



NEVADA LEGISLATURE JOINT INTERIM STANDING COMMITTEE ON HEALTH AND HUMAN SERVICES

(Nevada Revised Statutes [NRS] 218E.320)

MINUTES

April 28, 2026

The fourth meeting of the Joint Interim Standing Committee on Health and Human Services for the 2025–2026 Interim was held on Tuesday, April 28, 2026, at 9 a.m. in Room 3, Nevada Legislature Hearing Rooms, 7120 Amigo Street, Las Vegas, Nevada. The meeting was videoconferenced to Room 3137, Legislative Building, 401 South Carson Street, Carson City, Nevada.

The agenda, minutes, meeting materials, and video recording of the meeting are available on the Joint Interim Standing Committee's [meeting page](#). The video recording may also be found at <https://www.leg.state.nv.us/Video/>. Copies of the audio or video record can be obtained through the Publications Office of the Legislative Counsel Bureau (LCB) (publications@lcb.state.nv.us or 775/684-6835).

COMMITTEE MEMBERS PRESENT IN LAS VEGAS:

Assemblymember Tracy Brown-May, Chair
Senator Fabian Doñate, Vice Chair
Senator Roberta Lange
Assemblymember Rebecca Edgeworth
Assemblymember Brian Hibbetts
Assemblymember Hanadi Nadeem

COMMITTEE MEMBERS PRESENT IN CARSON CITY:

Senator Robin L. Titus
Assemblymember Heather Goulding

OTHER LEGISLATOR PRESENT:

Assemblymember Blayne Osborn, Assembly District 39

LEGISLATIVE COUNSEL BUREAU STAFF PRESENT:

Davis H. Florence, Senior Policy Analyst, Research Division
Anthony Ciaramella, Senior Policy Analyst, Research Division
Serina Hale, Research Policy Assistant, Research Division
Eric Robbins, Senior Principal Deputy Legislative Counsel, Legal Division
Karl Kahambwe, Deputy Legislative Counsel, Legal Division

Items taken out of sequence during the meeting have been placed in agenda order.
[Indicates a clarification.]

AGENDA ITEM I—OPENING REMARKS

Chair Brown-May:

Good morning. Thank you all for being here this morning. Welcome to the Interim Committee on Health and Human Services. Let us start with, Secretary, will you please call the roll.

[Roll call was taken and reflected in Members Present.]

Please mark Senator Doñate present when he arrives. He is running just a little bit behind schedule today.

Before we begin, I want to just make several housekeeping announcements. First, as a reminder, please silence your electronic devices, especially your cell phones and your laptops. Mine just went off a minute ago. Agenda items may be taken in a different order than listed. We do not anticipate that; however, it is always a possibility, and two or more agenda items may be combined for consideration. The Committee's meeting material can be found on the Nevada Legislature's website. You can also sign up for electronic notifications related to any activity on the Committee's website. If you wish to testify in person, sign in at the table; leave us a business card, please. When testifying in person, turn on the microphone to speak and then off to listen. We have others that are listening and viewing the meeting in Las Vegas, up in Carson City, and online. With that, we will officially move to public comment.

AGENDA ITEM II—PUBLIC COMMENT

Chair Brown-May:

Public comment is limited to two minutes. If you would like to offer public comment, please come forward, fill in the seats. Staff will time each speaker during public comment to ensure that everyone has a fair opportunity to speak. In addition to testifying in person, members of the public may provide public comment in lots of other ways, all of which are listed on the agenda. If you would like to call in to provide telephonic testimony, please dial 888-475-4499 and then when prompted, provide the meeting ID. Enter 857 3089 0851 and then press the pound sign. When prompted to provide a participant ID, press the pound sign again. With that, we will start with public comment for those in physical locations, and then we will move to public comment online. We will start here in Las Vegas. Please state and spell your name for the record. You may begin when you are ready.

Patti McGuire, Pastoral Associate, Human Concerns Ministry, and Outreach and Food Pantry Coordinator, Saint Elizabeth Ann Seton Catholic Church:

Good morning. I am here today representing Nevadans for the Common Good, NCG, which is a broad-based, nonpartisan community organization made up of 30 congregations, neighborhood coalitions, and community nonprofits representing thousands of families in southern Nevada. In November of this past year, our congregations, nonprofits, and food pantries were overwhelmed when people lost their SNAP [Supplemental Nutrition Assistance Program] benefits during the government shutdown. This recalled our experience during the pandemic when we all faced endless lines for food and housing assistance. It was chaos and people suffered. Through our work we have talked to over 1,000 people, so we know

Nevadans are already beginning to feel the impact of what we know is coming with the full brunt of H.R. [House Resolution] 1. People with eligibility letters, people with questions, people who are fearful of losing benefits are already showing up to our churches, food pantries, and food lines to try and find help.

Understanding the health care system can be daunting to everyone. As eligibility for Medicaid and SNAP changes, public resources for clinics and hospitals shrink, and the cost of private insurance increases. An already strained and confusing system will now be forced to deal with an increase of people needing help navigating. They need face-to-face navigation help in a location that is familiar and trusted, such as a church or community center. In reality, this is where many people go seeking help. Faith formation leaders and pantry managers, including myself, have shared how we are frequently asked questions we are not equipped to answer, such as how do I apply for Medicaid or SNAP? How can I find housing that I can afford? My power was disconnected; what can I do? Most people seeking help have multiple needs, so finding solutions can be complex.

As our entire state's social safety net faces the dramatic loss of federal revenue and an overwhelming increase in demand, Nevadans for the Common Good strongly advocates for a coordinated, face-to-face navigation system with trained navigators located throughout the valley, particularly in neighborhoods most affected by the coming program changes. Technology alone cannot fix this. Having navigators located only within the health care system also does not solve the problem. We need face-to-face assistance in trusted institutions. Thank you ([Agenda Item II](#)).

Connor Cain, on behalf of HCA Hospital Corporation of America and the Sunrise Hospital and Medical Center:

Chair Brown May, members of the Committee. In front of you today, just to thank you for making time to look at this really impactful piece of legislation at the federal level. As many of you know, Sunrise Hospital is our state's largest acute care facility. It is also our state's largest provider of Medicaid services. Nineteen percent of Nevadans who receive care under the Medicaid program receive that care at Sunrise Hospital. That is roughly one in five Nevadans, something that we are incredibly proud of. We want to continue to work with this Committee, with the Health Authority, with the state to continue to provide those critical services. Again, we thank you for looking further into the future and calling this meeting today. Thank you.

Liz Ortenburger, Chief Executive Officer (CEO), SafeNest:

I am here today to talk about the H.R.1 work requirements related to Medicaid. At SafeNest, we currently have 40,000 volunteer hours available every year. These are not simply informal volunteering opportunities. They are technical and they are log in, log out, and geocached to ensure that people actually are doing the volunteer hours that they have signed up for, and they are also tracked by supervisors. This opportunity will be missed if we do not allow organizations like SafeNest to be part of the H.R.1 volunteer requirement to Medicaid. Looking ahead, we will be having 60,000 plus hours on our campus as we open October 15. Medicaid is designed to help the clients that we work with, and we want to be part of the solution. We stand ready to partner with the state, the county, and the city to make this possible, and I am not alone as a volunteer organization. SafeNest is one of many who has this opportunity available. Thank you.

Chair Brown-May:

Thank you. Is there anyone else here in Las Vegas or in Carson City who would like to offer public comment at this time? Seeing none, we will go to AVH [Audio Visual and Hearings Unit]. Is there anyone on the telephone line who would like to offer public comment?

AVH, Information Technology Services, Administrative Division, LCB:

Thank you, Chair. The public line is open and working. We have no callers for public comment at this time.

Chair Brown-May:

Thank you, AVH. We will wrap up our public comment phase and move into the next section on our agenda. Before we do that, I want to take a moment of personal privilege as we have our members here and present. I want to recognize our distinguished colleague who is celebrating the anniversary of the next turn around the sun. Senator Lange, we wish you all the very best and are grateful that you are here with us spending your birthday in Committee. On behalf of the entire Committee, we want to wish you the very best day. Thank you for sharing it with us. That was a nice moment of levity. Let us move into the topic and why we are here.

AGENDA ITEM III—UPDATE FROM THE NEVADA HEALTH AUTHORITY ON THE IMPACTS OF H.R.1, 119TH CONGRESS (2025) (FEDERAL LEGISLATION KNOWN AS THE ONE BIG BEAUTIFUL BILL ACT) TO NEVADA MEDICAID, INCLUDING THE IMPLEMENTATION OF WORK REQUIREMENTS AND CHANGES TO ELIGIBILITY REQUIREMENTS AND PROVIDER TAXES

Chair Brown-May:

As you are all aware, today's very focused topic is about the impacts on H.R.1, the federal legislation that is making changes through much of our state. I am going to go ahead and open up the next agenda item and ask our presenters to come forward. We are going to hear from the Nevada Health Authority (NVHA) on the impacts of H.R.1 and the federal legislation. I am sure we will have lots and lots of comments, so at your convenience, if you will please take the testimony table, and we look forward to hearing your presentation.

Stacie Weeks, J.D., M.P.H., Director, NVHA:

Good morning, Madam Chair, Committee members. Thank you for having us today. I have with me Ann Jensen, our Administrator of Nevada Medicaid, as well as Malinda Southard, who is in the Carson City office, so she should probably be on the screen if you can see her. She is here to also talk and present some of these slides. I also have additional team members here in the audience in case there are questions about a variety of the topics.

We are going to kick it off and kind of hand off, but we are going to start with Medicaid. There are a couple of things for the Exchange [Silver State Health Insurance Exchange] as well, so I am going to go ahead and just start the presentation ([Agenda Item III](#)).

First, we are going to talk generally about high level, some of the big key changes we see from H.R.1 for any of our programs at the Nevada Health Authority. Second, we are going to dive in a little bit to H.R.1 fiscal and budget.

I know this is not a budget committee, but I think it is important to understand some of those pieces, and so I will be doing a little 101 on that Medicaid budget just to ground us.

Then last, but not least, is let us look at the bigger picture on health care for the state, and then we will open it up for questions. All right. Ann, I think this is you.

Ann Jensen, Administrator, Nevada Medicaid, NVHA:

Good morning, Madam Chair, Committee members. I am excited to share a little bit more about the work we have been doing for nearly the past year to prepare for and implement the new federal legislation, what we will refer to here as H.R.1.

What I would really like to communicate and what I hope is clear in our presentation today is this is a really complex piece of federal legislation that has two really specific impacts on our Nevada Medicaid program. All 56 Medicaid programs in the U.S. [United States] are experiencing these changes differently, and what we really want to communicate is exactly what this looks like in Nevada.

For us, those changes are felt in two categories. Firstly, on who can maintain and earn eligibility to the Medicaid program—that will change starting January of this year primarily, and the second impact is on our hospital provider tax program. For most of my time today, I will be sharing more on those eligibility policy changes, and then I will turn it back to Stacie to share more on the hospital provider tax program. What I also hope is clear through each of our slides is that we are deeply committed to avoiding coverage loss and ensuring continuity of care and coverage for Nevadans so that people can choose the health plan that is high-quality and affordable to them. We are also committed to the sustainability of our program and are working hard to ensure the long-term sustainability through all of these changes anticipated in the years ahead.

With that, I am going to dive in to share a little bit more about exactly what these changes look like on the eligibility side. I think one of the biggest misconceptions or areas of confusion is who this impacts, what is actually changing. What I like to start with whenever I talk about H.R.1 is really clarifying who is exempt. For the following people, nothing about their Medicaid coverage is going to change in the coming years based on this federal legislation. Those groups include: children, seniors, pregnant individuals, people with disabilities, and parents of children that are under age 13. That is the majority of our Medicaid population, if that is the category that folks are eligible for health coverage in, nothing is changing on that front. The focus of these changes are specifically for what is called our “adult expansion population.” Those folks are adults ages 19 to 64. They cannot have, they cannot be caregivers for young children. And importantly, there is about 147,000 people in our state that fall into this category. The changes I am going to talk about shortly, work and community engagement requirements, six-month redeterminations, and cost sharing all apply only to that group. Again, a very specific part of our population.

If you move to the next slide, I like to visualize this or talk about it like a bit of a funnel. We start at the top with our total Medicaid population, which is just under 800,000 people. Of that overall program, about 270,000 people fall within our adult expansion population. The way federal legislation is written, not every single one of those people will need to meet work and community engagement requirements though. Further down the funnel we have the population that actually will be required to meet those work requirements, and that is about 147,000 people. Most importantly, there is still that tip of the funnel or tip of the triangle, and those are the people that we actually need to request documentation from when they are applying for Medicaid or renewing their coverage. And notably, we are working hard to make that tip of the triangle as small as possible, using data that we have to demonstrate that people are either exempt or already compliant with these requirements. Importantly, about two-thirds of adults in this population are already working, so we expect for those people this may be an exercise primarily in submitting documentation if we do not

already have it. For the other one-third of adults in that population, it will be an exercise of noting whether they are compliant through a variety of different mechanisms, which I will talk about in a second.

Before we get there though, I want to share a little bit more about the timeline. As we all know, this piece of federal legislation was signed on July 4, 2025. We have been hard at work since then to prepare for implementation. I will note we are expecting formal guidance and regulation from our federal partners in June of this year. It is a really lengthy process. I know that they have been working quite hard to pull that together, but we cannot wait until June to begin this work. So, we have been moving forward with our implementation based on everything we know and more informal guidance that CMS [U.S. Centers for Medicare and Medicaid Services] has given, and we expect our efforts to align with that formal guidance we will get in just about a month.

We had our first public workshop on these changes and getting public feedback on them in March of this year. We will continue those at least quarterly through the rest of 2026 and likely into 2027. We are really committed to hearing feedback from our community and also hearing what is going well and where there may be challenges. We recognize, as this significant change is unfolding, we need to hear directly from people and hear from them frequently, so that is the intention of those public workshops.

What we are moving towards, the big date on that timeline, is January 1, 2027. That is when anyone who is applying for Medicaid in that adult population will have to meet work or community engagement requirements or be exempt in order to enroll in the program. Also, after that time, anyone in that 147,000 estimated population that renews their Medicaid coverage will also go through that same process. I am going to talk about this a bit later, but the six-month redetermination change, basically changing how frequently people renew their health coverage, that also goes into effect in January.

Then there are a couple other changes that I will note. In October of this year, there are a few changes related to immigration status and who is eligible for Medicaid, and then in 2028, fall 2028, is when our cost sharing provisions take effect. I will share a little bit more about that in a couple of slides, but there is not going to be as much time on this particular component of the presentation given that we are awaiting our first federal guidance on that piece and there is not as much detail in H.R.1 on what that will look like. We will have a lot more conversation and public workshop on that piece at a later date.

Let us move into those exemptions like I have talked about. This is an area of policy decision that the state will have within broader federal guidelines. I will talk about those exemptions a little bit more, but generally, the federally mandated exemptions fall into three categories. People can be exempt based on who they are, like I mentioned, children and youth, seniors, tribal members, people who also are enrolled in Medicare. You can also be exempt based on your health needs. The way that is described in federal legislation is "medically frail." I think what we would refer to more generally is someone who is unable to meet the requirements due to their health needs. The last piece is someone may be exempt based on their situation—people that are caregivers, people that may be recently leaving incarceration. There is a number of requirements outlined in federal law that would exempt people from that program. I will talk about this in a couple more slides, but there is a fourth category that states can opt in if they would like to select related to short-term hardships. The high level is, of that bucket, the reason it goes from 220,000 people to 147,000 people is because we are removing those that are federally exempt from those requirements.

If you move to the next slide, this is kind of a summary of, again, what those requirements actually are. Once we know who is eligible, who is exempt, what do they actually have to do? Like I talked about, work and community engagement is probably the one people are most focused on, and I will share a little bit more about what actually counts for that in a second. The second piece is six-month eligibility redetermination. The same group of people, instead of renewing their Medicaid coverage every 12 months, will renew it every 6 months. This is a more frequent cycle of renewal. The last piece, as I mentioned, is cost sharing or co-pays. Currently in our Medicaid program, no services or providers have a co-pay associated. It is free of charge to members, so this is a change in federal law. States will be required to collect co-pays from this particular population for a particular set of services, the details of which I mentioned we are still awaiting federal guidance on. I think this one is a little bit more nebulous as we await further clarification from our partners at the Centers for Medicare and Medicaid Services.

Diving into the definition of *work and community engagement*. I think what is important is it is not just work requirements. We recognize that there is a range of activities Nevadans are doing right now that count towards engagement with their community. I was really excited to hear during public comment, SafeNest's commitment to volunteer hours. Those exactly are what would count for these types of requirements. Fundamentally, people have to meet two thresholds. Either they are completing 80 hours per month of a qualifying activity, or they are earning at least \$580 a month. We recognize Nevada's employment landscape is unique. There is a lot of seasonal work; there is a lot of shift work. And so, what we are continuing to do in our work with CMS is determine what flexibilities we have to collect and document information on all different types of employment to ensure that all of the activities that folks are doing is clearly captured and documented.

On the slide, we talked about, again, employment obviously counts. Job training, such as apprenticeships, are also considered part of those work activities. Community service, as I mentioned, counts as well. School, so being part of education is a qualifying activity, and it seems that CMS is accepting a pretty wide range of educational levels in that definition, but that is one of the components we are awaiting further federal guidance on. Self-employment and seasonal work both do count. There has been a lot of discussion on how those are calculated and how do you ensure that they are accurately reflected at the time of renewal or application for Medicaid. Trust that there is a lot of detail that goes into how we calculate those, and the intention from our federal, and of course our own state policy decision, is to ensure that folks' seasonal work and schedules are reflected accordingly.

The next question is how do we verify compliance? These are the activities that you can complete. How do we verify it? First and foremost, we will do everything we can to use current and new sources of data to validate it without ever asking members for more information. We have done a really comprehensive data review, and this is ongoing with a number of our sister agencies to get data on wage and employment history from DETR [Department of Employment, Training and Rehabilitation] and other agencies that are collecting that already. We are working to collect education data from our partners that already have that. Our intention is to ensure that anything that the state has access to, that we are able to connect our data systems to—which I am deeply grateful for our IT [Information Technology] teams that have been hard at work since last year to really do this analysis and figure out what we can do from a technological perspective—will be to determine folks are automatically compliant or exempt without asking for more information. If we do though, this will be done at the time of renewal or at the time of application. There will be a screening form that folks can complete and essentially attest to the fact that they have met these requirements and that will be audited throughout the time that they are

part of the program, and there will be essentially these exemptions that they can also attest to as well. So, either that they meet requirements or that they are exempt, there will be different paperwork for that piece. Again, this follows the federal guidance there and is really intended to be as comprehensive as possible while limiting the outreach that we are going to do.

I will talk in a couple of slides about the patient outreach that we are planning. I will note, I think this is one of the most important times that we have been communicating with Medicaid members, and we will continue to do so. We are deploying a similar playbook like we did during the unwinding when we had to redetermine a lot of people after COVID, but I think there is a lot that we learned from that will continue to improve, and I am excited to work with our community partners to really get the word out.

Before we move into that timeline and kind of path ahead, I do want to talk about four key decision points that we have as a state. As I mentioned, the federal law and the guidance from CMS is fairly prescriptive. All Medicaid programs in the country that have to implement these work requirements are doing so in a pretty similar way. But there are four areas where we do have flexibility as a state to make some decisions. This is what we shared at our public workshop about a month and a half ago and what we would love feedback on from the Committee today and from any others that are listening and were not able to join our public workshop. We would love to hear from you. Our public comment period is open until April 30, so nearly the end of this week. And what you will see in the next slide is reflecting the feedback that we have gotten so far.

Those four decision points we have are: (1) whether we should offer a short-term hardship exemption, which I talked about earlier; (2) determining what our lookback period is for compliance—how long will people have to meet work requirements to be compliant with the program; (3) how do we transition to six-month redeterminations; and then lastly, and very importantly, (4) how do we define medically frail. I will ask you all to kind of buckle up and bear with me as we get a little bit wonky in Medicaid policy in this, but I think it is really important that you all see the kind of thought and preparation we are going through in making these decisions, and we really do want input on how to do this right for Nevadans, so I am happy to take any questions at the end if any of this remains unclear.

As I mentioned, that first decision point is related to short-term hardships. This would be the fourth kind of exemption point in addition to those ones I already mentioned. It would allow for people that are experiencing disasters, hospitalization, having to travel a long way to receive health care, or living in a high-unemployment county from being exempt from work and community engagement requirements. This would essentially allow people to protect their Medicaid coverage while they are experiencing what we believe to be a short-term and somewhat unexpected event. States have an option to utilize that exemption, or they can choose not to and stick with the three federally required exemptions. Our recommendation is that we do include this fourth category. This is because it aligns with our commitment to member access to coverage and avoiding disruption and continuity of care. We also recognize that one of Nevada's unique aspects is how far people do often have to travel for care, especially in our rural and frontier communities. We believe this better aligns with our goals of ensuring people have access to high-quality care and can maintain that access.

The feedback we have gotten so far is at the bottom of the slide in smaller fonts, but has been aligned with that approach. People had offered suggestions to expand that definition more broadly. Our understanding, and we will see what that guidance looks like in June, but it is pretty prescriptive in federal guidance, so we do not believe we can expand it further,

but the feedback we received was strongly in favor of that Option B, which would be to accept that fourth exemption.

We move to the next slide, you will see this is where things do get a little wonky and we have to do some math, but it is an important, really crucial piece of this program implementation. States have an option of how far back we look to determine that people have been compliant with work and community engagement requirements when they apply or when they renew. As I mentioned, this happens twice. First, when you apply to Medicaid the first time. Say I am applying in April 2027, I would have to demonstrate either that I was compliant with work requirements in March of that year or in January, February, and March of that year to be compliant for Medicaid. States essentially can pick between one and three months of look back when determining eligibility. Our recommendation is to do a one-month look back. So, if I was applying in April, I would need to demonstrate compliance in the month of March. That is because we believe it is better aligned with what people's current activities are. It minimizes the reporting burden for members, for how much data essentially, they would have to submit, and it helps the state's administrative burden in processing all of that information as well.

The second time compliance is checked is when you renew your Medicaid coverage. If I am renewing my coverage, I am currently a Medicaid member, I am renewing my coverage in August 2027. I would have to demonstrate that I was compliant with work and community engagement requirements either in any month of 2027 or in February, March, April, May, June, and July. So those are kind of— And they can have any option within that. States essentially can pick between one and six months' look back during an active coverage period. Our recommendation is that we would accept compliance with work requirements any one of the six months before you renew coverage. That is similar. It again minimizes administrative burden on our staff and our intake process. It also allows people to not have to assemble six months' worth of information when submitting documentation if they need to do so. Again, our recommendation was that one month look back.

