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

**Eighty-second Session**
**March 2, 2023**

The joint meeting of the Subcommittees on Human Services of the Senate Committee on Finance and the Assembly Committee on Ways and Means was called to order by Chair Rochelle T. Nguyen at 8:04 a.m. on Thursday, March 2, 2023, in Room 3137 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to Room 4412 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Exhibit A is the Agenda. Exhibit B is the Attendance Roster. All exhibits are available and on file in the Research Library of the Legislative Counsel Bureau.

**SENATE SUBCOMMITTEE MEMBERS PRESENT:**

Senator Rochelle T. Nguyen, Chair
Senator Nicole J. Cannizzaro
Senator Marilyn Dondero Loop
Senator Heidi Seevers Gansert
Senator Robin L. Titus

**ASSEMBLY SUBCOMMITTEE MEMBERS PRESENT:**

Assemblywoman Michelle Gorelow, Chair
Assemblywoman Daniele Monroe-Moreno, Vice Chair
Assemblywoman Natha C. Anderson
Assemblywoman Jill Dickman
Assemblyman Gregory T. Hafen II
Assemblywoman Sandra Jauregui
Assemblyman Howard Watts
Assemblyman Steve Yeager

**STAFF MEMBERS PRESENT:**

Cathy Crocket, Chief Principal Deputy Fiscal Analyst
Sarah Coffman, Assembly Fiscal Analyst
John Kucera, Principal Program Analyst

Helen Wood, Committee Secretary
Marie Bell, Committee Secretary

**OTHERS PRESENT:**

Richard Whitley, Director, Nevada Department of Health & Human Services
Stacie Weeks, Administrator, Division of Health Care Financing and Policy, Nevada Department of Health and Human Services
Lynnette Aaron, Administrative Services Officer, Division of Health Care Financing and Policy, Nevada Department of Health and Human Services
Sandie Ruybalid, Deputy Administrator, Division of Health Care Financing and Policy, Nevada Department of Health and Human Services
Antonina Capurro, DMD, Deputy Administrator, Division of Health Care Financing and Policy, Nevada Department of Health and Human Services
Keith Benson, DMD, State Dental Officer, Division of Health Care Financing and Policy, Nevada Department of Health and Human Services
Theresa Carsten, Deputy Administrator, Division of Health Care Financing and Policy, Nevada Department of Health and Human Services
Sarah Adler, Nevada Advanced Practice Nurses Association
Brett Salmon, Nevada Health Care Association/Nevada Center for Assisted Living

CHAIR NGUYEN:
I will open the budget hearings for Health and Human Services.

RICHARD WHITLEY (Director, Nevada Department of Health & Human Services):
The budget accounts we are presenting represent pass-through funds to the Nevada Department of Health and Human Services (DHHS), Division of Health Care, Financing and Policy (DHCFP) also known as Nevada Medicaid. Both budget accounts serve to make supplemental payments to hospitals. Page 3 of the DHHS budget presentation (Exhibit C), shows budget account (B/A) 628-3244, the Indigent Hospital Care budget.

HEALTH AND HUMAN SERVICES

DHHS DIRECTOR'S OFFICE

HHS-DO - Indigent Hospital Care — Budget Page DHHS-DIRECTOR-46 (Volume II)
Budget Account 628-3244

As described on page 3 of Exhibit C, B/A 628-3244 was established to reimburse hospitals for care provided to persons who are indigent or do not have a health payer source. It has two primary funding sources, the ad valorem tax and the unmet freecare obligation, as noted on page 4 of Exhibit C and as laid out in *Nevada Revised Statutes* (NRS) 428.175. The Board of Trustees determines the priorities for the account. There are no major changes in this budget account.

The Upper Payment Limit Holding Account B/A 101-3260 shown on page 6 of Exhibit C is another pass-through account associated with the private hospital collaborative Upper Payment Limit (UPL) program.

HHS-DO - Upl Holding Account — Budget Page DHHS-DIRECTOR-49 (Volume II)
Budget Account 101-3260

Page 7 of Exhibit C shows the total projected amount of the contracts and the amount projected to be reverted to the General Fund or the Fund for A Healthy Nevada. There are no major changes in this budget account.

ASSEMBLYWOMAN GORELOW:
How are the contracted services anticipated to be provided by the nonprofit organization identified?

MR. WHITLEY:
We work with the nonprofit Nevada Clinical Services, Inc., to determine the appropriate opportunities to partner with them. We leave no stone unturned in terms of what opportunities exist with that nonprofit. Anytime a new funding stream or funding opportunity has been identified, we review it and then work closely with the nonprofit.

SENATOR TITUS:
Regarding the nonprofits, how does the State monitor the nonprofits' accountability and whether the results are what we want?

MR. WHITLEY:
We utilize the same scope of practice we would if we implemented the services directly. It is a congruent process with the scope of activities. Also, we monitor them for outcomes. We will provide more detail if requested. We treat it as if we are providing the services; it is part of the negotiation with the nonprofit.

STACIE WEEKS (Administrator, Division of Health Care Financing and Policy, Nevada Department of Health and Human Services):
The DHCFP budget presentation is (Exhibit D). There are a few updates to the organizational chart on page 2 of Exhibit D for our leadership team. Amber Law is now the Deputy Administrator for Fiscal, Budget and Payments and Theresa Carsten is now the Deputy Administrator for Managed Care and Behavioral Health.

In our last presentation, I stated one in four Nevadans are covered by Medicaid, but it is actually one in three, based on the latest census data, as shown on page 3 of Exhibit D.

The updates on page 5 of Exhibit D concern the Federal Public Health Emergency (PHE) unwind. The last point concerns the budget impact of losing 6.2 percent of the enhanced Federal Medical Assistance Percentage (FMAP) in calendar year 2023. The FMAP step down by quarter will result in a $120 million impact to the General Fund.

The DHHS Director's Office, Office of Analytics has provided updates on page 6 of Exhibit D to address some of your questions at the last budget hearing. This provides some high level analysis and estimates, based on a sample of 50 percent of the Medicaid population. Concerning use of services, about 77 percent had at least one health care service from a core service provider paid by Medicaid in the past year, 50 percent had seen a physician specialist; 45 percent had seen primary care providers; and 9 percent had seen behavioral health providers. Some utilization information is also provided on page 6 of Exhibit D.

The projected Medicaid caseload on page 9 of Exhibit D, shows during the pandemic our enrollment increased. It went from around 600,000 to about 900,000 today. It will start to drop off as we work through the PHE unwind,

which will begin in April 2023. The first redeterminations will start in June, and people will begin falling off coverage. From there, it is going to be a three-month cycle in which every three months a wave of people will fall off coverage. We are doing this on a 12-month cycle so we do not overburden our system and overwhelm our capacity.

The Nevada Check Up caseload projections on page 10 of Exhibit D show caseload is projected to ramp up slowly to about 25,000 in April of 2025.

Page 11 of Exhibit D lists our seven budget accounts. There is one new account for the hospital provider tax, B/A 101-3177, which was established under State law. We are asking to establish the budget account if we are able to get authority to begin the provider tax and receive those payments, the account will be in place.

HEALTH CARE FINANCING AND POLICY

HHS-HCF&P - Improve Health Care Quality & Access — Budget Page DHHS-DHCFP-39 (Volume II)
Budget Account 101-3177

The first account on page 12 of Exhibit D is B/A 101-3157, the Intergovernmental Transfer (IGT) account.

HHS-HCF&P - Intergovernmental Transfer Program — Budget Page DHHS-DHCFP-8 (Volume II)
Budget Account 101-3157

Intergovernmental transfers are the nonfederal share of Medicaid. Typically, there is both a State and federal share to pay for services. Federal law allows us to take local funding from counties, school districts and other public entities to pay the State share.

