**SENATE COMMITTEE ON FINANCE AND
ASSEMBLY COMMITTEE ON WAYS AND MEANS**

**JOINT SUBCOMMITTEE ON HUMAN SERVICES
CLOSING REPORT**

DEPARTMENT OF HEALTH AND HUMAN SERVICES DIRECTOR'S OFFICE AND DIVISION OF HEALTH CARE FINANCING AND POLICY

The Joint Subcommittee on Human Services has completed its review of the Department of Health and Human Services Director's Office and Division of Health Care Financing and Policy, and made the following recommendations for the 2015-17 biennium budget. The closing actions taken by the members of the Subcommittee have resulted in a decrease in General Fund appropriations of $11,403,120 in FY 2016 and $6,425,653 in FY 2017 when compared to the Governor's recommended budget. The following comments describe the more significant recommendations of the Joint Subcommittee.

Intergovernmental Transfer Program (101-3157) DHHS-DHCFP-10: The Subcommittee recommended to continue budgeting for Clark County Intergovernmental Transfer revenues at the current voluntary contribution rates based on 50 percent of supplemental and enhanced payments received by non-state governmentally owned or operated hospitals in Clark County, after considering a potential voluntary contribution rate decrease.

The Subcommittee recommended approval of the Governor's recommendation, as amended, to continue an enhanced Managed Care Organization payment program approved by the Interim Finance Committee, during the interim, to provide additional Medicaid reimbursements to safety net medical service providers for targeted services provided to Medicaid recipients enrolled in a Managed Care Organization, including inpatient and outpatient hospital services and mental health services. The enhanced payment program is projected to provide additional Medicaid reimbursements totaling $122.1 million over the biennium to safety net providers, including the University Medical Center of Southern Nevada and the Division of Public and Behavioral Health. The enhanced payment program would generate a net benefit to the state of $9.4 million over the biennium, reducing the need for General Fund appropriations by the same amount in the Medicaid budget.

The Subcommittee recommended approval of the Governor's recommendation to continue the Indigent Accident Fund Upper Payment Limit (UPL) program and the Private Hospital Collaborative UPL program in the 2015-17 biennium. The programs, which are projected to provide supplemental payments to hospitals totaling $73.3 million over the biennium, were approved by the Interim Finance Committee during the interim.

Administration (101-3158) DHHS-DHCFP-13: The Subcommittee recommended approving 29 of the 41 new positions recommended by the Governor for the division, including eight positions for the Long Term Support Services Unit to address federally mandated changes to home and

community based services, four positions for the district offices to provide additional support for customer service and care coordination, three positions for the IT Business Process Management Unit to manage information system modifications, three positions for the Surveillance and Utilization Review section to establish a Las Vegas office, two positions for the Rates and Cost Containment Unit to analyze fiscal data and complete federally mandated reports, two positions for the Hearings section to address a growing hearing workload, two positions for the IT Project Management section to manage IT projects, one position for the Clinical Policy Team to manage policy for Autism Spectrum Disorder services, one position for the Budget and Accounting Unit to complete federally mandated reports, one position to manage the Compliance section, one position for the Provider Support section to evaluate access to health care issues, and one position for the Fiscal Integrity Unit to audit fiscal agent invoices.

The Subcommittee did not recommend approving the remaining 12 new positions recommended by the Governor for the division, including five positions for the Surveillance and Utilization Review section, two positions for the Fiscal Integrity Unit, two positions for the district offices, two positions for the Long Term Support Services Unit for waiver services, and one position for the Clinical Policy Team for pharmacy policy, reducing General Fund appropriations by $246,223 in FY 2016 and $304,994 in FY 2017.

The Subcommittee recommended approval of the Governor's recommendation to implement the first portion of the third and final phase

of the Medicaid Management Information System replacement project, including General Fund appropriations totaling $3.3 million over the biennium. The Subcommittee recommended approval of transferring operation of the Waiver for Persons with Physical Disabilities to the Aging and Disability Services Division, as recommended by the Governor, including 25 existing positions and associated operating costs.

Nevada Medicaid, Title XIX (101-3243) DHHS-DHCFP-41: The Subcommittee recommended approving revised Medicaid caseload and cost per eligible projections based on February actual caseload and cost-associated technical adjustments, resulting in a net General Fund decrease of $23.5 million over the biennium from the General Fund appropriations included in The Executive Budget. The updated caseload projections estimate average monthly Medicaid caseload of 587,831 in FY 2016 and 577,330 in FY 2017.

The Subcommittee recommended approving revised Federal Medical Assistance Percentage (FMAP) projections, which result in a slight decrease in the FY 2017 standard FMAP rate, from the 65.30 percent recommended in the Governor's recommended budget to 65.25 percent, requiring additional General Fund appropriations of $921,436 in FY 2017 when compared to General Fund appropriations included in The Executive Budget.

The Subcommittee recommended approval of mandatory provider reimbursement rate increases as recommended by the Governor, and associated technical adjustments, requiring additional General Fund

appropriations totaling $1.5 million over the biennium when compared to the General Fund appropriations recommended by the Governor.

The Subcommittee recommended approval of physician, physician assistant, and certified nurse practitioner provider reimbursement rate increases as recommended by the Governor to align reimbursement rates more closely with the 2014 Medicare fee schedule. The Subcommittee recommended approving an increase in the reimbursement rate for radiology services, from the 90 and 94 percent of the 2014 Medicare fee schedule as recommended by the Governor in FY 2016 and FY 2017, respectively, to 100 percent of the 2014 Medicare fee schedule effective FY 2016, requiring additional General Fund appropriations of $5.3 million over the biennium. The Subcommittee also recommended approving a further rate increase for laboratory services, from the 50 percent of the 2014 Medicare fee schedule recommended by the Governor to 95 percent of the 2014 Medicare fee schedule, requiring additional General Fund appropriations of $3.0 million over the biennium. In total, the Subcommittee's recommendations bring total General Fund appropriations for physician, physician assistant, and certified nurse practitioner provider reimbursement rate increases to $31.5 million over the biennium.

The Subcommittee recommended approval of the Governor's recommendation to increase the reimbursement rate for acute inpatient hospital services by 2.5 percent in FY 2017. The Subcommittee also recommended approval of a 2.5 percent reimbursement rate increase in FY 2016 and an additional 2.5 percent reimbursement rate increase in

FY 2017, requiring additional General Fund appropriations of $9.2 million over the biennium when compared to the $4.4 million recommended by the Governor.

The Subcommittee recommended issuing a letter of intent, instructing the agency to report to the Interim Finance Committee on options for providing Medicaid reimbursement for telemedicine, community paramedicine and community health worker services.

The Subcommittee recommended approval of the Governor's recommendations to increase the reimbursement rate for home-based nursing services by 25 percent beginning in FY 2017, and to increase the reimbursement rate for Intellectual Disabilities and Related Conditions Waiver services by 5.7 percent in FY 2017. In closing the Aging and Disability Services Division budgets on May 12, 2015, the money committees approved beginning the Intellectual Disabilities and Related Conditions Waiver services rate increase in FY 2016 rather than FY 2017, requiring an adjustment in this budget.

The Subcommittee recommended approval of the Governor's recommendation to provide additional funding totaling $42.6 million, including $14.8 million in General Fund appropriations to implement coverage for applied behavior analysis services to address a recent federal mandate requiring states to provide behavior intervention services to children with Autism Spectrum Disorder. The division intends to begin covering these services in January 2016. In the 2015-17 biennium, the division anticipates that 1,900 children would receive applied behavior

analysis services funded by the division. The Subcommittee recommended issuing a letter of intent, instructing the agency to report to the Interim Finance Committee on its implementation of applied behavior analysis services.

The Subcommittee recommended approval of the Governor's recommendation to implement a number of cost saving measures for the Medicaid program, generating cost savings totaling $65.3 million, including $22.1 million in General Fund savings over the biennium. The Governor's recommended cost savings measures include implementing a Health Care Guidance Program to provide care management for certain fee-for-service recipients with chronic conditions, reducing the dental fluoride provider reimbursement rate, reducing the non-emergency transportation broker capitation rate, implementing policy changes to ensure that personal care services and basic skills training are medically necessary, implementing a federally mandated asset verification system for aged, blind and disabled Medicaid recipients, continuing the expansion of the Preferred Drug List until June 30, 2017, increasing third party liability recoveries and increasing improper payment recoveries. Considering the magnitude of the recommended cost saving measures, the Subcommittee recommended issuing a letter of intent instructing the agency to report semiannually to the Interim Finance Committee on the degree to which budgeted cost savings materialize over the biennium.

The Subcommittee recommended approval of the Governor's recommendation, including $1.4 million in General Fund appropriations over the biennium to increase waiver slots for the state's three approved

Medicaid waiver programs, including an increase of 51 slots for the Waiver for Persons with Disabilities, an increase of 93 slots for the Intellectual Disabilities and Related Conditions Waiver, and an increase of 173 slots for the Home and Community Based Waiver for the Frail Elderly.

Nevada Check Up Program (101-3178) DHHS-DHCFP-36: Based on revised caseload projections, the Subcommittee recommended approval of additional General Funds totaling $397,771 over the biennium to support an uncapped average monthly Nevada Check Up (Check Up) caseload of 16,670 in FY 2016 and 16,667 in FY 2017, compared to the average monthly caseload of 13,974 throughout the upcoming biennium originally recommended in The Executive Budget.

The Subcommittee recommended approval of expanding Check Up eligibility to allow state employees who meet existing income eligibility requirements to enroll their children in the program, effective January 2016, contingent upon the approval of a state plan amendment, requiring additional General Fund appropriations of $148,655 over the biennium. This eligibility change is anticipated to increase Check Up average monthly caseload by 1,410 in FY 2016 and 2,373 in FY 2017, based on projections produced by the Director's Office.

The Subcommittee noted that the federally funded portion of the Check Up program is supported by an annual allotment of federal Title XXI funding and that the state would spend its annual allotments more quickly, considering a pending increase in the enhanced federal medical assistance percentage rate. Accordingly, the Subcommittee recommended approval of

a letter of intent instructing the agency to report to the Interim Finance Committee quarterly on its Title XXI allotment.

The Subcommittee recommended approving revised Federal Medical Assistance Percentage (FMAP) projections, which include a slight decrease in the FY 2017 enhanced FMAP rate, from the 98.71 percent recommended in the Governor's budget to 98.68 percent, requiring additional General Fund appropriations of $9,175 in FY 2017 when compared to General Fund appropriations originally included in The Executive Budget.

The Subcommittee approved mandatory and discretionary rate increases consistent with rate increases approved for the Medicaid budget, requiring additional General Fund appropriations of $69,973 over the biennium.

The Subcommittee recommended approval of the Governor's recommendation to provide coverage for Autism Spectrum Disorder services for Check Up recipients. The Subcommittee recommended maintaining this decision unit at the level included in The Executive Budget, including General Fund appropriations of $64,675 over the biennium to align statewide funding budgeted for Autism Spectrum Disorder services with the number of service providers that are expected to be available in the 2015-17 biennium.

The Subcommittee recommended approval of all Other Closing Items in the agency's budgets, with technical adjustments, as recommended by the Governor.

The Subcommittee recommended closing the following Department of Health and Human Services budgets as recommended by the Governor, with minor technical adjustments:

- **Division of Health Care Financing and Policy, Increased Quality of Nursing Care (101-3160) DHHS-DHCFP-34**
- **Director's Office, Indigent Hospital Care (628-3244) DHHS-DIRECTOR-41**
- **Director's Office, UPL Holding Account (101-3260) DHHS-DIRECTOR-20**

Department of Health and Human Services
General Fund Impacts of Subcommittee Closing

Page	Budget	Title	FY 2016	FY 2017
AS CLOSED BY SUBCOMMITTEE:				
DHHS-DIRECTOR-20	101-3260	*UPL Holding Account	-	-
DHHS-DIRECTOR-41	628-3244	*Indigent Hospital Care	-	-
DHHS-DHCFP-10	101-3157	*Intergovernmental Transfer Program	-	-
DHHS-DHCFP-13	101-3158	Administration	(352,331)	(171,080)
DHHS-DHCFP-36	101-3178	Nevada Check Up Program	352,360	141,950
DHHS-DHCFP-34	101-3160	*Increased Quality of Nursing Care	-	-
DHHS-DHCFP-41	101-3243	Nevada Medicaid, Title XIX	(11,403,120)	(6,396,523)
			(11,403,091)	(6,425,653)

* No General Fund impact

Title: HHS-DO - UPL HOLDING ACCOUNT **Budget Page:** DHHS-DIRECTOR-20, **Volume II**

Account: 101 - 3260

Revenues	2013-14 Actual	2014-15 WP	% Chg	2015-16 GOV REC	% Chg	2016-17 GOV REC	% Chg
INTERAGENCY TRANSFER	1,250,000	6,517,000	421.36	2,229,840	(65.78)	2,158,340	(3.21)
REVERSIONS	(337,500)						
Total Revenues	912,500	6,517,000	614.19	2,229,840	(65.78)	2,158,340	(3.21)
Total FTE							

Adjustments to Revenue

Dec Unit	Cat	GL	Description	2015-16	2016-17
B000	00	4669	Reduce revenues due to projected decrease in transfers resulting from decrease in pharmacy benefits manager contract.	(164,600)	(164,440)
Sub-total				(164,600)	(164,440)
Line Item Changes to Revenues				(164,600)	(164,440)

Adjustments to Expenditures

Dec Unit	Cat	GL	Description	2015-16	2016-17
B000	08	9000	Reduce transfers due to projected decrease in transfers resulting from decrease in pharmacy benefits manager contract.	(115,912)	(112,208)
B000	93	9000	Reduce General Fund reversions due to projected decrease in transfers resulting from decrease in pharmacy benefits manager contract.	(48,688)	(52,232)
Sub-total				(164,600)	(164,440)
Line Item Changes to Expenditures				(164,600)	(164,440)
Total				0	0
Grand Total General Fund Impact of Closing Changes				0	0

Overview

The Upper Payment Limit (UPL) Holding Account was established for the 2013-15 biennium pursuant to Section 51 of Assembly Bill 507 of the 2013 Legislative Session (Appropriations Act) to allow various divisions of the Department of Health and Human Services (DHHS) to transfer savings associated with health care-related contract expenditures that are budgeted but not incurred to this budget in the Director's Office. When needed, funds are transferred to the Division of Health Care Financing and Policy (DHCFP) to support the state share of the Private Hospital Collaborative UPL supplemental payment program. Excess funding is reverted to the General Fund.

Major Closing Issue

Continuation of the UPL Holding Account

Discussion of Major Closing Issues

Continuation of the UPL Holding Account: At its October 22, 2013, meeting, the Interim Finance Committee (IFC) approved creating the UPL Holding account for the purpose described in the Overview, including establishing authority in FY 2014 to receive revenues of $5.4 million from savings transferred

from other DHHS budgets, to transfer $3.9 million to the DHCFP to support the state share of the Private Hospital Collaborative UPL supplemental payment program, and to revert $1.5 million to the General Fund.

The Executive Budget recommends continuing the UPL Holding account for the same purpose in the 2015-17 biennium. The agency anticipates that a nonprofit organization would provide certain medical services that the Division of Public and Behavioral Health (DPBH) is budgeted to pay contractors for state clients at no charge. This would eliminate the need to pay the contractor and generate savings in DPBH budgets that would be transferred to this account. The Executive Budget recommends transferring $2.2 million in each year of the 2015-17 biennium to this budget from DPBH budgets resulting from savings associated with having medical services provided to state clients by a nonprofit organization free of charge. The table below displays budgeted contract medical services in DPBH accounts that the agency indicates would be provided to state clients by the nonprofit organization at no cost to the state in the 2015-17 biennium.

Contracted Medical Services to be Provided by a Nonprofit Organization in the 2015-17 Biennium

Budgets	Service	FY 2016*	FY 2017*
Northern Nevada Adult Mental Health Services (NNAMHS) and Southern Nevada Adult Mental Health Services (SNAMHS)	Mental health services	$ 1,450,000	$ 1,350,000
NNAMHS, SNAMHS and Rural Clinics	Pharmacy Benefits Manager	$ 380,000	$ 380,000
NNAMHS	Licensed group care facility	$ 459,000	$ 459,000
Total		**$ 2,289,000**	**$ 2,189,000**

* The total amount identified for transfer to the budget does not match the budgeted amount of revenue because a portion of the identified transfer amount is funded by Fund for a Healthy Nevada monies. This portion of funding is retained in the originating budgets for reversion to the Fund for a Healthy Nevada in accordance with NRS 439.620.

The Executive Budget recommends authorizing transfers of $1.6 million in FY 2016 and $1.5 million in FY 2017 from this budget to the DHCFP to provide the state share of the Private Hospital Collaborative UPL supplemental payment program and General Fund reversions of $617,926 in FY 2016 and $639,174 in FY 2017.

Considering recent decreases in projected caseload for DPBH, staff asked the agency whether transfers in this budget should be reduced. On May 4, 2015, the agency informed Fiscal staff that the budgeted amount for pharmacy benefits manager services should be reduced from the $380,000 amount included in the Governor's recommended budget to $215,400 annually due to projected caseload decreases in DPBH. Fiscal staff has completed technical adjustments, shown on the closing document, to reduce annual transfer revenue from the $2.2 million included in the Governor's recommended budget to $2.1 million in FY 2016 and $2.0 million in FY 2017. Further technical adjustments have been completed, as shown on the closing document to reduce transfers to the DHCFP to $1.5 million in FY 2016 and $1.4 million in FY 2017 and to reduce General Fund reversions to $569,238 in FY 2016 and $586,942 in FY 2017.

In FY 2014, the agency indicated that an outside firm reviewed the department's contracted services and identified $16.2 million in contracted medical services that could be provided to state clients by the nonprofit organization, compared with the $2.3 million and $2.2 million in contracted medical services identified for provisions by the nonprofit organization in FY 2016 and FY 2017, respectively. Fiscal staff asked the agency why the amount of contracts included in the Governor's recommended budget for the 2015-17 biennium is lower than the amount of contracts originally identified. The agency indicated that upon further investigation, it was determined that it would not be permissible to transfer contracts to the nonprofit organization where the state has a statutory or regulatory obligation to provide services, if the contract is fully funded by a third party, or if the contract is supported by General Funds that are utilized as match to federal funding. The agency indicates that it continues to work to identify contracts for services that could be provided by the nonprofit organization.

Does the Subcommittee wish to approve the UPL Holding Account as recommended by the Governor with the noted technical adjustments? Fiscal staff requests authority for further technical adjustments as necessary.

The Subcommittee recommended approving this budget as recommended by the Governor, with the noted technical adjustments, and authority for Fiscal staff to make any necessary technical adjustments.

<u>**Statutory Authority for the UPL Holding Account**</u>: The UPL Holding Account was established by the 2013 Legislature for the 2013-15 biennium through the approval of Assembly Bill 507 (2013 Appropriations Act). The UPL Holding Account will need to be reauthorized for the 2015-17 biennium through language in the 2015 Appropriations Act. **Does the Subcommittee wish to approve back language in the Appropriations Act to authorize continuation of the UPL Holding Account?**

The Subcommittee recommended approving back language in the Appropriations Act to authorize continuation of the UPL Holding Account.

Title: HHS-DO - INDIGENT HOSPITAL CARE **Budget Page:** DHHS-DIRECTOR-41, **Volume II**

Account: 628 - 3244

Revenues	2013-14 Actual	2014-15 WP	% Chg	2015-16 GOV REC	% Chg	2016-17 GOV REC	% Chg
BALANCE FORWARD	535,423						
OTHER FUND	12,935,813	19,223,037	48.60	14,012,641	(27.10)	14,616,657	4.31
Total Revenues	13,471,236	19,223,037	42.70	14,012,641	(27.10)	14,616,657	4.31
Total FTE							

Adjustments to Revenue

Dec Unit	Cat	GL	Description	2015-16	2016-17
B000	00	3320	Adjust to align real property tax revenue with April 2015 projection.	(153,169)	(252,248)
Sub-total				(153,169)	(252,248)
Line Item Changes to Revenues				(153,169)	(252,248)

Adjustments to Expenditures

Dec Unit	Cat	GL	Description	2015-16	2016-17
B000	12	9000	Adjust to align real property tax revenue with April 2015 projection.	(153,169)	(252,248)
Sub-total				(153,169)	(252,248)
Line Item Changes to Expenditures				(153,169)	(252,248)

	2015-16	2016-17
Total	0	0
Grand Total General Fund Impact of Closing Changes	0	0

Overview

The Indigent Hospital Care budget, previously known as the Indigent Supplemental budget, was established to reimburse hospitals for the care provided to indigent persons. The Indigent Hospital Care budget consists of the Fund for Hospital Care to Indigent Persons (Fund), which is administered by a Board of Trustees consisting of four county commissioners and one director of a county social services agency appointed by the Governor. Counties seek reimbursement or partial reimbursement from the Fund for unpaid charges in excess of $25,000. In addition, the Board may enter into an agreement with the Division of Health Care Financing and Policy (DHCFP) to transfer funding from the Fund to the DHCFP to provide the state share of certain supplemental payment programs or to satisfy any portion of a county's obligation to pay the state share of certain Medicaid expenditures relating to long-term care. The budget is primarily funded through a property tax levy of 1.5 cents on each $100 of assessed valuation, unmet hospital indigent free care obligation assessments, and interest earned on money deposited to the fund.

Major Closing Issues

Transfer of Funding to the DHCFP

Discussion of Major Closing Issues

Transfer of Funding to the DHCFP: Historically, this budget has been used to provide reimbursement to Nevada counties for unpaid hospital charges for medical treatment of indigent persons and to hospitals for

care provided to indigent persons injured in motor vehicle accidents in Nevada. During the 2013 Legislative Session, it was predicted that unpaid hospital charges would decrease as a result of provisions in the Patient Protection and Affordable Care Act, including the individual insurance mandate and Medicaid expansion, reducing the need for payments to counties and hospitals from this budget. The 2013 Legislature approved Senate Bill 452, which authorizes the Board of Trustees to enter into an agreement with the DHCFP to transfer funds from this budget to DHCFP to provide for enhanced reimbursement rates for hospital care for Medicaid recipients, to satisfy any portion of a county's obligation to pay the state share of certain Medicaid expenditures relating to long-term care, or make supplemental payments to hospitals in accordance with the State Plan for Medicaid.

At its August 14, 2013, meeting, the Board of Trustees approved utilizing funding from this budget to provide the state share of a new Medicaid supplemental payment program, known as the Indigent Accident Fund Upper Payment Limit program, and to provide relief to counties that are unable to meet the obligation to fund their portion of the state share of costs associated with the County Indigent population in the Medicaid budget. The Interim Finance Committee approved transferring funding from this budget to the DHCFP for these purposes at its October 22, 2014, meeting.

The Executive Budget recommends continuing the transfer of funding from this budget to the DHCFP to support the state share of the Indigent Accident Fund Upper Payment Limit program and includes transfers of $13.5 million in FY 2016 and $14.1 million in FY 2017. In addition, the Governor's budget recommends $60,000 per year for administrative costs and $500,000 in each year to pay claims to hospitals and counties for unpaid hospital charges.

Ad Valorem Tax Revenue – Staff has completed technical adjustments, as shown on the closing sheet, to decrease $0.015 ad valorem tax revenues from $12.2 million to $12.1 million in FY 2016 and from $12.8 million to $12.6 million in FY 2017 to align with April 2015 tax revenue projections. A corresponding technical adjustment was completed to decrease transfers to the Division of Health Care Financing and Policy.

Does the Subcommittee wish to approve this budget as recommended by the Governor, including the transfer of funding to the Division of Health Care Financing and Policy to support the Indigent Accident Fund Upper Payment Limit program with the noted technical adjustment?

The Subcommittee recommended approving this budget as recommended by the Governor, with the noted technical adjustment.