Community feedback has been generally in favor of both of those approaches. Again, in alignment with Nevada's commitment to ensuring access to high-quality care, as well as trying to ensure the state can implement these requirements as efficiently as possible and minimize staff burden throughout that process, we would recommend this approach. Bear with me, that was the second of four.

Moving to decision point number three. This is an option that states were given based on the guidance from CMS that came to Medicaid directors just a couple weeks ago about how states will transition to a six-month renewal cycle. Like I mentioned, every person on Medicaid right now goes through an annual renewal cycle. Every 12 months they have to submit information to demonstrate that they are still eligible for the program. The adults in that population that are not exempt, that will now move to every six months. States have two options on how to do that. Either Option A is you reschedule everyone's current redetermination dates to early 2027 to say regardless of whether you are scheduled to be renewed at any month in 2027, everyone will be renewed in the months of January, February, or March or whatever state decision makes. The other option is keep everyone's redetermination dates as they are right now. If they are still Medicaid-eligible and they meet work requirements, then it moves to six months after that time.

In either option, we are federally required to provide notice to people in advance of that redetermination, and they of course have an opportunity to appeal if they do not meet those requirements off the bat. Our recommendation is to go with Option B, primarily because it is a really complex process to reschedule a lot of people's redetermination dates in a system that we are already working very hard to update and to edit in reflection of this

new guidance. Our recommendation is to keep the dates for 2027 that are already scheduled and will be already scheduled in an effort to really spread this out throughout the year, avoid burdening our state systems and helping us to learn quickly. If there are things that we can improve in our systems and our process early in 2027, we want to do that right away in order to reflect those updates to the process as soon as we can. Feedback on that point has been similar. I think the general public consensus has been Option B on that one as well.

The last piece is the definition of *medically frail*. Again, that is the term in federal law that would exempt people from having to meet these requirements in the first place. In the left—and I will read these here; I think it is important for you all to hear—this is what every state is required to include in their definition: people with significant physical, intellectual, or developmental disabilities; people with disabling mental health disorders; people with substance use disorder; people with serious or complex medical conditions; and people currently receiving treatment for substance use or other serious health conditions. As you are reading that list, you can probably appreciate there is a lot of variation, or those are pretty broad categories. In our world, every broad category has about 1,000 different medical codes and diagnoses, and so, every state has the opportunity to really define specifically what does that mean for the state's definition and how do you translate that to diagnoses and to codes that we would then process in our system.

You can find our draft definition of *medical frailty* on our website right now. This is what we shared with our stakeholders in our public workshop and over a number of our LISTSERVs and websites over the past month and a half. It is a very comprehensive definition that we believe aligns with federal law and will allow us to really, clearly determine whether someone would be medically frail.

Community feedback has supported this definition. We have gotten a lot of feedback on specific conditions that folks would recommend to be included. We are evaluating each of those to determine how they align with federal law, and we are really grateful for that feedback and would welcome that in our final days of this public comment period.

As I mentioned, members will have an opportunity to self-declare a definition of medically frail if, for example, they recently moved to Nevada, and we do not have any of their claims' history. We cannot already determine that someone has cancer, but they can self-identify that they are experiencing that condition. They would be exempt from work requirements, and we would audit that in the coming six months once they are able to see a doctor in our state in that particular example.

All of those policy decisions covered here, I want to walk you through what happens next. We are collecting feedback on our policy implementation of this process. Again, that closes on April 30. We will share our final decisions in a public workshop that we are currently slated for early June. We will have an exact date for you all very soon.

From there, our focus really shifts to how do we communicate about this and how do we leverage our community partners. There is a ton of work that I am really excited that our teams have been thinking about and working on since well into last year on how do we apply some really creative, new approaches.

We have funding for our new navigator program that was approved during the special legislative session last fall that will, and those navigators will be trained to really support people to walk through that process and if they do not meet work requirements to help them select a plan that they are eligible for.

We are also going to be developing a lot of public-facing content, so social media content, flyers, other ways to really try to get the word out. We recognize the state has plenty of channels that we can and will use, but really, the trusted voices for our patients are community organizations, and providers, and other groups in our communities. We are going to be doing a lot of work to meet with them directly, equip them with the information that they need to be able to have the conversations that I recognize people are asking questions on today and they need the information to kind of help folks through that process. Know that this will be a top priority for us through 2026. I am really excited about what it means in terms of the ways that we can really continue to be creative and modern in the way that we communicate with our members, meeting them where they are with whatever technology and tools that they feel most comfortable in, as we prepare for the go live in January of this year. Again, those public workshops will continue and we look forward to your feedback in that forum, and of course, happy to answer any questions on that piece.

Before I turn it over to Stacie, I do want to touch on one other component of our federal changes to our program, and again, for this one, I will ask that you kind of step outside that funnel view. This is not specific to adults in that expansion population. It is applicable more generally. This is related to Medicaid coverage of lawful immigrants on our program. The federal law has changed, so certain categories of lawful immigrants that previously had an ability to receive Medicaid coverage based on the current status and after a current period of time, those people will no longer be eligible for the Medicaid program. There is a lot of detail here on the process, but I want to be very clear on the people that will remain eligible. Those are lawful permanent residents, Cuban and Haitian entrants, and COFA [Compacts of Free Association] migrants or lawfully residing children or pregnant women that qualify for what is determined as a CHIRPA [*sic*] [Children's Health Insurance Program Reauthorization Act] option.

We expect about 5,000 people to lose their Medicaid coverage in Nevada if they are not determined to fall within a different immigration category when we reverify their status. This summer, all states will have to reverify which immigration status a beneficiary is part of and determine whether that is part of a satisfactory category based on the new federal rules. If they are, we will send notification and let them know that they are part of a new Medicaid eligibility category. If they are not, we will provide advanced notice, written notice with information on where to submit documentation if they believe that is not an accurate determination and how to appeal that notice as well. That will happen late summer in preparation for October 1, which is when those federal provisions hit. Again, as I mentioned, there is a 90-day period after which people can always appeal their Medicaid decisions, and so, that will be happening through the end of this year.

The next slide just talks about that noticing piece. Again, we are really committed to being as transparent and clear with members as we can as we implement these federally required changes to the program overall, and we will continue to provide transparency in terms of the actual number and population size as we move through that process.

That is my summary on the eligibility category. As I mentioned, the second really specific impact for Nevada from H.R.1 is on our hospital provider tax program, and I will turn it over to Stacie to talk about that.

Director Weeks:

Madam Chair, I wanted to see if you wanted us to stop for questions or keep going because I know we got a lot here.

Chair Brown-May:

Thank you. I appreciate that. If you will go through the rest of your presentation and then we will stop for questions.

Director Weeks:

Sounds good. You got it. I am going to try to drive my slides here and talk. Real quick, like Ann mentioned, when we look at just big picture for Medicaid, and again, it is eligibility and then it is provider tax changes that are really impacting Nevada. Now some states have different impacts depending on their programs, so we are talking about Nevada here today.

There are three ways that our tax programs are impacted. The first is that there is a moratorium on states now that has gone into effect. I think it goes into effect completely last October for provider taxes. So, no new state Medicaid provider taxes, which reduces our ability to generate revenue for our program. One of the reasons states like provider taxes or provider fees is because it generates the state's share of the program. We use that to match and providers often, if they are getting a rate increase, for example, from that or supplemental payments, they also sometimes like the program, not all of them, but most of them. States all across the country use their provider tax revenue differently, and I want to talk today about how Nevada uses it. When you are looking at national publications, you have to be very mindful that they do not understand how we use our provider tax revenue. A lot of states use it to replace state general fund. We do not primarily use it that way, and so we will talk more about that in a minute. And that is why some of the numbers, like in the RAND study, that we will talk about in a minute, is not accurate, and we have reached out to them and we are still waiting to get a conversation.

The second item here that has happened is that it lowers our ability to collect a percentage of total revenue. Right now, we collect approximately about 6 percent, for example, on total patient revenues, minus Medicare, from our hospitals, our private hospitals. We will have to reduce that over the coming years down to 3.5 percent. So that reduces how much revenue we can collect, which also reduces how much we can match, which reduces the output. We will talk in a minute about there are multiple ways that impacts the budget and we will walk through that.

The third thing that happens here is that when we collect that revenue, for example, for our hospital tax program, we supplement the base rate. You will hear later from the Hospital Association about their rates and they are very low, but we supplement those payments up to Medicare UPL [Upper Payment Limit] with the provider tax program. Then on the managed care side, any claims that come in, we supplement up to average commercial rate today. It is a big, big piece of the money, and it is driving the program. The new federal statute says that they have to lower that down to what we call generally Medicare rates. It is not the same as Medicare UPL, which— We are waiting for guidance to figure out how are they going to define that because not everything we cover in Medicaid is applicable or the same in Medicare. They do not often cover all the services. Medicare can be limited to a certain population, which is typically seniors. We are waiting for more guidance in this space.

Until then, it is really hard for us to really throw— We are kind of throwing a dart at what we think the impact will be, depending on how much more we can supplement managed care claims. We are working closely with Mercer on all of those pieces, and again, like Ann said, we are hoping for guidance this summer, and we are waiting anxiously for that. I think every state is right now.

Let us look at the timeline here. H.R.1 does— There were different iterations when the bill was passing, and some are superfast and this, at the end, they landed with, we are going to phase this in. We do not want to— It is like a whiplash, but we are going to take it over a couple of years essentially. The moratorium goes into effect, sorry, this October, and then October 2027, we start to reduce the rate down. We are collecting less. I do want to note that our skilled nursing facility tax program is our second tax program. They are exempt under H.R.1. They clearly had a great lobby at the federal level. They are the only ones that were exempt from provider tax changes. Skilled nursing facility tax remains the same under federal law. Any new taxes, like I mentioned, moratorium. For example, EMS [Emergency Medical Services] passed last session, we will talk about that in a minute, how that is impacted, but the only other tax we have is our hospital tax. Right now, we are looking at how do we start to phase that over this timeline, reducing that rate, but also applying the new Medicare rate cap for the managed care side in October 2028. All of these things kind of compound over time, and by the end of 2031, we will be down to a 3.5 percent. When it comes to the tax program, just to remind everyone, there is always winners and losers in a tax provider payment program. There is no such thing as everyone being a winner, and that is why we always have a couple angry, unhappy people and then a lot of really happy people. That is part of the deal with the tax program. I think the key we are watching as we phase down is what happens to hospitals. Are we going to have more losers than winners and what does that mean for the viability of the program? We are going to be, once we get formal guidance, we can start to do some modeling around that with Mercer.

Before I dive into the budget impact, I did want to note real quick, let us not forget H.R.1 did impact our Nevada Health Link. Under the Nevada Health Authority, we do have our State Exchange. I just want to point out that a lot of the folks moving off of Medicaid, the adult population that may not qualify any longer for work requirements, there are some new restrictions for them as well as immigrants in our Exchange. We wanted to add this slide here today to make sure that that does not get lost in this conversation because there are some activities that our Exchange needs to do to try to ensure continuity of coverage and that people are getting information on resources to how they can get coverage.

Just here on the slide are a couple of things that are changing, but as you guys recall, our private market, we had these COVID-era enhanced subsidies helping buy down premiums in addition to what was already in the Exchange as a subsidy. Those have expired, and so that was for this open enrollment period. We still saw a pretty steady enrollment, which was good, but then there are all these new things that are going to be added on over time, and they are all listed here. I think the one I really wanted to point out is that anyone who is ineligible for work requirements cannot access premium subsidies through the Exchange. If they are determined ineligible, they go to the Exchange, they cannot find the reduced coverage, reduced cost coverage. So that is going to be a challenge. It is something we are working through. I think all states are looking at waiting for formal guidance on what they can and cannot do. One thought is you could do state subsidies. You could do additional things, but you just have to remember, implementing things like that through the Exchange can be complicated when you are doing just a state subsidy. But there are some solutions. Again, we are really waiting on some more guidance from CMS on all of these pieces.

All right, let us dive into my favorite topic for a policy committee's budget, so my apologies. I am going to do a little quick grounding on the Medicaid budget because it is really important to understand so you can understand how the tax program is really is a budget and it is not a budget impact. We will talk about why that can be true all at the same time.

Some of you may recall, if you have been a part of these conversations before, total Medicaid spending in our budget, which is about \$15 billion for this biennium, is made up of

federal and state money, our state share and federal share. Federal share, generally speaking, is roughly 60 percent in Nevada, and state share—we will talk about what can be made up of the state share—but state share is generally 40 percent of the cost. You can kind of slice it that way, generally speaking. About 3 percent of the spending goes to administrative costs and operational spending, and then 97 percent goes to what we consider paying for the cost of health care services and delivery. Ninety percent, we do get some 90 percent match, and that is for that adult expansion population I mentioned earlier, which impacts budget, and then we also do additionally get 90 percent and 75 percent match for IT. There are different ways to look at the match, but it is a shared program with the federal government.

Just like I mentioned, there are limited ways that we can make up the state share. There is the local county government, for example, funds that we can take in through interlocal agreements. We can also use obviously State General Fund, which is made up— It does not come out of thin air. It comes from tax revenues and so those tax revenues can be used. Then there are other ways that we can offset, like I mentioned, is that provider tax revenue. By taking that off the table, that does impact our budget, or by reducing it, it does impact the budget. And there are some other pieces here that we look at in Medicaid. The last one there, pharmacy rebate revenues, is the one, the big one that has been really generating a lot of revenue for us. Like I mentioned, state budget impact. Depending on the state, the impact on the provider tax program can be a “make it or break it” for your budget. It depends on how you were using the revenue. It is really key to remember that.

I think when I made this slide it made sense; let me see if I can remember. It is a little complicated. Like I mentioned, there are several taxes that we have in the state that are impacted, the H.R.1. Like I mentioned, private hospital tax has the most changes to the program. Our EMS tax, as it was passed, there are potential changes to that program because when the modeling was done last session, we were not sure where we were going to land and there were some conversations about what do we do. The modeling around that, we were assuming a 6 percent tax rate. So now that program will change because it will be reduced under the new law. Like I mentioned, nursing facilities are exempt, and then let us not forget our premium tax, and I will talk about in a minute, but it is impacted by our private hospital tax program, and I will talk about that soon, too. And then, like I mentioned, the tax revenue is reduced, you can see there. Then every tax, except for the nursing facility, and then state budget impact, which tax has an impact because of this? Private hospital, yes. When it comes to children's behavioral health because we use that fund to offset State General Fund. So that is the reason the Children's Behavioral Health Fund will be reduced from the changes.

Then the second piece here is our premium tax. In Nevada, the state taxes all insurance payments, and the big one is through the Medicaid managed care program. The private hospital tax payments, a big, big portion of them run through the managed care program. When you lower those, you reduce how much revenue you can collect. We are going to be reducing how much revenue is coming through by lowering the tax revenue and the match. That ends up meaning less in premium tax collection for the State General Fund, so just throwing that out there. We do have some early projections on that, but again, it just all depends on the summer guidance.

Hopefully everyone is still with me. When we looked at guidance, and what we are trying to put out right now is a real, I would say, a guesstimate, and trying to put out more of a range because depending on the guidance, we could be high or low. But right now, we are looking at the following. The private hospital tax, like I mentioned, it can be used to supplement what we do today in the state supplement our State General Fund for supplementing hospital reimbursement. It does not replace or supplant State General Fund

for hospital payments. It does supplant and replace State General Fund for children's behavioral health, so there are some losses in General Fund in that sense.

H.R.1, specifically, we are thinking it looks like \$25 to \$30.5 million loss for our Medicaid budget when it comes to children's behavioral health services and Medicaid. Now, we are still going to be collecting about \$88 million to \$93 million still for to support children's behavioral health and that is unmatched. I want to be clear. When you match that, it is still a big portion of money. It is over \$100 million at least a year or more depending on how we match and what services. The bad news is we are losing \$25 to \$30 million for children's behavioral health, but like I mentioned, the tax program, if it is still in existence, is still producing close to \$100 million for the state.

When it comes to the hospital pieces, we will talk about that here in a second, but I would just say that we do estimate that the supplemental payments hospitals receive today, that they will be reduced down by \$600 to \$800 million per year. That is not a state budget impact because those did not replace or supplant general funds. Those were in addition to what they were getting from our state as of two to three years ago. I like to consider the provider tax payment program like the cherry on top for them. We would just remove the cherry, and it was not state-funded. Not to say that that does not have an impact, and we will talk about that in a minute, on the health care system, but it does not have a direct impact to the state budget.

On the premium tax side, we do have a situation; we are supplanting some state share using premium tax. Like I mentioned, the premium tax is applied to our managed care payments, which is billions of dollars. Every year we tax that, we match that, and that generates good revenue for the State General Fund. That will be reduced because we are reducing the payments that are going to hospitals now through the managed care plans because the tax program is being reduced. We estimate that is about \$66 to \$79 million in State General Fund revenue that we might have been projecting for this biennium, or upcoming biennium. All of these numbers we are sharing with the Governor's Finance Office. We have also sent them over to LCB Fiscal, but again, we are waiting for guidance to really narrow down that range.

Let us dive in a little bit for the bigger picture. Let us not forget that coverage is important. Regardless of the state budget, there is still an impact when it comes to— Uncompensated care is the big one for our health care system, not just for our hospitals, but for our safety net providers like our FQHCs [federally qualified health centers]. Ann mentioned earlier, originally, we were talking somewhere between 100,000 and 200,000 people would be impacted by work requirements and community engagement. Because of the federal guidance and what some of the choices we have been able to already kind of make with some of the public feedback, is that we are thinking we can narrow that down, like Ann mentioned, to 147,000, but possibly even more with some of those hardship exemptions. Because imagine that there are so many counties that, for example, people that live in counties that have no jobs. We think a lot of people could be exempt for that, too. So that number could get even more narrow because Ann's nice triangle slide, where we narrowed it down like a funnel, we are hoping to really narrow that down with more decision points.

Also, to remember, once we lose folks that are covered, that affects our uninsured rate. So, looking at this range, it could impact our uninsured rate. We could actually go down, and we are, or go up, sorry, increase anywhere from 15 to 18 percent. Right now, we are currently 11.4 percent. We are expecting it could go up to 15 percent on the low end if it is 100,000. If we end up getting more people lose coverage because of paperwork and the process, it could go up. Our uninsured rate could go up to as much as 18 percent in Nevada by 2028. It is important that we give you the range because it is really hard right now to

know. Right now, just to remind everyone, there are still today 367,000 people uninsured. That is a big bucket, and this will be adding to that bucket. But like Ann mentioned, we are trying to do a lot of things in this space to try to reduce that down and to help get people connected to services, including employment.

The other piece that we are looking at is how do we address some of the increasing cost to emergency room (ER) visits. Uninsurance often leads to more emergency costs, delayed care, which grows costs in our Medicaid program and health care costs in our state. It is a real strain, and we all know this on our safety net providers, and so that is something we are acutely aware of and looking at strategies and trying to think through what can we do to support them. But as you guys know, we have limited funds, so some of those strategies may need to come from next session.

Population health is also something we have to think about. When you think of the number of people impacted by H.R.1 and how much Medicaid plays into our health care system, there is an impact on our ecosystem and the health care system. Like I mentioned, \$600 to, it should be \$800 million, sorry, it says \$700, \$600 to \$800 million in losses for our state's private hospitals that will have an impact on their operations. Period. It is important to remember, though, in 2028 and 2029, they are still getting over \$2 billion in that provider tax program, so it is still money on the table, it is just less money. It is less cherry on top, if that makes sense, but that does impact our system. They, for the last two to three years, have relied on that funding, relied on that increase, that cherry on top, and now they cannot, and that may change some of their decisions for growth and for outreach and all the things that they are doing that we do want them to be doing.

Like I mentioned, population health will be impacted. We also know that people end up using the ER more. They delay their medical care. I have here some examples from Arkansas. Arkansas did see about 56 percent of people that were impacted and uninsured with work requirements delayed medical care. Sixty-four percent delayed their use of medications, and they also noted that they were concerned about increased risk of chronic illness in the affected population. It is something we need to be watching very carefully, as with this rolls out.

Then indirectly, there are always indirect economic impacts when hospitals lose funding and systems of care; job losses in the health care system is something we need to be mindful of. At the same time, we are trying to attract workforce, so it is sort of a challenge that we need to think through as a state. Also, it puts more strain on our public health partners. They are already feeling some strain, but we have to think through access to preventative care and primary care is really essential to really controlling costs in our state, and how do we do that if we are losing access to coverage.

Then medical debt is another piece I wanted to mention. In Arkansas, they saw medical debt for this population increase by 50 percent. Now, Arkansas did not have some of the hardship exemptions in place that we are looking at applying, so we are hopeful that some of that, again, like I mentioned, we can really narrow down the population and help those that are affected get employed quickly.

I promise I am almost there. How do we address upcoming challenges? There is a lot that needs to be done. It cannot all come from the state. I think we have limited resources. We are going to have to rely a lot on our private partners as well. A big one, though—I want to end on a positive note because I know it is a lot for the day—is that we did get a lot of funding, \$180 million from our Rural Health Transformation Grant. As a reminder, this amendment that was added to the bill was really in recognition of the hospital impact from the provider tax programs. States like Texas, Florida, I want to say Washington, too,

they have had some historic provider tax programs around much longer than ours, and they were using these not only supplement rates but sometimes offset state general fund, so a big piece. Senator Murkowski in Alaska really fought to get some rural health funding, and so that is where this grant comes from. As we are rolling it out, we are really mindful of that and making sure that hospitals in our rural areas are really engaged on where these funds go, because if they are not really supporting that system, it is not going to the intent of the grant.

We are also looking at, like Ann mentioned, a lot of outreach and education, trying to think through some more marketing and really more technology and how we reach our recipients. Our navigator program, thanks to lawmakers here today that put that into place, some funding for that program. We are looking with our Exchange to really roll that out to support Medicaid enrollment and address some of these work requirement pieces. Then some of the things we were already doing at Nevada Health Authority as we are looking at our purchasing strategy, we just brought on Milliman to be working to put together a purchasing strategy for the state around health care. A big piece is value-based care, which I know some of you are interested in. That is the best way we can remove barriers to care and really reward our systems for primary care and prevention. Then looking with our public health partners, how do we manage population health better in the state? Then last but not least, is a new kind of partnership, I would say, between us and Medicaid and our employment supports and resources at the state level as well as even broadly with private employers. How are we helping people get jobs so they do not have loss of coverage and continuity?

Now, I am going to turn it over to Malinda Southard in Carson City, so she can walk through the great work that she has been doing on the Rural Health Transformation Grant. Thanks, Malinda.