This account collects payments from counties, school districts and other public entities that voluntarily offer funding to pay the State share of costs to enhance payments to providers in their communities. These payments include Medicaid supplemental payments to hospitals which we refer to as the UPL. This is in our

Fee-For-Service Program. Federal law does not allow us to pay higher than Medicare. The UPL allows us to increase our base rate up to the Medicare rate.

The Disproportionate Share Hospital (DSH) program is an important program for our safety net. Many hospitals that have uncompensated care benefit from this program.

There are three participants in the Medicaid Graduate Medical Education (GME) program: the University of Nevada, Reno, Humboldt General Hospital and University Medical Center (UMC). The program totals about $30 million annually.

We also collect IGT funds for school-based healthcare services and emergency paramedics. This increases and enhances our payments for services in the localities that participate in the IGT.

Decision unit E-351 in B/A 101-3157 shown on page 13 of Exhibit D reflects changes to the State's FMAP claiming credit on supplemental payment programs and GME. Clark County's portion of this federal share will increase from 60 percent to 87.5 percent.

E-351 Promoting Healthy, Vibrant Communities — Page DHHS-DHCFP-10

This results in a net reduction to B/A 101-3157 of $3.6 million in the 2023-2025 biennium. There is a companion decision unit E-351 in B/A 101-3243 which will be discussed in more detail later.

HHS-HCF&P - Nevada Medicaid, Title XIX — Budget Page DHHS-DHCFP-47 (Volume II)
Budget Account 101-3243

E-351 Promoting Healthy, Vibrant Communities — Page DHHS-DHCFP-58

Decision unit E-353 in B/A 101-3157 shown on page 13 of Exhibit D reflects the funding change for the State's DSH program and Clark County's contribution to the IGT program. This will be discussed in more detail later in our presentation.

E-353 Promoting Healthy, Vibrant Communities — Page DHHS-DHCFP-11

ASSEMBLYMAN HAFEN:
The FMAP cuts are about $120 million. You have a proposal for provider fees that will pick up most of that. I am curious about the uncompensated care currently being provided by UMC. How does the decrease in uncompensated care compare to the recommended decrease in disproportionate share hospital payments?

MS. WEEKS:
The provider fee does not offset the 6.2 percent loss to the State program. Those payments go to the hospitals. Regarding the DSH program, there is a reduction to UMC. Because we have expanded Medicaid in Nevada, many of the uncompensated care levels for UMC have gone down. They have hit their limit on DSH and end up paying back about $30 million annually. That is a big financial problem for them each year in planning their budgets.

The request was to reduce UMC, and hold the other hospitals that are benefiting harmless. This is what the new structure does by offsetting some of those losses to UMC through our State-directed payment programs on the managed care side. Clark County is offering new IGT to help offset those losses through our managed care program which is not limited as much as the DSH program.

ASSEMBLYMAN HAFEN:
Though we are losing about $120 million in FMAP, the State has done a great job enrolling individuals in Medicaid.

SENATOR TITUS:
I am not sure we are actually losing $120 million. It is my understanding the FMAP at 6.2 percent was almost a gift. The funds were more than what we projected and went longer than what the federal government indicated. We had not been spending that money, and there was a reserve. It is $120 million less because it stopped. Were the funds ever allocated? Is there really a hole, or was it a surplus?

LYNNETTE AARON (Administrative Services Officer, Division of Health Care Financing and Policy, Nevada Department of Health and Human Services):
The $120 million impact to the General Fund is the change from the legislatively approved FMAP for fiscal year (FY) 2021-2022, when the FMAP was 65.87 percent. The new changes to the FMAP for FY 2024-2025, as a result of the unwinding of PHE, will be a rate of 61.57 percent. This represents an overall decrease of 4.3 percent, which reflects the $120 million impact in General Fund monies.

SENATOR TITUS:
To clarify, is it not actually a hole?

MS. AARON:
It is not.

SENATOR TITUS:
Regarding the GME component, there are three hospitals where funding can go. We had a residency close in Elko due to lack of funding. Is there no avenue in which other residency programs could be supported?

MS. WEEKS:
I can follow up with you. Yes, we could look at adding more programs.

SENATOR SEEVERS GANSERT:
Both medical schools have approached us about expanding GME. When you get back to us, please look at opportunities to use federal dollars. Normally, you are able to establish a program and then Medicare will reimburse residency programs, but it was portrayed or suggested they will not do that.

MS. WEEKS:
Yes, I can follow up and send you the details regarding what is required for more providers to participate.

The Medicaid Administration account, B/A 101-3158 is shown on page 14 of Exhibit D. This budget collects funding for the mandated administrative activities we carry out for Medicaid and the related cost for vendors and other resources we need to operate. For general operations, if the work is related to

the Medicaid program, there is a 50 percent match with federal funds. For the Medicaid Management Information System which relates to provider enrollment, other issues or billing, costs can be matched by 75 percent federal funds. Eligibility and enrollment changes, updates and information technology systems can be matched by 90 percent federal funds.

HHS-HCF&P - HCF&P Administration — Budget Page DHHS-DHCFP-13 (Volume II)
Budget Account 101-3158

The positions we need at the Division to not only continue and sustain the current operation, but to also take on the new things being added to the budget for the 2023-2025 biennium are shown on pages 15-17 of Exhibit D. The first item is decision unit E-125 in B/A 101-3158 concerning the hospital provider tax.

E-125 Economic Opportunity & Skilled Workforce — Page DHHS-DHCFP-17

This request reflects the positions needed for startup, getting through the next year and making sure we have the capacity to implement the program. All of us are working on this program and additional staff is needed to take on the responsibilities and become experts in this area. We expect we will need additional staff not reflected here. We plan to take some of the revenue from the provider tax for administrative costs and use some of that funding to hire additional staff.

Decision units E-128 and E-131 in B/A 101-3158 are requests to add two positions. One position is needed for compliance reasons, for a third-party liability program, so we can collect what is owed to the State. The other position, a social services program specialist, is needed for the fair hearings program.

E-128 Economic Opportunity & Skilled Workforce — Page DHHS-DHCFP-18
E-131 Economic Opportunity & Skilled Workforce — Page DHHS-DHCFP-19

Decision units E-133, E-227 and E-248 in B/A 101-3158 are shown on page 16 of Exhibit D. The third item, decision unit E-248 is related to needs in our fiscal

and budget program. There are a number of positions needed to better support our budget team. Once we get the positions, hiring is difficult; it can take six to nine months for training as Medicaid is complicated.

E-133 Economic Opportunity & Skilled Workforce — Page DHHS-DHCFP-20
E-227 Efficiency and Innovation — Page DHHS-DHCFP-22
E-248 Efficiency and Innovation — Page DHHS-DHCFP-24

Decision unit E-227 in B/A 101-3158 requests two positions to support the Statewide managed care program. Establishing this program Statewide will require us to have more items in our contracts and bigger networks to review. The larger the program and the more money involved, the more people we need for contract oversight.

Decision unit E-133 in B/A 101-3158 requests positions to manage the Home and Community-Based Services, American Rescue Plan Act (ARPA) of 2021 initiatives and to oversee the self-directed program for personal care services. These programs received ARPA funds, and this request continues some of the staffing related to these programs and initiatives.

Page 17 of Exhibit D shows the final three decision units requesting positions in B/A 101-3158. Decision unit E-353 funds one business process analyst position, as well as the implementation and ongoing costs for an All-Payer Claims Database (APCD) program. This program was passed during the Eighty-first Legislative Session, however expected federal funding to help get this off the ground did not come through. We are asking for State funding to implement the APCD program.

E-353 Promoting Healthy, Vibrant Communities — Page DHHS-DHCFP-26

Decision unit E-357 in B/A 101-3158 concerns our tenancy support services work. We are currently implementing housing supports and services at no cost to the State as an optional service in managed care. This request will add two positions to help us establish the State Plan and look at benefits we can add to our Fee-For-Service Program for recipients.