Informational Item

Assembly Bill 41: Assembly Bill 41, passed by both houses as introduced, amends statute governing the Fund for Hospital Care for Indigent Persons to specify that funding remaining at the end of the year remains in the Fund rather than reverting to the General Fund. Additionally, the bill abolishes the Supplemental Account for Medical Assistance to Indigent Persons and the Hospital Assessment Account within the Fund. **No action is required on this item.**

Title: HHS-HCF&P - INTERGOVERNMENTAL TRANSFER PROGRAM **Budget Page:** DHHS-DHCFP-10, **Volume II**

Account: 101 - 3157

Revenues	2013-14 Actual	2014-15 WP	% Chg	2015-16 GOV REC	% Chg	2016-17 GOV REC	% Chg
BALANCE FORWARD	(26,430,509)	31,001,804	(217.30)	25,378,958	(18.14)	7,252,967	(71.42)
INTERAGENCY TRANSFER	13,788,313	16,164,724	17.23	12,857,606	(20.46)	12,764,858	(0.72)
OTHER FUND	101,714,101	119,965,340	17.94	123,219,324	2.71	115,851,544	(5.98)
Total Revenues	89,071,905	167,131,868	87.64	161,455,888	(3.40)	135,869,369	(15.85)

Total FTE

Adjustments to Revenue

Dec Unit	Cat	GL	Description	2015-16	2016-17
B000	00	2511	Adjust FY 2016 balance forward to account for FY 2015 state net benefit associated with enhanced MCO payment program.	2,984,229	
B000	00	3321	Decrease real property tax revenues to align with April 2015 projection.	(102,112)	(168,165)
B000	00	4102	Adjust DSH receipts to account for projected increase in state DSH allotment due to provisions of the Medicare Access and CHIP Reauthorization Act of 2015.		2,281,885
B000	00	4102	Increase county contributions in support of the DSH program due to projected decrease in real property tax decrease.	102,112	168,165
B000	00	4669	Reduce revenues due to projected decrease in transfers from the UPL Holding budget.	(115,912)	(112,208)
E233	00	4108	Budget amendment A150633157- New enhanced MCO payment program	15,632,815	16,280,566
Sub-total				18,501,132	18,450,243
Line Item Changes to Revenues				18,501,132	18,450,243

Adjustments to Expenditures

Dec Unit	Cat	GL	Description	2015-16	2016-17
B000	10	9000	Adjust transfer to Medicaid to account for FY 2015 state net benefit associated with enhanced MCO payment program. Funding will be used to offset FY 2016 General Fund appropriations in the Medicaid budget.	2,984,229	
B000	10	9000	Adjust transfers to Medicaid to account for projected increase in state DSH allotment due to provisions of the Medicare Access and CHIP Reauthorization Act of 2015.		2,281,885
B000	10	9000	Reduce transfers to Medicaid due to projected decrease in transfers from the UPL Holding budget.	(115,912)	(112,208)
E233	10	9000	Budget amendment A150633157- New enhanced MCO payment program	15,632,815	16,280,566
Sub-total				18,501,132	18,450,243
Line Item Changes to Expenditures				18,501,132	18,450,243

	2015-16	2016-17
Total	0	0
Grand Total General Fund Impact of Closing Changes	0	0

Overview
The Intergovernmental Transfer (IGT) budget collects funds from other governmental entities to provide the state share of certain Medicaid expenditures, thereby reducing the need for General Fund appropriations. Funds collected in the IGT budget are transferred to the Medicaid, Nevada Check-Up and Administration budgets to provide the state share of supplemental payment programs and related administrative costs. In addition, revenues to support the state share of Medicaid services provided by local governmental entities, such as school-based services provided by school districts and non-emergency para-transit transportation services provided by regional transportation commissions, are collected in this budget and transferred to the Medicaid budget. Intergovernmental Transfer payments that are in excess of the required state match are used to offset General Fund appropriations for other Medicaid expenditures, referred to as the state net benefit.

The Disproportionate Share Hospital (DSH) program provides payments to hospitals that have a disproportionate share of uncompensated costs due to services provided to indigent and uninsured persons in comparison to other hospitals. The federal government provides a specific annual allotment of federal funds for each state for DSH payments. Pursuant to *Nevada Administrative Code* (NAC) 422.105, Clark and Washoe Counties are required to make IGT payments to the division in support of the DSH program. Through the enactment of Senate Bill 452, the 2013 Legislature directed revenue from a $0.01 ad valorem tax on each $100 of assessed value of taxable property to the Intergovernmental Transfer Program budget. Pursuant to NAC 422.105, this revenue is used as an offset to county contributions to the DSH program. Previously, this funding was allocated to the Supplemental Account for Medical Assistance to Indigent Persons.

The Public Hospital Upper Payment Limit (UPL) supplemental payment program provides supplemental payments to public hospitals. Federal Medicaid law allows states the option of making supplemental payments to qualifying hospitals up to the amount Medicare would have paid for the same services provided to fee-for-service recipients, known as the upper payment limit. The intent is to preserve access to inpatient hospitals for needy individuals by reimbursing qualifying hospitals for uncompensated or under-compensated care. The Public Hospital UPL program provides payments to county-owned hospitals for both inpatient and outpatient services. Pursuant to interlocal agreements, counties make IGT payments to this budget to provide state matching funds for the Public Hospital inpatient UPL program. In addition, counties make further voluntary contributions.

The University Of Nevada School of Medicine (UNSOM) supplemental payment program provides supplemental payments to the UNSOM in recognition of the gap between Medicaid reimbursement and the average private insurance reimbursement for the same services (primarily outpatient services). The UNSOM provides the IGT revenue to be used as the state's match to receive federal Title XIX funds.

The Graduate Medical Education (GME) program provides supplemental payments to teaching hospitals, currently the University Medical Center of Southern Nevada (UMC), to recognize the higher cost of providing medical care in a teaching environment. Pursuant to an interlocal agreement, Clark County provides the state match for this program.

Major Closing Issues
1. Clark County Voluntary Contribution
2. Enhanced Managed Care Organization Payment Program
3. Continuation of New Supplemental Payment Programs

Discussion of Major Closing Issues
1. Clark County Voluntary Contribution: The Governor's recommended budget, as amended (Budget Amendment A150633157), for the 2015-17 biennium includes IGT revenue from Clark County equal to 50 percent of supplemental payments received by non-state governmentally owned or

operated hospitals in Clark County (currently the University Medical Center of Southern Nevada (UMC)) for the Public Hospital UPL programs, the GME program, the enhanced Managed Care Organization (MCO) payments related to the traditional Medicaid population, and 15 percent of the enhanced MCO payments received by UMC that relate to the Newly Eligible Medicaid population. The IGT revenue included in The Executive Budget from Clark County is based on the contribution percentages specified in Clark County's current contract with the state, which expires June 30, 2015.

The Executive Budget, as amended, includes IGT revenue from Clark County in support of the Public Hospital UPL, GME and enhanced MCO payment programs totaling $125.6 million over the 2015-17 biennium. Of the $125.6 million in Clark County IGT revenue over the 2015-17 biennium, $88.1 million provides the required state match for the supplemental and enhanced payment programs. Contributions in excess of the required state match are considered voluntary. Voluntary contributions are transferred to the Medicaid budget to offset General Fund appropriations for Medicaid medical expenditures, referred to as the state net benefit. The Executive Budget, as amended, includes state net benefit amounting to $37.5 million over the 2015-17 biennium from Clark County's voluntary contributions in excess of the required state match for the Public Hospital UPL program, the GME supplemental payment program and the enhanced MCO payment program. For participating in the Public Hospital UPL, GME, and enhanced MCO payment programs, Clark County benefits by receiving $290.4 million in additional Medicaid revenues over the 2015-17 biennium.

Fiscal staff would advise that on May 5, 2015, the Clark County Commission approved a voluntary contribution contract which reduces the voluntary contribution rate to 47.5 percent of total supplemental payments received by UMC for the Public Hospital UPL program, the GME program, the enhanced MCO payments relating to the traditional Medicaid population, and 12 percent in FY 2016 and 13.25 percent in FY 2017 of enhanced MCO payments relating to the Eligible Medicaid population. It is unclear whether a negotiated agreement is in place between Clark County and the state. It is also unclear to staff as to the next step the state would take in considering the contract. If the state were to accept the terms of the county, the contract would be presented to the Board of Examiners for approval. However, the contract is not agenized for the May 12, 2015, meeting of the Board of Examiners.

Fiscal staff calculates that the decrease in Clark County's voluntary contribution rates would reduce the state net benefit from the $37.5 million over the 2015-17 biennium included in the Governor's recommended budget to $29.6 million. This would result in a reduction of state net benefit transferred to the Medicaid budget, creating a General Fund shortfall totaling $7.9 million over the 2015-17 biennium in the Medicaid budget. The agency indicates that staff's calculation is reasonable. It appears that Medicaid revenues received by Clark County for the Public Hospital UPL program, the GME supplemental payment program and the enhanced MCO payment program would remain unchanged from the $290.4 million included in The Executive Budget over the 2015-17 biennium.

Does the Subcommittee wish to approve the budget with Intergovernmental Transfer revenue from Clark County based on 50 percent of supplemental payments and 15 percent of enhanced Managed Care Organization payments relating to the Newly Eligible Medicaid population as recommended by the Governor?

The Subcommittee recommended approving budgeting for Intergovernmental Transfer revenue from Clark County at the current voluntary contribution rates.

2. Enhanced Managed Care Organization (MCO) Payment Program (Budget Amendment A150633157): At its April 9, 2015, meeting, the Interim Finance Committee approved two work programs to implement a new enhanced MCO payment retroactive to January 1, 2014, as a means of providing increased reimbursement to safety net medical service providers for targeted services, including inpatient and

outpatient hospital services and behavioral health services, provided to Medicaid recipients enrolled in MCOs. Safety net providers are defined as state and local government providers and currently include University Medical Center (UMC) and the Division of Public and Behavioral Health (DPBH). On March 31, 2015, the Governor submitted budget amendments for the Medicaid and Intergovernmental Transfer Program budgets to continue the new enhanced payment for Managed Care Organizations (MCO) in the 2015-17 biennium. The closing document reflects the amendment.

The budget amendment includes IGT revenue from Clark County of 50 percent of the enhanced MCO payments received by UMC relating to the traditional Medicaid population and 15 percent of the enhanced payments received by UMC relating to the Newly Eligible Medicaid population. The budget amendment includes Clark County IGT revenue of $15.6 million in FY 2016 and $16.3 million in FY 2017. Clark County would benefit by receiving $102.9 million in additional Medicaid reimbursement for services provided by UMC over the 2015-17 biennium, or $71.0 million more than its contribution.

Voluntary contributions in excess of the required state match are used to offset General Fund appropriations for other Medicaid expenditures, referred to as the state net benefit. The enhanced MCO payment program would generate a net benefit for the state. The budget amendment includes a state net benefit amounting to $4.8 million in FY 2016 and $4.6 million in FY 2017 associated with the enhanced MCO payment program, which would be transferred to the Medicaid budget to offset General Fund appropriations by $4.8 million in FY 2016 and $4.6 million in FY 2017.

The enhanced MCO payments further benefit the state by providing additional Medicaid reimbursements of $9.6 million in FY 2016 and $9.5 million in FY 2017 for outpatient behavioral health services provided by DPBH. According to the Budget Office, The Executive Budget as submitted for the DPBH includes General Fund savings resulting from enhanced MCO payments in the Southern Nevada Adult Mental Health Services (Budget 3161) and Northern Nevada Adult Mental Health Services (Budget 3162) budgets.

It should be noted that the agency does not have direct control over payments made by MCOs to medical service providers, including enhanced MCO payments. The DHCFP is unable to direct the MCOs to pay specific safety net providers specified amounts. The DHCFP is only able to specify services that qualify as targeted services. Accordingly, the payments to UMC and DPBH in the 2015-17 biennium are estimates at this time. If payments to UMC are lower than anticipated, the state net benefit, which is directly dependent upon the voluntary contribution amount, would be lower than estimated. If payments to DPBH are lower than anticipated, the DPBH could experience a budget shortfall. Furthermore, payments to DPBH are based on its outpatient behavioral health caseload. The payments to DPBH would decrease if its outpatient behavioral health caseload decreases. The agency indicates that it maintains close contact with safety net providers and would discontinue the enhanced MCO payment program if the providers report issues with receiving enhanced payments.

Does the Subcommittee wish to approve Budget Amendment A150633157 and the adjustments noted by staff to continue the Managed Care Organization enhanced payment program approved by the Interim Finance Committee on April 9, 2015, in the 2015-17 biennium?

The Subcommittee recommended approving Budget Amendment A150633157 as recommended by the Governor to continue the Managed Care Organization enhanced payment program in the 2015-17 biennium.

3. Continuation of New Supplemental Payment Programs: The Executive Budget recommends continuing two UPL supplemental payment programs, the Private Hospital Collaborative UPL program and the Indigent Accident Fund UPL program, that were authorized by the 2013 Legislature and approved by the Interim Finance Committee (IFC) during the 2013-15 biennium.

Indigent Accident Fund (IAF) UPL Program: The IFC approved establishing the IAF UPL program to make supplemental payments to qualifying public and privately owned acute care hospitals for inpatient services at its October 22, 2014, meeting. The intent of the program is to preserve access to inpatient hospital services for needy individuals. The Governor recommends continuing the IAF UPL program in the 2015-17 biennium, with the state share of supplemental payments provided by funding transferred from the Director's Office Indigent Hospital Care budget to this budget. The Indigent Hospital Care budget is primarily funded through property tax levies and unmet free care funding collected from hospitals pursuant to NRS 439B.340. Participating hospitals are projected to receive supplemental payments of $31.9 million in FY 2016 and $32.4 million in FY 2017. This program does not generate a state net benefit.

As previously noted, federal regulations allow UPL supplemental payment programs to make payments to hospitals up to the amount Medicare would have paid for the same services provided to fee-for-service recipients. In calculating the allowable UPL supplemental payment amount for each hospital, both fee-for-service reimbursements and other supplemental payments made to the hospital are taken into consideration. Public hospitals are eligible to receive supplemental payments under both the Public Hospital UPL program and the IAF UPL program. As a result of public hospitals receiving supplemental payments under both of these UPL programs, Public Hospital UPL supplemental payments to hospitals are likely to decrease with the implementation of the IAF UPL program.

The Public Hospital UPL program generates a state net benefit, which is used to offset General Fund need in the Medicaid budget, as follows. The state enters into contracts with counties for the counties to provide an IGT in support of Public Hospital UPL supplemental payments. The amount of the IGT payment each county provides is a specified percentage of Public Hospital UPL payments made to hospitals in that county. The state net benefit is the difference between voluntary contributions from the counties and the state share of Public Hospital UPL supplemental payments. Since the state net benefit amount is based on the county voluntary contribution amount, which is tied to the Public Hospital UPL payment amount, the state net benefit decreases as Public Hospital UPL supplemental payments decrease. The result of implementing the IAF UPL program is likely to result in a decrease in the amount of state net benefit available to offset General Fund need in the Medicaid budget. The decrease in state net benefit is likely to grow in the future as the revenues available to provide the state share of the IAF UPL program, including property tax revenues and unmet free care obligations, increase. In a March 18, 2015, follow-up memo, the agency indicated that the IAF UPL program is projected to decrease the state net benefit by $1.2 million in FY 2016 and $2.6 million in FY 2017. The state net benefit recommended in The Executive Budget includes these decreases.

Private Hospital Collaborative UPL Program: At its October 22, 2013, meeting, the Interim Finance Committee approved establishing the Private Hospital Collaborative UPL program to make supplemental payments for inpatient services to privately-owned hospitals that have entered into an agreement with the state or a local government in Nevada to collaborate in providing health care services to low income and needy persons. The intent of the program is to preserve access to inpatient hospital services for needy individuals. The Executive Budget recommends continuing the Private Hospital Collaborative UPL Program in the 2015-17 biennium. The Director's Office transfers funding from savings realized in other departmental budgets to this budget to provide the state share of the supplemental payments. Participating hospitals are recommended to receive payments totaling $4.6 million in FY 2016 and $4.4 million in FY 2017. The state net benefit from the Private Hospital Collaborative UPL, which is budgeted in the Director's Office for reversion to the General Fund rather than as an offset to General Fund in the Medicaid budget, is projected to total $1.3 million over the 2015-17 biennium. Fiscal staff has completed technical adjustments, shown on this closing document, to align revenue and transfers in this budget with the amount of funding projected to be available in the UPL Holding budget.

Does the Subcommittee wish to approve the Governor's recommendation to continue the Indigent Accident Fund Upper Payment Limit program and the Private Hospital Collaborative UPL program with the technical adjustments noted by staff?

The Subcommittee recommended approving continuing the Indigent Accident Fund Upper Payment Limit program and the Private Hospital Collaborative Upper Payment Limit program in the 2015-17 biennium, as recommended by the Governor.

Other Closing Items

1. Disproportionate Share Hospital Program (DSH): The Executive Budget recommends that participating hospitals receive payments of approximately $78.4 million for FY 2016 and $75.1 million for FY 2017. Fiscal Year 2017 projected payments are lower due to a provision of the ACA which decreases federal DSH allotments to states beginning in FY 2017. The counties benefit indirectly from these payments by approximately $23.2 million for FY 2016 and $22.1 million for FY 2017 when comparing the hospital DSH payments to the amount of the IGT payments. For the 2015-17 biennium, The Executive Budget estimates the IGT program will generate state net benefit amounting to $27.6 million in FY 2016 and $26.8 million in FY 2017.

   The Medicare Access and CHIP Reauthorization Act of 2015, signed by the President on April 16, 2015, contains a provision which delays the implementation of DSH allotment reductions to FY 2018. Accordingly, Fiscal staff asked the agency to reproject FY 2017 DSH payments and associated state net benefit. The revised projections indicate that FY 2017 DSH payments would increase to from $75.1 million to $78.3 million, receipts from counties in support of the DSH program would increase from $44.5 million to $46.8 million, and the state net benefit would by increase by $1.1 million, from $26.8 million to $28.0 million. Fiscal staff has completed technical adjustments, shown on the closing document, to reflect these changes. **This recommendation appears reasonable, with the noted technical adjustment.**

2. Public Hospital UPL Program: The Executive Budget recommends continuing the Public Hospital UPL programs for the 2015-17 biennium, with payments to participating hospitals totaling $92.3 million in FY 2016 and $81.1 million in FY 2017. The net benefit to counties (hospital payments less IGT payments) is budgeted to be approximately $46.0 million for FY 2016 and $40.2 million for FY 2017. The estimated net benefit for the state is $13.8 million for FY 2016 and $12.7 million for FY 2017. The Governor's budget assumes that county voluntary contribution percentages remain unchanged from the current biennium, with Clark County's contribution percentage at 50 percent and other county contribution percentage at 60 percent of Public Hospital UPL supplemental payments made to hospitals in their counties. **This recommendation appears reasonable.**

3. UNSOM Supplemental Payments: The Executive Budget recommends supplemental payments to UNSOM of $5.0 million in FY 2016 and $5.5 million in FY 2017. **This recommendation appears reasonable.**

4. GME Supplemental Payments: The Executive Budget provides the necessary budget authority to pay GME payments of $12.0 million in FY 2016 and $13.1 million in FY 2017. The GME state net benefit is estimated at $1.8 million for FY 2016 and $2.0 million for FY 2017. The Governor's recommended budget assumes that Clark County's voluntary contribution percentage would remain unchanged from the current biennium, at 50 percent of supplemental payments made to UMC. **This recommendation appears reasonable.**

5. Reserves: The budget, as recommended, includes a beginning FY 2016 reserve balance totaling $25.4 million for the following purposes:

- $2.0 million reserve throughout the 2015-17 biennium in funding transferred from the Indigent Hospital Care budget to provide relief to counties that are unable to meet the obligation to fund their portion of the state share of costs associated with County Indigent population in the Medicaid budget.

- $5.2 million reserve throughout the 2015-17 biennium in funding transferred from the Indigent Hospital Care budget to support the state share of the Indigent Accident Fund UPL program, should revenues not materialize as budgeted.

- $18.1 million beginning FY 2016 state net benefit reserve, which would be utilized to reduce General Fund need in the Medicaid budget in FY 2016. All state net benefit funding from this budget is recommended to be used as a General Fund offset in the Medicaid budget. Fiscal staff has completed technical adjustments, shown on the closing document, to reflect a projected $3.0 million increase in the FY 2016 balance forward due to an increase in FY 2015 state net benefit resulting from the enhanced MCO payment program. An additional technical adjustment, shown on the closing document, has been completed to transfer the $3.0 million to the Medicaid budget to offset General Fund expenditures. No unobligated state net benefit reserve is budgeted for FY 2017 for cash-flow purposes or unforeseen expenditure needs in the Medicaid or Nevada Check-Up budgets.

  These recommendations appear reasonable with the noted technical adjustments.

6. Ad Valorem Tax Revenue – The Executive Budget estimates that ad valorem tax revenues would reduce county contributions in support of the DSH program by $8.1 million and $8.5 million in FY 2016 and FY 2017, respectively. Staff has completed technical adjustments, as shown on the closing sheet, to decrease $0.01 ad valorem tax revenues from $8.1 million to $8.0 million in FY 2016 and from $8.5 million to $8.4 million in FY 2017 to align with April 2015 tax revenue projections. A corresponding technical adjustment was completed to increase Receipts from Local Government in support of the DSH Program to account for the projected ad valorem tax decrease. This adjustment appears reasonable.

   Fiscal staff recommends that the Other Closing Items be approved as recommended by the Governor with the noted technical adjustments. Fiscal staff requests authority to make further necessary technical adjustments.

   The Subcommittee recommended approval of the Other Closing Items as recommended by the Governor with noted technical adjustments, and authority for Fiscal staff to make further technical adjustments, as needed.

