MINUTES OF THE MEETING OF THE
INTERIM FINANCE COMMITTEE
LEGISLATIVE COUNSEL BUREAU
Carson City, Nevada

Chairman Morse Arberry Jr. called a special meeting of the Interim Finance Committee (IFC) to order on Thursday, June 3, 2004, at 9:10 a.m. in Room 4401 of the Grant Sawyer Office Building, Las Vegas, Nevada, and via simultaneous videoconference, at the University and Community College System of Nevada, Chancellor's Office, Reno, Nevada and Room 2135 of the Legislative Building, Carson City, Nevada. Exhibit A is the Agenda. Exhibit B is the Guest List. All exhibits are available and on file at the Fiscal Analysis Division of the Legislative Counsel Bureau.

COMMITTEE MEMBERS PRESENT:

Assemblyman Morse Arberry Jr., Chairman
Senator William J. Raggio, Chairman
Senator Mark Amodei, Sitting as an Alternate for Senator Tiffany
Senator Barbara Cegavske
Senator Bob Coffin
Senator Bernice Mathews
Senator Raymond D. Rawson
Senator Dean A. Rhoads
Assemblyman Walter Andonov
Assemblyman Bob Beers
Assemblywoman Vonne Chowning
Assemblywoman Dawn Gibbons
Assemblywoman Christina R. Giunchigliani
Assemblyman David Goldwater
Assemblywoman Sheila Leslie
Assemblyman John Marvel
Assemblywoman Kathryn (Kathy) McClain
Assemblyman David Parks
Assemblyman Richard Perkins

COMMITTEE MEMBERS EXCUSED:

Senator Sandra Tiffany
Assemblyman Lynn Hettrick

LEGISLATIVE COUNSEL BUREAU STAFF:

Lorne Malkiewich, Director, Legislative Counsel Bureau
Brenda J. Erdoes, Legislative Counsel
Scott G. Wasserman, Chief Deputy Legislative Counsel
Mark W. Stevens, Fiscal Analyst, Assembly

Steven J. Abba, Principal Deputy Fiscal Analyst
Gary Ghiggeri, Fiscal Analyst, Senate
Connie Davis, Secretary

A. ROLL CALL.

Lorne Malkiewich, Director, Legislative Counsel Bureau (LCB), called the roll and advised the chairman a quorum of each house was present.

B. APPROVAL OF GIFTS, GRANTS, WORK PROGRAM REVISIONS, ALLOCATION OF BLOCK GRANT FUNDS AND POSITION CHANGES in accordance with Chapter 353, *Nevada Revised Statutes.

1. **Department of Human Resources – Health Care Financing and Policy – Intergovernmental Transfer Program – FY 04 –** Addition of $3,692,245.00 in Receipts from Local Governments to reflect the increase in the disproportionate share hospital payments as a result of the new Medicare Prescription drug bill. These additional funds will be used to offset the increased costs in the Medicaid budget. Requires Interim Finance approval since the amount added to the Transfer to Medicaid Program category exceeds $50,000.00.

2. **Department of Human Resources – Health Care Financing and Policy – Medicaid – FY 04 –** Addition of $20,000,000.00 in General Fund Appropriation (***transferred from FY 2005)***, $37,834,644.00 in Federal Title XIX Funds and $3,692,245.00 in Funds transferred from the Intergovernmental Transfer Account to cover a projected shortfall as a result of reduced federal funding created by the non-certification of the Medicaid Management Information System by the Center for Medicare and Medicaid Services, outstanding balance of cash payments for unprocessed provider claims, and previous system practices relating to cash receipts and manual check issuance. Requires Interim Finance approval pursuant to AB 553, Chapter 327, Section 32 of the 2003 Legislature.

3. **Department of Human Resources – Health Care Financing and Policy – Medicaid – FY 05 –** Deletion of $20,000,000.00 in General Fund Appropriation and $24,375,416.00 in Federal Title XIX Funds to cover a projected shortfall in fiscal year 2004 as a result of reduced federal funding created by the non-certification of the Medicaid Management Information System by the Center for Medicare and Medicaid Services, outstanding balance of cash payments for unprocessed provider claims, and previous system practices relating to cash receipts and manual check issuance. Requires Interim Finance approval pursuant to AB 553, Chapter 327, Section 32 of the 2003 Legislature.

Charles Duarte, Administrator, Division of Health Care Financing and Policy identified himself for the record and introduced Debbra J. King, Administrative Services Officer.

On behalf of division staff, recipients and providers, Mr. Duarte expressed thanks to the committee for agreeing to hold a special meeting to consider the division's request for additional funding.

Mr. Duarte asked for the committee's approval to move $20 million in General Fund appropriation from fiscal year 2005 to fiscal year 2004 to cover the immediate cash needs in the Nevada Medicaid program, Budget Account 3243.

Mr. Duarte explained that the urgency of the request resulted from several Medicaid Management Information System (MMIS) issues as well as cash payments to Medicaid providers for unprocessed claims, and other cash-related problems.

