Welfare System in Nevada

Legislative Counsel Bureau

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WELFARE SYSTEM IN NEVADA

BULLETIN NO. 93-21

LEGISLATIVE COMMISSION

OF THE

LEGISLATIVE COUNSEL BUREAU

STATE OF NEVADA

SEPTEMBER 1992

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SUMMARY OF RECOMMENDATIONS

This summary represents the conclusions and recommendations reached by the subcommittee. The conclusions and recommendations are based on: (1) testimony and suggestions made to the subcommittee from representatives of various organizations involved in the delivery of welfare services, a representative from the National Conference of State Legislatures (NCSL) and others attending the public hearings who are familiar with welfare services in Nevada at the state and local levels; (2) the experience and knowledge of the members of the subcommittee; (3) research by the subcommittee members and staff; and (4) other correspondence, studies and materials made available to the subcommittee.

The subcommittee's recommendations/actions are as follows:

1. The subcommittee recommended the Welfare Division proceed with a freedom of choice waiver (1915b) request to the Health Care Financing Administration (HCFA) to mandate statewide Medicaid recipient enrollment in a primary care case management program and waive statewideness and comparability of service requirements.

2. The subcommittee recommended that the 1993 Legislature, by resolution, urge the United States Congress to approve the Medicaid Managed Care Improvement Act (S.B. 2077). This proposed legislation would allow states significant flexibility in developing Medicaid managed care programs. (BDR R-785)

3. The subcommittee recommended and endorsed the Aid to Dependent Children (ADC) "fill the gap" budgeting concept. "Fill the gap" budgeting allows ADC recipients to retain earned income (earned income from employment only) without reducing their ADC grant payment, until the combined maximum ADC grant plus earnings reach 100 percent of the Nevada need standard. In support of this recommendation the subcommittee:

   A. Requested the Welfare Division include the "fill the gap" budgeting methodology and costs in the Division's 1993-95 biennial ADC budget request;

   B. Directed staff to draft a memorandum to the Director, Department of Human Resources, requesting the Department's cooperation to include the ADC "fill the gap" budgeting methodology in the Welfare Division's 1993-95 biennial ADC budget request.

   C. Recommended legislation which would incorporate the ADC "fill the gap" budgeting methodology for earned income only into the Welfare Division's ADC grant determination and eligibility process. (BDR 38-784)

4. The subcommittee endorsed the "concept" of increasing maximum ADC payments to 100 percent of need by the year 2000.

5. The subcommittee recommended to endorse the "concept" of restoring payment of ADC benefits retroactive to the date the ADC application was received versus the date ADC eligibility is determined.

6. The subcommittee recommended the Welfare Division compile and prepare a biennial ADC characteristics study to coincide with the Executive Budget process and legislative budget review cycles.

7. The subcommittee recommended the Welfare Division, county social service directors and the Nevada Association of Counties initiate a dialogue to further study the feasibility of establishing an Emergency Assistance program. The subcommittee's intent was for these entities to develop a viable program, tailored to meet in the most efficient and cost effective manner while maximizing available funding resources the needs as they exist at the state and local levels.

8. The subcommittee recommended the adoption of presumptive eligibility which is an option in the Medicaid program that allows states to establish presumptive and continuous eligibility criteria for pregnant women. The subcommittee's intent was to create expedited, easy and early access to pre-natal care for potentially eligible Medicaid clients. (BDR 38-786)

9. The subcommittee endorsed for consideration during the upcoming Executive Budget and legislative budget review process to expand the coverage threshold for the Child Health Assurance Program (CHAP) (which provides Medicaid coverage to pregnant women and children) to a higher percentage of poverty than the federal mandated minimum coverage level of 133 percent of poverty currently supported in Nevada.

10. The subcommittee recommended the state/county shared responsibility for funding the Medicaid long-term care program up to the federal allowable maximum (300 percent SSI) be continued. However, the subcommittee recommended adjusting the state's current maximum coverage threshold of $714 with an annual cost-of-living increase (COLA) using a recognized cost-of-living index.

11. The subcommittee recommended the Welfare Division enter into a 1634 agreement with the Social Security Administration (SSA) whereby the SSA would make Medicaid determinations for Supplemental Security Income (SSI) recipients. This subcommittee recommendation will not expedite the eligibility determination process. However, the recipient would not be required to formally complete duplicate applications for Medicaid at the SSA and Welfare Division offices; would eliminate the need for the Welfare Division case workers to process Medicaid applications for SSI recipients; and assures the maximum Medicaid coverage would be available to the SSI recipient retroactive to the date of formal application.

12. The subcommittee recommended further study be conducted to determine if an optional deduction for nursing home residents receiving Medicaid called a "home maintenance allowance," is a viable cost effective measure worthy of future consideration. The optional home maintenance allowance provision

allows the Medicaid agency to deduct from total income an amount for maintenance of the individual's or couple's home if certain conditions are met.

13. The subcommittee recommended to completely eliminate the budget funding "caps" currently placed on the Welfare Division's Aid to Dependent Children, Food Stamps, Medicaid and Employment and Training Program budgets for the upcoming 1993-95 biennium.

14. The subcommittee recommended the creation of a statewide human resources planning committee to function in an advisory capacity, providing assistance, advice and direction on human services issues and human services long-range planning. The intent of the subcommittee was to establish an advisory committee whose membership consists of diverse backgrounds and orientation to provide guidance in continuing the development and refinement of a statewide human services master plan. (BDR 38-787)

15. The subcommittee recommended to endorse support for legislation to be sponsored by Clark County Social Services which eliminates single employables and employable childless couples from mandatory county financial aid.

16. The subcommittee recommended the Department of Human Resources explore all avenues in attempting to re-structure and develop a provider tax program maximizing state benefits for the upcoming biennium which will conform to federal provider tax rules and regulations.

17. The subcommittee recommended that the 1993 Legislature, by resolution urge the U.S. Congress to evaluate the implications and/or ramifications legislation will potentially have on maintaining family stability and family unity. (BDR R-783)

REPORT TO THE 67th SESSION OF THE NEVADA LEGISLATURE BY THE LEGISLATIVE COMMISSION'S SUBCOMMITTEE TO CONDUCT AN INTERIM STUDY OF THE WELFARE SYSTEM IN NEVADA

This report is submitted in compliance with Assembly Concurrent Resolution No. 16 (file No. 0179, Statutes of Nevada, 1991) which directed the Legislative Commission to conduct an interim study of the welfare system in Nevada. The resolution requires that the results of the study and any recommended legislation be reported to the 67th Session of the Nevada Legislature.

The legislative members of the subcommittee appointed to conduct the study were:

Assemblywoman Vivian L. Freeman, Chairman
Senator Diana M. Glomb, Vice Chairman
Senator William R. O'Donnell
Senator Ron Cook (resigned)
Assemblywoman Myrna T. Williams
Assemblyman Joan A. Lambert
Assemblyman Wendell P. Williams
Assemblyman Phil Stout

Legislative Counsel Bureau staff services for the subcommittee were provided by: Steve Abba, Program Analyst; Mark Stevens, Assembly Fiscal Analyst; Thomas Linden, Senior Deputy Legislative Counsel; Jane Juve, Deputy Legislative Counsel; and Secretary Terry Cabauatan of the Fiscal Analysis Division.

This report represents the findings and recommendations of the subcommittee. The subcommittee, during the course of holding five (5) meetings, received considerable testimony and reviewed a great deal of information concerning the delivery of welfare services in Nevada, and has attempted in this report to present its findings and recommendations briefly and concisely. The information which relates directly to the subcommittee's recommendations is included either in the narrative or in the appendices. All supporting documents and meeting minutes are on file in the Fiscal Analysis Division of the Legislative Counsel Bureau. The subcommittee wishes to recognize and thank the many people who attended and participated in the meetings of the subcommittee for their cooperation and assistance in conveying invaluable information and expertise on welfare services in Nevada.

Respectfully submitted,

Legislative Commission
Legislative Counsel Bureau
State of Nevada

Carson City, Nevada
September 1992

I. INTRODUCTION AND BACKGROUND

The 66th Session of the Nevada Legislature, adopted Assembly Concurrent Resolution No. 16 (File No. 179), which directed the Legislative Commission to conduct an interim study of the welfare system in Nevada.

Since the 1989 legislative session, Nevada's welfare system has experienced unprecedented caseload growth and subsequent demands for public assistance benefits. Occurring simultaneously has been the federal government's incessant efforts to expand welfare by mandating new programs and requirements for the states to provide greater and/or more enhanced levels of welfare services. These two-fold and inter-related occurrences have resulted in significant cost increases, the magnitude of which is still unknown, however, has already become a massive burden to the state's finances and is growing. These occurrences have also changed the stereotyped definitions and impressions of welfare and the type or category of persons who access public assistance. The impact of these occurrences has not been an isolated phenomenon affecting only state government but has severely impacted and strained all tiers of government providing services within Nevada's welfare network. The impact has and will continue to be extremely costly, and has occurred as policymakers and program administrators contend with limited financial resources and increased competition for available funding among the various public service needs and priorities provided for in Nevada.

Not only beset with the problems of expanding welfare costs and a delivery system taxed to an extreme, policymakers must also contend with a growing public concern, attitude and perception that the welfare system is not working and requires a major re-structuring. The dimensions of this additional factor are difficult to quantify. However, it appears the public's general attitude supports the premise that welfare should re-emphasize such values as family and work, and re-enforce the intended concept of welfare as only a transitional support mechanism, not an indefinite maintenance and dependency program.

Paralleling these occurrences has been the proliferation of autonomous service providers statewide who administer many localized program components which make up Nevada's welfare network. The growth in Nevada's welfare network and delivery system and the autonomous nature in which services are rendered has added complexities and has fueled a degree of confusion and misunderstanding when attempting to determine the appropriate roles and responsibilities of the many welfare service providers. It is in this state of affairs the 1991 Legislature directed, with passage of Assembly Concurrent Resolution 16, the Legislative Commission to conduct a study of Nevada's welfare system.

The Resolution provided that the study should include the following:

1. An evaluation of the various welfare services being provided by the state and its counties, and by any private organizations in the communities of the state;

2. The identification of any programs established by the federal government which are available to Nevada for the provision of welfare services, whether or not they are currently being conducted in the state;

3. The identification of any needs for welfare services in this state which are not being satisfied, and of any welfare services being duplicated by the various providers of those services in Nevada; and

4. The identification of means to improve the welfare system in this state.

The Legislative Commission appointed a subcommittee composed of seven legislators to conduct the study. The subcommittee conducted five meetings, two meetings were held in Carson City (one of which was video teleconferenced to Las Vegas), two meetings were held in Reno and one meeting was held in Las Vegas (teleconferenced to Carson City).

FIRST MEETING

The first meeting of the subcommittee took place in Reno on November 22, 1991. The focus of the first subcommittee meeting was designed as an organizational meeting to provide the subcommittee an overview of welfare services and programs administered at the federal, state, and local levels.

At the initial meeting, the Administrator, Nevada Welfare Division, presented the subcommittee a comprehensive overview of welfare programs and services administered by the Nevada Welfare Division. The presentation included information on the Welfare Division's mission, services provided and their intended purpose(s), eligibility requirements, recipient groups and client profiles, caseload data, budget and program cost data, and limitations and/or hardships incurred in the provision of services. The Welfare Administrator also presented five major issues/topics and suggestions affecting the delivery of welfare services in Nevada which in the opinion of the Welfare Division the subcommittee should consider during the course of the interim study. The Welfare Administrator's suggestions are located in Appendix B.

The initial meeting also included presentations designed to provide the subcommittee members a clear understanding of the differentiation of welfare services provided by the state and the services provided by county social service departments. As an introduction to the overview of the welfare services provided at the county level, the Executive Director of the Nevada Association of Counties (NACO) provided the subcommittee an overview of the primary funding sources available for administering county welfare programs. The Executive Director presented the subcommittee a current and historical perspective on the use of property taxes for funding county welfare programs. The Executive Director testified the current system is inflexible and cited the ad valorem tax base is not an equitable basis to fund health and human service programs. The Executive Director explained the ad valorem tax base from one county to another bears no relationship to the population and/or clientele accessing the county welfare services provided.

The Clark and Washoe County Social Service Directors presented to the subcommittee an overview of county welfare general assistance, medically indigent and child protection programs and services administered by Nevada's two most populous counties. Each Director presented information on the clientele and population groups served, discussed the similarities between the Washoe and Clark

counties' social service programs however, also discussed each entity's unique program characteristics and problems in delivering services, and how caseload increases over the past five years have placed significant strains on each county's ability to continue providing welfare services at their current levels. Additionally, the Clark and Washoe County Social Service Directors discussed the major issues and topics in their opinion the subcommittee should consider during the course of the interim study. The Clark and Washoe County Social Service Directors' suggestions are located in Appendix C.

The Churchill and Nye County Social Service Directors presented to the subcommittee an overview of typical county welfare programs administered in rural Nevada counties and cited examples of the uniqueness of rural based county welfare programs because of land mass and small populations. The Churchill and Nye County Social Service Directors cited how typical local social service problems such as homelessness and transportation must be dealt with differently in rural areas since there is a lack of low-income housing and public transportation availability. The Churchill and Nye County Social Service Directors presented the subcommittee the major issues and topics in their opinion the subcommittee should consider during the course of the interim study. The Churchill and Nye County Social Service Directors' suggestions are located in Appendix C.

The subcommittee's first meeting also included testimony from representatives of the United Way of Northern and Southern Nevada. Their testimony was designed to provide the subcommittee information on the increasing role private non-profit organizations play in the delivery of human services for emergency and generally localized needs. Each presenter testified as to the need to develop partnerships and/or at a minimum establish better communications between public and private administered human service programs. This would promote more efficient and coordinated services and would initiate localized input to completely understand the ramifications or repercussions policies and changes in the delivery of human services adopted at the state level may ultimately have on private non-profit organizations providing services on a localized level.

Other witnesses representing Nevada Legal Services and the ADC Coalition presented their suggestions and issues for the subcommittee's consideration during the course of the interim study.

SECOND MEETING

The second meeting of the subcommittee was held in Reno on January 24, 1992. The second meeting's focus was designed to provide the subcommittee an overview of federal mandates which have significantly impacted the provision of welfare services (primarily Medicaid and ADC), to assess current statewide and localized efforts to develop a statewide human services master plan and to review alternative welfare assistance programs allowed by the federal government to determine their applicability to Nevada's welfare system.

Representatives from the Nevada Welfare Division testified concerning federal mandates imposed upon the states since passage of the Medicare Catastrophic Act of 1988 and the effect of mandates on welfare caseloads and costs for administering state

welfare programs. The presentation was divided into three primary segments, federal mandates affecting eligibility i.e., enhancements to the Medicaid Child Health Assurance Program (CHAP) and the Aid to Dependent Children Unemployed Parent program; federal mandated services and payments i.e., Medicaid program expansions such as the Pre-Admissions Screening and Annual Resident Review (PASARR) and the Early Periodic Screening, Diagnosis and Treatment (EPSDT) programs; and court cases which have impacted eligibility and services i.e., Sullivan versus Zebley, which has added a new Medicaid eligible group (disabled children which were formerly not eligible for Medicaid services).

Representatives from the Welfare Division also provided an overview to the subcommittee on the federal Emergency Assistance (Title IV-A) and Medicaid Medically Needy programs. Currently, these two federal programs are not mandated, therefore, it is the state's discretion whether or not they should be implemented. If the state chooses to do so, federal match funding is available. The ACR 16 legislation, stipulated the subcommittee identify any programs established by the federal government which are available to Nevada for the provision of welfare services and determine whether or not they are currently being conducted and their applicability for Nevada. The testimony provided information on each optional program's requirements, eligibility criteria, examples of how other states have implemented Emergency Assistance and Medicaid Medically Needy programs tailored to their specific state circumstances and scenarios of how these programs might be designed and initiated for Nevada. The testimony included discussion on the feasibility of developing a joint/cooperative Emergency Assistance program between Welfare Division and county social service departments maximizing the utilization of available federal match funding.

A representative for the Director, Department of Human Resources provided testimony updating the subcommittee on the Department's goals and objectives, methodology employed and progress to date for developing a statewide master plan for the provision of human services as required with passage of Assembly Bill 239 by the 1991 Legislature. Testimony indicated the Department would complete and submit to the 1993 Legislature an initial draft master plan. However, planning is an evolving process and further refinements are anticipated.

The Executive Director, Northern Nevada Food Bank, and current President, Truckee Meadows Human Services Association (TMHSA), provided testimony overviewing the TMHSA's efforts and methodology employed for developing a master plan for the delivery of human services for the northern Nevada Truckee Meadows area. The TMHSA is a somewhat unique model originally developed to foster the sharing of information among numerous social service agencies in the Truckee Meadows. However, as the need to develop a better understanding and inventory of social services provided at the local level became more apparent and with passage of A.B. 239, the TMHSA became a very well suited vehicle for accomplishing this task. The master plan developed by the TMHSA as the subcommittee learned will be used as the guide for developing the statewide master plan for human services.

The January 24, 1992 meeting was held at the Washoe Medical Center. The subcommittee received an overview of the pre-natal care services provided low-income families at the hospital's Washoe Pregnancy Center by the hospital's Chief

Executive Officer and medical staff from the Washoe Pregnancy Center. The representatives of Washoe Medical Center discussed issues involving access to early pre-natal care, barriers to pre-natal care, client profiles, pregnancy outcomes, and the financial implications for not providing or accessing adequate and early pre-natal care.

Other witnesses from the Nevada Legal Services, Nevada Welfare Division, Clark County Social Services, and interested citizens provided testimony regarding issues discussed during the course of the second meeting.

THIRD MEETING

The subcommittee convened the third meeting in Carson City on April 2, 1992. The focus of the subcommittee's third meeting was fact finding, but also served as a focal point for the subcommittee to focus on direction and formulation of study recommendations. The subcommittee, at this meeting was interested in exploring alternatives which have been determined to be cost effective, efficient and improves the delivery of welfare services at the state and local levels. The meeting was designed to explore welfare reform proposals to determine their applicability for Nevada; to understand the federal waiver process and to receive current information on the waiver processes greater flexibility as promised by the President in his state of the union address; and, to gather information on current demonstration projects administered at state as well as local levels, which are potentially cost effective and improve services. For this fact finding meeting, the subcommittee's guest speaker was Sherie Elissa Steisel, Director of Human Services Committee of the National Conference of State Legislatures (NCSL). The NCSL Human Services Committee provides a key role in the development of policy and lobbying strategy on the state and federal level for human services issues.

The Director of the Human Services Committee's testimony was categorized into three basic components. The introductory segment provided the subcommittee a briefing on welfare and the current national perspective. The introductory segment was followed by an overview of state and local welfare reform and recession proposals which have been implemented as cost savings or budget control measures as well as measures which are designed to modify welfare client behaviors and attitudes. Extensively covered during this segment of the Director's testimony was the Job Opportunities and Basic Skills program (JOBS) mandated by the Family Support Act of 1988. The Director's testimony discussed how states are implementing JOBS program mandates and the outlook for states to continue to meet increasingly more complex and difficult JOBS program requirements. Information was also presented on current research regarding welfare clients having additional children for increased welfare grants and welfare shopping or moving to states which pay a higher welfare cash assistance payments.

The second segment of the Director's testimony also focused on welfare reform proposals now under discussion in New Jersey and California and congressional legislation introduced proposing comprehensive welfare reform measures and the legislation's status. The Director specifically testified on Senator Moynihan's Work for Welfare Act of 1992 which would significantly expand the current JOBS program beyond the 1988 Family Support Act mandates. The Director also provided the

subcommittee insight on the President's expedited waiver proposal process and what effect these proposals may have on states which are studying extensive welfare reform measures.

The third section of the Director's presentation focused on the current status of several state welfare demonstration projects, such as the Wisconsin and Ohio LEARNFARE programs and the Washington Family Independence program. The Director's testimony provided the subcommittee information on Wisconsin's and Ohio's efforts to modify welfare recipient behaviors by tying the receipt of welfare assistance to school attendance and preliminary information on the success of these reform efforts. The Director also testified on welfare reform demonstration projects involving specific welfare programs such as efforts to enhance child support collections; unique approaches to improve employment and training efforts at local county welfare levels; state and local efforts to integrate the delivery of welfare services through the concept of one-stop shopping; providing incentives to AFDC recipients to seek and maintain employment by allowing the retention of income; and, the growing trend to computerize benefits with the use of electronic benefit transfer networks and methodologies.

Two representatives of Nevada Legal Services testified on their perceptions of the Nevada welfare system from an advocacy as well as the welfare client perspective. The Nevada Legal Services representatives testified and cited examples of how the Nevada's welfare system, in their opinion is failing to meet the needs of Nevada welfare recipients when compared nationally, yet Nevada has realized significant economic gains in the past several years. The presenters provided eight proposals and recommendations to the subcommittee to improve the delivery of Nevada's welfare services to consider during the course of the interim study. Nevada Legal Services' proposals are located in Appendix D.

The public testimony at the third meeting included two witnesses, one representing the American Association of Retired Persons (AARP) and one representing the Nevada Hospital Association. The AARP representative provided testimony concerning the rising costs for providing welfare and health care benefits and the need to budgetarily plan for these rising costs during a period when funding availability is limited. The Nevada Hospital Association representative provided testimony regarding the Nevada Legal Services suggestions on the hospital provider tax program.

FOURTH MEETING

The subcommittee convened the fourth meeting in Las Vegas on May 21, 1992. The meeting was teleconferenced to Carson City. The subcommittee's fourth meeting focused on providing Medicaid services using managed care concepts. The subcommittee was particularly interested in alternative approaches to providing Medicaid services which were not only cost effective from a budget perspective but would guarantee the availability of providers and insure quality of care for Medicaid recipients. The fourth meeting was also the last meeting where formal testimony and presentations would be taken.

A representative from the Nevada Welfare Division provided testimony to the subcommittee on Managed Care and the Medicaid program. The presentation was designed to provide the subcommittee an overview on the principles of managed care and the evolution of managed care arrangements with Medicaid programs, the benefit of managed care arrangements and potential limitations. The testimony also provided the subcommittee information on freedom-of-choice waivers, how such waivers work within a Medicaid program environment, the federal waiver application and review process and an explanation of pending federal legislation (the Medicaid Managed Care Improvement Act of 1991). The proposed federal legislation would provide states significantly more flexibility in utilizing and mandating managed care arrangements without having to seek cumbersome and time consuming federal waivers. The Welfare Division's representative also discussed the various types of managed care contracts within the Medicaid setting; the types of services allowable via managed care contracts; and, provided an update on the Nevada Medicaid program's joint contractual arrangements with the University Medical School's Primary Care Case Management program (PCCM); and, a recent contractual agreement consummated with NevadaCare, an Arizona-based health plan providing Medicaid managed care services in the Clark County area.

The subcommittee was particularly interested with the information provided on the cost savings Nevada Medicaid has realized with the University Medical School's PCCM program which provides for the reimbursement of services using capitated rates versus Medicaid's more predominant and traditional fee-for-service arrangements. According to testimony, additional program saving should be realized in time with the new Medicaid managed care provider. A copy of this presentation is located in Appendix E.

The Associate Dean for Medicaid and Student Health at the University of Nevada Medical School, presented the subcommittee an overview of the University of Nevada Medical School's Primary Care Case Management program and the medical school's philosophy for providing Medicaid managed care services to ADC and aged recipient in the Clark and Washoe county areas. The testimony provided information on the University PCCM program's efforts to expand Medicaid participation in their enrolled health program and how the program has been able to reduce medical costs to the Medicaid program through strict managed care and capitated rates while guaranteeing quality medical care and access to Medicaid providers. Additionally, the Associate Dean testified to the University Medical School's current efforts to implement a case management program for Medicaid's disabled recipients. The Associate Dean testified Medicaid saving with disabled clients can be realized through aggressive case management. However, case management services for disabled clients is a relatively new approach with no guarantees, and will take time to realize significant returns on initial investments.

The Vice President of Planned Management for NevadaCare, provided the subcommittee a presentation on the recent contractual agreement consummated with Nevada Medicaid to provide managed medical care services in southern Nevada. The Vice President testified NevadaCare has extensive experience providing such services in Arizona (the Arizona Health Care Cost Containment System). The Vice President indicated NevadaCare had been in operation in Nevada for approximately two months and has already enrolled approximately 800 Medicaid recipients to the NevadaCare program. The Vice President indicated that the NevadaCare

organization has over ten years experience in the Medicaid health care field and administers several health plans in the Arizona area and currently manages over 175,000 members in health plans in various states. The Vice President provided the subcommittee information on medical services which will be provided southern Nevada Medicaid recipients and NevadaCare's future goals and objectives for Nevada. At the subcommittee's request, the Vice President discussed proposals NevadaCare would suggest the subcommittee consider to facilitate more comprehensive utilization of managed care opportunities for the Nevada Medicaid program. The suggestions presented can be found in Appendix F.

The Medical Director, Community Health Centers of Southern Nevada, provided the subcommittee a presentation on the organization's current endeavors to enter into a contractual relationship with the Welfare Division to provide managed medical care services at their various community health center sites in the greater Las Vegas area. The subcommittee learned, unfortunately due to extensive fire and water damage to the North Las Vegas clinic, negotiations with Nevada Medicaid have been delayed but interest has not waivered. The Medical Director testified that the Community Health Centers work closely with the University of Nevada Medical School's PCCM program and when a final contractual relationship is consummated with the Nevada Medicaid program, the Centers' plan is to increase the number of physicians on their staff and expand to other clinic sites in the Las Vegas area. The Medical Director testified the Community Health Centers' prime objective is to increase the Centers' capacity to provide Medicaid managed care services to a greater number of Medicaid recipients living in the Clark County area at clinic sites which are easily accessible.

At the request of the subcommittee, the Administrator, Nevada Welfare Division, and the Directors of the Clark, Washoe, Nye and Churchill County Social Service Departments presented their input on suggestions and recommendations for the subcommittee to review and consider at the work session meeting. The suggestions and recommendations presented can be found in Appendix G.

A representative from the Nevada Legal Services testified providing clarification on the status of the Emergency Assistance program administered by the Welfare Division. The representative also explained Nevada Legal Services' perspective on single employables accessing general assistance at the county welfare level.

FIFTH MEETING

The subcommittee convened the work session meeting in Carson City on June 26, 1992. In addition to Legislative Counsel Bureau staff, resource witnesses testifying at the meeting included representatives of the Nevada Welfare Division, the Director, Clark County Social Services, the Director, Washoe County Social Services, the Director, Churchill County Social Services, representatives from Nevada Legal Services and a representative from the American Association of Retired Persons (AARP).

The subcommittee considered various proposals including their cost estimates (where applicable) and implications in approximately twenty areas concerning welfare and human services issues. The subcommittee adopted 17 recommendations in the following areas:

Aid to Dependent Children;
The provision of Medicaid services;
Emergency Assistance;
Human Services master planning;
Welfare Division budget "caps";
General Assistance and single employables; and,
Family unity.

II. RECOMMENDATIONS

The subcommittee adopted a total of seventeen recommendations.

1. EXPAND MEDICAID MANAGED CARE (AGED AND ADC RECIPIENTS) WITH A "FREEDOM OF CHOICE WAIVER" MANDATING ENROLLMENT.

Managed care is an arrangement under which each Medicaid recipient has a primary care physician responsible for providing primary care, authorizing referrals to other providers and providing 24-hour coverage for urgent care needs.

At the May 21, 1992 meeting, the subcommittee received extensive testimony regarding initiatives expanding Medicaid managed care arrangements as a way of providing Medicaid recipients access to a quality of health care which is better than the traditional fee-for-service arrangements the Medicaid system affords them; a way of guaranteeing Medicaid recipients access to physician providers (which Welfare Division representatives cited in testimony was a significant problem); a way of controlling access to costly specialty hospital and emergency room care; and, as a way of controlling rapidly increasing Medicaid costs. Supporting testimony for managed care arrangements was provided by Diane Hooley, Medicaid Managed Care Coordinator, Nevada Welfare Division; Owen Peck, M.D., Associate Dean, Medicaid and Student Health, University of Nevada School of Medicine; and Mary Temm, Vice President of Planned Management, NevadaCare.

A managed care program may be voluntary or mandatory for Medicaid recipients by state option, however, a mandatory enrollment program requires a federal waiver of freedom of choice (1915b) which is renewable every two years. The Health Care Financing Administration (HCFA) is authorized to grant waivers of state plan requirements under 1915(b) provisions only in cases where they are found to be cost effective, efficient and not inconsistent with the intent of the Medicaid program. A 1915(b) waiver renewal must substantiate savings, improved recipient access to care and actuarial soundness of the capitated rates. The Nevada Welfare Division has contractual arrangements with two Medicaid enrolled health plans with a third health plan pending (University School of Medicine's Primary Care Case Management program (PCCM) and NevadaCare and the Community Health Centers of Southern Nevada, when a contract is consummated as anticipated) under authority of a 1915(a) federal waiver. The Welfare Division indicated to the subcommittee the 1915(a) waiver provides the Medicaid program the same benefits and latitude as a 1915(b) waiver without having to comply with cumbersome and strict federal reporting requirements, which are necessary with a 1915(b) waiver. However, the subcommittee noted, in their research, the primary difference is a 1915(b) waiver allows the state to mandate recipient enrollment in a primary care case management program and waives the statewideness and comparability of services requirements. A 1915(a) waiver does not provide for mandated enrollment.

The Welfare Division in their response to the subcommittee's request to develop an operational plan requesting federal approval for a 1915(b) freedom of choice waiver for implementation in Clark County indicated the Medicaid program prefers to operate without such a waiver. The Welfare Division stated HCFA has determined

the Medicaid program may enroll recipients in managed care unless the recipient has a valid reason for not being able to use one of the managed care contract sites. The Welfare Division stated this provides the same latitude and opportunities to increase managed care without requesting a 1915(b) waiver. The subcommittee, in discussing the options of whether to mandate enrollment in managed care by seeking HCFA approval of a freedom-of-choice waiver or simply to aggressively pursue voluntary enrollment determined the Welfare Division's assumption is untested and contains no guarantee of how aggressive the Division can be in selecting and enrolling Medicaid recipients with a managed care provider. The subcommittee felt without the freedom-of-choice waiver numerous loopholes and exceptions may occur which would circumvent the subcommittee's intent of promoting widespread utilization of Medicaid managed care.