Malinda Southard, D.C., Deputy Director of Community Engagement, NVHA:

Thanks, Stacie. Good morning, Madam Chair, and members of the Committee. Thank you so much for allowing us to present these slides today ([Agenda Item III](#)). I want to talk a little bit more about the Rural Health Transformation Program (RHTP). We were awarded as a state \$179,931,608, and very importantly, 42 cents. This grant application, we submitted four primary initiatives that we wanted to focus on that I will go over here. I want to note that this grant program is for a period of five years, and each year the state is awarded approximately around the same amount. It can go up or down depending upon how the state meets the goals and objectives that we put forward in our application.

For this first box here, this is the Rural Health Outcomes Accelerator Program. This is one of our primary initiatives. In this first budget period, we have almost \$27 million allocated towards this initiative to help to fund evidence-based initiatives intended to improve rural health outcomes, particularly in the areas of chronic disease, primary care and prevention, maternal and infant health, and of course, behavioral health. We will have a request for application (RFA), which will result in subawards available in May of this year, and we estimate that the awards will be announced in summer of 2026.

Next, we have the Rural Health Innovation and Technology Initiative. This also is another nearly \$27 million intended to fund innovation and technology solutions that fill gaps in health care services in rural Nevada. This is a targeted investment towards aligning with the CMS health technology ecosystem and additional, obviously including interoperability between health systems. We intend to have these funds available through an RFP, which is a request for proposals, that would result in contracts available in May, so early May. We

are working on finalizing these documents at this moment and anticipate, again, awards in summer of this year.

Next, we have the Workforce Recruitment and Rural Access Program. This is where we allocated a majority of the funds each year of the Rural Health Transformation Grant, due to the high need in Nevada for health care workforce. We have \$71.9 million allocated in this initiative to attract and retain physicians, including a wide variety of other provider types, to rural areas and frontier areas that include recruitment and retention strategies, training and apprenticeships, and rural workforce programs. We do have two RFAs that are currently open. Those are for recruitment and retention and training and apprenticeship. Those are due, or the deadline is May 15 to apply for those. We will have an additional RFA available under this initiative for rural workforce programs that we anticipate coming out early May, and we will have awards announced for all of these, again, in summer.

Lastly, we have the Rural Health Flex Fund Grant Program. This is almost \$36 million to fund capital expenditures and infrastructure costs that help to enhance and modernize local rural and frontier health care infrastructure. This is, as an RFA, it was released in March, and the deadline is in a couple of days, so deadline to apply for this Flex Fund Program is April 30, and we anticipate announcing those awards in May. Again, with these funds for this first budget period, we have to have everything obligated by October 30, 2026. Obligated means that it has to be obligated in a subaward, or a contract, or another formal notice of obligation of those funds, and then we have to have it liquidated or fully spent no later than September 30, 2027. This is so that CMS has the opportunity to take any of those unobligated funds and redistribute it to states in the next budget period. If we go to the next slide.

The Rural Health Transformation (RHT) funds. Of course, the primary initiative or goal of this is to truly benefit our rural and frontier health care systems. This is really the heart of everything that we have put forward in the Rural Health Transformation Program to date. In Nevada, we are doing it a little bit different than other states. We are asking that the rural and frontier communities come to us with what they need most, what will benefit them the most, and have those vendors and other contractors and providers to work with the local rural and frontier communities on what works best for that community. It is definitely not a state-dictated process. It is more a grassroots effort, and I think that is really important for our state.

Additionally, the RHT awards and programming must include a sustainability plan that obviously does not solely rely on new State General Fund approval. That was another really important thing that we wanted to put forward in this program, that everybody that is applying for these funds must have a sustainability plan built in of how they are going to carry forward this program once the grant ends.

The next slide, we go over the Rural Health Transformation Steering Committee. In our grant application, we put forward a list of 15 members that includes a broad array of representatives from rural and frontier health systems and communities within our state, plus state, local, and tribal health representatives. We had our first meeting on March 11, and I am happy to say it was a huge success. We did receive a lot of feedback that we were able to incorporate into how we release the RFAs and pending RFPs for each of these initiatives. It was really helpful feedback from the Steering Committee members. The Steering Committee is not involved in making specific funding decisions related to how the RHT funds are spent or who they are awarded to. However, they do track progress on all of the initiatives and can recommend adjustments to change course or align with some best practices or what is working better in our state or another state and make those recommendations. Our next meeting for this Steering Committee is on June 9. These

meetings will be held quarterly, and they are open public meetings, so anybody is welcome to join and attend.

Then lastly, I just wanted to touch quickly on community engagement and outreach with the Rural Health Transformation Program. As I mentioned, June 9 is our upcoming meeting of the Steering Committee. Also, today, we actually have a rural health innovation and technology pre-RFP webinar. It is going to provide some important information about the health IT functionalities and capabilities that we may speak to in the RFP that will be released early May. If you are unable to join that webinar, we will have that recording available on our website along with the slide deck. Yesterday, we had another webinar along those same lines talking about the CMS health ecosystem. This was a really important informational webinar because we talk about this health IT ecosystem, but really, what does that mean? This webinar went into the details of what that is and what it means to be aligned with that. Then lastly, we just recently had a workforce recruitment and rural access program webinar for interested applicants and the two open RFAs that we have right now. Again, that was recruitment and retention and training and apprenticeship.

Then lastly on this slide, we did include some online links to our rural health transformation web page. We try to be very transparent and put everything we possibly can on our web page. We even have our notice of award on our webpage so that folks can see exactly what Nevada was awarded and how. We would also encourage folks to sign up for our Nevada Health Authority LISTSERV to stay informed about all rural health transformation-related meetings and announcements including funding opportunities. We also included a link to our RHT meetings page. As I mentioned, all of the meeting recordings, and slide decks, and supplementary meeting information is included on that meetings page under each of those sections. With that, I think I will turn it over to folks for questions. Thank you so much.

Director Weeks:

Madam Chair, I just want to end with saying thank you guys for having us. I know it has been a lot. Excited to answer questions. I want to give Malinda Southard and her team a shout-out. Apparently, we are one of the few states leading on how we are implementing RHT, and we have been hearing really great feedback, so I just want to give her a shout-out and let you guys know that. It is a very short time that they have been able to stand this up and get it moving, so thank you guys.

Chair Brown-May:

Thank you all for the presentation. We really appreciate that you are here. As you know, we have been looking forward to this conversation from the beginning of the interim and so grateful for the compilation of all of the information. I know that we have a number of questions, so we are going to go ahead and start here. Members, are there questions? Assemblymember Nadeem.

Assemblymember Nadeem:

Thank you so much, Madam Chair. Thank you so much for the wonderful, comprehensive presentation. My question is regarding the Medicaid for the homeless people. As we know, right now they have, many of the homeless, they have Medicaid coverage. Moving forward with the Medicaid cuts, what is the plan for the homeless people?

Ms. Jensen:

Madam Chair, Committee members, thank you for the question. This is absolutely a population, a very vulnerable population in our state, that I know many states are trying to

be as creative as possible in how we support. I think the way our medically frail definition is written, the majority of people experiencing homelessness due to a health condition, such as substance use disorder or a mental health condition, would automatically be exempt. We recognize not everyone is engaged in the health care system, and so it will be important for us to be able to get that documentation if we are not or if we do not already have claims information. For people that may not be exempt, there will be again a range of options. We are hopeful to connect people to job supports, to volunteer opportunities, or education opportunities that they may be interested in. We recognize it is going to be a very person-driven approach. It is going to be different for every person, but we are really committed to being as comprehensive with those options as we have a state ability to do so and help ensure that people are compliant with the new Medicaid regulations and avoid disruptions in coverage where possible. Thank you for the question and we look forward to further collaboration with our community partners that are working with this population on a daily basis. We are grateful for them and look forward to learning how we can best support them in the months and years ahead.

Assemblymember Nadeem:

Thank you so much. Chair, can I have one more question? Thank you. My other question is regarding the hospitals. These Medicaid cuts would have a serious impact on hospitals because when people lose coverage, they often delay treatment until their condition becomes an emergency. That is leading to more emergency room visits, higher uncompensated costs. So how, that burden, the hospitals are going to deal with that burden? Is there any plan ahead?

Director Weeks:

Madam Chair, like I mentioned, this provider tax has been around for about two years. Unlike some states, this is a newer increase in funding. Not to say it was not needed, but like I mentioned, there is still a couple billion that they are going to be receiving. So yes, it will be an impact, but I do think that one of the things that we are trying to work with our hospitals through our Medicaid quality collaborative is for them to participate more in what we call transitions of care, the value-based payment arrangements where we are trying to help them help us avoid unnecessary ER visits. That is something we can work on that way. But yes, there is always going to be a challenge, I think, in revenues when you lose revenue sources. Thank you.

Chair Brown-May:

Thank you. Next, we will go up north to Assemblymember Goulding.

Assemblymember Goulding:

Thank you, Chair. Thank you for the presentation. I have a couple questions. One, you said, Director Weeks, you said that you were hoping to help affected Nevadans get employed quickly, those who are, would be losing their coverage. Can you expand on that a little bit?

Director Weeks:

Yes. One of the things that we are already talking to is DETR, our state agency, and trying to make sure that people who may be losing their coverage that there is some sort of connection through the eligibility process, if they are denied eligibility, that we are letting them know that there are employment resources. One thing that I think could be helpful for next session, as we start to think out budget bills and items for special consideration, one item that I think we probably want to think about is technology beyond just DETR. Is

there some sort of technology and tools where we can connect people online to a lot of employment resources, other job training sites? There is a variety of technology and resources that we could probably try to, if we have the funds, to purchase that could help us do that better. But right now, it is really primarily with DETR in making sure there is a handoff there to resources. As you know, Assemblywoman Goulding, is that a lot of people, there is a lot of job training programs, too, that we need to be ensuring that we are connecting people with.

Assemblymember Goulding:

Thank you, Chair. Another?

Chair Brown-May:

Go ahead.

Assemblymember Goulding:

When addressing the Rural Health Transformation Grants, you mentioned sustainability. One of my concerns about that is we know our rural communities are hurting now, and I am having a hard time imagining what those sustainability plans would look like when they are in desperate situations now. If you make this funding contingent upon future funding when there is nothing there right now and they are facing dire circumstances now, how do you envision a sustainability plan?

Director Weeks:

Madam Chair, Malinda, I am going to start it and then kick it over to you. I think our point there is that we heard loud and clear from this Committee and also IFC [Interim Finance Committee] that we do not want a billion-dollar cliff for the state budget either. We are trying to be sensitive to the fact that this is a billion dollars over five years, and if there is no sustainability plans at all, everyone is going to look at this body to fund it, and we cannot have that. I am going to turn it over to Malinda, but that is sort of our goal. It does not mean everyone has to be 100 percent sustainable, but we have to think about some sustainability strategies. It could be future grants; it could be private donations. There are a lot of people here with a lot of money that could help out, and there are other things that people are going to have to think through. Medicaid reimbursement is another one, but it cannot be a huge cost to the state. We are also thinking through if people want to bring items for next session, it could be supportive of year two of sustainability funds. Malinda, did you want to talk through some of the strategies and what you are asking members to put together in a business plan?

Dr. Southard:

Sure. Some of the things that we have talked about is folks may need a bolus of funding for startup costs. If it is already a project that has tried to be funded, but they just do not have the funds to start it up, the Rural Health Transformation Grant is a great funding source for that, and then they can carry it on with their additional funding. We have, also, as Stacie mentioned, we have talked about Medicaid reimbursement, or private donors, or just other strategies. The lack of a sustainability plan does not preclude somebody from being funded through the Rural Health Transformation Grant. But it is, we would like that consideration put forward into the applications, and the stronger the sustainability plan, if the project goes on for multiple years, the better opportunity that is. Thanks.

Assemblymember Goulding:

Thank you. I agree that having a fiscal cliff is a bad scenario, so I do not criticize that objective to not be facing that. I am just concerned that we will be, in fact, facing a fiscal cliff, and I think it is a conundrum of the funding. Certainly, it is a welcome funding source, but I think it is a big concern.

Chair Brown-May:

Thank you. We will go next to Senator Titus.

Senator Titus:

Thank you, Madam Chair. I have a number of questions, if that is okay. I will start first by thanking all of you here today, Director Weeks, and your entire team. One of the things that is hard to navigate is making sure and paying attention to the human component of this, and I think you, all your departments have done a tremendous job making sure the human impact of these decisions that are coming out of Washington. Having said that, you are also paying attention to the potential fiscal impact to Nevada and our budget and those are two very hard things to navigate, recognizing they sometimes have different avenues to solve. So very much appreciate your time and your considerations.

Director Weeks, in the past, we have heard about a percent of eligible Nevadans that are eligible for Medicaid but do not actually access that. Do we have a number on those, on that particular number? You are throwing out numbers like perhaps 5,000 people working et cetera. Do we have those that are currently eligible but do not apply? Do you have any of those numbers?

Director Weeks:

Madam Chair, Senator, unfortunately the Guinn Center has not updated that analysis since I think it was 2021 or 17, something like that. The numbers we used to use on that are pretty old, so we do not use those. It is a survey that I think we probably need to revamp in the states to really get a sense of our uninsured today. I think some of the things that we are doing to modernize eligibility and enrollment with our sister division and our Exchange around Medicaid, I think, will help get some of those folks enrolled and possibly reduce some of those numbers. But it is a number we do not really have really updated data on.

Senator Titus:

Well, thank you for that, and if I might continue, Madam Chair. That kind of brings me to the next question that I have. I know under Decision Point 1: Determining Short-Term Hardships, there are a couple issues there and that really reaching out to folks, and I am wondering, how exactly are you going to reach out? Do you have online assistance? We talk about the rurals and the high-unemployment counties; how do you actually reach out to these Nevadans or are planning on reaching out?

Ms. Jensen:

Madam Chair, Committee members. Thank you, Senator Titus, for the question. This is something that we are really wrestling with is what are the ways that we can communicate, as effectively, knowing for each of our geographic communities and general communities throughout the state, it is going to look a little bit different of actually what is effective. What we are exploring is a combination of physical outreach, mailed items, flyers and posters in grocery stores or health centers, but also our current texting and email

capabilities, social media, and other mediums of getting the word out. We are also working to secure resources to find more creative ways to do kind of earned media and marketing to try to get in front of people in more creative ways that maybe we have not done in the past. As we have more details on that, I am excited to share.

But we also recognize that in-person connection, particularly in our rural and frontier communities, goes a long way and we need to find those trusted community members that people already know to really communicate through. Thinking about our federally qualified health center staff, as we mentioned before, our navigators are going to be really key partners, and I am excited to have an ability to expand that to support this Medicaid process. But I think, candidly, it will be a challenge. I think we are trying to communicate with a lot of people, and we are trying to do it in the best way possible, but we expect that there will be people that are harder to reach. If you all have creative ideas on how we can do that better, or if you are getting feedback from your constituents throughout the process, we want to hear it because we recognize this process will evolve, especially throughout the first year.

Senator Titus:

Last question if I might, Madam Chair, and this is deep in the weeds. On one of your slides regarding H.R.1, the Nevada Medicaid eligibility for immigrants, the very first paragraph mentioned certain categories that will still be covered of immigrants, and then it said, in the last line it says, “. . . women in states that have elected the CHIRPA 214 option.” Did Nevada elect that option?

Ms. Jensen:

Madam Chair, Committee members. Those are the weeds we like to be in, so thank you for the question. Yes, Nevada does have that option, and we can get you additional detail on what that looks like, but again, all the components of how we cover those populations right now will not change. It is the additional populations that do not meet those requirements that will be impacted on October 1.

Senator Titus:

Great, thank you. Because, as a fiscal conservative, I have pushed out a long, long time that prenatal care really saves our state money, and I would hate to lose any of that coverage for these women and children. Thank you very much for that. Thank you, Madam Chair, for the patience with all these questions.

Chair Brown-May:

Thank you. Next, we will go to Senator Lange.

Senator Lange:

Thank you and thank you for the presentation. You always give great complex presentations, and we really appreciate that. I have a couple questions. On slides 26 and 27, they reflect a combined loss to the state budget of approximately \$91 million to \$110 million in 28 and 29 from hospital provider taxes and premium tax reductions alone, and in slide 30, it is \$600 to, I think you changed it to \$700 million, to \$800 million in losses to the state's private hospital system by the end of the next biennium. Where does the Health Authority expect those gaps to be filled? If they are not filled, which services, or reimbursement programs, or rates will be cut? Then, if I could just ask you another part

that you could add on to that. Are you aware of a plan that could be coming from the Governor's Office to deal with all of this?

Director Weeks:

Madam Chair. So that was a lot of questions. Just to be clear, the \$600 to \$800 million, like I mentioned, is not a budget impact. It is additional funding that will just be reduced. It is essentially federal money that is just going to be going down for them. We do not have \$600 to \$800 million, but it is not going to— It does not affect our budget, which means there is no provider cuts from that specifically. Now, depends on the state revenue. There are a lot of things that happen in the forecast. None of us can see what is coming in this fall. That is a different conversation. I do not want to sit here and say I do not know where we are going to be, but I can tell you from these changes, we are not proposing any cuts to our budget related to H.R.1, mostly because of the decisions that this body has smartly made to not use a lot of that provider tax funding to supplant general funds. Thankfully, we are not in the same position as some other states like Minnesota, as well as Florida, and Texas, and others that have really relied on some of those funds for general fund dollars. Like I mentioned— And the Governor's stuff, I cannot speak to the budget bill; that is confidential, but you guys will find out at the end of the year. Thank you.

Senator Lange:

If I could ask another question, Madam Chair? We are all really concerned about the budget. We have other things that we want to include in the budget, so when we ask these questions, it is a lot to digest. Are you considering proposing Medicaid reimbursement rate cuts in the *Executive Budget*? Will your office be proposing that?

Director Weeks:

Madam Chair. Not from H.R.1, and I do not know, again, what the state's budget is going to look like and how much revenue we will have. That is rely on casino tax, gaming tax, a lot of taxes. But when it comes to H.R.1, there is no need for us to be cutting provider rates. I can tell you that.

Senator Lange:

Thank you. I may have [inaudible], but that is good for now.

Chair Brown-May:

Senator Doñate.

Vice Chair Doñate:

Thank you, Madam Chair. First and foremost, I have commentary that I think is important for the record and then I have questions that follow subsequently. First and foremost, I just want to thank your staff. I think God knows where we would be without Director Weeks at the helm, and Ann and so forth. I cannot underscore that. I think that in moments like this, it really does matter the leadership that we have, and I have my full confidence in your team to help us navigate this process.

I also want to be cognizant of Committee rules, Chair, just because I know it is important to be respectful, but I also want to make sure that the record is set straight in terms of the situation that we are going to fall into in the coming months. Last year, a couple of us sent a letter to you, Director, asking for projections in terms of what would it take if Congress

were to make certain cuts to the budget or of how Medicaid and Medicare were funded. And we, of course, it was about a year ago, that we were in a similar room between the Assembly and the Senate discussing those matters. It was interesting that some of my colleagues went to the *Review Journal* and mentioned that President Trump was not planning to make those cuts and that we were crying wolf, but obviously, we have seen that that was not true. In fact, they did get enacted, and now we are in the consequence of having to figure out what we are going to do in place of that.

I also want to make sure that as we go through this hearing process, in my opinion, this is the most important one that we have this legislative interim. The reason why I mentioned that is because we are about to step into an economic crisis with the amount of Nevadans that are going to be uninsured and kicked off of Medicaid within the coming years. I think it is important for all the Committee members to try to solve that as much as we can, simply because of the seriousness that is going to occur when people are put in that position.

In terms of my questioning, I know on slide 29, we talk about utilizing the Rural Transformation Funds. I think that is just a short backstop; it does not really address the issues. I think it is more of a federal thing that we all have to navigate together. It is not a kick towards you guys. I think all, every state is having to deal with this situation. My problem with the plan that we have right now is that as much outreach as we can do to knock on the doors and educate Nevadans on how they can navigate health care, if they were on Medicaid and now they are going to be in a different situation, there is no proposal that I am seeing right now to help with that coverage gap. My question is, how— And just to put this into perspective for the public, when we say 100,000 to 200,000 Nevadans are about to get kicked off, in total, that is going to be half a million, correct? I just want to make sure with the current uninsured rate that we have right now.

Ms. Jensen:

Madam Chair, Committee members. On the Medicaid component, I understand your question is on the overall uninsured rate, and we can kind of speak to what that total looks like. On the Medicaid front, as Stacie noted, our estimates are continuing to evolve. We expect about 147,000 people have to meet work requirements. We do not expect that all of them will not achieve them, so we expect— I think Arkansas and other states have seen around 50 percent of people drop off, which would be closer to 70,000 people on Medicaid losing coverage. But again, we will continue to provide updates on what that looks like.

Vice Chair Doñate:

Just to be clear, our uninsured rate right now, we have about 300,000 Nevadans, so we are going to be adding about 70,000 to them. That is about comfortably 400,000 Nevadans. Again, half a million Nevadans, so I think there could be a plus or minus around that differentiation.

I guess my question is, as much outreach as we can do, what are we proposing in terms of a plan for the coverage gap for the Nevadans that are going to experience—whether they are at the fault of not meeting compliance requirements with work requirements or volunteering hours, et cetera—when that moment hits, if they cannot afford the plans on the Health Exchange because they make not enough to afford, but they are also in that small window, what are we going to do to help those Nevadans? We can do as much outreach as we can, but how do we solve that coverage gap?

Director Weeks:

Madam Chair, as you guys know, we do what you guys tell us often and what you fund us. This body passed the public option and that is one avenue that if it does live up to its vision and its goals, it should be helpful in lowering costs. You are right that there will be people that do want to remain covered will have to pay a lot of money. But the big key is looking at our private individual markets or Exchange. This body could fund and pass state subsidies. That is on you; I cannot do that piece. Right now, the tools I have are outreach, working with vendors, technology, getting the best data match I can so it is not a burden. Doing all the things that we have been talking about, leveraging our navigators, and thank you, Senator, for that funding. All of those pieces I am doing with what you guys give us. If you guys want a plan like that, we are more than happy to look at that. I cannot speak to what the Governor's proposal will be unfortunately.

Vice Chair Doñate:

Madam Chair, if I may follow up? Thank you. That is exactly the type of answer that I wanted. Just to be clear, if the Committee were to decide, yes, it is imperative of us, from all of us collectively, to help solve the coverage gap, that is something that we have to address together and we decide that the public option pass-through funds are the vehicle for that. Is that something that we have to go back to the federal government for approval, or is that something that we already have the statutory authority to do so within the state?

Director Weeks:

Madam Chair, yes and no. I would say it is a mixed bag. Right now, based on what we have been able to achieve in year one, we are really just only able to pay for reinsurance. I think we would have to rethink our proposal and what we use those funds for, yes. We could ask for a larger target to reduce the— We could do that. We are looking at that now, on how to generate more pass-through dollars, but as you may recall, the more we push on that reduction target, the more that our plans have to push down on other things, too. We do have them pushing down on their admin costs, but they would also have to look more on their providers as well. There is a give-and-take in health care. You squeeze one end of the balloon, and it is somebody else that pops. So, yes, those are things that we could talk through and consider, but that would have to be— I would consider that a legislative request.