Mr. Duarte said the division made cash payments of over $280 million to medical providers for unprocessed claims, and as of May 28, 2004, the balance of payments to providers was approximately $85 million. Mr. Duarte explained that the division would be unable to pay claims after June 4, 2004 unless additional budget authority was approved. Mr. Duarte said the accounting process in the MMIS reduced the cash payments account after budget authority for payment was checked. However, an outstanding cash payment balance, which used up budget authority, would disallow the continued payment of claims.

Mr. Duarte discussed several critical issues that contributed to the need to request IFC approval for additional funding:

- Cash payments for unprocessed claims -- As of May 28, 2004, an outstanding negative cash balance of $85 million existed. It was not currently known how much of the negative balance would be offset by the implementation of MMIS "fixes" and adjudicated claims that would reduce the need for cash.

- Enhanced federal funding for MMIS operations -- It was assumed during the division's budget preparation the MMIS would be federally certified in April 2004 which would have allowed the division to receive 75 percent Federal Financial Participation (FFP) as opposed to the base administrative FFP rate of 50 percent. Certification was currently anticipated in fiscal year 2005.

- Old fiscal agent practices and the previous Legacy computer system's functionality related to cash payments and manually written checks

also contributed to cash shortages. The issues were not previously a problem as the practice was ongoing and the differences were offset in the following year's collections. However, implementation of the MMIS brought the issues to light.

Mr. Duarte also reported that the projected budget authority shortage was a second issue that contributed to the need for additional funding. Mr. Duarte indicated the budget authority shortage was created as a result of increases in high-cost Medicaid caseloads over levels approved in the budget, despite decreases in overall caseload relative to the budget.

Mr. Duarte reviewed a Medicaid Payment Projection model (Exhibit C) of caseload differences between division projections and those approved by the Legislature. Identified by major aid expenditure categories, Mr. Duarte noted the largest variance in caseload occurred in the category identified as Medical Assistance for Aged, Blind and Disabled (MAABD). However, Mr. Duarte pointed out again that overall caseloads were below what was approved by the Legislature. Additionally, Mr. Duarte pointed out that for budget purposes, low-income Medicare beneficiaries, a group of Medicare beneficiaries who had a Medicaid benefit for whom a part of their insurance was paid, were not included because their numbers skewed the averages for cost per eligible clients.

Additionally, Mr. Duarte said the cost per eligible was over the budgeted amount in all but two of the caseload groupings, leading to an overall increase in cost per eligible. Mr. Duarte explained that a monthly cost per eligible for total Medicaid for fiscal year 2004 was projected at $395.30 while the legislatively approved cost per eligible for total Medicaid for fiscal year 2004 was $375.12. The legislatively approved cost per eligible excluded certain budget reduction items that were added later in the budget process.

Mr. Duarte reiterated that the increase in cost for Medical Assistance for Aged, Blind and Disabled caseloads as well as the increase in cost per eligible in most aid categories had led "to a projected need to increase state fiscal year 2004 budget authority."

Additionally, Mr. Duarte said that to exacerbate the higher than budgeted cost per eligible, the division had been unable to achieve some of the cost reductions included in decision units E-600 and E-601 approved by the Legislature. The largest savings initiative not implemented involved changing physician reimbursements to 90 percent of the Medicare rate except for obstetrics and perinatal procedures, which were to be reimbursed at 100 percent of the Medicare rate. As a result of concerns over recipient access to care which started to occur in June 2003, Mr. Duarte said the division was unable to achieve its projected savings.

Physician reimbursements were adjusted in order to maintain physician participation in the program and allow access, which was federally mandated in the Medicaid program. Current estimates were that physician rates would be approximately $10.1 million over budget.

Mr. Duarte also discussed the preferred drug list (PDL), which had been delayed pending federal approval of a multi-state pooling initiative. Approval occurred in April 2004, and Mr. Duarte reported the project was currently on track for full implementation in September 2004.

Mr. Duarte advised the members of the committee that while the remaining initiatives in decision units E-600 and E-601 had been implemented, the actual impact of the initiatives was difficult to measure as a result of the claims payment issues.

Mr. Duarte provided the following series of questions and answers:

1. *Why was the need for the work program not identified to the committee prior to April 8, 2004?*

   Work programs were prepared well in advance of each IFC meeting. The work programs for the April 8, 2004, IFC meeting were prepared in early March 2004. At that time, Mr. Duarte said the division anticipated a larger number of pended claims would pay against negative balances created by cash advances, which would have freed up budget authority and reduced the urgent need for cash.

2. *What would happen if the work programs were not approved by June 4, 2004?*

   Projections indicated that the division would be unable to process checks dated June 11, 2004, and thereafter. Provider payments would be held until the end of the fiscal year or until the work programs were approved.

3. *Why did the division not better project medical payments?*

   The division regularly monitored cash payments, claims payment trends, remaining budget authority by medical category, and cost per eligible. Cost projections were based on historical data. Since fiscal year 2000, a number of issues had occurred that skewed eligibility and payment trends. Unstable eligibility and payment trends reduced statistical confidence in payment projections for budgeting.