The Welfare Division's operational plan for pursuing a 1915(b) waiver, cited three conditions which must be met to initiate the waiver or a stronger enrollment policy:

1. A contract must be entered into with the Community Health Centers of Southern Nevada (this would allow greater client access to medical providers in the hard to serve Las Vegas areas);

2. Three marketing specialist positions must be approved for the Las Vegas area in addition to the existing two marketing specialists for each of the five Welfare Division offices located in Clark County; and

3. A registered nurse position must be provided to monitor medical care complaints and audit quality of care.

The Welfare Division also indicated an additional position will be needed to prepare the 1915(b) waiver and manage its reporting requirements. In addition, the Welfare Division indicated actuarial services are needed to study and establish the enrolled health plans' capitated rate structure.

Managed Care Savings

Diane Hooley, Nevada Welfare Division, testified at the May 21, 1992 meeting, that savings through the existing University PCCM program have been significant for the ADC and aged populations served. The FY 1991 fourth quarter savings for aged recipients voluntarily accessing the program versus traditional fee-for-service providers were approximately $73 per person per month. Similarly, the FY 1991 fourth quarter savings for ADC recipients were approximately $40 per person per month.

The subcommittee in their review of this proposal, determined by introducing and promoting the widespread utilization of managed care principles to the Medicaid program, the Medicaid recipient, as well as the state, would realize significant benefits. The Medicaid recipient would realize benefits from managed care through guaranteed health care access and quality of care. The state would realize benefits through managed care's cost effectiveness compared to traditional fee for service health care provider arrangements. The subcommittee considered these two outcomes of tantamount importance since both the recipient and the state would ultimately benefit. The subcommittee considered this recommendation to be the

cornerstone of the study's findings especially in light of the spiraling costs of health care which has significantly impacted the Medicaid program and has added to the state's gloomy budgetary outlook.

Therefore, ***the subcommittee recommended the Welfare Division proceed with a freedom of choice waiver (1915b) request to the Health Care Financing Administration (HCFA) to mandate statewide Medicaid recipient enrollment in a primary care case management program and waive statewideness and comparability of service requirements.***

The subcommittee noted a statewide freedom of choice waiver is most desirable and advantageous to the Medicaid program and its recipients, however, primarily due to provider availability constraints in Washoe County and the rural areas of the state, obtaining a freedom of choice waiver will most likely occur in the Clark County area.

The subcommittee did not formally recommend the staffing augmentations the Welfare Division had indicated were needed to pursue this recommendation. However, the subcommittee expressed their understanding additional administrative burdens would be experienced in seeking a freedom-of-choice waiver and overseeing a widespread managed care program.

2. MEDICAID MANAGED CARE IMPROVEMENT ACT (S.B. 2077)

Diane Hooley, Medicaid Managed Care Coordinator, Nevada Welfare Division, testified at the May 21, 1992, subcommittee meeting and requested the subcommittee's assistance in urging Nevada's Congressional delegation to support passage of the Medicaid Managed Care Improvement Act of 1991 (Senate Bill 2077). S.B. 2077 would allow greater flexibility in implementing Medicaid managed care programs without having to apply for a federal waiver as discussed in the preceding recommendation. Specifically, S.B. 2077, if approved, would allow (1) mandatory enrollment of Medicaid recipients if there is a choice of two or more plans or at least two-thirds of the doctors in an area are in a managed care contract; and (2) allows a state to guarantee Medicaid eligibility to enrollees from one to six months.

In researching this proposed legislation with the National Conference of State Legislatures (NCSL) and HCFA, the subcommittee learned the S.B. 2077 legislation is currently stalled pending negotiations in the U.S. Senate. The likelihood of early passage of S.B. 2077 from information gathered was not promising. In lieu of waiting, the subcommittee recommended the Welfare Division proceed with a freedom of choice waiver (see recommendation No. 1). The subcommittee however, felt strongly that states should be allowed the flexibility S.B. 2077 would provide in developing Medicaid managed care programs.

Therefore, ***the subcommittee recommended that the 1993 Legislature, by resolution, urge the United States Congress to approve the Medicaid Managed Care Improvement Act (S.B. 2077). This proposed legislation would allow states significant flexibility in developing Medicaid managed care programs.*** (BDR R-785)

NOTE:

Congressional negotiations on the Medicaid Managed Care Improvement Act (S.B. 2077) failed and the legislation died. In August 1992, the Medicaid managed care legislation was reintroduced as S.B. 3191 and included a host of compromises designed to satisfy the various opposing interest groups who were not supportive of the original S.B. 2077 legislation. S.B. 3191 was extensively discussed, however, this legislation also failed when it became apparent continued opposition existed and a satisfactory resolution would not be achieved prior to the close of the Congressional session.

In light of these circumstances, the intent of the subcommittee's recommendation for the 1993 Legislature to adopt a resolution specifically endorsing the approval of Congressional legislation which no longer exists is not appropriate. However, the intended objective of the subcommittee's recommendation to allow states greater latitude and discretion to implement Medicaid managed care programs is still valid. Therefore, the resolution not the subcommittee's recommedation has been modified to eliminate any reference to specific pending Congressional legislation. The modifications reflect the subcommittee's intent and desire (at the time of the work session) to urge the United States Congress to approve legislation allowing states a greater degree of flexibility in developing and implementing comprehensive Medicaid managed care programs without having to apply for a federal waiver.

3. ADC "FILL THE GAP" BUDGETING

Nevada Legal Services formally proposed at the April 2, 1992 subcommittee meeting, the Welfare Division seek a state plan change which would allow ADC recipients to retain earnings (all countable income) without reducing the ADC grant payment until the combined maximum ADC grant, plus earnings, reaches 100% of the Nevada need standard.

Every state has an ADC standard of need and an ADC maximum payment level which may be less than the established standard of need. Nevada's current standard of need for a three person household is $620. Nevada's maximum ADC grant payment for a three person household not receiving public housing is $348 per month or $272 less than the established standard of need. Under federal law, the state does not need to meet the standard of need, and can set a lower payment level. As in Nevada, most states have established an ADC payment level lower than the standard of need.

ADC budgeting in Nevada as well as most states (in its most simplest form) is determined by calculating the family's countable income. The ADC payment is the difference between the payment level and the countable income. For example, if the payment level is $348, and the family's countable income is $200, the ADC grant will be $148. In actual ADC budgeting, work incentive disregards and child care expenses are also factored into determining the ADC payment level.

In a fill the gap scenario, the family's grant may be the difference between the standard of need and the countable income, with the maximum grant being the payment level. For example, the standard of need is $620, the payment level is $348

and countable income is $200. The family would receive the difference between the standard of need ($620) and the countable income ($200) up to the payment level ($348). The family's grant would not begin to be reduced until countable income started to exceed $272 per month ($348 + $272 = $620). As compared to the previous non-fill the gap scenario, this family would receive an ADC payment of $348 plus retain the $200 in earning since the total of the two is less than the $620 standard of need ($348 + $200 = $548 $\leq$ $620). Fill the gap budgeting can be applied in several different manners not exclusively using 100 percent of the need standard. For example, a fill the gap approach at 75 percent, or 50 percent, of the standard of need can be implemented, or simple limitations on the amount of countable income retained can be applied.

Pros and Cons

The subcommittee in researching the ADC fill the gap budgeting approach and from testimony provided by Sherie Steisel, National Conference of State Legislatures determined there are positive and negative benefits to this proposal. The primary positive feature of the fill the gap approach is its less punitive affects for those ADC recipients with countable income. The approach assures families will recoup a financial benefit for obtaining income. Secondly, it allows ADC recipients an opportunity to reach the established standard of need level with income retention without penalty, since the state is unable to afford to budget ADC payment levels at the established need standard. Thirdly, the approach arguably provides a positive incentive for ADC recipients which has been one of the underlying themes in many state welfare reform proposals.

The subcommittee determined there are several disadvantages. First, there are additional costs because there is no saving in reduced ADC grant payments when a family receives income. Secondly, the subcommittee learned the Nevada Legal Services proposal does not differentiate between earned and unearned income. Earned income is earnings and wages from some form of employment. Unearned income is income derived from other sources such as social security, unemployment benefits, child support or subsidized housing. With the Nevada Legal Services proposal, ADC recipients with unearned income would benefit from the fill the gap approach as would recipients who are actually working. Thirdly, since subsidized housing is budgeted as income (unearned), when applying the fill the gap approach with all types of income (including subsidized housing) the ADC grant payment differentiation between subsidized and non-subsidized housing recipients would disappear. The subcommittee, during their study of this proposal, realized that for the past several bienniums when approving the ADC budget, the Nevada Legislature has consciously differentiated between those ADC recipients who receive a housing subsidy and those who do not with a lower ADC grant payment.

Fill the gap budgeting alternative

The subcommittee was enthusiastic about the concept of fill the gap budgeting and its positive benefits and incentives for ADC recipients. However, the subcommittee felt it was important that ADC recipients who seek, obtain and retain employment should be rewarded, and were concerned if all countable income was allowed for fill the gap budgeting, the differentiation between grant payments for ADC recipients who receive public housing subsidies and those who do not, would disappear. Therefore,

the subcommittee requested the Welfare Division provide to the best of their ability information on potential costs if the fill the gap budgeting approach was implemented for those ADC recipients who receive earned income only. This alternative was suggested to the subcommittee by Sherie Steisel, NCSL. The subcommittee realized this alternative would require a federal 1115 waiver from the Administration for Children and Families since ADC budgeting determinations on countable income would not be uniformly applied. Currently, 1115 waivers must be cost neutral. However, the subcommittee decided this alternative truly rewards those ADC recipients who are working and will maintain the differentiation between public housing and non-public housing ADC grant levels.

Costs

Per the subcommittee's request, the Welfare Division ran a special computer tape at the end of March 1992 on ADC caseload with earned and unearned income. There were 2911 cases with subsidized housing income only, and an additional 763 cases with a combination of earned, unearned and/or subsidized housing income. Based upon the data generated from this special computer tape, the Nevada Legal Services fill the gap budgeting proposal would cost approximately $4.1 million (federal/state) per year. The cost for the alternative approach for fill the gap budgeting for ADC recipients with earned income only was approximately $573,000 (federal/state) per year.

In response to the subcommittee's questioning, the Welfare Division expressed support for the fill the gap budgeting concept and the specific alternative for counting only earned income. However, the Welfare Division could not commit the alternative fill the gap budgeting proposal would be included in the Division's 1993-95 biennial budget request since it would be considered an ADC program expansion which due to the state's current budgetary constraints may not be recommended.

The subcommittee deliberated at length on how best to incorporate fill the gap budgeting for earned income only into the forthcoming biennial budget process. The subcommittee was especially concerned this approach might not be included in the Governor's budget. Additionally, the issue of obtaining a federal waiver and demonstrating cost neutrality could be troublesome since from information provided by the Welfare Division indicated the proposal was not cost neutral. The subcommittee determined the fill the gap approach for earned income is meritorious and deserves complete legislative consideration during the 1993 session. The subcommittee realized the issue of cost neutrality needed further study and development.

Therefore, ***the subcommittee recommended and endorsed the Aid to Dependent Children "fill the gap" budgeting concept. "Fill the gap" budgeting allows ADC recipients to retain earned income (earned income from employment only) without reducing their ADC grant payment, until the combined maximum ADC grant plus earnings, reach 100 percent of the Nevada need standard. In support of this recommendation, the subcommittee:***

A. Requested the Welfare Division include the "fill the gap" budgeting methodology and costs in the Division's 1993-95 biennial ADC budget request;

B. *Directed staff to draft a memorandum to the Director, Department of Human Resources, requesting the Department's cooperation to include the ADC "fill the gap" budgeting methodology in the Welfare Division's 1993-95 biennial ADC budget request (see Exhibit 1).*

C. *Recommended legislation which would incorporate the ADC "fill the gap" budgeting methodology for earned income only into the Welfare Division's ADC grant determination and eligibility process.* (BDR 38-784)

EXAMPLE A: FILL THE GAP SCENARIOS - EARNED INCOME ONLY (MINIMUM WAGE)

ADC Budgeting Non-Public Housing recipient (3-person household)

	$680.	(minimum wage $4.25 X 40 hours per week X 4 weeks)
	-90.	(standard work expense)
subtotal	$590.	
	-30.	(work incentive disregard)
subtotal	$560.	
	-186.67	(deduct 1/3 earnings)
subtotal	$373.33	
	-350.	(child care expense $175 per child per month)
Total	$ 23.33	(net earned income)

	$348.	(maximum ADC payment allowance 3 person non-public household)
	-23.33	(net earned income)
Total	$324.67	

$324. Eligible ADC cash payment (rounded to the next lowest dollar)

Fill the Gap Budgeting

Household Size	Need Standard	100%[A]	75%[B]	50%[C]
3	$620	$272 (348+272=620)	$204	$136

A. Client can retain up to $272 in net earned income at 100% fill the gap.

B. Client can retain up to $204 in net earned income at 75% fill the gap.

C. Client can retain up to $136 in net earned income at 50% fill the gap.

Example A client with fill the gap budgeting would be eligible for the maximum ADC grant of $348.00 in either the 100, 75 or 50 percent fill the gap scenarios since the net earned income does not exceed the 100, 75 or 50 percent thresholds.

EXAMPLE B: FILL THE GAP SCENARIOS-EARNED INCOME ONLY ($7.00 PER HOUR WAGE EARNER)

ADC Budgeting Non-Public Housing recipient (3-person household)

	$1,120.	($7.00 per hour X 40 hours per week X 4 weeks)
	- 90.	(standard work expense)
subtotal	$1,030.	
	- 30.	(work incentive disregard)
subtotal	$1,000.	
	- 333.33	(deduct 1/3 earnings)
subtotal	$ 666.67	
	- 350.00	(child care expense $175 per child per month)
Total	$ 316.67	(net earned income)

	$ 348.	(maximum ADC payment allowance 3 person non-public household)
	- 316.67	(net earned income)
Total	$ 31.33	

	$ 31.	Eligible ADC cash payment (rounded to next lowest dollar)

Fill the Gap Budgeting

Household Size	Need Standard	100%[A]	75%[B]	50%[C]
3	$620	$272	$204	$136

A. Example B client with fill the gap budgeting at 100% would be able to retain $272 in earned income; ADC cash payment would be $303 ($316.67 net earned income - $272 maximum earned income which could be retained = $44.67 net earned income to be reduced from maximum ADC grant; $348 - $44.67 = $303.33 or $303.)

B. Client at 75% would be able to retain $204 in earned income; ADC cash payment would be $235 ($316.67 net earned income - $204 maximum earned income which could be retained = $112.67 net earned income to be reduced from maximum ADC grant; $348 - $112.67 = $235.33 or $235.)

C. Client at 50% would be able to retain $136 in earned income; ADC cash payment would be $167 ($316.67 net earned income - $136 maximum earned income which could be retained = $180.67 net earned income to be reduced from maximum ADC grant; $348 - $180.67 = $167.33 or $167.)

VIVIAN FREEMAN
ASSEMBLYWOMAN
District No. 24 (Washoe)

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Chairwoman
Natural Resources, Agriculture and Mining
Vice Chair
Health and Welfare
Member
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State of Nevada Assembly

Sixty-Sixth Session

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August 12, 1992

Mr. Jerry Griepentrog, Director
Department of Human Resources
505 E. King Street, Room 600
Carson City, Nevada 89710

SUBJECT: LEGISLATIVE COMMITTEE STUDYING NEVADA'S WELFARE SYSTEM (ACR 16)

Dear Mr. Griepentrog:

The ACR 16 Committee at their final work session meeting, endorsed the recommendation which will allow ADC recipients to retain earned income (earned income from employment only) without reducing their ADC grant payment until the combined maximum ADC grant, plus earnings, reach 100% of the Nevada need standard. This recommedation commonly called ADC "fill the gap" budgeting ensures ADC families will recoup a financial benefit for obtaining employment, allows ADC recipents an opportunity to reach the established standard of need level with income retention without penalty and arguably provides a positive incentive for ADC recipents to actively seek and retain employment. As you are aware, under current ADC budgeting guidelines, an ADC recipient's maximum grant is reduced $1.00 for every net non-exempt $1.00 earned.

In support of the "fill the gap" recommendation, the ACR 16 Committee also endorsed requesting the Department's cooperation to include the ADC "fill the gap" budgeting methodology and costs in the Welfare Division's 1993-1995 biennial ADC budget request, or to include an alternative or comparable proposal which conceptually provides a similar positive incentive. Including this information in the Welfare Division's ADC budget submittal will allow a comprehensive analysis of costs for this recommedation as well as afford an opportunity to openly discuss the pros and cons of this welfare reform proposal.

I would appreciate your consideration for the ACR 16 Committee's request, and if I can be of any assistance, please do not hesitate to contact me.

Sincerely,

Vivian Freeman

Assemblywoman Vivian L. Freeman
Chairman, ACR 16 Subcommittee

ACR16 ADCJG:/tc
WELFARE STUDY

(EXHIBIT 1)

4. INCREASE MAXIMUM ADC PAYMENT LEVELS TO 100% OF NEED BY THE YEAR 2000

The subcommittee received testimony from Nevada Legal Services and the ADC Coalition proposing a gradual increase in the maximum ADC payment level to 100% of the standard of need by the year 2000 be enacted in Nevada statute. If ADC payment levels are statutorily prescribed, regardless of budgetary issues, ADC payment levels could not be subject to reductions during non-legislative periods unless repealed by a subsequent legislature.

Throughout the course of the study, the subcommittee received testimony that allowing ADC payment levels to be reduced as a cost savings measure due to state budget problems is unfair and inappropriate for those in our society who can least cope with such actions. Proponents of the proposal cited the 1989 Legislature approved ADC payment increases for families without public housing only to see the approved increases never implemented due to substantial ADC caseload growth and subsequent budget shortfalls. Proponents also cited the 1991 Legislature approved an increase in the ADC grant level for recipients not receiving a public housing subsidy from $330 to $372 per month. For households receiving subsidized housing, payments were approved to remain at $300 per month. The ADC grant level increase for non-public housing recipients was increased to $372 effective October 1, 1991. However, due to the state's budget crisis and as part of the Governor's budget reduction plan, the grant level for recipients not receiving public housing assistance was reduced to $348, and for recipients receiving public housing assistance the grant level was reduced to $272 (from $300), effective February 1, 1992. The proponents' testimony before the subcommittee suggested the Legislature support efforts to make a long-term commitment to ADC families, and not subject ADC payment levels to economic crises and/or caseload fluctuations.

The subcommittee in discussing this proposal was concerned over the future costs for establishing guaranteed ADC payment increases as well as establishing in statute a law only future Legislatures could change. However, a majority of the subcommittee felt an obligation as part of this study to recommend public policy goals which are free of financial or other constraint considerations. Although these goals may not be met or addressed within specified timeframes, they set standards for future policymakers to strive for.

Therefore, ***the subcommittee endorsed the "concept" of increasing maximum ADC payments to 100 percent of need by the year 2000.***

5. RESTORE PAYMENT OF ADC BENEFITS TO DATE OF APPLICATION

Nevada Legal Services, the ADC Coalition and to a more limited extent the various county social service directors, proposed ADC benefits be provided retroactive to the date the recipient formally applies for benefits versus the date the application is approved by the Welfare Division (or 30 days, whichever is shorter).

Currently, the federal government allows states either of these two options. Prior to November 1, 1989, the Welfare Division's policy was to make ADC payments retroactive to the date the ADC application was received. This policy was changed

effective November 1, 1989 because of significant budget shortfalls in various Welfare Division programs which occurred during the 1989-91 biennium. The Division's policy has not changed since ADC benefit retroactivity was discontinued.

The subcommittee received testimony from the county social service directors which argued due to the length of time to determine ADC eligibility by the Nevada Welfare Division (average eligibility determination period 27 days as of June 1, 1992), ADC applicants must access with greater frequency and for longer periods of time local social service resources i.e., county assistance programs pending eligibility notification. The subcommittee learned upon further review, the county social service departments do not typically attempt to recoup county assistance benefits provided ADC applicants pending eligibility approval regardless if retroactivity is restored or not. The subcommittee therefore questioned if the county welfare programs are significantly impacted by the current policy or just due to the sheer increase in clients accessing benefits of the welfare system at the state and local levels. The Director, Clark County Social Services, speaking for the county social service directors, testified cost estimates to her knowledge of applicants accessing county general assistance pending ADC eligibility are not available. However, based on her experience, recipients do access county assistance programs pending ADC eligibility determination.

The subcommittee during their discussions on this issue, expressed concern over the costs to restore ADC payment retroactively which are estimated by the Welfare Division to be approximately $2.4 million for FY 1992 and $2.8 million for FY 1993 (federal/state) in light of the state's current budget constraints. The majority of the subcommittee, in discussing this proposal reasoned historically, it was the Nevada Welfare Division's policy to provide the initial ADC payment retroactive to the date of application since it is arguably the most critical payment for a family to re-establish themselves and to get back on their feet. It was not a policy designed to minimize client access to county assistance programs. A majority of the subcommittee reasoned the intent of the ACR 16 legislation was to identify welfare service needs and to improve the delivery of welfare services which this proposal would provide.

Therefore, ***the subcommittee recommended to endorse the "concept" of restoring payment of ADC benefits retroactive to the date the ADC application was received versus the date ADC eligibility is determined.***

6. ADC RECIPIENT CHARACTERISTICS STUDY

The Welfare Division is responsible for the compilation of ADC client data from the Division's welfare master file in the eligibility and payments computer system and from ADC client surveys. The data gathered is analyzed and characteristic profiles of Nevada ADC clients are developed. This information is published by the Welfare Division in the form of an ADC program recipient characteristics study. The information gathered and quantified is an invaluable source of data to be used when studying ADC recipients, determining ADC trends, and for making decisions which may affect current ADC policy i.e., welfare reform. The Welfare Division's last ADC characteristics study was compiled during the last quarter of calendar year 1988 and completed in December 1988. The previous characteristics study was completed in 1984. The subcommittee during the course of the study, several times requested information from the Welfare Division regarding ADC recipient profiles.

Unfortunately, in several circumstances, the information requested either was not collected, therefore not available, or was compiled and analyzed for the last characteristics study completed in 1988.

The subcommittee seriously questioned the usefulness of the data compiled for the 1988 ADC characteristics study in attempting to develop an understanding of today's ADC recipient. The subcommittee felt this is especially germane when considering Nevada's population explosion, changing demographic characteristics, economic diversification and federal mandates which have expanded the ADC program since completion of the last ADC characteristics study. The subcommittee determined it was logical to assume the ADC recipient profile today may very well be significantly different from the 1988 recipient profile.

The subcommittee, in deliberating this issue felt, a biennial ADC characteristics study timetable should be implemented which should coincide with the Executive Budget process and legislative budget review cycles. It was determined this should be accomplished with minimal costs, with existing staff and existing data base.

Therefore, ***the subcommittee recommended the Welfare Division compile and prepare a biennial ADC characteristics study to coincide with the Executive Budget process and legislative budget review cycles.***

7. EMERGENCY ASSISTANCE

Emergency Assistance is an optional Title IV-A program which provides emergency services to needy families with children who are in a temporary crisis situation because of a sudden reduction of their income, unexpected emergency expenses or because they are homeless. Assistance may be provided for one 30-consecutive day period in 12 consecutive months. States determine the kinds of emergencies they will cover as long as the program's scope is equitable and reasonable.

In previous years, the Welfare Division administered a limited Emergency Assistance program with a small general fund appropriation (FY 1990 $61,435, FY 1991 $61,818) and matching federal funds. The Welfare Division in their budget submittal for the 1991-93 biennium requested the program be discontinued. The Welfare Division indicated the current level of funding was insufficient to provide adequate services for any length of time.

With passage of SB 417 and AB 479, the 1991 Legislature increased the real property transfer tax from 55¢ to 65¢ per $500 value. Per AB 479, fifteen (15) percent of the funds accumulated from the tax are to be allocated in support of an Emergency Assistance program to be administered by the Welfare Division.

Per Housing Division regulations, monies will not be allocated until $1.5 million is available for distribution. It is anticipated by the end of the calendar year 1992, the $1.5 million threshold will be reached and $225,000 will be distributed to the Welfare Division for implementation of an Emergency Assistance program. This amount will be matched by a like federal share, therefore, the program will have funding in the amount of $450,000 to distribute to needy families. The monies the Welfare Division

receives by legislation must be used exclusively for emergency assistance activities relating to low-income housing.

At the subcommittee's first meeting, the Welfare Division proposed the possibility of designing an Emergency Assistance program whereby a designated amount of participating county funds could be accessed as match for 50 percent match funding from the federal government. The Welfare Division cited the federal Emergency Assistance program's regulations are very flexible, and a program tailored to specific county needs could be developed and funded with 50 percent federal funds in lieu of 100 percent county general funds now being utilized.

The county social service directors and the Nevada Association of Counties (NACO) were strongly not supportive of a joint program using this funding mechanism, however, endorsed the expansion of an Emergency Assistance program using state funds only.

The county social service directors and NACO in testimony before the subcommittee, stated their belief is all welfare assistance programs which are eligible for matching federal funds should be a state responsibility and funded with state general funds. Additionally, in testimony, the county social service directors and NACO expressed apprehension in participating in another joint program with the state in light of the Governor's budget proposal for the 1991-93 biennium to shift a majority of the Medicaid long-term care costs from the state to the counties. The county social service directors testified there still exists animosity between the counties and the Administration for not having openly communicated with them on the long-term care issue. The county social service directors and NACO did not testify this would totally preclude them from working with the Welfare Division, however, they expressed it would be difficult because of the recent events to enter into any other effort involving a partnership. The county social service directors also indicated the emergency assistance programs they currently administer locally have a great deal more flexibility than an emergency assistance program administered in accordance with cumbersome federal regulations. As an example of the county administered program's flexibility, the Director, Clark County Social Services, specifically cited many rural counties do not provide cash assistance, but use various forms of in-kind assistance.

The subcommittee, during their review and discussion of this issue, believed an opportunity exists to leverage available federal funding for an emergency assistance program which would provide benefits to the state as well as the counties. The subcommittee also felt if designed appropriately, which would require the county social service agencies and the Welfare Division to jointly cooperate, by leveraging federal Title IVA emergency assistance funds, county general funds could be redirected to other programs such as general assistance. The subcommittee, during their review, recalled the county social service directors in earlier subcommittee meetings testified the costs for administering local general assistance programs over the last five years have increased significantly.

The subcommittee did not want to lose what they felt was an opportunity to broaden the scope of the existing emergency assistance program which limits assistance for low-income housing purposes only. However, the subcommittee realized due to the adamancy of the county social directors against another joint state/county partnership, a great deal more discussion was necessary.

Therefore, ***the subcommittee recommended the Welfare Division, county social service directors and the Nevada Association of Counties initiate a dialogue to further study the feasibility of establishing an Emergency Assistance program. The subcommittee's intent was for these entities to develop a viable program, tailored to meet in the most efficient and cost effective manner while maximizing available funding resources the needs as they exist at the state and local levels.***

In support of this recommendation, the subcommittee directed staff to draft a memorandum to all affected parties encouraging their participation in fruitful discussion with the specific purpose of resolving current differences which have precluded the realization of the intended recommendation.

8. PRESUMPTIVE ELIGIBILITY

The Omnibus Budget Reconciliation Act of 1986 (OBRA 86) allows states the option of establishing presumptive and continuous eligibility for pregnant women. Presumptive eligibility allows reimbursement to providers for up to 45 days, even if Medicaid eligibility is ultimately denied. It is argued this Medicaid option is important because women may delay pre-natal care until their eligibility is established.

The intent of presumptive eligibility is to create easy and early access to pre-natal care to potentially eligible Medicaid clients. This is accomplished by a "qualified" Medicaid provider who determines presumptive eligibility on the basis of preliminary information that the pregnant women's income does not exceed income limits established in the state Medicaid plan. The determination is made immediately, and services can be initiated at that point. The pregnant woman has until the last day of the month following the month of the provider determination to make a formal application to Medicaid. Once formal application is made, presumptive eligibility continues until an eligibility decision is made. The pre-natal care provider is guaranteed reimbursement during the presumptive eligibility period regardless if the woman is ultimately found eligible or ineligible for Medicaid.

Studies indicate comprehensive pre-natal care can eliminate or reduce the effects of specific diseases or disorders in pregnant women which can lead to grave consequences for the birth outcome such as low-birth weight babies. Studies indicate the lifetime cost of caring for a low-birth weight infant can reach $400,000 while pre-natal care which may have prevented the low weight birth can be as little as $400 (National Commission to Prevent Infant Mortality, 1988).

Studies also indicate the importance of pre-natal care as an intervention to low-birth weight is heightened by its cost effectiveness. Every low-birth weight birth that is averted can save the health care system from $14,000 to $30,000 (National Commission to Prevent Infant Mortality, 1988). Additionally, other studies indicate that anywhere from $2 to $10 can be saved for every $1 spent on pre-natal care (Institute of Medicine, 1985 and Kolb, 1989). These statistics can be argued against because it is difficult to quantify that early comprehensive pre-natal care positively impacts pregnancy outcomes, and that available data does not clearly substantiate the relationship between obtaining pre-natal care and having a healthy baby.

The subcommittee at their second meeting received testimony from representatives of the Washoe Medical Center and the Washoe Pregnancy Center strongly urging the subcommittee to use the opportunity the ACR 16 interim study has provided to make a strong public policy commitment to early pre-natal health care and to establish a comprehensive statewide peri-natal health care system. The subcommittee also received testimony and supportive endorsements from the Maternal Child Health Advisory Board and the Chairman, University of Nevada's School of Medicine OB/GYN Department. (See Exhibits 2 and 3.) The information provided by the Maternal Child Health Advisory Board reinforced that early and continuous pre-natal care is the foundation for healthy babies. In 1991, according to their findings only 68% of pregnant women in Nevada received care in the first trimester of pregnancy. The Maternal Child Health Advisory Board also strongly suggested the Nevada Legislature make a strong public commitment to improve the outcome of pregnancy for all Nevada women by taking steps toward establishing a statewide peri-natal health care system. One important step in that direction is providing for presumptive eligibility in the Medicaid program.

