 essentially represent the green and orange pieces of the bar graph on page 12. One [green] is related to general waiver caseload growth and the other [orange] is the number of additional waiver spots needed to eliminate the waitlist and fully comply with the Olmstead provisions. Decision unit E-350 [page 36] proposes to divert the 1.5 cent tax revenue from the Indigent Accident Fund Supplemental Payment Program to help counties with their obligations for the long-term care county match program increase. Decision unit E-351 is the Medicaid medical companion that restores the provider rate reductions that were required to address the economic crisis.

Page 37 has three decision units. Decision unit E-352 funds the managed care organization (MCO) directed payment program. Decision unit E-676 is a risk mitigation measure we are taking to address some of the financial uncertainty related to managed care payments. As this Subcommittee has noted before, the MCOs are paid a monthly capitated fee. This is to fund an estimated recoupment from the MCOs based on a mitigation strategy

called a risk corridor. Decision unit E-678 is the balancing forward of the state net benefit from the intergovernmental transfer budget account, BA 3157.

Page 38 shows the companions that we talked about with the Check Up program. This is the proposed elimination of three services: basic skills training, psychosocial rehabilitation services, and biofeedback and neurotherapy services. I would also note that behavioral health case management services are included here. In addition to these proposed eliminations, we also have some proposed reductions [page 39]. Decision unit E-686 proposes reducing the monthly capitated rate that the Division pays to the nonemergency medical transportation vendor. Decision unit E-687 proposes policy changes to the personal care program.

Page 40 has three additional decision units. Decision unit E-689 and decision unit E-690 will address the budget shortfall by changing the timing of certain payments to the current fiscal year rather than in the 2021-2023 biennium. Decision unit E-500 relates to the transfer of drug rebates to our newest budget account that we discussed earlier [BA 3245].

**Assemblywoman Carlton:**
I want to have a conversation about caseload. I think it is important for us to analyze what is going on here. In the special session, I made statements about what I was afraid was going to happen. I know there was discussion about thinking that Medicaid dollars would come in higher than proposed but if you look in this Medicaid program in this interim, we are recommending $10 billion over the 2021-2023 biennium. That is huge. This is health care for families in Nevada that we want to have health care. If you project out the caseload growth, we could end up with almost 850,000 people on Medicaid. I believe the driver of this is the current economic situation on the strip. We have a large group of Nevada families who had excellent health care coverage for a long time. Because of the pandemic, that coverage will possibly be going away. Without COBRA [Consolidated Omnibus Budget Reconciliation Act] coverage in the future to help these families hold on to their current health care, they will naturally transition to Medicaid. Then the state will be picking up the cost. I would like to have a conversation about these projections on health care and what investigations have been done to figure out who will be accessing it and how they will be able to process all these people. Managing this amount of people without planning for it two years in advance could be difficult. If you could elaborate on that it would be helpful.

**Suzanne Bierman:**
We have talked previously about the enhanced FMAP that the Division is currently receiving from the Families First Coronavirus Response Act, which has been incredibly helpful. That funding is tied to the declaration of public health emergency, but it also has conditions related to maintenance of effort (MOE) for eligibility. There are three exceptions for which the Division of Welfare and Supportive Services can close Medicaid cases during this time: if someone dies, moves out of state, or makes an affirmative ask that their case be closed. Otherwise, anyone who was on during any part of the public health emergency will continue

getting coverage through Medicaid and CHIP for the duration of the public health emergency.

The timing of the public health emergency is critical. One thing that state Medicaid directors and other Medicaid stakeholders pushed for was additional clarity from the Biden administration regarding how long the public health emergency might last to help provide some information regarding caseload and FMAP levels and try to provide some certainty in state budgets. There are a lot of factors at play. One is how quickly the economy recovers. There were employers that had employer-sponsored insurance in place that are not able to provide it for the long run. We are aware and have been working with some of the large employers to which you referred. That certainly is a component of what is driving our caseload increase but as long as the state of emergency is in place, we can expect to see those maintenance of effort requirements remain in place. We should be prepared for our caseload to remain high for the duration of the public health emergency.