4. *When did the division anticipate the payment problems would be resolved?*

The division and First Health Services Corporation had agreed to a plan of correction in a contract amendment, which required compliance with key performance contract criteria by July 1, 2004. Financial sanctions that could not be appealed by the vendor were included in the amendment. If compliance targets in the amendment were not achieved, daily penalties would be assessed.

5. *Was the division planning to reduce programs and/or defer new initiatives that were funded to begin in fiscal year 2005?*

   Currently, no decisions had been made. However, the division would continue to closely monitor their budget and would work with the Director's office and the Governor's office to determine the appropriate course of action.

Mr. Duarte provided an update on the Medicaid Management Information System and claims payments.

Mr. Duarte advised that the division continued to work with First Health Services Corporation to optimize claims adjudication rates. He said that while significant progress had been made, there were remaining unresolved issues.

Mr. Duarte provided information on key indicators that he said reflected general trends and represented a "dashboard" for the division to monitor improvement of the vendor:

Monthly Medicaid Payments

A chart titled *Monthly Medicaid Payments* (Exhibit C) provided information on cumulative MMIS claims payments that totaled $479 million. The $479 million did not include supplemental payments to hospitals or "offline" payments. Mr. Duarte said the chart reflected a graph of actual claims payments against a budget baseline. The lighter colored bar represented the actual claims payment amount, and the darker bar represented the projected amount. Mr. Duarte pointed out that the trend line was positive, and during the last several months, the budgeted amount for payment had been exceeded. In May, a total of $101,344,966 had been paid. Mr. Duarte pointed out that a note at the bottom of the chart that indicated May figures included 3 of 5 payment cycles was incorrect.

Percent of Rejected Claims

Mr. Duarte described the next chart titled *Percent of Rejected Claims* (Exhibit C) as an indicator of the providers' adjustment to the new system. Initially, Mr. Duarte said many claims were rejected by the new MMIS because the claims contained incorrect information. The rejection of claims presented a challenge to the provider community since guidance to

them had been changing on an ongoing basis. However, Mr. Duarte indicated the providers were cooperative and had adapted to the changes. Mr. Duarte expressed his appreciation to the provider community for their continued acceptance of Medicaid clients. Mr. Duarte pointed out that the chart reflected that the actual percentage of rejected claims was now below the goal of 5 percent.

Total Pended Claims Decreasing; Increasing Aging on Pended Claims

Mr. Duarte said that while the general trend was that the total volume of claims in the system awaiting adjudication was decreasing, claims remaining in the system were aging. The graph titled *Pend Aging Comparison January, March and May* (Exhibit C) reflected "three snapshots" of the pended claims volume in January, March and May. The first section of bars reflected new pended claims from 1-30 days, the second were claims aged 31-90 days, and the third was claims over 90 days. Mr. Duarte pointed out that the overall volume had decreased from a high of 292,000 claims to 173,000 claims, but was still above a target level of 60,000 claims. Mr. Duarte advised that while less than 60,000 claims was considered a normal operating level; many of the remaining claims were submitted in the period from October 2003 to January 2004, which was a significant contributor to provider discontent.

Increasing Electronic Claims

In his presentation on the chart titled *Increasing EDI Claim Lines* (Exhibit C), Mr. Duarte advised that the MMIS was built to accept electronic claims. With the number of electronic claims steadily increasing, it was expected the projected goal of 70 percent would be met by September 2004. Currently, Mr. Duarte said that over 94 percent of claims were adjudicated, paid or denied within 30 days, and the division's contract required a 95 percent compliance rate. However, Mr. Duarte indicated that problems associated with edits in the MMIS might cause claims to be inappropriately rejected. Mr. Duarte explained that while 45 percent of claims were paid on a first pass through the system, an increase to 65 or 70 percent on a first pass would be preferred.

Mr. Duarte said the division had undertaken an initiative with First Health Services Corporation to review all edits which numbered approximately 1,000 to assure claim denials were occurring per policy. Additionally, attention by state and First Health Services Corporation personnel continued to focus on fixing issues related to older claims. Mr. Duarte said that efforts continued to improve claims payment rates for hospital inpatient and outpatient claims, as well as specific physician specialties such as anesthesiology, pathology, dental and sister state agency claims.

Mr. Duarte also discussed the problem of Medicare crossover claims, which he explained were claims for those clients receiving Medicare as

well as Medicaid benefits. The claims were intended to cross over to the MMIS electronically without intervention on the part of providers. However, as a result of "significant issues" with the Medicare intermediaries that provided service for Nevada, electronic submission of claims had not occurred. Mr. Duarte indicated that while discussion had taken place with officials from the Centers for Medicare and Medicaid Services, the federal oversight agency for both Medicare and Medicaid, progress had been slow. Mr. Duarte indicated First Health Services Corporation had been directed to accept non-HIPPA (Health Insurance Portability and Accountability Act) compliant claims files from the intermediaries, which was anticipated, would reduce the need for providers to submit paper claims.