E-357 Promoting Healthy, Vibrant Communities — Page DHHS-DHCFP-27

Decision unit E-370 in B/A 101-3158 on page 17 of Exhibit D, funds two positions needed as we expand our Certified Community Behavioral Health Centers (CCBHC) Program from 9 to 15 providers. This Program has many federal and State quality metrics we monitor. We need the support to monitor the metrics and to make sure we can support providers that try to become CCBHCs and sustain that status, because it allows them to bill at a more beneficial rate.

E-370 Promoting Healthy, Vibrant Communities — Page DHHS-DHCFP-28

Page 18 of Exhibit D reflects the vendors and resources we need for the program's compliance activities. The last two items are for ongoing requirements by Centers for Medicare & Medicaid Services (CMS).

Decision unit M-501 in B/A 101-3158 requests funding for new activities CMS is asking us to do.

M-501 Mandates Core Set of Measures — Page DHHS-DHCFP-16

Decision unit M-503 in B/A 101-3158, shown on page 18 of Exhibit D, requests funds to monitor quality in the managed care program. We need to hire an external independent review entity to do that work. We are going back out to bid. This funding will help support that program and vendor.

M-503 Mandates- External Quality Review Org — Page DHHS-DHCFP-17

Decision units E-352 and E-132 in B/A 101-3158, detailed on page 19 of Exhibit D, reflect additional vendor resources we need. These contractors have become more important to our work as it becomes harder to hire staff. These resources may be at a higher cost; however, we often rely on them.

Decision unit E-352 in B/A 101-3158 will help us increase onboarding of new providers to our State-certified health information exchange.

E-352 Promoting Healthy, Vibrant Communities — Page DHHS-DHCFP-25

Decision unit E-132 in B/A 101-3158 will increase funding for our current actuarial contract to allow us to do prospective risk adjustments in regard to the annual rate setting process. Each year we set the rates for the managed care plans, and this will allow us to do it better. There are many unknowns within our population, enrollment and the PHE unwind. This will allow us to adjust rates in a way that will cause less harm to the State and to the managed care plans. Depending on whether costs increase or decrease, we can make adjustments to mitigate financial losses.

E-132 Economic Opportunity & Skilled Workforce — Page DHHS-DHCFP-20

Page 20 of Exhibit D summarizes our positions in the base budget and the enhancements. Our vacancy rate is slightly higher than when we gave our last presentation. We have been able to hire but are still losing employees. Filling positions and knowing where our vacancies exist is necessary when new programs important to our beneficiaries are added. We need to consider our capacity at the Division.

The vacancy rate of DHCFP's fiscal, budget and supplemental payment team is 28 percent. They are working hard to keep up and also catch up from COVID-19. Our district offices where our care coordinators for recipients are located has a 21 percent vacancy rate. These care coordinators work with our recipients who cannot find a provider or need care coordination. Our IT section has a vacancy rate of 15 percent. The remaining vacancies are scattered throughout DHCFP.

SENATOR DONDERO LOOP:
If the Nevada Public Option funding and personnel are eliminated as recommended by the Governor, does the Agency anticipate it will be able to submit the Waiver by the statutory deadline of January 1, 2024?

MS. WEEKS:
Yes. That application has already been drafted, is online and available. We need to submit that by January 1, 2024, which was in the original legislation.

ASSEMBLYWOMAN MONROE-MORENO:
Concerning Statewide managed care decision unit E-227 of B/A 101-3158, what are the primary challenges related to the recommended Statewide expansion of the Managed Care Organization (MCO) delivery model?

MS. WEEKS:
We will learn as we go. We are going to do a new contract and ensure there is network adequacy in our rural areas. Another challenge will be to make sure the rates paid through the managed care program are sufficient to sustain those networks and ensure access. Those are always challenges when we go Statewide, especially in rural areas.

Senate Bill (S.B.) No. 420 of the 81st Session requires us to do State-directed payments or a managed care program if we go Statewide. Essentially, that says the managed care plans have to pay the providers what they receive today at our fee schedule or better. That is a benefit. That helps ensure there will be no losses to those safety net providers with the expansion.

ASSEMBLYWOMAN MONROE-MORENO:
What has prevented us in the past from expanding the delivery model?

MS. WEEKS:
It is often hard for MCOs to build networks where there are not providers. The expansion of telehealth has made this Statewide expansion a more viable option for the State. It also helps save the State money because our managed care program overall does better managing care while Fee-For-Service does not manage care.

ASSEMBLYWOMAN MONROE-MORENO:
How would the Statewide MCO program impact the individuals receiving the services through the waiver and the county match budget categories?

MS. WEEKS:
The populations that would be excluded from the Statewide expansion would be our waiver populations: the aged, blind and disabled. Also, children and intensive behavioral health services are currently Fee-For-Service. I believe this is what you mean regarding the county match population. Families and children,

parents, individuals without children, and some seniors would also be part of the expansion.

ASSEMBLYMAN WATTS:
Regarding the current Fee-For-Service participants that would be transitioned to managed care, how would the quality and availability of Medicaid services be impacted? How will we keep track of that?

MS. WEEKS:
Unlike Fee-For-Service where we do not track any quality, managed care requires us to track quality and to ensure services and network access requirements are being met. We have more tools in the managed care structure. Fee-For-Service has access requirements, but CMS has not enforced much along those lines in a long time. Managed care is not perfect.

SENATOR DONDERO LOOP:
Can you detail the increased number of requests for fair hearings being experienced by the Agency?

SANDIE RUYBALID (Deputy Administrator, Division of Health Care Financing and Policy, Nevada Department of Health and Human Services):
We do not have the exact figure but can get it for you. The goal of having this position located in Las Vegas is to reduce travel. Carson City staff travel to Las Vegas where the majority of hearings are held.

ASSEMBLYWOMAN DICKMAN:
Under the ARPA-funded programs, in decision unit E-248 of B/A 101-3158, you want to continue seven positions. If you intend to request continuation of the fiscal and program support personnel beyond the 2023-2025 biennium, what funding sources would replace the ARPA funds?

MS. AARON:
Regarding decision unit E-248, those positions are actually being requested with ARPA funding to continue those positions in the upcoming 2023-2025 biennium. In the next 2025-2027 biennium, we will need to request additional General Fund monies and match it with federal funding.

SENATOR SEEVERS GANSERT:
Regarding the tenancy support program, there is a request for two positions. Looking back to the 2021-2023 biennium, it does not look like any funds were spent, and the program was not up and running. How do you anticipate lifting that program up, and how many dollars are associated in the General Fund?

MS. WEEKS:
You are correct. We had challenges with the authority that is under State law that we are supposed to seek, which is Section 1915(i) of the Social Security Act for a State Plan change. We had some issues using that authority. We are looking at using a different federal authority that will make it easier for counties and providers to be part of our Fee-For-Service Program. We anticipate being able to cover the costs in our current budget for that Program because we are picking up many of these services for a large portion of the population we have found are homeless through the managed care program.

SENATOR SEEVERS GANSERT:
How many homeless people do you think you will be able to help? What do you think the outcomes will be for people who need those services?

MS. WEEKS:
I will follow up with you on those exact numbers. We have them broken down by managed care and Fee-For-Service.

ASSEMBLYWOMAN JAUREGUI:
Regarding the APDC decision unit E-353 of B/A 101-3158, could you walk us through the timeline and implementation plan for the database?

MS. RUYBALID:
We just released the Request for Proposal for the APCD. We have to get a vendor on board. The timeline for the implementation is January 2024. I could get the detailed project plan to you if that would be helpful.

ASSEMBLYWOMAN JAUREGUI:
January 2024 is sufficient if that is when you are expected to be online and running. Can you provide us information on how much the ongoing maintenance and operations of this database will cost?