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Revenues	2013-14 Actual	2014-15 WP	% Chg	2015-16 GOV REC	% Chg	2016-17 GOV REC	% Chg
BALANCE FORWARD	190,443	1,314,128	590.04	1,424,535	8.40	1,509,984	6.00
FEDERAL FUND	101,481,740	136,637,196	34.64	138,866,236	1.63	146,549,307	5.53
GENERAL FUND	19,814,852	28,976,303	46.24	27,346,696	(5.62)	28,903,277	5.69
INTERAGENCY TRANSFER	339,419	(3,772,552)	(1211.47)	349,286	(109.26)	352,159	0.82
INTERIM FINANCE	14,770						
OTHER FUND	1,464,075	2,007,231	37.10	1,414,528	(29.53)	1,234,386	(12.74)
Total Revenues	123,305,299	165,162,306	33.95	169,401,281	2.57	178,549,113	5.40
Total FTE		277.51		291.51		291.51	

Adjustments to Revenue

Dec Unit	Cat	GL	Description	2015-16	2016-17
M501	00	2501	Eliminate decision unit M501 consistent with Subcommittee closing action not to approve two new Waiver staff.	(54,629)	(68,213)
M501	00	2501	Update retirement code for new positions to employer paid to align with Budget Instructions	(1,059)	(1,313)
M501	00	3511	Eliminate decision unit M501 consistent with Subcommittee closing action not to approve two new Waiver staff.	(54,629)	(68,214)
M501	00	3511	Update retirement code for new positions to employer paid to align with Budget Instructions	(1,060)	(1,313)
M502	00	2501	Eliminate two new Program Integrity positions consistent with Subcommittee closing action.	(45,752)	(56,012)
M502	00	2501	Update retirement code for new positions to employer paid to align with Budget Instructions	(3,366)	(4,218)
M502	00	3511	Eliminate two new Program Integrity positions consistent with Subcommittee closing action.	(48,780)	(60,120)
M502	00	3511	Update retirement code for new positions to employer paid to align with Budget Instructions	(3,620)	(4,535)
M503	00	2501	Eliminate two district office positions consistent with Subcommittee action.	(45,060)	(53,289)
M503	00	2501	Update retirement code for new positions to employer paid to align with Budget Instructions	(1,040)	(3,085)
M503	00	3511	Eliminate two district office positions consistent with Subcommittee action.	(45,195)	(57,136)
M503	00	3511	Update retirement code for new positions to employer paid to align with Budget Instructions	(3,919)	(3,318)
M504	00	2501	Update retirement code for new positions to employer paid to align with Budget Instructions	(1,071)	(1,332)
M504	00	3511	Update retirement code for new positions to employer paid to align with Budget Instructions	(1,152)	(1,433)
M505	00	2501	Update retirement code for new positions to employer paid to align with Budget Instructions	(492)	(610)
M505	00	3511	Update retirement code for new positions to employer paid to align with Budget Instructions	(530)	(656)
M506	00	2501	Update retirement code for new positions to employer paid to align with Budget Instructions	(1,456)	(1,805)
M506	00	3511	Update retirement code for new positions to employer paid to align with Budget Instructions	(1,566)	(1,941)
M507	00	2501	Update retirement code for new positions to employer paid to align with Budget Instructions	(3,811)	(4,724)

M507	00	3511	Update retirement code for new positions to employer paid to align with Budget Instructions	(4,097)	(5,080)
M511	00	2501	Update retirement code for new positions to employer paid to align with Budget Instructions	(984)	(1,220)
M511	00	3511	Update retirement code for new positions to employer paid to align with Budget Instructions	(1,059)	(1,312)
M512	00	2501	Align fiscal agent costs with projected applied behavior analysis caseload.	(89,226)	156,688
M512	00	3511	Align fiscal agent costs with projected applied behavior analysis caseload. Align fiscal agent costs with projected applied behavior analysis caseload.	(267,678)	470,066
E226	00	2501	Eliminate two new positions from decision unit M502 consistent with Subcommittee closing action.	(27,932)	(34,931)
E226	00	2501	Update retirement code for new positions to employer paid to align with Budget Instructions	(560)	(696)
E226	00	3511	Eliminate two new positions from decision unit M502 consistent with Subcommittee closing action.	(29,828)	(37,510)
E226	00	3511	Update retirement code for new positions to employer paid to align with Budget Instructions	(604)	(748)
E227	00	2501	Update retirement code for new positions to employer paid to align with Budget Instructions	(585)	(725)
E227	00	3511	Update retirement code for new positions to employer paid to align with Budget Instructions	(629)	(780)
E229	00	2501	consistent with Subcommittee closing action.	(77,542)	(98,977)
E229	00	2501	Update retirement code for new positions to employer paid to align with Budget Instructions	(2,062)	(2,555)
E229	00	3511	consistent with Subcommittee closing action.	(88,538)	(105,892)
E229	00	3511	Update retirement code for new positions to employer paid to align with Budget Instructions	(2,217)	(2,748)
E230	00	2501	Eliminate two new Program Integrity positions consistent with Subcommittee closing action.	(49,937)	(61,785)
E230	00	2501	Update retirement code for new positions to employer paid to align with Budget Instructions	(1,455)	(1,804)
E230	00	3511	Eliminate two new Program Integrity positions consistent with Subcommittee closing action.	(53,264)	(66,311)
E230	00	3511	Update retirement code for new positions to employer paid to align with Budget Instructions	(1,566)	(1,940)
E901	00	2501	Eliminate three Management Analyst positions consistent with Subcommittee's closing action.	54,629	68,213
E901	00	2501	Update retirement code for new positions to employer paid to align with Budget Instructions	1,059	1,313
E901	00	3511	Eliminate three Management Analyst positions consistent with Subcommittee's closing action.	54,629	68,214
E901	00	3511	Update retirement code for new positions to employer paid to align with Budget Instructions	1,060	1,313
Sub-total				(906,573)	(52,474)
Line Item Changes to Revenues				(906,573)	(52,474)

Adjustments to Expenditures

Dec Unit	Cat	GL	Description	2015-16	2016-17
M501	01	5000	Eliminate decision unit M501 consistent with Subcommittee closing action not to approve two new Waiver staff.	(94,153)	(128,010)
M501	01	5000	Update retirement code for new positions to employer paid to align with Budget Instructions	(2,119)	(2,626)
M501	04	7000	Eliminate decision unit M501 consistent with Subcommittee closing action not to approve two new Waiver staff.	(6,392)	(7,733)
M501	05	8000	Eliminate decision unit M501 consistent with Subcommittee closing action not to approve two new Waiver staff.	(4,780)	
M501	26	7000	Eliminate decision unit M501 consistent with Subcommittee closing	(1,297)	(684)

			action not to approve two new Waiver staff.		
M501	26	8000	Eliminate decision unit M501 consistent with Subcommittee closing action not to approve two new Waiver staff.	(2,636)	
M502	01	5000	Eliminate two new Program Integrity positions consistent with Subcommittee closing action.	(81,018)	(109,918)
M502	01	5000	Update retirement code for new positions to employer paid to align with Budget Instructions	(6,986)	(8,753)
M502	04	7000	Eliminate two new Program Integrity positions consistent with Subcommittee closing action.	(4,923)	(5,689)
M502	05	8000	Eliminate two new Program Integrity positions consistent with Subcommittee closing action.	(4,780)	
M502	26	7000	Eliminate two new Program Integrity positions consistent with Subcommittee closing action.	(1,175)	(525)
M502	26	8000	Eliminate two new Program Integrity positions consistent with Subcommittee closing action.	(2,636)	
M503	01	5000	Eliminate two district office positions consistent with Subcommittee action.	(75,823)	(102,920)
M503	01	5000	Update retirement code for new positions to employer paid to align with Budget Instructions	(4,959)	(6,403)
M503	04	7000	Eliminate two district office positions consistent with Subcommittee action.	(5,719)	(6,820)
M503	05	8000	Eliminate two district office positions consistent with Subcommittee action.	(4,780)	
M503	26	7000	Eliminate two district office positions consistent with Subcommittee action.	(1,297)	(685)
M503	26	8000	Eliminate two district office positions consistent with Subcommittee action.	(2,636)	
M504	01	5000	Update retirement code for new positions to employer paid to align with Budget Instructions	(2,223)	(2,765)
M505	01	5000	Update retirement code for new positions to employer paid to align with Budget Instructions	(1,022)	(1,266)
M506	01	5000	Update retirement code for new positions to employer paid to align with Budget Instructions	(3,022)	(3,746)
M507	01	5000	Update retirement code for new positions to employer paid to align with Budget Instructions	(7,908)	(9,804)
M511	01	5000	Update retirement code for new positions to employer paid to align with Budget Instructions	(2,043)	(2,532)
M512	10	7000	Align fiscal agent costs with projected applied behavior analysis caseload. Align fiscal agent costs with projected applied behavior analysis caseload.	13,562	123,485
M512	21	7000	Align fiscal agent costs with projected applied behavior analysis caseload. Align fiscal agent costs with projected applied behavior analysis caseload.	(370,466)	503,269
E226	01	5000	Eliminate decision unit E226 consistent with Subcommittee closing action.	(50,735)	(68,980)
E226	01	5000	Update retirement code for new positions to employer paid to align with Budget Instructions	(1,164)	(1,444)
E226	04	7000	Eliminate decision unit E226 consistent with Subcommittee closing action.	(1,916)	(2,514)
E226	04	7000	Eliminate two new positions from decision unit M502 consistent with Subcommittee closing action.	(753)	(604)
E226	05	8000	Eliminate decision unit E226 consistent with Subcommittee closing action.	(2,390)	
E226	26	7000	Eliminate decision unit E226 consistent with Subcommittee closing action.	(648)	(343)
E226	26	8000	Eliminate decision unit E226 consistent with Subcommittee closing action.	(1,318)	
E227	01	5000	Update retirement code for new positions to employer paid to align with Budget Instructions	(1,214)	(1,505)
E229	01	5000	consistent with Subcommittee closing action.	(135,981)	(184,994)
E229	01	5000	Update retirement code for new positions to employer paid to align	(4,279)	(5,303)

			with Budget Instructions		
E229	03	6000	consistent with Subcommittee closing action.	(7,592)	(7,592)
E229	04	7000	consistent with Subcommittee closing action.	(9,437)	(11,258)
E229	05	8000	consistent with Subcommittee closing action.	(7,170)	
E229	26	7000	consistent with Subcommittee closing action.	(1,946)	(1,025)
E229	26	8000	consistent with Subcommittee closing action.	(3,954)	
E230	01	5000	Eliminate two new Program Integrity positions consistent with Subcommittee closing action.	(89,005)	(121,069)
E230	01	5000	Update retirement code for new positions to employer paid to align with Budget Instructions	(3,021)	(3,744)
E230	04	7000	Eliminate two new Program Integrity positions consistent with Subcommittee closing action.	(5,221)	(6,081)
E230	05	8000	Eliminate two new Program Integrity positions consistent with Subcommittee closing action.	(4,780)	
E230	26	7000	Eliminate two new Program Integrity positions consistent with Subcommittee closing action.	(1,297)	(684)
E230	26	8000	Eliminate two new Program Integrity positions consistent with Subcommittee closing action.	(2,636)	
E230	30	6000	Eliminate two new Program Integrity positions consistent with Subcommittee closing action.	(41)	(41)
E230	30	7000	Eliminate two new Program Integrity positions consistent with Subcommittee closing action.	(221)	(221)
E901	01	5000	Eliminate decision unit M501 consistent with Subcommittee closing action not to approve two new Waiver staff.	94,153	128,010
E901	01	5000	Update retirement code for new positions to employer paid to align with Budget Instructions	2,119	2,626
E901	04	7000	Eliminate decision unit M501 consistent with Subcommittee closing action not to approve two new Waiver staff.	4,885	6,526
E901	04	7000	Eliminate three Management Analyst positions consistent with Subcommittee's closing action.	1,507	1,207
E901	05	8000	Eliminate decision unit M501 consistent with Subcommittee closing action not to approve two new Waiver staff.	4,780	
E901	26	7000	Eliminate decision unit M501 consistent with Subcommittee closing action not to approve two new Waiver staff.	1,297	684
E901	26	8000	Eliminate decision unit M501 consistent with Subcommittee closing action not to approve two new Waiver staff.	2,636	
Sub-total				(906,573)	(52,474)
Line Item Changes to Expenditures				(906,573)	(52,474)
Total				0	0
Grand Total General Fund Impact of Closing Changes				(352,331)	(171,080)

Overview

The mission of the Division of Health Care Financing and Policy (DHCFP) is to purchase and provide quality health care services to low-income Nevadans through the Medicaid and Check Up programs in the most efficient manner; to promote equal access to health care at an affordable cost; to restrain the growth of health care costs; and to maximize the receipt of federal revenue for the provision of health care programs.

The Executive Budget recommends total funding increases of $1.94 billion over the 2015-17 biennium for the division when compared to the amount of funding legislatively approved for the 2013-15 biennium, which is an increase of 38.5 percent. The increase is primarily attributable to a $1.75 billion increase in federal funding, which is largely a result of Medicaid caseload increases associated with implementing the Medicaid expansion component of the Patient Protection and Affordable Care Act (ACA). Increased General Fund appropriations for the division represents $47.2 million of the overall increase, a 4.1 percent

increase from the amount of General Fund appropriated for the 2013-15 biennium. The table below provides an overview of funding approved by the 2013 Legislature for the 2013-15 biennium compared with funding recommended in The Executive Budget for the 2015-17 biennium.

	Legislature Approved 2013-15 Biennium		Governor Recommends 2015-17 Biennium		Increase/(Decrease)	
	Amount	% of Total	Amount	% of Total	Amount	%
General Fund	$ 1,151,406,119	22.9%	$ 1,198,571,087	17.2%	$ 47,164,968	4.1%
Balance Forward	$ 3,882,822	0.1%	$ 37,366,444	0.5%	$ 33,483,622	862.4%
Federal Funds	$ 3,272,177,189	64.9%	$ 5,019,285,801	71.9%	$ 1,747,108,612	53.4%
Interagency Transfer	$ 271,472,457	5.4%	$ 368,291,490	5.3%	$ 96,819,033	35.7%
Other Funds	$ 339,219,603	6.7%	$ 355,862,061	5.1%	$ 16,642,458	4.9%
Total DHCFP	**$ 5,038,158,190**	**100.0%**	**$ 6,979,376,883**	**100.0%**	**$ 1,941,218,693**	**38.5%**
Less Interagency Transfer	$ (271,472,457)		$ (368,291,490)		$ (96,819,033)	
Net DHCFP	**$ 4,766,685,733**		**$ 6,611,085,393**		**$ 1,844,399,660**	**38.7%**
Supplemental Appropriation for FY 2015 is not included in the table above.						

The Administration budget provides administrative staff and support services for the DHCFP, which includes administration, accounting, budgeting, personnel, rates, compliance, utilization review, privacy, recipient rights, provider enrollment and information technology, as well as the cost containment function required under NRS 439B.

Major Closing Issues

1. Staffing Increases
2. Medicaid Management Information System Replacement Project
3. Transfer Operation of the Waiver for Persons with Physical Disabilities

Discussion of Major Closing Issues

1. Staffing Increases: The Governor recommends additional funding of $2.2 million ($1.1 million General Fund appropriation) in FY 2016 and $2.7 million ($1.3 million General Fund appropriation) for 41 new positions and associated operating costs. The 41 new positions represent a 15 percent increase in the agency's staffing from the 278 positions (277.51 FTE) legislatively approved for the 2013-15 biennium.

   Of the 41 new positions, the agency indicates that 31 positions are required to address federal mandates. Staff notes that while the federal government mandates the agency to perform certain activities, it does not dictate how many positions are required to carry out these activities. The remaining ten positions are considered to be discretionary. Staff asked the agency to prioritize the 41 new positions, and the agency provided a list that prioritized both the new positions and associated decision units (Attachment A). The Subcommittee should note that the agency ranked the ten discretionary positions as its lowest priority. The new positions, which are all recommended to start October 1, 2015, are described below.

   New Positions to Address Federal Mandates

   - Business Process Management Staff (M-506, DHHS-DHCFP-21) – Additional funding totaling $355,468 ($171,682 General Fund appropriation) is recommended in the 2015-17 biennium to add three Business Process Analyst positions (priorities 1, 2, and 18) to the Business Process Management section of the Information Services Unit to support ACA-related workload increases, a 33 percent increase over the nine positions currently in the section. The agency indicates that increases in Medicaid caseload and the continuing implementation of the Health Insurance Exchange has resulted in increasingly complex information system issues. The new positions would address Medicaid Management Information System (MMIS) maintenance and enhancement

requests, including the recommended MMIS replacement project (Decision Unit E-550, Major Closing Issue 2). The agency indicates that the new positions would be retained after the MMIS replacement project is complete.

Fiscal staff asked the agency how an increase in Medicaid caseload results in an increase in information system issues. The agency indicated that system issues and weaknesses that were previously manageable through manual resolution now require system changes and enhancements due to the increasing frequency with which issues arise. The new Business Process Analyst positions would identify issues that require resolution, define system change project requirements and project scope, monitor the project during the development and implementation phases, and monitor the system change after implementation to ensure that the change is working as designed. The agency indicates that system changes often take months or years to implement due to the complexity of the MMIS.

Does the Subcommittee wish to approve three new Business Process Analyst positions for the Information Services Unit?

The Subcommittee recommended approving the Governor's recommendation to add three new positions to the Information Services Unit for business process management.

- Rates and Cost Containment Staff (M-504, DHHS-DHCFP-20) – Additional funding of $271,132 ($131,167 General Fund appropriation) is recommended over the 2015-17 biennium for two new Management Analyst positions (priorities 15 and 23) for the Rates and Cost Containment Unit to support workload increases resulting from health care reform. The 2 new positions represent a 14 percent increase in Rates and Cost Containment Unit staff, from the 14 positions shown on the agency's organizational chart.

  The agency indicates the positions would analyze the fiscal impact of Medicaid rate adjustments for services provided under both fee for service and managed care service delivery models, and support additional Upper Payment Limit (UPL) and other supplemental payment program reporting requirements imposed by the ACA. The agency indicates that the federal Centers for Medicare and Medicaid Services (CMS) now requires 16 annual UPL demonstration reports, compared to the 4 annual reports required prior to implementation of the ACA. In addition, two new supplemental payment programs and an enhanced Managed Care Organization payment program were implemented during the 2013-15 biennium, further increasing reporting requirements.

  The new positions would also review and update medical service reimbursement methodologies included in the state plan. According to the agency, some Medicaid fee-for-service rate methodologies are antiquated. The agency indicates that the positions would allow the division to complete a methodical review of state plan reimbursement rates on an ongoing basis, including an analysis of the impact of rates on recipient access to health care services.
  Fiscal staff asked the agency how it determined that it would be appropriate to add two new positions to the Rates and Cost Containment Unit. In a March 18, 2015, follow-up memo, the agency estimated that the previously described job duties would require 5,860 hours of work annually, equating to 2.8 FTE (5,860 hours / 2,080 hours per year per FTE = 2.8 FTE).

  Does the Subcommittee wish to approve two new Management Analyst positions for the Rates and Cost Containment Unit?

  The Subcommittee recommended approving two new positions for the Rates and Cost Containment Unit, as recommended by the Governor.

- Accounting Staff (M-505, DHHS-DHCFP-20-21) – Funding totaling $119,765 ($57,841 General Fund appropriation) is recommended over the 2015-17 biennium for one new Management Analyst position (priority 16) for the Accounting section of the Budget and Accounting Unit to track and analyze Affordable Care Act (ACA) related expenditures, forecast future expenditures and compile federally mandated reports. Currently, the accounting section has 14 staff. The agency indicates that the ACA requires additional federal reporting for the Newly Eligible Expansion population costs, resulting in increased workload for the unit. The agency indicates that it has experienced federal financial reporting accuracy issues since the implementation of Medicaid expansion in January 2014 and that several federal reports had to be corrected and resubmitted.

  Does the Subcommittee wish to approve one new Management Analyst position for the Budget and Accounting Unit?

  The Subcommittee recommended approving one new position for the Budget and Accounting Unit, as recommended by the Governor.

- District Office Staff (M-503, DHHS-DHCFP-19 - 20) – Funding totaling $611,205 ($295,374 General Fund appropriation) is recommended over the 2015-17 biennium to add six positions to the division's district offices, including three Administrative Assistants and three Health Care Coordinators. Four positions would be added to the Las Vegas district office (priorities 14, 22, 30, and 31), and two positions would be added to the Reno district office (priorities 13 and 21).

  The new positions would serve as customer service and care coordination staff and would answer both telephone and in-person recipient inquiries and assist recipients with accessing Medicaid providers and other community resources. The agency notes that Medicaid caseload has significantly increased during the current biennium, as discussed in the closing document for the Medicaid budget. As a result, the agency reports that district offices have experienced an increase in call volume and recipient requests for care coordination services.

  Given the trend of increased enrollment of Medicaid recipients in Managed Care Organizations (MCO), particularly in Clark and Washoe counties, and the fact that recipients enrolled in a MCO should seek customer service and care coordination through their MCO, staff asked the agency why additional district office staff is necessary. In a March 18, 2015, follow-up memo, the agency indicated that fee-for-service enrollment has increased by a large degree in recent years, from 87,113 in January 2011 to 125,172 in January 2015, with no corresponding increase in district office staff.

  Fiscal staff asked how the agency determined that the recommended number of positions to add to the district offices was appropriate. The agency indicates that it does not have customer service or care coordination staffing ratios. Regarding customer service workload, the agency reports that call volume in the northern area of the state (including Reno, Elko and Carson City) has increased from 2,144 monthly average calls in FY 2013 to 2,790 monthly average calls to date in FY 2015, a 30 percent increase. The agency indicates that call volume at the Las Vegas district office has increased from 4,031 monthly average calls in FY 2013 to 5,479 monthly average calls to date in FY 2015, a 36 percent increase. The agency further noted that two Administrative Assistants in the Las Vegas office who currently assist with customer service would transfer to the Aging and Disability Services Division (ADSD), if the transfer of the Waiver for Persons with Physical Disabilities (WIN) is approved (Decision Units E-900 and E-901, Major Closing Issue 3).

The agency did not provide workload statistics for care coordination. Based on the information provided and the lack of available staffing ratios, it is unclear how many new positions would be adequate to address the agency's stated workload increase.

The Subcommittee may wish to approve one of the following options:

a) Approve four new positions for the Las Vegas district office and two new positions for the Reno district office as recommended by the Governor; or
b) Approve four new positions, including one Health Care Coordinator and one Administrative Assistant for the Las Vegas district office and one Health Care Coordinator and one Administrative Assistant for the Reno district office; or
c) Disapprove new positions for the district offices.

The Subcommittee recommended approving option b, to add a total of four new positions, including two for the Las Vegas district office and two for the Reno district office.

- Long Term Support Services Staff (M-507, DHHS-DHCFP-21-22) – Additional funding of $940,415 ($454,328 General Fund appropriation) is recommended over the upcoming biennium to add eight new positions, including two Social Services Program Specialists (priorities 19 and 28) and six Health Care Coordinators (priorities 3, 4, 5, 6, 20, and 26), for the Long Term Support Service Unit to implement new federal requirements for the division's existing 1915(i) state plan amendment (SPA) services. Section 1915(i) SPAs allow states to provide home and community based services that would otherwise be disallowed by CMS to Medicaid recipients who meet state-defined needs-based criteria before they require institutional care. The state's 1915(i) SPA currently allows for adult day health care, home-based habilitation and partial psychiatric hospitalization services to qualifying individuals. According to information attached to the budget, approximately 980 recipients receive 1915(i) services.

  In January 2014, CMS released guidance clarifying the definition of home and community-based services. The agency indicates the recent federal policy clarification results in the need for additional staffing to perform additional person-centered planning and complete more quality reviews. Person-centered planning is a process that is designed to address long-term services and supports in a manner that reflects individual preferences and goals.

  Currently, 1915(i) SPA service providers also provide case management services for 1915(i) SPA recipients. A key provision of the recent federal guidance requires that case managers be independent from service providers, necessitating the addition of independent case managers to the division. Six positions would provide case management services to 1915(i) SPA recipients through the district's offices, including four in Las Vegas and two in Reno, and two positions would monitor the program to ensure the state remains in compliance with federal standards and perform federally required quality reviews. The agency indicates that positions located in the Reno office would manage cases in the rural areas of the state. In addition, Elko district office staff would be able to see recipients in person as needed.

  According to the agency, each case management position would be assigned a caseload of 140 cases. In comparison, case management positions for the agency's 1915(c) home and community based waivers typically carry a caseload of 40 to 45. According to the agency, the amount of work required to appropriately manage 1915(i) cases is expected to be lower than for 1915(c) waivers because 1915(i) case management does not require monthly recipient contacts as 1915(c) case management does. Considering the 1915(i) caseload of 980, it appears that each

case management position would carry a caseload of approximately 160 (980 cases / 6 positions = 163.3 cases per worker).

Regarding the two positions recommended for quality assurance, the agency indicates that the recent federal policy guidance requires that quality reviews be conducted on 1915(i) recipients to ensure that recipients continue to meet 1915(i) services needs-based criteria, medical services are aligned with recipients' service plans, and the health, safety and welfare of recipients is monitored and safeguarded.

The agency initially indicated in a February 10, 2015, email that a state plan amendment and changes to the division's Medicaid Services Manual would be required in order to implement person-centered planning. In addition, the existing 1915(i) plan must be reviewed by CMS and renewed. However, in a March 18, 2015, follow-up memo, the agency indicated that no state plan amendment would be required.

Does the Subcommittee wish to approve eight new positions for the Long Term Support Services Unit?

The Subcommittee recommended approving the Governor's recommendation to add eight new positions to the Long Term Support Services Unit.

- Autism Spectrum Disorder Staff (M-511, DHHS-DHCFP-23) – Funding totaling $239,528 ($115,682 General Fund appropriation) is recommend over the upcoming biennium to add two new Social Service Program Specialists to support a recent federal mandate requiring states to provide certain services to children on Medicaid with Autism Spectrum Disorder. One position is requested for the Clinical Policy Team to develop policies and procedures for Autism Spectrum Disorder services and a new specialized provider type as well as to oversee utilization of Autism Spectrum Disorder services. The other position is requested for the Hearings section of the Program Integrity Unit.

  The agency indicates the new position recommended for the Clinical Policy Team (priority 7), which is currently staffed with 18 positions, would be responsible for developing and refining program policy for and monitoring utilization of Applied Behavior Analysis (ABA) services, which the agency is proposing to address a recent federal mandate to provide certain medically necessary services to children with Autism Spectrum Disorder. The agency indicates the position would research best practices, work with stakeholder groups, research Autism Spectrum Disorder services offered by other state Medicaid programs, monitor ABA services utilization, analyze provider service levels and payments, and provide provider trainings as necessary.

  Regarding the new position recommended for the Hearings section (priority 8), which is currently staffed with seven positions, the agency indicates that it is anticipating an increase in hearing requests associated with implementing ABA coverage. Pursuant to NRS 422.276, a recipient may appeal a denial of benefits, and federal regulations require that a hearing must generally be held and a determination made within 90 days of a hearing request. According to the agency, an increase in hearings is anticipated because it expects that many recipient requests for ABA services will be denied or reduced from the level requested due to the requirement that services be medically necessary and supported by appropriate medical evidence. Fiscal staff asked the agency how many additional hearings are anticipated to result from adding ABA services. The agency did not provide a specific number, but indicated that it expects hundreds of additional hearing requests per month.

According to the agency, the pending implementation of ABA services is not the only factor related to the new Hearings section position. The agency indicates the recent Medicaid expansion and changes to Personal Care Services and Basic Skills Training policies have resulted in a significant increase in hearing requests. In FY 2013, the agency indicates that there were 840 total hearing requests and five staff assigned to the Hearings section, equating to a monthly hearing request to staff ratio of 14:1. In the first half of FY 2015, the agency reports that there were 2,070 hearing requests and seven staff assigned to the Hearings section, equating to a monthly hearing request to staff ratio of 49:1.