Chairman Arberry questioned whether the request for a $20 million General Fund appropriation was just a starting point or whether a supplemental appropriation would be needed in fiscal year 2005.

Debbra King, Administrative Services Officer, Division of Health Care Financing and Policy responded that the $20 million request was calculated through a projection of medical claims through the end of fiscal year 2004, taking into consideration the availability of non-federal funds. Ms. King advised that the balance forward from fiscal year 2004 to fiscal year 2005 included the County Match Reserve, MMIS design, development and implementation funds, nursing facility penalty funds, and administrative cash needs for the last three months of the fiscal year.

Ms. King advised that pending approval of the transfer of $20 million from fiscal year 2005 to fiscal year 2004, the division currently projected a $35.8 million General Fund shortfall over the biennium of which $3 million would be offset by the enhanced federal funding for the MMIS operations drawn in from federal fiscal year 2005.

Chairman Arberry expressed concern in reference to the medical providers who had not yet been paid and questioned what mechanism would be employed to ensure payment to providers.

Mr. Duarte advised that staff was working to ensure that any problems with the claims system were resolved while the option to pay cash advances to providers for claims pending in the system remained available to them. Mr. Duarte reiterated that over $280 million in cash advances had been paid to providers since implementation of the system in October 2003. While many providers' current claims were being paid correctly, Mr. Duarte advised that the option to pay cash advances would remain in effect. However, Mr. Duarte explained that providers had an accounting issue with application of a lump sum cash payment to appropriate patient accounts.

Mr. Duarte assured the committee the division had the necessary trained and experienced staff and contractors to work on the current operating responsibilities and issues under discussion.

Chairman Arberry expressed concern for the patients who might be turned away if providers were not paid.

Mr. Duarte explained he had been meeting with providers over the past six months to discuss their particular issues, and claims would be paid based of the division's ability "to make the fixes to the MMIS." Mr. Duarte advised that currently a determination was being made on which fixes would result in the biggest improvement in claims payment performance by the vendor, and an amendment to the contract had established key contract performance criteria and priorities.

Mr. Duarte explained that while staff was meeting frequently with members of the Nevada Medical Association and the Nevada Hospital Association, the vendor had to be kept on target with respect to the performance criteria in the contract. Mr. Duarte explained political concerns had to be balanced with providers' who indicated they would not see Medicaid clients because of problems with the MMIS. Mr. Duarte said that continually refocusing priorities for First Health Services Corporation and staff jeopardized not just the MMIS, but also the entire Medicaid program. Mr. Duarte said that the contract could be breached if the division deviated from the established priorities, and the vendor was directed away from the contract performance criteria.

Chairman Arberry indicated providers should be made aware that all attempts were being made to pay them for services rendered and that it was hoped they would not turn patients away.

In response to questions from Assemblywoman Giunchigliani concerning the MMIS performance based contract and certain deliverables, Mr. Duarte provided the following information:

- The contract was approved in October 2002 after a procurement process of approximately a year and a half.

- The contract contained key performance criteria, such as adjudication of all clean claims in 30 days, or 90 percent of the dollar amount of claims paid within 30 days.

- Additionally, criteria were established for payment of 99 percent of clean claims within 90 days as well as other criteria identified for performance.

In response to questions Ms. Giunchigliani posed concerning the contract language and the state's flexibility to make changes, Mr. Duarte confirmed that the state and the vendor agreed not to deviate from the amended contract.

Ms. Giunchigliani indicated it appeared the state needed to improve drafting contract language to ensure that contracts worked for the benefit of the state and the taxpayers as well as the vendor.

Mr. Duarte indicated it was his understanding that any vendor had the opportunity to appeal a breech of contract or pursuit of liquidated damages. Mr. Duarte explained that in a court of law a vendor could attempt to show that the state was partially responsible for some of the problems with a contract. Rather than deal with that type of a situation, Mr. Duarte said an amendment to the MMIS contract was drawn up that basically indicated that if the vendor did not achieve certain key performance goals by July 1, 2004, the state could impose penalties of up to $50,000 for the term of the contract amendment, and the vendor could not appeal. The vendor agreed to the terms of the amendment, which went into effect on May 15 pending approval by the Clerk of the Board of Examiners. Mr. Duarte explained that the Board of Examiners did not require approval since the amendment did not involve a dollar amount.

In response to additional questions Ms. Giunchigliani had concerning contract implementation, Mr. Duarte explained that the division had been faced with competing priorities in meeting the needs of particular provider groups. With the contract amendment, Mr. Duarte said a broader set of criteria and priorities would focus on performance defined in the contract.

In response to a question from Ms. Giunchigliani, Mr. Duarte confirmed that the division currently had 180,000 older claims.

In response to a question from Ms. Giunchigliani concerning how the division would use the $20 million, Ms. King advised that the $20 million would allow the division to continue to provide advance payments to providers.