Vice Chair Doñate:

Thank you. Just as a follow-up. I would welcome the ability maybe to— I think you kind of got that based on my email correspondence that it would be nice to see the financials of what it would take to say, create a program to help the—I am going to call them the “missing middle”—the folks that make too much money to qualify for Medicaid or cannot comply with it, but not enough to afford health insurance on the Exchange. I would like to see the financials and work with your team in terms of what it would cost to work with the current ACA [Affordable Care Act] subsidies so that by the time they enroll into the— When we have the navigators meet them and we get the chance to talk to them and say, looks like you are part of that “missing middle,” the state passed these level of funds, do not worry, even though you are now enrolled in the public option, the state is still supplementing and supporting you. I hope that we can work together to get to that point. I just want to be clear, we cannot use those Rural Transportation Fund dollars for that option right now, correct?

Director Weeks:

Madam Chair, I do not think so. I think that would be challenging and we would have to get that approved. One thing I would just say, Senator, that we are waiting to see. What we have seen from this administration at the federal level is often if they do not like that a state may be state only funding a subsidy for a certain population, they will put it in guidance that if you do that, you do not get federal funding. Until we get federal guidance this summer, we are happy to help you go ahead and look at what that would cost; that is easy or easier. But once we get the guidance, I think it would be a matter of, is there anything that we will be doing that might affect other programs? I just want to throw that out there as something that we have to be mindful of.

Vice Chair Doñate:

Thank you, Madam Chair. One more. I want to come back later on. I am just putting this as a feeler more. It is not my question, but I just want to make sure that you know that I think we have to have perhaps maybe more on the mental, on a separate concurrent meeting when we talk about mental health. It would be interesting to talk about the reductions in the behavioral health program through the mechanisms that we already have. Is that going to be out of compliance with the DOJ [U.S. Department of Justice] settlement? That is more of a commentary.

The only question that I have is more on slide 18 regarding immigrant eligibility. Do we have a projection now in terms of how many individuals will be affected from this? I have always been an advocate on making sure this is— I do not need to divulge into this of the importance of level. I just need to know how many Nevadans are going to be impacted, if you have some preliminary numbers on that aspect yet.

Ms. Jensen:

Madam Chair, Committee members. First, we would be happy to chat about children's behavioral health anytime; so happy to have that conversation. On the data projections on the October 1 immigration changes, we are currently projecting between 5 and 6,000 Nevadans may be impacted by those changes. Again, that June guidance will help us really nail down exactly what that number looks like. We plan to communicate as broadly as possible and as early as possible so people will at least know what their options may look like, but appreciate that that is a significant number for our state.

Chair Brown-May:

Thank you. I do have a couple of questions, and I would like to go back to the children's behavioral health piece. Can you speak to what are the impacts given that we do have the Department of Justice settlement agreement? We are working on a robust plan. We do know that we have a lot of time and attention that is necessary to serve this population. What are really the impacts to the plan that we have?

Ms. Jensen:

Madam Chair, Committee members. I am excited to share that I am not concerned about our ability to achieve compliance based on these funding changes. We have taken a very close look at all of the funding that is coming in through this account, and based on our projections for the upcoming biennium, we will be able to continue to cover everything that we plan to and have included in the implementation plan that has been reviewed and approved by the Department of Justice. We appreciate that there is less money coming in

the door for that program and we need to be as thoughtful as possible on what that looks like, but given the funding that we do have coming in—up to about \$100 million in State General Fund resources that we will be able to match federally every year, every biennium, excuse me—our projections indicate we are able to continue to cover it. We meet monthly with our Department of Justice team and our independent reviewer, and we are working very closely with them to keep them informed on what our implementation looks like. If at any point we need to alter where those funds are coming from, that is something that we would bring to this body. We are deeply committed to this program and to transforming the way that we serve kids and families with behavioral health needs, and I am excited for us to continue to do so, and we will keep you posted on any long-term impacts.

Chair Brown-May:

Thank you. I want to go back to slide 10—Work and Community Engagement: What Counts? Specifically, there is a lot of detail here. I am curious to know, how are we addressing the populations that may have language barriers?

Ms. Jensen:

Madam Chair, Committee members. It is a great question. We are working, as we always do, to translate our written resources and online resources into the languages that our patients speak. I think our Navigator Program is going to be an exciting way to partner with organizations that have staff that can communicate in the languages that our Medicaid patients would prefer to interact with our system in. But we recognize it is really complicated information, regardless of what language we are communicating in, and so we always welcome feedback on ways to do that better. But it is a deep component of the way that we communicate in line with ADA [Americans with Disabilities Act] requirements and really trying to ensure that [inaudible] as excessively as possible.

Chair Brown-May:

Thank you. And you just said it, Navigators. Can you give us an update? Where are we with regard to the implementation of the Navigators, so that we really are addressing these needs?

Director Weeks:

Madam Chair, I am going to call up Jennifer Krupp, our Administrator over Division of Consumer Health Services, so she can give us an update.

Chair Brown-May:

Thank you. Welcome.

Jennifer Krupp, M.P.H., Administrator, Division of Consumer Health Services, NVHA:

Thank you so much for having me. Again, we are incredibly grateful for the additional funding that was allocated to the Nevada Health Authority to help support our Navigator efforts through the 36th Special Session. We are looking to actually publish our RFA, or our request for applications, on Friday, May 1, so we are going through the final stages right now. We are really excited about this opportunity. We are looking to expand our Navigator or Exchange enrollment facilitator population so that we are actually having enrollment assisters at points of service. We are really looking to face with community-based

organizations and community partners to have on-the-ground support for consumers who may need assistance understanding their Exchange health insurance requirements, their Medicaid requirements, helping fulfill, as Administrator Jensen had mentioned, any of those exemptions they may qualify for application assistance and really helping Nevadans select the best plan for them or the best Medicaid option that is available for them.

Chair Brown-May:

Thank you. I am going to follow up on this. This is something that popped up in a conversation within the last week relative to community organizations who are Medicaid-certified can, do eligibility determinations specific for Medicaid. Have we considered that or do we have access to that currently to better facilitate the Navigator piece that you all are initiating right now?

Ms. Jensen:

Madam Chair, Committee members. Just want to clarify the certification you are talking about. Is that related to presumptive eligibility and helping people get access to Medicaid more quickly? Yes? Always happy to speak on that. We actually just got a state plan amendment approved by CMS to expand that program so pregnant moms can go through that process. It is a really simple form that when they are accessing care in whatever setting they are in, they can complete that and they are presumed to be eligible for Medicaid and will go through the full and comprehensive eligibility and enrollment process after that time. Our intention is to roll that out. Our tech systems and trainings for providers will be ready to go by July at the latest. We are going to be really focused on how do we continue to expand that program and help folks get access to their Medicaid coverage earlier that they are eligible for. If particular community organizations are interested in learning more about what that looks like, we would be happy to have that conversation. There are slightly different flavors of presumptive eligibility versus our Navigator Program, and I think there is a place for anyone who wants to be part of that conversation, and we would be happy to figure out what that looks like.

Chair Brown-May:

Thank you for that detail. Following up on that community organization piece, there will be volunteer hours in order to help folks meet eligibility requirements. Is there a centralized data portal that organizations will be able to utilize, input those pieces so that we can streamline that determination process?

Ms. Jensen:

Madam Chair, Committee members, I think it is a really important question, and it is kind of a two-part answer. One is how do we connect people to volunteer resources if they are looking for something? And the second is, if they have completed volunteer hours, how do they submit that information?

The first piece, we do not have a central hub at this point. What Stacie mentioned, I think there is a lot of very interesting and helpful technology out there. We are trying to do is find ways to connect to local organizations or at least include information on our outreach for where folks can go. But at this point, we do not have a single point that lists the volunteer opportunities right now.

On the second piece, if you do complete volunteering with a community organization, that would need to be submitted by the member through an attestation form. Exactly what

that looks like, we are waiting on that June CMS guidance. But our intention is to make that process very clear and to have all of those forms along with all of our other outreach materials be reviewed by our Medicaid member advisory council and beneficiary advisory council, so people who are actually in our program right now can advise us on whether those forms make sense or how we can improve them. We will do everything possible to be very clear and to equip our community organizations with the information to help folks that are volunteering with them navigate that process.

Chair Brown-May:

Thank you. I am almost there. I do sincerely appreciate the detail that you have provided in this report and your presentation. There are a number of questions throughout the community and people are very concerned and confused, so giving us an opportunity to get this out to the public is really essential.

On slide 13 you talk about high unemployment as a possibility for an exemption. What does that mean? What is the percentage that we are considering? Is there wiggle room to identify what high unemployment means?

Ms. Jensen:

Madam Chair, Committee members. It is an excellent question and one that states have been asking CMS for guidance on. This is where the rule in the federal law requires a little bit more detail and that is what comes from CMS in the form of guidance. We expect to have more detail on what they define as a “high-unemployment county” in that June guidance. If they decide not to define it federally, then we will have an opportunity as a state to define that, and we would bring that to a public workshop and seek input. But at this point, I do expect that they will have some sort of standard national or federal definition on that. We just do not know what it is quite yet.

Chair Brown-May:

Thank you. I would offer a suggestion to bring forward is that it is not just a high unemployment overall rate but high unemployment in specific positions. If you are trained in a specific position, is there high unemployment for that job? As a way, then we work to retrain folks through Department of Employment, Training and Rehabilitation to get them employed, just as an exemption consideration.

Then I do have one last question. It is really about the look back period. On slide 14, we talk about the one to three months before a person applies, one month prior. That is your recommendation. What happens if a person does not apply right away and we are only looking back at one month? When we look at eligibility for DETR, we are looking at the quarters, first three of the last four completed, basically. What happens if there is no compliance mechanism in that one-month look back?

Ms. Jensen:

Madam Chair, Committee members. It is a great question, and these are the wonky ones that we are having with CMS candidly right now. Here is an example of a scenario and what would that look like. If we choose the one month prior, my understanding—and again, I know you are hearing this a lot, we are awaiting that federal guidance in June to confirm this interpretation is correct—our understanding is that it could be any of the three months prior, similar to how it is any of the six months prior at renewal. For example, if they are applying and we have in April, we are looking back at January, February, or March if we

have data from DETR that would indicate they met requirements in February, for example, that would count as compliance. That is what we are anticipating. We will see what that federal guidance looks like in June, but does that help answer your question?

Chair Brown-May:

Yes, it does. Thank you for that. I just have one final one. I want to be really clear. This really is the final question. Final, final. We talk about the hospital provider tax and how there is no impact to the General Fund because of the way that we have structured it, but the impact then falls directly on the hospitals. I know that the state is very concerned about serving patients and the viability of the hospital network. How does the lack of or decreased provider tax then affect the sustainability of our hospitals—rural, urban, new? We have a brand-new children's hospital planned in the middle of southern Nevada. All of those hospitals are building their business plans based on projections from provider tax revenue. Have we considered, as a state, what are the implications and are we going to be required to help shore up the hospital system if their revenues are decreased through this measure?

Director Weeks:

Madam Chair, no, we are not required to. If you guys choose to, you have to find the funding. I think that is the challenge. Remember, this program has been around for two years, so we go backwards, about two and one-half years. We are going backwards, \$600 to \$800 million, but remember, they are still going to be getting over at least \$2 to \$3 billion each year. Mercer initially— Now again, I always preface it with federal grants, and I hate to have to say that, but I want to be careful because it could change. But right now, when we looked at how this would impact in the way we have structured our provider tax, that the biggest impact is on our large acutes, which are our bigger for-profit. Probably not to say that they are going to be happy with me when I say this, but more likely to be able to weather it. The way we have structured our program is we have really prioritized our critical access hospitals, our sole community hospitals, so they get more of the funding under it. They have what we call kind of like a “policy indicator” where the funding goes. Because we structured it that way, we have kind of done our best, I think, to protect our rurals. Not to say there will not be some shifts down, but I think the biggest impact that we see coming is on our largest acute hospitals. And yes, they have been budgeting for the last two and one-half, three years, hoping for more windfall. But I do think they are still going to make some money under this, it is just not going to be as much. And yes, the Legislature can decide, if they choose to, to supplement or replace that on their own.

Chair Brown-May:

Thank you. I appreciate that. Members, any last questions? Thank you so much for being here. We appreciate you and we will officially close this agenda item.

AGENDA ITEM IV—UPDATE FROM THE DEPARTMENT OF HUMAN SERVICES ON THE CHANGES FROM H.R.1 TO THE SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM, INCLUDING AN OVERVIEW OF ELIGIBILITY CHANGES AND DEPARTMENT EFFORTS TO MAINTAIN A PAYMENT ERROR RATE BELOW 6 PERCENT

Chair Brown-May:

Thank you. This moves us to the next item on our agenda, Item Number IV, which is an update from the Department of Human Services (DHS) on the changes from H.R.1 to the

Supplemental Nutrition Assistance Program, including an overview of eligibility changes and the Department efforts to maintain a payment error rate below 6 percent. Welcome to both of our presenters. We are grateful to have you here. You may begin whenever you are ready.

Laura Rich, Director, DHS:

Thank you, Madam Chair, and members of the Committee. With me today, we have Deputy Administrator Kelly Cantrelle from the Division of Social Services (DSS). We are happy here today to provide some information on the impacts of H.R.1 to the SNAP program, which is Supplemental Nutrition Assistance Program. I think that the Health Authority did an amazing job setting the stage, and they gave you kind of a good benchmark of what those changes are to Medicaid. We are here just to talk about what those changes are going to be to SNAP and the Division of Social Services. I think I am going to pass this on to Kelly, who lives and breathes this every day and can speak to this much better than I can. Go ahead.

Kelly Cantrelle, Deputy Administrator, Program and Field Operations, DSS, DHS:

Good morning, Madam Chair, and Committee members. As Director Rich said, we are going to talk today a little bit about the impacts of H.R.1 on the SNAP program ([Agenda Item IV](#)). As you are well aware, H.R.1 has reshaped a little bit how we administer the SNAP program. There are changes to administrative funding. It reduces the federal share of administrative funding. It is implementing a cost sharing, a share of the benefit cost on states based on the payment error rate that individual states have. It has more stringent work requirements, and it eliminates certain eligibility for immigrant families.

Let us talk about the administrative cost increase first. Right now, currently, administrative costs for SNAP program are shared 50-50 between the federal government and the state of Nevada. As of October 1, 2026—so this year—the share of costs for the administrative costs goes from a 50-50 split to a 75-25 split. And right now, it roughly takes \$100 million to run the SNAP program every year, so the impact of this is an additional \$25 million per year to the General Fund, to the state's budget. What was once \$50 million a year is now \$75 million a year.

With bipartisan support in this last special session that we just had, we did receive an additional \$19 million in funding to get us through the remainder of the state fiscal year (FY). And starting in 27, that will be an additional \$25 million ask to continue the program based on just the administrative costs, which we have no control over whatsoever. The administrative cost is very important to note here. It does not just affect DSS. We have nine community partners that take applications on our behalf and do conduct eligibility interviews, and their share of costs for the administrative piece will also go from 50-50 to 75 percent and 25 percent. I am going to pause for just one moment. Forgive the interruption. I think we have some technical difficulties.

As I was saying, the administrative cost increase to the state does not just affect the State of Nevada and our agency, but it also affects our community partners. Overall, the collective impact to these community partners is approximately \$880,000 for these partners who continue to take or who take applications on our behalf.

The payment error rate. With the new share of cost for benefits based on payment error rate, we have never before had to do that. As of right now, 100 percent of the SNAP benefits are currently funded by the federal government. Effective October 1, 2027, this

could shift based on the state's error rate. The screen you see, or the slide that you are currently looking at, is a little bit outdated. We have run new projections since this slide was created, and we now know that for an error rate between 6 and 7.99 percent, we are at approximately \$44 million, and for error rates 8 percent to 9.99 percent, it is \$88 million, and the dreaded 10 percent or higher would be a \$132 million impact to the State of Nevada based on our new projections. The higher your error rate is, the higher percentage you pay ranging from the 5 percent up to 15 percent of the benefits.

How is this error rate calculated? SNAP cases are randomly pulled each month following mandated review requirements by the federal government. Quality control (QC) staff review these cases for all elements of eligibility to ensure that the decision that was made is accurate. They look at things such as income resources, they reinterview the customer, they reach out directly to the sources to verify a lot of this information so they can reach out to the bank, to the employers to verify the information. Any case that has an allotment that differs by \$58 or more is considered a payment error. It can be \$58 over or \$58 under, but if the difference is \$58, that is considered an error and for each month, those errors are put together, and the cumulative amount is what makes up our error rate. The QC findings, or quality control findings, are then transmitted to the federal government, and they go through a type of purification process to ensure that the determinations we have made are accurate.

One important thing that I like to note here is that quality control can take up to eight hours on one case to spend verifying the information and to make sure that all elements of eligibility were accurately determined. The average caseworker processes six to eight of these cases per day with an average of about just an hour per case. We do not have the luxury, unfortunately, of taking eight hours on one case because we have customers to serve and benefits to get out, but we do make every effort to ensure that cases are going out as accurately as possible.

On this slide you can see a little bit of the history of past error rates. Our goal, I know it says 5.99 percent, but our goal is actually to get below 5.99. Zero would be great. I would feel much better with zero going into paying a share of costs for benefits, but I think a 0 percent is challenging, would be very challenging to achieve. We put efforts to lower our error rate into effect back in June of last year. We saw the federal changes coming. We saw the proposals, the writing on the wall, and so we made changes then to try and get ahead of this. Our error rate has never been terrible. It has always been in a reasonable amount, but we knew that it needed to come down under that 6 percent. One of the things we did is we started interviewing applicants with every application that is submitted. The federal requirement only indicates that we have to interview individuals once per year and so we stopped doing that. Most of our people have the requirement of providing an application every six months, and so instead of not touching base at that six-month mark and just taking everything based on paperwork, we now are completing interviews with those customers.

One of the other things we did is we looked at—which we frequently looked at—what was the common causes of our errors and what was the biggest impact to our error rate at that time. During that time, and still today, shelter expenses accounted for a large percentage of our error rate. We, at that time, were taking customer attestation for their expenses. We asked how much rent they paid. They told us. We took the statement. We asked what their mortgage, or if they pay utilities, or heating and cooling costs. We took their statement, and we entered it into the case and we moved on. Effective June of last year, we stopped doing that and customers now have to verify what those shelter amounts are. We have to get

utility bills, rent receipts. We talk to the landlord, mortgage statements, stuff of that nature. Those are some of the very early impacts that we made to try and reduce the error rate.

In special session, along with the \$19 million that we were awarded, we also were awarded funding to pick up some technology initiatives to assist us with lowering our error rate. I am happy to report that both of the initiatives that we picked up are in full swing, and we are seeing some fruits of our labors. The first one we will talk about is a continuous evaluation of income and hours of individuals who work. At that time, our errors based on income that exceeded the income limit accounted for 1.46 percent. With this new platform, once a month, we receive a report and it lets us know that if any of the individuals that we have that are showing income, if that income has gone over the income limit, it lets us know in a report. If we have individuals who are not working, who have not reported income, and they now are working over that income limit, that is on a report. Those reports we have received twice now. We have received over 3,000 individuals, and we have closed over, or readjusted, over 3,000 cases to account for their actual income and hours worked. Moving forward, the 1.46 percent we definitely anticipate to drop drastically based on this technology because it is allowing us to identify anyone whose income goes too high for the program or if it has gone up high enough to cause an error. It is easy for individuals to get a raise and not think the first thing they need to do is call SNAP and report to the program that their income has increased. This is very helpful for us, and we anticipate that part of our error rate to go down.

The second solution we have is a data analytics platform. What it does is it incorporates all of the case information for our entire SNAP caseload, and it looks for anomalies in shelter expenses, in income. It can tell us if multiple cases have the same phone number. Yesterday we identified a case where the same phone number was used on 45 cases. The good news was out of all of the 45, only 2 of those cases were active because our staff had identified that something was wrong with the cases, and they recognized that there was an identity issue on those cases. Through this initiative, we have saved already over \$25,000 that would have been misspent SNAP dollars. And whether it is underreported income, whether, let us say, one of my employees accidentally instead of putting \$1,000 a month in rent, they put \$10,000 a month in rent, which could drastically change the SNAP allotment, those things are identified, and our team of quality assurance goes in and they either update the case or terminate it if termination is warranted. In some situations, we do reach out to the customer because we have to verify what information we are looking at. We have high hopes for these initiatives. We have high hopes that in the coming months that those will affect our error rate. One thing that I do want to note is that quality control works retroactively. They just finished reviews for December and so it will take a few months before they catch up to these initiatives, but by the end of this review cycle, we are hoping that we see great impacts.

One of the things I do want to put out, I am going to shout out to the team and to everyone who does this eligibility work, is on the screen, it shows a 6.2 percent current error rate. Our error rate was just reported two days ago, and for the first three months of this review cycle, we are at 5.79, and that is very close.

Director Rich:

I just want to point out—sorry, I did not mean to interrupt—but I just want to point out that we are having more technical difficulties. The screen is not showing what our laptop is showing. I know you just said on the screen; it is not on the screen.

Ms. Cantrelle:

If you had a screen and if you could see it, you would see that it is showing our error rate at 6.2 percent, and indeed, it is 5.79. And while this is very close to the 6 percent, I do want to point out that at no time during last year was our error rate showing a 5.79. And being this early in the reporting cycle, having an error rate that low reflects good for the future. I am going to pause again. There we go. I am going to leave this here. I am just going to— Current error rate is 5.79.

We are going to go ahead and go to the next screen, the next slide, and talk a little bit about the SNAP work requirements. I know we heard a lot about the Medicaid work requirements this morning. They are quite similar. As we move through, you will be able to notice some of the similarities. Nevada has been under a waiver from able-bodied work requirements for the past 15 years. On January 31 of this year, the ABAWD [able-bodied adults without dependents] waiver that we had expired. With the new rule, waivers are not approved anymore unless your error rate is 10 percent or higher. As we know, the State of Nevada currently is sitting at about a 5.3 percent unemployment rate, so we do not meet that 10 percent. However, we do still request the waiver from ABAWD work requirements, and because Mineral County does have an unemployment rate at 10 percent or higher, that county is exempt from ABAWD work requirements. Despite the fact that we know the majority of our state is not at 10 percent, we will continue to request this waiver every year to see if anything changes.