The subcommittee in their discussions of presumptive eligibility, unanimously supported the "concept" of early pre-natal care. The subcommittee concluded it is reasonable to assume although difficult to quantify, the state at some point incurs considerable costs such as life-long health care costs and special education costs for not expediting early pre-natal care.

The subcommittee, in consideration of the convincing testimony and endorsements received, and their desire to make a strong and positive statement emphasizing and encouraging early and continuous pre-natal care, ***recommended the adoption of presumptive eligibility which is an option in the Medicaid program that allows states to establish presumptive and continuous eligibility criteria for pregnant women. The subcommittee's intent was to create expedited, easy and early access to pre-natal care for potentially eligible Medicaid clients.*** (BDR 38-786)

Governor's
Maternal & Child Health Advisory Board

June 25, 1992

Assemblywoman Vivian Freeman, Chairman
Nevada State Legislature's Committee on Welfare (A.C.R.16)
Capital Complex
Carson City, Nevada 89710

Dear Assemblywoman Freeman:

I am writing to you as Chairman of the Governor's Maternal and Child Health (MCH) Advisory Board to encourage efforts by the Committee on the Welfare System in Nevada to provide for prenatal care.

In December of 1990, the MCH Advisory Board issued its Annual Report to the Governor. In this report the recommendation was made that the Nevada State Legislature make a strong public commitment to improve the outcome of pregnancy for all Nevada women by taking steps toward the establishment and funding of a comprehensive statewide perinatal care system. One of the steps listed was providing for presumptive Medicaid eligibility for low income pregnant women.

Early and continuous prenatal care is the foundation for healthy babies. In Nevada in 1991, only 68% of pregnant women received care in the first trimester of pregnancy. The majority of those who received late and inadequate care did so due to the inability to pay for care. The lack of early and continuous prenatal care often results in low birthweight infants who place a great financial burden on the State because of higher NICU costs, life-long health care costs and special education needs.

The present MCH Advisory Board again makes the recommendation for presumptive eligibility and hope that your committee will take this opportunity to move Nevada forward in caring for the most vulnerable of our citizens. The MCH Advisory Board encourages the committee to consider this issue at the committee's meeting on Friday, June 26, 1992.

I offer to you the resources of the MCH Advisory Board to examine this issue. Please feel free to contact me in Las Vegas at 733-4944.

Sincerely,

Bernard Feldman, M.D.

Bernard Feldman, M.D., M.P.H.
Chairman

505 E. King Street, Room 205, Carson City, NV 89710 (702) 687 - 4885

(EXHIBIT 2)

June 25, 1992

Assemblywoman Vivian Freeman, Chairman
Nevada State Legislature's Committee on Welfare (A.C.R.16)
Capital Complex
Carson City, Nevada 89710

Dear Assemblywoman Freeman:

I am writing to you as a member of the Governor's Maternal and Child Health (MCH) Advisory Board to encourage efforts by the Committee on the Welfare System in Nevada to provide for prenatal care.

In December of 1990, the MCH Advisory Board issued its Annual Report to the Governor. In this report the recommendation was made that the Nevada State Legislature make a strong public commitment to improve the outcome of pregnancy for all Nevada women by taking steps toward the establishment and funding of a comprehensive statewide perinatal care system. One of the steps listed was providing for presumptive Medicaid eligibility for low income pregnant women.

Early and continuous prenatal care is the foundation for healthy babies. In Nevada in 1991, only 68% of pregnant women received care in the first trimester of pregnancy. The majority of those who received late and inadequate care did so due to the inability to pay for care. The lack of early and continuous prenatal care often results in low birthweight infants who place a great financial burden on the State because of higher NICU costs, life-long health care costs and special education needs.

I repeat here the recommendation for presumptive eligibility and hope that your committee will take this opportunity to move Nevada forward in caring for the most vulnerable of our citizens. I encourage the committee to consider this issue at the committee's meeting on Friday, June 26, 1992.

Sincerely,

Jeff R. Wright MD

Chairman, Department OB/GYN
University of Nevada School of Medicine

(EXHIBIT 3)

9. INCREASE CHILD HEALTH ASSURANCE PROGRAM (CHAP) COVERAGE TO PREGNANT WOMEN AND CHILDREN

The Nevada Medicaid Child Health Assurance Program (CHAP) provides coverage to pregnant women and children up to 133 percent of poverty (which is the federal minimum requirement), and phase-in Medicaid coverage for children up to age 19 with income up to 100 percent of poverty. Coverage for children age 7 was effective 7/1/91, age 8 effective 10/1/91, age 9 effective 10/1/92. One additional age group will be added October 1 of each year until clients up to age 19 are eligible.

Federal regulations allow states the option to provide Medicaid coverage to pregnant women and children up to 185 percent of poverty and receive federal match funding. Expanded Medicaid coverage for pregnant women and children is arguably a means for expanding the availability of pre-natal care and post-partum care and therefore, improve chances for positive pregnancy outcomes and early detection and treatment of childhood diseases and reduces the possibility of having low birth weight babies.

As in the preceding recommendation on presumptive eligibility, the subcommittee received considerable testimony supporting the expansion of Medicaid services for pregnant women and children up to 185 percent of poverty. The testimony from proponents in support of this proposal argued, by expanding Medicaid services for pregnant women and children to the 185% poverty level, another positive and logical step toward developing a comprehensive statewide peri-natal health care system would be taken.

The subcommittee, in their discussions, considered both presumptive eligibility and the expansion of the Child Health Assurance Program critical for improving access to pre-natal care and for reinforcing the importance of obtaining early and continuous pre-natal care to significantly improve positive pregnancy outcomes and the delivery of healthy babies. The subcommittee also recognized both proposals, although arguably cost effective, would be costly to implement. Costs projections were difficult to estimate because of the rapid increases in CHAP caseload and lack of a historical base of data due to the continuous expansion in the program over the last several years. The subcommittee conscious of the state's fiscal picture, determined improvements have been made for expanding pre-natal care to greater numbers of pregnant women. However, the subcommittee reasoned early, expedited and continuous eligibility for Medicaid pre-natal services remains the key for increasing the likelihood of positive pregnancy outcomes. The subcommittee did not wish to de-emphasize the importance of expanding CHAP, and determined expanding the program remains a pivotal component for establishing a comprehensive peri-natal health care system. However, the subcommittee recognized that funding new program enhancements will be difficult for the upcoming legislative session. The subcommittee decided to concentrate the study's recommendations for pre-natal care in support of adopting presumptive eligibility and emphasizing early, expedited and continuous eligibility for pregnant women.

Therefore, ***the subcommittee endorsed for consideration during the upcoming Executive Budget and legislative budget review process to expand the coverage threshold for the Child Health Assurance Program (CHAP) (which provides Medicaid coverage to pregnant women and children) to a higher percentage of poverty than the federal***

mandated minimum coverage level of 133 percent of poverty currently supported in Nevada.

10. MEDICAID LONG-TERM CARE

The Nevada Association of Counties (NACO) and the Nevada Association of County Welfare Directors (NACWD) in testimony throughout the course of the study strongly urged the subcommittee recommend the state assume total responsibility for funding the non-federal share of the Medicaid long-term care program and maintain the income limit at 300 percent of the social security income threshold. This proposal is consistent with both parties' suggestions to the subcommittee that the state should be held responsible and should fund all welfare assistance programs eligible for federal match funding. Currently, the Medicaid program's long-term care costs are jointly shared by the state and counties. The state funds Medicaid coverage for long-term care clients who have incomes up to $714 per month. The counties fund Medicaid coverage for long-term care patients whose incomes exceed $714 up to 300 percent of SSI limit (currently $1,221).

The Governor's 1991-93 Medicaid budget proposed shifting a greater share of the Medicaid program's long-term care costs to the counties. The 1991 Legislature by approving Assembly Bill 577, which created the provider tax program was able to reverse the Governor's recommendation, and have the state re-assume responsibility for Medicaid long-term care services at their historical coverage levels at a cost of approximately $25 million for the 1991-93 biennium.

NACO and the county welfare directors informed the subcommittee the state's level of responsibility for funding the Medicaid long-term care program has not changed since $714 was the 300 percent SSI threshold. NACO and the county welfare directors argued maintaining the state's funding responsibility at $714 is arbitrary and unfair since the SSI limit has been indexed higher each year due to the cost of living and has now reached $1,221. Eventually, NACO and the county welfare directors argued, if the state's share of responsibility for Medicaid long-term care costs remains for only those eligible at or below $714, more and more Medicaid long-term care patients will become a county level responsibility as their incomes exceed $714.

The subcommittee considered the arguments introduced by NACO and the county welfare directors reasonable especially since the $714 threshold for state responsibility has remained static for many years. The subcommittee, in recognition of the arguments presented, reviewed several options and alternatives which included assuming total control of the Medicaid long-term care program, maintaining the existing program at current state/county levels of coverage responsibility and providing for an annual index adjustment to state's threshold level based upon "cost of living" increases. The subcommittee requested and was provided information on costs for these options and alternatives from the Welfare Division.

The subcommittee, in reviewing and discussing the option, for the state to assume total responsibility for the Medicaid long-term care program was concerned with the state's current fiscal dilemma. The subcommittee realized the state was only able to re-assume responsibility for their historical share of Medicaid long-term care costs with the introduction of the provider tax program. As testimony during the course of the

study indicated, the state's benefits from the provider tax program in the future are anticipated to be significantly less than projected for this biennium. The subcommittee, in recognition of this probable occurrence realized it was fiscally not possible for the state to assume total responsibility for the program as NACO and the county welfare directors proposed. On the other hand, the subcommittee considered the option for the state to maintain responsibility for the Medicaid long-term care program at the existing coverage level unfair in light of cost-of-living increases provided annually which affect the SSI coverage maximum.

The subcommittee determined for the joint program to continue and to operate in a more equitable manner, the state coverage level of $714 should be indexed annually for cost-of-living adjustments. The subcommittee's intent is for the annual cost-of-living adjustment applied to the 300 percent SSI threshold also be applied to the state's coverage threshold. The subcommittee realized indexing would increase the state's share of costs for the Medicaid long-term care program. However, the subcommittee felt the state and counties must share in the burden of costs for this program mutually since no one level of government can shoulder the costs alone. A provision for indexing the state's threshold allows for an equitable distribution of costs for the program.

Therefore, ***the subcommittee recommended the state/county shared responsibility for funding the Medicaid long-term care program up to the federal allowable maximum (300 percent SSI) be continued. However, the subcommittee recommended adjusting the state's current maximum coverage threshold of $714 with an annual cost-of-living increase (COLA) using a recognized cost-of-living index.***

11. ENTER INTO A "1634" AGREEMENT WITH THE SOCIAL SECURITY ADMINISTRATION TO PROCESS MEDICAID APPLICATIONS FOR SSI RECIPIENTS.

Nevada Legal Services proposed at the third subcommittee meeting, the Welfare Division enter into a 1634 agreement with the Social Security Administration (SSA) whereby the SSA would make Medicaid determinations for Supplemental Security Income (SSI) recipients. Nevada Legal Services testified a 1634 agreement would eliminate the need for welfare eligibility workers to process Medicaid applications for SSI recipients, relieve clients from making duplicate applications at the SSA and Welfare Division offices and assure that maximum Medicaid coverage could be available to SSI recipients.

In researching this issue, the subcommittee learned SSI eligibility determinations are currently made by the SSA. Clients determined to be SSI eligible are automatically eligible for Medicaid services. The Welfare Division requires the recipient applying for SSI to also formally apply for Medicaid services. The SSA when notifying the client they are SSI eligible also notifies the client they are Medicaid eligible, however, they must first apply for Medicaid. The SSI recipient will not be eligible for Medicaid until they have formally applied and eligibility is determined. Currently, the SSA takes an average of 120 days to render an eligibility decision. If eligible, benefits are retroactive to the date of application for SSI. Medicaid benefits will also be retroactive depending on when or if the client formally applied for Medicaid.

The subcommittee, during the course of their review, noted the 1634 agreement will not expedite the eligibility determination process because the SSA still must determine eligibility. The 1634 agreement will save the recipient from having to formally apply for Medicaid since a tape transfer of SSI determined eligibles will be provided Nevada Medicaid from the SSA. Also, the agreement insures the recipient will receive retroactive Medicaid benefits back to the date of the individual's SSI application because formal Medicaid application is no longer necessary.

To further analyze and study this proposal, the subcommittee requested information from the Welfare Division on costs for entering into a 1634 agreement. The Welfare Division, in responding to the subcommittee's request, explained it was difficult to estimate costs since they have no information about SSI eligible recipients who have for whatever reason not enrolled in the Medicaid program (2,218 potential Medicaid eligibles). The Welfare Division further explained to the subcommittee it can be assumed and argued with a 1634 agreement, the SSI eligibles who have not accessed Medicaid may be more inclined to do so if they automatically receive Medicaid eligibility and a Medicaid card. Based on this assumption, the Welfare Division surmised to the subcommittee the costs for entering into a 1634 agreement could potentially be significant.

The subcommittee, in analyzing the proposal, determined a duplication of services currently exists requiring SSI recipients to file duplicate applications with the SSA and the Welfare Division. The subcommittee learned a 1634 agreement would save five eligibility worker positions in the Welfare Division which could then be re-assigned to other responsibilities. Additionally, the subcommittee reasoned it was not logical to assume SSI eligibles who have not accessed Medicaid would automatically do so if a 1634 agreement was implemented. The subcommittee theorized the group of potential Medicaid recipients who have not accessed the program, most likely have pursued other avenues for health care and would most likely not access Medicaid even though eligible.

Therefore, ***the subcommittee recommended the Welfare Division enter into a 1634 agreement with the Social Security Administration (SSA) whereby the SSA would make Medicaid determinations for Supplemental Security Income (SSI) recipients. This subcommittee recommendation will not expedite the eligibility determination process. However, the recipient would not be required to formally complete duplicate applicaiions for Medicaid at the SSA and Welfare Division offices; would eliminate the need for the Welfare Division case workers to process Medicaid applications for SSI recipients; and assures the maximum Medicaid coverage could be available to the SSI recipient retroactive to the date of formal application.***

12. PROVIDE A HOME MAINTENANCE ALLOWANCE FOR UP TO 6 MONTHS FOR NURSING HOME RESIDENTS RECEIVING MEDICAID.

Nevada Legal Services proposed the Medicaid program provide for an optional deduction in the post-eligibility (patient liability) determination process known as a home maintenance allowance. The deduction which is federally allowable is for single individuals and couples (both members of which are institutionalized). The option allows the Medicaid program to deduct from total income an amount for maintenance of the individual's or couple's home. The following conditions apply:

1. The amount deducted is for a period which does not exceed 6 months, and

2. A physician has certified that the individual or either member of the couple is likely to return to the home within that period.

Nevada Legal Services, in their proposal, explained this allowance will provide a means for eligible nursing home residents to maintain and return to their homes rather than selling their homes and becoming a long-term nursing home client. The Nevada Legal Services' proposal would require the Welfare Board's approval and a state plan change.

The subcommittee requested the Nevada Welfare Division provide additional analysis as to the feasibility and potential costs for the Nevada Legal Services' proposal. The Welfare Division, in response to the subcommittee's request, confirmed very few Medicaid eligible long-term care (nursing home) patients would meet the eligibility criteria for this allowance (based upon a 5-month review of Medicaid case closures). The cost based upon the number of cases reviewed by the Welfare Division and the $500 per month allowance suggested by Nevada Legal Services is $72,000 per year.

However, the Welfare Division informed the subcommittee nursing facility patients are not the only affected Medicaid recipient population. Hospital patients also qualify for this allowance. In 1991, 15,981 Medicaid recipients received inpatient hospital services. The Welfare Division hypothesized if only one month of home maintenance at $500 was allowed for 15,981 recipients, the cost to the Medicaid program could be as much as $7,990,000 per year.

At the subcommittee's June 26, 1992 work session meeting, representatives from Nevada Legal Services strongly disagreed with the Welfare Division's cost estimates for the home maintenance allowance based on the Division's hospital patient access assumptions. Nevada Legal Services did not dispute that hospital patients would also qualify for the allowance, however, the number of hospitals patients qualifying would most likely be small (because of the average length of hospital stays) therefore, the Welfare Division's estimates were overexaggerated. The Welfare Division, in responding to the subcommittee's request to clarify the cost estimates projected, explained the cost projections may be overstated since it is difficult to breakout Medicaid hospital admissions by categories of eligibles (i.e., aged, blind, or disabled) who may qualify for the allowance. The Division explained if their assumption included all Medicaid hospital admissions, the projections very well may be overstated.

The subcommittee was interested and supportive of the concept and benefits the proposal would provide. However, the subcommittee did not feel the information provided on the potential costs and implications the home maintenance allowance proposal would have on the Medicaid program was either reliable or sufficient enough to formulate a specific recommendation. The subcommittee determined the proposal had merit and instructed the Fiscal Analysis Division staff to work in conjunction with the Welfare Division to develop and provide more complete information.

Therefore, ***the subcommittee recommended further study be conducted to determine if an optional deduction for nursing home residents receiving Medicaid called a "home maintenance allowance," is a viable cost effective measure worthy of future***

consideration. The optional home maintenance allowance provision allows the Medicaid agency to deduct from total income an amount for maintenance of the individual's or couple's home if certain conditions are met.

13. WELFARE DIVISION BUDGET CAPS

The subcommittee received considerable testimony from Nevada Legal Services, the Nevada Welfare Division and county social service directors proposing the budget funding "caps" placed on the Welfare Division's Aid to Dependent Children, Food Stamps, Medicaid and Employment and Training Programs be eliminated.

The caps in the past fiscal years have prohibited the Welfare Division from requesting additional state funds from the Interim Finance Committee or the upcoming legislature. However, the Welfare Division was provided flexibility through the General Appropriations Act to transfer appropriated amounts between the Division's various budgets and between fiscal years. The caps when originally implemented were seen as a mechanism to force the Welfare Division to better manage their various program expenditures. In years prior to the imposition of the budget caps the Welfare Division required several significant supplemental appropriations due to budget overruns.

The 1991 Legislature did modify the capping language for the 1991-93 biennium with passage of Assembly Bill 818 (General Appropriations Act). The Legislature decided in light of the inability to predict actions taken by the federal government which may have a costly impact on Nevada's welfare programs, to include a provision in AB 818 to allow the Welfare Division to seek additional funding for services required by the federal government on or after October 1, 1990, which were not specifically budgeted in the 1991-93 biennium.

The testimony the subcommittee received recommending the removal of the budget caps emphasized this action would not obligate the Legislature or Interim Finance Committee to appropriate the Welfare Division additional funding during the interim. The removal of the caps would simply allow the Welfare Division to approach and request additional funding to meet unforeseen budget needs due to caseload growth, new mandates or changes in the interpretation of rules. It was argued the Legislature and/or Interim Finance Committee would still have the authority to approve or deny the request as they do with any other requesting state agency.

The subcommittee agreed with the arguments presented in favor of eliminating the Welfare budget caps. The subcommittee in discussing the issue noted in recent years the Welfare Division has been significantly underfunded due to caseload expansion and the imposition of federal mandates unforeseen or underestimated. The budget caps have further complicated the problem and in several circumstances the Welfare Division has had to enact program cuts or forego program enhancements legislatively approved in order to remain within their overall budget.

Therefore, ***the subcommittee recommended to completely eliminate the budget funding "caps" currently placed on the Welfare Division's Aid to Dependent Children, Food Stamps, Medicaid and Employment and Training Program budgets for the upcoming 1993-95 biennium.***

14. ESTABLISH A STATEWIDE HUMAN RESOURCES PLANNING COMMISSION.

The Director, Clark County Social Services, proposed the subcommittee recommend the establishment of a statewide Human Resources Commission. The Commission would include a diverse membership with representation from various state and local governmental agencies, private non-profit human service organizations, the state Legislature, advocacy groups, and the general public. The Commission as proposed, would report to the Governor and would be a policy making body. The commission's mission would be to establish statewide assessment and planning mechanisms for human resources, to ensure that adjustments to social programs have a measured impact on communities, to develop a philosophy toward service and delivery of social services in Nevada, define current and future needs and to review and make recommendations regarding state and local human service programs.

The subcommittee, at their second meeting, received considerable testimony on the status of implementing Assembly Bill 239 passed by the 1991 Legislature. Assembly Bill 239 requires the Director, Department of Human Resources to adopt a statewide master plan for the provision of human services, and to update the plan biennially. In so doing, AB 239 stipulates the Director shall seek advice from agencies of local governments and non-profit organizations in developing the plan and for communicating and coordinating the delivery of human services in the state. A representative from the Director's Office testified a draft master plan will be compiled and completed for the 1993 Legislature's review. The representative stressed the goal for the Director's Office is to implement a viable ongoing planning process. This process as was pointed out is essential as cutbacks in funding and services has affected all integral components of the human services network requiring the better utilization of limited resources.

The subcommittee also received testimony from the current President of the Truckee Meadows Human Services Association (TMHSA) on their efforts to create a master plan for the delivery of human services in the Truckee Meadows. The subcommittee learned the TMHSA is a somewhat unique organization comprised of interested professionals representing hundreds of public and private agencies that provide human services in Washoe County. The subcommittee learned the TMHSA spearheaded efforts to develop and implement a community planning process to enhance the quality of life in Washoe County. The planning process utilized by the TMHSA and the information compiled according to the Director's Office representative would be heavily relied upon for developing the statewide master plan.

The subcommittee was enthusiastic at the current efforts being undertaken to develop a human services planning process. The subcommittee realized planning is an evolutionary process and recognized the importance of creating an appropriate forum to continue the positive steps which have been realized to date. The subcommittee specifically cited and commended the work of the TMHSA and the Director's Office for their efforts to develop a comprehensive inventory of human services provided at all levels in Nevada and their inter-relationships. The subcommittee was supportive of developing a linkage between the many human services providers which would allow

for open communication and to foster the sharing of information and experiences among all social service entities.

The subcommittee in their discussions, supported the concept for creating a formal body or organization which would be the focal point for continuing the evolution of the statewide human services master planning process. However, the subcommittee was concerned with the mechanics of interfacing the proposed policy making Human Resources Commission with other existing boards such as the state Welfare Board, Maternal Child Health Board and state Health Board. The subcommittee determined at this juncture, an advisory board rather than a policy making body would be more useful until a more clear definition and role of the Human Resources Commission could be developed. The subcommittee felt the role of the Commission would be better understood and consequently defined with time.

Therefore, ***the subcommittee recommended the creation of a statewide human resources planning committee to function in an advisory capacity, providing assistance, advice and direction on human services issues and human services long-range planning. The intent of the subcommittee was to establish an advisory committee whose membership consists of diverse backgrounds and orientation to provide guidance in continuing the development and refinement of a statewide human services master plan.*** (BDR 38-787)

15. ELIMINATE SINGLE EMPLOYABLES AND EMPLOYABLE CHILDLESS COUPLES FROM MANDATORY FINANCIAL AID.

The Director, Clark County Social Services, requested the subcommittee's support for Clark County sponsored legislation, which will be introduced to the 1993 Legislature, eliminating single employables and employable childless couples from mandatory county financial aid.

The Clark and Washoe County Social Service Directors testified this proposal will provide the county welfare agencies flexibility when necessary to prioritize needs and benefit levels among the various client groups served at the local level. According to the two county welfare agencies, the stagnant economy which has caused county welfare caseloads to swell similar to the state Welfare caseloads has forced the need to prioritize under certain circumstances who receives financial aid. The subcommittee received testimony from Nevada Legal Services strongly not in support of this proposal.

The subcommittee in discussing this proposal expressed concerns regarding how determinations on employability are made. The Director, Clark County Social Services testified a staff of professional social workers as well as eligibility workers are trained and experienced in making such determinations.

The subcommittee determined the county welfare agencies should be provided latitude and flexibility in determining who receives financial aid and felt it was important for the entire Legislature to debate the proposal.

Therefore, ***the subcommittee recommended to endorse support for legislation to be sponsored by Clark County Social Services which eliminates single employables and employable childless couples from mandatory county financial aid.***

16. MEDICAID PROVIDER TAX

The 1991 Legislature with approval of Assembly Bill 577 established Nevada's hospital and non-institutional provider tax programs. The provider tax program, sometimes referred to as the Kentucky Plan allowed the state to re-acquire responsibility for long-term care Medicaid costs recommended in the Governor's 1991-93 biennial budget to be shifted to the counties. The projected costs for the state to re-assume responsibility for the shift was estimated at $25 million for the 1991-93 biennium.

At the May 14, 1992 Interim Finance Committee meeting, the Director, Department of Human Resources reported the net state benefit attributed to the provider tax programs for the 1991-93 biennium is estimated to be approximately $66.5 million. Applying the projected net state benefit from the provider tax program of $66.5 million, to the projected costs for re-assuming the long-term care shift would leave a net balance of approximately $41.5 million. However, the Director also reported the Medicaid program will need for FY 1992 and FY 1993 a majority of the remaining $41.5 million in provider tax benefits for projected Medicaid medical expenditures due to caseload increases and mandates not budgeted.

The Nevada provider tax program must be significantly altered to comply with federal law (HR 3545) effective July 1, 1993. Nevada's non-institutional provider tax program will most likely be totally dismantled. The hospital provider tax program must be significantly restructured eliminating the hold harmless provisions currently provided for within AB 577. The Director at the May 14, 1992 IFC meeting could not provide a projection of provider tax revenues which may be attainable under a completely restructured provider tax program for the upcoming biennium. The Director did indicate the provider tax program would most likely be continued in some fashion, however, the program's revenue generating capacity will be significantly reduced.

The subcommittee recognized the importance of the significant revenue generating capabilities the provider tax program has had for the current 1991-93 biennium. The subcommittee also realized significant Medicaid budget increases will be necessary for the upcoming 1993-95 biennium and the problem will be exacerbated if provider tax revenues need to be replaced with state funds.

In recognition of the state's current financial dilemma, ***the subcommittee recommended the Department of Human Resources explore all avenues in attempting to re-structure and develop a provider tax program maximizing state benefits for the upcoming biennium which will conform to federal provider tax rules and regulations.***

17. FAMILY IMPACT STATEMENT

The subcommittee, at the May 21, 1992 meeting, discussed the importance in developing and maintaining a perspective when changes are introduced in the delivery of human services via legislation, regulation or policy, that the impact on family unity be taken into consideration. The subcommittee was concerned that in certain circumstances policy and legislation primarily developed at the federal level fails to re-enforce and in some situations, provides disincentives to retain family unity and

promote family togetherness. The subcommittee felt this was an opportune time as policy makers and public leaders nationwide struggle to how best to promote family togetherness to re-emphasize the importance of this issue.

Therefore, ***the subcommittee recommended that the 1993 Legislature, by resolution urge the U.S. Congress to evaluate the implications and/or ramifications legislation will potentially have on maintaining family stability and family unity.*** (BDR R-783)

III. FINDINGS

MEDICALLY NEEDY

The ACR 16 legislation charged the subcommittee to identify programs established by the federal government which are available to Nevada for the provision of welfare services, and whether or not they are currently conducted in Nevada.

The major optional program available to Nevada and which in some fashion has been implemented in a number of states is the medical needy program. A medical needy program provides Medicaid services to coverage groups (as designated by the state), who have more income and/or resources than is allowed by cash assistance programs such as ADC or SSI but who are at risk of not being able to afford adequate medical care.

A medically needy program has certain flexibility in terms of optional coverage groups and optional services. However, mandatory groups include the following:

A. All pregnant women during the course of their pregnancy and for 2 months following the end of pregnancy, who but for income and resources would be eligible as categorically needy.

B. Newborns born to women who are medically needy and receiving Medicaid on the date of the child's birth. The child remains eligible for one year after birth.

C. All persons under age 18 who would be eligible as categorically needy except for income and resources (ADC, SSI, CHAP, IV-E).

   Optional groups - individuals under age 21, caretaker relatives, aged, blind and disabled.

A medically needy program would make available Medicaid services to a significantly larger population of potential recipients currently not eligible for Medicaid. The degree of expansion is dependent upon the mandatory groups covered and optional groups selected.

Costs

The subcommittee received considerable testimony on the implementation options and benefits a medically needy program provides those individuals whose economic status is extremely vulnerable to the costs of medical care. Per the subcommittee's request, the Welfare Division attempted to project costs for a medically needy program in Nevada. This task was difficult since there is little information available which can be used for accurately projecting potential caseload and program utilization. The Division used for a base the fiscal note prepared for the 1989 Legislature on legislation introduced, however, not approved, mandating a medically needy program and updated this information to respond to the subcommittee's request. The Division's analysis estimated, if implemented, a medically needy program in Nevada would have a potential caseload of 12,295 additional Medicaid eligible recipients (based upon national percentages and May 1992 welfare caseload data) at a cost of approximately

$66.1 million. (The Welfare Division's projected costs for implementing a medically needy program, according to the fiscal note developed for the 1989 Legislature, was approximately $54.1 million for FY 1990 and $63.1 million for FY 1991.)

As an option for the subcommittee to review, the Welfare Division also provided a projection of costs for scaled down version of a medically needy program which would strictly provide Medicaid services for pregnant women and children. The projected costs for the scaled down medically needy program based upon FY 1992 caseload data and medical costs ranged from approximately $13.5 million to $16.2 million, depending upon the assumptions used.

The subcommittee expressed interest with the objectives a medically needy program was designed to provide and acknowledged a definite need exists to expand the accessibility of medical care for those who cannot afford it. However, the subcommittee felt expanding medical and health care accessibility are public policy issues which will require a great deal of debate and reliable information to make rational and logical decisions. The subcommittee felt a medically needy program in some fashion may be one component to an overall approach for responding to Nevada's health care needs, but the issue should be studied in total, not in parts. The subcommittee felt this issue could not be fully addressed within the time frames and limitations of the ACR 16 mandates as it should be. Therefore, the subcommittee decided the information developed should be included in their report for future use, however, no recommendations concerning the medically needy program were made.

APPENDIX A

ASSEMBLY CONCURRENT RESOLUTION NO. 16
(FILE NO. 0179, STATUTES OF NEVADA, 1991).

Assembly Concurrent Resolution No. 16—Assemblymen Evans, Callister, Marvel, Price, McGinness, Pettyjohn, Goetting, Giunchigliani, Heller, Spitler, Myrna Williams, Stout, Dini and Humke

FILE NUMBER.....