In response to questions from Ms. Giunchigliani concerning development of the MMIS, Mr. Duarte explained the MMIS was implemented primarily because of enactment of the federal Health Insurance Portability and Accountability Act (HIPPA), which required state compliance by October 16, 2003. Mr. Duarte explained that the division wanted to replace their information system, and the federal government would pay for 90 percent of design, development and implementation costs once a system was certified HIPPA compliant.

Additionally, Mr. Duarte explained that federal certification required the state to initiate through a letter to the Centers for Medicare and Medicaid Services (CMS) a request for certification of the system. Currently, the division was in discussion with CMS officials to begin that process for certification to occur in 2005.

Mr. Duarte further explained that while design, development and implementation was federally reimbursed at 90 percent, day-to-day operations were reimbursed at 75 percent by the federal government. Once certified, the state would receive an enhanced federal match rate of 75 percent for operations as opposed to the 50 percent normally received for administration.

In response to questions from Ms. Giunchigliani concerning standard Medicaid systems and certification in other states, Mr. Duarte, explained a standard Medicaid system did not exist. Mr. Duarte said that in order to receive the 75 percent operating federal match, the federal certification process tested functionality such as the achievement of certain statutory and regulatory requirements.

In response to additional questions from Ms. Giunchigliani, Mr. Duarte said that claims payments and ensuring that providers did not turn Medicaid patients away were not included as standards.

Mr. Duarte confirmed Ms. Giunchigliani's understanding that while the request was for $20 million, over the biennium the division faced a $35 million shortfall minus a $3 million return from the federal government.

Senator Cegavske asked for responses to the following questions:

How many other states used intermediaries or facilitated their own programs.

Why First Health Services Corporation received $500 of a $1,900 payment for normal delivery services rendered by a doctor of obstetrics and gynecology.

How much money had First Health Services Corporation received since implementation of the contract.

Why an optometrist who was owed $100,000 for the last nine months had not been paid.

In light of the dissatisfaction expressed by doctors, patients, and hospitals, Senator Cegavske recalled comments made during the 2003 Legislative

Session in reference to First Health Services Corporation' work in other states that she indicated should have raised some concerns.

Senator Cegavske discussed the availability of other vendors she indicated had the capability to service the provider community. Additionally, Senator Cegavske expressed agreement with Ms. Giunchigliani's statement concerning the improvement that was needed in drafting language for vendor contracts.

Senator Cegavske also questioned how much more health benefit coverage Nevada provided than other states.

In response, Mr. Duarte explained that First Health Services Corporation was considered a fiscal agent, not a third-party administrator, HMO, or an insurer. Mr. Duarte said that First Health Services Corporation administered Nevada's program according to the division's policies and received payment based on administration of the program. In accordance with established controls, Mr. Duarte explained that First Health Services Corporation did not receive any portion of payments to providers for medical claims, nor did they retain dollars for medical services in their account.

Mr. Duarte indicated the reference to First Health Services Corporation having received $500 of a $1,900 payment to an obstetrical/gynecological doctor was incorrect.

Mr. Duarte advised that while First Health Services Corporation had been paid for ongoing operations, they had only received partial payment for design, development, and implementation since the system had not yet been fully accepted. Mr. Duarte advised that the amount First Health Services Corporation had been paid would be researched and the information provided to the committee.

In reference to the question concerning other states' use of intermediaries, Mr. Duarte indicated that the majority of his colleagues used fiscal agents. In a recent visit, Jeff Flick, the San Francisco Regional Administrator for the Centers for Medicare and Medicaid Services, said other states experienced the same problems and difficulties with vendors in transitioning management systems. Mr. Duarte indicated it had been his experience that systems, such as the MMIS, could not be delivered without a significant amount of struggle.

With respect to the capability of other vendors, Mr. Duarte said he was scheduled to attend a conference during the following week and would inquire about major vendors and their experience. Mr. Duarte also indicated he would be open to discussions with vendors who believed they

could implement a seamless transition. Additionally, Mr. Duarte pointed out that transition of a system, such as Nevada's MMIS, normally took 18 to 24 months from procurement to development to testing to implementation. While the MMIS was "fast tracked," Mr. Duarte said that in retrospect the federal deadlines for HIPPA should have been ignored. Mr. Duarte explained that even if the division should change fiscal agents and maintain the same system, a tremendous amount of expense and disruption would occur in the transition. Mr. Duarte indicated he wanted to avoid additional disruption to the providers and recipients. He said he preferred to concentrate on stability by ensuring that the system delivered after which a decision on the long-term viability of the contract with First Health Services could be determined.

In response to questions concerning optional programs and benefits, Mr. Duarte discussed two programs scheduled for implementation in July 2004. The Health Insurance for Work Advancement Program provided Medicaid benefits to individuals who were disabled, a large number of whom had "serious mental illness." The program allowed those individuals to work and retain key Medicaid benefits that were generally not available through employer sponsored insurance programs. The overall General Fund cost of the Health Insurance for Work Advancement Program was anticipated at approximately $2 million in fiscal year 2005.