Individuals for ABAWD work requirements—ABAWD stands for able-bodied adults without dependents. For individuals aged 18 to 64 who receive SNAP can only receive SNAP benefits for 3 months out of every 36 months unless they are either: (a) exempt from the program or the requirements; or (b) they are meeting the requirements. Who is an ABAWD? Ages 18 to 64. That is a little bit of a change, and we will talk about that as we move along here. Anyone who is physically or mentally able to work, anyone not living in a SNAP household with a child under age 14, and anyone who is not pregnant.

Let us talk about the age limit change. Prior to this legislation, the age requirement for ABAWD was 18 to 54. With the change, that requirement went from 18 to 54 to 18 to 64, and that 54 to 64 age increase increased the people who must cooperate with this by over 20,000. This is hitting over 20,000 individuals between the ages, actually, of 60 and 64, who will now either need to be exempt or cooperate with these work requirements. Previously, a parent with a child under 18 was also exempt from these requirements, but the age has changed to under 14. So now, if you are a parent with a child in the home, the child to exempt you from this program, the child would have to be age 0 to 13 years old.

Lastly, certain exemptions that were once on the table and that we could use, have been suspended. They have not been done away with, but they are suspended through October 1, 2030, and those exceptions were veterans, youth who aged out of foster care, and homeless individuals. Those exemptions will not be back till October 2030.

How do we meet work requirements? The first and easiest thing that is on the table here in front of you is work at least 20 hours per week or work enough to account for 20 hours times the federal minimum wage. Let us say in Nevada you are paid more than the federal minimum wage, you can take what they earn, divide it by the federal minimum wage, and if it equates to 20 hours, that is allowable. I know that is a little bit in the weeds, but it does not have to just be 20 hours. It depends on the earnings that an individual would make.

On-the-job training; community service; vocational schools or training; volunteer work; work programs, such as cooperating with our TANF [Temporary Assistance for Needy Families] program work requirements or our SNAP program work requirements, many of those can also help someone meet the requirements of the ABAWD program.

Lastly, I want to talk about who it does not apply to. It does not apply to children; work requirements do not apply to children. Zero to 17 do not have to meet ABAWD work requirements. Seniors aged 65 and older, it does not apply to them. Pregnant individuals and members of Indian tribes, it does not apply to. SNAP households with children 13 and under and people with disabilities. If there is a bright spot, that is what it is in that regard.

The next thing we want to talk a little bit about are the noncitizen categories who were previously eligible, who are no longer eligible with this implementation of H.R.1. Some of the common ones are the refugees, parolees, asylees, victims of trafficking, and a few other little, a little lawfully residing noncitizens are no longer eligible based on their status. Who does remain eligible are your U.S. nationals, your legal permanent residents who have been here five years or more, Cuban-Haitian entrants, and those who entered as part of COFA, which is the international treaty that we have with Pacific Island nations—so Marshall Islands, Micronesia, and Palau. Those are the ones who are across-the-board eligible and are not affected. This particular change we did back in August of last year, and it was just over 2,000 individuals that lost eligibility due to their status change.

Either I went really fast, or we are wrapping up quick. I am not sure which, but let us talk about overall changes. What does this impact look like? What does this feel like? The 75 percent of the administrative costs is big. We talked about the financial impact that will have on the state as a whole and with community partners who currently do assist us with the SNAP program in taking applications on our behalf. Initially, the changes in this bill, we realized, affected over 133,000 individuals, whether that was the work requirements or the noncitizen changes, and as of the first of May, we anticipate seeing a reduction in 27,700 individuals who will lose eligibility due to these work requirements.

Initially, that date was February 1, then they pivoted a little bit and let us know that we could continue to live out our waiver, and we will now see this loss as of May 1. Now, if this loss holds true, if truly 27,000 plus individuals lose eligibility on May 1, that is roughly 6 percent of the total SNAP number of recipients that we have.

Each month in the last 12 months, we issued approximately \$89 million a month in SNAP benefits, and if you reduce by 6 percent, it is a \$5.3 million reduction in Nevada's economy, to be fair. It is not just the people who will lose the benefits, but it is also the food chain, the entire food chain. It is easy to think right off the bat if SNAP benefits go down, who is the first person impacted? Retailers—that is an easy one; you can get there without thinking about it. But what we do not think about sometimes are the other people who are in the food industry: the farmers, the ranchers, the truckers who bring the food in and out or travel it, trains. There is a whole different many ways that this happens. Anyone that works in the food supply chain is affected by the reduction of \$5.3 million and that is Nevada. We are a small state. We work closely with our partners in California, and they are ten times our size. When you think nationwide, this is a big impact.

The USDA [United States Department of Agriculture] has estimated that for every \$1 in SNAP benefits that are spent, \$1.54 comes back to the local economy. When it is a \$5.3 million actual decrease in funds, if you take that into account, it is more of an \$8 million impact in reduction that you will see based on these changes and the amount of

people who could lose benefits. We will know more about how many actually receive benefits as we move into May, but the anticipation is 27,000, just over 27,000.

With that, I will go ahead and stop here and make ourselves available for any questions that you may have.

Chair Brown-May:

Thank you for the presentation. As we begin with questions, I just want to get loud and clear the numbers—27,000 individual people are expected to be affected May 1. Is that correct?

Ms. Cantrelle:

Yes ma'am. That is correct, and that equates to just over 23,000 cases. So yes.

Chair Brown-May:

And the financial impacts to that, and thank you so much for calling that out, that there is an entire food supply chain and demand not just affecting the individual benefit recipient totaling \$5.3 million in reduced food supply chain dollars, which then equates to approximately an \$8 million impact when you look at the economic impacts of those dollars.

Ms. Cantrelle:

Yes, ma'am.

Chair Brown-May:

Thank you for that clarity. Members, questions? Assemblymember Hibbetts.

Assemblymember Hibbetts:

Thank you, Chair, and thank you for your presentation. I have a question on slide 6 when we are talking about error rates. I am a bit concerned that lodging dollars, or shelter dollars as you put it, there was no verification until last June. What else is not being verified?

Ms. Cantrelle:

At this time, that is the only thing that we— That was the only thing that was not being verified at the time, and that was a concentrated effort to reduce our timeliness impact, how quickly we were getting cases done, and we have always maintained a relatively low error rate, certainly much lower than the majority of the states. I will say right now, the average error rate in the nation is 10 percent, and so even last year, closing out at the 6.49 percent, which I think is unpurified by the feds at this point, we took that on as a concentrated— We knew that there would be some impact to that, and we cannot do that anymore. We have to get it down under 6 percent.

Assemblymember Hibbetts:

Thank you. A quick follow-up, Chair? I believe you had said in one example that there was 44 different cases using the same phone number. I believe that was the number, and 42 of those were already determined to be fraudulent. Have any of these been referred for prosecution?

Ms. Cantrelle:

Thank you for the question. There were 45 of them; 43 had already been closed and had been identified. Currently, our investigations and recovery team is working with the District Attorney and other law enforcement agencies, yes.

Assemblymember Hibbetts:

Thank you and thank you for correcting my numbers. Thank you.

Chair Brown-May:

Next, we will go to Senator Titus.

Senator Titus:

Thank you, Madam Chair, and again, thank you for recognizing fiscal impacts but most importantly, the human impact of these decisions that are being handed down. I want to address page 9. You brought up, and I appreciate you addressing this, the \$5.3 million reduction in Nevada economy. Is the state doing anything to reach out to the small businesses, the retailers, and potential impact of where folks visit, the corner mom and pop store, where they rely sometimes on the SNAP beneficiaries to come into their stores? I know that other states have. We are not the only state being impacted, and I know Florida has reached out a little bit. Are we doing anything to address this?

Ms. Cantrelle:

Thank you for the question, Senator Titus. We have worked very closely with not only retailers but our community partners in every aspect of this. We have created toolkits that we sent out via LISTSERV not only to help build a robust volunteer site for individuals who want to continue receiving eligibility, but to also inform and notify individuals that this is coming. I have spoke with the Nevada's Retailers Association as well as the association who represents the rural areas in our state, and so, they are informed. They know this is coming. We work closely with the food banks. They know that there is going to be an impact to the food banks and to people who need assistance. I am not sure if there is anyone that we have not spoken to in this regard, but it is definitely a community working together to try and reduce the number of people who lose eligibility and to try and point people in the correct pathways so that they can continue to receive some type of assistance. So, yes, ma'am.

Senator Titus:

Just a brief follow-up, mostly a comment, I think. I appreciate you reaching out. I think the larger retailers can absorb this—the Walmarts, the Raley's, the Krugers [*sic*], whatever. They can absorb some of this, but those small folks, like in my little rural communities, they might have a tougher time. I am wondering if there has been any— I know you did not mention it, but some of the foods— If you look at Florida's list, and we have been addressing some of this, and we have been almost mandated that we have to go to quote, unquote "healthier foods," whatever that definition may be. Have we done it? Is there any assistance to let these retailers know that maybe they should stock granola bars instead of some of these refined sugars? Just again, not that we are— I just think we need to offer them some assistance on some better ideas that they might have so they know what is happening out here when we make these decisions, that those donuts may not go boughten and maybe offer better choices. Do we do anything like that at all?

Ms. Cantrelle:

At this time, the definition of *food* is set by the USDA, and it is very broad, and it just indicates that if it is a food product—not alcohol, tobacco, or anything of those natures—that it is a covered item. And a grocer, a retailer, also, has to have specific items that it carries and so many of a specific item. It has to have an X number of dairy, X number of carbohydrates, proteins, stuff like that. But at this time, we are not doing anything in that realm to talk to grocery stores. SNAP education is a program that has sunset, and as of September 30 of this year, will no longer be a program that is in existence due to the changes in H.R.1. Those individuals were responsible, and currently are today, are responsible for nutrition education and helping individuals make the right choices or make their choices stretch financially, if you will. When that program sunsets, I think that we will lose some of that conversation, although we do try to have those conversations as much as possible.

Senator Titus:

Well, hopefully we can do as much as possible and not just ignore it. I appreciate you being here, and thank you, Madam Chair, for the questions.

Chair Brown-May:

Thank you. Before we go to the next question, I just want to clarify. There is a little bit of confusion up here. Are we talking about the \$5.3 million dollar reduction monthly or annually?

Ms. Cantrelle:

Monthly.

Chair Brown-May:

Thank you. I just want to make sure that is extremely clear. We are talking about a \$5.3 million reduction “monthly” to our residents, which will have a significant impact on just our local grocery store. With that, we will go up to Assemblymember Goulding for the next question.

Assemblymember Goulding:

Thank you, Chair. Thank you for the presentation. I had the opportunity recently to talk to some of your frontline workers who are working with your DSS clients who are losing their eligibility. One of the things that they expressed was that in the past, they were able to provide information to folks who were losing their benefits with information that gave them guidance on where they could find other resources. What they told me last month is that they were no longer able to provide any information that was not printed material from the Department. Can you expand on that and explain why those frontline workers are not able to provide information about resources to help folks?

Ms. Cantrelle:

Thank you very much for the question. At no time have we ever instructed our frontline staff that they cannot provide resources to our customers. One of our greatest assets is our ability to know what resources are out there and be able to relay that information to our customers. Frequently, we will use Nevada 211 to get information from them because it is

the most updated resource information that we have access to, but just as during the government shutdown when we provided information regarding where food pickups were and where items were made available, we do encourage staff, and maybe we need to do it again, to provide that information to our customers. But we definitely have not formally or informally as I am aware of, at this time, indicated that our staff cannot have these conversations with our customers or that they can only discuss what is formally printed. That is the first time I am hearing that, so I think that that needs to be— I will take that back, and we will make some changes and have some conversations.

Assemblymember Goulding:

Thank you. I think that there are some folks that are very passionate about helping folks in Nevada and they will be very happy to hear that they are allowed to provide that information because I know that if that was a misunderstanding there, they definitely wanted to be able to provide that information. Thank you for that clarification. I know that those employees will be happy to hear that.

The second question that I have is— I appreciate the fact that there is a federally mandated threshold level on the error rates, but one of the things that I think is important to keep in context is the cost of driving those error rates down. I am wondering if you have quantified how much it is costing to reduce that error rate and if you keep that into consideration?

Ms. Cantrelle:

A lot of the things that we are doing, we are doing with the staff we currently have. As far as staffing, there has not been any increase or any cost. What there is, is increased administrative time spent having these conversations and talking to individuals about these things. Now, the money that we were awarded in special session was just about \$3 million for the remainder of this biennium to stand up the two technology initiatives that we are currently doing right now. We are considering future initiatives. We are looking at future initiatives, but I will say that the cost of these is far less than the amount we would pay if we did not meet the 6 percent, or heaven forbid, 9 percent, 10 percent error rate. Those costs are staggering. While there is some cost to this, it is definitely far less than the anticipated payment we would have to pay for the benefits, if it got to that point.

Director Rich:

I just wanted to add to that. The technology that we have put in place creates efficiencies as well, so right now, we have humans that are doing the very manual work of verifying all of this. This is very manually intensive. It takes, as Kelly mentioned, it takes a lot of time. The technology that we are putting into place, yes, it costs money, but in the end, it actually reduces our costs. It saves money just because of the efficiencies that it creates. You can do a lot more with that technology to reduce that error rate. Again, it saves us not just in the costs that come with a higher error rate, but it also just increases efficiencies through our own human resources, and we are able to use those staff for outreach, for some of those high-touch cases, things like that. I think that there are tradeoffs there as well.

Assemblymember Goulding:

Thank you. There was a number that you shared earlier that surprised me. So yes, certainly technology, in the long run, is less expensive. When you just said it is not costing anymore, but then you went on to say that it is very costly in time, so it is very costly to reduce

the error rates. I appreciate that moving to a more technology-oriented solution will be in the long term less expensive.

You said you found \$27,000 that had been awarded fraudulently; \$27,000 seems like a pretty small number when compared to the labor required to uncover that \$27,000. That was a surprising number to me, and I think that that is important to keep in context. Did I misunderstand the \$27,000?

Ms. Cantrelle:

I think so. That money, it was \$24,000. That has come by way of a technology initiative that identified \$24,000 worth of increased income, if you will. One of the errors that we have that caused over a 1 percent error rate was when individuals would have a job or not have a job at all and they would either get a raise or obtain employment that put them over the income limit for the program that was accounting for, like I said, about 1.5 percentage of our error rate. This initiative identified those cases that either had an increase in income or had new income that would have changed the SNAP benefit by \$58 or more. We were able to save \$27,000 so far by identifying increases in income that we otherwise may not have known, especially not as timely, had we not had this initiative. I hope that made sense.

Assemblymember Goulding:

Thank you. Was that \$27,000 a year or monthly?

Ms. Cantrelle:

The \$24,000 right now is cumulative for the first report that we received from the technology initiative. That report will be received once per month, and we do not know yet if that amount will hold true or if, as we move forward, we will see a reduction in the overall errors that we find, because once we find them and address them, that number should go down.

Assemblymember Goulding:

Thank you.

Chair Brown-May:

Thank you. Next, we will move to Senator Doñate.

Vice Chair Doñate:

Thank you, Madam Chair, and thank you, Director, and Ms. Cantrelle for being here. I just want to make sure— Most of my questions are related to federal waivers in terms of some of the mechanisms of, okay, so this happened, what can we do next? But I just want to be clear. In terms of—part of this is in my math of what is coming after this—to be clear, I guess my first question is in total, it is my understanding through public reporting that we estimated that the population that is going to be affected from these new requirements and so forth, we estimated that to be 122,000. Is that still correct? Within the next, let us say—I know that there is federal litigation going back and forth—but anticipated, it is around 120,000. Is that still accurate?

Ms. Cantrelle:

Yes, we started with an anticipated number of being about 133,000, but once we purified it, it did go down a little bit to 122,000. That is the number of overall people who were affected by all of the changes in the H.R.1 legislation.

Vice Chair Doñate:

Great, thank you. Just for the public to understand this. There are 122,000 or so Nevadans that we anticipate that will be affected right now. That does not exclude the people that will be denied when they come into our offices because they do not qualify, just the same amount that we would have in general, when people, when folks come in front of our offices. The reason why I wanted to mention this was—and I think I am just going to point back to the historical record—there was some discussion earlier during this interim when we were talking about some of the waivers that the office was taking on. I had obviously shared my discontent with the SNAP waiver that is being implemented right now for the coverage of soda, and snacks, and so forth. I want to be clear that the reason why I was so vehemently against it is not on the policy front, but it is because this, to me, is more of a priority that we have to be looking at. It is about misplaced priorities, and so, the amount of effort that your staff is going to undertake for the error rate and developing contingency plans if we fall over that, that to me, is more of a pressing priority than anything else. I think from my perspective, I want to hear from you in terms of the feedback. This is part of my—I am trying to understand this as well. When it comes to waivers submitted through the USDA, it is my understanding that they are not as flexible as Medicaid often is or CMS is in terms of acceptance.

Do we have the ability to say, can we submit a federal waiver to the USDA that says if the unemployment is high within a certain county, say Nye County, Mineral County, that we can suspend the work requirements because it is leading to an impediment? Is that something that we can do? And if so, are we working on submitting something of that essence?

Ms. Cantrelle:

Thank you, Senator, for the question. The way it is, we could request a waiver for anything we wanted to, to be honest with you. Whether or not it is approved is a different conversation. We have submitted, I want to say, at least three to five regarding some of the changes that are in this bill. As of right now, it is very clear that we do submit a waiver every year for ABAWD work requirements and to try and see if we qualify for an exemption as a state or by county. Right now, the exemption— Give me a minute. Right now, you have to have an unemployment rate at 10 percent to qualify for the waivers. In Nevada right now, the only county that meets that number is Mineral County. When we did our ABAWD, when we submitted it this year and said looking for exemption, once again, the only county that was granted the exemption from the ABAWD work requirements was Mineral County due to the unemployment rate in that county meeting the 10 percent. The rest of the state was not approved, and we have implemented the ABAWD work requirements in every other county throughout the state.

Vice Chair Doñate:

Great. Madam Chair, if I can follow up? The reason why I was asking that— Again, submitting a waiver is different from the acceptance of the waiver from the administration. In my similar questions that I was asking towards Medicaid and the Health Authority earlier, if the Legislature were to decide that we want to cover—as I mentioned, the missing middle, the folks that were impacted from the implementation of H.R.1 that now are finding

themselves in the middle where they cannot afford their groceries because now they are kicked off of SNAP or they cannot afford their health care through the Exchange because they made too much but not enough—if the state were to implement a state-funded parallel program to help supplement those individuals, I just want to understand that my math is correct. On average, we spend about \$2,700 per person on SNAP. Is that an accurate assessment?

Ms. Cantrelle:

The average person is about \$193 per person on SNAP per month.

Vice Chair Doñate:

Okay, so it is about, we would say, \$2,000 something. I am trying to get an annual assessment in terms of how much per person.

Ms. Cantrelle:

Yes, it would be just right around \$2,000, a little over.

Vice Chair Doñate:

If I am doing my math correctly, just obviously mentally, we are talking, if the state were to implement a parallel program to cover the missing middle that were affected by, again, the 122,000 I started off with my questioning, we are looking at a program that would be around \$200, \$250, \$270 million in State General Fund dollars just to go back to what we had before in each year, correct?

Ms. Cantrelle:

I am trying to map that out in my head as well. So, \$5 million per month is what we anticipate, reducing by \$5.3 million, so times 12 would be over \$60 million per year. A little more than that based on fuzzy math, but yes.

Vice Chair Doñate:

Great. Thank you. In the biennium, it would be anywhere from 122 plus, right? I think that is kind of— The rationality of why I am asking these questions is because I think it is imperative for us to discuss what it would take to get back to the normal, what we had before. For the state to be able to absorb such a cost within the next ten years, I think, is becoming astronomical, and that is on top of what we have to deal with Medicaid. I think it is imperative for Nevadans to understand the severity of what we are facing and how this is not just reverberating on the individual purchasing dollars of a person, but also to the economy of scale that we were talking about with small wholesalers, grocery stores in the rural areas, and so forth. That is why I wanted to ask for verbatim in terms of what it would cost for us to get to that point because I think other states are finding themselves in that situation, and the answer is, there probably is not an answer. Thank you.

Chair Brown-May:

Thank you. I have one question. Believe it or not, just one. I want to go back to the work requirements. Sixty-two to 64. So now we are changing the age requirements. We have gone from 54 to 64, but specifically, does not Social Security kick in at age 62? So, we are

asking people who are now required and receiving Social Security to go back to work? Is that in essence what we are doing?

Ms. Cantrelle:

If they are not disabled or meeting any of the other exemptions, yes, ma'am.

Chair Brown-May:

It just feels like we are a little bit federally in conflict with, hey, you can retire, but it is like you cannot, now you have to go to work. I want to make sure that we are really clear. We are now moving this benefit after Social Security qualifications.

Members, any other questions? No, okay. Thank you.

Director Rich:

Madam Chair, can I just add just a few closing comments?

Chair Brown-May:

Yes.

Director Rich:

I just wanted to add our SNAP and Medicaid have a lot of overlap. I think it is about 90 percent of SNAP recipients also have Medicaid. I just wanted to make this body aware that DHS is working very, very closely with the Health Authority as well in our outreach efforts, in a lot of the work that we are doing with the work requirements, with our technology efforts. Director Weeks and I are working as closely as we can to ensure that this population, because it is a collective population between DHS and the Health Authority, and to make sure that we are protecting as many Nevadans as we can and getting the word out and finding ways to communicate and do outreach and educate our people and ensure that we can catch as many as we can. We know we are not going to catch everybody, but I think between the two departments, we are going to do a great job of doing the best we can.

Chair Brown-May:

Thank you for those statements. We sincerely appreciate that you are here and that you are leading your Division in such a way that cares for Nevadans, so I thank you for that, and thank you very much for being here today and presenting this information for us.

We will close this agenda item.

AGENDA ITEM V—DISCUSSION OF IMPACTS TO HOSPITALS AND HEALTH CENTERS MADE BY H.R.1, INCLUDING THE ANTICIPATED REDUCTION OF HOSPITAL PROVIDER TAX FUNDING, INCREASED BURDEN OF UNCOMPENSATED CARE, AND CONSIDERATIONS FOR MITIGATION STRATEGIES

Chair Brown-May:

We are now at 11:46, so given the fact that we will take a break for lunch, what I would like for us to do is take the next presentation. We will open up Agenda Item V and take the first presentation, which is hospitals. If you will please come forward, we will discuss the impacts of hospitals and health centers by H.R.1. We will do this first presentation and then take questions, and then we will break for lunch for a short period of time and then come back and do the last two presentations. Thank you for being here, gentlemen. We see Mr. Osborn up north. You may begin whenever you are ready.

A. NEVADA HOSPITAL ASSOCIATION

Patrick Kelly, President and CEO, Nevada Hospital Association (NHA):

Good morning. We appreciate the opportunity to present here today. A lot of the information we are going to cover has been covered by other presentations, so we are going to move a little bit quickly, but we do want to show you some of the practical ways that these changes are going to impact hospitals ([Agenda Item V A](#)).