ASSEMBLY CONCURRENT RESOLUTION—Directing the Legislative Commission to conduct an interim study of the welfare system in Nevada.

WHEREAS, The State of Nevada is experiencing an unprecedented rate of growth in its population; and

WHEREAS, The welfare system in this state was not designed to meet the changing demands of this increase in population; and

WHEREAS, It is in the public interest to identify the specific nature of those demands, the availability of resources to provide the necessary welfare services and the means to ensure that the necessary welfare services are provided efficiently; now, therefore, be it

RESOLVED BY THE ASSEMBLY OF THE STATE OF NEVADA, THE SENATE CONCURRING, That the Legislative Commission is hereby directed to conduct an interim study of the welfare system in Nevada; and be it further

RESOLVED, That the study include:

1. An evaluation of the various welfare services being provided by the state and its counties, and by any private organizations in the communities of this state;

2. The identification of any programs established by the Federal Government which are available to Nevada for the provision of welfare services, whether or not they are currently being conducted in this state;

3. The identification of any needs for welfare services in this state which are not being satisfied, and of any welfare services being duplicated by the various providers of those services in Nevada; and

4. The identification of means to improve the welfare system in this state; and be it further

RESOLVED, That the results of the study and any recommended legislation be reported to the 67th session of the Nevada Legislature.

19 91

APPENDIX B

SUGGESTED ISSUES/TOPICS FROM THE NEVADA WELFARE DIVISION FOR CONSIDERATION BY THE SUBCOMMITTEE ON NOVEMBER 22, 1991.

BOB MILLER
Governor

STATE OF NEVADA

JERRY GRIEPENTROG
Director

LINDA A. RYAN
Administrator

DEPARTMENT OF HUMAN RESOURCES
WELFARE DIVISION
2527 North Carson Street
Carson City, Nevada 89710
(702) 687-4128

November 6, 1991

MEMORANDUM

TO: STEVE ABBA

FROM: LINDA A. RYAN

SUBJECT: A.C.R. 16 STUDY - WELFARE SYSTEM IN NEVADA

Pursuant to your October 17, 1991 memo, enclosed please find the overview material on programs administered by the Welfare Division.

The material includes a brief summation of each program to include its purpose, application process, eligibility requirements, client profile, expenditures and data on caseload, where appropriate.

You also requested definitions of public welfare, mission statements and the five major issues/topics affecting the delivery of welfare services in Nevada which we feel the Interim Study Committee should address.

I believe the purpose statements provided in the overview material adequately defines the public welfare programs administered by State Welfare.

The Welfare Division recently developed a mission statement when we participated in a project directed by the State Budget Office to identify critical issues and key performance indicators. The mission statement is as follows:

> The Welfare Division administers public welfare programs in the state by providing helping services, medical and/or financial assistance. State Welfare assists aged, blind and disabled people who have exhausted their resources; children who are the victims of parental abuse and neglect or whose parents can no longer care for them because of behavior, physical or medical problems; and poor families experiencing a disability or temporary crisis in need of food, cash and medical assistance for their dependent children.

Regarding the five major issues to be considered, we believe the committee should focus their attention on the following:

1) Examining the Emergency Assistance program and how it may be used to meet the needs of families with immediate short-term problems. The counties now assist these families with 100% Nevada tax dollars. It is possible to design a program to assist certain families with 50% funding from the federal government.

2) Analyzing Medicaid coverage groups to determine if the program should be expanded. Indigent care costs are covered 50% by the federal government when clients are Medicaid eligible versus 100% by Nevada tax dollars or bad debts to hospitals/providers. The Medically Needy Program and expanded coverage to pregnant women and children are areas for consideration.

3) Developing (or encouraging) referral systems to ensure clients who have categorical eligibility for assistance receive all the help they are entitled to receive. Examples are: ADC and Food Stamp families are automatically eligible for free/reduced school lunches, not all receive this benefit. SSI recipients are categorically eligible for Medicaid, not all receive this benefit.

4) Developing information sharing systems. County and State Welfare programs share little information. Better exchange systems (preferably automated) would increase efficiency and decrease the possibility of duplicate benefits.

5) Recommending legislation which would clearly define county and state responsibility in the overall welfare system. This would improve long-range planning and budget development.

It is also my intent to have transparencies for an overhead projector when giving the presentation on November 22, 1991. If you could please provide the necessary equipment, I'd appreciate it.

If you have any questions on the material enclosed, please contact me at 687-4128.

LAR/ka
cc: Mike Willden
April Hess
Patty Williams
Diane Nassir

STATE OF NEVADA
LEGISLATIVE COUNSEL BUREAU
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CAPITOL COMPLEX
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Fax No.: (702) 687-5962

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LEGISLATIVE COMMISSION (702) 687-6800
JOHN M. VERGIELS, *Senator, Chairman*
John R. Crossley, *Director, Secretary*

INTERIM FINANCE COMMITTEE (702) 687-6821
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Daniel G. Miles, *Fiscal Analyst*
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LORNE J. MALKIEWICH, *Legislative Counsel* (702) 687-6830

October 17, 1991

MEMORANDUM

TO: Linda Ryan, Welfare Administration
Bob Hadfield, Nevada Association of Counties
Michael J. McMahon, Churchill County Social Services Director
May Shelton, Washoe County Social Services Director
Denell A. Hahn, Clark County Social Services Director
Pat Christensen, Nye County Social Services Director

FROM: Steve Abba, Program Analyst
Fiscal Analysis Division

SUBJECT: Preliminary Meeting of the A.C.R. 16 Study (Welfare System in Nevada)

On behalf of Assemblywoman Vivian Freeman, Chairman of the Interim Study Committee on the Welfare System in Nevada, I would like to thank you for attending and participating in the September 30, 1991 meeting which explored possible issues and topics to be addressed by the A.C.R. 16 study. The meeting was very informative and brought into focus the significant number of complex issues which impact the public welfare system in Nevada and theoretically could be considered in the A.C.R. 16 study. However, the meeting, I believe, also reinforced the need for the A.C.R. 16 interim study committee to prioritize and concentrate on specific number of far reaching issues and topics which affect the delivery of public welfare services in order for the committee's findings to be of significant value.

As was discussed at the September 30, meeting, the first formal A.C.R. 16 interim study committee meeting will be designed to provide an overview of public welfare services at the state and local levels. I believe an overview will provide legislative members of the interim study committee a solid working understanding of public welfare services and programs currently administered at both the local and state levels. The committee's sound understanding of state and local public welfare programs and their inter-relationship is an essential foundation for subsequent meeting which will delve into more critical issues incurred with the provision of welfare services in Nevada. For the overview meeting, I am requesting your assistance as experts in the administration of welfare services in your respective agency to present an overview of the services and

programs provided by the particular agency you represent; and to provide this information to me in advance of the scheduled meeting for assimilation and inclusion into each committee member's agenda package.

To assist you in planning for your presentation, I offer you the following as a general guide for preparation. Each presentation should last between 30 and 45 minutes (no longer than 45 minutes). This will allow ample time for questions by the committee and/or the public, and other planned presentations. The presentation should address the public welfare programs and services administered by your agency, a description and purpose of services, eligibility requirements, client profiles, target recipient groups, clients served, any limitations on services, etc. The presentation should be all encompassing, the goal being the more information brought to the attention of the committee, the greater the understanding of the scope and nature of public welfare services currently available in Nevada. The presentations can be made using audio-visual aids for which the Legislative Counsel Bureau will provide necessary equipment.

At the September 30 meeting, I also requested that each representative provide to me their definitions of public welfare, the mission statements for their representative agencies and the five major issues/topics affecting the delivery of Welfare services in Nevada which you feel should be addressed by the interim study committee. Please cite and describe the issues briefly and expound upon the importance of why this issue should be included in the scope of the interim study. Due to the overwhelming nature of issues facing the delivery of public Welfare services, it will be important for the committee to develop a concensus and focus on a finite number of major issues in order for the committee findings or recommendations to be of a definitive and productive nature.

In order to have adequate time to correlate and format the written materials on the programs and services provided at the state and local level, I request that written information on your presentations and issues for possible consideration be provided no later than November 6, 1991.

I would like to thank you in advance for your cooperation and your willingness to provide a presentation before the A.C.R. 16 interim study committee. If you should have any questions, please do not hesitate to contact me.

cc: Assemblywoman Vivian Freeman

ACR16ATTS:SJA/tc
WELFARE STUDY

APPENDIX C

SUGGESTED ISSUES/TOPICS FROM COUNTY SOCIAL SERVICE DIRECTORS AND NACO FOR CONSIDERATION BY THE SUBCOMMITTEE ON NOVEMBER 22, 1991.

MEMORANDUM

Social Service Department

DENELL A. HAHN
DIRECTOR

TO: Steve Abba, Program Analyst, Fiscal Analysis Division

FROM: Denell A. Hahn, Social Service Director

SUBJECT: ACR 16 Study (Welfare System in Nevada)

DATE: November 6, 1991

In accordance with your memorandum dated October 17, 1991, the following is a brief synopsis of the content of my presentation to the committee at its November 22nd meeting.

During my presentation, I will give an overview of the Nevada counties' current general assistance programs, both medical and financial. I will also discuss the interrelationship between the county/state programs. Specifics of the Clark County program will also be a part of my testimony.

The mission statement for Clark County Social Service is to ensure the health, welfare and safety of its constituents by providing programs as directed by the Clark County Board of Commissioners that channel available resources to provide service, support, prevention, outreach, and relief to eligible persons who are indigent, medically needy, or at-risk individuals. The mission of providing assistance to agency clients is carried out with the overall goal of enabling recipients to become self-sufficient.

It is difficult to isolate five major topics/issues I feel the committee should take under consideration as all issues surrounding welfare in Nevada are important. During my presentation, I will be suggesting to the committee that we make a concerted effort to inform Nevadans what welfare is and who it serves. Widespread support is achievable if the public becomes aware of the benefits to each citizen. Secondly, I would suggest that the committee attempt to define county, state and federal roles, a philosophy of service, and coordination of services to our citizens. Thirdly, counties and local resources can and will respond to the needs of our citizens, but only if we are supported in planning and financing. During my overview of assistance provided by Nevada counties, it will be pointed out that the counties are fairly uniform statewide. Most counties have community responsive programs in addition to the mandated services.

The last issue must be to tell you we need the legislature's help in allowing counties to prioritize service categories, raise funds for necessary programs and growth, and to have assurance we will not receive mandated services or shifted responsibilities without <u>real</u> - not just paper funding.

DAH/t

WASHOE COUNTY

"To Protect and To Serve"

91 NOV 18 PM 12:06

DEPARTMENT OF SOCIAL SERVICES

FISCAL ANALYSIS DIVISION

WELLS AVE. AT NINTH ST.
POST OFFICE BOX 11130
RENO, NEVADA 89520 — 0027
PHONE: (702) 328-2300

November 15, 1991

Steve Abba, Program Analyst
Fiscal Analysis Division
Legislative Counsel Bureau
Legislative Building
Capitol Complex
Carson City, NV 89710

Dear Steve:

As you requested in your memorandum of October 17, 1991, following are the issues that I believe affect the delivery of welfare services in Nevada. The major issue is the lack of a clear state policy on human services -- which programs are the state's responsibility and what is the minimum level of services the public can expect from the state.

When this is decided, the state should adequately fund the programs for client services and staff needed to deliver services. Currently, the state balances their budget by eliminating or underfunding state programs. Because the needs for services do not disappear, this practice results in shifting responsibilities and costs to counties whose revenues are derived from local taxes. Counties individually are not eligible, generally, for matching federal dollars for human service programs.

Examples of cost shifts include:

- The Administration's attempt during the 1991 legislative session to shift long-term care responsibilities and costs to counties.

- The state has not indexed up the 300% of SSI eligibility criteria used in Medicaid for long-term care applicants and patients since 1980; currently 300% of SSI is $1,221 per month. This results in counties assuming heavier burdens for nursing home patients each year as people on pensions and Social Security receive cost of living increases.

- The County Match program; the local share, which is 50% of the cost of care for nursing home patients whose incomes fall between $714 a month and $1,221 a month is paid by counties rather than by the state. Each year the counties' financial responsibility for this program increases (see previous example). Nursing home care for patients with incomes up to the current 300% of SSI should be the responsibility of the state.

- Not staffing the ADC program sufficiently to reasonably keep up with the growing numbers of applications and caseloads; this results in ADC applicants staying on county general assistance longer because the ADC application processing time is protracted. During this time counties are also assisting these individuals and families in their medical programs.

- Insufficient funding of the Bureau of Disease Control and Intervention Services for reimbursement for inpatient and residential placements of tuberculosis patients; this adds a heavy financial burden on counties.

- Insufficient funding for Senior Protection Services (age 60 and older); State Welfare investigates complaints of abuse, and neglect and self-neglect, but if removal from the home is indicated and alternative placement is necessary, the state has no funds for placement costs. The county is routinely asked to assume costs for emergency placements.

A second issue is the lack of statutory designation for a state agency to protect adults (between ages 19 and 60) from abuse or neglect. Specifically, vulnerable adults include the mentally retarded, parent(s) who are exploited/abused by their adult children and other frail adults. The county is frequently called by law enforcement and other agencies to intervene and/or provide placement and services.

The third issue is the fact that Nevada does not supplement the $407 per month Supplemental Security Income grant for disabled persons as they do for old age and blind recipients. We have 111 disabled persons in adult group care homes whose cost of care, including the $55 personal allowance, is $683 a month. The client's income of $407 is applied toward the cost of care; the county makes up the difference of $276 for each client in group care.

If you or the committee would like more details on the above, please feel free to call me. Thank you for the opportunity to participate in interim study committee process.

Sincerely,

May Shelton

May Shelton, Director
Department of Social Services

WASHOE COUNTY

"To Protect and To Serve"

DEPARTMENT OF SOCIAL SERVICES

WELLS AVE. AT NINTH ST.
POST OFFICE BOX 11130
RENO, NEVADA 89520 — 0027
PHONE: (702) 328-2300

MISSION STATEMENT

The mission of the Washoe County Department of Social Services is to provide social services authorized and funded by the Board of County Commissioners to Washoe County residents in a caring, courteous and respectful manner.

Churchill County Welfare Department

190 West First Street
Fallon, NV 89406

☎ 702/423-5136
Fax 702/423-0717

Cyril Schank
Commissioner
Ruby Anderson
County Clerk
Michael J. McMahon
Welfare Director

1) Eliminate gaps and overlaps in the two systems.

Within the existing systems there are gaps and overlaps in service. Indicative of these problems is an ineffective utilization of available funding sources. The most obvious overlap in service is seen with long term care and Emergency Assistance. Both the State and County welfare departments are expending monies for the provision of long term care and emergency assistance. Medical assistance for the working poor is a blaring example of the gaps that exist in the two systems.

Many of these problems exist due to the lack of integration between eligibility criterion for the various federal, state, and local programs. The lack of continuity in eligibility criterion produces many gaps. An example of this can be seen with the capped Medicaid rates for long term care. As Medicaid recipients receive cost of living increases the increased income will eventually render them not eligible for Nevada Medicaid. None of the rates (Medicaid, ADC, NRS428) are integrated or allowed to adjust with a cost of living index.

Ineffective utilization of resources is exemplified by using County funds (property tax revenues) for emergency assistance and long term care. Funds for these services can be enhanced by accessing matching Federal funds. The counties are not able to access these funds. The State of Nevada is the only entity that may access Federal match funds.

2) Availability of professionals in rural Nevada.

Out of the fifteen rural counties, there are two county welfare representatives that have college degrees. Many of the counties have individuals assigned to the welfare departments that have no understanding or training on health, human or social services issues. This interferes with the mission of facilitating self-sufficiency. The need for educated/trained human service professionals is paramount to effective intervention. The taxpayers bear the cost of ineffective intervention.

3) Limitations of Service

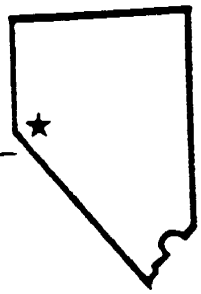
There are no uniform statistics documenting need or services throughout the state. Without a uniform structure to capture and identify the needs and services being provided we end up comparing apples and oranges. The counties provide quarterly financial information on expenditures. However, the counties, collectively, do not identify the number of clients or services provided. We cannot have a complete picture of the human service system without a mechanism of monitoring our status.

Geographic separations inhibits the provision of services, especially in the rural areas of the state. The State Welfare Division manages a "District Office". A district office may provide services to several counties. This does not allow for fluctuations in the type or amount of service in many rural areas. This is exemplified by the communities who experience a boom due to the mining industry. The State Welfare Division, alone, cannot meet the needs of a rapid increase or decrease in population in a rural community. the State Welfare Division is not present in the communities. The States' lack of presence inhibits their ability to respond rapidly to changing needs in the outlying communities.

Potential clients must travel sometimes great distances in order to access services from the state system. Additionally, social workers must travel those same distance to assess or intervene in situations.

Unclear and conflicting language in NRS 428,450 and 439B. The statutes do not specify the services the counties must provide. As a result, there is a great disparity amongst the counties as to the types of services provided. The statutes also are not clear on the taxes that the counties must levy to support the health and human service system.

NACO
NEVADA ASSOCIATION OF COUNTIES
308 NORTH CURRY STREET, SUITE 205 • CARSON CITY, NEVADA 89703 (702) 883-7863



NACO POLICY STATEMENT
ON HUMAN SERVICES

The State Welfare Division should continue to be responsible for federal/state Medicaid and public assistance care for the following categories: families with dependent children, aged, disabled, blind, foster children and individuals targeted by federal programs. Medical coverage must comply with the Medicaid mandates. Income eligibility limits for long term care should be fixed to 300% of SSI.

The Board of County Commissioners should continue to establish and approve funding, policies and eligibility criteria for those programs not available through matching federal funds. Current programs include: emergency assistance to all needy residents, transportation for transients, burials, medical and/or financial aid for non-Medicaid eligible individuals and families and programs addressing unique community or social needs.

This should provide for a clear separation of services and eliminate gaps/overlaps in the system. It will also ensure that the taxpayers' dollars will be maximized by acquiring the full leveraging of available funds.

STATE OF NEVADA
LEGISLATIVE COUNSEL BUREAU
LEGISLATIVE BUILDING
CAPITOL COMPLEX
CARSON CITY, NEVADA 89710
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October 17, 1991

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I would like to thank you in advance for your cooperation and your willingness to provide a presentation before the A.C.R. 16 interim study committee. If you should have any questions, please do not hesitate to contact me.

cc: Assemblywoman Vivian Freeman

ACR16ATTS:SJA/tc
WELFARE STUDY

APPENDIX D

NEVADA LEGAL SERVICES PROPOSALS AND RECOMMENDATIONS APRIL 2, 1992.

NEVADA LEGISLATURE'S COMMITTEE
ON THE
WELFARE SYSTEM IN NEVADA
(ACR 16)

Exhibits in support of testimony offered by
Nevada Legal Services, Inc., through
Jon L. Sasser, Esq. and Mary Ellen McCarthy, Esq.
April 2, 1992

Exhibit A - Eliminate Dollar-For-Dollar Reduction In ADC Grants For Earnings Up to Nevada Standard of Need.

Exhibit B - Finance Expansion Of Medicaid Eligibility Through Extension Of Hospital Tax.

Exhibit C - Increase ADC Payment Levels To 100% Of Need By Year 2000.

Exhibit D - Restore Payment Of ADC Benefits Back To Date Of Application.

Exhibit E - Eliminate Caps On Welfare Division's Budget.

Exhibit F - Enter Into 1634 Contract With Federal Government To Process Medicaid Applications For SSI Recipients.

Exhibit G - Allow A "Home Maintenance" Deduction For Up To Six Months For Short Term Nursing Home Cases.

Exhibit H - Adopt Medicaid For The Medically Needy Program.

EXHIBIT A

ELIMINATE DOLLAR-FOR-DOLLAR REDUCTION IN THE ADC PROGRAM FOR EARNINGS UP TO NEVADA'S STANDARD OF NEED

SUMMARY OF PROPOSAL

With a narrow exception, current law requires that an ADC recipient who earns any extra money must report those earnings and as a result have her grant reduced by $1.00 for each net $1.00 earned. This proposal would seek a state plan change to allow ADC recipients to retain earnings without a dollar-for-dollar reduction until the combined maximum ADC grant, plus earnings, reaches 100% of the Nevada Need Standard.

BACKGROUND

Under federal law, each state must adopt a "Standard of Need" which is a dollar amount representing the cost of the basic necessities of life for families of various sizes in that state. The Nevada Standard of Need was last updated for 1990. Under that Standard, a typical ADC family of a mother and two children would need $620 per month to purchase basic necessities, excluding food. The Nevada Standard of Need is based upon a formula recommended by a 1986 Interim Legislative Study which utilizes the federal poverty level for a family of a particular size and subtracts from it the maximum dollar amount of food stamps which that family could receive (on the theory that the family's food needs are met through the food stamp program).

Federal law allows states to also set a maximum benefit level which may be less than the Standard of Need. The maximum grant today for a family of three is $348 per month for families without publicly subsidized housing (which is $272 short of the price of basic necessities) and $272 per month for those receiving housing subsidies ($348 per month less than the Need Standard).

The $348 per month is the maximum benefit which may be received by a family of three. If a family member has non-exempt earnings the maximum grant is reduced $1.00 for every net $1.00 earned (a participant may receive a small standard work deduction

plus a reduction based on actual dollars spent on child care from gross earnings to determine net earnings).

The only narrow exception to the above general rule is the allowance of a "work incentive disregard" which is provided for the first four months after an ADC recipient returns to the work place. Under the work incentive disregard, a recipient may exclude $30 per month, plus one-third (1/3) of earnings after the deduction of the standard work expense and out-of-pocket child care expenses (up to $200 monthly for children under age 2 and $175 for older children). After four months, the recipient may continue to deduct the $30 only (no longer the one-third) for an additional eight months. The following example shows how the work incentive disregard operates:

GROSS EARNINGS	$550.00	Maximum Grant	$348.00
- Standard Work Exp.	90.00	- Net Income	180.00
Balance	460.00	Benefit Paid	$168.00
- Child Care	160.00		
Balance	300.00		
-Deduction	30.00		
Balance	270.00		
-1/3 of balance	90.00		
Net Income	$180.00		

Under the above example, after four months the recipient would lose the $90 deduction reducing the grant to $78 (1/3). After eight months the recipient would lose the additional $30 deduction further reducing the grant to $48.

EXHIBIT A
Page 2

The above example shows that in the present system there is little "incentive to work". The recipient's $550 gross wages will be reduced by F.I.C.A., income tax withholding, and may be further lowered by uniforms, union dues, or transportation expenses. In this example, the recipient is paying $160 out-of-pocket for child care. Depending on the age of the children, the hours worked, the ability to find inexpensive neighbors as opposed to expensive professional day care, etc., will have a large impact on the reality of that figure. It is likely therefore that the recipient will get to keep only approximately $300 of the $550 earned. That $300 plus the remaining $168 ADC grant provide the recipient a total of $468 a month which is only $120 a month more than the ADC benefit alone. That benefit is eliminated because the $550 gross earnings will cause the recipient's food stamp allotment to drop from $250 per month to $134 per month (assuming rent of $310).

Some 40 states, like Nevada, require a dollar-for-dollar reduction for each dollar in countable income. Some 10 states, however, have adopted some form of "fill the gap budgeting", which allows receipts to make up the difference between the payment level and the standard of need.

RATIONALE FOR PROPOSAL

The current system is hypocritical. The state of Nevada says to recipients, while we recognize that the basic necessities of life, excluding the cost of food, cost $620 during 1990, we will only give you $348 to purchase basic necessities for yourself and your children in 1992. Although we know that you need at least $272 more per month for these necessities, we will reduce your ADC check $1.00 for each $1.00 that you earn if you work for this $272. If you earn extra money under the table to provide necessities for your children, we will label you a "welfare cheat" and remove you from the program for fraud. We know the system offers you no incentive to take a part-time or low-paying job, yet we are silent when the taxpayers call you "lazy" and "welfare bums".

EXHIBIT A
Page 3

The current hypocritical system would be easy to fix at a minimum cost. If this state cannot afford to provide basic necessities to these children, why not let their parents earn the difference between what the state can afford to pay and what these necessities cost without penalty? Under the current system, a recipient is unable to obtain basic necessities for her children unless she is able to obtain a job which pays well enough to net $620 per month (after deducting from gross pay, F.I.C.A. withholding, other work expenses, child care, and the cost of food. While current law allows them to retain Medicaid for up to one year after going back to work, the lack of medical care also becomes a major problem after twelve months if not offered by the employer. Few ADC recipients will have the training, education or experience to secure jobs which pay this well.

Under the proposal the incentive to work is greatly heightened. Assuming for example, that the current 1990 Need Standard were still in effect, an ADC recipient could obtain a job which netted (after deduction of the standard work expense plus actual out-of-pocket child care costs) $272 per month without any reduction of her $348 ADC grant. For each net dollar she earned above $272 there would be a dollar-for-dollar reduction in the grant until eligibility is lost when net income exceeds $620.

The cost to the state should be minimal. At the present time, only 8% - 9% of ADC households have any earnings which reduce their grants below maximum levels. The only direct cost therefore would be to bring the grant levels of this 8% - 9% up to the maximum. At current caseload and benefit levels, the estimated cost would be approximately $500,000.00 in state funds. For this nominal investment the lives of children could be greatly improved, taxpayers would probably feel less angry about this program, and the self-esteem and ultimate employability of recipients could be greatly enhanced.

EXHIBIT A
Page 4

EXHIBIT B

FINANCE MEDICAID EXPANSION THROUGH PERMANENT ENACTMENT OF THE PROVIDER TAX

SUMMARY OF PROPOSAL

Amend NRS 422.380 through 422.390 by conforming the statute to comply with federal law in effect after July 1, 1993 in order to make the hospital tax permanent, increase rates, and use the proceeds to extend Medicaid eligibility.

BACKGROUND

Pursuant to a so called "loop-hole" in federal Medicaid laws, the 1991 Nevada Legislature passed a "tax" on hospitals and other providers of medical services in order to increase revenue which may be matched with federal funds for the Medicaid program. The revenue collected from the hospitals and other providers is used to attract federal match money and then return the collected "tax" to providers either directly or through Medicaid payments. The tax should gross approximately $80 million in FY '92 and $85 million in 'FY 93. Approximately $18 million will be returned directly to hospitals without attracting any federal match. This money is unmatchable because the hospitals in question either do not serve enough Medicaid patients to allow return to the hospital through the Medicaid program or are ineligible for "disproportionate share" payments through the Medicaid program. For the biennium it is projected that hospitals will receive some $20 million back in excess of the amount of taxes paid.

The state is expected to net some $66 million from the tax. $25 million over the biennium will attract federal match money and will be used to pay the cost of preventing the dumping of Medicaid nursing home patients on to the counties. The remaining $41 million is also matchable with federal funds and most of that money should be used to pay cost over-runs in the Medicaid program.

The federal Department of Health and Human Resources proposed regulations to close this "loop-hole". However, Congress enacted Legislation of the Fall of 1991 to allow

the continued use of these revenues as federal match monies through July 1, 1993. After that time, these revenues cannot be used as matched monies unless state statutes are changed to make them a "true tax". The current Nevada revenue raising scheme is not a "true tax" because of "hold harmless" provisions in the law. Under the law, hospitals are guaranteed the return of all tax monies paid within the year plus guaranteed earnings of $100,000 each. To make the tax permanent, the "hold harmless" provisions must be removed so that if a hospital did not do enough Medicaid business to get its tax money back it would actually lose the balance of taxes paid.

RATIONALE FOR DECISION

The proposal attempts to create a "win-win" solution for the poor, the hospitals, the state, and the counties. It seeks to restructure the tax in such a way that all hospitals paying into the program should profit in that more would be returned through additional Medicaid payments than is paid through taxes. The poor and county governments would profit because Medicaid eligibility would be expanded to cover additional persons (many of whom must have their medical bills paid at county expense). The state would profit not only by improving the access to health care of its citizens, but by relieving pressure on the General Fund from the rapidly increasing Medicaid budget.

Under the laws passed by Congress in fall of 1991, states may not continue to increase their "disproportionate share" payments to hospital above current levels (plus cost of living). The only viable way therefore to increase the amount of money returned to hospitals is by expanding eligibility so that persons now receiving hospital services who are not covered by Medicaid would be covered in the future and to some degree by increasing the rate of payment to providers. It is only through a combination of these Medicaid increases could the hospitals which now must rely on the "hold harmless" provisions of the law to receive the return of their tax monies. Under federal law all hospitals in the state would have to be covered by such a tax (not just those who serve a high number of Medicaid recipients).

The key to the success to this new legislation would be to find the right combination of tax rates, payment rates for services, expansion of Medicaid eligibility, and disproportionate share payments to make the system profitable for all. We would urge that you seek the assistance of LCB, Welfare Division, and the Department of Human Resources staff to derive at such a formula.

It is possible that some hospitals at present levels of services to Medicaid recipients would still lose money even under an expanded formula. However, it has long been the goal of the Governor and the Legislature to require all hospitals to serve their share of indigent patients. This proposal provides a carrot (return on tax monies) and a stick (potential loss of tax monies) to get such hospitals to increase services to indigents.

To expand Medicaid eligibility the state could look toward adopting optional Medicaid coverage which is not now utilized in this state. Included would be the adoption of a Medicaid for the medically-needy program (see Exhibit H), presumptive eligibility for pregnant women under the CHAP program, an extension of the CHAP program to pregnant women and children whose income fall below 185% of the poverty (instead of the current 133%), extension of the CHAP program to children up to age 18 immediately, and the allowance of a home maintenance deduction for up to six months for short-term nursing home recipients (see Exhibit G).

Private physicians and nursing homes remain problematic. To continue the tax with private physicians the state would have to make the tax uniform to all physicians in the state. Under the present statute only those physicians serving Medicaid patients pay the tax and receive a return. It is unlikely that this tax could pass the Legislature and continue in existence after July 1, 1993.