The second program, funded by the Legislature in 2003 to begin in July 2004, was the elimination of the assets test for the Children's Health Assurance Program (CHAP). Mr. Duarte explained that the Children's Health Assurance Program was available to pregnant women, infants and children of very low income. One of the barriers to acceptance into the program and to receiving pre-natal care and prompt preventive services was the assets requirement. Mr. Duarte reported that Nevada was one of the few states that had an assets requirement, the elimination of which would assist clients to more quickly receive preventive services. The total General Fund impact of the CHAP assets test was approximately $1.55 million.

In reference to the question concerning optional services and benefits, Mr. Duarte referred to a document titled *Medicaid White Paper on Optional Program Expenditure and Cost Savings Implementation* dated January 15, 2003, (Exhibit D). Mr. Duarte pointed out that the federal government mandated state Medicaid agencies to provide medical services to a diverse population of individuals from birth through death. Mr. Duarte advised that the division tried to achieve the best outcomes under the federal requirements and provided many optional benefits, if medically necessary.

Mr. Duarte advised the committee that optional benefits were provided to Medicare beneficiaries and children, but some optional benefits such as pharmacy and podiatry services were also provided to Medicaid recipients over the age of 21 who were not qualified Medicare beneficiaries. Mr. Duarte explained that, for example, podiatry services for individuals falling under that category would be provided by a physician rather than a podiatrist, and the physician would be paid at a higher rate. Mr. Duarte explained that the division's responsibility was to provide key benefits to eligible recipients in order to maintain their health and to help them restore function.

In response to questions from Senator Coffin concerning the waiver of certain HIPPA requirements, Mr. Duarte advised that the criteria established by the federal government in order to waive certain HIPPA options was that the state develop a HIPPA compliant system which had been accomplished. Mr. Duarte explained that the criterion was met for declaring a contingency for some of the HIPPA rules in order to accept Medicare claims in a non-HIPPA format.

In response to additional questions from Senator Coffin concerning the providers' ability to waive HIPPA requirements, Mr. Duarte indicated that certain key components of HIPPA, such as the privacy requirements, could not be waived. As previously indicated, the division's declaration of a contingency provided for the acceptance of non-HIPPA compliant claims files.

Senator Coffin questioned the forecasting of future claims payments and whether consultations occurred with other Medicaid chiefs concerning trends and problems they were facing in the next year.

Mr. Duarte responded that he routinely communicated with Medicaid officials in other states particularly in those states that had First Health Services Corporation as a fiscal agent. Mr. Duarte indicated that trends in other states, especially overall cost increases for aged populations, did not differ greatly from those in Nevada. However, Mr. Duarte reported that Nevada differed significantly from other states in terms of program makeup. Mr. Duarte explained that in the mid and late nineties, many states had the revenue to dramatically expand their Medicaid programs and enacted optional program initiatives and programs to increase the number of people who could access care. However, Mr. Duarte explained those states were now in the position of reducing enrollment in those optional programs because of budget shortfalls.

Programs that served Nevada's categorically eligible clients under federal law included:

- The Health Insurance for Work Advancement Program for disabled individuals who wanted to work and retain their Medicaid benefits.

- A program for recipients treated for breast and cervical cancer and pre-cancerous conditions.

- Nevada Check Up, which provided low-cost, comprehensive health care coverage to low income, uninsured children (birth to 18) who were not covered by private insurance or Medicaid.

Mr. Duarte did not recommend eliminating the optional programs since the overall cost impact would be minimal.

Senator Coffin asked if the division communicated with any reliable forecasting sources, such as Sierra Health and Blue Cross.

Ms. King responded that the division's staff communicated with others in the business, such as the Center for Health Systems Information and Analysis, watched the trends, and utilized a number of professional publications. However, Ms. King pointed out that problems existed with the standard methodology of projecting health care costs based on historical trends. Ms. King indicated the division had three data sources that projected the same base data, utilized the same methodology and resulted in three different costs. Ms. King recalled that implementation of the NOMADS in 2000 and 2001 resulted in eligibility issues, which resulted in claims payment problems.

In response to a question from Senator Coffin concerning the gender population of clients, Ms. King advised that she did not have data with her but would provide the information.

Mr. Duarte mentioned that the division had a contract with Milliman USA, an actuarial firm, that provided access to data on HMOs from across the nation. Mr. Duarte indicated that while more ambulatory care and disease related grouping methodologies were being looked at, most carriers used age and gender based criteria. Mr. Duarte indicated that an age and gender based projection model would not be suitable for a diverse population in terms of age, makeup and medical needs. However, Mr. Duarte pointed out there were about 90,000 mothers and children in two HMOs across the state, for which the projection model using age and gender as the primary variables worked very well.

Mr. Duarte indicated states were moving the aged, blind and disabled population, for whom care was very costly, into managed care, and cost projections, provided by actuarial models, were adjusted for diagnosis, age, and gender. Mr. Duarte explained that Medicare had been using

adjusted actuarial models with their HMOs for several years, which would be expanded in 2006 with the Medicare Modernization Act.