**Assemblywoman Carlton:**
There was a list shared about which employers have a large percentage of their employees on Medicaid. I will not call out any employer, but there is one employer who was not affected by the pandemic and has done well, yet they have many employees on Medicaid. They have, in essence, cost-shifted their employees over to the state, which I believe is a concern that this legislature needs to discuss. We are supposed to be here for those families who are affected, not to be a subsidy for a private business that does not want to step up to the plate and be a good corporate citizen.

**Senator Kieckhefer:**
As we see these dramatic increases in caseloads, we should remember that Nevada has more restrictive eligibility requirements than many states. That number could be a lot higher. With the MOE requirement and the continued eligibility requirement, does that mean if someone becomes reemployed and becomes insured through a private employer that they continue as a part of our caseload?

**Suzanne Bierman:**
It is my understanding that that could happen, and Medicaid could be the secondary payer. It is also my understanding, during this period, that the reasons for which the Division of Welfare and Supportive Services may close cases is limited to those three factors I mentioned earlier: death, moving out of the state, or asking for their case to be closed. I think that the situation you are outlining is possible, and Medicaid would become the payer of last resort in that instance.

**Senator Kieckhefer:**
What percentage of this growth that we have seen is in the MCOs, where we are paying a capitated rate regardless of care?

**Cody Phinney:**
I do not know the exact percentage, but I would say it is the majority of this population. Seventy-five percent of our overall program is in our managed care delivery model. Many of the people who are affected, as Assemblywoman Carlton described, by losing their job, particularly in Clark County, would go into our managed care program because of the way we have that designed. We would make a capitated payment for those recipients. We do have requirements that the managed care program connect with those recipients who make certain efforts to make those connections, assign them to a primary care provider, and do a health risk assessment. There are some safeguards in place to make sure people are being connected to health services and we are not just paying a capitated rate and not getting anything. Beyond that, our decision unit is looking to get some help and making sure that we are appropriately assessing that medical loss ratio. We also have the risk corridor in place to make sure that our managed care partners are not walking away with unreasonable amounts of profit.

**Senator Kieckhefer:**
It is great that we are the payer of last resort, but if we are paying a capitated rate then we still have expenses for people who may be covered elsewhere. We are budgeting caseload based on this letter. We are saying that they are going to extend the public health emergency so we are going to have this MOE, so this is our caseload projection yet we are not using this letter to justify an enhanced FMAP for the rest of the calendar year. Why are we using it for caseload but not FMAP?

**Suzanne Bierman:**
I think current caseload projections predated the letter so they are not reflected in the caseloads today but will be in the March update.

**Senator Kieckhefer:**
In the March update, our numbers will go up because we will require MOE extensions for two more calendar quarters, is that correct?

**Suzanne Bierman:**
Yes. According to the letter from the Biden administration, they have indicated that they plan to continue the public health emergency throughout calendar year 2021. That would include the first two quarters of the 2021-2023 biennium. Again, I think as long as the public health emergency is in place, we can safely assume that we are going to continue to see this high level of caseload and, along with that, the enhanced federal matching rate as well.

**Senator Kieckhefer:**
When we update this in March with the additional caseload, are you also going to update the enhanced FMAP for those two quarters? My understanding is we estimate that at approximately $30 million per quarter. That would be approximately $60 million in the plus for us, correct?

**Suzanne Bierman:**
Yes. We have seen fluctuation in actual quarters of public health emergency enhanced FMAP, but that is the ballpark figure we use to estimate.

**Senator Ratti:**
I would like to go back to the service eliminations. Just like the CHIP budget, this includes basic skills training again; it includes psychosocial rehabilitation again; and it includes biofeedback and neurotherapy again. I think we have had good answers on those. What is new here is behavioral health case management. In my experience, you can never have enough case managers. Is this a strategic shift to a different type of service or is this a cut? How are we going to be okay without behavioral health case management?

**DuAne Young:**
The Division is expanding the array of case management services. This is a unit of behavioral health case management for nonseriously mentally ill and nonseriously emotionally disturbed children that can be handled by community providers. It was titrated on their ability to receive hours, minimizing each month. Where we are expanding case management services are those being formed by government entities. We have our other eight existing target case groups which include seriously mentally ill and seriously emotionally disturbed, as well as bringing on new targeted case groups that focus on pregnant women and homelessness that will be administered by the counties. What this is doing is shifting to continued state funding. You will see that represented in the ADSD, DCFS, and DPBH budgets, providing those services and contracting with community provider partners to perform those services as an extension of their agency. You will also see a migration of these services to be performed by the counties. The counties then form public and private partnerships with agencies so those dollars are not coming from the state but rather from the counties; they pay the match and draw down the federal share to help fund some more ambitious projects such as housing initiatives and overall connections to social determinants of health.