The Subcommittee should note that one additional Social Services Program Specialist position is recommended for the Hearing section in Decision Unit M-502. The two new positions represent a 28 percent increase in Hearings section staffing, when compared to the seven positions shown on the agency's current organizational chart. The Legislature has approved recent increases in Hearings section staff, including one new position in 2011 and two new positions in 2013.

Does the Subcommittee wish to approve one new position for the Clinical Policy Team and one new position for the Hearings section, contingent on the approval of coverage for Applied Behavior Analysis in the Medicaid budget?

The Subcommittee recommended approving the Governor's recommendation to add two new positions to support services for Autism Spectrum Disorder.

- Waiver Staff (M-501, DHHS-DHCFP-18) – Funding totaling $250,430 ($125,214 General Fund appropriation) over the 2015-17 biennium is recommended for two new Health Care Coordinator positions (priorities 17 and 29) for the Long Term Support Services Unit in Las Vegas for the operation of the Waiver for Persons with Physical Disabilities (WIN). The new positions are recommended in conjunction with the Governor's recommendation to increase WIN waiver slots by 51 over the upcoming biennium, from 754 to 805, as discussed in the closing document for the Medicaid budget.

  The agency indicates that one position would provide case management for WIN waiver recipients and is recommended to maintain the agency's historical 40 to 45 cases per worker ratio. The 40 to 45 cases per worker ratio is consistent with other waiver programs in the department, including the Home and Community Based Waiver for the Frail Elderly. Currently, the agency has 23 case management staff, including three lead workers who serve as managers, meaning that at least 20 case management staff would carry a full caseload of 40 to 45 cases. Considering the agency's stated 40 to 45 cases per case worker, it appears that the agency currently has sufficient WIN waiver staff to meet its staffing ratio in the 2015-17 biennium. With the 805 WIN cases recommended in The Executive Budget, the existing 20 case workers would have an average of 40.25 cases (805 WIN cases / 20 case workers = 40.25 cases per worker). If a new case management position were approved, each case worker would have an average caseload of 38, below the agency's stated staffing ratio.

  The other new position would be primarily dedicated to recipient intake and functional eligibility assessment services in Las Vegas. This position would also perform outreach and wait list prioritization. Currently, the agency does not have dedicated intake and eligibility assessment staff. Intake and functional eligibility assessments are performed by two lead case workers in Las Vegas who carry a reduced caseload to account for dedicating approximately 50 percent of their time to these responsibilities. Case workers at the Reno district office are responsible for performing intake and functional eligibility assessments as part of their regular duties. Considering the agency's stated case per worker ratio of 40-45:1, it is unclear why it is now necessary to add a dedicated position to perform intake and eligibility assessments.

The Subcommittee may wish to consider the following options, contingent upon the approval of WIN waiver slot increases in the Medicaid budget:

a) Approve two positions as recommended by the Governor; or
b) Disapprove both new positions as the agency appears to have sufficient waiver staff to meet its stated 40 to 45 case per worker ratio.

The Subcommittee recommended that the Governor's recommendation to add two new positions for the WIN waiver not be approved (option b).

- Program Integrity Staff (M-502, DHHS-DHCFP-19) – Additional funding totaling $827,355 ($399,672 General Fund appropriation) is recommended over the upcoming biennium to add seven new positions, including five Management Analysts (priorities 9, 10, 11, 12, and 24), one Social Services Program Specialist (priority 27), and one Administrative Assistant (priority 25) for the Program Integrity Unit to ensure that the state complies with federal program integrity mandates, including ACA-related mandates.

  One position would be added to the Provider Support section to address growing provider and recipient complaints and inquiries and to perform provider outreach. One position would be added to the Hearings section to support an anticipated increase in hearing requests related to Medicaid caseload growth. Five positions would be added to the Surveillance and Utilization Review (SUR) section to address a backlog of 185 cases that have not yet been reviewed related to potential program fraud, waste, and abuse.

  The SUR section works to detect fraud, waste and abuse in the Medicaid program. The section conducts claim reviews, reviews provider records and conducts on-site visits to identify improper payments. In addition to the SUR section, the division is federally mandated to engage outside entities to review for fraud waste and abuse, including:

  - Recovery Audit Contractor: The agency indicates this contractor executes division-approved reviews. This activity is funded through a percentage of overpayments recovered. In FY 2013 and FY 2014, the state's contractor recovered a total of $6.0 million.
  - Medicaid Integrity Contractor: CMS hires and pays contractors to audit claims, identify overpayments, and educate providers. The agency indicates that the purpose of this program is to support but not replace state program integrity efforts. In FY 2013 and FY 2014, the state's Medicaid Integrity Contractor recovered a total of $14,512.

  For comparison with the recoveries noted above, SUR staff recovered $3.9 million in FY 2013 and FY 2014 combined. In FY 2012, the agency reported $4.6 million in SUR recoveries. In addition to recoveries, there is also cost avoidance associated with SUR staff as a result of educating providers about appropriate billing procedures. However, the agency is unable to quantify cost avoidance generated by the SUR section. According to the agency, the new SUR positions would generate $2.5 million ($795,752 General Funds) in medical service savings in the Medicaid budget (Decision Unit M-502) through recovering improper payments over the 2015-17 biennium.

  In addition to the Recovery Audit Contractor and the Medicaid Integrity Contractor, the federally mandated Payment Error Rate Measurement (PERM) program is conducted once every three years to determine the percentage of Medicaid payments that are in error. This activity is fully federally funded. The agency indicates that PERM does not identify large payments for recovery. Additional Medicaid fraud-related investigations are conducted by the Medicaid Fraud Control Unit in the Office of the Attorney General.

According to the agency's organizational chart, the Surveillance and Utilization Review section is currently staffed with 14 positions. A total of eight new positions are recommended for the SUR section (five in this decision unit and three in Decision Unit E-229), representing a 57 percent increase in SUR staff. Fiscal staff asked the agency for historical and projected Surveillance and Utilization Review workload and the agency indicated that there were 1,048 cases opened in FY 2014, 1,272 cases projected for FY 2015, and 1,425 and 1,596 cases projected for FY 2016 and FY 2017, respectively, representing a projected 52 percent increase in cases between 2014 and 2017. Open cases include the previously mentioned backlog.

The agency indicates that four of the five new Surveillance and Utilization Review staff would establish a Las Vegas office for the section, including three Management Analysts and one Administrative Assistant. The agency indicates that a Las Vegas location would allow staff to conduct additional on-site visits to providers in the southern area of the state, which the agency believes would create opportunities to educate providers on proper billing procedures. If one of the Management Analyst positions were not approved, and two staff were assigned to the Las Vegas office, the agency indicates that its operations would be constrained by staff absences and position vacancies because at least two staff must be present during on-site visits.

The Subcommittee should note that the Carson City SUR office is staffed with 13 Management Analysts and one Administrative Assistant, compared to the three Management Analysts and one Administrative Assistant proposed for the Las Vegas office. The agency indicates that the proposed Las Vegas SUR unit could function without an Administrative Assistant, but other staff would spend time on lower-level duties.

The other new SUR position would be located in Carson City and would serve as a data systems coordinator. The position would primarily be responsible for designing and developing reports and dedicate approximately ten percent of its time to conducting provider reviews. If this position were not approved, the agency indicates that other SUR staff would be responsible for developing their own reports and extracting data from various information systems for analysis.

The calculated medical service savings associated with the increase in SUR staff assumes that all five new SUR staff would generate savings. However, it appears that just three positions, the Management Analyst positions recommended for the Las Vegas office, would be directly involved in recovering improper payments.

Regarding the new position for the Provider Support section (priority 24), the agency indicates that the position would monitor provider enrollment and disenrollments to trend provider statistics in relation to Medicaid caseload in order to evaluate access to various health care services throughout the state and develop recommendations for addressing identified access to care issues. The position would also be responsible for monitoring claims reprocessing and keeping providers informed of pending claims reprocessing, so providers are aware in advance of the financial impact.

Regarding the new position for the Hearings section (priority 27), the workload of the Hearing section was previously discussed in Decision Unit M-511. If the two new positions for the Hearings section in this decision unit and Decision Unit M-511 are approved, and the average monthly hearing requests experienced to date in FY 2015 continues, the monthly hearing requests per staff would be 38:1, compared with a 14:1 staffing ratio in FY 2013.

With regard to the five positions recommended for the Surveillance and Utilization Review section, the Subcommittee could consider the following options:

a) **Approve five new positions for the Surveillance and Utilization Review section, as recommended by the Governor; or**
b) **Disapprove five new positions for the Surveillance and Utilization Review section and direct the agency to utilize the Recovery Audit Contractor for additional program integrity efforts; or**
c) **Approve three new positions for the Surveillance and Utilization Review section, including three Management Analysts to establish a Las Vegas office and disapprove one Management Analyst data system coordinator and one Administrative Assistant.**

The Subcommittee recommended approving option c to add three new positions to the Surveillance and Utilization Review section.

Does the Subcommittee wish to approve one new position for the Provider Support section, as recommended by the Governor?

Does the Subcommittee wish to approve one new position for the Hearings section, as recommended by the Governor?

The Subcommittee recommended approving the Governor's recommendation to add one new position for the Provider Support section and one new position for the Hearings section.

New Discretionary Positions

- Project Management Staff (E-227, DHHS-DHCFP-24-25) – Additional funding totaling $268,764 ($129,682 General Fund appropriation) is recommended over the 2015-17 biennium to add two new IT Professional positions (priorities 33 and 36) for the Project Management section of the Information Services unit for project management of IT-related projects, such as the MMIS replacement (Decision Unit E-550, Major Issue 2). The agency's organizational chart shows that five positions are currently dedicated to IT project management. Accordingly, the two new positions represent a 40 percent increase in IT project management staff.

  The agency anticipates that IT projects would increase from the historical average of 22 projects annually to 50 annually in the upcoming biennium. According to the agency, it is not currently adequately staffed to manage the number of IT projects that are anticipated in upcoming years, including the MMIS replacement. The positions would be responsible for defining project objectives and requirements, assessing, identifying and minimizing project risk, and manage project resources.

  Does the Subcommittee wish to approve two new positions for IT project management?

  The Subcommittee recommended approving the Governor's recommendation to add two new positions for IT project management.

- Clinical Policy Staff (E-226, DHHS-DHCFP-24) – Additional funding of $132,809 ($64,119 General Fund appropriation) is recommended in the 2015-17 biennium to add one new Health Resource Analyst (priority 32) for the Clinical Policy Team to add management for the pharmacy benefit team, which currently includes two existing policy staff. According to information attached to the budget, the new position would be dedicated to pharmacy strategic planning and would develop utilization management models, manage coverage policies, refine delivery system models, and work with external stakeholders on pharmaceutical policy issues.

Does the Subcommittee wish to approve one new position for the Clinical Policy Team?

The Subcommittee recommended approving the Governor's recommendation to add one position to the Clinical Policy Team.

- Fiscal Integrity Staff (E-230 and E-235, DHHS-DHCFP-26-27) – In Decision Unit E-230, additional funding of $355,443 ($171,672 General Fund appropriation) is recommended in the 2015-17 biennium to add three new positions for the Fiscal Integrity Unit, including two Management Analysts (priorities 35 and 39) and one Auditor (priority 34), to increase fiscal agent oversight, perform agency internal audits, complete the agency internal controls report required by NRS 353A.025, oversee Medicaid payments for Department of Corrections inmates, and track provider debt. In Decision Unit E-235, The Executive Budget recommends cost reductions of $671,721 ($167,930 General Fund) in each year of the 2015-17 biennium resulting from fiscal agent savings associated with adding the staff included in Decision Unit E-230. Of the total annual projected cost reductions, $167,930, or approximately 25 percent, would be General Fund, with the remainder being federal funds. In comparison, position costs in this budget are funded at approximately 50 percent General Fund and 50 percent federal funds. The duties of the new positions are further described below.

  The new Auditor position would perform agency internal audits, complete the agency internal controls report required by NRS 353A.025, and oversee Medicaid payments for Department of Corrections inmates. One new Management Analyst position would track, collect, and produce reports on provider debt. The 2013 Legislature approved two new positions to perform this function. The agency indicates that the workload is becoming unmanageable for existing staff and that there may be delays in recovering provider debt.

  The other new Management Analyst would implement an audit of fiscal agent monthly invoices, which is expected to generate savings. The projected annual fiscal agent savings amount to approximately two percent of total costs in the fiscal agent category. According to documentation attached to the budget, fiscal agent savings were calculated assuming that each of the new positions in Decision Unit E-230 would generate annual savings of approximately $223,907. However, documentation attached to the budget indicates that only one new Management Analyst position would be involved in reviewing fiscal agent invoices.

  The Subcommittee may wish to consider the following options:

  a) Approve three new positions for the Fiscal Integrity Unit, as recommended by the Governor; or
  b) Approve one new position to audit fiscal agent invoices, which is expected to generate savings and disapprove the other two new positions; or
  c) Disapprove three new positions for the Fiscal Integrity Unit, requiring the elimination of General Fund savings totaling $167,930 in each year of the 2015-17 biennium.

  The Subcommittee recommended approving option b, to approve one new position and disapproving the other two new positions.

- Program Integrity Staff (E-229, DHHS-DHCFP-25) – Funding totaling $518,748 ($250,877 General Fund appropriation) is recommended over the 2015-17 biennium to add four new Management Analyst positions (priorities 37, 38, 40 and 41) for the Program Integrity Unit to ensure that the state maintains compliance with federal program integrity initiatives and to support the Governor's initiative for a responsive and efficient government. One position would manage and oversee the

Compliance section, which consists of the Medicaid Estate Recovery section, Hearings section and Data Compliance section, and three positions would be added to the SUR section. The positions are discussed further below.

The agency indicates that the three new positions for the SUR section would review medical service encounter data for recipients enrolled in managed care organizations (MCO) to identify fraud, waste, and abuse. The agency anticipates that the requested SUR positions would generate $2.0 million ($636,601 General Fund) in medical service savings over the upcoming biennium in the Medicaid budget (Decision Unit E-229). As previously mentioned, the SUR section is currently staffed with 14 positions. A total of eight new positions are recommended for the SUR section (three in this decision unit and five in Decision Unit M-502), representing a 57 percent increase in SUR staff.

The Subcommittee should note that the three new SUR positions in this decision unit are included in an enhancement decision unit because the state is not required by CMS to review or audit payments made by MCOs. The agency indicated that CMS is requiring states to increase oversight of program integrity policies and activities in MCOs. Fiscal staff asked the agency for documentation of this requirement and the agency provided a federal Governmental Accountability Office (GAO) report regarding oversight of managed care expenditures. However, the GAO report makes recommendations directed at CMS and does not appear to constitute a requirement for the state.

Fiscal staff notes that Chapter 3600 of the state's Medicaid Services Manual specifies rules that are applicable to the activities of MCOs. Section 3603 indicates that MCOs must have procedures to guard against fraud and abuse, including internal monitoring and auditing processes. Therefore, it appears that the MCOs would already have utilization review procedures in place and the SUR staff may be duplicative to some degree.

The agency further indicated that the federal Department of Health and Human Services Office of Inspector General will be conducting an audit in August 2015 targeted at evaluating whether the state's MCOs properly identify fraud and abuse. The results of this audit would likely provide information regarding how to best target resources to increase state oversight of MCOs.

As previously mentioned, the other new Management Analyst position is recommended to manage and oversee the Medicaid Estate Recovery section, Hearings section and Data Compliance section. The Medicaid Estate Recovery unit has eight positions, the Hearings section is recommended to have nine positions, and the data compliance section has one position. Currently, these sections report directly to the Chief of Program Integrity and Compliance. The Management Analyst would provide additional oversight of the operations of these sections. The agency indicates that the new position would also be responsible for oversight of other compliance-related activities, including managing state plan amendments, overseeing regulation review, and coordination of the Medical Care Advisory Committee.

The Subcommittee may wish to consider the following options:

a) **Approve four new positions for the Program Integrity Unit, including one position to manage the Compliance section and three positions for the Surveillance and Utilization Review section, as recommended by the Governor; or**
b) **Approve one new Management Analyst position to oversee the Medicaid Estate Recovery section, Hearings section and Data Compliance section and disapprove three positions**

for the Surveillance and Utilization Review section, requiring the elimination of General Fund savings totaling $636,601 over the 2015-17 biennium in the Medicaid budget; or

c) Disapprove four new positions for the Program Integrity Unit, requiring the elimination of General Fund savings totaling $636,601 over the 2015-17 biennium in the Medicaid budget.

The Subcommittee recommended approving one new position to manage the Compliance section of the Program Integrity Unit and disapproving three new positions for the Surveillance and Utilization Review section (option b).

2. Medicaid Management Information System Replacement Project (E-550, DHHS-DHCFP-28): The agency requests funding totaling $33.5 million ($3.3 million in General Fund) in the 2015-17 biennium for a technology investment request (TIR) to implement a portion of the final phase of a three phase project to replace the existing MMIS. The MMIS is an automated claims information and processing solution. Nevada's existing MMIS solution is hosted and operated by a vendor, which serves as Medicaid's fiscal agent. Currently, the fiscal agent utilizes the MMIS to provide claims processing, medical service prior authorization, prescription point of sale processing, third-party liability recovery, recipient ID management, managed care drug rebate processing, and other functionality.

   Phase I of the MMIS replacement project, which compared the state's existing MMIS with the federal government's requirements for such systems, was completed in 2009. Phase II, which is expected to be complete in October 2015, involves planning the MMIS system replacement effort. Phase III of the project is scheduled to begin in November 2015 and consists of the design, development, implementation and federal certification of the replacement system. The agency anticipates that phase III of the project will take 60 months, including 36 months for system design and development, with testing and CMS certification during the remaining 24 months.

   The TIR for phase III of the MMIS replacement project attached to The Executive Budget indicates that the project is expected to cost a total of $116 million. However, the TIR document for phase II of the project indicated that phase III was expected to cost $53 million. Therefore, the current phase III cost estimate is $63 million, or 118 percent, more than the previous cost estimate. According to the agency, the replacement cost estimate included in the phase II TIR document was produced by internal staff. The agency indicates that the current phase III cost estimate is produced by their procurement consultant and is based on research of MMIS contract awards in other states and takes data conversion and scope of integrating MMIS functionality into consideration.

   The agency intends to contract with vendors to implement phase III of the project. During the upcoming biennium, the TIR indicates that the agency would release a project request for proposal (RFP), obtain CMS and Board of Examiners contract approval for the selected vendor, and begin system design and development. To replace the existing MMIS system, the agency considered a number of options, including updating the existing system, designing and developing a new system, and procuring an existing MMIS system. The agency has selected to procure an existing MMIS system currently in use by another state and customize it to meet Nevada's needs, referred to as a MMIS transfer system. According to the agency, selecting a transfer MMIS system is likely to provide the state with a lower level of risk at a lower cost than other system replacement options.

   It should be noted that the MMIS transfer system does not appear to include all of the functionality currently provided through the fiscal agent. In particular, it appears that the MMIS transfer system would not include prescription point of sale processing, medical service prior authorization, recipient ID management or managed care drug rebate processing. The agency indicates that these services are considered to be outside the scope of the core MMIS system. The agency indicates that it may seek to

have these services provided through the fiscal agent after the MMIS system replacement is complete or it may seek to contract with a separate vendor. The agency notes that the current fiscal agent subcontracts for some of these services. It may benefit the agency to contract directly for these services in the future.

The Executive Budget indicates that the first portion of phase III, recommended for the 2015-17 biennium, would be supported by 90 percent federal Title XIX funding and 10 percent General Fund appropriations. The Subcommittee should note that the federal financial participation percentage (FFP) for the operation of an MMIS is 75 percent, while an enhanced FFP of 90 percent is available for the design, development and implementation of a new MMIS. The agency indicates that customizing a transfer system for the state's needs would qualify for the enhanced 90 percent FFP. The agency further indicates that an advance planning document must be approved by CMS prior to beginning Phase III of the project, which would constitute approval for the 90 percent FFP for the design, development and implementation phase.

The agency anticipates that ongoing MMIS system costs would amount to approximately $25 million annually after the replacement system is fully deployed. In the 2015-17 biennium, the Governor's recommended budget includes approximately $20 million annually for the MMIS-related services that are in the scope of the $25 million ongoing cost estimate. Considering annual inflation, the $25 million cost estimate for annual ongoing costs appears reasonable.

Does the Subcommittee wish to approve the Governor's recommendation to implement the first portion of the third and final phase of the MMIS replacement project?

The Subcommittee recommended approving the Governor's recommendation to fund the first portion of the third and final phase of the MMIS replacement project.

3. Transfer Operation of the Waiver for Persons with Physical Disabilities (E-900 and E-901, DHHS-DHCFP-30-31): The Governor recommends transferring operation of the WIN waiver to the Aging and Disability Services Division (ADSD) beginning July 1, 2015. To effect the transfer, operating and personnel costs for 27 positions, including 2 Administrative Assistants and 25 Health Care Coordinators, totaling $4.1 million over the 2015-17 biennium ($2.0 million in General Fund), would be transferred to the Home and Community Based Services budget in ADSD. Currently, the ADSD operates Medicaid's two other CMS-approved waiver programs, the Home and Community Based Waiver (HCBW) for the Frail Elderly and the Intellectual Disabilities and Related Conditions Waiver. As with the other two waiver programs, the administrative authority over the waiver would remain with DHCFP. Decision Unit E-900 transfers existing costs and personnel, and Decision Unit E-901 would transfer two new positions recommended for the WIN program in Decision Unit M-501 (Major Closing Issue 1).

   The agency indicates that transferring operation of the WIN waiver to ADSD is the first step in combining the WIN waiver with the HCBW for the Frail Elderly to create one state waiver program for individuals who would otherwise likely be institutionalized in a nursing facility. It should be noted that CMS approval is required for integrating waiver programs. However, CMS approval is not required to transfer the operation of the WIN waiver.

   The ADSD has recently combined several Medicaid waiver programs after obtaining CMS approval. In July 2011, the Waiver for Elderly in Adult Residential Care (WEARC) and the Community Home-Based Initiatives Program waiver (CHIP) were combined to form the HCBW for the Frail Elderly. In July 2014, the agency combined the Assisted Living (AL) waiver with the HCBW for the Frail Elderly.

According to the agency, the goal of the waiver integration is to reduce duplication of effort, increase access to services, increase service quality, and allow for the efficient utilization of state resources. The agency indicates that administering multiple waiver programs creates duplicate federal reporting requirements, multiple quality assurance systems, and duplicative provider review processes. The agency further indicates that waiver integration would benefit recipients by simplifying service access for recipients, increasing service quality, and allowing service coordinators to provide integrated case management of all recipient service needs. The ADSD reports that because of the previous waiver integrations, 274 recipients have been able to access services without having to re-apply for a different program, be placed on another waitlist, or experience a delay in services.

The Subcommittee approved transferring operation of the WIN waiver to the ADSD in closing the Home and Community Based Services budget on May 1, 2015.

Staff recommends the Subcommittee approve transferring operation of the WIN waiver to the Aging and Disability Services Division, consistent with its previous action.

The Subcommittee recommended approving transferring operation of the WIN waiver to the Aging and Disability Services Division, as recommended by the Governor, including 25 existing positions and associated operating costs. The Subcommittee did not recommend transferring two new positions, consistent with its recommendation on Decision Unit M-501.