In summary Mr. Duarte said if a decision was made to move into other types of projections, there were several methodologies and disease related models that could be examined.

Senator Coffin requested a copy of the typical demographic data that had been provided for the HMO as well as the aged, blind, and disabled populations. It was Senator Coffin's opinion that because of unreliable projections, eventually all groups would be under managed care.

It was Mr. Duarte's opinion that projecting rates for an aged, blind, and disabled population in an HMO would result in the same issues currently being faced.

Senator Coffin reiterated that managed care would have to be entered into sooner rather than later.

Senator Rawson indicated the special meeting was called to allow the committee to take action concerning the division's cash flow problem and to help providers receive payment through the remainder of the year. While Senator Rawson anticipated little dissention concerning the assistance being requested, he questioned whether the division had a plan to mitigate the probable shortfall and whether anything could be done to achieve balance by the end of fiscal year 2005.

Mr. Duarte responded that discussions concerning possible options were being held with the director, but no decisions had yet been made. Mr. Duarte indicated he would be back before the committee during the next fiscal year to discuss any plans that had been made.

Senator Rawson indicated a mitigating plan that could be reviewed by the committee was needed as soon as possible.

Assemblyman Beers referred to page 5 of the presentation document (Exhibit C) and noted that the actual claim line for the Electronic Data Interchange (EDI) was slightly lower in May than April. Mr. Beers questioned whether claims for the entire month of May had been recorded.

Ms. King attributed the significant increase in April to a major provider who had just begun EDI filing and at the same time filed previous claims numbering in the thousands, which generated an "artificial" increase.

Mr. Beers referred to another chart on page 5 titled *Pend Aging Comparison January, March and Ma*y (Exhibit C) and noted there were 173,000 claims for May. Mr. Beers questioned whether the dollar value of the 173,000 claims was at least partially offset by the $85 million in outstanding balances. Additionally, Mr. Beers discussed an earlier reference concerning the uncertainty of offsetting the negative balance and reducing the need for cash as MMIS fixes were implemented and claims adjudicated. Mr. Beers questioned whether the uncertainty was in the timing or the ability to apply the entire $85 million against claims.

Ms. King responded that there were "very stringent controls in place" to ensure that the $85 million in outstanding cash payments for unprocessed claims was either applied to unprocessed claims or collected back from the provider if they were no longer submitting bills. Ms. King advised that if claims paid between the present time and the end of the fiscal year hit against the negative balance, the $20 million that was being requested could go forward.

In response to a question from Mr. Beers concerning advance payments, Ms. King confirmed that advance payments continued to be made. Ms. King explained that while providers might be receiving payment for their February, March, April, May, and June claims, they continued to have unpaid claims from perhaps October through December. Ms. King further explained if claims "hit against the advance," the provider received no additional money.

Mr. Beers requested that a debit account balance for pre-payments over the last six months be provided to the committee at the June 16, 2004 meeting.

Ms. King advised that the information was available for the past two months, which Mr. Beers indicated was acceptable.

In response to a question from Mr. Beers concerning a downward trend, Ms. King confirmed that a downward trend was being seen and indicated payments were in the $120 million range at the beginning of the fiscal year.

Mr. Beers questioned the percentage of pended claims that had been prepaid in the $85 million.

Ms. King responded that 100 percent of pended claims had been prepaid.

In response to additional questions from Mr. Beers concerning pended claims, Ms. King reported $45 million in pended claims. Ms. King explained the difference between the $85 million advance and the $45

million in pended claims were claims that might have been inappropriately denied and resubmitted for payment.

Mr. Beers questioned if inappropriately denied claims were included in the pended claims.

Ms. King responded that a procedure code had been identified for inappropriately denied claims that were resubmitted, and claims identified by that particular procedure code were pulled and processed for payment.

Mr. Beers questioned whether the system allowed the dollar value of the denied claims to be calculated over time.

Ms. King indicated that the difficulty in calculating the dollar value of the denied claims was in determining why the claims were denied since some were appropriate denials. Ms. King indicated she would check on availability of the information for the June 16th meeting.

Assemblyman Goldwater pointed out that a large balance had been carried in the Intergovernmental Transfer (IGT) account before being spent down to $3 million to "plug holes" in the budget. Mr. Goldwater indicated that he and Ms. Giunchigliani had been critical of spending the IGT down in view of poor caseload projections. Mr. Goldwater questioned whether a significant IGT balance should be maintained.

Ms. King advised that even with the availability of an IGT balance, a $20 million transfer would have been required. However, Ms. King explained that it would have been possible to transfer funds from the IGT into Medicaid budget account 3243 utilizing an expeditious action work program item, which would have rendered an IFC meeting unnecessary. In accordance with the Appropriations Act, transferring money from one fiscal year to another year required approval of the IFC.

Assemblywoman Leslie questioned whether the amount of the supplemental appropriation that would be required would be determined by the August IFC meeting.

Mr. Duarte responded that an estimated $35 million was currently the best estimate that could be projected.