**Senator Ratti:**
In doing that, do we shift the focus from higher functioning individuals to those who are in the seriously mentally ill or seriously socially emotionally disturbed category, or do you think we will still be providing care for this level?

**DuAne Young:**
I believe through the creation of some of these other target groups, if they are homeless but not seriously mentally ill, as we talked about the tenancy support that is still coming online from last session—the pregnant women, those who are criminally justice involved, those that have a need that is comorbid with a medical condition—we will be getting those individuals. If they just need a little extra help or navigation, that is where we rely on the care management programs of our managed care or our district offices and our hardworking staff

throughout the state who provide navigational assistance to providers for those that are within fee-for-service.

**Senator Ratti:**
I believe you and your team are being as thoughtful as you can about this, but I still have significant questions. I think we need a clear explanation of how it has been done in the past, how it will be done in the future, where we may see a new category of people getting needed services, and how we will ensure that the people who have traditionally been served in these services will not fall through the cracks. Perhaps that is something that we can ask you to bring back. My other question is on public engagement, in terms of conversations with providers and families who make these decisions. How is that being handled?

**DuAne Young:**
Typically, we do public engagement sessions through public workshops. We are also required by CMS to have public hearing on the matter on which comments can be put on the record. We have not begun any typical engagement sessions when we put something through our budget because, as it goes through the Governor's budget process, it is confidential. Once it is released to the public, we work one-on-one with stakeholders to answer public questions, but we really let things play out in this public process and then, once our budget is finalized, we will start the public engagement sessions through workshops.

**Senator Ratti:**
On the topic of elimination or significant cuts, could you touch on the personal care services? It looks like the policy decision is that if you are an in-home caregiver, your household will no longer be eligible for personal care services, is that correct?

**DuAne Young:**
You would still be eligible for those services. What you would lose is the assistance with instrumental activities of daily living. Those are activities that help a person to live independently. Obviously, the person is not living independently, so they would lose some time particularly in housekeeping, assistance with chores, and some food preparation. They would lose some time in that area because they do have a live-in caregiver. They would still be eligible for assistance with activities of daily living. We know that any change in Medicaid services obviously changes services that affect the budget of ADSD so opening up those waiver slots is really moving those higher acuity level people who are meant for more long-term services and support into the waiver services as well as getting the waiver-like services from ADSD. You will see some discussion on that next week but, yes, you will see fewer hours administered to people who have in-home caregivers but not a total embargo on them receiving assistance.

**Senator Ratti:**
Again, I want to log some concerns on this account. We have had many conversations about how we can support caregivers to keep people in their homes. If we can keep people in their

homes, it is significantly less expensive than if they go into a care facility. I hear what you are saying that the activities of daily living are intended to be the piece that keeps the individual supported, but the help with housekeeping and shopping are things that keep the caregiver supported. It sounds like, for a whole group of households, a support around which they have organized their lives will no longer be there. I would like to continue that conversation because I think caregivers generally have been put through the wringer. We have data that shows caregivers generally have shorter lifespans. Caregivers during the pandemic have been isolated and under duress. To have things start to turn around and then say we are going to take away this extra support feels justified possibly from a budget standpoint, but for the real humans who are involved, I am going to be struggling with that one.

**Senator Dondero Loop:**
Did the agency experience a decrease in provider enrollment for any provider types or note access to care issues for Medicaid participants following the announcement of the 6 percent rate reduction that we approved during the 31st Special Session?

**Cody Phinney:**
The agency has not seen a decrease in overall provider enrollment or identified a noticeable decrease in any individual provider type since the announcement of those cuts; we monitor that. Overall, over the last three years, our provider enrollment is trending slightly upward. We were able to implement some flexibility with the public health emergency to ensure providers could enroll as easily as possible so that may have had an effect. We were notified by three providers that they would not continue and would not see new Medicaid patients as a result. Out of the 35,000 providers we have, there were about three groups. We have had some discussion with other states about their experience, and that is consistent with their experience. While that is a concern, they do not see large decreases in that enrollment. We also have not been able to identify specific access-to-care issues but we continue to monitor that and continue to work with CMS to improve our mechanisms and our comparison studies; the way in which we are doing that monitoring.