Other Closing Items

1. Mandatory Rate Changes (M-101, DHHS-DHCFP-15-16): The Governor recommends decreasing funding by $2.9 million ($623,049 General Fund appropriation) in FY 2016 and $1.8 million ($293,940 General Fund appropriation) in FY 2017 for mandatory rate changes for services provided by the fiscal agent, including claim processing cost decreases and prior authorization cost increases. In particular, the agency notes that the per claim processing cost would decrease, from the current $0.67 per claim to $0.60 per claim in the 2015-17 biennium. **This recommendation appears reasonable.**

2. Caseload Driven Administrative Costs (M-200, DHHS-DHCFP-16): The Governor recommends $6.7 million ($2.0 million General Fund appropriation) in FY 2016 and $7.0 million ($2.1 million General Fund appropriation) in FY 2017 to support increases in caseload-driven administrative costs, including travel, operating costs, and fiscal agent costs, such as claims processing and prior authorizations. **This recommendation appears reasonable.**

3. Waiver Administrative Costs (M-201, M-202 and M-203, DHHS-DHCFP-16-17): The Executive Budget recommends $15,242 ($3,810 General Fund appropriation) in FY 2016 and $47,271 ($11,817 General Fund appropriation) in FY 2017 for increases in claims processing and prior authorization costs associated with the Governor's recommendation to expand the number of waiver slots for the division's home and community based waiver programs. The recommended increase in waiver slots is discussed further in the closing document for the Medicaid budget. **These recommendations appear reasonable. Staff requests authority to make technical adjustments necessary to align these decision units with the Subcommittee's closing actions in the Medicaid budget.**

4. Replacement Equipment (E-710 and E-719, DHHS-DHCFP-29): The Governor recommends $211,064 ($105,532 General Fund appropriation) in FY 2016 and $111,680 ($55,840 General Fund appropriation) in FY 2017 to replace computer hardware and software, including desktop computers, servers and network devices, and microwave communication equipment that has reached the end of its useful life. **This recommendation appears reasonable.**

5. New Equipment (E-720, DHHS-DHCFP-29-30): The Governor recommends $68,133 ($34,066 General Fund appropriation) in FY 2016 and $38,561 ($19,280 General Fund appropriation) in FY 2017 to purchase new computer hardware and software, including networking devices, e-discovery software, and document management software, to enhance the agency's productivity. **This recommendation appears reasonable.**

6. Electronic Data Interchange (M-508, DHHS-DHCFP-22): The Governor recommends $821,534 ($177,483 General Fund appropriation) in FY 2016 and $719,036 ($179,759 General Fund appropriation) in FY 2017 for increased fiscal agent costs associated with implementing a standardized electronic data interchange format for health care data mandated by the federal government in the MMIS. **This recommendation appears reasonable.**

7. Health Plan Identifier (M-509, DHHS-DHCFP-22-23): The Executive Budget recommends $852,475 ($90,797 General Fund appropriation) in FY 2016 and $36,000 ($9,000 General Fund appropriation) in FY 2017 for increased fiscal agent costs associated with implementing a federally mandated unique health plan identifier in the MMIS. **This recommendation appears reasonable.**

8. Autism Spectrum Disorder Administrative Costs (M-512, DHHS-DHCFP-23-24): The Governor recommends additional funding of $1.3 million ($318,680 General Fund appropriation) in each year of the upcoming biennium to support increased fiscal agent costs, including claims processing and prior authorization costs, associated with the federally mandated addition of services for children with Autism Spectrum Disorder. Fiscal staff has completed technical adjustments, shown on the closing document, to align fiscal agent costs with projected expenditures. The technical adjustments result in a General Fund decrease of $89,226 in FY 2016 and a General Fund increase of $156,688 in FY 2017. **This recommendation appears reasonable with the noted technical adjustments, contingent upon the approval of Decision Unit M-512 in the Medicaid budget.**

9. Network Connectivity (E-232, DHHS-DHCFP-26): The Governor recommends additional funding totaling $71,157 ($35,578 General Fund appropriation) over the 2015-17 biennium to add redundant network connections at the agency's Carson City, Reno, and Las Vegas offices. Currently, the agency utilizes Silvernet services provided by the Division of Enterprise IT Services. The agency cites several significant network outages during the current biennium as driving this request. The agency estimates that 1,334 hours of productive staff time were lost as a result of these network outages. **This recommendation appears reasonable.**

10. Transparency Website (E-237, DHHS-DHCFP-27): The Governor recommends additional funding of $210,000 ($105,000 Title XIX and $105,000 Cost Containment Fees) in each year of the upcoming biennium to contract with the University of Nevada Las Vegas (UNLV) for a health care transparency website. Pursuant to NRS 439A.270, the Department of Health and Human services must maintain a website containing information on charges imposed and the quality of the services provided by hospitals and surgical centers, if there is sufficient money available. The agency indicates that UNLV currently maintains this website at no cost to the department and that the university is no longer able to support the costs associated with the website. The agency indicates that it relies on information from the website to determine Upper Payment Limit supplemental payments as well as payments to Nursing Facilities. Considering that the agency utilizes this information to calculate payments to providers, the agency indicates that the website should be maintained by an objective entity rather than a group that receives payments from the division. **This recommendation appears reasonable.**

11. Building Security Systems (E-238, DHHS-DHCFP-27-28): The Governor recommends $10,291 ($5,146 General Fund appropriation) in FY 2016 to install a new security card system at the division's Reno office and to repair the existing security card system at the division's Carson City office. **This recommendation appears reasonable.**

12. Cost Allocation Adjustments (E-800, DHHS-DHCFP-30): The Executive Budget recommends additional funding of $22.1 million ($11,964 General Fund appropriation) in FY 2016 and $22.9 million ($11,964 General Fund appropriation) in FY 2017 for adjustments to transfers from this budget to other budgets in order to align with the level of Medicaid-related administrative costs recommended in these other budgets. The increase is primarily related to an increase in Medicaid related administrative costs in the Division of Welfare and Supportive Services over what was legislatively approved for the 2013-15 biennium. **This recommendation appears reasonable. Fiscal staff requests authority to make necessary technical adjustments to align transfers from this budget with revenues in other budgets.**

13. Technical Adjustment: Fiscal staff completed technical adjustments in a number of decision units, shown on page one this closing document, to correct the retirement code for new positions in this budget. According to the Budget Instructions, new classified positions are to be budgeted at the employer paid retirement code. However, the new positions in this budget were budgeted at the employee/employer paid retirement code. Fiscal staff corrected the retirement codes of the new positions, resulting in a General Fund reduction of $39,656 over the 2015-17 biennium. **This adjustment appears reasonable.**

Does the Subcommittee wish to approve all Other Closing Items as recommended by the Governor, with the noted technical adjustments and authorize Fiscal staff to make further technical adjustments as necessary.

The Subcommittee recommended approving the Other Closing Items as recommended by the Governor, with the noted technical adjustments and authority for Fiscal staff to make further technical adjustments as needed.

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Title: HHS-HCF&P - NEVADA CHECK-UP PROGRAM **Budget Page:** DHHS-DHCFP-36, **Volume II**

Account: 101 - 3178

Revenues	2013-14 Actual	2014-15 WP	% Chg	2015-16 GOV REC	% Chg	2016-17 GOV REC	% Chg
FEDERAL FUND	27,272,090	30,499,011	11.83	24,053,247	(21.13)	25,635,879	6.58
GENERAL FUND	9,208,719	9,732,616	5.69	1,914,503	(80.33)	334,242	(82.54)
INTERAGENCY TRANSFER	158,181	(202,702)	(228.15)	30,025	(114.81)	5,633	(81.24)
OTHER FUND	1,435,369	2,203,442	53.51	822,520	(62.67)	822,520	
Total Revenues	38,074,359	42,232,367	10.92	26,820,295	(36.49)	26,798,274	(0.08)

Total FTE

Adjustments to Revenue

Dec Unit	Cat	GL	Description	2015-16	2016-17
B000	00	2501	Update FMAP rate		10,479
B000	00	3501	Update FMAP rate		(10,479)
M101	00	2501	Expand Check Up eligibility to include children of state workers FMAP reprojection.		670
M101	00	2501	Expand Check Up eligibility to include children of state workers.	4,948	2,979
M101	00	2501	Increase caseload to align with April 2015 projections.	15,190	3,826
M101	00	2501	Update FMAP for increased caseload.		588
M101	00	3501	Expand Check Up eligibility to include children of state workers FMAP reprojection.		(670)
M101	00	3501	Expand Check Up eligibility to include children of state workers.	61,915	273,528
M101	00	3501	Increase caseload to align with April 2015 projections.	190,080	292,799
M101	00	3501	Update FMAP for increased caseload.		(588)
M200	00	2501	Expand Check Up eligibility to include children of state workers FMAP reprojection.		(1,118)
M200	00	2501	Expand Check Up eligibility to include children of state workers.	87,300	53,240
M200	00	2501	Increase caseload to align with April 2015 projections.	315,440	55,096
M200	00	2501	Update FMAP for increased caseload.		(2,304)
M200	00	3501	Expand Check Up eligibility to include children of state workers FMAP reprojection.		1,118
M200	00	3501	Expand Check Up eligibility to include children of state workers.	1,092,427	3,895,145
M200	00	3501	Increase caseload to align with April 2015 projections.	3,947,256	4,215,785
M200	00	3501	Update FMAP for increased caseload.		2,304
M200	00	4355	Expand Check Up eligibility to include children of state workers.	29,731	140,000
M200	00	4355	Increase caseload to align with April 2015 projections.	158,689	160,143
M512	00	2501	Update FMAP		389
M512	00	3501	Update FMAP		(389)
E275	00	2501	Expand Check Up eligibility to include children of state workers.		4
E275	00	2501	Increase caseload to align with April 2015 projections.		42
E275	00	2501	Increase reimbursement rate for inpatient hospital services by 2.5 percent in FY 2016 and an additional 2.5 percent in FY 2017 (based on caseload including April 2015 projection and expanding eligibility to include children of state workers and reduced FY 2017 FMAP rate).	1,585	344
E275	00	2501	Update FMAP for expanded Check Up eligibility to include children of state workers.		6
E275	00	2501	Update FMAP for increased caseload.		7
E275	00	3501	Expand Check Up eligibility to include children of state workers.		869

E275	00	3501	Increase caseload to align with April 2015 projections.		3,293
E275	00	3501	Increase reimbursement rate for inpatient hospital services by 2.5 percent in FY 2016 and an additional 2.5 percent in FY 2017 (based on caseload including April 2015 projection and expanding eligibility to include children of state workers and reduced FY 2017 FMAP rate).	19,845	25,701
E275	00	3501	Update FMAP for expanded Check Up eligibility to include children of state workers.		(6)
E275	00	3501	Update FMAP for increased caseload.		(7)
E277	00	2501	Expand Check Up eligibility to include children of state workers.		184
E277	00	2501	Increase caseload to align with April 2015 projections.	6,619	1,558
E277	00	2501	Increase reimbursement rate for radiology and laboratory services (based on caseload including April 2015 projection and expanding eligibility to include children of state workers and reduced FY 2017 FMAP rate).	33,205	34,839
E277	00	2501	Update FMAP for expanded Check Up eligibility to include children of state workers.		233
E277	00	2501	Update FMAP for increased caseload.		225
E277	00	3501	Expand Check Up eligibility to include children of state workers.		31,428
E277	00	3501	Expand Check Up eligibility to Update FMAP for expanded Check Up eligibility to include children of state workers.		(233)
E277	00	3501	Increase caseload to align with April 2015 projections.	82,830	119,198
E277	00	3501	Increase reimbursement rate for radiology and laboratory services (based on caseload including April 2015 projection and expanding eligibility to include children of state workers and reduced FY 2017 FMAP rate).	415,512	545,343
E277	00	3501	Update FMAP for increased caseload.		(225)
E913	00	2501	Eliminate decision units E513 and E913 - transfer of immunization costs from DPBH to DHCFP	(110,927)	(19,337)
Sub-total				6,351,645	9,836,007
Line Item Changes to Revenues				6,351,645	9,836,007

Adjustments to Expenditures

Dec Unit	Cat	GL	Description	2015-16	2016-17
M101	12	7000	Expand Check Up eligibility to include children of state workers.	66,863	276,507
M101	12	7000	Increase caseload to align with April 2015 projections.	205,270	296,625
M200	12	7000	Expand Check Up eligibility to include children of state workers.	1,188,909	4,017,862
M200	12	7000	Increase caseload to align with April 2015 projections.	4,369,525	4,378,209
M200	12	8000	Expand Check Up eligibility to include children of state workers.	20,549	70,523
M200	12	8000	Increase caseload to align with April 2015 projections.	51,860	52,815
E275	12	7000	Expand Check Up eligibility to include children of state workers.		873
E275	12	7000	Increase caseload to align with April 2015 projections.		3,335
E275	12	7000	Increase reimbursement rate for inpatient hospital services by 2.5 percent in FY 2016 and an additional 2.5 percent in FY 2017 (based on caseload including April 2015 projection and expanding eligibility to include children of state workers and reduced FY 2017 FMAP rate).	21,430	26,045
E277	12	7000	Expand Check Up eligibility to include children of state workers.		31,612
E277	12	7000	Increase caseload to align with April 2015 projections.	89,449	120,756
E277	12	7000	Increase reimbursement rate for radiology and laboratory services (based on caseload including April 2015 projection and expanding eligibility to include children of state workers and reduced FY 2017 FMAP rate).	448,717	580,182
E513	12	7000	Eliminate decision units E513 and E913 - transfer of immunization costs from DPBH to DHCFP	(1,108,423)	(1,108,423)
E513	14	7000	Eliminate decision units E513 and E913 - transfer of immunization costs from DPBH to DHCFP	1,108,423	1,108,423
E913	12	7000	Eliminate decision units E513 and E913 - transfer of immunization	(110,927)	(19,337)

costs from DPBH to DHCFP		
Sub-total	6,351,645	9,836,007
Line Item Changes to Expenditures	6,351,645	9,836,007
Total	0	0
Grand Total General Fund Impact of Closing Changes	353,360	141,950

Overview

The Balanced Budget Act of 1997 created the state Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act to enable states to expand health care coverage targeted to low-income and uninsured children. Nevada's CHIP, called the Check Up program, is approved as a combination program that covers low-income, uninsured children who are not eligible for Medicaid from ages birth through 18 years from families with incomes up to 205 percent of the federal poverty level (FPL). Families pay quarterly premiums ranging from $0 to $80 based on household income and family size. Services are provided under a managed care arrangement with participating Managed Care Organizations (MCO) in Clark and Washoe Counties and on a fee-for-service basis in areas of the state where an MCO network does not exist. Enrollment in the program began in October 1998.

Major Closing Issues

1. Federal Title XXI Allotments
2. Check Up Caseload
3. Expand Check Up Eligibility
4. Provider Reimbursement Rate Increases
5. Autism Spectrum Disorder Coverage
6. Federal Medical Assistance Percentage Rate

Discussion of Major Closing Issues

1. Federal Title XXI Allotments: The federal component of the Check Up program is not an entitlement program like Medicaid and annual expenditures are capped at the federal level. Accordingly, states receive an annual allotment of federal Title XXI funding. In the Division of Health Care Financing and Policy, Title XXI funding supports the Check Up program in this budget, the Check Up to Medicaid population in the Medicaid budget, and associated administrative costs in the Administration budget. The following table displays Title XXI funding included in the Governor's recommended budget.

Title XXI Funding in the Governor's Recommended Budget		
Budget	FY 2016	FY 2017
Check Up Program	$ 24,053,247	$ 25,635,879
Medicaid	$ 25,486,148	$ 27,847,343
Administration	$ 1,190,051	$ 1,163,459
Totals	**$ 50,729,446**	**$ 54,646,681**

For comparison, the federal FY 2015 Title XXI allotment is $43.1 million, or 15 percent less than the $50.8 million included in The Executive Budget for FY 2016. The agency indicates that its federal FY 2016 Title XXI allotment will be $43.5 million, and the projected increase in Title XXI expenditures would be incorporated into the states federal FY 2017 allotment. However, the amount of the federal FY 2017 Title XXI allotment is unknown at this time.

In addition to the amount of Title XXI funding recommended in The Executive Budget, the Subcommittee expressed an interest in considering supporting projected Check Up caseload growth in the 2015-17 biennium (Major Closing Issue 2) and expanding Check Up eligibility to allow the children

of state employees to enroll (Major Closing Issue 3). The table below displays the total amount of Title XXI funding that would be needed by the Division, should the Subcommittee choose to recommend approval of these options.

Revised Title XXI Funding Projections		
	FY 2016	FY 2017
Check Up Program as Recommended by the Governor	$ 24,053,247	$ 25,635,879
Check Up caseload growth	$ 4,220,166	$ 4,631,075
Expand Check Up coverage to children of state employees	$ 1,154,343	$ 4,202,453
Medicaid, including caseload reprojections	$ 22,573,469	$ 24,963,080
Administration	$ 1,190,051	$ 1,163,459
Totals	**$ 53,191,276**	**$ 60,595,946**

Considering the amount of Title XXI funding included in The Executive Budget, the increase in projected Check Up caseload in the 2015-17 biennium and the Subcommittee's interest in expanding Check Up eligibility to allow the children of state employees to enroll in the program, Fiscal staff asked the agency whether Title XXI allotments would be sufficient to support program expenditures in the 2015-17 biennium. According to the agency's projections, which include revised Check Up caseload, Medicaid caseload, and expanding Check Up eligibility, the federal FY 2015 and federal FY 2016 allotments would be sufficient to support program expenditures through September 2016. The state would receive the federal FY 2017 Title XXI allotment in October 2016. The agency indicates that the state's level of Title XXI expenditures, including Medicaid expenditures and Check Up expenditures including any enrollment increase, would be taken into consideration by the federal government when determining the state's federal FY 2017 allotment amount.

As previously mentioned, states receive an annual Title XXI allotment. States have two years to spend their allotments, after which time unspent funds are redistributed to other states. If Nevada exhausted its Title XXI allotment, it could apply for an increase in Title XXI funding through this redistribution. Program costs related to Title XXI funding are federally funded at an enhanced federal medical assistance percentage (FMAP) rate. A provision in the Patient Protection and Affordable Care Act (ACA) temporarily increases the Check Up Enhanced FMAP rate by 23 percent beginning October 1, 2015. The increase is set to expire September 30, 2019. As a result of this FMAP increase, states will exhaust their federal CHIP allotments more quickly, making the availability of redistribution funds less likely.

The Subcommittee may wish to consider issuing a letter of intent, directing the agency to report to the Interim Finance Committee on its Title XXI allotment, including the amount of funding available and the amount of funding necessary to cover projected program expenditures.

Does the Subcommittee wish to issue a letter of intent, instructing the agency to report to the Interim Finance Committee quarterly on its Title XXI allotment?

The Subcommittee recommended issuing a letter of intent, instructing the agency to report to the Interim Finance Committee quarterly on its Title XXI allotment.

2. Check Up Caseload (M-200, DHHS-DHCFP-37): The Governor recommends funding reductions totaling $25.2 million ($1.0 million General Fund appropriation reduction) over the 2015-17 biennium to reduce Check Up monthly caseload to 13,974 in each year of the 2015-17 biennium, from the FY 2014 actual average monthly caseload of 21,771. The department's November 2014 projections, based on actual October 2014 caseload, showed Check Up caseload declining throughout FY 2015, from 24,062 actual cases in July 2014 to 13,974 in projected cases in June 2015.

Check Up caseload was projected to decrease due to recipients transitioning to other health care programs or choosing other health care coverage options. Specifically, provisions of the ACA transition certain Check Up recipients to Medicaid and make subsidized private health insurance available to families that are also eligible for Check Up through the Silver State Health Insurance Exchange. Children age 6 to 18 with family incomes between 123 and 138 percent of the FPL that were eligible for Check Up coverage prior to the ACA are now eligible for Medicaid coverage, referred to as the Check Up to Medicaid population. The number of Check Up recipients that transitioned to subsidized private insurance is unknown.

However, Check Up caseload decreases have not materialized to the degree originally anticipated. The most recent caseload projections, prepared in April 2015 based on March 2015 actual caseload, project monthly average Check Up caseloads of 16,670 in FY 2016 and 16,667 in FY 2017. The most recent caseload projections are approximately 19 percent higher than the caseload projections included in The Executive Budget for FY 2016 and FY 2017. The Subcommittee is reminded that the Check Up program is not an entitlement program and the state has the option of capping program enrollment and establishing a waiting list. The agency indicates that a state plan amendment would be required to implement an enrollment cap.

If the Subcommittee wishes to align funding in this budget with the most recent caseload projections, additional funding totaling $4.6 million ($337,249 General Fund appropriation) in FY 2016 and $4.8 million ($60,522 General Fund appropriation) in FY 2017 would be required in this budget, including other decision units in this budget.

The Subcommittee may wish to approve one of the following options:

a) **Approve monthly average Check Up caseload of 13,974 throughout the 2015-17 biennium as recommend in The Executive Budget and instruct the agency to seek a state plan amendment to cap program enrollment.**

b) **Approve monthly average Check Up caseload of 16,670 in FY 2016 and 16,667 in FY 2017 to align with the agency's most recent caseload projections, requiring additional General Fund appropriations of $397,771 over the 2015-17 biennium in the Check Up budget.**

The Subcommittee recommended increasing Check Up caseload to align with April 2015 projections.

3. Expand Check Up Eligibility: During the February 18, 2015, budget hearing, the Subcommittee expressed interest in exploring the possibility of expanding Check Up eligibility to allow state employees who meet existing Check Up income eligibility requirements to enroll their children in the Check Up program. Testimony by the agency at the budget hearing indicated that federal law prohibited the children of state employees from enrolling in the Check Up program prior to the passage of the ACA in 2010. Provisions in the ACA allows states to expand their CHIP programs to include children who have access to health insurance through a state's health insurance program. The state has not previously chosen to expand Check Up eligibility as allowed by the ACA.

   Provisions in the ACA gave states the option to expand Check Up eligibility to include the children of state employees if one of two conditions are met, including a maintenance of agency contribution condition (MOE) or a hardship condition. To meet the MOE condition, a state must demonstrate it has been consistently contributing to the cost of employee health care coverage since 1997. To meet hardship condition, a state must demonstrate that health care coverage currently available through the

Public Employees' Benefits Program's (PEBP) cost sharing requirements would exceed 5 percent of a family's income during the year the child would be enrolled in Check Up. The agency indicates that the state met these requirements in 2010 and believes that the state continues to meet these requirements. The state would be required to demonstrate that it currently meets one of the two conditions prior to expanding Check Up eligibility.

According to the agency, expanding Check Up eligibility to allow the children of state employees to enroll would require that the federal Center for Medicare and Medicaid Services approve a state plan amendment. Considering the time involved in gaining approval for a state plan amendment, the agency indicates that it would be reasonable to begin offering Check Up coverage to the children of qualifying state employees beginning January 2016. The Subcommittee should note that non-state governmental entities have the option to participate in PEBP. However, the agency indicates that eligibility could be restricted to include only the children of state employees.

Fiscal staff asked the Director's Office to project how many children of state employees would be eligible for the Check Up program if eligibility were expanded. Based on an analysis of state employee wage data, the Director's Office estimates that Check Up average monthly caseload would increase by 1,410 from January 2016 to June 2016 and by 2,373 in FY 2017 if Check Up eligibility were expanded. It should be noted that the state does not have access to employee family income data or comprehensive information about the number of children state employees have. However, the Director's Office caseload estimate appears reasonable, given the information available for calculating caseload projections.
Based on the Director's Office caseload projections, Fiscal staff calculates that additional funding totaling $1.3 million ($92,248 General Fund appropriation) in FY 2016 and $4.4 million ($54,963 General Fund appropriation) in FY 2017 would be required to expand Check Up eligibility to allow qualified children of state employees, beginning January 2016. The agency agrees with these projections.

Does the Subcommittee wish to expand Check Up eligibility to allow the children of state employees who meet income eligibility guidelines to enroll in the program, contingent upon Centers for Medicare and Medicaid Services approval of a state plan amendment, beginning in January 2016, including additional General Fund appropriations of $92,248 in FY 2016 and $54,963 in FY 2017?

The Subcommittee recommended expanding Check Up eligibility to allow the children of state employees to enroll beginning in January 2016, contingent upon the approval of a state plan amendment by the federal Centers for Medicare and Medicaid Services.

4. Provider Reimbursement Rate Increases (M-101, DHHS-DHCFP-36-37 and E-275 and E-277, DHHS-DHCFP-38): The Executive Budget recommends $2.0 million ($151,642 General Fund appropriation) in FY 2016 and $2.3 million ($29,756 General Fund appropriation) in FY 2017 for mandatory and discretionary provider rate increases. The recommended rate increases align Check Up provider reimbursement rates with provider rates recommended in the Medicaid budget. The policy issues surrounding the recommended rate increases are discussed in the closing document for the Medicaid budget. The recommended rate increases for this budget are described below.

   Mandatory Rate Increases – The Executive Budget recommends additional funding totaling $2.8 million ($107,247 General Fund appropriation) over the 2015-17 biennium for mandatory rate increases. MCO rates are recommended to increase by 2 percent in each year of the biennium, rates for Rural Health Centers and Federally Qualified Health Centers are recommended to increase by

2.05 percent in each year of the biennium, and inflation for pharmaceuticals is recommended at 2 percent in each year of the biennium.

Discretionary Rate Increases – The Executive Budget recommends additional funding totaling $1.5 million ($74,151 General Fund appropriation) over the 2015-17 biennium for discretionary rate increases. Beginning in FY 2016, the Governor recommends increasing reimbursement rates for physicians, physician assistants and nurse practitioners. The intent is to increase current rates, which are based on the 2002 Medicare fee schedule, to align more closely with rates in the current Medicare fee schedule. Beginning in FY 2017, the Governor recommends a 2.5 percent rate increase for acute inpatient hospital services.

Staff recommends that the Subcommittee approve or disapprove Check Up provider rate increases consistent with its actions in closing the Medicaid budget.