Just starting off with the basic slide to let you know that we are probably looking at a little over 20 percent of the state's population that will be impacted by the changes in H.R.1. And I think to have any discussion about the impact, you have to understand a little bit about hospital Medicaid reimbursement, and there is basically two categories. One is base rates, and the other is supplemental payments. Base rate is what we get paid for delivering a particular service. For example, with newborns, we get paid \$327 per day for the newborn, and that is the base rate for that service. Now, supplemental payments—and that is what we are talking about primarily today—is a fixed amount that is paid over a period of time when you have provided care to a group of Medicaid folks. One of the things I want to make sure you understand is that on these supplemental payments, hospitals only get them if they are providing care to patients. Some hospitals get more because they treat more Medicaid patients, and some hospitals get less. It all has to do with serving the Medicaid beneficiaries.

To look at the base rates over the last 23 years, we have only had a 5 percent increase in base rates for hospitals, and that has not even come close to keeping up with the inflationary costs that we have experienced. I will give you an example. The American Hospital Association just put out this chart that in 2025, our drug costs increased 13.6 percent, supplies 9.9 percent, and workforce went up 5.6 percent for a total expense increase of 7.5. That is only one year, and the med-surg [medical-surgical] rates, base rates have only gone up 5 percent in 23 years, so we have not been keeping up with that.

That is why the supplemental payment programs are so incredibly important. I have to give a lot of credit to Stacie Weeks and her team at Medicaid because they work diligently to help us put together the Private Hospital Medicaid Provider Fee Program that 43 hospitals participate in, and that is the one that is getting hit hard. Kudos to them for doing this. We were doing well. We have had hiccups along the way in getting this thing started. She said it is about two to two and one-half years that we have gone, but it seems like every quarter

something comes up, and it is not Nevada Medicaid's fault. It has been mainly at the federal level. For example, when we had the shutdown, federal shutdown, we could not get our preprints approved. You cannot get the preprints approved, you cannot get money distributed. It seems like there has always been something that delays this program and getting the money. Now, we have gotten the money, it is just not coming in on a regular basis like we would like.

But H.R.1 is going to be absolutely a game changer because this was coming in— These supplemental payments were really making a difference, and now, we are going to have a little bit of trouble with significant reductions in payments. If you look at this chart, I have got State Fiscal Year 27 be \$15 million cut, 28, \$300 million, \$507 million. You heard earlier higher numbers. Here is the frustrating part about all this. These numbers change all the time. I used to, when I first gave this after H.R.1 passed, talk about \$200 to \$300 million in cuts, and it just seems like it is going up all the time. And as Director Weeks said, the issue is we are waiting for guidance from CMS to tell us what the rules are and how it is going to be calculated. Until that is done, we are really not going to know where we are going to fall on this, but I will just simply put this, it is going to be a whole lot of money, and it is going to have a big impact.

As they say in the commercial, but that is not all, there is more, and that is the situation here because not only are we going to take that cut, but we are going to also be taking additional changes from other aspects of the bill, and that is what I want to talk to you about.

We have talked about Medicaid eligibility. We have got the work requirements going in, and we are going to have redeterminations more frequently. We are probably going to have people falling off of Medicaid on a routine basis, and so that is going to be a problem.

And of course, when they are off Medicaid and they come to the hospital, they are going to be uninsured, so we are going to be providing care to people and not receiving any reimbursement for that.

Retro Medicaid eligibility. A little bit was talked about that. Right now, if a person comes to the hospital and they do not have any insurance, we try to get them signed up for Medicaid, if they qualify. Right now, we have 90 days to do that. Under this new bill, we are going to have for one group, 60 days, and for another group, 30 days. If you are part of the expansion enrollees, you only get 30 days. If you were part of, would have fallen in under traditional Medicaid enrollees, you get 60. But by the time you work with this person to get all the documents and all the information you need, 30 days is not a lot of time. What is going to happen is we are going to have even more uninsured people that are going to come in because we are not going to be able to get the paperwork and everything done and submitted in time, so that is a concern.

I have put on a slide about noncitizen Medicaid eligibility. I know Director Jensen did a great job in explaining that, so I am not going to go into detail. This is not a huge financial for us. We will lose money because these people will be uninsured. But boy, for the people who used to fit in these categories, it is going to be a really big deal, so we need to worry about them.

Then the premium tax credits. I just want to mention this. This is not part of H.R.1, but it all happened near the same time. When we did the Affordable Care Act, we put in a program where low-income people would get premium tax credits to help them pay for their insurance. Then during the pandemic, the American Rescue Plan expanded the number of

people who could receive that benefit as well. Now, the problem in the American Rescue Plan is that it had a time period where it was going to end if it was not renewed, and that ending period was the end of last year. A lot of people thought H.R.1 would renew that and allow that group to continue to receive the subsidies. That did not happen. As a result, we have got a lot of people who are not going to get that benefit, and we have been anxiously trying, awaiting to see how many people are not going to have insurance as a result of that. That is not answered yet.

To give you an idea, in 2026, we had about 104,000 Nevadans enrolled in coverage through the marketplace; 95,000 of those individuals received some kind of enhanced subsidy and that number is going to drop. KFF, the Kaiser Family Foundation, estimates that there will probably be about 24,000 Nevadans not having insurance by 2034.

What does this mean from a hospital's perspective? People are going to make the decision as to whether they are going to go without insurance or not, and I think that there will be people who do that, or they are going to go out into the market and buy cheaper insurance with super high deductibles. Well, sometimes these deductibles discourage people from going and getting routine health care because it is starting, it comes out of their pocket, and as they delay receiving health care, a lot of times they just get sicker. And so, when they come to us— I mean, we have a huge number of people who come with these high deductibles. There is no possibility they can pay us, so they basically become uninsured for their deductible part of their insurance. You have a \$6,000 deductible and you have got a bunch of people coming in who cannot pay the \$6,000, that obviously impacts the financials of the hospital.

The overall impact is that we are going to see a lot more uninsured people, and this is going to increase our uncompensated care costs, and we are already at about a half a billion dollars of uncompensated, unreimbursed care costs for hospitals, so it just continues to add to that weight.

What we wanted to do was to give you an idea of what is going to happen is to take one hospital as kind of a case study. Mason Van Houweling from UMC [University Medical Center of Southern Nevada] is going to talk about how it is going to impact his hospital.

B. NEVADA RURAL HOSPITAL PARTNERS

[This agenda item was taken out of order.]

Blayne Osborn, President, Nevada Rural Hospital Partners (NRHP):

Thank you, Madam Chair, and members of the Committee. I also have the honor of serving as a member of this body representing District 39. If it is okay with you, Madam Chair, I am going to go first as I have a hard stop and I appreciate your flexibility with my schedule, and then I will turn it over to Mr. Kelly and Mr. Van Houweling for the rest of the presentation.

Chair Brown-May:

Thank you, Assemblymember. Go right ahead.

President Osborn:

Thank you. Really appreciate the opportunity to be here today. As you all know, Nevada Rural Hospital Partners is the association of the 13 critical access hospitals in the state. That

is every rural hospital with the exception of Elko, which is a little bit larger. I also wanted to mention we are very grateful for our partners: the Nevada Health Authority, Nevada Hospital Association, Department of Human Services, the Office of Rural Health, the Primary Care Association, and the Governor's Office, who we have worked very closely with on the implementation of H.R.1, and of course, the Rural Health Transformation Program. Nevada Health Authority did a great job covering the eligibility and work requirements, which our critical access hospitals will see some impacts from ([Agenda Item V A](#)).

Our member hospitals see anywhere from about 10 percent of their patient population to as high as nearly 40 percent in some of our communities on Medicaid. Six of our critical access hospitals participate in the private hospital provider fee program at a net benefit of roughly \$22 million per year, so that is some of that loss that Director Weeks spoke about earlier.

While we wait on guidance, on implementation of work requirements from CMS, our member hospitals are busy educating themselves, their frontline staff, and patients on eligibility requirements. They are busy working to try to increase community health workers and patient navigators to assist patients and are trying to work with those affected to offer opportunities for work and volunteer hours to try to help comply with those work requirements.

I want to talk briefly about the Rural Health Transformation Program. As has been alluded to in several of the questions and comments this morning, the Rural Health Transformation Program will not be any kind of a one-to-one offset for projected losses to Medicaid for our member hospitals, but what it is doing is allowing our member hospitals to get ahead of some very costly expenses to do some modernization of property plant equipment and hopefully be in a much better position to be able to withstand any losses projected from H.R.1.

I wanted to say, too, the Legislature has done really well in the last couple of legislative sessions supporting our critical access hospitals with the passage of cost-based outpatient reimbursement and the rural emergency hospital designation, as well as other supports, so thank you for that. Because of those bills, our member critical access hospitals are in a much more stable financial position currently, and the Rural Health Transformation Program is hopefully only going to help that.

As you know, the primary focus of the Rural Health Transformation Program is to benefit rural Nevada—rural Nevada's residents, patients, hospitals, clinics, and providers. I want to thank Nevada Health Authority for all of the work they have done in establishing the applications and the processes to support this effort. One great example of that is in the Nevada Flex Fund, which is the grant application that is supporting infrastructure costs. The Nevada Health Authority is requiring that any of those applications show, demonstrate a commitment from rural hospitals, rural clinics, rural providers through letters of support, MOUs [memorandum of understanding], whatever that agreement is, to show that we are not just distributing RHTP funds to outside vendors or entities, but that those dollars are actually going to partner and assist rural communities.

We have member hospitals busy submitting their applications right now. The Flex Fund, as was mentioned earlier, is due later this week, I think two days from now, and those other grant opportunities are all in various states of opening and submission. Our member hospitals have worked together to put forward applications that include: equipment upgrades for their aging buildings; AI [artificial intelligence] opportunities and innovation; workforce recruitment; retention training; minor alterations and renovations; transportation; mobile simulators; mobile imaging; more specifically, beds, bassinets,

stethoscopes, imaging equipment, boilers, chillers, generators, new transit vans, ambulances, and housing supports for providers as well.

What we are really trying to do as an association and our member hospitals is to try to transform. We are taking data-driven approaches to try to improve patient outcomes, expand services and service areas, and improve payment models through Medicaid to ensure that our Nevada rural hospitals are never put at risk of closure. Collaboration, shared services, leveraging of funds, regionalization, where appropriate, are all goals that our member hospitals are currently trying to implement. For example, if two or three of our hospitals that are close to one another can share a pulmonologist. Alone, they do not have the volumes to be able to do that, but sharing where you can have a provider in one community for two days, another community for another two days, and a third community for the fifth day, those are the types of innovative approaches that our member hospitals are taking with Rural Health Transformation Program.

With that, I would open it up to any questions before I have to leave and then I would turn it over to Mr. Kelly and Mr. Van Houweling.

C. UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA

Mason Van Houweling, CEO, UMC:

Great. Thank you, Mr. Kelly, and good afternoon, Madam Chair and Committee members. For those that may not know UMC, we started out in 1931 taking care of the workers of the Boulder Dam with one doctor and one nurse ([Agenda Item V A](#)). Fast forward to today, UMC is the largest public hospital in the state of Nevada, the only magnet hospital, and the largest academic medical center. UMC serves about 500,000 patients on an annual basis whether they are in our primary care; our quick cares, which is our urgent cares throughout the valley; online care; our specialty care; and then also the main hospital acute care services. All those services are trying to keep patients out of the hospital so we can reduce the cost of care in the valley.

Typically, I am here to talk to you about our clinical services, but today I will be talking to you about some of the financial operations of UMC, and as Mr. Kelly mentioned, H.R.1 is certainly going to have an impact on UMC, but every hospital in Nevada will be impacted in some shape or form.

Just a little bit about our payer mix. This is our inpatient payer mix. As you can see, 42 percent is Medicaid, which has been described as a program for low-income family, children, and disabilities. Medicare, which is a federal insurance program, usually based off of age and disabled under 65. At 4 percent is our governmental payers; that is typically our veterans and our military under TRICARE. All that and the remaining is commercial insurance, which is typically your employer-based insurance, self-funded. Then, UMC experienced about 5 percent self-pay on our inpatient business. When you add in the governmental payers, that equals about 78 percent, so you can see that we are very heavily reliant on government reimbursement. Certainly, that dependency shapes how we operate both financially and clinically.

You have seen this chart. In the first couple of slides, this is Clark County and 622,000 enrolled in Medicaid and the two different programs. Clark County is about 2.4 million in population, so that 622 equals about 25.9 percent of the overall population. And just on a national basis, Medicaid program, U.S. wide, is the largest single source of health care coverage in the United States.

As Mr. Kelly mentioned, we are talking about supplemental payments beyond the base rate of Medicaid, which is kind of the enhanced rates. UMC, through FY 26 year-to-date actuals, we have about \$769 million in patient revenue; \$261 million of that is the supplemental payments that come in at UMC. You can see how vitally important the supplemental payments are as part of our overall net revenue equaling 34 percent.

This is a little bit of a complex slide, but it is really about the history of supplemental payments at UMC, kind of showing pre-ACA before 2014, how we were in a disproportionate share program. The expansion of Medicaid in Nevada took a bold move, the right move back in 2014, to expand Medicaid. For years we operated in this Disproportionate Share. We opted out of DSH [Disproportionate Share Hospital] in 2022, FY 2022, because it really limited the county and the state on the amount of dollars that they could accept from the federal government, so we moved over to the state-directed prepayment programs and then that is where we started experiencing our reimbursement at Medicare rates a very short time.

Then we moved to average commercial rates, which Ms. Weeks talked about early on. As you can see, that was really a game changer for us. After 2022, that last hash marks, we started experiencing a higher reimbursement, which we have been able to reinvest in our community and response.

The next slide is really a hypothetical slide. This is not UMC today, but what we did is kind of take a look back to FY 20. UMC was clipping along, meeting budget, positive cash flow until March 2020 hit, and then this is what pretty much every hospital in the nation experienced. But then, we rebounded in FY 21. Then, what we have done is just layered in the Medicare rates for our state-directed payment programs. As you can see, both our income from operations and our EBITA [earnings before interest, taxes, and amortization] are below budget, and these are in thousands, so you can see \$20 million, \$40 million, and then over \$80 million.

Next slide is just kind of us projecting. Our financial team took rate reductions beginning on January 2028 on the state-directed payment program. This is a ten-year, phased-in approach. Every year, 10 percent compounded. In FY 28, UMC starts seeing, taking out of the financial system of UMC, \$4 million, and another 10 percent the following year, \$12 million, until you go all the way to 2038, \$83 million, and that will be the dollars that UMC will have to operate without in our largest public hospital. This story, I will be frank with you, is unlike— It is the same story that you will hear in Alameda Hospital, which is a safety net hospital; Denver Health in Colorado; Parkland in Texas; Jackson Memorial; Grady in Atlanta. This story is the same throughout the nation. Just as a reminder, as Mr. Kelly mentioned, Medicare rates really only cover about 83 to 85 percent of the cost of care for all hospitals in the country. Again, that reduction, we still have to make things up even at Medicare rates. Becomes very difficult for UMC.

We did talk about noncitizen and undocumented patients. I just wanted to highlight this. This is a slide of what we are experiencing at UMC. Medicaid emergency, Medicaid for patients that are undocumented or noncitizens, represents about 6 percent of our overall discharge, but interesting enough, it is about 14 percent of our Medicaid patients. Again, the patient segment that all hospitals will have to take care of. Nevada, that for us, is about \$6 million a year on top of what we have got to figure out how to make up the difference. And to Senator Doñate's comments about more patients uninsured but also less money to do that with, so it becomes a challenge for our safety net hospital.

Really, our commitment is our mission at UMC. That really is what drives essential hospitals such as UMC throughout the nation. We are very driven on accessing high-quality care and that is really what our foundation is as a safety net hospital. But as you can see in some of these bullet points, our ability to bring some of these community services that fill some of the health gaps, some of those lifesaving services. GME [graduate medical education] is vitally important to us, our state, as you all know. Then population health care, that is where we are reaching outside the walls of UMC and trying to influence social and economic influences on health care to drive down cost of care for the state.

We have mentioned that the behavioral health impact—and I do want to compliment the state and the Health Authority for making excellent strides on addressing mental health and the access and the cost of care—but that is certainly something we are going to have to address and you have already started to think about that.

I do want to personally say thank you, and on behalf of the Nevada Hospital Association as well, thank you all in the Legislature; the Patient Protection Commission; the Health Authority; the Hospital Association; the American Hospital Association; HEALS [Health, Education, Advocacy, and Leadership in Southern Nevada] has been very active; and many, many others: our federal delegation, all our physicians and nursing out there that are working together to solve the problem. With that, I will turn it back to Mr. Kelly.

President Kelly:

You asked what would be the likely impact in Nevada hospitals, so we want to put a couple of thoughts out there. One is emergency departments are probably going to see the biggest impact because we are going to see increased ER utilization, longer wait times, and more nonemergency visits because people are not going to have the health care to go see a primary care provider.

The financial impacts. We are going to see rising uncompensated care, more self-paid patients, and most of the time, self-paid patients mean very low or no pay patients, and that is going to put pressure on the hospital margins.

What options will be out there? People always say, what is going to happen? Well, you know what, I do not know, and I think that every hospital is sitting there waiting to see exactly how much money it is going to be, how it is going to impact them before making any final decisions, but everybody has to start thinking things through. Here are some of the options, and that is: reducing or eliminating services, cutting some staff, delay the replacement of equipment and other investments. A lot of people say, well, that is not a big deal. Well, it is for this reason, because once you start delaying replacing and updating things, then all of a sudden, in a few years, you have major problems, that your equipment's not working, that your facilities are not adequate, and unless there is going to be a big pot of money coming in the next few years, you are always going to get behind once that starts, and that is very dangerous. Closing facilities is always a possibility. But you know, we need to start innovating and building efficiencies to shape the future of health care. AI could become very important and a way to minimize some of our costs.

How can the Legislature help? We talked about the base Medicaid rates. There is always an opportunity to increase those. Reducing administrative burdens. It is just amazing to me how much we spend just to collect money for the care we provided, and it just does not make sense. Then improving the sharing of health care information is important. We would ask you not to pass any laws that is going to increase the cost of health care, and one of the big ones out there is mandatory nurse staffing ratios. It is a huge amount of money. And do

not pass any laws that unreasonably restrict the cost benefits of AI in health care. I know there is a lot of talk about AI. People are concerned about it, but please go gently here because there are going to be opportunities for us to use AI that will save money and improve the delivery of health care.

Mason has already kind of gone through this and thank you. This is Blayne's slides. I made him go first because he had to leave, so we will just go on to questions. Thank you.

Chair Brown-May:

Thank you. Thank you for your presentation. We appreciate that. Members, questions? We are going to go up north. We will start with Senator Titus.

Senator Titus:

Thank you, Madam Chair. Much appreciated. All three of you, I very much appreciate all of your perspectives, having lived and breathed it my whole career. One of my questions, Mr. Kelly, is your comment in that list you had about how you are going to survive and what is going to happen and the impact on self-pay patients. I am one of those self-pay patients. I have Medicare A and B but no supplements, and so, I want to go in and I pay for my portion of my care. One of the things that we are trying to do and one of the things I know this body, and federally, we are looking at price transparency. When I go to the hospital and I have to pay my cash for that, are we making any progress on the transparency and what it actually cost and what my bill is going to be for those of us that will be impacted by this?

President Kelly:

Thank you for that question, Senator. There was AB [Assembly Bill] 343 was passed last year and it requires us to put a bunch of the information up. There are a lot of questions regarding that legislation and how to report it, but it will be up there. We are already in compliance with the federal law; the state law just goes a little bit faster. But one of the things about this whole price transparency thing that I do not think people quite get is that it really does not tell you what you are going to pay because what you are going to pay depends on the type of insurance you have. We put out the information on standard charges, but mostly no one pays that. Even if you did pay that, you get 30 percent off of that under state law. If you have Aetna insurance, the real answer is what deal did Aetna do with the hospital and what is your deductible? That is what is going to come down to driving what you pay. Looking up and just seeing that standard charge is not going to tell you what your liability is going to be for having that service performed.

Senator Titus:

Follow-up, Madam Chair? Along that same question, are you doing a better job about letting patients know that this is your hospital charge, but hey, heads-up, you are going to be charged by the radiologist, the person interpreting the X-ray, the lab charges, plus the lab, the pathologists, and all of those? I think people get very confused sometimes about that transparency of what a cost really is—like this is X, but you are going to have all of these other things added, too. How are you navigating that information?

Mr. Van Houweling:

Madam Chair and Senator Titus, I will speak to what UMC is doing, but also, typically every hospital in the State of Nevada does. Certainly, there are two types. If we know a patient is coming in and it is elective business and scheduled, as you know, very well know, we have

time to be able to figure out what that pricing is going to be and what type of procedure code and so we can give availability of that pricing. Every hospital has financial counselors that help patients navigate the system, whether it is seeing if they qualify for some of the Medicaid products or any of the charity discounts that our hospitals offer, but also trying to negotiate a price that is affordable and set them up on payment arrangements. When it comes to the inpatient side, obviously you know things move very quickly, but all of our financial counselors in our consent for treatment do disclose that to the patient that hey, we also have partners, whether it is a radiologist, ER physician, or your specialist, and that some of those, whether they are employed or not or partnered, we do disclose that to the patients that they may, will get additional bills.

Then often, if there is lack of business, we will try to connect them prior to so they can work those discounts with their partnership. But again, we are always trying to see if they are eligible for something, whether it is through the Exchanges, or some of the Medicaid products, or some of our uncompensated care discounts throughout the state.

Senator Titus:

Thank you for that. I just remain very concerned about— Throughout this morning we have heard about the possible increase in individuals' medical debt and that is something as a nation, I have concerns about, our nation is concerned about, and worried about some of these programs actually increasing patient medical debt. Thank you for that, and hopefully we will see a little bit more clarity. Thank you. Thank you, Madam Chair.

Chair Brown-May:

Thank you. Next, we will go to Senator Doñate.

Vice Chair Doñate:

Thank you, Madam Chair, and thank you for the presentation. I want to dive— First and foremost, thank you for the recommendations. I am going to come back to them. I want to dive deeper so that the public understands the ramifications of H.R.1 in terms of what are the specifics of what is going to— It is not a potential scenario, this is going to happen.

In one of your slides, you mentioned that there was going to be closures that could potentially occur because of the passage of H.R.1. It is my understanding that traditionally, when we look at services that hospitals would close— I think there are conversations to be held with rural hospitals. I am going to put them on a different bucket because I think they operate in a very different particular situation because of patient volume. I think I will come back to Boulder City in a little bit, but it is my understanding that generally, for most hospitals, or most acute care hospitals, when you are looking at how do you make the budget make sense based on— I am looking at you, Mr. Van Houweling, how do you make the budget make sense? Oftentimes, as administrators, we look at the services that often do not have the revenue in place to self-finance them. It is the critical services that we do because we need to, but oftentimes, the volume might not be there, or so forth.