**Senator Dondero Loop:**
Does the agency anticipate that the access to care for Medicaid participants will improve following the recommended rate restoration?

**Cody Phinney:**
We would hope so. I know the providers would be more satisfied with our program with those restorations and more likely to continue to see Medicaid patients—and a higher percentage of Medicaid patients—as they had been in the past. Again, we have not been able to identify specific decreases except for a small number of providers.

**Assemblyman Watts:**
My first question is around utilizing projected savings from 2021 from the General Fund. Given the caseload trends, how confident are you that the budget surplus will materialize as it is projected?

**Suzanne Bierman:**
We have acknowledged that this is a volatile time and there are several unpredictable factors in the Medicaid realm. However, regarding this current year's surplus, we feel relatively confident given the fact that it is in the next couple of months. It is harder to project out over the course of two years than just for the next four months. We feel reasonably certain that, for the next four months, the public health emergency will be in place and we will be receiving the enhanced FMAP. At this point, we acknowledge that there are some variables that make budgeting for Medicaid difficult but, for the remainder of this fiscal year, we feel reasonably certain about those projections.

**Assemblyman Watts:**
One of the things included in the 31st Special Session was the implementation of the specialty pharmacy network, which is anticipated to create some General Fund savings. Could you give us an update on the status of that?

**DuAne Young:**
Some of you may have been contacted by constituents. We held a public engagement workshop to talk about the classes of drugs that we were moving to specialty pharmacy. The 1915(b) waiver was submitted to CMS, however, it also requires a state plan amendment that would not be submitted until after our public hearing. The 1915(b) waiver asked us to address how we would incorporate the hemophilia treatment center. It is a requirement through CMS that each state have one. They expressed some concerns during that public workshop, so we are actively working with them as well as our subcontractor through our fiscal agent, to come to an agreement to launch specialty pharmacy. We are on track to launch prior to the beginning of the new state fiscal year so that those savings can materialize in the next biennium.

**Assemblywoman Tolles**:
You mentioned the hearings. Do you also have a process by which you engage the various policy boards in determining these proposed cuts and changes?

**DuAne Young:**
My staff and I attend all the regional behavioral health policy boards as well as all the boards and commissions through each of our sister agencies, addressing each of the areas of care within Medicaid policy. One of the strategies we talked about before was cutting these services so that we could use the savings to increase the rates for other services, to attract more psychiatrists, psychologists, and licensed clinicians. Unfortunately, because of the pandemic and our current budget situation, we were not able to bring that proposal to the

table. However, they are not foreign to these discussions of the efficacy of these services and the need to move people into services that are done by certified peers, someone who has an accountability board representing them and other arrays of service.

**Assemblywoman Benitez-Thompson:**
Regarding the proposed increase for the home- and community-based waiver slots, I support getting more dollars, and I understand it is important to stay in compliance with the Olmstead Act, ensuring that people are not waiting more than 90 days, and that we have a way for people not to be institutionalized, to waive them out of institutions and into the community with those supports. As we move through this process of having a deeper conversation about the staffing side, I think we could hypothetically fund slots to the nth degree, but without the appropriate staffing on the ADSD side, I do not think we will have the resources to actually enroll and move through. Just like we are seeing right now, where we have a waitlist despite having approved slots, speaks to that. Is it likely the waiver caseload increases will materialize this biennium?

**DuAne Young:**
You will hear some of that conversation next week in the ADSD budget presentation. I think it is no mystery that the state is often challenged in recruiting and hiring social workers; that is always at the forefront of the Department's mind, making sure we can recruit and retain staff, but I also want to commend staff for the ways in which they have worked with the current waiver recipients and organized the processes. I know that Administrator Schmidt and her staff will speak to that more directly.

**Assemblywoman Benitez-Thompson:**
I know we could be on this conversation for a while, but what I was hoping to do was just put on the record, if you could, the timeline. We have submitted the state plan with the recommendation of 6 percent cuts from the special session, and those cuts have not yet been implemented. We know that there is a lag between our legislative budget and how we fund, appropriate, and unappropriate dollars and how those dollars flow out to providers and hit services in the real world. Could you give us a timeline of when you think the state plan for those cuts might be actualized, when providers might start to see the reduced rates paid to them, and when that might actually hit the ground?