MS. RUYBALID:
We can get estimates based on other states but, until we have a contract in place, we do not know the exact figures.

ASSEMBLYWOMAN JAUREGUI:
Once you get that cost, please provide it to us.

SENATOR CANNIZZARO:
Concerning the elimination of the Nevada Public Option in the Executive Budget, there was a recommendation to eliminate funding of $2.2 million for five positions, plus additional revenues and expenditures related to the Nevada Public Option and its implementation. A question was asked about having that funding and personnel eliminated from the budget and whether that would affect the ability for the Waiver to be submitted by January 2024. Can you delineate exactly what was taken from that budget item?

MS. WEEKS:
Yes, there were five positions eliminated as well as funding for the actuarial support needed to support the negotiations for the State Innovation Waiver under Section 1332 of the Affordable Care Act.

SENATOR CANNIZZARO:
I want to make sure we are clear because chapter 695K of NRS, which is the Nevada Public Option, requires this Waiver to be submitted. We have heard the Waiver will be open for public comment starting in November 2023 and will be submitted by January 2024. Without those positions to help with the actuarial pieces, how is the Agency planning to absorb that work so it can get done? Simply eliminating the positions does not eliminate the requirements under NRS 695K.

MS. WEEKS:
In Medicaid, we often get told to do much work without the staffing. We would absorb that work and implement the State law.

SENATOR CANNIZZARO:
As anticipated by the actuarial analysis, the Waiver is expected to help the State bring in almost $500 million in the first five years. These are federal

dollars that could be reinvested in health care here, to support other services, or whatever the State might need in order to facilitate access to care and affordability for Nevadans. Without those positions, how would the Agency be able to take in and monitor those dollars? That is additional work the Agency will have to absorb.

MS. WEEKS:
Yes.

SENATOR CANNIZZARO:
The $2.2 million will allow them to have the personnel to implement this, to operate the Nevada Public Option Trust Fund and to have those positions rather than needing to continue asking, similar to what we have repeatedly heard from many departments, including the hardworking people in Medicaid and DHHS. Director Whitley has a number of employees who are doing three or four jobs at once. I struggle with the reasoning for eliminating what feels like a very small amount of money in comparison to the rest of this budget. Our hardworking State employees and those at Medicaid are doing a good job to make sure we have access to health care. They should be able to do their jobs but not the jobs of five and six people.

MS. WEEKS:
Increased Quality of Nursing Care is B/A 101-3160 shown on page 21 of Exhibit D. There are no major changes to this account.

HHS-HCF&P - Increased Quality of Nursing Care — Budget Page DHHS-DHCFP-36 (Volume II)
Budget Account 101-3160

This account was established about 20 years ago under State law. It sets up a nursing facility tax, similar to the hospital tax. The account serves as the State match with federal funds to increase payments to nursing facilities via supplemental payments. The funds are transferred to B/A 101-3243, our medical spend budget account. A portion is held back to cover administrative costs for this effort.

Our next account is B/A 101-3177, the Improve Health Care Quality & Access Account, shown on page 22 of Exhibit D. As previously mentioned, this is a new account for the hospital provider tax and payment program to improve healthcare quality and access. This account, established under State law, provides that a majority, or 67 percent of a provider type referred to as an operating group, may vote to impose a tax on themselves. If they do so, we can then tax those entities and use that funding for three purposes.

Two of those purposes are related directly to supplemental payments to those providers in addition to paying administrative costs. Once we have polled providers and have the authority, we will use that revenue for two types of payments: the managed care option directed payments to private hospitals and Fee-For-Service supplemental payments to private hospitals. This tax would only be on private hospitals. To ensure we receive the federal Medicaid match, we have to ensure all private hospitals are taxed because it must be broad-based under federal law.

These funds will be transferred to B/A 101-3243 for medical spending and a portion will be transferred to B/A 101-3158 for administrative costs.

Page 23 of Exhibit D shows an updated timeline for this new program. The timeline was updated for changes regarding capacity issues. We want to make sure the program implementation is successful and that we can continue the payments we currently make. We have a backlog we are working on now.

Some of the timelines have been pushed back. Once we get through the Eighty-second Legislative Session and have this new account, we will begin polling hospitals throughout the summer of 2023 to get the agreement and authority to move forward. If we obtain an agreement and the authority, we will issue regulations and guidance as required by State law.

In mid and late summer 2023, we will host workshops and hearings around this effort. In August 2023, we plan to be done and will submit all approvals for payments to CMS. We can do a retroactive effective date, to the first day of the quarter we submit the State Plan amendment or the preprint to CMS. We are still determining what the right date will be based upon capacity. We are aiming for October 2023 to be a retroactive effective payment date. Any claims

submitted after October 2023 would be eligible to receive the increased supplemental payments under this new effort.

If all goes well, we will be able to implement the new provider tax starting January 1, 2024. At that time, the invoices for the tax payment would be submitted to hospitals. Once we receive those payments, we will issue the payments to the hospitals on a quarterly basis, similar to what we do for our current supplemental programs.

In the first calendar quarter of 2024, we plan to have the first payments done and out the door. By January 1, 2024, if we are able to staff up and support this effort, we will meet the timelines. These payments are important and will benefit more than 55 hospitals in the State.

Page 24 of Exhibit D shows decision unit E-354 in B/A 101-3177, what we expect to collect through this program. It is a conservative estimate, and we are doing a budget amendment to update some of these numbers based on current estimates. This is a rough estimate of how much we expect to collect in tax revenue in FY 2023-2024 and in FY 2024-2025. Based on the most recent numbers we have run with our actuaries, we expect the total payments to private hospitals will be about $1 billion or more.

E-354 Promoting Healthy, Vibrant Communities — Page DHHS-DHCFP-39

ASSEMBLYWOMAN ANDERSON:
It seems many notifications and discussions need to take place using your small staff. If you had to do a percentage, how certain are you this can all happen by January 1, 2024?

MS. WEEKS:
My concern is overworking staff. I believe in staff at the Division. I am 75 to 80 percent certain we can get there. If we burn people out, we will lose. We will add additional staff over the next year through the administrative portion of the tax revenue we will receive.

Based on recent guidance from CMS about tax-funded payment programs and Medicaid, we will need a new auditing team to audit hospital financial records.

We can be held liable for any deals or arrangements hospitals have that violate federal law. Building that team over the next year is important to protect the State. Depending on the contractors, hiring and training, we will get there because we are small but scrappy.

ASSEMBLYWOMAN ANDERSON:
I understand there are some other partners interested in this program such as, the Nevada Hospital Association. Are they currently working with you to start this process even earlier? Do you have other partners also helping you start earlier, rather than waiting until June or July 2023?

MS. WEEKS:
We are working with them, but we have to represent the State, do the work ourselves and build it internally to ensure the State is protected.

CHAIR NGUYEN:
Regarding the provider fee, is it correct that you need to maintain that 67 percent, and that is a delicate balance?

MS. WEEKS:
I believe so, but I would not want to speak for the Nevada Hospital Association.

CHAIR NGUYEN:
Am I correct that you have not done polling yet to see if there is 67 percent?

MS. WEEKS:
No, we have not.

CHAIR NGUYEN:
Assuming this goes through, what is the Agency's intended use of the 14.5 percent of the provider tax revenue? I understand about $62.2 million is recommended to be held in an administrative reserve. Can you explain that to the Committees?

MS. WEEKS:
We are in the process of doing a budget amendment to update and restructure how it was drafted. We are still working on how much in administrative costs

we will need. We recently realized this impacts our State share cost to our medical spend budget for the cost of the premium tax. We are looking at what that means. We are setting a placeholder, knowing we may need less, but we will not know until we get through all of the different analyses.