In response to a question from Ms. Leslie concerning whether a supplemental appropriation would be requested from the state and whether it included a federal match, Mr. Duarte responded the supplemental appropriation would be requested from the General Fund. However, Mr. Duarte indicated that the amount could change over the next several months. As indicated in previous remarks by Ms. King,

Mr. Duarte indicated that claims could pay against the outstanding balance, and the system could stabilize more quickly than anticipated.

In response to further questioning by Ms. Leslie, Mr. Duarte indicated that the next quarterly projections for Medicaid payments would be available in about six weeks and legislative staff would be briefed on those projections.

Ms. Leslie requested an update be provided to the committee at the September IFC meeting.

Ms. Leslie referred to Mr. Duarte's earlier remarks concerning the Health Insurance for Work Advancement Program and the CHAP assets test scheduled for implementation on July 1. While it appeared a decision to defer the programs had not yet been made, Ms. Leslie asked whether implementation could take place in October or December, if not by July 1.

Mr. Duarte indicated his preference to refrain from answering until further decisions could be made on whether or not the two programs would be deferred at all.

Ms. Leslie pointed out that many people were depending on the Health Insurance for Work Advancement Program and the CHAP assets test programs being implemented on July 1. Ms. Leslie indicated that from her perspective a high priority should be placed on implementation by July 1, and if not then, then at least by October 1.

Mr. Duarte indicated his understanding.

Senator Raggio asked that a letter (Exhibit E) from Bill M. Welch, President/CEO, Nevada Hospital Association, supporting the request for transfer of $20 million, be made a part of the record. A copy of the letter had been distributed to each of the committee members.

Ms. Giunchigliani requested that a letter (Exhibit F) from Charles Perry, Executive Director/CEO, Nevada Health Care Association, supporting the request for transfer of $20 million, be made a part of the record. A copy of the letter had been distributed to each of the committee members.

Ms. Giunchigliani asked for information related to the federal Medicare Prescription drug bill and the $3.6 million increase in receipts from local governments.

In response, Mr. Duarte said that the Medicare Modernization Act reflected components besides prescription drug benefits, some of which

benefited physicians, while others benefited rural providers and disproportionate share hospitals that served indigent and Medicaid clients.

Mr. Duarte explained that in Nevada, the Medicare Act resulted in an increased allotment of $3,692,245 for the Disproportionate Share Hospital Program, which was reflected in one of the work programs before the committee.

In response to questions from Ms. Giunchigliani concerning the addition of funds for the disproportionate share hospitals, Ms. King confirmed the disproportionate share payments would be used to offset the increased costs in the Medicaid budget. Ms. King indicated the additional funds would be received from local governments, primarily Clark County who would also receive the majority of the benefit.

Ms. Giunchigliani questioned whether anything could be done to make it simpler for providers to submit claims.

Mr. Duarte explained it had been anticipated that active electronic file sharing would abrogate the need for paper claims, which had not occurred. Mr. Duarte added that he did not want to blame the Medicare intermediaries because the division had their own issues with file transfers and technical details. However, Mr. Duarte pointed out that the problem with Medicare carriers resulted from the implementation of HIPPA not the Medicare Modernization Act. Mr. Duarte said it was anticipated the contingency plan the division hoped to implement would reduce the submittal of paper claims.

Mr. Duarte explained that while several new processes had been developed to assist providers with submittal of claims, even the most sophisticated providers were experiencing difficulty working with the intermediaries. Mr. Duarte explained that some providers wanted to submit claims electronically and refused to submit paper claims because, in many cases, Medicaid did not make up a very large portion of their practice. Additionally, submittal of paper claims was an administrative and labor-intensive burden that required special procedures for billing managers or billing staff.

Senator Mathews questioned whether other western states had contracted with First Health Services Corporation.

Mr. Duarte advised that while there were 23 states that had various contracts with First Health Services Corporation, Alaska and Virginia had contracts for the same type of MMIS services as Nevada.

Senator Mathews expressed concern with companies that appeared to lack a track record.

In response to Chairman Arberry's request for a motion,

> SENATOR COFFIN MOVED APPROVAL OF THE DIVISION'S REQUEST FOR THE TRANSFER OF $20 MILLION.
>
> ASSEMBLYMAN DAVID PARKS SECONDED THE MOTION.

Senator Raggio requested clarification on whether the motion was to approve all three of the work programs before the committee.

Chairman Arberry clarified that the request for approval by Senator Coffin encompassed all three of the work programs.

> THE MOTION WAS CARRIED UNANIMOUSLY BUT WITH RESERVATIONS EXPRESSED BY SENATOR MATHEWS AND MS. GIUNCHIGLIANI.

C. PUBLIC COMMENT.

There was no public comment.

D. ADJOURNMENT.

Chairman Arberry adjourned the meeting at 10:40 a.m.

Assemblyman Morse Arberry Jr., Chairman
Interim Finance Committee

Lorne Malkiewich, Director
Legislative Counsel Bureau, and
Secretary, Interim Finance Committee