**Suzanne Bierman:**
The process is lengthy. We started implementing the cuts from the special session in the summer, and we are still in the process of doing that. A handful of the state plan amendments related to those rate reductions have been approved and are being implemented, but it is the minority. The vast majority are still pending CMS approval. There is a process with CMS that they call stopping the clock, where it slows down the normal process when they have requests for additional information (RAI). We have seen a couple of those periods because CMS takes issues of access to care very seriously. The Division has been working with others in the state. The Public Employees' Benefits Program has been helpful in

providing us with data and information that has been requested by CMS related to their rates and access to care in the state generally. I want to highlight that our state plan amendments did seek retroactive approval, and we have preserved that date of August 15, 2020, so we are still working through the process and we will implement as soon as we get CMS approval. I want to highlight that, with the Governor's recommended budget, that will be restored by October 1, 2021. The rate reductions will be in place August 15, 2020 to October 1, 2021, but we are still working through the process.

**Phillip Burrell:**
We are meeting with CMS weekly, working through the RAI process and getting them the additional information that they need. When you are pursuing a cut of more than 3.9 percent, it is federally required to go through an Access Monitoring Review Plan, where we will look into the details to ensure access to care to ensure that we are not hurting the state in any way. We will continue to meet with CMS and move through the process as quickly as possible.

**Cody Phinney:**
In the interest of full transparency, I want to make sure everyone is clear that the payment for our managed care plans has been implemented because we had to do new capitation rates with the 6 percent reduction. Those have been implemented, and some of the managed care plans have passed those along to their providers through their processing mechanisms. The CMS is aware of that; everyone is aware that we are still working through the approval process and that is something that is allowed. Should something change, then those rates would be reprocessed.

**Assemblywoman Benitez-Thompson:**
I think that is helpful to know, that a piece of the Medicaid universe is already accounting for those cuts. The MCOs are probably the bigger piece, so it is mostly the fee-for-service people who are still going along with business as usual. I think this is important for us as legislators, as we have a conversation about restoring cuts, to keep in mind that, in the real world, those cuts will be implemented. For community providers, those providers who are not surrounded by lobbyists and lawyers, there may be some confusion about how this is coming about because there is such a long lag in how these decisions are implemented.

**Assemblywoman Carlton:**
Senator Kieckhefer mentioned it earlier, but I am still a bit confused about what a two-sided risk corridor is. What is the problem that we are trying to fix? Are we just doing this for one year or do we plan to do this again?

**Cody Phinney:**
A two-sided risk corridor is a strategy that is used in prospective payment models like managed care, that allows us to address situations which are difficult to predict. During the pandemic, it has been difficult for the actuaries to make their usual firm predictions about how much things are going to cost. We did not know how much COVID-19 care would cost.

We did not know how much the utilization reductions from shutdowns would affect things. The Centers for Medicare and Medicaid Services (CMS) allowed the implementation of a risk corridor in 2020 that allows the state and the plans to share that unpredictable risk. If the capitation payments were too high, the state would get some of that money back. If they are too low, the state would owe for some of those services. Usually these arrangements must be done in advance; it would have to be set up and contracted before the beginning of 2020. Because of the unusual circumstance this year, CMS allowed us to set this up during that period. We intend to continue for 2021 because the situation continues. Risk corridors can be used for different mechanisms, but this one is more broad than those we have used in the past and is particularly aimed at this unusual period to try to ensure that we are good partners and that our partners are good partners to us as well.

**Assemblywoman Carlton:**
A statement was made that some of the responsibilities for next fiscal year are going to be paid out of this fiscal year. I am not sure if we have done that before. How can we pay for what is going to happen next year out of this year?

**Melissa Laufer-Lewis:**
In terms of decision unit E-690, this is related to the noncapitation payments that were proposed to be delayed. These are truly FY 2022 expenses. However, due to the budget reduction, we have proposed to process those payments in FY 2022. Given the Division's cash balance, we can make those payments within this fiscal year and are seeking approval to do so.

**Chair Monroe-Moreno:**
Are there any questions from the Subcommittee? [There were none.] I would like to ask about our specialized foster care services. If a state plan amendment is approved by CMS, does the agency anticipate additional General Fund costs beyond the amount that was recommended in The Executive Budget?