CHAIR NGUYEN:
You talked about needing an Audit Division or an auditor to make sure the hospitals are complying, holding the hospitals accountable and making sure the State is not in jeopardy. If this goes through, would that be included in the administrative costs that come from the tax?

MS. WEEKS:
Yes.

CHAIR NGUYEN:
Does the Agency intend to take any action to allow for a State net benefit associated with the recommended private hospital provider tax program, given the potential impact of the new program on the State net benefit associated with existing supplemental payment programs?

MS. WEEKS:
Technically, under State law we do not have a State net benefit. We are putting in a budget amendment to address that issue. Our argument would be it should not cost the State any new money, it should not cost our program. We should not need current positions to do this work. State law allows it to cover administrative costs which we are still determining.

CHAIR NGUYEN:
Do you want to make sure the extra $1 billion that goes to the private hospitals, as a part of their paying this fee, is a cost benefit to the State?

MS. WEEKS:
No, under State law we cannot have any benefit; it must be net neutral.

CHAIR NGUYEN:
How would the proposed private hospital tax program actually improve care or access to care for Medicaid recipients?

MS. WEEKS:
If we increase provider rates, the assumption is providers will more likely be able to serve our population. Hospitals are struggling to make ends meet, especially in our rural areas. This will help sustain the access we currently have and help us to not lose providers. As inflation goes up, private market goes up and somehow Medicaid, as a taxpayer-funded program, is supposed to keep up. This will allow us to help hospitals which we often do not have the State funds to do.

CHAIR NGUYEN:
Do we have any metrics or anything in State law to measure the success, increased quality or access to care with these provider fees?

MS. WEEKS:
Yes, one of the payment programs under federal law has a quality metric requirement. We are looking at having, at least in the first year, one metric per hospital subclass that we will monitor to see if they are improving. We would not withhold payment because some of these hospitals need the funding, but it is something we will be monitoring. We are required to monitor and report to CMS. We are considering posting those findings online.

SENATOR SEEVERS GANSERT:
Based on the information provided, the anticipated numbers for both FY 2023-2024 and FY 2024-2025 were approximately $286 million per fiscal year. On page 24 of Exhibit D you show $388,807,192 for FY 2024-2025. Was there an increase in expected funds in FY 2024-2025?

JOHN KUCERA (Principal Program Analyst):
The difference is the reserves requested in the Executive Budget, separate from the revenue source.

SENATOR SEEVERS GANSERT:
You made a comment about the State becoming liable for any laws or anything not followed at the federal level. All hospitals go through an accreditation process. I do not know if that is strictly for quality of care or if it also is to make sure the boundaries are provided. Does that give us any comfort because they have to go through accreditation processes for different types of care?

MS. WEEKS:
No, we are talking about making sure there are no hold harmless agreements amongst hospitals. Also, is the amount of claims they report accurate? For example, if we have to use their data for average commercial rates for basing our payments, is the data accurate? It involves looking at the financials we do not currently see. We would not have the capacity to audit everyone every year. It would just be a random check to make sure there is nothing that would result in the State owing money back to the federal government.

SENATOR CANNIZZARO:
I know we talked about some of the positions and the audit pieces. Last night during the Legislative Commission meeting we heard there were some audits regarding Medicaid payments, overpayments and some significant issues with how that is being managed. Do you have sufficient financial and audit positions to be able to monitor those MCO contracts and the payments going out? This plays into what we see proposed here with the provider tax and whether or not there is sufficient staff. We just received an audit report that showed some concerning details we probably should clarify.

MS. WEEKS:
There are two new positions in the program for Statewide managed care. These positions are important for providing oversight. We are doing other things internally to restructure how we monitor and oversee our contracts. If we get these two positions, I am hopeful we will be able to do some things we have not been able to in the past. As we increase the program, we will be able to keep up.

SENATOR CANNIZZARO:
Looking at this budget detail, there is not a piece specifically dedicated to community investment or how we might use some of the funds to help with other programs, such as programs for more robust health care in the State and more access to different services. Why is that not included? Has that been discussed? That would be important, given the revenues that will come in and how this is supposed to make sure we can continue to provide increased access in Nevada.

MS. WEEKS:
State law limits uses of this funding. If the poll occurs and the votes are there, this funding must go back to those hospitals and be used for administrative costs. If the Nevada Legislature and the Governor want to see changes, there would need to be a change in the State law.

The Nevada Check Up Program, B/A 101-3178, is detailed on page 25 of Exhibit D. This account collects funding for the Children's Health Insurance Program (CHIP), which is a federal program under Title XXI of the Social Security Act.

HHS-HCF&P - Nevada Check Up Program — Budget Page DHHS-DHCFP-41 (Volume II)
Budget Account 101-3178

Federal funds provided through CHIP are used to support low-cost coverage for uninsured children ineligible for Medicaid whose income is at or below 200 percent of the federal poverty level. Families pay a quarterly premium based on the family size and income. There are 21,832 children enrolled in this program.

Maintenance unit M-101 in B/A 101-3178, on page 26 of Exhibit D reflects various provider rate changes in the Executive Budget impacting the Nevada Check Up Program. Maintenance unit M-101 is related to rising healthcare costs and inflation.

M-101 Agency Specific Inflation — Page DHHS-DHCFP-41

Some of our rates and payments are based on cost. We have to assume some rates will go up. This decision unit reflects some specific inflation we expect for pharmacy, hospice, federally qualified health centers and rural health centers. The federal government sets the rate for Indian Health Services, so it reflects those changes also.

There have also been fund adjustments to base expenditures including the elimination of one time expenditures for equipment and for partial year costs for the continuation of programs.

Page 27 of Exhibit D lists two maintenance units, M-200 and M-201 in B/A 101-3178, which reflect some of the caseload changes shown on the graph on page 10 of Exhibit D. Maintenance unit M-200 reflects a decrease in the projected average monthly caseload from 23,114 in FY 2021-2022 to 22,847 in FY 2022-2023.

M-200 Demographics/Caseload Changes — Page DHHS-DHCFP-42
M-201 Demographics/Caseload Changes — Page DHHS-DHCFP-42

Maintenance unit M-201 shown on page 27 of Exhibit D funds an increase in the projected average monthly caseload from 22,847 in FY 2022-2023 to 24,077 in FY 2023-2024.

Some of the changes we are making in Nevada Check Up also impact our Medicaid budget to improve access. These are shown on page 28 of Exhibit D.

Decision unit E-125 in B/A 101-3178 funds a provider rate increase found in the Executive Budget. This is a 5 percent rate increase for physicians licensed in the State of Nevada. This request is a companion to decision unit E-130 in B/A 101-3158, the DHCFP Administration budget.

E-125 Economic Opportunity & Skilled Workforce — Page DHHS-DHCFP-43
E-130 Economic Opportunity & Skilled Workforce — Page DHHS-DHCFP-19

Decision unit E-127 in B/A 101-3178 funds a 5 percent rate increase for dentists.

E-127 Economic Opportunity & Skilled Workforce — Page DHHS-DHCFP-43

Access to both of these areas is important and the Executive Budget recommends we increase the rates for these providers.

Page 29 of Exhibit D shows some of the changes in the Nevada Check Up Program. I will skip these for now but discuss them later in the Medicaid budget presentation.

Decision unit E-225 in B/A 101-3178 is the elimination of coverage in Nevada Check Up for biofeedback and neurotherapy as detailed on page 30 of Exhibit D.

E-225 Efficiency & Innovation — Page DHHS-DHCFP-44

The elimination of these services was initially proposed and passed during the Eighty-first Legislative Session to reduce costs in the Medicaid program. It was related to budget cuts. The change in services was recommended by the Division because we saw a high volume of investigations around fraud and misuse of these services due to improper billing. This was recommended and passed.