Under the present statute nursing homes are not taxed. The cost of long-term care is however an increasing burden to the counties (50% of the cost of those whose

incomes fall between $714 monthly and $1,229 plus 100% of the cost of those whose incomes exceed $1,229 up to the monthly cost of their care). We request that you also have staff take a look whether it is possible to structure a tax against all nursing homes in the state which would guarantee a return to them by adopting the medically-needy coverage for these nursing home revenue. All (or at least virtually all) of the nursing homes in the state have Medicaid patients. Expanded eligibility and perhaps even expanded payment rates could potentially profit both the nursing homes and the state.

Expansion of Medicaid eligibility is badly needed in Nevada. It is estimated that some 200,000 Nevadans do not have either private or government medical coverage. These persons therefore tend to wait until problems rise to the level of emergency room care before seeking medical services. The cost of this care does not disappear simply because it is not covered. The cost must either be borne by the counties (with no federal funds) or written off by hospitals as medical bad debts (which are passed along in the form of higher rates to private paying patients).

This proposal presents a unique opportunity to help solve some of the most serious health and fiscal problems facing the state with the necessity of taxing our citizens either directly or indirectly. While the technical and political obstacles may be great it is worth indepth study.

The fact that many Nevadans are uninsured (19% as opposed to the National average of 15%) contribute to the poor general health of our citizens. In fact Nevada ranks 48th among the 50 states in the general overall health of our population.

The state also desperately needs a new revenue source to help fund the continued growth of the Medicaid program. Even without expansion of eligibility the Medicaid program is growing at alarming rates. The General Fund appropriated for Medicaid has grown from $42.9 million for FY '88 to $80.4 million for FY '91. For FY '93 total

expenditures (from all funding sources) are budgeted at $335.6 million). With other revenue problems facing the state this rapid expansion is a major drain on the state General Fund. All Nevadans will profit from the shift of the cost of this program from General Fund monies to a hospital tax.

It is possible that this idea will not work. There may not be a financial formula that returns monies to "all hospitals". As a result the legislature may not be able to pass such legislation over the objections of these providers. Because of the potential "win-win" solution, however, this possibility should be examined in great detail.

EXHIBIT C

INCREASE MAXIMUM ADC PAYMENT LEVELS TO 100% OF NEED BY YEAR 2000

SUMMARY OF RECOMMENDATION

Enact a statute which would require the gradual increase of the maximum ADC payment level to 100% of the standard of need by the year 2000. The standard of need would be updated annually utilizing the current formula of deducting the maximum food stamp level for families of various sizes from the federal poverty level. Because the grant amounts would be in statute, they would be mandatory regardless of state budget problems unless repealed by a subsequent legislature.

BACKGROUND

The ADC payment level over the last decade has repeatedly been victimized by state budget problems and the cap on the Welfare Division's budget. The grant for a family of three in 1982 was $270 per month. Due to a turndown in tax revenues and increased caseloads the grant was cut to $228 per month effective January 1, 1983, and further reduced to $199 a month effective April 1, 1983. 1985 grants were increased to $285 per month, $325 in 1987 and $330 in 1988. The 1989 Legislature proposed increases to $348 for 1989 and $364 for 1990. Due to caseload growth, however, these increases were never implemented. The 1991 Legislature proposed benefits at $372 a month (remaining at $300 a month for those in publicly subsidized housing). The increases were effective October 1, 1991, but due to the state's budget crisis grants were cut effective February 1, 1992, to $348 for those without subsidies and $272 for those with publicly subsidized housing.

RATIONALE FOR PROPOSED CHANGE

Nevada should make a long term commitment to the welfare of its poorest children. The past pattern has been modest increases during good economic years and severe setbacks during poor years or years in which caseloads grew beyond projections. This

long term commitment should in enacted in statute to remove it from the fluctuations of tax revenue collections.

The standard of need defines the amount of money necessary to purchase basic necessities. The formula subtracts the maximum food stamp level from the federal poverty level. The 1990 standard (still in use) is $880 (poverty level) - $260 (maximum food stamps) = $620. No child in Nevada should have to survive without these basic necessities.

Similar legislation was proposed by Assemblyman John Norton in the 1991 session as AB 598. The timetable in that bill should be amended by starting with FY '94.

EXHIBIT D

RESTORE PAYMENT OF ADC BENEFITS TO DATE OF APPLICATION

SUMMARY OF PROPOSAL

The federal government gives Nevada the option of paying ADC benefits to applicants either (1) back to the date of application or (2) as of the date of approval (or 30 days whichever is shorter). This proposal would require Nevada to pay benefits as of the date of application.

BACKGROUND

Prior to November 1989, Nevada paid ADC applicants benefits back to date of application. As of that date, due to the state's budget crisis, Nevada opted to pay benefits as of date of approval. The Assembly Ways and Means Welfare sub-committee originally voted to return payment to date of application. Due to budget constraints, however, that proposal was not adopted in the final state budget.

RATIONALE FOR PROPOSAL

Families applying for ADC are generally destitute. Because of the caseworker shortage, a person coming to the office to apply is generally asked to come back two to four weeks later for an appointment. Once the application is filed (some applicants know to assist on filing an application at the first office visit while others may wait until the appointment weeks later), it takes approximately 45 days before approval. The first check will usually not be received until 10 to 14 days of approval. At issue is the amount of the check. The state can either include an amount in that first check back to the application date or to a date 30 days after application. For a typical ADC family of three that first check is $348 lower under the present system.

ADC applicants must survive somehow while awaiting on their first check. In Washoe and Clark Counties assistance may be obtained through the General Assistance program (in Clark County the assistance is limited to a check for 18 days, with an

extension to 24 days within the Director's suggestion). In rural counties there is no cash General Assistance program (though some limited type of assistance like one-half month's rent may be available). Families usually survive, by borrowing money from friends or relatives, delaying the payment of bills, or putting off the purchase of necessaries. These applicants rely on the first check to pay delayed bills, repay loans, or make necessary purchases. Therefore, this first check is very important of the well being of these children.

The 1991 Legislature estimated that the cost of restoring the old policy at approximately $500,00. Today the cost would be somewhat higher due to caseload and application growth in the interim period. It is relatively small investment, however, will make our lives different in the lives of these families.

EXHIBIT D
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EXHIBIT E

REMOVE THE CAP ON THE WELFARE DIVISION'S BUDGET

SUMMARY OF PROPOSAL

Under section 55 of the 1991 General Appropriation Act (A.B. 818) the amounts appropriated to the Welfare Division are limits and the Division may not request additional money for its programs. The only exception is for costs relating to additional services mandated by the federal government not specifically funded in the Medicaid account. This proposal would exclude similar language from subsequent general appropriation acts.

BACKGROUND

Since either 1979 or 1981 the Welfare Division budget has been capped either totally or, like this year, with some exceptions. The Welfare Division is the only state agency which does not have the authority to come before the Interim Finance Committee with a recommendation from the Board of Examiners to seek money from the state's Contingency Fund. Moreover, the Division may not seek a supplemental appropriation for the last six months of its biennium from the following Legislature. A supplemental appropriation may be obtained only by the adoption of special legislation (like A.B. 285 in 1991) which is passed by the full Legislature and signed by Governor.

Eliminating the cap would not give the Welfare Division a blank check to spend. It would only provide authority to ask for additional funding. The Welfare Division has perhaps the most difficult job of any state agency in forecasting its expenses. The federal government may mandate new programs, change its interpretation of rules, or make worthwhile optional programs available. In recent years, caseloads have often exceeded the projections of the Legislature which had provided an appropriation based upon those estimates.

Removal of the cap would not create any additional authority on the Welfare Division. A request for an Interim Finance Committee can be presented only with approval of the Board of Examiners. The Interim Finance Committee may, of course, say yes, no, or modify a proposal. The cap is a way for the Legislature to dodge its responsibilities for policy decisions. If the caseloads increase, new programs are mandated or made available then the Legislature should use its judgment to decide what should be done. Its decision to be subject to public debate and review like all other decisions.

The interim between the 1989 and 1991 sessions is a good example. Based upon caseload estimates the 1989 Legislature had appropriated money which it felt was sufficient to increase ADC grants from $330 per month to $348 for the first year of the biennium and to $364 in the second. Due to increased caseloads there were insufficient dollars appropriated to fund these increases. Moreover, in order to stay under budget the Welfare Division eliminated payments of benefits back to date of application. The Interim Finance Committee presided over a Contingency Fund of $8 million during the interim. The Welfare Division was not allowed to ask Interim Finance for money from that fund either to pay all or part of the promised increase or to continue to pay benefits back to date of application. At the end of the biennium over $3.5 million remained in the Contingency Fund. The Governor's office and IFC should have made the decision as to whether as a matter of policy the state should have spent its Contingency Fund dollars on this crisis. Welfare was never allowed to ask.

EXHIBIT F

ENTER INTO A "1634" AGREEMENT WITH THE SOCIAL SECURITY ADMINISTRATION TO PROCESS MEDICAID APPLICATIONS FOR SSI RECIPIENTS

SUMMARY OF PROPOSAL

Amend NRS 422.270 to require the Welfare Division to enter into a so-called "1634" agreement with the Social Security Administration under which the Social Security Administration would make Medicaid determinations for Supplemental Security Income "SSI" recipients. This would eliminate the need for welfare case workers to process Medicaid applications for thousands of SSI recipients, relieve the clients of making duplicate applications at Social Security and Welfare offices and assure that maximum Medicaid coverage would be available to SSI recipients.

BACKGROUND

States, such as Nevada, which use "SSI" criteria in determining the Medicaid eligibility of aged, blind and disabled persons are permitted to enter into an agreement with the Social Security Administration called a "1634" agreement. This agreement between the Social Security Administration and the State Medicaid agency provides that the Social Security Administration will determine the Medicaid eligibility of aged, blind and disabled persons who qualify for financial assistance under the "SSI" program. At the present time, Nevada is one of the 6 of the 36 states eligible to have such an agreement which does not have one. With a "1634" agreement some of the administrative costs of processing Medicaid applications by the state agency would be eliminated or reduced significantly.

In states which have signed such an agreement, the SSI application is treated as an application for Medicaid. In Nevada at the present time, aged, blind and disabled SSI applicants must also complete and file a 14 page application for Medicaid in addition to their application for SSI. Both forms ask similar questions and require similar documentation. Until they have filed a separate application for Medicaid, SSI recipients are not eligible for Medicaid even though they meet all of the criteria for eligibility.

In many cases Medicaid eligibility may be provided for three months retroactive to the date of application. An SSI application date can be "protected" by a telephone call to the Social Security Administration. A Medicaid application is not considered filed until the completed application if presented to the local Welfare office. With a "1634" agreement, it is possible to provide for earlier Medicaid eligibility in some cases. Under a "1634" agreement the Social Security Administration can be asked to obtain information concerning medical bills incurred for up to three months prior to the month of application in order to determine the retroactive eligibility of SSI recipients. As of October, 1991[1] there were approximately 12,280 SSI recipients in Nevada. Approximately 12,103 of these had also filed applications for Medicaid at the local welfare offices and were receiving Medicaid.[2] Only an estimated 177 of the SSI recipients eligible for Medicaid were not receiving it.

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[1] Telephone conversation with Manny Semetin, Social Security Administration, Reno, Nevada District Office, March 20, 1992.

[2] Telephone conversation with Nevada State Welfare, Statistics Office March 20, 1992. (SSI Medicaid data as of August, 1991).

EXHIBIT F
Page 2

RATIONALE FOR DECISION

The proposal would eliminate the need for state welfare workers to process separate Medicaid applications and redeterminations for SSI recipients, saving the administrative expenses and duplication of effort by federal and state employees. State workers could focus their time and energy on other cases in a timely manner. While the state would be required to reimburse the Social Security Administration for 50% of the **additional cost** of processing the Medicaid information not required in the SSI process (such as third party liability for medical care and prior medical expenses to be considered in determining retroactive Medicaid eligibility), this cost should be minimal and be substantially less than the present administrative cost of processing a separate application for thousands of SSI recipients.

Because not all SSI applicants immediately file a separate application for Medicaid upon filing an application for SSI, in some cases county medical indigent funds may be used to pay for services which would be covered by Medicaid had the SSI filing date been treated as a Medicaid filing date under a "1634" agreement. Instead of bearing the entire cost of this care using local tax dollars, federal matching funds would be available on a dollar for dollar basis. There would be some additional cost to the state for the state share of Medicaid attributable to those SSI recipients who have not applied for Medicaid. These costs should be minimal since only about 1% of the currently eligible clients have not been approved for Medicaid. It is also likely that these persons do not have significant medical costs or

possibly qualify for health care through other sources such as Indian Health Service,[3] since they would be likely to apply for Medicaid should that occur. To the extent that any of the costs of medical care are currently being paid with county monies because the client did not file a timely Medicaid application, there could be a net savings to the taxpayers.

[3] The demographic characteristics of those who are receiving SSI but not Medicaid is not presently ascertainable. Given Nevada's significant Native American population, it is probable that some of the SSI recipients who have not applied for Medicaid qualify for care through Indian Health Services.

EXHIBIT G

PROVIDE A HOME MAINTENANCE ALLOWANCE FOR UP TO SIX MONTHS FOR NURSING HOME RESIDENTS RECEIVING MEDICAID

SUMMARY OF PROPOSAL

Under federal law, states are allowed to exclude a "home maintenance allowance" from monies which would otherwise be paid toward the cost of nursing home care for a single nursing home resident for up to a maximum of six months. This proposal would ensure that nursing home residents would not be permanently institutionalized at government expense because they could not afford to maintain a home to return to after institutionalization.

BACKGROUND

At the present time, some Nevada residents who lived alone prior to institutionalization and who are likely to return home after an institutionalization of less than six months are required to remain in the institution permanently because they are unable to pay the costs necessary to maintain their home. Ordinarily, a nursing home resident on Medicaid is required to pay all but $35.00 of her monthly income to the facility and thus cannot afford the rent, utilities, mortgage and other expenses necessary to maintain the home. New nursing home residents are frequently advised to sell their homes and use the proceeds towards the cost of their care. Under these circumstances persons who would otherwise be returned to the community after a relatively short stay in a nursing home are forced to remain institutionalized permanently at significant government expense.

It is estimated that 43 percent of persons who turned 65 in 1990 will need nursing home care at some point in their lives.[1] Nevada's population over 65 years of age has increased significantly over the last decade and can be expected to continue growing. While the average stay of nursing home residents is expected to be 2.8 years, 68 percent of persons 65 years of age and older (including nonusers) will use less than three months of

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[1] Kemper, Spillman and Murtaugh, "A Lifetime Perspective on Proposals for Financing Nursing Home Care", 28 Inquiry (Winter, 1991) pp. 333-344.

care.[2] Federal law permits a home maintenance allowance using a uniform standard set by the state Medicaid agency to be deducted from the patient's income when a physician certifies that the expected duration of institutionalized care is six months or less. Typical patients are those recovering from a fractured hip or stroke where a period of rehabilitation may be necessary before the patient can safely return home.

RATIONALE FOR DECISION

It is costly to both the finances of the state and the best interests of the Medicaid recipient to force nursing home residents to be institutionalized indefinitely at a cost to Medicaid of thousands of dollars per year because the resident has not been able to maintain a home to which she/he can return. Because all Medicaid funds are matched at least 50 percent by the federal government, the proposed deduction would cost the state several hundreds of dollars per month for a maximum of six months at least 50 percent of which would be paid by the federal government. For example, if the agency established a monthly home maintenance allowance of $500.00, the maximum cost to the state for one client would be $1,500.00 (50 percent of $500.00 per month for a maximum of six months). This amount is approximately equal to the State cost of maintaining one nursing home resident on Medicaid for one month.

Persons who need only short term nursing home care can be returned to the community at a fraction of the cost of long term care. The costs of providing long term care for persons who could be living in the community if they had a home to return to is eliminated. This proposal affects only the small number of nursing home residents who are certified by their attending physician to be likely to return home within the six month period provided by federal law. It is, however, extremely important to those persons who are forced into needless long term institutionalization under present policies.

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[2] Id.

EXHIBIT H

ESTABLISH A MEDICALLY NEEDY MEDICAID PROGRAM

SUMMARY OF PROPOSAL

Amend NRS 422.270 to provide Medicaid for persons who meet the criteria for categorical assistance such as Aid to Dependent Children ("ADC") or Supplemental Security Income ("SSI") except for income or assets. Under a medically needy program these persons will be eligible for Medicaid for time periods in which they have large medical expenses.

BACKGROUND

Historically Nevada has had one of the lowest Medicaid participation rates and payment rates in the United States. In 1986, Nevada ranked 49th out of 52 jurisdictions in the amount and percent of Medicaid payments.[1] In addition a large percentage of Nevadan lack private health insurance. Persons without health insurance comprise 16.5% of the population.[2] Nevada ranked 41st of 51 jurisdictions with the lowest percentage of the population without health insurance. The "federal Medicaid mandates" which are often cited by public officials as the cause of state budgetary problems have had a significant impact on Nevada because so many of Nevada's low income population had lacked Medicaid or alternative access to health care under prior Nevada policies. Nevada has the fastest growing population in the United States, the fastest growing elderly population and one of the unhealthiest populations.[3]

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[1] Source Health Care Financing: Program Statistics Medicare and Medicaid Data Book, 1990, U. S. Department of Health and Human Services, March, 1991) Table 4.18, (1986) p. 95. Only Delaware, Wyoming and the Virgin Islands made lower payments.

[2] Source "State-by-State Rank of the Uninsured", Public Citizen Health Research Group, form 1990 Census Data (Washington Post 1/14/92).

[3] Source "Health Care Spending in Nevada: A Microstudy" 17 The State Factor, American Legislative Exchange Council, Washington, D.C. (January 1991), p. i.

Nevada remains one of the few states which does not have a medically needy Medicaid program to provide Medicaid for the aged (65 and over), the blind, the disabled, pregnant women and children (up to 21 years of age) who have more income and/or resources than is allowed for receipt of cash assistance like ADC or SSI, but are unable to afford the full cost of medical care. In most cases, persons would be eligible for Medicaid under a "medically needy program" would remain responsible for some of the cost of their medical care with Medicaid covering the balance. Some of those who currently have their medical costs paid with local tax assessments under the county medically indigent program or the indigent accident fund would qualify for Medicaid with federal reimbursement under this program.[4] A medically needy Medicaid program provides a "safety net" for vulnerable persons who have medical bills which effectively reduce their income or assets to well below the poverty level.

If the state adopted a medically needy program, the following groups would have to be covered[5]:

1. Pregnant women who, except for income and resources, would be covered as mandatory or optional categorically needy;

2. Children under 18 who, but for income and resources, would have to be covered as mandatory categorically needy;

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[4] At the present time Nevada tax payers pay twice for such care. Our federal tax dollars are used to assist with the cost of care for persons in the 36 states which have adopted a medically needy program. Our county tax dollars are used to pay the full cost of care for persons who receive assistance from the county medically indigent program, but who would qualify for Medicaid with at least 50% federal reimbursement if Nevada had a medically needy program.

[5] Coverage of these groups is mandated by the federal Medicaid statute, 42 U.S.C. §§ 1396a(a)(10)(C) and 1396a(e).

3. Women who, while pregnant, received Medicaid as medically needy, continue to be eligible for 60 days postpartum and pregnancy related and postpartum services beginning on the last day of pregnancy;

4. Newborn children born to women who are medically needy for one year as long as the woman remains eligible;

If the state adopted a medically needy program, any of the following additional groups could also be covered:

1. Aged (over 65) persons;

2. Blind persons;

3. Disabled persons;

4. Children under age 21, or under age 20, 19, or 18 as the state provides, who but for income and resources would qualify as categorically needy;

5. Caretaker relatives caring for a dependent child;

6. Individuals enrolled in HMO's who lose eligibility due to increased income or resources for up to six months;

7. Pregnant women who are determined to be presumptively eligible if they meet the state's income standard for medically needy.

Adults who are not aged, blind or permanently and totally disabled[6] or who do not have children under age 21 in their care would not be eligible for this program.

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[6] Disability must be expected to last for at least 12 months or result in death.

A. Implications of a Medically Needy Program For Pregnant Women and Children Under 21

With a medically needy program, a medically needy standard is established by the state. The standard cannot be higher than 133-1/3% of the state's ADC payment levels for a family of that size. Using current ADC levels, the medically needy amount could not exceed $385.00 for a one or two person family. With a medically needy program, the medical bills incurred by the individual or family would be subtracted from their income. If their income was reduced to $385.00 after subtraction of these bills, the individual or couple would be eligible for Medicaid for the balance of their medical bills. States are now required by federal law to cover children up to nine years of age in families with income at or below 100% of the federal poverty level and will eventually be required to cover such children to age 19. The federal poverty level is significantly higher than 133-1/3% of Nevada's ADC payment levels. The medically needy standard of $385.00 per month for a two person family under medically needy criteria is significantly below 100% of the current federal poverty limit of $765.00 for a two person family. A family of two with income of $785.00 per month would need to incur $400.00 in medical bills before becoming eligible under a medically needy program.

Although a medically needy program must include certain children and pregnant women, the Medicaid cost for this medically needy group tends to be significantly less than that for other segments of the population. National data from 1986 suggests that the Medicaid costs for children receiving Medicaid as "medically needy" was about 23% of the cost for Medicaid for children receiving Medicaid under the ADC program.[7] In Georgia, a state with a comparable ADC standard to Nevada only an estimated 0.7% of the total

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[7] Source Health Care Financing: Program Statistics Medicare and Medicaid Data Book, 1990, U. S. Department of Health and Human Services, March, 1991) Table 2.8, (1986) p. 23.

population receive Medicaid as medically needy children.[8]

B. Implications of a Medically Needy Program For Aged, Blind and Disabled Persons

The largest group of users of a medically needy program are the aged. The Medicaid costs for medically needy persons over 65 is about 300% of the cost for such persons who are categorically eligible aged Medicaid recipients.[9] Many of these medically needy recipients are nursing home residents including those whose care in Nevada is paid solely with locally funds provided by county tax revenues.

The blind comprise a very small percentage, of the medically needy and the Medicaid population in general. Only 0.7% of Medicaid payments are for services provided to blind persons.[10] The Medicaid cost for services to the medically needy disabled population comprises about 64% of the cost of services for recipients of Medicaid under the categorically needy program.[11] This population includes persons who receive Medicaid as medically needy Social Security beneficiaries who have received Social Security payments for less than two years and are therefore ineligible for Medicare.

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[8] Source Telephone conversation with Angie Vincent, Georgia Medicaid, 3/29/92.

[9] Source Health Care Financing: Program Statistics Medicare and Medicaid Data Book, 1990, U. S. Department of Health and Human Services, March, 1991) Table 2.8, (1986) p. 23.

[10] Id.

[11] Id.

C. Implications of a Medically Needy Program For Nursing Home Patients

The cost of nursing home care is beyond the reach of many citizens. An income of more than $45,000 per year is needed to pay privately for such care and meet other expenses. Nursing home costs are the fastest growing segment of the Medicaid budget on a national level with more than four out of every 10 Medicaid dollars spent on such care. Presently the cost of privately paid care in Nevada averages $3,300 per month. A medically needy program would provide federal reimbursement for the cost of care to those residents with income between $15,200 and $45,000 per year.

A medically needy program would also allow persons residing in counties which do not use federal spousal impoverishment criteria to provide more adequately for the needs of a community spouse residing outside the nursing home under the Medicaid spousal impoverishment provisions.

It is in the interest of Nevada citizens to have access to nursing home care when it is medically necessary and to spread the cost risk by maximizing federal dollars available to assist with the cost of such care. Under the present Medicaid program, a nursing home resident who currently has income of $1,266.01 or more per month is ineligible for Medicaid and has any excess nursing home costs paid with local tax revenues under the local county medically indigent program. If a medically needy program were adopted, the resident would be eligible for Medicaid because his/her income after deduction of monies paid toward the cost of nursing home care would be less than the medically needy standard. With a medically needy program 50% of the cost of care in excess of the income paid by the nursing home resident would be paid by local Medicaid monies and the balance by federal Medicaid dollars.

RATIONALE FOR DECISION

Persons whose income and/or resources are not sufficient to pay the full cost of medical care would be able to receive care paid in part by the local and federal governments. Some of those who presently lack access to adequate health care would be able to receive the care they need. The availability of Medicaid reimbursement under a medically needy program would reduce somewhat the uncollectible bad debts which may add to the cost of health care in the state.

Under the present system Nevada taxpayers pay twice for certain kinds of medical care for indigent persons. Because we do not have a medically needy program we give "at home" and "at the office". Nevada taxpayers through their federal tax dollars contribute to the cost of the medically needy program in the 35 states and the District of Columbia which offer this program. We also pay the full cost of the county medically indigent program for some persons whose cost of medical care could be paid with 50% federal monies if a medically needy program were adopted.

The Interim Finance Committee should request that accurate cost data be developed for the cost of a medically needy program. Such development has been particularly difficult due to a number of factors emerging at the same time. These factors include the rapid growth of Nevada's population, especially its population over 65, Nevada's unstable tax base, the downturn in the national economy and the high percentage of uninsured persons in the population. Using the present Medicaid funding formula,[12] the cost in state/local funds for the program would be a maximum of 50% of the cost of medical care provided to this group. In estimating costs for this program, it is essential that data be developed based upon the experience of states with a similar ADC payment level.

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[12] The percentage paid by the federal government is a minimum of 50%. This percentage is tied to average per capita income and may increase with recent census data.

Furthermore a careful analysis needs to be made of the cost savings to the taxpayers by transferring some of the costs currently borne in full by the county medically indigent program to the federal government. Specific cost data should be separately developed for the mandatory and optional groups which could be covered under this program. The data should indicate what costs currently bring borne by local funds such as the county medical indigent program and the indigent accident fund would be covered under a medically needy program.

The cost of county medical indigent care between fiscal year 1990 - 1991 ($28,263,250.00) and fiscal year 1991 - 1992 ($59,655,416.00) has doubled.[13] These costs can be expected to continue to accelerate. Presently 103 Nevada long term care cases are receiving care for which no federal reimbursement is available. Another 305 are receiving care matched by federal dollars under the "county match" program. Absent a comprehensive national health insurance program, it is not fiscally responsible to reject federal funds to assist in the cost of health care. Federal matching dollars should be made available under a medically needy program to assist in this burden and to slow the cost to the local tax base of this important and necessary care.

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[13] Source Preliminary data, Nevada State County Welfare Directors, Michael Mc Mahan (March, 1992).

MEDICAID ELIGIBILITY 1992

MONTHLY INCOME CRITERIA

SSI RECIPIENT	
$422.00	Disabled
$458.40	Aged

ADC RECIPIENT

INSTITUTIONALIZED FOR MORE THAN 30 DAYS

Income Less Than $1,266.00 (300% of Federal SSI Amount)

NON-MEDICAID SPOUSE May Get Up To $1,018.56 Per Month In Income More Under A Court Order Or If Shelter Expense (Rent, Mortgage, Utilities, Etc.) Exceed $305.57/Month

CHIPS RECIPIENT
(Community Home-Based Initiatives Program)
Income Less Than $1,266.00

QMB RECIPIENT
Income Less Than $567.50

Resource Limits Are: $2,000 For An Individual
$3,000 For A Couple

Except For ADC And QMB Recipient

QMB Resource Limits Are: $4,000 For an Individual
$6,000 For A Couple

QMB Recipients Receive Only Coverage For Medicare Premiums, Deductions And Co-Insurance (No Prescription Drugs Or Other Non-Medicare Covered Care)

ADC Resource Limits Are: $1,000 Per Case

EXHIBIT H
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MEDICAID ELIGIBILITY 1992
PRESENT LIMITATIONS

AGED, BLIND AND DISABLED PERSONS
MONTHLY INCOME CRITERIA

Aged (Over 65) Person With Income of $458.40 Or More Ineligible For Medicaid Regardless Of Medical Bills (Unless Institutionalized Or A CHIPS Recipient)

$$$$$$$$$$$$$$$$
$ $
$ NO MEDICAID $
$ $
$$$$$$$$$$$$$$$$

Institutionalized Person With Income Of $1,266.00 Or More Ineligible For Medicaid. (May Be Eligible For County Aid With 100% Local Tax Dollars)

INSTITUTIONALIZED FOR MORE THAN 30 DAYS

NO MEDICAID

Spousal Allocation Varies By County For County Cases

Person In Need Of Home And Community-Based Care With Income Of $1,266.00 Or More Ineligible For Medicaid.

NO HOME CARE

NO MEDICAID

MEDICAID ELIGIBILITY WITH A MEDICALLY NEEDY PROGRAM FOR AGED, BLIND AND DISABLED PERSONS

MONTHLY INCOME CRITERIA

Aged (Over 65) Person With Income Above $458.40 INCURS MEDICAL BILLS WHICH REDUCE INCOME BELOW $385.00

RECIPIENT MEDICALLY NEEDY

Income Below $385 After Deduction of Cost of Medical Care (Medically Needy)

INSTITUTIONALIZED FOR MORE THAN 30 DAYS

INCOME LESS THAN COST OF MEDICAL CARE (MEDICALLY NEEDY)

NON-MEDICAID SPOUSE May Get Up To $1,018.56 Per Month In Income More Under A Court Order Or If Shelter Expense (Rent, Mortgage, Utilities, Etc.) Exceed $305.57/Month

Person In Need Of Home And Community-Based Care With Income Above $1,266.00 INCURS MEDICAL BILLS WHICH REDUCE INCOME TO BELOW $1,266.00

CHIPS RECIPIENT (Community Home-Based Initiatives Program)

Resource Limits Are: $2,000 For An Individual
$3,000 For A Couple

EXHIBIT H
Page 11

APPENDIX E

NEVADA WELFARE DIVISION - MANAGED CARE AND MEDICAID PRESENTATION MAY 21, 1992.

MANAGED CARE SPEECH

MANAGED CARE IS AN ARRANGEMENT UNDER WHICH EACH MEDICAID RECIPIENT HAS A PRIMARY CARE PHYSICIAN RESPONSIBLE FOR PROVIDING PRIMARY CARE, AUTHORIZING REFERRALS TO OTHER PROVIDERS AND PROVIDING 24-HOUR COVERAGE FOR URGENT CARE NEEDS. MANAGED CARE PROGRAMS MAY BE VOLUNTARY OR MANDATORY FOR MEDICAID RECIPIENTS, BY STATE OPTION, BUT MANDATORY ENROLLMENT PROGRAMS STILL REQUIRE FEDERAL WAIVERS OF FREEDOM OF CHOICE WHICH ARE RENEWABLE EVERY TWO YEARS.