**DuAne Young:**
We will see an offset to the expenditures to which Assemblywoman Titus alluded. Because basic skills training (BST) and psychosocial rehabilitation (PSR) were used for that population in specialized foster care, we made special allowances during the pandemic for PSR to occur via telehealth for children 18 and under. However, there was a dip in services in BST and then an increase because we were not able to bring the specialized foster care system in time. That state plan was approved already. We have providers going through the enrollment and training processes. We put together a joint training with the Division of Child and Family Services. In the meantime, we have waived the titration down of those rehabilitative mental health services to support specialized foster care providers as they move over. Once they enroll, they have 60 days to move over and out of the other provider type, with all providers expected to be moved out in June. We will see some late expenditures in the current fiscal year for specialized foster care, but we will not see a skyrocketing effect.

In FY 2022, we will see some expenditures for those services but knowing that part of those expenditures, because of the case management and assessment component, will be done by the state and county, will be contained within those budgets and what we will only be seeing is the service provision. So, I believe we will see a decrease in overall expenditures because we are shifting from that rehabilitative mental health model to the specialized foster care model.

**Chair Monroe-Moreno:**
Are there any other questions from the Subcommittee? [There were none.] I will open the meeting for public comment.

**Steven Cohen, private citizen, Las Vegas, Nevada:**
For the sake of time, I will submit my remarks in writing [Exhibit E].

**Barry Gold, Director of Government Relations, AARP Nevada:**
First, I would like to thank Senator Ratti for her absolutely great recognition of the critical role that family caregivers do. We rely on the 350,000 of them that take care of older adults. I would also like to thank Assemblywoman Benitez-Thompson for talking about the staffing need to go ahead with caseload growth and the waiting list growth for the waiver programs. I am really wanting to talk to you about the waiver programs. For those of you who have heard me talk about this before, those waiver programs keep people living independently, where they want to be, with dignity. Plus, they are the fiscally prudent thing to do. I have talked to you before about that. The Nevada Legislature has been wonderful about funding caseload growth for these waiver programs, but we really need to talk about the waiting lists as well. Decision unit M-203 and decision unit M-511 address caseload growth and the waiting list for the frail elderly waiver. It is so important that we fund those because we need to keep people out of those nursing homes. As you heard before, it is much more expensive. It costs about $14,000 to keep someone in the waiver program as opposed to approximately $80,000 to put them in a nursing home and we pay for all that.

What I want to mention is, at the Commission on Aging meeting last time, I asked how many people dropped off the waiting list in this biennium and for what reasons. I was appalled to find out that approximately 200 people have dropped off the waiting list because they either died or they went into a nursing home. If they went into a nursing home, that is terrible because it is costing us more money, and they did not want to go into a nursing home. They would much prefer to stay living more independently in the community. If they died, that is just a human tragedy, something that possibly we could have prevented if we had found space to put them in these waiver programs. It is important that we fund these different programs and, in terms of the waiting list, I know the Olmstead Act talks about 90 days, but I will tell you that there are often people on the waiting list more than 90 days. Some people are on the waiting list more than 180 days so I am urging the Legislature, on behalf of the 345,000 AARP members, to fund not just caseload growth for the waiver programs but to eliminate the waiting list. Thank you for listening to me today.

**Eddie Ableser, representing the Nevada Dental Association:**
I would like to thank the Chair and the Subcommittee for hearing the Division of Health Care Financing and Policy's budget this morning. I am calling on behalf of the Nevada Dental Association. We are excited about the actions taken by DPBH and state Medicaid in the move to colocate the oral health program in both DPBH and DHCFP. We believe this will help sustain the program and draw more policy initiatives ubiquitously throughout the state to help oral health and the underserved populations. We would like to show our support for decision unit E-400 that you heard today as well as DPBH budget account 3220 for chronic disease and the oral health program. Thank you for your attention and support for this initiative.