Traditionally, what I have seen across the nation is that the types of services that we end up cutting are outpatient facilities, psychiatric inpatient, psychiatric beds, behavioral health, maternal, fetal medicine, high-risk obstetrics, diabetes, chronic care management, dental clinics—sometimes some hospitals have dental clinics—or ancillary services. Is it a fair judgment to say that all of these could be potentially at risk for being cut, depending on the hospital and the situation, to be able to meet the revenue goals that you have?

President Kelly:

Thank you for the question, Senator. You are right. When you look at it nationally, when programs have decreased, it is usually behavioral health and maternal-related services because they are heavy intensity in the resources that are needed and you often do not have the volumes to be able to justify that after a while, so those are looked at. I am not sitting here—I do not want to alarm everybody—I am not saying that hospitals are going to close because of this. What I will say is that hospitals do not close for any one reason. They close because there is a multiple set of things that are occurring and it just becomes overwhelming for them, or they have to make the changes you were talking about, referring to Boulder. They went to a rural emergency hospital. I am sure part of the decision was looking at they are part of the Provider Fee Program that is going to decrease. I am not saying that that happened because of the decrease. What I am saying is that when you are looking at everything as a whole, you start to judge where you need to put that institution so that it will remain and be able to service the community.

Mr. Van Houweling:

Madam Chair and Senator Doñate. I think, Senator, you actually hit some of the high points related to how you look at services and how you are operating, and I know your background is well steeped to this, but those are the things you look at. For example, we, postpandemic, did a lot of things but started looking at how can UMC help solve some of the behavioral health problems. We have opened up a crisis stabilization center with the support of the state and the county and UMC coming together. Those are all things kind of at the top of mind for health care executives. What is the rate of growth of that? Are we going to perhaps continue that, those type of things across the State of Nevada? I certainly think your list are certainly ones that every hospital in the State of Nevada is thinking about. Again, we want to work with everyone to be able to ensure those services and not unwind and go back to pre-2014.

Vice Chair Doñate:

Thank you. Madam Chair, may I follow up? Thank you. Perfect. The reason why I was asking that is, Mr. Kelly, you hit it right on. When a hospital decides to close either a service or the facility themselves, there could be multiple reasons. Obviously, H.R.1 could have been a catalyst for certain closures that are currently happening or will be happening just by the nature of the revenue shortfalls that we are going to reach. I think that is just a general, something that we have to accept. I want to make sure that, as lawmakers, you are making sure that you are briefing us before those closures are occurring. Because if we can utilize the Rural Transformation dollars or the public option pass-through funds or General Fund dollars to make sure that that maternity ward or those services are protected, I want to make sure that we are the first ones that you call and that the funds are available for you. Before we start jump funding GME, before we start going into all these different pots of money or allocations, I want to make sure that we protect what we already have, and I cannot implore you enough that we have to have that level of routine communication, both to state lawmakers, because I do not want us to be a year from now and you are telling me that the City of Elko and their hospital is closing their maternity ward because they had a funding shortfall of \$2 million when we could have used the Rural Transformation Funds to help supplant that. I want to make sure that we have that level of commitment from you.

The only other thing that I would, and perhaps you can ask— I understand the rationality of administrative burdens. I know that it is difficult having to fight with the insurance

companies as to why patients need their adequate care. As much as we can implement AI and we can try to reduce the burdens for our hospitals, we still run into the same issue, which was my question earlier, which is how are we going to solve the coverage gap for the people that are going to be a part of the missing middle? I just want to make sure that I can— If you can give me some feedback that the Hospital Association would be supportive of using the pass-through funds to help cover the missing middle for the people that are going to be displaced from Medicaid. I do not want to be in a scenario where the Hospital Association is advocating against that, and certainly, I think that we should work together. I mean, if there is any other ideas that you can think of on how to solve that coverage gap, I would love to hear your perspective, but I want to make sure that you are also helping us solve that crisis that we are going to be facing pretty soon.

President Kelly:

Senator, thank you for making those points. We are always committed to working with you on different things. That coverage gap is going to impact us as well because if those people are not insured, they are going to be uninsured and come in and we are going to provide care for free, and that is going to be a burden on us. I am not sure what you mean by the pass-through funds, but you have my commitment that we will work with you on that.

Just one thing, I am more than happy to tell you when something is going to happen, that service is going to close, but usually I read about it in the newspaper. I do not get that information in advance from a lot of the hospitals. One of the reasons I do not get that information is they are worried about it getting out into the community too soon and then the nurses start leaving and different medical professionals leave. There is usually not a bunch of advance notice. There was just one service that closed that I read about in the newspaper. If I know about it and I can come to you, I will be happy to do that, but just please know, I do not always know in advance of this happening.

Chair Brown-May:

Thank you. I believe the Senator was referring to the public option as the pass-through. Just for clarity. We have one question from Assemblymember Nadeem.

Assemblymember Nadeem:

Thank you so much, Madam Chair. I want to deter Senator Doñate's concern and what he just said that we are here to help because the concerns the Hospital Association is telling us it is very concerning, and we are there to help. All the Legislators, we want to work with the Department of Health; we want to work with the Governor Office. How we can help it, how we can make it more affordable and accessible because this is affecting the lives of all the Nevadans, and we are there to help and make it better. Thank you so much.

Chair Brown-May:

I do have one additional question. I know that Mr. Osborn, Assemblymember Osborn, has moved on, relative to the rurals, so I am just going to go with new hospitals. We do know—and I asked the Division earlier to talk a little bit about the Intermountain Health and not to just identify Intermountain Health—but there is a new hospital bill that is projected in southern Nevada. That is the Children's Focus Hospital. I am curious to know if you have any idea relative to the change in the provider tax and what that does when we are looking at a new hospital build. What is the sustainability of a business model in that way? I do not know if we have anyone from Intermountain Health that is here that could speak to what

does that business plan look like, but I just want to make sure that I ask that question, and I do not know if you have any response to that.

President Kelly:

Madam Chair, the Intermountain is not yet a member because you have to be a licensed hospital to be a member of the Association. But I think, as a practical matter, they are going to see a lot of Medicaid patients at that hospital. Those kids are going to be— I would not even be surprised if half or more of their patients were Medicaid. It is going to have an impact on them, and that has to be concerning to them. Obviously, they are moving forward and everything, but that has to be concerning, and I have actually sat back and wondered about that myself.

Chair Brown-May:

Thank you. Then, just one last final piece that I would like to get out there for Assemblymember Osborn with regard to the Rural Health Transformation Program Funds. We know that they are only going to last for five years. We are not supplanting funds, so we are doing good programming in order to enhance the support services that we are doing in the rural area of our state. I am curious to know if those funds ending would then increase the likelihood that rural hospitals would face closures or cuts as a result. I am hoping that is not the case, given that we are not supplanting things, but that we are building out new programs, but I am curious to know and look forward to following up with Assemblymember Osborn in the rural hospitals, in particular.

It looks like we are done with questions. Thank you so much for this presentation. We appreciate you being here. We will officially stand in recess for the next 30 minutes. We will be back at 1:00 this afternoon.

D. NEVADA PRIMARY CARE ASSOCIATION

Chair Brown-May:

We are officially back from recess. Thank you. I hope you enjoyed your lunch. We are all present and accounted for and ready to move on to the next agenda item, which is number two of Item V, the Primary Care Association discussing the impacts of H.R.1. Did he— Thank you, thank you. We will stand in a brief recess until we find our presenter. Thank you. Welcome. Thank you for joining us. You are welcome to begin whenever you are ready.

Nancy Bowen, CEO, Nevada Primary Care Association (NVPCA):

We are the association for federally qualified health centers, and we also actually work with look-alike organizations and what are FQHC tribal organizations. It has been a while since we sort of went over what the FQHC is, so we want to do a quick 101. What is an FQHC? It is a federally qualified health center ([Agenda Item V B](#)). They actually receive federal funds to do comprehensive care in medically underserved areas. You have actually heard them called MUAs. They are designed to serve Medicaid and underinsured patients and uninsured patients. That was the whole point that they started back in the '60s, and you will see by the percentage of numbers of what our FQHC serve, how important that really is. One of the big features of a FQHC is that they have to serve patients regardless of ability to pay. They have a pretty high uninsured rate, and so, no matter what, patients get care, whether they can pay for it or not. Thank you, Steve.

The majority of a board for a health center is 51 percent patients; that is the bare minimum. A lot of our health centers actually have boards that are all patients. They typically have a board of 10 to 11 individuals. They are all nonprofits, so their patients are serving on their board. Some of the board members are patients, most of them are, and that really helps with the governance piece so that they understand the health center and all that is involved.

Each health center has to have a sliding fee scale that goes from 0 to 200 percent of the federal poverty level. Right now, when I looked it up, the federal poverty level is about \$66,000 for a family of four for a year. Not a lot of money. Each health center has to provide integrated care, so they start off with primary care and then they add on behavioral health. We have a couple that do dental or oral health services, and of course, they do care coordination services.

This is the network that serves Nevada. There are eight Nevada-based health centers. There are about four that come from California, one from Arizona, and then we have two tribal health centers which are FQHC tribal health centers.

This is the map. You can see all of the health centers, the majority of the health centers, are based in the urban areas of Washoe County and Clark County. There are some in the rural Clark County, and then you have some in other counties. It is a challenge. I mean, 80 percent of our population, or 90 percent of our population, is in the urban areas, so the health centers are located in the urban areas.

Who do we serve? We have 2024 data. Our 2025 data is still being analyzed. Back in 2024, the Nevada-based health center served over 128,000 Nevadans, unique Nevadans with about 428,000 visits. This was done at 62 clinics and 12 mobile units. As I mentioned earlier, the patient population is— Eighty-eight percent of those patients are 200 percent of the federal poverty level or below, so that leaves 12 percent who are actually 201 and above. About one-third of the patients are served in a language other than English, which speaks to the diversity of the communities that we serve.

That uninsured and Medicaid rate is about 69 percent of the patients that the health center serves. Thirty percent of those patients are uninsured, and you will hear later on how we anticipate that that number is going to go up. That is five times more than the national average for a private practice, and 39 percent of those patients are on Medicaid, and that is about twice as a typical physician practice.

Their patients typically are very, very ill or very sick. We hear that a lot. This is typically due to lower income than average. The patients have a lower income than average. They are more racially and ethnically diverse. It speaks to the language being, one-third being served in a language other than English. More are likely to be unemployed or uninsured. Again, poor health, and we have higher rates of chronic disease, so 50 percent higher for asthma and hypertension. Chronic disease management about diabetes is another big piece that the health centers provide care for.

The care that they do provide is really high-quality. Fifty percent of the health centers are what is considered a patient-centered medical home. We do have another one that is actually going to be recognized, planning to get recognized later this year, so we will have six of our eight Nevada-based health centers are patient-centered medical homes. When you compare the patients to their peers, low-income individuals who do not go to a health center, children actually get a regular checkup and dental visit each year when they come to a federally qualified health center. Adult patients receive regular cancer screenings, and the

chronic disease conditions are managed. We actually have a peer network of the health centers that work together and they have been working in this last year around diabetes management and increasing the controlled percentage. The data shows that they were able to increase the patient control of diabetes by 2.7 percent. We hope that keeps continuing to go up.

Who do we serve? Typically our patients are— They have unpredictable work hours. They are day labor, babysitting, housekeeping, gig-type jobs. That is not always captured in the automated wage information. Our health centers usually have extended hours so they can meet the patient care when the patient can come in.

I am going to pass it over to Steve Messinger. He is our Policy Director, and he is going to go over the remaining slides.

Steve Messinger, Policy Director, NVPCA:

Thank you, Nancy. Thank you, Madam Chair. When we are asked to look at what it is going to happen from H.R.1, we are really like the hospitals, like Medicaid, dealing with a wide range of uncertainty because we have not had this guidance that we keep talking about coming in June. Basically, we are looking at \$6 to \$11 billion in losses as our working sort of number. We have been working with Nevada Health Authority and other stakeholders to minimize that loss coverage. But the bill is designed, basically, this is where we start from this analysis. If they are going to get \$1 trillion of cuts over ten years, Nevada's share of that is about \$6 to \$11 billion.

Nevada Medicaid is the largest funding source for our FQHCs. Nancy mentioned that about 30 percent of our patients are uninsured. Almost 40 percent of them are on Medicaid. That is really our bread and butter. We are one of the few provider types that is designed to get cost-based reimbursement for Medicaid patients. Basically, everyone else will tell you that they lose money for seeing Medicaid. This is our biggest funding source. The other being a discount drug program called 340B that we will talk about in a little bit, and then only about 11 percent from our Community Health Center Grant from the federal government. Just to put that in context, that grant is about \$24 million across the eight health centers every year. It has been that way—I think we got a 4 percent raise in this last cycle—but it has basically been that way for a long time.

We estimate that about 25,000 patients could lose coverage at our FQHCs. We believe that we disproportionately serve that expansion population. We believe that based on the effects that the Affordable Care had on us. But about 48,000 of our patients were covered by Medicaid in 2024. We know about 38 percent of them are children and not subject to the changes in H.R.1. If we exclude the disabled patients and those in prenatal care, that leaves us about 25,000 that we think we are going to be working through with work requirements.

Because we do not know the federal or state rules yet, again, there is wide variation. Some studies say that we could lose up to 72 percent of that work requirement eligible population, down to about 36 percent. A midpoint of 54 percent implies about a \$17 million loss per year or about 11 percent of our operating revenue.

Want to get back off the numbers and think a little bit about the patients here and the people that we are really serving. We know that cost shifting is not cost saving. Somebody, I think, mentioned the health economy balloon that you squeeze on one side and it pops on the other. We really believe strongly that preventive primary care is the most cost-effective investment in population health. We consistently see studies that look at FQHCs and the

outcomes that they have. And it is for the last 30 years that they have been doing these studies, we know that the comprehensive approach we have saves the system money, saves Medicaid money, saves private insurers money. We prevent costly hospitalizations by managing chronic conditions upstream, and it is much better for the patients, and the providers, and the finances of the entire system if we do it there and not in the emergency room.

Reducing Medicaid coverage does not eliminate costs. It shifts them to the emergency room, which cannot turn patients away. Those uncompensated costs are passed on to Nevada employers and privately insured families. I am not sure that we have really explored this idea yet.

I know the hospitals do not want to talk about what they are going to have to do to recoup their costs, but at the end of the day, there is only so many payers who are able to pay, and that is your private insurers, that is your employer's premiums, and that is your employee premiums, as well, and that is where we would expect a rise in uncompensated hospital care to show up for the rest of us.

We know for an uninsured patient, a primary care visit that identifies a serious condition becomes a dead end, a diagnosis without a treatment pathway. This is one of the— Nevada has always had one of the highest uninsured rates because of our demographic population, and it is one of our biggest challenges of our health centers. We are constantly doing cancer screening, and if you find cancer, as a provider and a patient who does not have insurance to go on and see that specialist, it is traumatic for both the provider and the patient. A lot of them will feel like they were better off, and their families were better off not knowing that they had this big expensive looming problem, and that is not how we want anyone to have to feel.

How will FQHCs respond? If 13,000 patients that are estimated to lose coverage and remain within our FQHCs, that would take the share of uninsured patients to 40 percent from 30 percent. Our members tell us that that is not something that they are able to do with their current arrangements, their current costs. Without a replacement in Medicaid reimbursement, we could see overall services drop in line with the increased share of uninsured. This is basically the pot just getting smaller for everybody. We cannot afford to keep seeing so many people that are uncompensated, so we end up seeing fewer and fewer people overall. An 11 percent revenue reduction translates to an estimated loss of 107 full-time equivalent jobs across our FQHC network.

And it is not just H.R.1. We have had financial pressure from— We have been cutting to the bone like the hospitals have said, similarly, for many years. Our federal grant has not kept up with inflation. We had 10.6 percent growth in funding between 2019 and 2024 compared to 19 percent growth in patients and about a 26 percent growth in visits. We are growing visits about twice the rate of patients, and we have been doing that for years. We know we already got our efficiencies ironed out.

Our 340B revenue has also been shrinking. This body has taken efforts in the 2023 Session to ensure that health centers that are entitled to discounted 340B drugs cannot be discriminated by payers. Just because a payer knows that we got the drug for less, does not mean that they can pay us less. We thank you for that. That was an important first step that almost all the states took. Most of the other states have also gone further to ensure that their safety net providers can continue to distribute those discounted drugs through a network of contract pharmacies that expands the reach of the program as far as possible, both to allow for the patients to get low-income drugs in their neighborhoods, but also to

allow for the health centers to bill for drugs to privately insured patients in their neighborhoods as well and also reap the benefits of that, which is, again, one of the three legs of our stool.

Some ideas for relief. We always talk about 340B as being kind of the closest thing to a free lunch, as the Legislature can see. As I said, it is worth more than \$30 million a year for us in nontaxpayer money that is propping up your safety net. That has been eroding at a fast pace, and we could actually do more to regrow that pot. We would encourage you to look back at a bill that this particular Committee approved in the last interim that was never introduced in the legislative session.

Our members have also been telling us that they could use some property tax relief. One of the benefits of a health center is that it is located near where its patients are. In Downtown Reno, that means that it is located right where there is a bunch of casino development and condo development happening all around it, making the land that those health centers are on very expensive and starting to be taxed at a rate that is profound for their budgets. There is more than \$1 million of relief that could be passed on that again would go straight into community safety net services if we just allowed FQHCs to be exempt from local property tax.

We could go even further. If you were to get creative and make something like a transferable tax credit that could allow the renters to also see some benefits. In Las Vegas in southern Nevada, there are going to be a lot more health centers that are part of some rental property than there are in some of the rural or northern areas. We really think that that could be a big benefit both to the landlords that rent to those health centers and to the health centers that could get lower rents and plow those savings right into the services.

We must decide whether uninsured residents receive care in costly emergency rooms or cost-effective FQHCs and fund accordingly, and we ask this Committee to champion FQHC investment as the smarter, more humane option.

We will stand for any questions. Thank you.

Chair Brown-May:

Thank you for your presentation. We appreciate you being here and sticking with us through lunch in particular. Questions? Assemblymember Hibbetts.

Assemblymember Hibbetts:

Thank you, Chair. I would like to go back to slide 13. At the very bottom it says, "Excluding disabled patients and those in prenatal care, we estimate nearly 25,000 expansion patients who will be subject to work requirements." Then fast forward to number 17, you estimate 13,000 patients will not be able to—I am paraphrasing—13,000 patients will lose coverage, I am assuming because you believe they cannot meet those work requirements. Why do you have such little faith in our citizens?

Mr. Messinger:

Thank you for the question. Well, we have had experience with this. We have studies, case studies, that happened in Arkansas, Georgia. We are very much just following the experience of the states that have tried this. As a federally qualified health center and as a primary care association, we are lucky to have lots of friends across the entire country. We

have peers of both of our health centers. There are health centers that are very similarly resourced and sized, and we have primary care associations that have worked on these policies. Despite their best efforts, that is the estimate, the experience that we have seen in the past. So, purely going by the experience of other states.

Chair Brown-May:

Assemblymember Nadeem.

Assemblymember Nadeem:

Thank you so much, Madam Chair. I just want to clarify when you said there is a deficit of \$6 to \$11 billion regarding the Medicaid cut, regarding the health care cut. Is that over the years? How many years?

Mr. Messinger:

Thank you for the question, Assemblymember. That is based on the CBO [Congressional Budget Office] estimate of H.R.1. They were able to get \$1 trillion of savings over a ten-year budget period. Of \$1 trillion, the \$6 to \$11 billion is Nevada's share of that.

Chair Brown-May:

Thank you. Next, Senator Doñate.

Vice Chair Doñate:

Thank you, Madam Chair. Thank you for the presentation. For the sake of time, I am not trying to belabor the same points that I made earlier, but I just want to make sure that I, at least, have a clear understanding of the financial health of some of your members. Do you have any estimates right now in terms of any services that could be potentially impacted or a gross estimate of— Let me rephrase my question. There are going to be, as of today, I am sure that you probably know some members or some clinics that could possibly be on the verge of closing. Do we have an anticipation of how many clinics could be potentially impacted either for a potential closure or a reduction in services based on the implementation of H.R.1?

Mr. Messinger:

Thank you for the question, Senator. I think that we are with everyone else. We do not know exactly. We would look to, again, the points that you made earlier, the most loss-leading sort of services. One of the things that we have been struggling to expand for many years is adult dental. We have finally got some of the policy and financing pieces in place, but that is still always been a loss leader for the health centers, and so that is something I would expect to continue to get kind of shrunk. It is all about, sort of, they shrink the capacity and that effectively shrinks the access. I do not have a number of patients to give you, but I can tell you they are going to look at the service lines that are not making money. If their behavioral health is not turning a profit, is that something that they have to cut? Pretty much all the health centers have more than one site, so you could very much see them trying to think about consolidating their resources. If they ask their patients to drive a little bit further, they can save some money on rent. They have a little bit smaller staff but try to maintain a similar capacity. That is what I would kind of expect the moves they would make.

Vice Chair Doñate:

Madam Chair, if I may follow up?

Chair Brown-May:

Go ahead.

Vice Chair Doñate:

The reason why I am asking these questions is, I think we both have had the discussion of how I have worked in primary care. Some of my health centers that I managed had a level of care navigation services. It is my understanding that many FQHCs have community health workers or care navigators that meet with patients to help them enroll but they do not bill. A lot of that comes from the institution feeling that it is a service that we have to provide to our members because that is what they expect of us. And so, it is a fair assessment, based on my understanding, that those are going to be the positions that are first cut, which are ultimately the people going out into the frontier in rural areas. Is that not correct?

Mr. Messinger:

Thank you, Senator, for the question. Absolutely. Anything that is not producing a revenue is going to end up being a cost. For them to focus on the mission that they see as most core, those are exactly the kind of services we kind of think of as the “special sauce” of what makes a health center a health center. That is the fact that they are able to really provide those wrap-around resources, navigation, not only to the health literacy, but also to the social services, addressing the social determinants of health. And that is all expense, so I would expect a reduction in those services.

Vice Chair Doñate:

Thank you. Madam Chair, the only comment that I just want to make is we have worked so hard as a state to help uplift our community health workers and I hate for us to take a step backwards, but there is also a lot of things that are going to be impacted by this. We did not even touch on the point of, obviously, earlier, we heard the cuts towards immigrants that are affected from the passage of H.R.1. Many of your FQHCs support that community, and so I think it is going to be a very daunting task to be able to solve this crisis. Any ideas that you would have in the interim, please communicate them to us. Talk to your members in terms of— You presented some today in terms of temporary relief on property tax, but I do not think that is going to be enough to support the members that you are and the patients that come to you. Please help us solve the coverage gap issue because it is going to be the most pressing issue that we have to face.