We would have already implemented this, but federal law prevented it due to the public health emergency. We were under a maintenance of effort requirement and were required to maintain all current benefits and eligibility until the end of the emergency. We are finally able to implement this change.

SENATOR SEEVERS GANSERT:
I want to look at the autism area. The behavioral analysis rates on our attachment show the different rates and some are decreasing between 2.7 percent to 42 percent. The net to this budget is not significant because some are going up and some are going down. What do you think the impacts will be as far as delivery of services to children with autism when we are cutting some rates 42 percent?

MS. WEEKS:
Anytime you cut rates you have to worry about access. We are required under State law to make these changes. Senate Bill No. 96 of the 81st Session required us to look at these rates biennially. All rates that are paid as Fee-For-Service must be adjusted to make sure they are comparable to rates paid in other states. As other states are changing their rates, we are now changing ours. These changes are just now being implemented due to the previously mentioned maintenance of effort requirement.

SENATOR SEEVERS GANSERT:
What is the total dollar reduction? How much are we not putting into the services that are being reduced?

MS. WEEKS:
I will have to get you that number.

SENATOR SEEVERS GANSERT:
Many of us are concerned about access to care. Although we have a statute that requires adjustments, it does not say to what level. There is probably some discretion, and there would be concern about children with autism losing services if we reduce the rates to the levels proposed here. It is part of your mission statement to make sure we get quality care to Nevadans.

MS. WEEKS:
Our Nevada Medicaid budget account, B/A 101-3243, shown on page 31 of Exhibit D. This account is for our medical spending, the big account. This account collects funds to cover the State share of healthcare cost provided to recipients.

Medicaid is an entitlement program. Under federal law, when Nevada Medicaid adds a new benefit, the State must budget for this service. We cannot deny reimbursement due to any budgetary concerns, according to federal requirements.

Any benefit or service added as a Medicaid covered benefit must be paid if it is provided by a qualified enrolled Medicaid provider and delivered to a recipient in a manner consistent with Medicaid policies. This means the State must pay its portion of the medical bill regardless of how many people it sees.

This account represents how much we project we will need. Every year we update this and use our caseload and medical costs to project budgeted medical expenditures. The table on page 31 of Exhibit D reflects all expenditures in B/A 101-3243 from FY 2014-2015 to FY 2022-2023. It includes Fee-For-Service medical expenditures, managed care payments, supplemental payments to providers, and other related services and expenditures.

Page 32 of Exhibit D represents caseload changes and inflation adjustments to provider rates in maintenance units M-101, M-200 and M-201 in B/A 101-3243.

M-101 Agency Specific Inflation — Page DHHS-DHCFP-48
M-200 Demographics/Caseload Changes — Page DHHS-DHCFP-49
M-201 Demographics/Caseload Changes — Page DHHS-DHCFP-50

Page 33 of Exhibit D, maintenance units M-202, M-203 and M-204 in B/A 101-3243, shows caseload changes in our waiver program. As mentioned in the pre-Session hearing, the Executive Budget recommends some changes to the program, but these are not shown here.

M-202 Demographics/Caseload Changes — Page DHHS-DHCFP-50
M-203 Demographics/Caseload Changes — Page DHHS-DHCFP-51
M-204 Demographics/Caseload Changes — Page DHHS-DHCFP-51

The maintenance units in B/A 101-3243 shown on page 34 of Exhibit D increase slots, allowing more members to access our waiver programs. These programs are the Home and Community-Based Services we provide for individuals with intellectual disabilities, the frail and elderly, and people with physical disabilities. Each waiver increases the number of slots. Decision unit M-510 adds 519 slots for individuals with intellectual disabilities. Decision unit M-511 adds 250 slots for the frail and elderly. Decision unit M-512 adds 96 slots for the physically disabled.

M-510 Mandate ID Waiver Slots — Page DHHS-DHCFP-52
M-511 Mandate FE Waiver Slots — Page DHHS-DHCFP-52
M-512 Mandate PD Waiver Slots — Page DHHS-DHCFP-53

Page 35 of Exhibit D details some of the recommended changes in the Executive Budget to increase enhancements for behavioral health. Decision unit E-800 in B/A 101-3243 is the Division's children's behavioral health initiatives. This funds ongoing children's behavioral health initiatives implemented by our sister division, the Division of Child and Family Services. This includes staffing and administrative costs. We are helping match that with federal funds to support their efforts set up with ARPA funds.

E-800 Cost Allocation — Page DHHS-DHCFP-62

Decision unit E-370 in B/A 101-3243 is the Certified Community Behavioral Health Centers expansion. This item funds the expansion from 9 to 15 providers. This will improve access to behavioral health care in a way that is integrated with primary care and substance use services.

E-370 Promoting Healthy, Vibrant Communities — Page DHHS-DHCFP-60

Page 36 of Exhibit D shows some of the same rate increases discussed earlier in the Nevada Check Up Program. The decision units E-125 and E-127 in B/A 101-3243 recommend the same rate increases for physicians and dentists in the Medicaid budget. Decision unit E-373 in B/A 101-3243 requests funding for some of the provisions passed in the Eighty-first Legislative Session to allow advanced practice registered nurses (APRN) and midwives to receive rates equal to physicians. We have seen in other states by doing this, it improves access and increases more of these services, especially in our rural areas.

E-125 Economic Opportunity & Skilled Workforce — Page DHHS-DHCFP-53
E-127 Economic Opportunity & Skilled Workforce — Page DHHS-DHCFP-55
E-373 Promoting Healthy, Vibrant Communities — Page DHHS-DHCFP-61

Provider rate increases continue on page 37 of Exhibit D. Decision unit E-126 is a rate increase for personal care service providers recommended by the Home Care Employment Standards Board. They would like rates to increase to $25 per hour for personal care assistants (PCA). This decision unit funds how much that would cost and how much we pay the providers. However, the PCA's that work for these providers would have to ensure the funds are used to increase wages. This does not necessarily mean everyone will get at least $25 per hour; the pay would still be up to the provider who employs the PCA's.

E-126 Economic Opportunity & Skilled Workforce — Page DHHS-DHCFP-54

Skilled nursing facility rate increases are noted in decision unit E-374 in B/A 101-3243 shown on page 37 of Exhibit D. This funds a 5 percent rate increase for skilled nursing facilities. The increase resulted from our quadrennial rate review and looking at the providers' needs.

E-374 Promoting Healthy, Vibrant Communities — Page DHHS-DHCFP-62

Decision unit E-371 in B/A 101-3243 on page 37 of Exhibit D is a rate increase for intellectual disability providers. As you can see, the total cost increases in FY 2024-2025.

E-371 Promoting Healthy, Vibrant Communities — Page DHHS-DHCFP-61

On page 38 of Exhibit D are some new benefits and eligibility expansion. Decision unit E-364 in B/A 101-3243 is an expansion of Medicaid eligibility for pregnant women from 165 percent of the federal poverty level to incomes up to 200 percent of the federal poverty level. This increase will bring us up to some national standards. The majority of states cover pregnant women with incomes up to 200 percent of the federal poverty level or higher.

E-364 Promoting Healthy, Vibrant Communities — Page DHHS-DHCFP-60

Decision unit E-227 in B/A 101-3243, shown on page 38 of Exhibit D, is the coverage of cardioverter defibrillators and supplies. These are life saving devices individuals can wear, to avoid having to go the Emergency Room and save their lives. Nevada is one of the only states that do not cover these services. We are joining the rest of the Nation by adding this coverage to our program.

E-227 Efficiency & Innovation — Page DHHS-DHCFP-56

The last item on page 38 of Exhibit D is decision unit E-229 in B/A 101-3243, which funds dental benefits for individuals with intellectual disabilities. This covers individuals diagnosed with intellectual and developmental disabilities, aged 21 and over in our waiver programs. This was originally funded with ARPA funds. This request continues the program.