IN THIS ERA OF CONSTRAINED RESOURCES, INITIATIVES INVOLVING PREPAID OR MANAGED HEALTH CARE HAVE BECOME INCREASINGLY IMPORTANT TO STATES FOR TWO REASONS; (1) AS A WAY OF PROVIDING MEDICAID RECIPIENTS ACCESS TO A QUALITY OF HEALTH CARE WHICH IS BETTER THAN THE TRADITIONAL FEE-FOR-SERVICE MEDICAID SYSTEM AFFORDS THEM; AND (2) AS A WAY OF CONTROLLING ACCESS TO COSTLY SPECIALTY, HOSPITAL AND EMERGENCY ROOM CARE.

BY LINKING MEDICAID RECIPIENTS WITH RELIABLE SOURCES OF ONGOING, COORDINATED PRIMARY CARE, AND REDUCING THEIR RELIANCE ON EPISODIC, HOSPITAL-BASED CARE, MANAGED CARE APPROACHES IMPROVE ACCESS AND QUALITY WHILE REDUCING COSTS.

THROUGH THE LATE 1970S AND UP TO 1981, MEDICAID ENROLLMENT IN HMOS AND OTHER PREPAID HEALTH PLANS NATION WIDE REMAINED BELOW 300,000 -- LESS THAN TWO PERCENT OF MONTHLY ELIGIBLES. CALIFORNIA AND MICHIGAN ALONE ACCOUNTED FOR OVER TWO-THIRDS OF THE TOTAL ENROLLMENT. ALTHOUGH 14 OTHER STATES ALSO HAD AT LEAST ONE HMO CONTRACT, ENROLLMENT WAS NEVER MORE THAN A FEW THOUSAND PERSONS PER STATE. BUT THE RECESSION AND FEDERAL BUDGET CUTS OF THE EARLY 1980S, COMING ON TOP OF THE 15 PERCENT-PER-YEAR MEDICAID EXPENDITURE INCREASES OF THE LATE 1970S, FORCED STATES TO TAKE A HARD LOOK AT THEIR

MEDICAID PROGRAMS AND TO SEARCH FOR MORE COST-EFFECTIVE WAYS OF PROVIDING NEEDED HEALTH CARE TO THEIR MEDICAID POPULATIONS. RESPONDING TO STATE RECOMMENDATIONS, THE FEDERAL OMNIBUS BUDGET RECONCILIATION ACT OF 1981 (P.L. 97-35) OPENED UP A VARIETY OF ALTERNATIVE FINANCING AND DELIVERY APPROACHES UNDER MEDICAID. UNDER THIS ACT, HMOS CONTRACTING WITH MEDICAID WERE PERMITTED TO HAVE UP TO 75 PERCENT MEDICARE AND MEDICAID ENROLLMENT, RATHER THAN THE 50 PERCENT PREVIOUSLY PERMITTED. WAIVERS OF FEDERAL MEDICAID REQUIREMENTS WERE CHANGED TO PERMIT STATES TO ESTABLISH PRIMARY CARE CASE MANAGEMENT (PCCM) SYSTEMS FOR THEIR MEDICAID RECIPIENTS. MEDICAID WAS FOR THE FIRST TIME ALLOWED TO SELECT PROVIDERS BASED ON THEIR COST EFFECTIVENESS.

IN 1983, THE NEVADA LEGISLATURE URGED MEDICAID TO LOOK FOR COST-EFFECTIVE ALTERNATIVES TO FEE-FOR-SERVICE MEDICAID, AND WAS THE IMPETUS FOR NEVADA TO TAKE ADVANTAGE OF THE PROVISIONS OF SECTION 1915 (B)(1) OF TITLE XIX OF THE SOCIAL SECURITY ACT TO DEVELOP A PRIMARY CARE CASE MANAGEMENT (PCCM) PROGRAM WITH THE UNIVERSITY OF NEVADA SCHOOL OF MEDICINE TO SERVE RECIPIENTS IN THE LAS VEGAS AND RENO AREAS. I WILL TALK MORE OF MEDICAID EXPERIENCE AFTER GIVING SOME BACKGROUND OF MANAGED CARE UNDER MEDICAID.

THE MOST SIGNIFICANT CHANGES IN THE MEDICAID PROGRAM SINCE ITS ENACTMENT IN 1965 WERE CONTAINED IN SECTION 2175 OF THE OMNIBUS BUDGET RECONCILIATION ACT OF 1981 (PL 97-35). THIS SECTION MODIFIED THE LONG-STANDING PROGRAM REQUIREMENT THAT INDIVIDUAL MEDICAID RECIPIENTS HAVE THE FREEDOM TO OBTAIN SERVICES FROM ANY QUALIFIED PROVIDER.

THE LAW AUTHORIZED CERTAIN NEW EXCEPTIONS TO THE MEDICAID FREEDOM OF CHOICE REQUIREMENT WITH WAIVER. THESE EXCEPTIONS ARE OF TWO GENERAL TYPES. FIRST, UNDER SECTION 1915(A) STATE MEDICAID PROGRAMS WILL NO LONGER BE

FOUND OUT OF COMPLIANCE WITH FEDERAL STATE PLAN REQUIREMENTS CONCERNING FREEDOM OF CHOICE, STATEWIDNESS AND COMPARABILITY OF SERVICES IF A STATE: 1) PROVIDES EXTRA SERVICES TO RECIPIENTS WHO VOLUNTARILY ENROLL IN PROGRAM; 2) ENTERS INTO CERTAIN ARRANGEMENTS TO PURCHASE LABORATORY SERVICES OR MEDICAL DEVISES THROUGH COMPETITIVE BIDS; OR 3) ESTABLISHED EITHER A "LOCK-IN" PROGRAM WHICH RESTRICTS FOR A REASONABLE PERIOD OF TIME THE CHOICE OF PROVIDER BY A RECIPIENT WHO HAS OVERUTILIZED SERVICES, OR A "LOCK-OUT" PROGRAM WHICH LIMITS THE PARTICIPATION OF A PARTICULAR PROVIDER WITHIN THE MEDICAID PROGRAM.

THE SECOND WAY IN WHICH STATES MAY BE EXEMPTED FROM THE FREEDOM-OF-CHOICE REQUIREMENT IS BY OBTAINING A FEDERAL WAIVER. SECTION 1915(B) OF THE SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS) MAY WAIVE CERTAIN STATE PLAN REQUIREMENTS CONTAINED IN SECTIONS 1902 AND/OR THE PROVISIONS IN 1903(M) GENERALLY LIMITING STATE RISK-SHARING ARRANGEMENTS TO FEDERALLY-QUALIFIED HMOS IN ORDER TO ALLOW A STATE TO:

1. IMPLEMENT A PRIMARY CARE CASE MANAGEMENT SYSTEM;

2. ALLOW A LOCALITY TO ACT AS A CENTRAL BROKER IN ASSISTING MEDICAID RECIPIENTS IN SELECTING AMONG COMPETING HEALTH PLANS;

3. SHARE WITH RECIPIENTS, THROUGH THE PROVISION OF ADDITIONAL SERVICES, SAVINGS RESULTING FROM RECIPIENTS' USE OF MORE COST-EFFECTIVE MEDICAL CARE, AND;

4. RESTRICT RECIPIENTS TO RECEIVING SERVICES (OTHER THAN IN EMERGENCY SITUATIONS) FROM ONLY EFFICIENT AND COST-EFFECTIVE PROVIDERS.

ONE OF THE OFTEN-CITED FLAWS IN THE MEDICAID PROGRAM IS THE ABSENCE OF INCENTIVES FOR RECIPIENTS OR PHYSICIANS TO MAKE COST-CONSCIOUS DECISIONS WHEN UTILIZING HEALTH CARE SERVICES. THE MEDICAID PROGRAM HAS REQUIRED PROVIDERS TO ACCEPT THE PROGRAM'S REIMBURSEMENT RATES AS PAYMENT IN FULL AND LIMITS THE IMPOSITION OF COPAYMENTS ON RECIPIENTS.

THE FOUR SUBSECTIONS OF 1915 (B) ALL ATTEMPT TO INCREASE THE IMPORTANCE OF PRICE CONSIDERATIONS IN THE DECISION ABOUT WHEN, WHERE, AND HOW TO UTILIZE HEALTH CARE SERVICES.

THE SECRETARY IS AUTHORIZED TO GRANT WAIVERS OF STATE PLAN REQUIREMENTS UNDER 1915 (B) ONLY IN CASES WHERE THEY ARE FOUND TO BE COST EFFECTIVE, EFFICIENT, AND NOT INCONSISTENT WITH THE INTENT OF THE MEDICAID PROGRAM. THESE WAIVERS CAN BE GRANTED FOR A PERIOD OF UP TO TWO YEARS, ALTHOUGH A STATE MAY REQUEST A CONTINUATION. NEVADA MEDICAID HAD A 1915 (B)(1) WAIVER FROM 1983 TO 1986 WHEN DURING WAIVER RENEWAL, HCFA DETERMINED OUR PCCM ARRANGEMENT COULD BE OPERATED UNDER 1915 (A)(1)(A) OF THE ACT AS RECIPIENTS MADE A VOLUNTARY DECISION TO ENROLL AND TO RECEIVE CASE MANAGEMENT SERVICES.

1915 (B) WAIVER REQUIREMENTS, THE SO CALLED FREEDOM-OF-CHOICE WAIVERS, STILL GO THROUGH A CUMBERSOME FEDERAL REVIEW PROCESS ALTHOUGH HCFA HAS RECENTLY STANDARDIZED THE FORMAT. THE TWO YEAR RENEWAL IS USUALLY MORE DIFFICULT THAN OBTAINING THE ORIGINAL WAIVER. THE RENEWAL MUST SUBSTANTIATE SAVINGS, IMPROVED RECIPIENT ACCESS TO CARE AND THE ACTURARIAL SOUNDNESS OF THE RATES. A WAIVER RENEWAL IS A THREE TO SIX MONTH PROCESS. VIRTUALLY ALL WAIVERS OFFERING MANAGED CARE IN DIFFERENT STATES OPERATE UNDER THE AUTHORITY OF 1915(B)(1).

THE SECOND WAIVER POSSIBILITY IN MANAGED CARE IS THE 1115 WAIVER OR DEMONSTRATION WAIVER. AN 1115 CAN BE GRANTED BY HCFA FOR A THREE YEAR PERIOD TO STUDY A UNIQUE COST-SAVINGS METHOD OF HEALTH CARE DELIVERY. THE ARIZONA ACCESS PROGRAM IS AN EXAMPLE OF AN 1115 WAIVER. ACCESS HAS BEEN OPERATING NINE YEARS UNDER THIS AUTHORITY.

HCFA IS NOT GRANTING 1115 DEMONSTRATIONS ANYMORE BECAUSE AN 1115 MUST DEMONSTRATE SOMETHING THAT HAS NEVER BEEN TRIED ANYWHERE BEFORE. ONE STATE CANNOT ASK FOR A WAIVER TO COPY A SUCCESSFUL PROGRAM IN ANOTHER STATE. 1115 WAIVERS, EVEN IF SUCCESSFUL, CANNOT BE CONTINUED AS THERE IS NO PROVISION IN LAW TO CHANGE THE WAY A MEDICAID PROGRAM DELIVERS HEALTH CARE. ACCESS IS FACING THIS DILEMMA NOW. THEIR 1115 WAIVER IS EXPIRING IN 1993. ARIZONA IS HOPING FOR THE PASSAGE OF THE "MEDICAID MANAGED CARE IMPROVEMENT ACT OF 1991" (SENATE BILL 2077).

STATES HAVE SUCCESSFULLY DEMONSTRATED THE COST-EFFECTIVENESS OF MANAGED CARE FOR THE PAST TEN YEARS BUT BY 1991 ONLY 10 PERCENT OF TOTAL MEDICAID RECIPIENTS (APPROXIMATELY 2.7 MILLION PEOPLE)WERE ENROLLED IN MANAGED CARE PROGRAMS. SENATE BILL 2077 WILL ALLOW MANAGED CARE WITHOUT WAIVER AND THE CONTINUATION OF EXISTING 1115 AND 1915 WAIVER PROGRAMS. THE PROPOSED LAW'S FEATURES ARE:

1. ALLOWING MANDATORY ENROLLMENT OF MEDICAID RECIPIENTS IF THERE IS A CHOICE OF TWO OR MORE PLANS OR AT LEAST TWO-THIRDS OF THE DOCTORS IN AN AREA ARE IN THE MANAGED CARE CONTRACT.

2. ALLOWING A STATE TO GUARANTEE MEDICAID ELIGIBILITY TO ENROLLEES FOR ONE TO SIX MONTHS.

THE LAW REQUIRES RATES OF PAYMENT WHICH ARE ACTUARILY SOUND AND DO NOT EXCEED THE COST OF FEE-FOR-SERVICES MEDICAID. IT ALLOWS FOR A PHYSICIAN INCENTIVE PLAN OR SAVINGS SHARING.

THE LAW WILL REQUIRE PATIENT ENCOUNTER DATA FROM PHYSICIANS, AND INTERNAL QUALITY ASSURANCE PROGRAM AND ALLOWS FOR PERIODIC AUDIT BY THE STATE AND BY AN EXTERNAL INDEPENDENT REVIEW ORGANIZATION.

I RECENTLY SPOKE WITH THE MEDICAID MANAGED CARE OFFICE IN BALTIMORE. THEY ARE OPTIMISTIC THE BILL WILL PASS. IT HAS THE SUPPORT OF HCFA AND THE BUSH ADMINISTRATION. THE BILL HAS BEEN INTRODUCED INTO THE SENATE. A FEW MINOR TECHNICAL CLARIFICATIONS WERE SUGGESTED. THE BILL IS SCHEDULED TO BECOME EFFECTIVE JANUARY 1, 1993.

HCFA SUGGESTS WE KEEP ASKING OUR CONGRESSIONAL DELEGATION TO SUPPORT SB 2077. THERE ARE TWO OPPOSED ADVOCACY GROUPS - THE CHILDREN'S DEFENCE FUND AND THE NATIONAL ASSOCIATION OF COMMUNITY HEALTH CARE CENTERS. PROVIDER GROUPS ARE NOT OPPOSING THE BILL. HCFA WANTS STATES TO PUBLICLY EXPRESS THAT THE INTENT OF MANAGED CARE IS TO HELP KIDS RECEIVE QUALITY CARE - NOT TO BALANCE BUDGETS AT THEIR EXPENSE. THE COMMUNITY HEALTH CARE CENTERS ARE WORRIED ABOUT LOSS OF PATIENTS TO MEDICAID HMOS. IN NEVADA WE PROPOSE TO WORK IN CONJUNCTION WITH OUR CHCCS.

TO GIVE THIS COMMITTEE SOME IDEAS OF THE DIFFERENT TYPES OF CONTRACTS ALLOWABLE IN MANAGED CARE, I WILL THUMB SKETCH A FEW:

1. FEE-FOR-SERVICE MEDICAID WITH A PRIMARY CARE CASE MANAGEMENT (PCCM) PHYSICIAN GATEKEEPER;

2. PARTIALLY CAPITATED DIRECT CONTRACTS WITH PCCM PROGRAMS (THE MODEL WE ARE USING FOR THE SCHOOL OF MEDICINE CONTRACT);

3. CONTRACTING THE PCCM SYSTEM TO AN INTERMEDIARY, OR HEALTH INSURING ORGANIZATION (HIO), WHICH IS PAID ON A FULLY CAPITATED RISK BASIS;

4. CONTRACTING WITH A HEALTH MAINTENANCE ORGANIZATION (HMO) FOR COMPREHENSIVE SERVICES ON A RISK OR NON-RISK BASIS; OR

5. CONTRACTING WITH A PRE-PAID HEALTH PLAN (PHP), AN ORGANIZATION WHICH DOES NOT QUALIFY AS A HMO, FOR LESS THAN COMPREHENSIVE SERVICES ON A PARTIAL CAPITATION RISK OR NON-RISK BASIS (THE NEVADACARE MODEL).

COMPREHENSIVE SERVICES IN FEDERAL TERMS ARE IN-PATIENT HOSPITAL SERVICES PLUS <u>ONE</u> OR MORE OF THE FOLLOWING SERVICES: OUT-PATIENT HOSPITAL SERVICES; LABORATORY/X-RAY SERVICES; NURSING FACILITY SERVICES; EARLY SCREENING; FAMILY PLANNING; PHYSICIAN SERVICES AND/OR HOME HEALTH SERVICES. WITHOUT HOSPITAL SERVICES A CONTRACTOR MAY SELECT TWO MANDATORY SERVICES. IF AN ORGANIZATION WANTS TO PROVIDE TWO OR MORE OF THE ABOVE MANDATORY SERVICES, THAT ORGANIZATION MUST BE AN HMO. IN OTHER WORDS, ONLY A QUALIFIED HMO MAY CONTRACT TO PROVIDE COMPREHENSIVE (ALL) MEDICAID SERVICES.

THE CONTRACTOR CAN OPT FOR ANY NON-MANDATORY MEDICAID SERVICES (UNDER THE ABOVE FIVE OPTIONS). EXAMPLES ARE: PHARMACY, THERAPY, EYEGLASSES, DENTAL CARE OR MEDICAL EQUIPMENT.

AS THE REGULATIONS CURRENTLY EXIST, ENROLLMENT IN MANAGED CARE MUST BE VOLUNTARY. ENROLLMENT ON A VOLUNTARY BASIS MEANS SELLING THE PROGRAM TO RECIPIENTS. INCENTIVES TO ENROLL IN OUR PROGRAMS ARE ACCESS TO CARE, NO LIMITS ON NECESSARY VISITS AND PRESCRIPTIONS. THE SCHOOL OF MEDICINE PCCM ALSO HAS SOME ADDITIONAL FEATURES.

THERE ARE VARIOUS WAYS TO MARKET MANAGED CARE PROGRAMS. IN FOUR NEVADA STATE WELFARE DISTRICT OFFICES WE HAVE ELIGIBILITY WORKERS MARKETING THE PROGRAMS. WE HAVE EXPERIMENTED WITH SPECIALIZED MARKETING WORKERS IN TWO LOCATIONS OVER ALMOST TWO YEARS. THE LOCATION HAS ROTATED TO THREE OFFICES. WE HAVE CONVINCING NUMBERS THAT SHOW THE SPECIALIZED MARKETING WORKERS ARE MORE EFFECTIVE. WE HOPE TO EXPAND THIS STAFFING ESPECIALLY IN LAS VEGAS.

UNDER THE MANAGED CARE CONCEPT, THE CONTRACTING PROVIDER IS THE "GATEKEEPER" FOR MEDICAID BENEFICIARIES' HEALTH CARE. THE MANAGED CARE PROVIDER IS RESPONSIBLE FOR PROVIDING OR APPROVING ALL MEDICAL CARE INCLUDING REFERRALS, CONSULTATION, ORDERING OF THERAPY, TREATMENT IN HOSPITALS, FOLLOW-UP CARE, AND PREPAYMENT APPROVAL OF REFERRED LABORATORY AND X-RAY SERVICES. THE NEVADA MEDICAID PCCM CONTRACTORS ARE AT RISK (CAPITATED) FOR PHYSICIAN, PHARMACY, LABORATORY AND X-RAY SERVICES. THESE SERVICES COUNT AS TWO MANDATORY MEDICAID SERVICES (PHYSICIAN PLUS LAB/X-RAY).

MANAGED CARE PROGRAMS REALIZE SAVINGS TO STATES BY PREVENTING ENROLLEES FROM SEEKING AMBULATORY CARE FROM COSTLY HOSPITAL EMERGENCY ROOMS OR OUTPATIENT DEPARTMENTS. LACK OF MANAGED CARE MAY LEAD RECIPIENTS TO DEFER CARE UNTIL THEIR MEDICAL NEEDS ARE ACUTE, THUS RAISING INPATIENT UTILIZATION AND COSTS. FURTHER, THE FRAGMENTED, EPISODIC NATURE OF CARE IN EMERGENCY ROOMS AND MOST HOSPITAL OUTPATIENT DEPARTMENTS, AND THE RESULTING LACK OF A CONTINUING RELATIONSHIP BETWEEN THE PATIENT AND THE PRIMARY CARE PHYSICIAN, ARE LIKELY TO LEAD TO DUPLICATION OF LABORATORY TEST AND PRESCRIPTIONS, UNNECESSARY HOSPITALIZATIONS, AND GENERALLY POOR QUALITY MEDICAL CARE.

SAVINGS CALCULATIONS IN MANAGED CARE ARE PRESUMPTIVE. MEDICAID COMPARES POPULATIONS OF FEE-FOR-SERVICES MEDICAID RECIPIENTS TO A LIKE GROUP OF ENROLLED RECIPIENTS. THE COMPARISONS ARE DRAWN BETWEEN PEOPLE IN THE SAME AREA (IN THIS CASE, RENO AND LAS VEGAS), THE SAME SEX, AGE GROUPING AND AID CATEGORY IN WELFARE. THE ASSUMPTION IS THAT GROUPS OF LIKE POPULATIONS HAVE SIMILAR MEDICAL NEEDS (REFER TO POPULATION GRAPHS). THE SCHOOL OF MEDICAID ENROLLEES ARE VERY SIMILAR IN DISTRIBUTION TO THE REMAINING FEE-FOR-SERVICES POPULATIONS.

I HAVE DISTRIBUTED THE FY 91 SAVINGS CALCULATIONS. WE MULTIPLY THE AVERAGE COST OF PROVIDING ALL SERVICES TO REGULAR MEDICAID RECIPIENTS BY THE MANAGED CARE ENROLLEE MONTHS TO SEE WHAT THE COST OF THE ENROLLEES WOULD BE IN REGULAR MEDICAID. THEIR ACTUAL COST IS SUBTRACTED FROM WHAT THEY PRESUMABLY WOULD HAVE COST IN FFS TO CALCULATE THE SAVINGS AMOUNT. THIS SHOULD BE A REASONABLE ASSUMPTION IF THE GROUPS ARE DEMOGRAPHICALLY SIMILAR AND THE SAMPLE IS LARGE ENOUGH.

THE ACTUAL COSTS FOR THE AGED AND THE ADC GROUPS IN THE FOURTH QUARTER 1991 ARE ALSO INCLUDED IN THE HANDOUTS. IN THE AGED IN THE COMMUNITY GROUP, THE ENROLLEES COST $81 LESS THAN THEIR EQUALS IN FEE-FOR-SERVICE. IN THE ADC POPULATION THE SAVINGS WERE $40 PER MONTH.

RATES ARE RE-CALCULATED ANNUALLY. BY FEDERAL REGULATION, RATES CAN NOT EXCEED THE COST OF PROVIDING CARE IN FEE-FOR-SERVICE GROUPS AND MUST BE SET ON AN ACTUARILY SOUND BASIS. NEVADA'S RATES ARE CALCULATED FOR SPECIFIC AGE GROUPINGS TO ACCOUNT FOR DIFFERENT MEDICAL NEEDS, I.E., NEWBORNS AND PREGNANT WOMEN. IF SELECTION IS OCCURRING BY AN AID CATEGORY OR AGE, THE RATE OF PAYMENT NATURALLY CORRECTS FOR THIS.

ALTHOUGH NEVADA HAS DONE WELL OVER THE TERM OF THE SCHOOL OF MEDICINE CONTRACT, WE HAVE A LONG WAY TO GO IN ENROLLING RECIPIENTS AS ONLY 20 PERCENT OF ELIGIBLES ARE ENROLLED. (REFER TO ATTACHED ENROLLMENT FIGURES).

AS OF MAY 1992, THERE WERE 7,815 PCCM ENROLLEES IN THE SCHOOL OF MEDICINE PROGRAM - 2,249 IN RENO AND 5,566 IN LAS VEGAS.

ON APRIL 1, 1992, MEDICAID CONTRACTED WITH A SECOND PCCM PROVIDER, INCORPORATED UNDER THE NAME "NEVADACARE". NEVADACARE IS AVAILABLE IN CLARK COUNTY. ENROLLEES MAY CHOOSE ONE OF FIVE PRIMARY CARE CLINIC SITES, NEVADACARE HAS ENROLLED 881 RECIPIENTS AS OF MAY 1, 1992.

WE ARE NEGOTIATING A CONTRACT WITH COMMUNITY HEALTH CENTERS OF SOUTHERN NEVADA. THE COMMUNITY HEALTH CENTERS OPERATE IN MEDICALLY UNDERSERVED NEIGHBORHOODS. IN THIS VANE, COMMUNITY HEALTH CENTERS IN LAS VEGAS AND THE SCHOOL OF MEDICINE IN RENO WILL BE OPENING ON-SITE PHARMACIES.

MEDICAID PLANS TO CONTINUE TO DEVELOP MANAGED CARE CONTRACTS. WE ARE HOPEFUL THE MEDICAID MANAGED CARE ACT OF 1991 WILL BECOME LAW TO EXPAND OUR OPTIONS. IF THIS HAPPENS, MEDICAID WILL CONSIDER A MANDATORY ENROLLMENT PROGRAM, FIRST IN LAS VEGAS. WE WOULD LIKE THE AUTHORITY TO OPEN TO CONTRACT NEGOTIATIONS WITH ANY ORGANIZATIONS WHO CAN MEET SPECIFIED MEDICAID REQUIREMENTS FOR MANAGED CARE, IN AREAS WHERE WE NEED MORE PROVIDERS. WE WILL BE PUBLISHING GUIDELINES FOR MANAGED CARE CONTRACTING. I WOULD LIKE TO THANK THE COMMITTEE FOR THE OPPORTUNITY TO PRESENT MANAGED CARE FROM THE MEDICAID PERSPECTIVE. THE MEDICAID OFFICE WOULD LIKE THE COMMITTEE'S SUPPORT IN OUR PLANS FOR PROGRAM AND STAFF EXPANSION. WE ALSO NEED THE COMMITTEE'S CONTINUED CONTACT WITH NEVADA'S CONGRESSIONAL DELEGATION TO URGE THE PASSAGE OF SENATE BILL 2077.

DH/ALD

ATTACHMENTS

1. ADC UNR/UNLV ENROLLEES BY SEX/AGE GROUPINGS

2. ADC FEE-FOR-SERVICE BY SEX/AGE GROUPINGS

3. FY 91 RENO PCCM SAVINGS

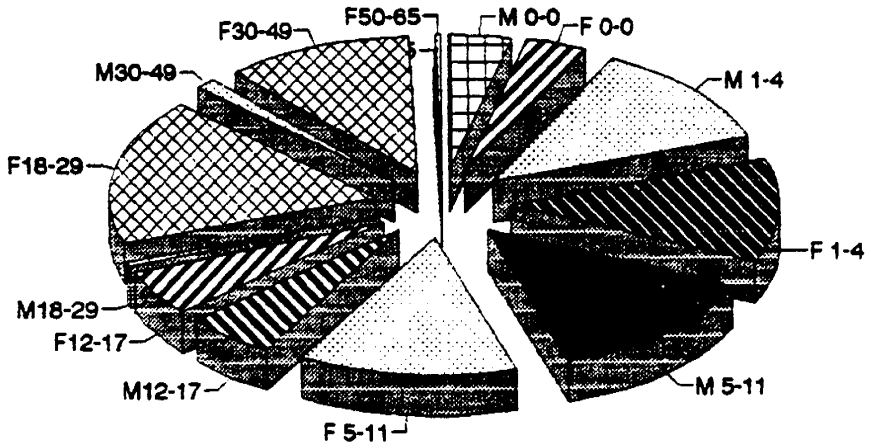
4. FY 91 LAS VEGAS PCCM SAVINGS

5. FOURTH QUARTER 91 FFS-ENROLLEE COMPARISON - AGED IN COMMUNITY

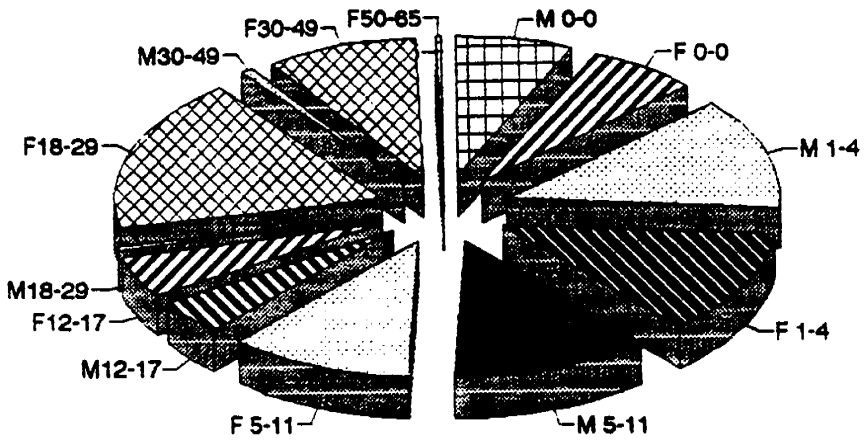
6. FOURTH QUARTER 91 FFS-ENROLLEE COMPARISON - ADC

7. MAY 1992 MANAGED CARE ENROLLEES

ADC UNR/UNLV ENROLLEES
BY SEX/AGE GROUPINGS-4TH Q 1991



ADC FEE-FOR-SERVICE
BY SEX/AGE GROUPINGS-4TH Q 1991



RENO PCCM SAVINGS
FY'91

CATEGORY	FFS COST/ELIG	PCCM MONTHS	COST IF NOT IN PCCM	PCCM COST/ELIG	PCCM MONTHS	COST IN PCCM	COST IF NOT IN PCCM	COST IN PCCM	SAVINGS BY AGE AND SEX	SAVINGS BY AGE	SAVINGS BY CATEGORY	
AGED INST												
M 65-79	$1,160	1	$1,160	$0	1	$0	$1,160	$0	$1,160	65-79	INST	
F 65-79	$1,337	13	$17,381	$1,305	13	$16,965	$17,381	$16,965	$416	$1,576	$358	
M 80+	$1,131	0	$0	$1,030	0	$0	$0	$0	$0	80+	$162	ADJUSTMENT
F 80+	$1,371	42	$57,582	$1,400	42	$58,800	$57,582	$58,800	($1,218)	($1,218)	$520	SAVINGS
AGED COMM												
M 65-79	$127	245	$31,115	$61	245	$14,945	$31,115	$14,945	$16,170	65-79	COMM	
F 65 79	$136	647	$87,992	$79	647	$51,113	$87,992	$51,113	$36,879	$53,049	$69,941	
M 80+	$188	45	$8,460	$44	45	$1,980	$8,460	$1,980	$6,480	80+	$2,802	ADJUSTMENT
F 80+	$128	137	$17,536	$52	137	$7,124	$17,536	$7,124	$10,412	$16,892	$72,743	SAVINGS
ADC												
M < 1	$364	576	$209,664	$84	576	$48,384	$209,664	$48,384	$161,280	0-0	ADC	
F < 1	$270	463	$125,010	$65	463	$30,095	$125,010	$30,095	$94,915	$256,195	$683,859	
M 1-4	$38	1450	$55,100	$50	1450	$72,500	$55,100	$72,500	($17,400)	1-4	$34,809	ADJUSTMENT
F 1-4	$56	1374	$76,944	$42	1374	$57,708	$76,944	$57,708	$19,236	$1,836	$718,668	SAVINGS
M 5-11	$50	1498	$74,900	$39	1498	$58,422	$74,900	$58,422	$16,478	5-11		
F 5-11	$52	1555	$80,860	$36	1555	$55,980	$80,860	$55,980	$24,880	$41,358		
M 12-17	$51	480	$24,480	$43	480	$20,640	$24,480	$20,640	$3,840	12-17		
F 12-17	$116	573	$66,468	$62	573	$35,526	$66,468	$35,526	$30,942	$34,782		
M 18-29	$34	67	$2,278	$73	67	$4,891	$2,278	$4,891	($2,613)	18-29		
F 18-29	$262	2183	$571,946	$169	2183	$368,927	$571,946	$368,927	$203,019	$200,406		
M 30-49	$228	105	$23,940	$118	105	$12,390	$23,940	$12,390	$11,550	30-49		
F 30-49	$226	1284	$290,184	$121	1284	$155,364	$290,184	$155,364	$134,820	$146,370		
M 50-64	$876	0	$0	$0	0	$0	$0	$0	$0	50-64		
F 50-64	$403	28	$11,284	$299	28	$8,372	$11,284	$8,372	$2,912	$2,912		
ADC TOTAL		11636	$1,613,058		11636	$929,199						

TOTAL RENO SAVINGS	$791,931
TOTAL LAS VEGAS SAVINGS	$1,560,610
TOTAL PROGRAM SAVINGS	$2,352,541

March-June 1991 Administrative & case management rate of $7.72 was adjusted out of the PCCM cost in "Adjustment" notation.