The Subcommittee recommended approval of discretionary provider rate increases consistent with its closing actions in the Medicaid budget.

5. Autism Spectrum Disorder Coverage (M-512, DHHS-DHCFP-37): The Governor recommends $1.9 million ($64,675 General Fund appropriation) to support costs associated with providing behavior intervention services to Check Up recipients. Recent federal policy changes require Medicaid to cover Autism Spectrum Disorder treatments. The Governor recommends providing the same coverage to Check Up recipients, as Nevada's federally approved Check Up state plan is designed to align services between the two programs. This issue is discussed in detail in the closing document for the Medicaid budget. Considering that the agency worked in conjunction with the Aging and Disability Services Division (ADSD) to set the amount of funding for Autism treatments budgeted in ADSD, Medicaid and this budget to align with the number of service providers expected to be available in the state in the 2015-17 biennium, Fiscal staff recommends that funding in this decision unit not be increased if the Subcommittee chooses to expand Check Up caseload beyond the level included in the Governor's recommended budget.

   Staff recommends that the Subcommittee approve or disapprove coverage for Autism Spectrum Disorder services consistent with its actions in closing the Medicaid budget.

   The Subcommittee recommended approval of the Governor's recommendation to provide coverage for Autism Spectrum Disorder services. The Subcommittee approved maintaining this decision unit at the level included in The Executive Budget to align statewide funding budgeted for Autism Spectrum Disorder services with the number of service providers that are expected to be available in the 2015-17 biennium.

6. Federal Medical Assistance Percentage (FMAP) Rate: As discussed in the closing document for the Medicaid budget, the Federal Funds Information for States (FFIS) released an issue brief on March 26, 2015, which indicated that the ACA Enhanced Check Up FMAP rate is projected to be slightly lower than the rate included in the Governor's recommended budget. Based on the information provided by FFIS, the FY 2017 blended ACA Enhanced Check Up FMAP rate is projected to be 98.68 percent, or 0.03 percent lower than was included in the Governor's recommended budget. According to the agency, the projected FY 2017 ACA Enhanced Check UP FMAP rate creates a General Fund shortfall of $7,981 in this budget. The FMAP decrease would also result in additional General Fund need of $820 in FY 2017 associated with increasing Check Up caseload (Major Closing Issue 2) and $223 associated with expanding Check Up eligibility (Major Closing Issue 3), over the amounts stated previously.

Does the Subcommittee wish to approve the revised FMAP rate, which would require additional General Fund appropriations of $7,981 over the biennium to address the shortfall and authorize staff to make any additional changes that may be necessitated by the Subcommittee's actions on Major Closing Issues 2 and 3?

The Subcommittee recommended approval of the revised FY 2017 FMAP rate projection.

Other Closing Item

Relocate Funding for Immunizations (E-513 and E-913, DHHS-DHCFP-39): With Decision Unit E-913, the Governor recommends transferring General Fund appropriations totaling $130,264 over the 2015-17 biennium to this budget from the Immunization budget in the Division of Public and Behavioral Health (DPBH) to transfer the state share of immunizations administered to Check Up recipients. Currently, the agency transfers federal funding to the DPBH for the purchase of vaccines provided to Check Up recipients. Beginning July 1, 2015, providers would bill DHCFP for these vaccines. Decision Unit E-513 places the federal share of immunization costs in the Program Medical Expenditures category rather than the Transfers to DPBH category. According to the agency, recent changes from the federal Centers for Disease Control and Prevention (CDC) regarding vaccine tracking requirements necessitated the recommended change.

On March 28, 2015, the Budget Office informed the Fiscal Analysis Division that it recommended Decision Units E-513 and E-913 be eliminated. The DHCFP developed a methodology that would allow it to capture data to meet CDC reporting requirements. Therefore, the current transfer of funding to the Immunization budget can continue. The Subcommittee should note that it approved retaining the transfer of funding to the DPBH in closing the Immunization budget on April 1, 2015. Accordingly, Fiscal staff has completed adjustments eliminating Decision Units E-513 and E-913 in this budget, as shown on the closing document. Fiscal staff has completed further technical adjustments to align transfers to DPBH with Check Up revenues budgeted in the Immunization budget. **Staff recommends that the Subcommittee approve eliminating Decisions Units E-513 and E-913, consistent with its decision in closing the DPBH Immunization budget.**

Does the Subcommittee wish to approve the Other Closing Item with the adjustment noted by staff and authorize staff to make further technical adjustments to this budget as necessary?

The Subcommittee recommended approving the Other Closing Item with the noted technical adjustment and authority for Fiscal staff to make further adjustments to the budget, as needed.

Title: HHS-HCF&P - INCREASED QUALITY OF NURSING CARE **Budget Page:** DHHS-DHCFP-34, **Volume II**

Account: 101 - 3160

Revenues	2013-14 Actual	2014-15 WP	% Chg	2015-16 GOV REC	% Chg	2016-17 GOV REC	% Chg
BALANCE FORWARD		900,000		900,000		900,000	
OTHER FUND	28,830,294	31,304,514	8.58	29,931,193	(4.39)	30,218,508	0.96
Total Revenues	28,830,294	32,204,514	11.70	30,831,193	(4.26)	31,118,508	0.93
Total FTE							

Adjustments to Revenue

Dec Unit	Cat	GL	Description	2015-16	2016-17
				Gov Rec	Gov Rec
Sub-total				0	0
Line Item Changes to Revenues				0	0

Adjustments to Expenditures

Dec Unit	Cat	GL	Description	2015-16	2016-17
				Gov Rec	Gov Rec
Sub-total				0	0
Line Item Changes to Expenditures				0	0
Total				0	0
Grand Total General Fund Impact of Closing Changes				0	0

Overview

The Increased Quality of Nursing Care budget account was created by the 2003 Legislature through the enactment of Assembly Bill (A.B.) 395. The bill instituted a methodology that requires the Division of Health Care Financing and Policy (DHCFP) to establish a provider tax program encompassing all free standing long term care facilities in Nevada (except those owned by the state). *Nevada Revised Statutes* (NRS) 422.3785 provides that funding received through the imposition of the provider tax, which is used to match federal Title XIX funds, must be applied to increasing reimbursement rates and cannot be used to replace existing state expenditures paid to long-term care facilities. *Nevada Revised Statutes* 422.3785 allows the division to use no more than 1.0 percent of the taxes collected to administer the provider tax program.

Federal rules require that health care-related taxes, such as the provider tax, be broad-based, uniform, and generally redistributive. Historically, the provider tax was established as a uniform rate equivalent of 6.0 percent of total annual gross revenues based on the number of days of care provided to non-Medicare patients. However, it was determined that the provider tax was not generally redistributive when a uniform tax rate was applied. Consequently, DHCFP obtained a federal waiver in 2011 for the uniformity requirement of the tax. The DHCFP now sets two tax rates not to exceed 6.0 percent of net patient revenue per quarter, with nursing facilities with a Medicaid occupancy rate greater than 65.0 percent paying a lower rate than nursing facilities with a Medicaid occupancy rate less than 65.0 percent. Tax rates are set using a statistical test to ensure that the tax is generally redistributive.

Major Closing Issues

There are no major issues for this budget. The Executive Budget continues the financing methodology for the nursing facility provider tax program approved by the 2013 Legislature. The Executive Budget indicates that the total nursing facility provider tax revenue available to provide the state share of supplemental payments would total $29.9 million in FY 2016 and $30.2 million in FY 2017. The Medicaid budget includes supplemental payments to long-term care facilities of $84.2 million and $86.2 million in FY 2016 and FY 2017, respectively.

Fiscal staff recommends that this budget be closed as recommended by the Governor, with authority for staff to make technical adjustments as necessary.

The Subcommittee recommended approving this budget as recommended by the Governor, with authority for Fiscal staff to make any necessary technical adjustments.

Title: HHS-HCF&P - NEVADA MEDICAID, TITLE XIX

Budget Page: DHHS-DHCFP-41, **Volume II**

Account: 101 - 3243

Revenues	2013-14 Actual	2014-15 WP	% Chg	2015-16 GOV REC	% Chg	2016-17 GOV REC	% Chg
BALANCE FORWARD	(1,380,710)	1,380,711	(200.00)				
FEDERAL FUND	1,364,492,510	2,205,211,996	61.61	2,311,061,671	4.80	2,373,119,461	2.69
GENERAL FUND	522,288,033	561,385,596	7.49	537,337,946	(4.28)	602,734,423	12.17
INTERAGENCY TRANSFER	116,157,545	175,063,279	50.71	183,604,804	4.88	158,327,119	(13.77)
OTHER FUND	25,924,481	29,629,730	14.29	26,116,987	(11.86)	26,230,551	0.43
Total Revenues	2,027,481,859	2,972,671,312	46.62	3,058,121,408	2.87	3,160,411,554	3.34

Total FTE

Adjustments to Revenue

Dec Unit	Cat	GL	Description	2015-16	2016-17
B000	00	2501	Offset General Fund appropriations with state net benefit resulting from projected increase in state DSH allotment due to provisions of the Medicare Access and CHIP Reauthorization Act of 2015.		(1,145,092)
B000	00	2501	Utilize FY 2015 state net benefit associated with enhanced MCO payment program to offset FY 2016 General Fund appropriations.	(2,984,229)	
B000	00	3501	Increase Title XIX funding to account for projected increase in state DSH allotment due to provisions of the Medicare Access and CHIP Reauthorization Act of 2015.		2,139,276
B000	00	4750	Adjust FY 2016 transfer from the IGT budget to account for FY 2015 state net benefit associated with enhanced MCO payment program.	2,984,229	
B000	00	4750	Adjust transfers from the IGT budget to account for projected increase in state DSH allotment due to provisions of the Medicare Access and CHIP Reauthorization Act of 2015.		2,281,885
B000	00	4750	Reduce revenues due to projected decrease in transfers to the IGT budget from the UPL Holding budget.	(115,912)	(112,208)
M101	00	2501	Adjust revenues to align with updated clawback payment projections.	(797,471)	2,462,427
M101	00	2501	Correct FY 2016 MCO maternity kick payment calculation for the TANF/CHAP category.	(204,982)	
M101	00	3511	Correct FY 2016 MCO maternity kick payment calculation for the TANF/CHAP category.	(647,186)	
M101	00	4103	Adjust revenues to align with updated clawback payment projections.	(7,221)	7,329
M200	00	2501	Reduce M200 decision unit to correct calculation error, which resulted in MCO mandatory rate increases included in both the M101 and M200 decision units.	(11,599,872)	(15,368,464)
M200	00	3501	Reduce M200 decision unit to correct calculation error, which resulted in MCO mandatory rate increases included in both the M101 and M200 decision units.	(2,296,600)	(2,693,958)
M200	00	3511	Reduce M200 decision unit to correct calculation error, which resulted in MCO mandatory rate increases included in both the M101 and M200 decision units.	(25,267,751)	(43,611,783)
M501	00	2501	Adjust decision unit M501 to correct savings calculation and to include anticipated reduction to SLMB caseload as a result of implementing the asset verification system.		(413,909)
M501	00	3511	Adjust decision unit M501 to correct savings calculation and to include anticipated reduction to SLMB caseload as a result of implementing the asset verification system.		(778,912)
E225	00	2501	Adjust preferred drug list savings to properly account for drug rebates.	(172,918)	(174,440)

E225	00	3511	Adjust preferred drug list savings to properly account for drug rebates.	(342,414)	(351,197)
E233	00	2501	Budget amendment A150643243 - New enhanced MCO payment program	(4,751,088)	(4,614,406)
E233	00	3511	Budget amendment A150643243 - New enhanced MCO payment program	55,256,404	53,464,843
E233	00	4750	Budget amendment A150643243 - New enhanced MCO payment program	15,632,815	16,280,566
E279	00	3511	Reduce revenues for IDRC waiver services rate increase to align funding with stated rate increase percentage.		(229,421)
Sub-total				24,685,804	7,142,536
Line Item Changes to Revenues				24,685,804	7,142,536

Adjustments to Expenditures

Dec Unit	Cat	GL	Description	2015-16	2016-17
B000	14	7000	Reduce revenues due to projected decrease in transfers to the IGT budget from the UPL Holding budget.	(115,912)	(112,208)
B000	28	7000	Increase DSH payments due to projected increase in state DSH allotment due to provisions of the Medicare Access and CHIP Reauthorization Act of 2015.		3,276,069
M101	12	7000	Correct FY 2016 MCO maternity kick payment calculation for the TANF/CHAP category.	(852,168)	
M101	28	7000	Adjust expenditures to align with updated clawback payment projections.	(804,692)	2,469,756
M200	11	7000	Reduce M200 decision unit to correct calculation error ,which resulted in MCO mandatory rate increases included in both the M101 and M200 decision units.	(2,480,131)	(2,728,213)
M200	12	7000	Reduce M200 decision unit to correct calculation error, which resulted in MCO mandatory rate increases included in both the M101 and M200 decision units.	(32,423,576)	(43,149,436)
M200	13	7000	Reduce M200 decision unit to correct calculation error, which resulted in MCO mandatory rate increases included in both the M101 and M200 decision units.	(4,260,516)	(15,796,556)
M501	14	7000	Adjust decision unit M501 to correct savings calculation and to include anticipated reduction to SLMB caseload as a result of implementing the asset verification system.		(1,192,821)
E225	12	7000	Adjust preferred drug list savings to properly account for drug rebates.	(59,481)	(60,670)
E225	13	7000	Adjust preferred drug list savings to properly account for drug rebates.	(24,231)	(24,716)
E225	14	7000	Adjust preferred drug list savings to properly account for drug rebates.	(388,751)	(396,525)
E225	15	7000	Adjust preferred drug list savings to properly account for drug rebates.	(17,999)	(18,359)
E225	19	7000	Adjust preferred drug list savings to properly account for drug rebates.	(24,870)	(25,367)
E233	12	7000	Budget amendment A150643243 - New enhanced MCO payment program.	30,905,218	31,173,557
E233	13	7000	Budget amendment A150643243 - New enhanced MCO payment program.	35,232,913	33,957,446
E279	18	7000	Reduce transfers to ADSD for IDRC waiver services rate increase to align funding with stated rate increase percentage.		(229,421)
Sub-total				24,685,804	7,142,536
Line Item Changes to Expenditures				24,685,804	7,142,536

Total	0	0
Grand Total General Fund Impact of Closing Changes	(20,510,560)	(19,253,884)

Overview

Medicaid is the state-administered program for medical assistance established in 1965 with passage of Title XIX of the Social Security Act. The Medicaid program purchases or provides medical services for low-income persons who meet certain eligibility criteria. Under federal Medicaid law, there are certain eligibility groups and benefits that must be covered by states. However, states are given discretion and flexibility to determine the various categories of benefits and the eligibility groups their Medicaid programs will cover. Nevada Medicaid covers low-income individuals, families, the elderly, and the disabled and has adopted optional benefit packages to be covered under its state plan. Nevada's Medicaid program currently covers approximately 20 percent of the state's population.

Overall total funding for the Medicaid program is recommended to increase to approximately $6.22 billion for the 2015-17 biennium, an increase of $1.81 billion when compared to the total funding legislatively approved for the 2013-15 biennium. General Fund support is recommended to increase to approximately $1.14 billion for the 2015-17 biennium, an increase of approximately $56.4 million, or 5.2 percent, when compared to the General Fund support approved by the 2013 Legislature for the 2013-15 biennium.

Major Closing Issues

1. Medicaid Caseload
2. Federal Medical Assistance Percentage (FMAP) Rates
3. Provider Reimbursement Rate Increases
4. Autism Spectrum Disorder Coverage
5. Cost Saving Measures
6. Increase Waiver Slots

Discussion of Major Closing Issues

1. Medicaid Caseload (M-200, DHHS-DHCFP-43): The Governor recommends additional funding of $632.7 million ($49.9 million General Fund appropriation) in FY 2016 and $674.0 million ($82.2 million General Fund appropriation) in FY 2017 to support increased medical service costs associated with projected Medicaid caseload growth over the 2015-17 biennium.

   The 2013 Legislature approved the Governor's recommendation to expand Medicaid eligibility to adults age 19 to 64 with household incomes up to 138 percent of the federal poverty level, as allowed by the Patient Protection and Affordable Care Act (ACA). Medicaid expansion was anticipated to increase average monthly Medicaid caseload by approximately 44,000 in FY 2014 and 131,000 in FY 2015. However, actual Medicaid caseload growth in the 2013-15 biennium far exceeded what was expected. In FY 2014, average monthly caseload was approximately 25,000 higher than was legislatively approved, at approximately 380,000 compared to the approved caseload of approximately 355,000. In FY 2015, the disparity between the legislatively approved caseload and projected caseload is expected to reach approximately 125,000, with a projected FY 2015 caseload of approximately 575,000 compared to the legislatively approved caseload of approximately 450,000.

   In the 2015-17 biennium, average monthly Medicaid caseload included in the Governor's recommended budget is projected to slightly decrease from the projected FY 2015 average monthly caseload of approximately 575,000 to approximately 570,000, according to the department's projections, which were prepared in November 2014 based on October 2014 actual enrollment. The department's November projections show Medicaid caseload peaking in October 2014 at approximately 608,000 and slightly declining throughout the remainder of FY 2015. Average monthly caseload was expected to stabilize at approximately 570,000 throughout the 2015-17 biennium, with projected monthly average caseloads of 570,711 and 570,062 in FY 2016 and FY 2017, respectively. It should be noted the department estimates that the majority of Nevadans eligible for Medicaid have enrolled in the program. In January 2015, the department indicated that just 32,469 people were eligible for

Medicaid, but were not enrolled in Nevada. Accordingly, the department does not expect the considerable Medicaid caseload growth experienced during the 2013-15 biennium to continue.

As in past legislative sessions, the agency has re-projected Medicaid caseload and cost per eligible (CPE) using the most recent actual caseload and cost data. These revised caseload and CPE projections are typically used as a guide to make adjustments to the Medicaid budget as recommended by the Governor. The agency provided the Fiscal Analysis Division revised Medicaid caseload and CPE projections for the 2015-17 biennium on April 8, 2015, based on February 2015 actual caseload and cost data.

The revised caseload projections show total Medicaid average monthly caseload higher than was previously projected. The projected monthly caseloads for the Newly Eligible, Medical Assistance to Aged, Blind and Disabled (MAABD), County Indigent and Child Welfare populations are higher than previously projected, while the monthly average caseloads for the Check Up to Medicaid and the Temporary Assistance for Needy Families/Children's Health Assurance Program (TANF/CHAP) populations are lower than previously projected. The table below compares the total Medicaid average monthly caseload projections included in the Governor's recommended budget and the revised caseload projections.

Actual and Projected Average Monthly Medicaid Caseload, FY 2014 - FY 2017

	FY 2016 Gov. Rec.	FY 2016 Revised	% Variance	FY 2017 Gov. Rec.	FY 2017 Revised	FY 2017 % Variance
Caseload *	570,711	587,831	3.0%	570,062	577,330	1.3%

*Caseload includes retroactive eligibility and does not include Special Low-Income Medicare Beneficiaries (SLMB, Medicare recipients with incomes between 100% and 120% of the federal poverty level. Medicaid pays Medicare Part B insurance premiums for these recipients.).

The costs associated with the projected caseload increases noted above are largely offset by projected decreases in the fee-for-service CPEs for the TANF/CHAP, MAABD and Child Welfare populations. Fiscal staff asked the agency what factors are contributing to the projected CPE decreases and the agency indicated that projected CPEs change monthly, based on actual caseload and costs incurred. The agency indicated that retroactive eligibility adjustments were also made, resulting in a lower CPE. According to the agency, based on the revised caseload and CPE projections, Medicaid General Fund expenditures are projected to increase by approximately $3.1 million over the 2015-17 biennium, as compared to the amounts included in *The Executive Budget*. This projection includes other decision units in this budget.

In reviewing the agency's caseload and cost per eligible recalculation, Fiscal staff determined that the projected Waiver caseload used in the recalculation was understated and asked the agency to provide updated calculations. The agency's recalculations resulted in additional General Fund expenditures totaling $449,221 over the 2015-17 biennium. The projected General Fund increase would be $3.5 million over the 2015-17 biennium after correcting for the understated Waiver caseload. This adjustment is not reflected on this closing document.

During the April 16, 2015, work session, the Subcommittee asked the agency why Medicaid caseload projections had increased from the projection included in the Governor's recommended budget since the agency indicated that caseload was projected to remain relatively flat during the February 18, 2015, budget hearing. The agency indicated that Medicaid caseload projections included in The Executive Budget were slightly understated due to the fact that a high number of eligibility redeterminations were processed just prior to completing the caseload projections included in the Governor's recommended budget. A number of individuals that were dropped from the Medicaid

caseload during the redetermination process subsequently reapplied and returned to the Medicaid caseload, resulting in a slight increase in caseload projected for the 2015-17 biennium.

Technical adjustment: In reviewing supporting documentation for this budget, Fiscal staff determined that projected expenditures in this decision unit were overstated because mandatory rate increases for managed care organizations that are included in the M-101 decision unit are also included in this decision unit. The agency agreed that it was reasonable to remove MCO mandatory rate increase costs from this decision unit. The technical adjustment results in cost decreases totaling $39.2 million ($11.6 million General Fund appropriation) in FY 2016 and $61.7 million ($15.4 million General Fund appropriation) in FY 2017, as shown on this closing document. This adjustment was calculated based the agency's corrected March 2015 caseload and cost per eligible projection.

Does the Subcommittee wish to approve the revised Medicaid caseload and CPE projections, requiring additional General Fund appropriations totaling $3.1 million over the 2015-17 biennium, representing the costs across all decision units, with the noted technical adjustments, including additional General Fund totaling $449,221 over the 2015-17 biennium to properly account for the Waiver caseload and General Fund savings totaling $27.0 million over the 2015-17 biennium to correct an error that double-counted Managed Care Organization mandatory rate increases?

The Subcommittee recommended approving the revised caseload and cost per eligible projections with the noted technical adjustments, resulting in a net General Fund decrease of $23.5 million over the biennium.

2. Federal Medical Assistance Percentage (FMAP) Rates: The federal government pays states for a specified percentage of Medicaid program expenditures. This percentage is referred to as the FMAP rate. The remainder of Medicaid program expenditures, known as the state share, is funded by General Fund appropriations, intergovernmental transfers, local governmental expenditures, and provider taxes. The standard FMAP rate for each state is determined annually based on a three-year average of the state per capita income compared to the national average per capita income. As the state's per capita income rises compared to the national average, the state's FMAP decreases, and vice versa. FMAP rates have a floor of 50 percent, and certain Medicaid populations and services are eligible for enhanced FMAP rates.

   Based on information included in a March 26, 2015, issue brief prepared by Federal Funds Information for States (FFIS), an independent organization that tracks and reports on the fiscal impact of federal budgetary and policy decisions on state budgets and programs, the FY 2017 blended standard FMAP rate (a blended rate is calculated using the federal fiscal year FMAP rates to align with state fiscal year budgeting) is projected to be 65.25 percent, or 0.05 percent lower than the FMAP rate included in The Executive Budget. The ACA Enhanced Check Up blended FMAP rate is projected to be 98.68 percent, or 0.03 percent lower in FY 2017 than was included in the Governor's recommended budget. It should be noted that the blended FMAP rate for the Newly Eligible Medicaid population remains unchanged from the rate included in The Executive Budget, at 100 percent for FY 2016 and 97.50 percent for FY 2017.

   According to calculations prepared by the agency, the projected decrease in FY 2017 FMAP rates creates a General Fund shortfall of $921,436 in the Medicaid budget in FY 2017. This adjustment is not reflected on this closing document. The following table displays the blended FMAP rates included in the Governor's recommended budget and the revised FY 2017 blended FMAP rates, along with the FY 2015 blended rate for comparative purposes.

Blended FMAP Rates, FY 2015 - FY 2017					
FMAP Type	Related Eligibility Groups	FY 2015	FY 2016	FY 2017 Gov Rec	FY 2017 Revised
Standard FMAP	Traditional Medicaid (Temporary Assistance for Needy Families/Children's Health Assurance Program (TANF/CHAP); Medical Assistance to the Aged, Blind, and Disabled (MAABD); Waiver; County Indigent; Child Welfare)	64.05%	64.76%	65.30%	65.25%
Newly Eligible FMAP	Newly Eligible Medicaid	100.00%	100.00%	97.50%	97.50%
Enhanced Check Up FMAP *	Check Up to Medicaid	74.83%	92.60%	98.71%	98.68%

* A provision in the Patient Protection and Affordable Care Act (ACA) temporarily increases the Enhanced Check Up FMAP rate by 23 percent beginning October 1, 2015. The increase is set to expire September 30, 2019.