Chair Brown-May:

Thank you. Just one clarifying question. Just following up on Senator's point, would those community health workers have the ability to apply to become navigators and then create a funding stream for the FQHCs? Is that something that you have considered or is even possible?

Ms. Bowen:

Thank you for the question. Yes. So right now, some of the community health workers are reimbursable for some services. Our health centers would love to be able to have navigators and to do eligibility screening at their health center and actually enroll, be enrollers for Medicaid at their health centers. Right now, they do have eligibility screeners, but it is a challenge, like the Medicaid employee has to come out to the health center. We would love to be able to do that ourselves.

Chair Brown-May:

Thank you. I believe you have a phone-a-friend directly behind you. Would you like to come forward and give us some information specifically about the navigators?

Ms. Krupp, previously identified:

Thank you so much. We will be releasing an RFA on Friday to help support community navigators. FQHCs would be eligible to apply, and we are very interested in working with many of our federally qualified health center partners. I have worked in many of the programs that you guys are describing in the past, particularly with having community health workers in place within the FQHCs. That is how, as we are designing this program, looking at how we can help assist in many of those areas and help connect our Nevadans to coverage. Thank you.

Chair Brown-May:

Thank you for providing that clarification, Ms. Krupp. Thank you so much for being here and our expert witness. We appreciate that. I see no other questions. No additional questions at this time. Thank you so much for being here and presenting this information. We sincerely appreciate you.

AGENDA ITEM VI—PRESENTATION ON THE IMPACTS TO NONPROFIT ORGANIZATIONS MADE BY H.R.1 AND OTHER FEDERAL CHANGES

Chair Brown-May:

We will close this Agenda Item V and move on to Agenda Item VI, which is a presentation on the impacts of nonprofit organizations made by H.R.1 and federal changes. Understand we do have a presenter up north. I believe we also have a presenter online, remote. There she is. Thank you. We appreciate you both being here and presenting this information. You may begin whenever you are ready. We have two online. Thank you. Thank you so much. Go ahead and begin whenever you are ready.

Janet Quintero, Chief Strategy and Advocacy Officer, United Way of Southern Nevada:

Thank you so much, Chairwoman. I want to start by sharing a thank you to Chair Brown-May and members of the Committee for the opportunity to share about the impact of H.R.1 and other federal actions to the nonprofit sector. I also appreciate the opportunity to join via Zoom as I am currently in D.C. for United Way's advocacy forum in Capitol Hill Day, so thank you for the flexibility there.

I am grateful to Legislators for the close partnership and the close partnership with state agencies as we navigate these changes together. I am also very proud to be joined by

Executive Director Jill Tolles from the Guinn Center and Mark, who will be copresenting with me. During my presentation, I will focus on some areas that United Way has addressed and how nonprofits have navigated changes that began in January of 2025 ([Agenda Item VI A](#)). Again, this partnership with the Guinn Center will allow for a deeper dive into the data.

The mission of United Way of Southern Nevada and nonprofit partners is to serve low-income and moderate-income populations, and to use Senator Doñate's term that he used earlier today, that also includes the "missing middle." United Way focuses on youth opportunity, financial security, community resiliency, and the nonprofit sector. I am not sure if you have slides. I am not seeing that on my end, but if you do, you will see that we have four core areas of impact and a fifth one that includes the nonprofit sector sustainability and supporting the sector as a whole. That means that all the topics addressed today fall within one of our impact areas.

To that extent, H.R.1 and federal funding changes impact our community. United Way is committed to be a convener and to make data-driven decisions powered by key partnerships, like the one today with the Guinn Center, but also feedback from those impacted directly by these changes, whether that is by nonprofits directly or by the communities that they serve.

I also similarly want to start by defining the scope of what these federal actions that are impacting the nonprofit sector are. In addition to H.R.1, as of April 10, there are 57 executive actions or orders impacting nonprofit organizations. That is in comparison to 42 executive orders or actions that impacted the nonprofit sector in April of last year. In addition to H.R.1, the nonprofit sector is actively navigating these changes that impact not only our mission but our operations and the way that we manage grants.

As a quick look back, I do want to share that on February 25, 2025, United Way had the opportunity to present an overview of federal funding in the nonprofit sector to the joint committee. That was over a year ago. And at that time of the presentation, we were responding to the OMB [Office of Management and Budget] memo, which resulted in positive funding for key social service programs.

As a quick look back, as of January 27, 2025, the Office of Management and Budget released a memo that required federal agencies to identify and review all federal financial assistance programs and supporting activities consistent with the President's policies and requirements. We know that resulted in mixed action from different state agencies, and we know for a fact that resulted in past funding or immediate funding to nonprofits.

In staying with our commitment to convene, the United Ways of Nevada—that means United Way of Southern Nevada in partnership with our partner United Way of Northern Nevada and the Sierra—hosted a rapid response call in partnership with Nevada Grant Lab with over 350 nonprofits and community leaders who joined as we learned to navigate the space together.

By February 21, 2025, United Ways of Nevada launched a survey and received 160 entries. Each entry was representative of a federally funded program. This was anecdotal information. We surveyed the nonprofits and we said, "Tell us how you feel; tell us which funding is being affected as of today." It served as a temperature check of the impact of federal changes at the time. We knew that the top constituencies that were impacted by these changes were children, parents, seniors, and people with disabilities.

When we presented to the joint committee on February 25, we shared what we knew at the time, but also what we did not know. At the time, we knew that nonprofit organizations are key partners to the state in the delivery of social services. We also understood, at the time, the short-term impact of these federal actions. Again, last year we knew that we did not understand the long-term impact of these actions, but now, a year later, we can reflect back and use this data to continue making data-driven decisions.

Fast forwarding to January 2026, United Way and the nonprofit sector have remained action-focused by convening regularly and strengthening key partnerships with state agencies. More recently, we hosted Deputy Administrator Cantrelle to share about changes to SNAP with our nonprofit partners. We understand the importance of education and outreach, as I know it has come up a couple of times during this hearing, and we want to support. The nonprofit sector wants to be a partner to not only Legislators but our state agencies as we continue communicating the changes to our community.

Now, four examples of how nonprofits have been affected, and again, these are on-the-ground examples firsthand for United Way or from one of our partners. These only represent a small sample, and a reminder that there are 57 executive orders or actions impacting nonprofit organizations as of April 10. The four examples that I will dive into are SNAP, Medicaid, charitable deductions, and ESFB [Emergency Support for Families/Beneficiaries].

Today you heard a lot about SNAP, so I will not really recap any of that data and information, but we can tell you that we have heard directly from nonprofits that they have seen a surge in clients seeking basic needs, but at the same time, they have expressed a difficulty in serving the communities because of fear of engaging with organizations and that includes immigrant communities. I also want to say that United Way and our nonprofits want to remain a partner to our state agencies by offering our United Way Volunteer Connect platform as an option when community engagement or volunteer opportunities are required in maintaining the eligibility status for SNAP.

The second example is the Emergency Food and Shelter Program funded by FEMA [Federal Emergency Management Agency]. This was not directly impacted by H.R.1, but this program has been paused since January 2025. This program has not been impacted by any formal federal action, but the board has not voted on releasing funding to that service the State of Nevada and Clark County directly. Since 2020, ESFB has helped more than 680,000 neighbors with 8.5 million in support for food, housing, and basic needs. The way this impacted our nonprofit community is United Way tried to launch, or we launched the Emergency Assistance Fund to try to fill the gap, or attempt to fill the gap, but were only able to do this at a significantly reduced rate.

Similarly, you heard today about Medicaid eligibility. The impact to nonprofits— We are seeing nonprofits with a surge in clients seeking basic needs as individuals attempt to rearrange spending to accommodate increase in premiums or SNAP changes. We also understand that some Nevadans may forego coverage altogether, putting a strain on nonprofit providing emergency or preventative health care services.

The fourth area is changes to the charitable deduction. This was a section of the tax bill. We know that H.R.1 imposes a 1 percent floor for the deduction for charitable contributions made by corporations. This creates limitations on the incentive to give to charitable organizations. Again, staying with data-driven decisions, we do not yet have statistical data on the impact of the charitable deduction, but whether directly or indirectly influenced by

these changes, we have seen firsthand donations from corporate partners have been impacted.

As you can see, federal changes pose direct and indirect impacts to the nonprofit sector and our ability to serve low- and moderate-income individuals in the state. We have already seen local nonprofit organizations affected by these changes, but most importantly, this has impacted the communities we serve.

Ongoing public-private collaboration paired with responsive policy solutions is critical to supporting our community. As United Way, our request is to continue being a partner to Legislators and to state agencies as you continue to design programs to support our community during this time. We believe the nonprofit sector perspective is not only complementary but critical to finding solutions for our community.

That concludes my remarks, Chair, so I will hand it back to you. I know that we have Executive Director Jill Tolles in northern Nevada ready to join, but I will hand it back to you. Thank you.

Chair Brown-May:

Thank you. We will go ahead and move to the second part of this presentation if you do not mind. Ms. Tolles, whenever you are ready.

Jill Tolles, Executive Director, Guinn Center:

Thank you so much, Chair. I do have a PowerPoint ([Agenda Item VI B-1](#)). It is loaded up here in our sparsely populated Carson City location. Is there a way to have that online for anyone watching? Thank you so much.

Chair Brown-May:

We can see it. Go ahead.

Executive Director Tolles:

Thank you, Chair, and members of this Committee. We are a statewide, independent, data-driven, nonpartisan policy research center and it is a pleasure to present to you today. I am also joined by Mark Krmpotic, who is one of the primary authors of the reports that we will be discussing today. I also want to thank you for spending time on this important topic and bringing in nonprofits, knowing that they are key service providers in our state and partners with the state of Nevada.

Over the past year, our Director of Health and Social Policy, Pierron Tackes, and our Interim Director of Economic and Fiscal Policy, Mark Krmpotic, published four reports addressing federal funding in our state with discussion of H.R.1 and its impacts. The first was a standard report that we produce every two years, an analysis of the legislatively approved budget, which included an appendix on the impacts of H.R.1 and considerations for this body ([Agenda Item VI B-2](#)). The second was a brief explainer on Medicaid and also including some discussion of H.R.1 ([Agenda Item VI B-3](#)). Then two reports on federal funding in Nevada, which we will focus on today ([Agenda Item VI B-4](#)) ([Agenda Item VI B-5](#)). I want to make a note that for anyone who is watching online, that all of our reports are available for free to the public at guinncenter.org.

In light of the shifts in federal funding, the research team sought to examine how much of the state's budget relies on federal dollars and where does that money go. In April 2025, the Guinn Center released our first report on this topic with an overview on federal funding in Nevada, examining the top five federally funded state agencies: (1) the Department of Health and Human Services; (2) Nevada's Department of Transportation; (3) Nevada's Department of Education; (4) Nevada's Department of Agriculture; and (5) the Department of Employment, Training and Rehabilitation ([Agenda Item VI B-4](#)).

What we found is that 27.7 percent of the 2023 to 2025 biennial budget relied on federal dollars. That number, I will note, rose to 28.1 percent in the current 2025 to 2027 budget. The largest share of those dollars in the last biennium, approximately 80 percent, were directed to health and human services, followed by transportation, education, agriculture, and employment training and rehabilitation where many of our disability services lie. If you go to that report online or in front of you in the appendix, you will see that we provided a line-by-line item breakdown of the state and federal dollars by program, which proved to be an incredibly useful tool for lawmakers and the public as taxpayers just to see where those dollars go.

Thanks to a grant from the Office of Federal Assistance, the team took a look at determining where the federal dollars go once they leave the state agency and particularly with an interest in how much goes to nonprofits. And so, in taking dollars, or taking numbers, from the state's Fiscal Year 2025, the team examined the top three agencies receiving federal dollars: (1) the Department of Health and Human Services; (2) Department of Education; and (3) Department of Agriculture ([Agenda Item VI B-5](#)).

I want to note that the Guinn Center set out to map all federal funding dollars that flow through the five state agencies that receive the most federal funding support. However, the team could only capture a partial picture because key data were inconsistent or unavailable. Additionally, funds that passed from the state through local governments or through school districts to nonprofits were not captured in this analysis. So, the utilization of nonprofits by the state for direct service delivery and the amount of federal dollars that go to those nonprofits is actually greater than what you see in this snapshot. The team was able to utilize state fiscal data to examine a snapshot of \$818 million that passed through Nevada's top three state agencies that engaged in federal grant distribution in state Fiscal Year 2025. Overall, the team found that 57 percent went to local school districts and charter schools, 17.5 percent went to local governments, and 17.5 percent went directly from the state to nonprofits.

Drilling down even deeper into the Department of Health and Human Services' pass-through, the team found that 44 percent went to local governments and 40 percent went to nonprofits. I would also direct this body, as well as the public, to go to the appendix where it outlines aggregate data analysis by department, budget account, and the pass-through entity receiving funds from the state agency budget accounts.

Although this report simply provided a snapshot, there were several policy considerations that emerged for this Committee and this body inevitably to consider. The first is to invest in data infrastructure. Without a comprehensive statewide system for tracking federal dollars from appropriation to final use, lawmakers lack the visibility needed to anticipate risks, respond to federal funding changes, or ensure resources reach communities and organizations that serve them. Second, to conduct an audit of service continuity risks. Nevada's dependence on federal pass-through dollars combined with its low per capita federal funding creates a fragile foundation for the state's service delivery system. Third, that future research is necessary, including a closer examination of the direct impacts of

federal funding on nonprofits is needed to analyze for small, medium, and large nonprofits and looking at the role that federal funding plays and the impact on services should these fundings be disrupted.

More specifically, some of the questions to consider. What has been or is anticipated to be the effect of federal budget cuts on the provision of services through local nonprofits? Have or will such cuts imperil organizations in general or specific services? What would the cost be to the state to replace any of those lost federal dollars? What would be the difference in costs to deliver those services through a government agency versus through the nonprofit entities? If you are interested in reading the full report, you can go to our website, guinncenter.org, and you will find the federal funding briefs, both parts one and two, as well as the legislatively approved budget analysis from this biennium and the Medicaid brief.

With that, I want to thank you, and I stand for any questions alongside with my partner Mark Krmpotic who is on Zoom.

Chair Brown-May:

Thank you. Thank you all for being here. Thank you for the presentation. Members, questions? Well, I have plenty. I think that you have heard, if you have been with us throughout the course of today, a number of immediate concerns relative to the effects of H.R.1 on the state and specific populations. The nonprofit sector, in my experience, is often delivering services to that middle group that does not qualify for services elsewhere. I am curious to know, has there been any modeling done with regard to anticipated changes in philanthropic support of the nonprofit sector given the new provisions in H.R.1?

Executive Director Tolles:

Madam Chair, that is part of our team's interest in further research. As you noted and as you have heard from other presenters throughout the day, there has been a double impact. There has been the impact of— Three different changes at the federal level can impact nonprofits. It could be the loss of government funding at the source. It could be pauses or delays to the distribution of funds or to stop work orders that interrupt work, and those have a tremendous impact on our nonprofits. The other side to that is the changes in tax benefits for philanthropy that is reducing the amount of giving. We would like to study that in a deeper capacity and would welcome that partnership.

Chair Brown-May:

Thank you. I appreciate that. Certainly, that seems to be of great concern.

Ms. Quintero:

Can I add to that?

Chair Brown-May:

Yes, you can. Go ahead.

Ms. Quintero:

Thank you. I also want to share that what we have seen is that due to the changes in mission, based on just limitations to the DEI [diversity, equity, and inclusion] language or other restrictions, we have seen that our funders are changing their priorities, which in turn

affects how they fund nonprofits and our work. So, just another indirect way in which the changes are affecting or impacting the nonprofit sector.

Chair Brown-May:

Thank you for that clarification. Thanks for getting that on the record.

Executive Director Tolles:

Madam Chair, if I could add on one more to the record. I do have a data point for you.

Chair Brown-May:

Go ahead.

Executive Director Tolles:

In our report we did highlight that nearly half of an average nonprofit's income come from charitable giving, and the share of Nevada's small business budgeting donations dropped from 67.1 percent in 2024 to 56.6 percent in 2025, and it is anticipated that we will see further drops as a result of those changes.

Chair Brown-May:

Thank you for that clarification. I would additionally ask if we could chase the numbers about corporate philanthropic contributions given that their tax policy is changing versus personal or individual philanthropic contributions and what are the tax implications relative to that if our nonprofit sectors are primarily funded largely through philanthropic dollars, not just federal grants. I think that we have to look at what is personal giving and what are the effects of that on the service delivery as we continue to see the impacts of H.R.1 across the nonprofit sector. And so, working to shore up a food bank, what other philanthropic support is the food bank then going to have to make up as a result of changes in charitable contributions to the organization, both corporate and personal? I am most curious to learn about that and what are the long-term effects to the nonprofit sector where we are able to cover that as that safety net in between.

Members, any other questions? No? Thank you so much for providing the information and the detail. Mr. Krmpotic, I want to say thank you for being here. Is there anything that you would like to add to this conversation that we perhaps need to be aware of as we consider H.R.1?

Mark Krmpotic, Interim Director of Economic and Fiscal Policy, Guinn Center:

Thank you, Madam Chair. I have nothing further to add. Thank you.

Chair Brown-May:

Thank you. We were successful in officially getting you on the record. I appreciate that.

We will officially close this agenda item, and I will say thank you all for being here. Thank you for presenting on the nonprofit sector and the effects of H.R.1.

AGENDA ITEM VII—PUBLIC COMMENT

Chair Brown-May:

That moves us to the next item on our agenda which is public comment. We will start with public comment for those who are here in our physical locations. If you would like to offer public comment here in Las Vegas or in Carson City, please come forward and take the table. Please remember to clearly state and spell your name for the record. We will limit your comments to two minutes. Also, you are welcome to call in. If you would like to call in to provide testimony during public comment period, please dial 888-475-4499 and then when prompted, hit the meeting ID number at 857 3089 0851 and then press the pound sign. We will go ahead and start here in Las Vegas. Welcome. Thank you. You may begin when you are ready.

Elisa Cafferata, Executive Director, Children's Advocacy Alliance of Nevada:

Good afternoon. Thanks for having us. We just want to raise the issue of, nationally, we know that one in five children are at risk of losing their Medicaid coverage as a result of H.R.1. I know they are specifically exempted from the main cuts, but two specific risks to children that we know of. One is the immigrant family exclusion. So now children in mixed families, both of their parents have to be in categories that are still covered in order for them to maintain their Medicaid coverage. And as I know you are aware, Nevada has a very high rate of mixed families, so we are going to be seeing children lose their coverage in that way.

And also, it has been reported that H.R.1 has rules against raising the reimbursement rates for pediatricians in MCOs [managed care organizations]. I have not seen this discussed, so I have not been able to run down the exact impact here, but we know we have a severe shortage of pediatricians in Nevada, and raising reimbursement rates is one way to attract doctors and specialists. If this is a decision point that the state can make, that would be great to investigate.

But overall, we are standing ready to work with you to make sure as many children maintain their Medicaid coverage as possible. We really appreciate you having the hearing to investigate what the impacts of this law will be so we can start to find solutions. Thanks for your attention.

Chair Brown-May:

Thank you. Seeing no one else here in person in Las Vegas and no one at the testimony table in Carson City, we will go to the telephone lines. AVH, is there anyone on the telephone line who would like to offer public comment at this time?

AVH:

Chair, the public line is open and working. We have no callers at this time.

Chair Brown-May:

Thank you, AVH.

Members, that leads us to the next item on our agenda. Our next meeting will be held on Tuesday, May 12, starting at 9 a.m. The Chair is planning to be in Carson City for that

meeting. You are welcome to attend in either location that you see fit and for now we are adjourned.

The following written public comments were submitted:

- Chris Doss, Member of the Public ([Agenda Item VII A-1](#)) ([Agenda Item VII A-2](#)); and
- David Lee Nace, Member of the Public ([Agenda Item VII B](#)).

AGENDA ITEM VIII—ADJOURNMENT

There being no further business to come before the Committee, the meeting was adjourned at 2:02 p.m.

Respectfully submitted,

Serina Hale
Research Policy Assistant

Davis H. Florence
Senior Policy Analyst

APPROVED BY:

Assemblymember Tracy Brown-May, Chair

Date: _____

MEETING MATERIALS

AGENDA ITEM	PRESENTER/ENTITY	DESCRIPTION
Agenda Item II	Patti McGuire, Pastoral Associate, Human Concerns Ministry, and Outreach and Food Pantry Coordinator, Saint Elizabeth Ann Seton Catholic Church	Written Public Comment
Agenda Item III	Stacie Weeks, J.D., M.P.H., Director, Nevada Health Authority (NVHA) Ann Jensen, Administrator, Nevada Medicaid, NVHA Malinda Southard, D.C., Deputy Director of Community Engagement, NVHA	Microsoft PowerPoint Presentation
Agenda Item IV	Kelly Cantrelle, Deputy Administrator, Program and Field Operations, Division of Social Services, Department of Human Services	Microsoft PowerPoint Presentation
Agenda Item V A	Patrick Kelly, President and Chief Executive Officer (CEO), Nevada Hospital Association Blayne Osborn, President, Nevada Rural Hospital Partners Mason Van Houweling, CEO, University Medical Center of Southern Nevada	Microsoft PowerPoint Presentation
Agenda Item V B	Nancy Bowen, CEO, Nevada Primary Care Association (NVPCA) Steve Messinger, Policy Director, NVPCA	Microsoft PowerPoint Presentation
Agenda Item VI A	Janet Quintero, Chief Strategy and Advocacy Officer, United Way of Southern Nevada	Microsoft PowerPoint Presentation
Agenda Item VI B-1	Jill Tolles, Executive Director, Guinn Center	Microsoft PowerPoint Presentation

AGENDA ITEM	PRESENTER/ENTITY	DESCRIPTION
<u>Agenda Item VI B-2</u>	Jill Tolles, Executive Director, Guinn Center	Policy Report
<u>Agenda Item VI B-3</u>	Jill Tolles, Executive Director, Guinn Center	Policy Brief
<u>Agenda Item VI B-4</u>	Jill Tolles, Executive Director, Guinn Center	Policy Brief
<u>Agenda Item VI B-5</u>	Jill Tolles, Executive Director, Guinn Center	Policy Brief
<u>Agenda Item VII A-1</u>	Chris Doss, Member of the Public	Written Public Comment
<u>Agenda Item VII A-2</u>	Chris Doss, Member of the Public	Written Public Comment
<u>Agenda Item VII B</u>	David Lee Nace, Member of the Public	Written Public Comment

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