E-229 Efficiency & Innovation — Page DHHS-DHCFP-56

We are excited about this program as we often note individuals with intellectual disabilities have a hard time finding a dentist. Nevada Medicaid does not cover adult dental services. Some of these individuals' dental needs are serious and the cost to the dentist to provide these services can be high. The individuals

often need anesthesia and other things to receive safe dental care. This new benefit is focused on ensuring these individuals get the dental care they need. Our dental health officer has been working on this program with the Aging and Disability Services Division (ADSD).

Decision unit E-350 in B/A 101-3243, shown on page 39 of Exhibit D reflects changes to the rates for applied behavioral analysis providers. Earlier, I discussed these rate increases and the Division's attempts to implement S.B. No. 96 of the 81st Session. We reviewed the median rates for each code and provider type in 25 states. There are some increases and decreases, but overall there is a net decrease in spending for this population.

E-350 Promoting Healthy, Vibrant Communities — Page DHHS-DHCFP-58

Decision unit, E-354 in B/A 101-3243, shown on page 39 of Exhibit D, is the nonfederal share of the new private hospital provider tax.

E-354 Promoting Healthy, Vibrant Communities — Page DHHS-DHCFP-59

Decision units E-351 and E-353 in B/A 101-3243 on page 40 of Exhibit D concern the budget impact of changes to the DSH funding model and also Clark County's FMAP contribution.

E-353 Promoting Healthy, Vibrant Communities — Page DHHS-DHCFP-59

The goal of these changes to the DSH program is to ensure viability of the program and to ensure other hospitals benefiting from the DSH payments today see no changes in their distributions. The key was to address some of the concerns and the viability raised by Clark County and UMC. Because UMC had seen a reduction in uncompensated care, thanks to some of the efforts in Medicaid and some expansion, their DSH payments were capped, and they had to repay about $30 million annually.

Under this proposal, instead of having Clark County put up the IGT, the State is going to be using the 1 cent property tax ad valorem paid by counties, to help fund the State share of the DSH program. Under federal law, the State is required to pay something towards the DSH program. This is our attempt to

ensure the budget is picking up any of these changes and ensuring there are no losses to any hospitals.

Some of the losses to UMC are being offset with new IGT investments by Clark County into our State directed payment programs through the managed care program. The ad valorem taxes are about $13 million to $14 million per year.

SENATOR TITUS:
Would you give us more on the expectations regarding caseloads returning to prepandemic levels following the PHE unwinding? During the presentation, you talked about initial overexpectations of caseloads, and now you are going to cut back on those. Where are you in the process?

MS. WEEKS:
We have not started unwinding yet. In April 2023, we will start some of the process as required by the federal government; there are no more extensions. In June 2023 we will start to see the first round of people actually dropping off and will be able to check to see if our caseload projections were accurate. We will check caseloads every three months in concurrence with the cycle of the redistribution.

SENATOR TITUS:
You presented a probable change in caseload of about 2 percent less. Is that still your expectation?

MS. WEEKS:
I think so, but I will follow up to make sure.

ASSEMBLYWOMAN GORELOW:
Regarding the waiver waitlist, I understand there is a waitlist of three months or longer for the frail and elderly, individuals with intellectual disabilities, and persons with physical disabilities. What are the contributing factors to the waitlist for these waiver programs, and what is the average wait time for services?

MS. WEEKS:
We expect these slots will help. There is a challenge because of the lack of providers. We can add slots, but if someone does not have somewhere to go to receive services, it is still a challenge. This is something we are going to be looking at and tracking.

I will have to get back to you on your last question. My colleagues at the ADSD will have more information on the waitlist for you.

ASSEMBLYWOMAN GORELOW:
When you talk about a lack of providers, is it a lack of a provider nearby, or do we not have someone to fulfill those services?

MS. WEEKS:
It is both.

SENATOR DONDERO LOOP:
Can you discuss how those increased rates of reimbursement for the physicians, dentists and the skilled nursing facilities will increase the access to care for the Medicaid recipients?

MS. WEEKS:
Today many providers, especially those who own their own practice, often struggle if they are serving a lot of Medicaid enrollees. Since one out of every three Nevadans is enrolled in Medicaid, the program is a big portion of most providers' patient revenue. Increasing these rates will help sustain some of the current providers but will also encourage more providers to offer these services.

SENATOR DONDERO LOOP:
When you talked about our disabled people not being able to get dental care services, I thought of dental care in general. Many times dentists will pull teeth instead of fixing them. That can even cause more problems for those with disabilities. Was there any discussion about how we might move forward so we can help our disabled people, and all people, who have Medicaid and who may not be able to get dental services?

MS. WEEKS:
Yes, that is a big goal. We have a new dental health officer, Dr. Keith Benson, who has been working closely with the Division that oversees the waivers and those who provide these services, to ensure the services individuals receive are what they need and will not result in more problems. The goal is to ensure these individuals have better care.

SENATOR DONDERO LOOP:
That is probably one of the important things we need to look at.

ASSEMBLYWOMAN MONROE-MORENO:
Regarding decision unit E-126, the personal care services reimbursement rate, there was a recommendation from the Home Care Employment Standards Board to increase the rate to $25 per hour. What was the methodology used to determine the $25 reimbursement rate?

MS. WEEKS:
I will have to get back to you on the actual methodology. I am not sure there was one. I will ask my colleagues who sat on the Committee and will get back to you.

ASSEMBLYWOMAN MONROE-MORENO:
There was also a recommendation the personal care service workers receive a minimum $15 hourly wage. Have there been any actions taken to move on that recommendation? How would you enforce that recommendation? We know they are the ones on the ground and in the homes who do the work and deserve to get the raise. Can you tell me what is going on with that?

MS. WEEKS:
I will have to follow up with you. The goal was to try to get at some of that issue. The providers will have to pay their employees more with this funding to make it happen.

ASSEMBLYWOMAN MONROE-MORENO:
Is there anything more we need to do to ensure that once the funding increase happens for the agencies, the money is actually given to the workers providing the services in the home?

MS. WEEKS:
Other states have added statutory language to require a percentage of funding be used for wages and benefits.

CHAIR NGUYEN:
When the Department contracts with home care employment agencies, do they include the ability to set minimum hourly rates in the contracts?

ANTONINA CAPURRO, DMD, (Deputy Administrator, Division of Health Care Financing and Policy, Nevada Department of Health and Human Services):
We enroll the personal care service providers the same as any other provider type. We are not directly contracting with them; we are enrolling them. They pay the home care employees directly.

CHAIR NGUYEN:
As part of enrolling these providers, are there no such requirements? Would it take a statutory change to require a percentage of the fee we pay them to go to the actual providers?

DR. CAPURRO:
That is correct. We do not set any standards between the employee and the employer.

SENATOR SEEVERS GANSERT:
For the dental benefits for adults who have intellectual or developmental disabilities, the budget shows a cap of $2,000 per person. There is a caseload of 5,247 and the budget anticipates 100 percent utilization. Do you expect 100 percent utilization of the maximum dental benefit of $2,000 per individual?

KEITH BENSON, DMD, (State Dental Officer, Division of Health Care Financing and Policy, Nevada Department of Health and Human Services):
Dentistry is costly. I expect most of the $2,000 per patient will be spent. It depends on need. I expect many have not received dental care before this program. They were not receiving comprehensive benefits. Now, we are providing comprehensive benefits, including cleanings, root canals, partials and dentures. If we can find the right providers for the right patients, we could easily use the $2,000.

SENATOR SEEVERS GANSERT:
This program was originally started with ARPA funds as an expansion. This is continuing that expansion. Do we have more dollars in the pool to be able to help people? Is that part of what we are trying to accomplish?

DR. BENSON:
We plan to try to increase the benefit from $2,000 to $2,500 within this program. Yes, we are trying to provide as much care as we can.