The decrease in the blended FMAP rates for FY 2017 is a projection at this time. The official federal FY 2017 FMAP rates will be released by the federal Department of Health and Human Services in the fall of 2016. Historically, the Governor and the Legislature have used FMAP rate projections prepared by FFIS in developing and modifying the division's budgets because FFIS is widely recognized for the accuracy and reliability of the information and data it publishes.

Does the Subcommittee wish to approve the revised FMAP rates for FY 2017, requiring additional General Fund appropriations of $921,436 in FY 2017, across all decision units in this budget?

The Subcommittee recommended approving the revised FY 2017 FMAP projections.

3. Provider Reimbursement Rate Increases: The Executive Budget recommends additional funding totaling $240.3 million ($59.7 million General Fund appropriation) over the 2015-17 biennium to support increased costs resulting from mandatory and discretionary medical service reimbursement rate increases, as described below.

   Mandatory Rate Increases (M-101, DHHS-DHCFP-42): The Executive Budget recommends $44.0 million ($12.4 million General Fund appropriation) in FY 2016 and $71.3 million ($16.7 million General Fund appropriation) in FY 2017 for federally mandated reimbursement rate increases for Medicaid providers. The mandatory Medicaid rate increases include Managed Care Organizations (MCO), Federally Qualified Health Centers, Rural Health Centers, Indian Health Services, hospice services, and prescription drugs. The table below displays the mandatory annual rate increase percentages by provider type.

Recommended Mandatory Provider Rate Increases		
Provider Type	FY 2016	FY 2017
Managed Care Organizations	2.00%	2.00%
Rural Health Centers and Federally Qualified Health Centers	2.05%	2.05%
Indian Health Services	6.96%	6.96%
Hospice Services	3.90%	4.00%
Prescription Drugs	2.00%	2.00%

Technical Adjustments to Mandatory Rate Increases

Clawback: On April 14, 2015, FFIS released an issue brief, which indicated that state clawback payments are projected to increase, beginning in 2016. The Medicare Modernization and Improvement Act (MMA) of 2003 enacted prescription drug coverage for Medicare recipients, known as Medicare Part D. The MMA requires states to reimburse Medicare for the costs of providing prescription drug coverage to individuals who are eligible for both Medicare and Medicaid (known as dual eligibles). This reimbursement is referred to as the clawback. The state's clawback payment is calculated based on the number of dual eligibles and state's per capita expenditures for prescription drugs covered by Medicare Part D.

Considering the FFIS issue brief, Fiscal staff asked the agency to reproject clawback payments for the 2015-17 biennium. Based on the agency's re-projections, Fiscal staff has completed technical adjustments to this decision unit, shown on the closing document, to align budgeted clawback payments with the updated projections, resulting in a net General Fund appropriation increase of $1.7 million over the 2015-17 biennium.

MCO Maternity Payments: The state pays MCOs a supplemental payment for the care of pregnant women, known as a maternity kick payment. Fiscal staff determined that the agency's July to December 2015 maternity kick payments were overstated due to a calculation error. Fiscal staff has completed technical adjustments, shown on this closing document, to correct the calculation error, resulting in savings totaling $852,168 ($204,982 General Fund appropriation) in FY 2016. This adjustment was calculated based the agency's March 2015 caseload and cost per eligible projection. The agency agrees that this technical adjustment is reasonable.

Does the Subcommittee wish to approve mandatory rate increases as recommended by the Governor with the noted technical adjustments, including additional General Fund appropriations of $1.7 million over the 2015-17 biennium for clawback payments and General Fund savings of $204,982 in FY 2016 to correct a calculation error?

The Subcommittee recommended approving mandatory rate increases as recommended by the Governor, with the noted technical adjustments.

Discretionary Rate Increases: The Governor recommends $37.6 million ($8.9 million General Fund appropriation) in FY 2016 and $87.3 million ($21.8 million General Fund appropriation) in FY 2017 for discretionary provider reimbursement rate increases. Beginning in FY 2016, the Governor recommends increasing reimbursement rates for physicians, physician assistants and certified nurse practitioners. Beginning in FY 2017, the Governor recommends increasing reimbursement rates for acute inpatient hospital services, home-based nursing services, and for Individuals with Intellectual Disabilities and Related Conditions (IDRC) waiver services. The discretionary reimbursement rate increases are discussed individually below.

- Physician, Physician Assistant and Certified Nurse Practitioner Rate Increase (E-277, DHHS-DHCFP-51): Additional funding totaling $97.8 million ($23.2 million General Fund appropriation) is recommended over the upcoming biennium to increase reimbursement rates for physicians, physician assistants and certified nurse practitioners beginning in FY 2016. The intent is to increase current rates, which are based on the 2002 Medicare fee schedule, to align more closely with rates in the 2014 Medicare fee schedule. According to the agency, the recommended funding would result in a 10 percent increase in the aggregate in the amount the division pays for physician, physician assistant and certified nurse practitioner services. The Subcommittee should

note that the 2013 Legislature approved a temporary Primary Care Physician (PCP) supplemental payment as required by the ACA for the 2013-15 biennium, which is set to expire on June 30, 2015.

The agency indicates that the reimbursement rate increase would not apply equally to all medical services provided by physicians, physician assistants and certified nurse practitioners. Rather, the reimbursement rate for some services would increase and the reimbursement rate for other services would decrease. The table on the following page shows the percentage the agency estimates revised reimbursement rates would vary from the current reimbursement rates, excluding the temporary PCP supplemental payment, and the percentage of the 2014 Medicare fee schedule the revised reimbursement rates would be set at, by service type.

Physician, Physician Assistant, and Certified Nurse Practitioner Reimbursement Rate Changes

	FY 2016		FY 2017	
Service Type	**% of 2014 Medicare Fee Schedule**	**% Change ***	**% of 2014 Medicare Fee Schedule**	**% Change ***
Surgery	95%	-4.5%	95%	-4.5%
Obstetrics	95%	-6.9%	95%	-6.9%
Radiology	90%	-25.6%	94%	-22.3%
Laboratory	50%	-48.7%	50%	-48.7%
Vaccine	85%	4.6%	85%	4.6%
Medicine	85%	2.2%	85%	2.2%
Evaluation and Management	90%	38.4%	95%	46.1%

* Percentage change is from the FY 2015 rate excluding the temporary Primary Care Physician Supplemental Payment and is not cumulative.

According to the agency, Nevada has a statewide primary care shortage and Medicaid has to compete with other payer sources for access to services. Considering the stated provider shortage and the pending expiration of the temporary PCP supplemental payment, the division indicates its focus is on increasing access for primary care services. Accordingly, the recommended reimbursement methodology was intended to focus on primary care reimbursement rates, shown in the table above as evaluation and management services.

Fiscal staff asked the agency whether the temporary PCP supplemental payment has increased recipient access to primary care services. In a March 18, 2015, follow-up memo, the agency indicated that at the time the PCP supplemental payment was implemented, there were 1,170 PCP providers. As of March 2015, the agency indicates that there were 1,365 providers, an increase of 17 percent.

During the budget hearing, the Subcommittee expressed concern that the reimbursement rates for radiology and laboratory services would decrease. Additionally, the Subcommittee expressed concern that the reimbursement rate for evaluation and management would decrease from the current reimbursement level, which includes a temporary increase due to the supplemental payment. For example, reimbursement for a primary care service office visit is currently $75 with the temporary supplemental payment. Reimbursement for the same service is recommended in The Executive Budget to be $67 in FY 2016 and $71 in FY 2017.

The agency indicates that the reimbursement rate for radiology services is recommended to be 90 percent and 94 percent of the 2014 Medicare fee schedule in FY 2016 and FY 2017, respectively. To maintain radiology rates at the current level, which is above the 2014 Medicare fee schedule, the agency indicates that additional funding totaling $71.2 million ($17.1 million General Fund appropriation) would be required over the 2015-17 biennium beyond the amounts included in The Executive Budget. The agency indicates that Medicaid is currently reimbursing providers above the upper payment limit (UPL), which is the amount Medicare reimburses providers

for the same service, for radiology services. In 2014, the agency estimates that Medicaid paid 23 percent over the UPL amount for radiology services. The agency also notes that paying over the UPL amount for radiology services would not provide equity among reimbursement methodologies for services provided by physicians. Accordingly, the agency does not recommend maintaining reimbursement rates for radiology at the current level. However, the agency indicates it would be reasonable to increase the radiology reimbursement rate to 100 percent of the 2014 Medicare fee schedule, requiring additional funding totaling $22 million ($5.3 million General Fund appropriation) over the 2015-17 biennium.

The agency also indicates that the reimbursement rate for laboratory services is recommended to be 50 percent of the 2014 Medicare fee schedule in the 2015-17 biennium. In a March 18, 2015, follow-up memo, the agency indicated that the laboratory reimbursement rate decrease was unintentional. The agency stated that if it would have recommended to set the laboratory services reimbursement rate at 95 percent of the 2014 Medicare fee schedule, the additional cost would be $12.5 million ($3.0 million General Fund appropriation) over the 2015-17 biennium beyond the amount included in The Executive Budget. Setting the reimbursement rate for laboratory services at 85 percent of the 2014 Medicare fee schedule would require additional funding totaling $10.4 million ($2.6 million General Fund appropriation) over the biennium, while setting the reimbursement rate at 100 percent of the Medicare fee schedule would cost $13.5 million ($3.2 million General Fund appropriation) over the biennium.

The agency further indicates that the reimbursement rate for evaluation and management services is recommended to be 90 and 95 percent of the 2014 Medicare fee schedule in FY 2016 and FY 2017, respectively. During the budget hearing, the agency noted that certain services currently qualify for the previously mentioned temporary Primary Care Physician (PCP) supplemental payment as required by the ACA for the 2013-15 biennium, which is set to expire on June 30, 2015. The recommended evaluation and management reimbursement rates for the 2015-17 biennium would be lower than the current reimbursement rates for certain services, when including the PCP supplemental payment. The agency indicates that setting the evaluation and management reimbursement rate at 100 percent of the 2014 Medicare fee schedule would require additional funding totaling $51.9 million over the 2015-17 biennium beyond the amounts included in The Executive Budget. The agency indicates the General Fund cost would be $13.3 over the biennium, calculated at the standard FMAP rate. Considering the 100 percent FMAP associated with the Newly Eligible population, Fiscal staff calculates a $12.4 million General Fund appropriation for this option. The agency indicates that another option would be to continue the current ACA primary care physician supplemental payment and maintain the rates for other physician, physician assistant and certified nurse practitioner services at the current level, at an additional cost of $5.0 million ($3.0 million General Fund appropriation) over the biennium.

Based upon previous Subcommittee discussions regarding provider rate adjustments, the Subcommittee may wish to consider the following options:

a) **Approve physician, physician assistant, and certified nurse practitioner reimbursement rate increases as recommended by the Governor, including additional General Fund appropriations of $23.2 million over the 2015-17 biennium; or**

b) **Approve physician, physician assistant, and certified nurse practitioner rates as recommended by the Governor, including additional General Fund appropriations of $23.2 million over the 2015-17 biennium, modified to include one or a combination of the following options:**

i. **Maintain radiology reimbursement rates at the current level above the 2014 Medicare fee schedule, requiring additional General Fund appropriations of $17.1 million;**

ii. **Set radiology reimbursement rates at 100 percent of the 2014 Medicare fee schedule, compared with the 90 and 94 percent level in FY 2016 and FY 2017, respectively, recommended by the Governor requiring additional General Fund appropriations of $5.3 million over the 2015-17 biennium;**

iii. **Increase the laboratory reimbursement rate above the 50 percent of the 2014 Medicare fee schedule recommended by the Governor to:**

   A. **85 percent of the 2014 Medicare fee schedule, requiring additional General Fund appropriations of $2.6 million over the 2015-17 biennium;**

   B. **95 percent of the 2014 Medicare fee schedule, requiring additional General Fund appropriations of $3.0 million over the 2015-17 biennium;**

   C. **100 percent of the 2014 Medicare fee schedule, requiring additional General Fund appropriations of $3.2 million over the 2015-17 biennium;**

iv. **Increase the evaluation and management reimbursement rate from the 90 and 95 percent of the 2014 Medicare fee schedule in FY 2016 and FY 2017, respectively, to 100 percent of the Medicare fee schedule, requiring additional General Fund appropriations of $12.4 million over the 2015-17 biennium.**

c) **Continue the ACA primary care physician supplemental payment and maintain reimbursement rates for other services as the current levels, requiring additional General Fund appropriations of $3.0 million over the 2015-17 biennium.**

d) **Disapprove the physician, physician assistant, and certified nurse practitioner rate increases as recommended by the Governor.**

The Subcommittee recommended approving physician, physician assistant, and certified nurse practitioner rate increases as recommended by the Governor, with additional rate increases to align the reimbursement rate for radiology services with 100 percent of the 2014 Medicare fee schedule (option B(ii)) and to align the reimbursement rate for laboratory services with 95 percent of the 2014 Medicare fee schedule (option b(iii)(B)), including additional General Funds totaling $8.3 million over the biennium.

- Acute Inpatient Hospital Rate Increase (E-275, DHHS-DHCFP-50 & 51): Additional funding of $14.4 million ($4.4 million General Fund appropriation) in FY 2017 is recommended to increase the reimbursement rate for acute inpatient hospital services by 2.5 percent beginning in FY 2017. The agency indicates that the acute inpatient hospital rate increase is intended to partially rectify previous reimbursement rate decreases. In FY 2009, inpatient hospital reimbursement rates were reduced by 5 percent as a cost-saving measure to address a statewide budget shortfall.

  The agency indicates that the 2.5 percent increase applies to acute inpatient hospital services in the aggregate rather than a 2.5 percent increase to each individual service. The agency intends to work with the Nevada Hospital Association to target rate increases to ensure access to care for Medicaid recipients.

Based upon previous Subcommittee discussion, if the Subcommittee wishes to begin the acute inpatient hospital services 2.5 percent rate increase in FY 2016 rather than FY 2017, additional funding totaling $15.0 million, including $4.6 million in General Fund appropriations, would be required.

If the Subcommittee wishes to increase the acute inpatient hospital services by 2.5 percent in FY 2016 and an additional 2.5 percent in FY 2017 (5.06 percent cumulative increase from the FY 2015 level), additional funding totaling $30.0 million, including $9.2 million in General Fund appropriations, would be required.

If the Subcommittee wishes to increase the acute inpatient hospital services reimbursement rate by 5 percent beginning in FY 2016, additional funding totaling $44.5 million, including $13.7 million in General Fund appropriations, would be required.

The Subcommittee may wish to consider the following options:

a) Increase the reimbursement rate for acute inpatient hospital services by 2.5 percent beginning in FY 2017 as recommended by the Governor; or

b) Increase the reimbursement rate for acute inpatient hospital services by 2.5 percent beginning in FY 2016, requiring additional General Fund appropriations of $4.6 million in FY 2016; or

c) Increase the reimbursement rate for acute inpatient hospital services by 2.5 percent in FY 2016 and an additional 2.5 percent in FY 2017, requiring additional General Fund appropriations of $9.2 million over the 2015-17 biennium; or

d) Increase the reimbursement rate for acute inpatient hospital services by 5 percent beginning in FY 2016, requiring additional General Fund appropriations of $13.7 million over the 2015-17 biennium; or

e) Disapprove the Governor's recommendation to increase the reimbursement rate for acute inpatient hospital services.

The Subcommittee recommended approving option c, to increase the reimbursement rate for acute inpatient hospital services by 2.5 percent in FY 2016 and an additional 2.5 percent in FY 2017, including additional General Funds totaling $9.4 million over the biennium. The Subcommittee recommended issuing a letter of intent, instructing the agency to report to the Interim Finance Committee on options for providing Medicaid reimbursement for telemedicine, community paramedicine and community health worker services.

- Home-Based Nursing Services Rate Increase (E-278, DHHS-DHCFP-52): Additional funding of $8.8 million ($3.0 million General Fund appropriation) is recommended in FY 2017 to increase the reimbursement rate for nursing services provided in the home by 25 percent in the aggregate beginning in FY 2017. The agency indicates that it is currently experiencing access to care issues with home-based nursing services, putting recipients at risk of institutionalization. According to the agency, home-based nursing service providers have indicated that their costs for providing home-based nursing services amount to approximately $65.00 per hour, while Medicaid reimburses providers $47.48 per hour for these services. Accordingly, providers indicate that they lose money when serving Medicaid recipients, and the agency indicates providers have been refusing to serve Medicaid recipients.

Does the Subcommittee wish to approve increasing the reimbursement rate for home-based nursing services by 25 percent beginning in FY 2017, as recommended by the Governor?

The Subcommittee recommended approving the Governor's recommendation to increase the reimbursement rate for home-based nursing services by 25 percent beginning in FY 2017.

- Intellectual Disabilities and Related Conditions (IDRC) Waiver Services Rate Increase (E-279, DHHS-DHCFP-52): Additional federal funding of $3.8 million is recommended in FY 2017 to increase the reimbursement rate for IDRC waiver service providers by 5.7 percent. The narrative in The Executive Budget incorrectly states the rate increase as 7.5 percent. The funding would be transferred to the Aging and Disability Services Division (ADSD), which reimburses providers for medical services provided to waiver recipients. The General Fund appropriation associated with this rate increase, which totals $3.9 million over the 2015-17 biennium, is contained in ADSD budgets. According to information attached to the budget, ADSD currently pays IDRC waiver service providers an average reimbursement rate of $18.86, compared with the average direct Medicaid provider reimbursement rate of $25.00 for the same services. The recommended 5.7 percent increase would bring the average IDRC waiver reimbursement rate to $19.94 in FY 2017, or 20 percent less than the direct Medicaid reimbursement rate. The ADSD indicates that waiver service providers in urban areas have closed or significantly reduced the numbers of Medicaid recipients served and that it has difficulties retaining qualified providers in rural areas of the state.

  The ADSD indicates that increasing waiver reimbursement rates would allow providers to offer more competitive salaries and benefits, which would increase employee retention and provide consistency in the care provided. Fiscal staff asked the ADSD how the new rates would entice providers to remain in business given the proposed rates would still be lower than the average Medicaid rates for the same services. The agency responded that providers have recognized the leadership at the division and how the division has worked to obtain an increase to their rate when few other provider types receive an increase. The ADSD further indicates the providers continue to work to develop new ways to deliver cost effective services.

  Fiscal staff notes that the 5.7 percent rate increase was calculated using a higher waiver caseload than was ultimately recommended in The Executive Budget. As a result, the funding recommended in this decision unit would support a provider rate increase of approximately 6.0 percent in FY 2017, rather than the stated 5.7 percent rate increase. In closing the Aging and Disability Services Division budgets on May 1, 2015, the Subcommittee approved an IDRC waiver services rate increase of 5.7 percent based on the caseload in The Executive Budget. Fiscal staff has completed technical adjustments, shown on page 2 of this closing document, to reduce funding by $229,421 in FY 2017 to correct the miscalculation included in the Governor's recommended budget.

  Fiscal staff recommends the Subcommittee approve an Intellectual Disability and Related Conditions Waiver Services rate increase of 5.7 percent in FY 2017, consistent with its previous action. Fiscal staff requests authority for further technical adjustments necessary to align this decision unit with corresponding decision units in Aging and Disability Services budgets.

The Subcommittee recommended approving the Governor's recommendation to increase the reimbursement rate for Intellectual Disability and Related Conditions Waiver Services by 5.7 percent in FY 2017, with the noted technical adjustment.

According to information produced by the Director's Office in April 2015, approximately 64 percent of Medicaid recipients received care through a MCO in March 2015. The recommended rate increases for physicians, physician assistants, certified nurse practitioners, acute inpatient hospital services and home-based nursing services would be provided to the MCOs through an increase in the per person per month capitation rate. However, the Subcommittee should note that the division does not have direct control on reimbursement rates paid to providers by the MCOs.

As previously noted, the majority of the reimbursement rate increases are intended to address access to health care issues that Medicaid recipients are experiencing. Currently, the agency has anecdotal information provided by recipients, providers and staff indicating that Medicaid recipients are experiencing difficulty accessing health care. However, the agency indicates that it is currently working with a vendor to complete an access to a health care study. The study will include a secret shopper survey to examine whether fee for service and managed care Medicaid recipients are able to readily obtain health care appointments. In a March 18, 2015, follow-up memo, the agency indicated that the study is expected to be complete in May 2015.

Nevada's Medicaid state plan, an agreement between the state and the federal government, which describes how the state administers its Medicaid program, specifies payment methodologies for medical service providers. Modifications to the Medicaid state plan require approval from the federal Centers for Medicare and Medicaid Services (CMS). The agency plans to submit the state plan amendment for the proposed reimbursement rate increases with an effective date of July 1, 2015.

4. <u>Autism Spectrum Disorder Coverage (M-512, DHHS-DHCFP-46)</u>: The Governor recommends $14.2 million ($5.0 million General Fund appropriation) in FY 2016 and $28.4 million ($9.8 million General Fund appropriation) in FY 2017 to support medical service costs associated with implementing <u>a recent federal mandate that requires states to provide medically necessary behavior intervention services for Medicaid recipients under age 21 with Autism Spectrum Disorder</u>. The division already provides coverage for a number of other interventions for Autism Spectrum Disorder, including occupational therapy, physical therapy and speech therapy. The Governor has identified expanding services for children with Autism Spectrum Disorder as a Major Budget Initiative for the 2015-17 biennium (MAJOR BUDGET INITIATIVES-20). Additional funding for this initiative is included in Aging and Disability Services Division budgets.

   On July 7, 2014, CMS issued policy guidance to states indicating that Medicaid must provide the full array of medically necessary services to children with Autism Spectrum Disorder under the program's federally mandated Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) provision. States are required to provide any Medicaid coverable service that is medically necessary to address any physical or behavioral condition under EPSDT for Medicaid recipients up to age 21. The policy guidance indicated that certain services that were previously not considered to be coverable by Medicaid were now coverable. In particular, the guidance indicates that behavior intervention services are now coverable by Medicaid. To address the federal mandate to cover behavior intervention services, the agency is proposing to implement an applied behavior analysis (ABA) benefit for Medicaid recipients up to age 21. The ABA is an evidence-based behavior intervention service, which is intended to increase useful behaviors and reduce behaviors that may be harmful or that interfere with learning in order to bring about meaningful behavior change.

   The Centers for Medicare and Medicaid Services has not established a deadline for states to comply with the Autism Spectrum Disorder mandate, but directed states to work expeditiously in order to avoid delaying providing medically necessary services to children with Autism Spectrum Disorder. In order to implement ABA service coverage for Medicaid, the agency must establish a new provider type, develop coverage policies and procedures, develop a state plan amendment, receive CMS approval for the

state plan amendment and coverage policies, and implement Medicaid Management Information System programming changes. The agency indicates that it intends to begin covering ABA services in January 2016.

According to information presented to the Legislative Commission's Budget Subcommittee on January 21, 2015, Autism Spectrum Disorder affects 1 in 68 children and over 6,000 children in Nevada have an Autism Spectrum Disorder diagnosis. The Executive Budget indicates that approximately 1,900 children would receive Autism Spectrum Disorder services funded through the division in the upcoming biennium, including approximately 250 children projected to receive Medicaid-funded services through the ADSD's Autism Treatment Assistance Program in the 2015-17 biennium.

Applied behavior analysis is an intensive treatment program, which generally requires a significant number of hours of treatment weekly. The following table shows the average number of hours per week of provider services necessary for Autism Spectrum Disorder treatment by recipient age group, based on information received from the ADSD Autism Treatment Assistance Program, along with the projected annual cost per child.

Projected ABA Services by Age Group		
Age Group	Hours of Service Per Week	Projected Annual Cost per Child
2-6	44.5	$ 56,596
7-11	24.5	$ 30,596
12-21	14.5	$ 17,596

Given the large number of hours of service required to provide services to children with Autism Spectrum Disorder, staff asked the agency whether the provider network would be sufficient to provide services to children in a timely manner. The agency indicated that there are currently 173 licensed or registered ABA specialized service providers in Nevada. Additionally, unlicensed paraprofessional providers may provide certain ABA direct services under the direction of a licensed provider. These direct service providers would not be able to directly bill Medicaid. In addition, licensed psychologists also provide ABA services. The number of licensed psychologists currently in Nevada with Autism Spectrum Disorder treatment as part of their scope of practice is unknown as this is not tracked. It is also unknown how many ABA service providers would be willing to enroll as a Medicaid provider. The agency indicates that the projected budget for ABA services was reduced by 50 percent due to projected provider sufficiency issues.