LAS VEGAS PCCM SAVINGS
FY'91

CATEGORY	FFS COST/ELIG	PCCM MONTHS	COST IF NOT IN PCCM	PCCM COST/ELIG	PCCM MONTHS	COST IN PCCM	COST IF NOT IN PCCM	COST IN PCCM	SAVINGS BY AGE AND SEX	SAVINGS BY AGE	SAVINGS BY CATEGORY	
AGED INST												
M 65-79	$1,290	2	$2,580	$942	2	$1,884	$2,580	$1,884	$696	65-79	INST	
F 65-79	$1,366	14	$19,124	$1,040	14	$14,560	$19,124	$14,560	$4,564	$5,260	$2,237	
M 80+	$1,164	3	$3,492	$772	3	$2,316	$3,492	$2,316	$1,176	80+	$139	ADJUSTMENT
F 80+	$1,334	19	$25,346	$1,555	19	$29,545	$25,346	$29,545	($4,199)	($3,023)	$2,376	SAVINGS
AGED COMM												
M 65-79	$185	833	$154,105	$88	833	$73,304	$154,105	$73,304	$80,801	65-79	COMM	
F 65 79	$137	1933	$264,821	$84	1933	$162,372	$264,821	$162,372	$102,449	$183,250	$239,566	
M 80+	$178	146	$25,988	$127	146	$18,542	$25,988	$18,542	$7,446	80+	$9,164	ADJUSTMENT
F 80+	$195	543	$105,885	$105	543	$57,015	$105,885	$57,015	$48,870	$56,316	$248,730	SAVINGS
ADC												
M < 1	$293	1495	$438,035	$115	1495	$171,925	$438,035	$171,925	$266,110	0-0	ADC	
F < 1	$251	1613	$404,863	$112	1613	$180,656	$404,863	$180,656	$224,207	$490,317	$1,208,944	
M 1-4	$54	4310	$232,740	$39	4310	$168,090	$232,740	$168,090	$64,650	1-4	$100,560	ADJUSTMENT
F 1-4	$41	3980	$163,180	$35	3980	$139,300	$163,180	$139,300	$23,880	$88,530	$1,309,504	SAVINGS
M 5-11	$36	4778	$172,008	$39	4778	$186,342	$172,008	$186,342	($14,334)	5-11		
F 5-11	$33	4260	$140,580	$34	4260	$144,840	$140,580	$144,840	($4,260)	($18,594)		
M 12-17	$61	1469	$89,609	$44	1469	$64,636	$89,609	$64,636	$24,973	12-17		
F 12-17	$111	1926	$213,786	$75	1926	$144,450	$213,786	$144,450	$69,336	$94,309		
M 18-29	$115	119	$13,685	$109	119	$12,971	$13,685	$12,971	$714	18-29		
F 18-29	$218	6285	$1,370,130	$147	6285	$923,895	$1,370,130	$923,895	$446,235	$446,949		
M 30-49	$217	263	$57,071	$194	263	$51,022	$57,071	$51,022	$6,049	30-49		
F 30-49	$180	3298	$593,640	$150	3298	$494,700	$593,640	$494,700	$98,940	$104,989		
M 50-64	$335	17	$5,695	$303	17	$5,151	$5,695	$5,151	$544	50-64		
F 50-64	$243	76	$18,468	$218	76	$16,568	$18,468	$16,568	$1,900	$2,444		
ADC TOTAL		33889	$3,913,490		33889	$2,704,546						

TOTAL LAS VEGAS SAVINGS	$1,560,610
TOTAL RENO SAVINGS	$791,931
TOTAL PROGRAM SAVINGS	$2,352,541

March-June 1991 Administrative & case management rate of $7.72 was adjusted out of the PCCM cost in "Adjustment" notation.

DH:dh 1/4/92

4TH Q'91 FFS-ENROLLEE COMPARISON
AGED IN COMMUNITY

	PCCM		FEE-FOR-SERVICE	
SEX/AGE	ENROLL MO	TOTAL COST	ELIG. MOS.	TOTAL COS
M 65-80	1,078	$90,484	6,974	$1,202,066
F 65-80	2,580	$211,011	21,945	$3,020,669
M 80+	191	$20,639	1,677	$302,763
F 80+	680	$64,886	7,730	$1,377,027
TOTAL	4,529	$387,020	38,326	$5,902,525
AVERAGE COST		$85.45		$154.01
	LESS $4.72	$80.73		

ADJUSTMENT OF $4.72 FROM ENROLLEES COST TO REMOVE ADMINISTRATIVE FEE.

PCCM SAVINGS PER PERSON PER MONTH = $ 73.28

DH:dh 4/30/92

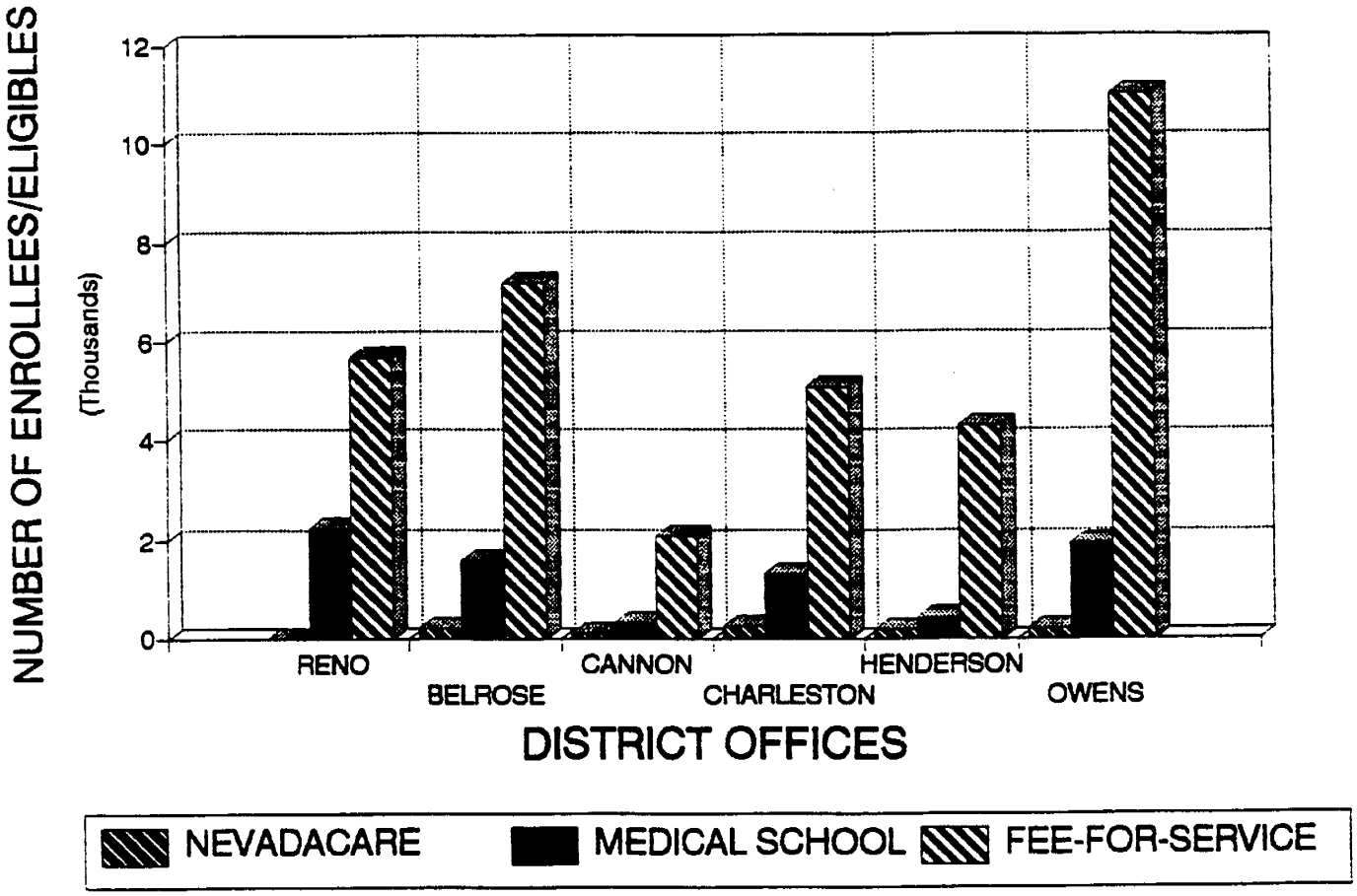
4th Q '91 FFS-ENROLLEE COMPARISON
ADC

	PCCM		FEE-FOR SERVICE	
SEX/AGE	ENROLL MOS.	TOTAL COST	ELIG. MOS.	TOTAL COS
M 0-0	587	$80,029	6,739	$2,319,783
F 0-0	591	$76,676	6,352	$1,535,520
M 1-4	2,015	$110,251	12,662	$715,661
F 1-4	1,992	$99,027	12,036	$541,687
M 5-11	2,147	$135,363	11,255	$565,004
F 5-11	2,105	$107,774	10,753	$373,213
M12-17	865	$95,778	4,029	$332,358
F12-17	876	$96,626	4,916	$684,781
M18-29	89	$10,779	535	$29,511
F18-29	2,818	$517,393	17,341	$4,524,534
M30-49	204	$28,666	844	$155,122
F30-49	1,827	$281,334	8,823	$1,741,531
M50-65	26	$5,541	84	$10,504
F50-65	45	$65,400	253	$80,091
TOTAL	16,187	$1,710,637	96,622	$13,609,300
AVERAGE COST		$105.68		$140.85
LESS $4.72		$100.96		

ADJUSTMENT OF $ 4.72 FROM ENROLLEES COST TO REMOVE ADMINISTRATIVE FEE.

PCCM SAVINGS PER PERSON PER MONTH= $39.89.

MAY 1992 MANAGED CARE ENROLLEES
VERSES FEE-FOR-SERVICE ELIGIBLES



APPENDIX F

RECOMMENDATIONS FROM NEVADACARE MAY 21, 1992.

Nevada Care

We Care About Your Family's Health

SUGGESTIONS/RECOMMENDATIONS FOR NEVADA MEDICAID

1. Freedom of Choice Waiver

2. Full-Risk Arrangements - Competitive Bid

3. Six (6) Month Guaranteed Enrollment Period

4. 75/25 Composition Waiver

HMA, INC.

HMA, INC. MISSION STATEMENT

To be a leading provider of quality, cost effective and innovative management and information services, to those who deliver and those who purchase health care, in a corporate environment responsive to our clients, employees and shareholders.

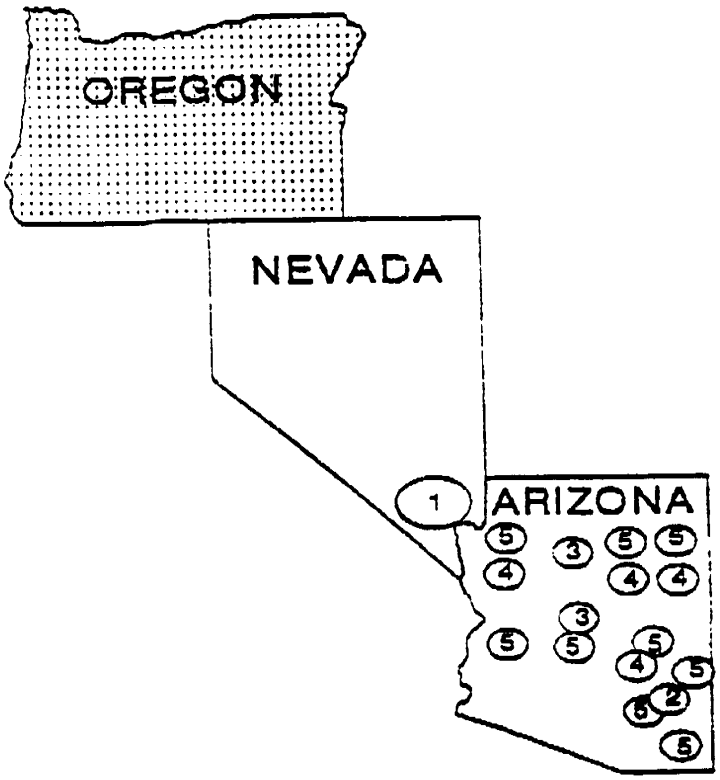
HMA, INC. FACTS

- Founded in Cottonwood, Arizona, 1981
- Became Wholly Owned Subsidiary of I/MX, 1990
- Corporate Headquarters - Tempe, Arizona
- Information Management Center - Cottonwood, Arizona
- Sharply Focused on Health Care and information Services
- Serve Both the Public and Private Sectors
- Revenues are Recurring Services Revenue
- Experienced Mangement
- Proprietary Information Mangement System/Software
- 120 Employees
- Personnel Have Strong Industry and Technical Skills
- Strong Rural Presence
- A Leader in Establishing Provider Networks
- 10 Years Experience in Medicaid Managed Health Care
- Experienced in Point of Service Plan Administration
- Directly Manage over $90 Million in Healthplan Revenue
- Directly Manage over 175,000 Members in Healthplans/Networks
- Owns Summit Medical, Medical Equipment Subsidiary

HMA PRODUCTS AND SERVICES

- Medicaid Managed Care Plans
- Preferred Provider Organizations (PPOs)
- Exclusive Provider Organizations (EPOs)
- Full Risk Individual Practice Associations (IPAs)
- Utilization Review and Quality Assurance
- Case Management
- Workers Compensation
- Third Party Administration (TPA)
- Claims Processing
- Point of Service Healthplans (Select Plus)
- Claims Repricing
- Durable Medical Equipment and Medical Supplies
- Information Management and Reporting

HMA MEDICAID HEALTHPLANS



Future Expansion

1 — NevadaCare
Clark County, NV

2 — Doctors Health Plan
(DHP)
Gila County, AZ

3 — Northern AZ Family Health Plan
(NAFHP)
Yavapai, Coconino
Counties, AZ

4 — Family Health Plan of NE AZ
(NEAZ)
Mohave, Apache, Navajo,
Gila Counties, AZ

5 — Ventana Health Systems
(Long Term Care)
Apache, Cochise, Gila,
Graham, Greenlee,
Mohave, Navajo,
Yavapai, LaPaz
Counties, AZ

COVERED SERVICES

Services covered by AHCCCS include:

* Outpatient Health Services
* Laboratory and Medical Services
* Pharmacy Services
* Medical Supplies and Equipment
* Inpatient Hospital Services
* Emergency Services
* Ambulance and Medically Necessary Transport
* Emergency Dental Care
* A Program Called EARLY & PERIODIC SCREENING DIAGNOSIS & TREATMENT (EPSDT) for Children
* Kidney, Cornea and Bone Transplants
* In-and-Outpatient Mental Health Services for Children under 18
* Family Planning Services

SERVICE DELIVERY

Services are provided to eligible Enrollees through Health Plans that are selected by competitive bidding. Enrollment in a prepaid Health Plan is mandatory for members. The Health Plans are reimbursed on a prepaid capitated basis. AHCCCS currently contracts with 15 prepaid Health Plans in the State.

HMA SERVICES PROVIDED TO AHCCCS HEALTH PLANS

HMA provides all administrative services to each of its managed Health Plans including the following:

- Regulatory Reporting
- Rate and Bid Preparation
- Contract Negotiation with Providers and with State
- Enrollment Processing and Reporting
- Claims Processing and Reporting
- Utilization Review and Quality Assurance
    * Hospital Pre-Certification
    * Specialist Authorization
    * Concurrent Hospital Review
    * Maternity Case Management
    * Provider Profiling
    * Retrospective Claims Review
    * Large and Catastrophic Case Management
- Accounting and Tax Services
- Maintain All Corporate Records and Reports
- Marketing
- Liaison with State AHCCCS Administration

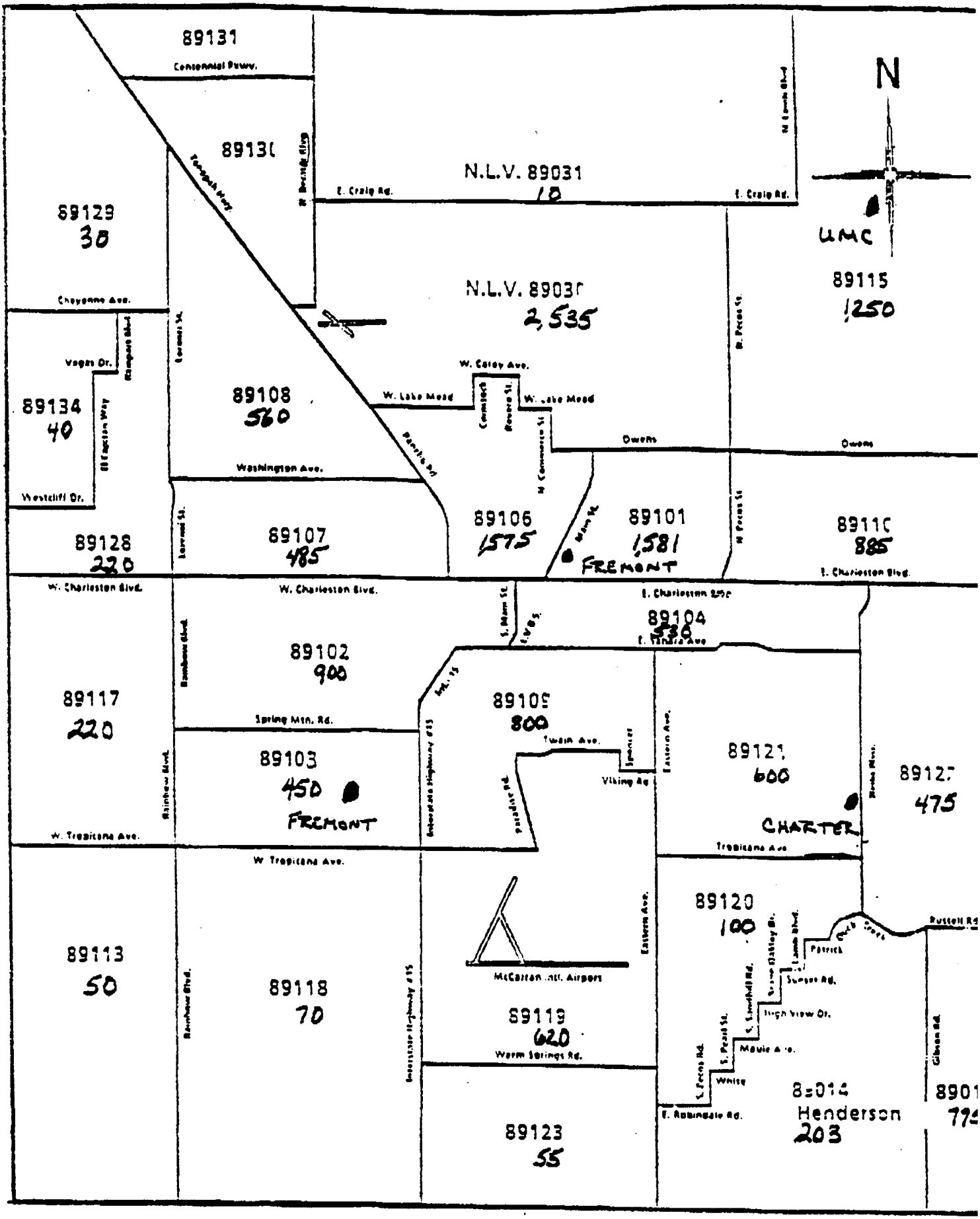
NEVADACARE COVERED SERVICES

* Inpatient and Outpatient Physician Services

* Outpatient Radiology

* Laboratory Services

* Pharmacy Services


89131
Centennial Pkwy.
89130
N.L.V. 89031
10
E. Craig Rd.
E. Craig Rd.
N
UMC
89129
30
N.L.V. 89030
2,535
89115
1250
Cheyenne Ave.
Vegas Dr.
89134
40
Westcliff Dr.
89108
560
W. Lake Mead
W. Lake Mead
W. Carey Ave.
Owens
Owens
Washington Ave.
89128
220
89107
485
89106
1575
89101
1,581
FREMONT
89110
885
E. Charleston Blvd.
W. Charleston Blvd.
W. Charleston Blvd.
89104
530
E. Tropicana Ave.
89102
900
89117
220
Spring Mtn. Rd.
89109
800
Twain Ave.
89103
450
FREMONT
89121
600
CHARTER
89127
475
W. Tropicana Ave.
W. Tropicana Ave.
Tropicana Ave
89113
50
89118
70
McCarran Intl. Airport
89120
100
Russell Rd
89119
620
Warm Springs Rd.
89123
55
89014
Henderson
203
E. Robindale Rd.
8901
775

APPENDIX G

RECOMMENDATIONS FROM: NEVADA WELFARE DIVISION;
DIRECTOR, DEPARTMENT OF HUMAN RESOURCES;
COUNTY SOCIAL SERVICE DIRECTORS;
AND NACO - MAY 21, 1992.

BOB MILLER
Governor

STATE OF NEVADA

JERRY GRIEPENTROG
Director

LINDA A. RYAN
Administrator

DEPARTMENT OF HUMAN RESOURCES
WELFARE DIVISION
2527 North Carson Street - Capitol Complex
Carson City, Nevada 89710
(702) 687-4128

May 11, 1992

MEMORANDUM

TO: STEVEN J. ABBA, PROGRAM ANALYST, FISCAL ANALYSIS DIVISION

FROM: LINDA A. RYAN

SUBJECT: ACR 16/APRIL 17 MEMORANDUM

You wrote two memoranda on April 17th requesting information for the May 21st ACR 16 meeting in Las Vegas. My response today concerns the memo requesting specific recommendations for the ACR 16 Committee's review.

You will recall we presented five issues to the Committee in November for its consideration. At the time I believed our recommendation for the Committee to examine the federal emergency assistance program was a good one. I realize the county welfare officials did not like it, but I believe their concerns could have been addressed in the legislation which would be necessary to change the existing focus of county welfare. Apparently though the committee agreed this idea did not merit further attention.

As you know, we're developing responses to your questions on ADC "gap" budgeting, managed care, medically needy, the 1634 waiver costs and a couple of additional ADC issues. I hope this information will be useful at the May 21st ACR 16 meeting.

The one other suggestion we have is related to the County Match Program. As you know, this program was initiated so the counties could leverage federal funding. The counties provide the non-federal share of funding and the state administers the program. The program has grown tremendously since implemented. When the program began there were approximately 300 cases; in March 1992 we served 546 cases. The cost of the program has also grown by leaps and bounds. The Division started with approximately $3 million the first year; in FY 91 $5.4 was expended and this year we expect to pay out $11 million. The administration has become too complex and a state/county agreement is no longer workable. The program should be operated by the state with a dedicated funding source. It would be less complex and more efficient if the program was simply operated and funded

like other Medicaid programs. Additionally, too much staff time is spent separately accounting for the county match program.

Steve, it is not possible to present any further recommendations at this time. We are in the early process of budget development for FY 94-95. Any proposals for changes impacting NSWD programs or clients must be submitted with our budgets to Mr. Griepentrog for consideration.

I will be available at the May 21st meeting to answer questions which may arise.

LAR/mh

BOB MILLER
Governor

STATE OF NEVADA

JERRY GRIEPENTROG
Director

DEPARTMENT OF HUMAN RESOURCES
DIRECTOR'S OFFICE
Room 600, Kinkead Building
505 E. King Street
Carson City, Nevada 89710
Telephone (702) 687-4400
Fax (702) 687-4733

May 13, 1992

MEMORANDUM

TO: Steve Abba, Program Analyst
Fiscal Analysis Division

FROM: Jerry Griepentrog, Director
Department of Human Resources

SUBJECT: Interim Committee Study Nevada's Welfare System (ACR 16)

The Welfare Division of the Department of Human Resources has worked closely with the ACR 16 Committee in providing information concerning the programs administered by that Division. The Administrator of the Welfare Division along with her senior staff have developed and submitted suggestions for the Committee's consideration.

I appreciate the Committee's invitation to provide suggestions on the Nevada Welfare system but do not have any substantive recommendations beyond those submitted by the Welfare Division to offer at this time. I thank the Committee for their work with the Division of Welfare and look forward to reviewing their findings.

JG/lu

WASHOE COUNTY

"To Protect and To Serve"

DEPARTMENT OF SOCIAL SERVICES

WELLS AVE. AT NINTH ST.
POST OFFICE BOX 11130
RENO, NEVADA 89520 — 0027
PHONE: (702) 328-2300

May 5, 1992

Steve Abba, Program Analyst
Fiscal Analysis Division
Legislative Counsel Bureau
Capitol Complex
Carson City, NV 89710

Dear Steve:

Thank you for your letter of April 17, 1992, inviting us to give input for the recommendation phase of the interim study on the welfare system in Nevada (ACR 16).

Following are the issues we would like the Committee to include in the recommendations and the reasons why we believe they should be considered:

1. The State Legislature should not establish a medically needy program. It does not make sense for the state to establish a new very costly program when it is having difficulty funding the current Medicaid Program. The State should not look to counties to provide match funds for existing or new State programs.

   Rather than establish yet another costly medical program, the Legislature should enact statutes that address the issues of accessibility and affordability of health care to uninsured citizens. These are the people who fall into the category of "medically needy." For example, statutes may be enacted similar to the Hawaii or Oregon programs.

2. The State should make greater effort to make outpatient care accessible to Medicaid patients. Currently, physicians in Washoe County are limiting the number of new Medicaid patients they are accepting into their practice. This makes it virtually impossible for Medicaid patients to access primary care and they, through desperation, end up using the emergency departments of the hospitals.

   It may be necessary for the State to set up Medicaid clinics in various locations in the state staffed by contract physicians or collaborate with existing county or private clinics. Primary care is less costly than acute care and will save taxpayers money in the long run.

3. The State Legislature should acknowledge the State's responsibility for long-term care in the Medicaid Program and revise the income limit to 300% of SSI (currently $1,266/month). The maximum would automatically change when the recipients receive annual cost-of-living increases.

   The State Legislature should abolish the 300% match program, which requires match dollars from counties for long-term care patients whose incomes exceed $714/month up to the current 300% of SSI level. The Legislature should appropriate State dollars for the local share with which to match federal dollars for all Medicaid services. In fact it should be a State policy to take responsibility for programs that have the potential for federal match dollars.

4. The State Legislature should establish and appropriate State funds for an emergency assistance program administered by State Welfare for ADC applicants. The federal government will provide 50% match to fund this program. This recommendation is consistent with the last sentence in item 3 above.

   The establishment of this program will eliminate the need for ADC applicants to go through two application processes: one for ADC at State Welfare and the second to apply for General Assistance at the county to receive assistance (30 days in Washoe County) while their ADC applications are pending.

   Also, this will eliminate confusion in the community as to whom the county General Assistance Program will help and whom State Welfare helps: The State assists individuals and families with children and counties will help individuals/couples with no dependents.

   The federal government limits emergency assistance to 30 days in any 12-month period. The State has the capability of accessing ADC application data statewide; counties do not have intercounty information exchange capabilities to prevent misuse of the program.

Thank you for giving us the opportunity to participate in the welfare study. If you have any questions, please feel free to call me.

Sincerely,

May Shelton

May Shelton, Director
Department of Social Services

Social Service

DENELL A. HAHN
DIRECTOR

651 SHADOW LANE
LAS VEGAS, NEVADA 89106
[702] 455-4270
FAX: [702] 386-0435

June 18, 1992

Steve J. Abba, Program Analyst
Fiscal Analysis Division
Legislative Counsel Bureau
Capitol Complex
Carson City, NV 89710

Re: Human Services Commission

Dear Steve:

I had stated in my testimony to the Committee established by ACR 16 that the time had come for a statewide Human Service Commission. You have requested more information about this recommendation.