**Ted Nagel, private citizen, Douglas County, Nevada:**
Thank you for listening to my comments. There were several places during the morning that I would have loved to ask some questions. I am going to put them together in an email and add them in. I would like to address the fact that, number one, I do hope they reestablish the 6 percent cut that was put in during the special session but even over and above that, they need more money because the caregivers are being paid so little money that people like me, who live in Douglas County in rural Nevada, are so shorthanded in caregivers because they can make more money going and working for a fast food joint. I was forced to put myself into a care facility for, what I thought was going to be a month or two, but ended being 30 months because there were no caregivers available to meet my need and my wife is physically disabled and is not able to provide my care. Although at this moment, while I am waiting to get back on the list, she is doing what she can, requiring me to stay in bed every other day or so to be able to get me out of the care facility because the COVID-19 had attacked that care facility so greatly that there were 10 people in one testing, in my hall, that were COVID-19 positive. I said that I had to get out of there no matter what it took so my wife stepped up, which she is more than happy to do, but her physical abilities are certainly giving her a lot of pain and grief and everything like that because she has constant pain and having to take care of me, who is quadriplegic, is difficult at best.

My interest is in raising the amount of money that people are paid to be caregivers so that we can get some quality people and not people just looking for a paycheck and taking. We have had things stolen in the past because the pay was so little that they had to supplement their pay in some way. They have stolen money. They have stolen drugs. It is because private paid caregivers are being paid $20 to $25 per hour where the best caregivers under the waiver program only get about $10.50 per hour. I, myself, would probably flip burgers before doing this kind of work for that kind of pay. I hope that you understand that we are a lot of people. I hope my other cohort who was on the line earlier will make a statement. We are in a Nevada disability community group and we are adamant about getting better pay for our caregivers. Thank you for your time.

**Connie McMullen, representing the Personal Care Association of Nevada:**
Thank you for your approval and support of restoring the 6 percent reduction and increasing the waiver slots for the frail elderly, intellectual disabilities, and people with disabilities. Our concern is with decision unit E-687, which is in personal care policy reductions that will be limited, modified, or reduced and that the instrumental activities of daily living will be limited to only those with the greatest need when a caregiver is present. As you know, we are in a caregiver crisis. There are shortages, as Mr. Nagel said. We are really challenged to go out to rural areas and the caregivers often work for more than one personal care agency because they have to meet some of the overtime rules. We also thank you for clarification on the payments when the rates were reduced and when they will be restored. I have been asking and asking because the bottom line is always how much money they are going to get for caring for people, and I just could not seem to get that answer. I am amazed at some of the knowledge and the questions that you have asked. I thank you so much for giving me this time on behalf of the Personal Care Association.

**Bill Welch, President and Chief Executive Officer, Nevada Hospital Association:**
Thank you, madam Chair. I appreciate the opportunity to speak to the Subcommittee. First, I would like to acknowledge the questions that were asked today were right on cue. There were a number of things that were presented today that we would like to respond to, as well as a number of questions. Two minutes certainly will not allow that so we will be preparing comments to be submitted to you in writing. This is clearly a very important issue to the medical community, particularly the hospital community, so we will be submitting questions and comments to you in the next couple of days. I appreciate the opportunity to provide that input to you. I would also like to acknowledge that we have been working with the state Medicaid division. We very much appreciate your openness over the last six months, working with us, and we look forward to continuing to work with them in this realm. I appreciate your time today.

**Chair Monroe-Moreno:**
Seeing that there are no other individuals wishing to make public comment, we are adjourned [at 11:10 a.m.].

RESPECTFULLY SUBMITTED:

Anna Freeman
Committee Secretary

APPROVED BY:

Assemblywoman Daniele Monroe-Moreno, Chair

DATE: _____

Senator Julia Ratti, Chair

DATE: _____

## EXHIBITS

Exhibit A is the Agenda.

Exhibit B is the Attendance Roster.

Exhibit C is a slideshow presentation entitled "Department of Health and Human Services, FY 2022-23 Budget Presentation, Director's Office" submitted by Richard Whitley, Director, Department of Health and Human Services.

Exhibit D is a slideshow presentation entitled "Department of Health and Human Services, FY 2022-23 Budget Presentation, Division of Health Care Financing and Policy" submitted by Suzanne Bierman, Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services.

Exhibit E is an email submitted by Steven Cohen for public comment, per Chair Monroe-Moreno's request.

Exhibit F is an email submitted by Stephanie Schoen for public comment, per Chair Monroe-Moreno's request.

Exhibit G is an email submitted by Sarah Adler for public comment, per Chair Monroe-Moreno's request.

Exhibit H is an email submitted by Robin Reedy for public comment, per Chair Monroe-Moreno's request.