The Subcommittee should note that the costs associated with providing ABA services to Medicaid recipients are estimates at this time. The agency projected ABA service costs for the 2015-17 biennium based on information provided by the ADSD Autism Treatment Assistance Program. However, actual service costs could vary from projected costs depending upon the procedure codes and reimbursement methodology that is ultimately approved by CMS. Additionally, the costs in this decision unit have been reduced to account for a service ramp-up period and a projected provider shortage. The decision unit also includes a cost reduction due to a projected decrease in basic skills training service utilization. The agency anticipates that basic skills training service utilization would decrease after Medicaid implements ABA coverage, because it is thought that children with Autism Spectrum Disorder that currently receive basic skills training would transition to ABA services once coverage is implemented. The Subcommittee should note that Medicaid is an entitlement program and that the agency could incur costs beyond the amount budgeted if the assumptions used when calculating the ABA services budget do not materialize as anticipated.

According to the ADSD, there are currently enough providers and licensed psychologists in the state to serve approximately 2,400 children, and there are projected to be a sufficient number of providers for the recommended caseloads for both the Medicaid ABA benefit and the Autism Treatment Assistance Program during the 2015-17 biennium.

Assembly Bill 6
Assembly Bill 6, as currently amended, may ease ABA direct service provider adequacy issues to some degree by simplifying and streamlining ABA service provider certification. As amended, the bill would eliminate state-level certification of certified autism behavior interventionists and provide for national-level credentialing of registered behavior technicians, paraprofessionals who deliver behavior intervention services under the direction of a licensed higher-level provider. If A.B. 6 is enacted, the number of ABA direct service providers may increase beyond the number anticipated at the time The Executive Budget was proposed. However, the magnitude of any such provider increase is unknown at this time. The Assembly passed the bill on April 21, 2015, and it was introduced and referred to the Senate Committee on Commerce, Labor and Energy on April 23, 2015.

Does the Subcommittee wish to approve $5.0 million General Fund appropriation in FY 2016 and $9.8 million General Fund appropriation in FY 2017 coverage for applied behavior analysis services, as recommended by the Governor?

The Subcommittee recommended approving the Governor's recommendation to provide coverage for applied behavior analysis services, effective January 2016, to address a recent federal mandate requiring states to provide behavior intervention services to children with Autism Spectrum Disorder.

The Subcommittee may wish to consider issuing a letter of intent, directing the agency to report on the implementation of the Applied Behavior Analysis benefit, including caseload, provider enrollment, and actual costs incurred.

Does the Subcommittee wish to approve issuing a letter of intent, directing the agency to report quarterly on its implementation of the Applied Behavior Analysis Benefit?

The Subcommittee recommended approving issuing a letter of intent for the agency to report to the Interim Finance Committee on the implementation of applied behavior analysis services.

5. Cost Saving Measures: The Governor recommends reducing funding by $51.3 million ($17.4 million General Fund appropriation) in FY 2016 and $65.3 million ($22.1 million General Fund appropriation) in FY 2017 biennium to implement a number of cost saving measures in Medicaid, as described below.

   - Health Care Guidance Program Savings (E-227, DHHS-DHCFP-47 & 48): Funding reductions totaling $38.0 million ($13.3 million General Fund appropriation) are recommended for cost reductions resulting from implementing the Health Care Guidance Program (HCGP). The HCGP requires certain fee-for-service Medicaid recipients with chronic conditions who are not otherwise required to enroll in managed care organization to enroll in a contracted care management organization (CMO) in order to improve patient health and reduce medical expenditures.

     The CMO works with recipients and providers to coordinate and manage the health care of the high-risk Medicaid recipients, resulting in medical service savings. The CMO conducts a comprehensive assessment and regular reassessment of enrolled recipients to develop and maintain a plan of care. The CMO operates eight care management designs, including disease management, care management, oncology care coordination, chronic kidney disease, mental

health program, pregnancy care coordination, complex condition care and health care coordination. The CMO aims to improve quality of care, health outcomes, recipient satisfaction, and cost reductions.

The division worked with CMS for some time to obtain approval for a demonstration waiver to allow the enrollment of fee-for-service recipients in a CMO. The 2011 Legislature approved implementing a care management program for the aged, blind and disabled, which was projected to result in General Fund savings totaling $15.75 million over the 2011-13 biennium. The division submitted a waiver application to CMS on April 20, 2012; however, CMS did not approve the waiver until June 28, 2013, and the division was unable to realize the projected savings in the 2011-13 biennium. Due to the delay in receiving CMS approval for the waiver, the legislatively approved budget for 2013-15 did not contain projected CMO-related savings. The waiver was approved as a five-year project effective July 1, 2013, and allows up to 41,500 Medicaid recipients to be enrolled in a CMO.

The contractor, which receives a $15.35 per member per month capitation rate for providing services, began enrolling recipients in the HCGP CMO in June 2014. According to the agency, approximately 38,000 recipients in the Temporary Assistance for Needy Families/Children's Health Assurance Program (TANF/CHAP) and the Medical Assistance to Aged, Blind, and Disabled (MAABD) eligibility categories are currently enrolled in the HCGP CMO. The agency projects that medical service costs for recipients participating in the HCGP would decrease by 5 percent, generating the savings recommended in this decision unit, which are net of capitation costs. According to the agency, the 5 percent reduction in medical service costs was projected by its actuary. The division believes the savings projection is reasonable.

Fiscal staff asked the agency whether any information exists regarding cost savings realized since the program was implemented 2014. The agency indicates that there is not sufficient information to determine whether the HCGP has generated savings to date. However, the division's actuary will review the HCGP after one year and determine the amount of savings attributable to the program.

It should be noted that the agency's contract with the HCGP CMO vendor contains a pay-for-performance provision, which provides the HGCP CMO vendor an annual bonus if medical service cost savings are realized in excess of capitation payments. The contract indicates that the HGCP CMO vendor is entitled to a bonus of 50 percent of generated cost savings net of capitation costs, with an annual bonus cap of 50 percent of capitation costs. However, it does not appear that bonus payments to the HGCP CMO are included in the budget. Staff asked the agency whether it is likely that the agency would be responsible for an incentive payment, and the agency did not indicate that it would be necessary to budget for an incentive payment.

Does the Subcommittee wish to approve savings totaling $38.0 million, including $13.3 million in General Fund appropriations, associated with the Health Care Guidance Program?

The Subcommittee recommended approving the Governor's recommendation for cost savings totaling $38.0 million associated with the Health Care Guidance Program.

- Provider Rate Reductions: Funding reductions totaling $12.1 million ($3.2 million General Fund appropriation) are recommended over the 2015-17 biennium to reduce the rates for two providers, as described below.

- Dental Fluoride Reimbursement Rate Reduction (E-228, DHHS-DHCFP-48): The rate for dental fluoride is recommended to be reduced from $53.30 to $15.00, a 72 percent decrease, resulting in savings of $2.0 million ($701,431 General Fund appropriation) over the biennium. According to the agency, the dental fluoride rate is recommended to be reduced because the agency determined that Medicaid is overpaying for this service. Medicaid is currently reimbursing providers above the upper payment limit (UPL), which is the amount Medicare reimburses providers for the same service, for dental fluoride services. The agency indicates that the UPL for dental fluoride is $12.30, and the current Medicaid reimbursement rate is $53.30. The agency does not anticipate that the recommended rate reduction would create access to care issues for recipients. Fiscal staff asked the agency if there was information available regarding the amount private insurance companies reimburse for dental fluoride services. The agency indicated that insurance reimbursement levels are proprietary and cannot be disclosed. However, the agency indicated that it confirmed that the proposed reimbursement rate was reasonable with one insurance company.

  Does the Subcommittee wish to approve reducing the reimbursement rate for dental fluoride services, including General Fund savings of $701,431 over the 2015-17 biennium?

  The Subcommittee recommended approving reducing the reimbursement rate for dental fluoride services, as recommended by the Governor.

- Non-Emergency Transportation Capitation Rate Reduction (E-230, DHHS-DHCFP-49): The per member per month capitated rate for the state's contracted non-emergency transportation broker, which arranges transportation for Medicaid recipients to medically necessary services, is recommended to be reduced by $0.75 per member per month, generating savings of $10.1 million ($2.5 million General Fund appropriation) over the biennium. The agency indicates that its contract with the non-emergency transportation broker specifies that the capitation rate administrative allowance is not to exceed 25 percent of the broker's costs of providing services.

  As discussed above in Major Closing Issue 1 (Medicaid Caseload), Medicaid caseload significantly increased during the 2013-15 biennium. However, the agency indicates that service utilization for non-emergency transportation services has remained relatively flat. Since the broker is compensated at a per member per month capitation rate and its costs have been flat, the broker's profit margin has increased beyond the contracted percentage. The budgeted capitation rate for the 2013-15 biennium was $3.30 per member per month. Effective January 1, 2014, the capitation rate was reduced to $2.19 per member per month. The recommended $0.75 per member per month decrease would result in a per member per month rate capitation rate of $1.44. According to the agency, it intends to amend the contract retroactive to January 1, 2015, as soon as FY 2014 cost data is finalized.

  Does the Subcommittee wish to approve reducing the non-emergency transportation broker capitation rate, to align with existing contract provisions, including General Fund savings of $2.5 million over the 2015-17 biennium?

The Subcommittee recommended approval of the Governor's recommendation to reduce the non-emergency transportation broker capitation rate to align with existing contract provisions.

- Projected Medical Service Utilization Reductions (E-226, DHHS-DHCFP-47 and E-232, DHHS-DHCFP-50): Funding reductions totaling $35.4 million ($12.4 million General Fund

appropriation) over the 2015-17 biennium are recommended for cost savings associated with decreased utilization for personal care services and basic skills training. Utilizations for personal care services and basic skills training are projected to decrease as a result of policy changes that have already been implemented by the agency.

- Personal Care Services (E-226) are services provided to recipients to assist, support, and maintain recipients independently in the home environment and include assistance with bathing, walking, meal preparation, eating, and light housekeeping. In 2011, the agency implemented a functional assessment process for personal care services to ensure that the provision of services was limited to recipients having a specific medical need. Due to concerns raised by advocates, the division placed a moratorium on reducing personal care services for recipients that were receiving services at that time. The division lifted the moratorium in August 2014, and all recipients are now required to have a functional assessment to qualify for personal care services. The agency anticipates that fewer units of service would be authorized in the future, resulting in a 5 percent decrease in utilization. The agency projects that savings totaling $8.4 million ($2.9 million in General Fund appropriation) would result from this policy change in the 2015-17 biennium.

  Does the Subcommittee wish to approve General Fund savings totaling $2.9 million over the 2015-17 biennium associated with policy changes for personal care services?

The Subcommittee recommended approval of the Governor's recommendation for savings associated with policy changes for personal care services.

- Basic Skills Training (E-232) are interventions designed to reduce cognitive and behavioral impairments and teach recipients a variety of life skills including self-care skills, social skills, communication skills, and time management. In January 2014, the agency implemented a prior authorization requirement for basic skills training and restricted services to a maximum of two hours per day. The agency's projected utilization reductions are based on an analysis of prior authorizations that were denied after the policy change was implemented. Savings totaling $27.0 million ($9.4 million General Fund appropriation) are projected to result from this policy change in the 2015-17 biennium.

  On May 4, 2015, the Legislative Counsel Bureau Audit Division released a performance audit of the agency's controls to detect and prevent fraud, waste, abuse, and billing errors that result in Medicaid overpayments. The audit found a number of overpayments for basic skills training services and noted that the agency has not established a process to ensure compliance with daily service limits. In particular, the audit indicates that the Medicaid Management Information System (MMIS) does not currently have a mechanism in place to limit basic skills training services to a certain number of hours per day. Testimony by the agency at the May 4, 2015, meeting of the Legislative Commission's Audit Subcommittee indicated that it would have to evaluate whether it would be cost effective to modify the MMIS to limit basic skills training services to a certain number of hours per day.

  Considering the findings of the recent audit and the limitations of the MMIS, Fiscal staff asked the agency whether the savings included in The Executive Budget for basic skills training are likely to materialize to the degree budgeted. The agency replied that it is certain that the budgeted savings will be realized.

  Does the Subcommittee wish to approve General Fund savings totaling $9.4 million over the 2015-17 biennium associated with policy changes for basic skills training services?

The Subcommittee recommended approving the Governor's recommendation for savings associated with policy changes for basic skills training services.

- Implement Asset Verification Information System (M-501, DHHS-DHCFP-45): Funding reductions of $12.2 million ($4.2 million General Fund appropriation) are recommended in FY 2017 for cost savings associated with implementing a federally mandated electronic asset verification system in the Division of Welfare and Supportive Services (DWSS) for aged, blind and disabled Medicaid (MAABD) recipients (M-501, DHHS-DWSS-16). The electronic asset verification system would be used by DWSS eligibility staff to verify that MAABD recipients do not have assets that would disqualify them from Medicaid coverage at the time of Medicaid application and annual eligibility redetermination. The agency anticipates that the asset verification process would reduce the MAABD caseload by 5 percent, equating to a projected MAABD monthly caseload reduction of 1,591 in FY 2017. The agency indicates that the 5 percent MAABD caseload reduction was estimated by the DWSS, based on information from other states that have already implemented the electronic asset verification system.

  Based on a review of the federal law mandating the electronic verification system, it appears that the state would be required to verify the assets of Special Low Income Medicare Beneficiaries (SLMB), Medicare recipients with income between 100 and 120 percent of the federal poverty level for who Medicaid pays the Medicare Part B premiums. However, a reduction in SLMB caseload is not included in this decision unit. Fiscal staff asked the agency whether asset verification would apply to the SLMB caseload, and the agency indicated that it would. The agency further indicated that it would be reasonable to include savings associated with a 5 percent reduction in the SLMB caseload in this decision unit. In FY 2017, savings associated with a 5 percent reduction in the SLMB caseload would result in General Fund savings of $252,326. In addition, the agency's original savings calculation for FY 2017 was based on FY 2016 caseload, understating General Fund savings by $161,583. Fiscal staff has completed a technical adjustment, shown on the first page of this closing document, to reflect these two items, which result in additional General Fund savings of $413,909, bringing total FY 2017 General Fund savings to $4.6 million.

  Does the Subcommittee wish to approve savings associated with implementing a federally mandated asset verification system, with the noted technical adjustments, contingent upon the approval of Decision Unit M-501 in the DWSS Administration budget?

The Subcommittee recommended approving savings associated with implementing the electronic asset verification system as recommended by the Governor, with the noted technical adjustments.

- Continue Expansion of the Preferred Drug List (E-225, DHHS-DHCFP-46 & 47): Funding reductions of $2.6 million ($867,683 General Fund appropriation) are recommended over the 2015-17 biennium for savings associated with continuing the expansion of the division's Preferred Drug List. The Preferred Drug List is a method of encouraging or emphasizing the prescribing, dispensing and reimbursement of specific prescription drugs for particular treatments. Medicaid recipients may receive non-preferred prescription drugs upon prior authorization if specified criteria are met. Temporary provisions in NRS 422.4025, set to expire July 1, 2015, currently allow Medicaid to include typical and atypical antipsychotics, anticonvulsants, and antidiabetic medications on its Preferred Drug List, thereby reducing the cost of these medications. Senate Bill 422, as amended, currently in the Senate Committee on Finance, would delay the expiration of the temporary provisions in NRS 422.4025 until June 30, 2017.

Fiscal staff has completed technical adjustments, shown on the first page of this closing document, to correct an error in the agency's savings calculation, which overstated the amount drug rebates would decrease as a result of lower prescription drug costs. As a result of this correction, total savings in this decision unit would be $3.7 million over the 2015-17 biennium, including $1.2 million in General Fund savings. The agency agrees with this correction.

Does the Subcommittee wish to approve savings totaling $3.7 million over the 2015-17 biennium, including the noted technical adjustments, associated with continuing the expanded Preferred Drug List in the 2015-17 biennium, contingent upon the passage and approval of Senate Bill 422?

The Subcommittee recommended approving savings associated with continuing the expansion of the Preferred Drug List with the noted technical adjustments, as recommended by the Governor, contingent upon the approval of Senate Bill 422.

- Increase Third Party Liability Recoveries (E-231, DHHS-DHCFP-49 & 50): Funding reductions totaling $11.7 million ($4.1 million General Fund appropriation) are recommended over the 2015-17 biennium for recovering funding from other entities that are legally responsible for paying for medical services provided to Medicaid recipients. According to federal law, Medicaid is the payer of last resort. If another program or insurer has a responsibility to pay for medical costs incurred by a Medicaid recipient, that entity is generally required to pay the cost of the claim prior to Medicaid making any payment, known as third-party liability. Examples of third parties that may be liable to pay for services include private health insurance, Medicare, employer-sponsored health insurance, settlements from a liability insurer, workers' compensation and long-term care insurance. The division is federally mandated to contract with a recovery audit contractor (RAC) to identify Medicaid overpayments, including overpayments related to third-party liability. The agency indicates that the budgeted third-party liability recovery amount is based on estimates provided by its RAC. The General Fund savings included in this decision unit are calculated based on applying the standard FMAP rate to the total amount recovered and does not take the Newly Eligible FMAP rate into consideration.

  Does the Subcommittee wish to approve savings totaling $11.7 million over the 2015-17 biennium associated with third-party liability recoveries, as recommended by the Governor?

The Subcommittee recommended approving the Governor's recommendation for savings associated with increased third party liability recoveries.

- Increase Improper Payment Recoveries (M-502, DHHS-DHCFP-45 and E-229, DHHS-DHCFP-48 & 49): Funding reductions of $4.5 million ($1.4 million General Fund appropriation) are recommended for increased recoupment of improper payments associated with recommended increases in program integrity staff in the Administration budget. The Governor's recommended budget includes eight new positions for the agency's Surveillance and Utilization Review section. The agency anticipates that the increase in Surveillance and Utilization Review section staffing would result in the identification and recovery of additional Medicaid payments that are fraudulent, abusive or non-compliant with established billing procedures.

  Does the Subcommittee wish to approve savings of $4.5 million over the biennium associated with recommended increases in Surveillance and Utilization Review section staffing, contingent upon its decisions regarding additional staffing in the Administration budget?

The Subcommittee recommended approving funding reductions to reflect increased recoupment of improper payments, with authority for technical adjustments to align budgeted savings with the Subcommittee's closing actions in the Administration budget.

Considering the magnitude of cost-saving measures included in The Executive Budget, the Subcommittee may wish to consider issuing a letter of intent directing the agency to report to the Interim Finance Committee on the degree to which cost savings materialize over the 2015-17 biennium, including savings associated with the Health Care Guidance Program with basic skills training and personal care services policy changes, and with caseload reductions resulting from the Asset Verification system.

Does the Subcommittee wish to issue a letter of intent directing the agency to report to the Interim Finance Committee semiannually on cost savings realized during the 2015-17 biennium, including savings associated with the Health Care Guidance Program, savings associated with basic skills training and personal care services policy changes, and caseload reductions resulting from the Asset Verification system?

The Subcommittee recommended issuing a letter of intent directing the agency to report to the Interim Finance semiannually on cost savings realized during the upcoming biennium.

6. Increase Waiver Slots (M-201, M-202, and M-203, DHHS-DHCFP-43–45): The Governor recommends $1.1 million ($350,041 General Fund appropriation) in FY 2016 and $3.7 million ($1.0 million General Fund appropriation) in FY 2017 for increased medical services costs associated with expanding the number of waiver slots for the division's three approved Medicaid home and community based services waiver programs. Home and community-based waiver programs allow Medicaid recipients that would otherwise likely be institutionalized to receive long-term care services in home and community settings. Federal regulations require that waiver services be a cost neutral alternative to institutional care, meaning that it is more cost effective for the state to expand waiver services for recipients than to incur the cost of institutionalizing recipients over the long term. The waiver slot increases would be phased in over the 2015-17 biennium. The number of waiver slots is recommended to increase as follows:

   - Waiver for Persons with Physical Disabilities (WIN) Waiver (M-201): Increase waiver slots for the WIN waiver by 51, from 754 to 805 over the 2015-17 biennium, a 6.8 percent increase. According to information obtained from Caseload Evaluation Organization (CLEO), periodic caseload reports produced by the Department of Health and Human Services, actual March 2015 WIN caseload was 720, with a waitlist of 85. In March 2015, the agency reports that 48 percent of those on the waitlist have been waiting more than 90 days for services.

     The agency indicates that the WIN waiver wait list is divided into three levels of priority. The 2013 Legislature approved 175 new WIN waiver slots, which the agency indicates reduced the priority one and priority two waitlists and decreased the amount of time individuals waited to access services. The agency indicates that the recommended waiver slot increase would decrease the priority three waitlist as well as provide for anticipated caseload growth. In March 2015, the agency indicated that 70 of the 85 people on the wait list were priority three.

     Does the Subcommittee wish to approve increasing WIN waiver slots by 51 over the 2015-17 biennium?

- Intellectual Disabilities and Related Conditions (IDRC) Waiver (M-202): Increase waiver slots for the IDRC waiver (previously known as the MRRC waiver) by 93, from 2,030 to 2,123 over the 2015-17 biennium, a 4.6 percent increase. According to information obtained from CLEO, actual March 2015 IDRC waiver caseload was 1,924, with a wait list of approximately 716. In closing the Rural Regional Center, Desert Regional Center, and Sierra Regional Center budgets on May 1, 2015, the Subcommittee approved increasing IDRC waiver slots.

- Home and Community Based Waiver (HCBW) for the Frail Elderly (M-203): Increase waiver slots for the HCBW for the Frail Elderly by 173 over the 2015-17 biennium, from 1,884 to 2,057, a 9.2 percent increase. It should be noted that the HCBW for the Frail Elderly was merged with the Assisted Living (AL) waiver during the 2013-15 biennium. The narrative in The Executive Budget omits the merged AL caseload from its discussion of this waiver caseload, resulting in a discrepancy between the caseload indicated above and the caseload indicated in The Executive Budget. According to information obtained from CLEO, actual March 2015 HCBW for the Frail Elderly caseload was 1,729, and the wait list was 609. The Subcommittee approved additional staffing in ADSD to support the recommended HCBW for the Frail Elderly caseload increase in closing the Home and Community Based Services budget on May 1, 2015.

  Staff recommends that the Subcommittee approve waiver slot increases for the IDRC and HCBW for the Frail Elderly, consistent with its previous closing actions.

The Subcommittee recommended approving waiver slot increases for the Waiver for Persons with Physical Disabilities, Intellectual Disabilities and Related Conditions Waiver, and the Home and Community Based Waiver for the Frail Elderly, as recommended by the Governor.

Other Closing Items

1. Disproportionate Share Hospital (DSH) Payments: The Medicare Access and CHIP Reauthorization Act of 2015, signed by the President on April 16, 2015, contains a provision which delays the implementation of DSH allotment reductions to FY 2018. Accordingly, Fiscal staff asked the agency to re-project FY 2017 DSH payments and associated state net benefit. The revised projections indicate that FY 2017 DSH payments would increase to from $75.1 million to $78.3 million, receipts from counties in support of the DSH program would increase from $44.5 million to $46.8 million, and the state net benefit would increase from $26.8 million to $28.0 million. Fiscal staff has completed technical adjustments, shown on this closing document, to the base budget to reflect these changes, including a General Fund reduction of $1.1 million in FY 2017 to account for the increase in state net benefit. **This adjustment appears reasonable.**

2. Budget Amendment A150643243: On March 31, 2015, the Governor submitted budget amendments for the Intergovernmental Transfer Program budget and this budget to continue a new enhanced payment for Managed Care Organizations in the 2015-17 biennium. The enhanced payment program is further discussed in the closing document for the Intergovernmental Transfer budget. The budget amendment results in General Fund reductions of $4.8 million in FY 2016 and $4.6 million in FY 2017 due to the state net benefit of the enhanced payment program. The budget amendment is reflected on this closing document. **This recommendation appears reasonable, contingent upon the approval of Budget Amendment A1506333157 in the Intergovernmental Transfer Program budget.**

Informational Item – No Action Required

Supplemental Appropriation (INTRODUCTION-19): The Executive Budget recommends a General Fund appropriation of $527,872 to support increased medical services costs associated with a caseload that is higher than was legislatively approved during the 2013-15 biennium. On March 19, 2015, the agency

informed Fiscal staff that the Supplemental Appropriation was no longer needed. **This item is informational only; no action is required.**

Fiscal staff recommends that the Other Closing Items be approved as recommended by the Governor with the noted technical adjustments.

Fiscal staff requests authority to make further necessary technical adjustments to this budget.

The Subcommittee recommends approving the Other Closing Items as recommended by the Governor, including Budget Amendment A150643243 and the noted technical adjustments, with authority for Fiscal staff to make any necessary technical adjustments.