I. The Commission should be Governor-appointed to four-year terms. Composition should include individuals from the following areas:

-State Department of Human Resources
-Nevada Association of County Welfare Directors
-Nevada Legislature
-Nevada Association of Counties
-Hospital Association
-NAMI or similar mental health/mental retardation advocacy agency
-State Physician Association
-Mental Health providers
-Public at large
-Education
-Nursing Home Association

II. The Commission should have the duty to:

1) establish a State philosophy towards provision of human services in Nevada;

2) develop and maintain a current program assessment;

3) define current and future needs;

4) develop goals and strategies for achievement;

5) act as a vehicle to communicate and participate with federal program development;

6) review and make recommendations regarding State and local human service programs;

7) prepare pubic impact assessments on program adjustments to include fiscal, social and long range considerations; and

8) develop emergency preparedness planning for human services.

III. The Commission should have a budget to acquire planning accounting and investigative staff, and a chairman.

IV. The chairman of the Commission should be a full time, unclassified State employee, independent of conflicts in employment, political or pecuniary allegiances. The background of the chairman should reveal expertise in human service systems and public or business administration.

V. The Commission must hold public hearings annually to solicit geographic input.

VI. The Commission must provide a State human service summary and recommendations to the Governor, to the Nevada Legislature, and the Boards of County Commissioners biannually to coincide with the opening of each legislative session.

I know this is a very preliminary proposal; however, without a statewide philosophy and a forum to accomplish statewide planning, Nevada will continue to underserve its citizens in the area of human services. Important planning will be done by budget and expediency rather than a consensus of representative and informed citizens.

Sincerely,

CLARK COUNTY SOCIAL SERVICE

Denell A. Hahn, Director
DAH/t/ABBA1

Social Service

DENELL A. HAHN
DIRECTOR

651 SHADOW LANE
LAS VEGAS, NEVADA 89106
(702) 455-4270
FAX: (702) 386-0435

May 7, 1992

Steve J. Abba, Program Analyst
Fiscal Analysis Division
Legislative Counsel Bureau
Capitol Complex
Carson City, NV 89710

Dear Steve:

As per your request, I have several recommendations for the interim committee. I would appreciate some time to speak at the next meeting and will plan to go into more detail about my recommendations.

Priority #1: Establish a statewide human resources planning commission with membership including state, county and private participation. The mission of the commission should be to establish statewide assessment and planning for human resources, to ensure that adjustments to social programs have a measured impact on communities, and to develop a philosophy toward service and delivery of social services in Nevada.

Priority #2: Retain Nevada Medicaid at the existing program level with COLA adjustments.

Priority #3: Restore the State responsibility to fund the nonfederal share of the long-term care program, maintain an income limit of 300% of SSI, consistent with NACO and NACWD policy, clarifying State-county responsibilities.

Priority #4: Support the county bill eliminating single employables and employable childless couples from mandatory county financial aid.

Priority #5: Support the Clark County bill eliminating physician payments relative to free care requirements for hospitals of over 100 beds.

My department will be represented at the May 21st meeting and we will be pleased to present and discuss these recommendations.

Sincerely,

CLARK COUNTY SOCIAL SERVICE

Denell A. Hahn, Director

DAH/t/ABBA

Churchill County Welfare Department

190 West First Street
Fallen, NV 89406

☎ 702/423-5136
Fax 702/423-0717

Cyril Schank
Commissioner
Ruby Anderson
County Clerk
Michael J. McMahon
Welfare Director

June 17, 1992

Ms. Vivian Freeman, Chair
ACR 16 Subcommittee
1665 Carlin Street
Reno, NV 89503

Dear Ms. Freeman:

I am writing subsequent your request to identify specific overlaps between the Nevada State Welfare and the County Welfare programs. The overlaps in services of the two agencies are not confined to specific programs, but rather, timing. The County Welfare Departments provide emergent and/or temporary assistance. Typically, this assistance is provided while children and families are awaiting benefits from other programs such as Social Security, Veterans and Nevada State Welfare.

Services provided through the County Welfare Departments include: rent, utility, indigent medical care, prescriptions, Long-term care, food (pantry), victims of sexual assault/molestation, and the removal of barriers to self-sufficiency. These services are funded exclusively by property taxes and other local dollars.

Services provided through the Nevada State Welfare Division include: General and Emergency assistance, medical care (Medicaid, CHAP, etc.), Long-term care and food (Food Stamps). These programs are subsidized with federal tax dollars on a matching basis.

Again, the primary differences between the two entities are that the County Welfare Departments provide initial and interim assistance with local property tax dollars while clients await assistance from other sources. I encourage you to adopt the NACo policy requiring all State Programs eligible for federal match dollars to secure and provide these programs. The County Welfare Departments will continue to provide services which eliminate barriers to families attaining self-sufficiency.

Please contact me should you have any questions.

Sincerely,

MICHAEL J. McMAHON
Welfare Director

MJM:wg

cc: Steven Abba
Linda Ryan

Churchill County Welfare Department

190 West First Street
Fallon, NV 89406

☎ 702/423-5136
Fax 702/423-0717

Cyril Schank
Commissioner
Ruby Anderson
County Clerk
Michael J. McMahon
Welfare Director

May 14, 1992

Steven Abba, Program Analyst
Legislative Counsel Bureau
Capitol Complex
Carson City, NV 89710

Mr. Abba:

I am writing to provide the following recommendations to the Interim Legislative Study on the Welfare System in Nevada (ACR 16). I offer my suggestions with the assumption that human resources are dwindling and the demand for services is rapidly increasing.

Nevada has a bifurcated welfare system. Specifically, there is a State and seventeen (17) separate County Welfare systems. This arbitrary bifurcation creates gaps and overlaps in the delivery of human service. If the current delivery system is to remain unaltered, I suggest that a clear delineation of roles and responsibilities be codified in statute. This alone, will eliminate waste through duplication in effort and cost. The State of Nevada should be responsible for providing services and programs targeted by federal programs, i.e.: Families with dependent children, aged, disabled, blind, foster children, etc. The Counties should continue to establish and approve funding, policies, and eligibility criteria for those programs not available through matching federal funds.

Beyond establishing a policy which clearly describes the responsibilities of service providers, I suggest that the committee establish a vision. I believe that having a vision of what a family in Nevada or the welfare system should look like is the start to making that vision become a reality. Then, prioritize the objectives in reaching that vision.

A tool to this process is the Human Service Master Plan. This plan is not the product of the State Department of Human Resources. It is the product of each local community describing its services, needs, and priorities for addressing its own issues. This is a product from the people. It is a valuable tool to reference when confronted with funding issues.

In conclusion, human services is not as simple as handing out a food basket. Human services, its systems, providers, regulations, and issues are very complex. When issues are to be addressed, all affected entities should share in the decision making process.

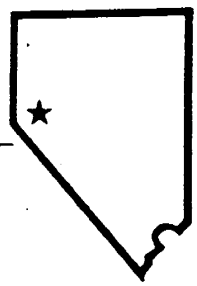
Please contact me should you have any questions or if I may be of any assistance.

Sincerely.

Michael J. McMahon

MM:jm

NACO
NEVADA ASSOCIATION OF COUNTIES
308 NORTH CURRY STREET, SUITE 205 • CARSON CITY, NEVADA 89703 (702) 883-7863



NACO POLICY
ON
MANDATES AND SERVICE RESPONSIBILITY

The provision of public services in Nevada is dependent upon a partnership between federal, state and local government that recognizes the need to blend private and public resources to promote efficient and cost effective government. Governments in Nevada must, as a matter of public policy, organize themselves so as to promote efficient administration and provision of services.

As such the state of Nevada with its statewide responsibility to ensure equity and uniform comprehensive services should use its statewide revenue base to underwrite federally mandated health and human services and other such regulatory functions necessary to provide for the health, safety and welfare of the citizens of Nevada. Failure to provide adequate funding for the state programs and federal mandates has resulted in program and cost shifting to counties already burdened by ever growing local demands.

County government should provide for locally administered programs based largely on the unique needs of its population without regard for the all encompassing needs of the overall population of the state.

This service driven alignment of responsibility requires a broad based system of taxation and fees. The local property tax should be reserved for locally determined needs and voter approved debt. This would provide local government with growth and stability to augment the complex system of state and local shared revenues borne out of the tax reform movement of the late 1970's and early 1980's.

The Nevada Association of Counties supports a state, county, and public private partnership that seeks to eliminate costly duplication of effort, streamlines administration and provides a baseline for services. A dynamic partnership based on the state assuming full responsibility for underwriting major statewide needs will enable local government and the private sector to work to meet the needs of our individual counties and communities statewide.

(public.txt)

STATE OF NEVADA
LEGISLATIVE COUNSEL BUREAU
LEGISLATIVE BUILDING
CAPITOL COMPLEX
CARSON CITY, NEVADA 89710
Fax No.: (702) 687-5962

JOHN R. CROSSLEY, *Director*
(702) 687-6800

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April 17, 1992

MEMORANDUM

TO: Denelle Hahn, Clark County Social Services Director
May Shelton, Washoe County Social Services Director
Michael McMahon, Churchill County Social Services Director
Pat Christensen, Nye County Social Services Director
Robert Hadfield, National Association of Counties

FROM: Steve J. Abba, Program Analyst
Fiscal Analysis Division

SUBJECT: ACR 16 (WELFARE SYSTEM IN NEVADA)

The fourth meeting of the interim committee studying Nevada's welfare system (ACR 16) has been scheduled for May 21, 1992 in Las Vegas at Cashman Field. The meeting will be video teleconferenced to Carson City. The meeting's focus will be on providing Medicaid services using managed care concepts. The meeting will include presentations from managed care providers as well as information on the current federal perspective in allowing states discretion to design and develop managed care models and programs.

As you are aware, the ACR 16 interim study was budgeted for five scheduled meetings. The fifth meeting will be a work session. The work session will most likely be held in late June (in Carson City) at which time recommendations developed from the study will be reviewed by the committee, discussed by the committee and voted upon. Work sessions are devoted to finalizing study findings, results and recommendations discussed during the course of previously held meetings. In order to allow the committee ample time to review and understand proposals developed for the work session, no new recommendations will be entertained the day of the work session.

Each of you have attended one or all of the previous ACR 16 meetings, provided testimony before the committee, and have provided information on issues or topics

which in your opinion were important for the committee to consider in their deliberations. As indicated early in the study, due to the overwhelming number of issues regarding the delivery of welfare services in Nevada, it was important for the ACR 16 committee to select and focus on a finite number of major issues in order for the committee's findings and recommendations to be definitive and productive. In so doing, not all issues and topics which you may have suggested were covered during the committee hearings. This was unavoidable, however, your input has been greatly appreciated and extremely beneficial for the committee.

As we enter the final stages of this study, I am again requesting your input on behalf of the chairman for suggested recommendations based upon information presented to the committee during the course of their hearings for consideration and possible committee action. Your input is extremely important, and as experts in the field, your insights and suggestions to rectify or better structure the provision of welfare services is crucial.

I am requesting that your input for the recommendation phase of this study be specific and include the issue to be addressed, the current problems or circumstances which need to be remedied, how the suggested recommendation will help resolve the particular situation cited and if a cost is anticipated, what the cost is projected to be, and what entity is recommended to assume the cost. Some of your suggested recommendations may require specific legislation. In such cases, please provide suggested language for the legislative changes requested. Additionally, I would encourage that your suggested recommendations be prioritized from most to least important.

In order to have adequate time to coordinate and format the written materials presented as part of your recommendation package, I request that all information be provided to me no later than May 11, 1992. Time will be made available for you to discuss your recommendations, suggestions, etc., at the May 21, 1992 meeting if you so desire. As we begin finalizing that meeting's agenda, I will contact you to discuss your time requirements.

I would like to thank you in advance for your cooperation and your willingness to work with the ACR 16 interim study committee. If you should have any questions, please do not hesitate to contact me.

ACR16SSCDIRS:SJA/tc
WELFARE STUDY

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May 12, 1992

MEMORANDUM

TO: Jerry Griepentrog, Director
Department of Human Resources

FROM: Steve J. Abba, Program Analyst
Fiscal Analysis Division

SUBJECT: Interim Committee Study Nevada's Welfare System (ACR 16)

This correspondence serves as a follow-up to my April 27, 1992 memorandum on behalf of the ACR 16 Committee, soliciting from the Department any suggestions or recommendations for the committee's consideration for their upcoming work session. This information was requested no later than May 11, 1992. In speaking with Charlotte Crawford, it appears the Director's Office will not have any substantive recommendations or suggestions for the committee's consideration. If such is the case, please respond in writing no later than May 13, 1992. Your response as well as all other information responses received as part of this portion of the study process will be discussed at the May 21, 1992 meeting.

If you should have any questions, please do not hesitate to contact me.

ACR16GRI:SJA/tc
WELFARE STUDY

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April 27, 1992

MEMORANDUM

TO: Jerry Griepentrog, Director
Department of Human Resources

FROM: Steve Abba, Program Analyst
Fiscal Analysis Division

SUBJECT: ACR 16 MEETING, May 21, 1992

Jerry, the interim committee studying Nevada's Welfare System (ACR 16) will hold their fourth meeting on May 21, 1992 in Las Vegas at Cashman Field. The meeting will be video teleconferenced from Las Vegas to the Carson City Legislative Building.

The focus of the May 21, 1992 meeting is providing Medicaid services using managed care concepts and models. For this meeting, I have requested that the Nevada Welfare Division provide an overview presentation on Nevada's existing and future efforts for developing managed care approach for providing Medicaid services and to provide the committee information on the current federal prospective for allowing states to be innovative in developing managed care model programs. Their presentation will include information on current federal regulations, the Medicaid Managed Care Improvement Act of 1991, incentives for enrollment in managed care programs, freedom of choice waivers, etc. Also speaking will be representatives from Nevada Care, Inc., the University of Nevada School of Medicine and a representative from the Community Health Centers of Southern Nevada.

Each participant speaking before the interim committee has been encouraged to discuss new concepts, ideas, suggestions, recommendations, etc., on how the provision of Medicaid services in Nevada would be improved upon and become more efficient and cost effective through the use of managed care services. Such information could be very beneficial for the committee as they deliberate and decide upon final recommendations for this study.

As we enter the final stages of this study, I have requested from all major participants recommendations based upon information presented to the committee during the course of their hearings for consideration and possible committee action. Study recommendations have specifically been requested from the Welfare Division, the county social services directors, and the Nevada Association of Counties. I would also like to request your input on behalf of Chairman Freeman since your office has also participated in earlier ACR 16 meeting. Your input, insights and suggestions to rectify or better structure the provision of welfare services in Nevada would be extremely beneficial.

Any input or information for the recommendation phase of this study should be specific and include the issue to be addressed, the current problem or circumstances which need to be remedied, how the suggested recommendation will help resolve the particular situation cited, and if a cost is anticipated, what the cost is projected to be, and what entity or level of government is recommended to assume the projected cost. Some of your suggested recommendations may require specific legislation. In such cases, please provide suggested language for the legislative changes requested. Additionally, I would encourage that your suggested recommendations be prioritized from most to least important.

In order to have adequate time to coordinate format the written materials presented as part of your recommendation package, I request that all information be provided no later than May 11, 1992. Time will be made available for you to discuss your recommendations at the May 21, 1992 meeting if desired. As we begin finalizing that meeting's agenda I will contact you to discuss any time requirements you may need.

I would like to thank you in advance for your cooperation and your willingness to work with the ACR 16 interim study committee. If you should have any questions, please do not hesitate to contact me.

ACR16JG:sja/tc
WELFARE STUDY

APPENDIX H

INDIVIDUALS WHO TESTIFIED TO THE SUBCOMMITTEE.

APPENDIX G

Individuals providing testimony to the subcommittee were:

Mr. I. R. Ashleman, II
Nevada Hospital Association

Ms. Lynn Atcheson
Washoe Health System

Ms. Trinidad Bengert
Private Citizen

Mr. Robert Burn
Washoe Health System

Ms. Pat Christensen
Nye County Social Services Director

Mrs. Donnis Derrera
Private Citizen

Ms. Barbara Drake
United Way, Reno

Ms. Barbara Fortney
Private Citizen

Ms. Bobbie Gang
ADC Coalition

Mr. Al Glover
Director's Office
Department of Human Resources

Mr. Robert S. Hadfield
Nevada Association of Counties (NACO)

Ms. Denell A. Hahn
Clark County Social Services Director

Dr. Michael Hennelly
Community Health Centers of
Southern Nevada

Ms. April Hess
Welfare Division - Medicaid

Ms. Jeanette Hills
Welfare Division

Ms. Diane Hooley
Welfare Division-Medicaid Managed Care

Mr. Minor Kelso
American Association of Retired People

Dr. Victor Knutsen
Washoe Pregnancy Center

Ms. Cherie Louvatt
Northern Nevada Food Bank

Ms. Ellen McCarthy
Nevada Legal Services

Mr. Michael J. McMahon
Churchill County Social
Services Director

Ms. Maya Miller
ADC Coalition

Mr. Dave Nicholas
Long-Term Care Association

Dr. Owen Peck
University of Nevada School
of Medicine

Mr. Mel Phillips
United Way, Las Vegas

Ms. Linda Ryan
Nevada State Welfare Division

Mr. Jon L. Sasser
Nevada Legal Services

Ms. May Shelton
Washoe County Social Services Director

Ms. Sherie Elissa Steisel
National Conference of State Legislatures

Ms. Mary Temm
Health Management Associates

Mr. Chris Thompson
Director's Office
Department of Human Resources

Dr. William Torch
Washoe Medical Center

Josefina Trujillo
Private Citizen

APPENDIX I

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APPENDIX H

BIBLIOGRAPHY

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APPENDIX J

SUGGESTED LEGISLATION

SUMMARY--Urges Congress to enact legislation allowing states greater flexibility in carrying out coordinated programs of health care. (BDR R-785)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: No.

JOINT RESOLUTION--Urging Congress to enact legislation allowing states greater flexibility in designing and carrying out coordinated programs of health care without having to obtain a waiver of freedom of choice from the Federal Government.

WHEREAS, The rising costs of health care have increased the costs of providing adequate coverage to persons who are eligible for medical assistance under the Medicaid Program; and

WHEREAS, Coordinated health care programs that provide medical services from a selected group of providers of medical care at fixed rates reduce the costs of medical care without affecting the quality of that care; and

WHEREAS, The provisions of Title XIX of the Social Security Act do not allow states the discretion or flexibility to design and carry out comprehensive coordinated programs of health care; and

WHEREAS, Widespread participation in and utilization of coordinated programs of health care may only be achieved by requiring recipients of Medicaid to enroll in coordinated programs of health care; and

WHEREAS, Before a recipient of Medicaid may be required to enroll in a coordinated program of health care, a waiver of freedom of choice must be obtained from the Health Care Financing Administration; and

WHEREAS, It requires a significant amount of time and cost to apply for, justify and receive a waiver of freedom of choice and involves extensive reporting to the federal authorities; and

WHEREAS, A waiver of freedom of choice must be renewed every 2 years; now, therefore, be it

RESOLVED BY THE AND OF THE STATE OF NEVADA, JOINTLY, That the Nevada Legislature hereby urges the Congress of the United States to enact an amendment to Title XIX of the Social Security Act allowing states greater flexibility in designing and carrying out coordinated programs of health care without having to obtain a waiver of freedom of choice from the Federal Government; and be it further

RESOLVED, That the of the prepare and transmit a copy of this resolution to the Vice President of the United States as presiding officer of the Senate, the Speaker of the House of Representatives and each member of the Nevada Congressional Delegation; and be it further

RESOLVED, That this resolution becomes effective upon passage and approval.

SUMMARY--Revises provisions of state plan relating to aid to dependent children. (BDR 38-784)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: Yes.

AN ACT relating to welfare; requiring the state plan for aid to dependent children to include provisions which ensure that a person who receives aid to dependent children is allowed to retain the income he earns each month under certain circumstances without a reduction in his monthly grant of aid; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. NRS 422.232 is hereby amended to read as follows:

422.232 1. The administrator shall establish a state plan for aid to dependent children. The state plan is subject to the approval of the board. The state plan must set forth the requirements for eligibility of a needy dependent child and the relative with whom he is living and must also set forth the nature and amounts of grants and other assistance which may be provided, the conditions imposed and such other provisions relating to the development and administration of the program for aid to dependent children as the

administrator and the board deem necessary. *The state plan must include a provision which:*

(a) Prohibits a reduction in a person's monthly grant for aid to dependent children which is based upon or is in any way related to his monthly net earned income if that income does not exceed the difference between his monthly standard of need and his monthly grant of aid to dependent children.

(b) Allows a person who receives a monthly grant of aid to dependent children to retain any income he earns in any month in which his monthly net earned income does not exceed the difference between his monthly standard of need and his monthly grant of aid to dependent children.

2. In developing and revising the state plan, the administrator and the board shall consider, among other things, the amount of money available from the Federal Government for aid to dependent children and the conditions attached to the acceptance of such money, and the limitations of legislative appropriations for aid to dependent children.

SUMMARY--Expands eligibility for coverage pursuant to state plan for assistance to medically indigent. (BDR 38-786)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: Yes.

AN ACT relating to public welfare; expanding eligibility pursuant to the state plan for assistance to the medically indigent to make ambulatory prenatal care available to a pregnant woman during a presumed period of eligibility; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. NRS 422.236 is hereby amended to read as follows:

422.236 1. As part of the health and welfare programs of this state, the welfare division may provide prenatal care to pregnant women who are indigent, or may contract for the provision of that care, at public or nonprofit hospitals in this state.

2. *Pursuant to 42 U.S.C. § 1396r-1, the administrator shall include in the state plan for assistance to the medically indigent the provision of ambulatory prenatal care to a pregnant woman during a presumptive period of eligibility.*

3. The welfare division shall provide to each person licensed to engage in social work pursuant to chapter 641B of NRS, each applicant for assistance to the medically indigent and any other interested person, information concerning the prenatal care available pursuant to this section.

[3.**]** *4.* The welfare division shall adopt regulations setting forth criteria of eligibility and rates of payment for prenatal care provided pursuant to the provisions of this section, and such other provisions relating to the development and administration of the program for prenatal care as the administrator and the board deem necessary.

SUMMARY--Creates advisory committee for human services. (BDR 38-787)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: Yes.

AN ACT relating to human services; creating the advisory committee for human services; providing its duties; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Chapter 422 of NRS is hereby amended by adding thereto the provisions set forth as sections 2 to 6, inclusive, of this act.

Sec. 2. *1. The advisory committee for human services, consisting of 11 members, is hereby created.*

2. The advisory committee consists of:

(a) One member of the legislature appointed by the legislative commission; and

(b) Ten members appointed by the governor. The governor shall appoint to the committee:

(1) One member who represents the department of human resources.

(2) One member who represents the department of education.

(3) One member who represents the Nevada Association of Counties.

(4) One member who represents the Nevada Association of County Welfare Directors.

(5) One member who represents the Nevada Hospital Association.

(6) One member who represents an association or other organized group of physicians in this state.

(7) One member who represents an association or other organized group of nursing homes in this state.

(8) One member who represents an association or other organized group of professionals who provide mental health services in this state.

(9) One member who represents an association or other organized group of persons who advocate the development and administration of services for the mentally ill and mentally retarded.

(10) One member who is a representative of the general public.

3. After the initial terms, each member of the committee serves a term of 4 years. If a vacancy occurs during the term of a nonlegislative member, the governor shall appoint a person qualified under this section to replace that member for the remainder of the unexpired term. If the legislative member ceases to be a member of the legislature, a vacancy occurs during his term as a member of the advisory committee and the legislative commission shall appoint another legislator to replace that member for the remainder of that unexpired term.

4. The members of the committee shall select one of its members to serve as chairman.

Sec. 3. *1. The members of the advisory committee for human services may meet at such times and at such places as are specified by the call of the chairman or a majority of the committee. In case of emergency, special meetings may be called by the chairman.*

2. A majority of the members of the committee constitutes a quorum for the transaction of business, and a majority of those present at any meeting is sufficient for any official action taken by the committee.

3. The committee shall hold annual public hearings to receive information regarding the delivery of human services in this state. The hearing must be held at a time, date and place selected by the chairman. Additional hearings may be held if deemed necessary by the chairman.

Sec. 4. *1. Each nonlegislative member of the advisory committee for human services is entitled to receive a salary of not more than $80, as fixed by the committee, for each day he is engaged in the business of the committee.*

2. The legislator who is a member of the advisory committee is entitled to receive the compensation provided for a majority of the members of the legislature during the first 60 days of the preceding regular session for each day or portion of a day during which he attends a meeting of the advisory committee or is otherwise engaged in the work of the advisory committee.

3. While engaged in the business of the advisory committee, each member and employee of the committee is entitled to receive the per diem allowance and travel expenses provided for state officers and employees generally.

Sec. 5. *The advisory committee for human services may employ all personnel necessary to the discharge of its duties.*

Sec. 6. *The advisory committee for human services shall:*

1. Establish policies to ensure adequate development and administration of human services for the residents of this state.

2. Develop and maintain a program to assess the needs of residents of this state for human services.

3. Develop goals and strategies for providing needed human services.

4. Promote the development of federal programs that provide human services to the residents of this state.

5. Review and evaluate state and local programs which provide human services.

6. Evaluate the impact of any adjustment made to programs which provide human services, including the fiscal, social and long-term impact of such an adjustment.

7. Develop plans for providing human services during emergencies.

8. Not later than January 31 of each odd-numbered year, submit a report to the governor, the legislature, the director of the department of human resources and the board of county commissioners of each county, summarizing the committee's activities, findings and recommendations.

Sec. 7. NRS 232.320 is hereby amended to read as follows:

232.320 1. Except as otherwise provided in subsection 2, the director:

(a) Shall appoint, with the consent of the governor, chiefs of the divisions of the department, who are respectively designated as follows:

(1) The administrator of the aging services division;

(2) The administrator of the health division;

(3) The administrator of the rehabilitation division;

(4) The state welfare administrator; and

(5) The administrator of the division of child and family services.

(b) Shall administer, through the divisions of the department, the provisions of chapters 210, 423 to 427A, inclusive, 432 to 436, inclusive, 439 to 443, inclusive, 446, 447, 449, 450, 458 and 615 of NRS, NRS 422.070 to 422.410, inclusive, 422.389, 444.003 to 444.430, inclusive, and 445.015 to 445.038, inclusive, and all other provisions of law relating to the functions of the divisions of the department, but is not responsible for the clinical activities of the health division or the professional line activities of the other divisions.

(c) Shall, after considering *the report submitted by the advisory committee for human services pursuant to section 6 of this act and* advice from agencies of local governments and nonprofit organizations which provide social services, adopt a master plan for the provision of human services in this state. The director shall revise the plan biennially and deliver a copy of the plan to the governor and the legislature at the beginning of each regular session. The plan must:

(1) Identify and assess the plans and programs of the department for the provision of human services, and any duplication of those services by federal, state and local agencies;

(2) Set forth priorities for the provision of those services;

(3) Provide for communication and the coordination of those services among nonprofit organizations, agencies of local government, the state and the Federal Government;

(4) Identify the sources of funding for services provided by the department and the allocation of that funding;

(5) Set forth sufficient information to assist the department in providing those services and in the planning and budgeting for the future provision of those services; and

(6) Contain any other information necessary for the department to communicate effectively with the Federal Government concerning demographic trends, formulas for the distribution of federal money and any need for the modification of programs administered by the department.

(d) Shall, upon request, provide the director of the department of general services a list of organizations and agencies in this state whose primary purpose is the training and employment of handicapped persons.

(e) May, by regulation, require nonprofit organizations and state and local governmental agencies to provide information to him regarding the programs of those organizations and agencies, excluding detailed information relating to their budgets and payrolls, which he deems necessary for his performance of the duties imposed upon him pursuant to this section.

(f) Has such other powers and duties as are provided by law.

2. The governor shall appoint the administrator of the mental hygiene and mental retardation division.

Sec. 8. As soon as practicable after July 1, 1993:

1. The governor shall appoint to the advisory committee for human services:

(a) Four members to terms that expire on June 30, 1994.

(b) Three members to terms that expire on June 30, 1995.

(c) Three members to terms that expire on June 30, 1996.

2. The legislative commission shall appoint a legislator to the advisory committee for human services for a term that expires on June 30, 1995.

Sec. 9. 1. This section and section 8 of this act become effective on July 1, 1993.

2. Sections 1 to 7, inclusive, of this act become effective on October 1, 1993.

SUMMARY--Urges Congress to consider effect of certain proposed legislation upon stability and unity of families in United States. (BDR R-783)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: No.

JOINT RESOLUTION--Urging Congress to give special consideration to the effect certain proposed legislation will have upon the stability and unity of families in the United States.

WHEREAS, The family unit is the basic institution in American society in which morals, social skills, traditions and other values essential to our society are imparted to younger generations; and

WHEREAS, The enactment of laws forms the structure in which all citizens must function in an ordered society and often has far-reaching effects not easily foreseen at the time of enactment; and

WHEREAS, The use of family impact statements, which analyze proposed federal legislation to determine whether it will strengthen or erode the stability of the family, was begun in the early 1970's; and

WHEREAS, Such statements have been helpful in determining the effect policies relating to such issues as medical care, urban renewal, tax laws and public education, will have on children and their parents; and

WHEREAS, Family impact statements have been ignored in recent years as policy makers often disagree on what actions are necessary to preserve and foster family stability; and

WHEREAS, The preservation of the family should be given the utmost consideration by all legislative bodies in the United States; now, therefore, be it

RESOLVED BY THE AND OF THE STATE OF NEVADA, JOINTLY, That the Nevada Legislature urges the Congress of the United States to give special consideration to the effect that proposed legislation relating to human resources and the delivery of social services will have on the stability and unity of families in the United States; and be it further

RESOLVED, That the of the prepare and transmit a copy of this resolution to the Vice President of the United States as presiding officer of the Senate, the Speaker of the House of Representatives and each member of the Nevada Congressional Delegation; and be it further

RESOLVED, That this resolution becomes effective upon passage and approval.