MS. WEEKS:
The goal is to drawdown the federal share to help match some of these funds. We will see how many people use these services.

SENATOR SEEVERS GANSERT:
We are excited about this program. We are just trying to determine if we budgeted enough money.

ASSEMBLYMAN WATTS:
Concerning the reimbursement rate increases in community-based services for individuals with intellectual disabilities, how will the recommended rate increase impact access to care for people in the program?

MS. WEEKS:
The hope is by increasing rates the number of providers that take these people and provide services will increase.

ASSEMBLYMAN WATTS:
Do you have an estimate of what the impact will be?

MS. WEEKS:
We do have some estimates around utilization, and we can follow up.

ASSEMBLYMAN WATTS:
Regarding the APRN reimbursement, could you discuss how the current rates and the proposed rates compare to neighboring states? How would it increase access to care?

MS. WEEKS:
I will have to follow up with you. I do not know off hand the rates of APRNs in other states.

ASSEMBLYWOMAN GORELOW:
You have mentioned several times the goal of these rate increases is to have more providers care for these individuals. What is the process for a physician, dentist or APRN to become Medicaid approved? How long is the process?

MS. WEEKS:
It depends on the provider.

MS. RUYBALID:
The provider enrollment process is largely driven by CMS regulations and rules. It is a complex and time consuming process. This is a priority; something the Division is working on. We are implementing a centralized credentialing process which we hope will lessen the time it takes for processing. We continually look at the process to make it less administratively burdensome for providers.

ASSEMBLYWOMAN GORELOW:
Is there any cost to the provider to become Medicaid-approved?

MS. RUYBALID:
There is a process in CMS in which we can charge a fee. Nevada has a waiver to not charge a fee.

ASSEMBLYWOMAN JAUREGUI:
Regarding the home healthcare workers, it was indicated the Division does not set the standards between the employer and the employee as to how much of the increased reimbursement goes to the employee. How do we set those standards? If we increase the reimbursement rate, how do we make sure some trickles down to the home healthcare worker and does not stay with the employer?

MS. WEEKS:
I have seen other states put in writing that the providers have to agree to provide a portion of these funds to their employees.

ASSEMBLYWOMAN JAUREGUI:
Is that done in the budget or by statute, that if we increase the reimbursement, a certain percentage of it must trickle down to the home healthcare worker or employee?

MS. WEEKS:
I would advise you to talk to your counsel about the best way to make sure that is represented.

MR. KUCERA:
Medicaid largely operates with the pool of funds available to provide the array of services as legislatively approved. For example, there are several decision units within the Medicaid B/A 101-3243 that add General Fund monies and federal funds to enhance, for example, dental services by 5 percent. Those funds are estimated. General Fund appropriations and federal funds are included in the budgets. Then, Medicaid is allowed to request federal approval through the State Plan amendment process. However, the Legislature does not typically approve specific rates for services outside of adding authority to the Division's budget.

ASSEMBLYMAN HAFEN:
During testimony it was said that 63 percent of the providers were unwilling to serve Medicaid patients related to the applied behavioral health services. With the increase that came out of S.B. No. 96 of the 81st Legislative Session, what kind of impact are we seeing for access to care for Medicaid participants?

MS. WEEKS:
We have not implemented the statute yet because of the maintenance of effort requirements. If approved, this will be the first time we make these changes.

ASSEMBLYMAN HAFEN:
Do we have any projections of what the impact will be?

MS. WEEKS:
I can follow up with utilization counts.

ASSEMBLYWOMAN GORELOW:
What quality or outcome data was used to determine the Certified Community Behavioral Health Center program should be expanded?

THERESA CARSTEN (Deputy Administrator, Division of Health Care Financing and Policy, Nevada Department of Health and Human Services):
I do not have that information available but will follow up.

ASSEMBLYWOMAN GORELOW:
I want to talk about the eligibility expansion for pregnant women. We are going to 200 percent of the federal poverty level, and it covers 60 days for postpartum. Have you done any calculations on what it would look like for a full year?

MS. WEEKS:
We have some estimates around postpartum, but it is not part of the current Executive Budget recommendations.

ASSEMBLYWOMAN GORELOW:
Do you have that?

MS. WEEKS:
We can follow up with our previous analysis.

ASSEMBLYWOMAN DICKMAN:
Regarding the expansion for pregnant women, how will people be made aware of this expansion? Do you have a plan for notification?

MS. WEEKS:
Yes, we have some outreach through social media and announcements to providers. Our provider network is important to ensure people who may be eligible are notified. Also, when people go to Nevada Health Link for health insurance options, they will now be told they are possibly eligible for Medicaid. Depending on when they seek coverage, they will be notified.

CHAIR NGUYEN:
Is it possible someone who would not normally be getting that type of coverage may not know about it?

MS. WEEKS:
Yes.

CHAIR NGUYEN:
Can you discuss the impact of eliminating the neurotherapy and biofeedback services to the Medicaid participants who currently receive those services and how their continuity of care will be maintained now that it has been eliminated?

MS. WEEKS:
We think there are other covered services that we provide that will yield similar results for these patients. I can follow up with you on exactly what those services are.

CHAIR NGUYEN:
I would like to see that. Anytime we cut services, I am concerned.

SENATOR TITUS:
We have talked about the expansion of postpartum coverage. One thing I have not heard in any of these presentations is the coverage for presumptive eligibility and what those figures are. We are trying to save money and have discussed multiple times that we know prenatal care lowers the cost overall. For example, they do not end up in the neonatal intensive care unit. It is better overall for mom, the babies and for society as a whole. Is that somewhere else in the budget? Are you going to talk to us regarding the presumptive eligibility piece, what it might look like and cost?

MS. WEEKS:
We have some good news. We are doing that work and are implementing presumptive eligibility for pregnant woman with more providers. We are also required to have presumptive eligibility in all hospitals that earn Medicaid.

DR. CAPURRO:
We can follow up with our implementation plan in writing. We have conducted the public workshops and are working with our sister agencies to implement it. We are also in communication with CMS on our State Plan amendment and have recently received some feedback.

MS. WEEKS:
On page 41 of Exhibit D, the Prescription Drug Rebate B/A 101-3245 collects rebates for physician outpatient facility administered drugs and drugs sold through pharmacies for Medicaid. It also collects rebates for drugs covered by an MCO.

HHS-HCF&P - Prescription Drug Rebate — Budget Page DHHS-DHCFP-65 (Volume II)
Budget Account 101-3245

Medicaid can only reimburse for drugs if the manufacturer participates in the federal Medicaid Drug Rebate Program. This program was put into place to address some of the costs state Medicaid programs were paying for drugs. The estimated collection annually is about $416 million for this program.

CHAIR NGUYEN:
We will close the hearing on these budgets and move to public comment.

SARAH ADLER (Nevada Advanced Practice Nurses Association):
Senator Dondero Loop and Assemblyman Watts asked about access to care, and the change in access to care through these improvements and rates. Through Nevada Nurses Day, I met Julie Coop who is in Winnemucca and is the only APRN who provides Medicaid assisted treatment in a large piece of rural Nevada. She said, "If I do not receive these rate increases and reimbursement parity, I will not be able to continue to provide this care." This is a very poignant example of the importance of rate parity for APRNs.

BRETT SALMON (Nevada Health Care Association/Nevada Center for Assisted Living):
I am here to highlight the important need for adequate reimbursement rates for nursing facilities in our State. We are very appreciative that the current

DHCFP budget contains a line item for a proposed rate increase for nursing facilities. In the coming weeks, we will be visiting with many of you to discuss additional proposed funding to further close the gap between the reimbursement rate and the actual cost to deliver care to our nursing facility residents.

Nursing facilities have had only two Medicaid rate increases in the past 20 years. Our facilities deliver about 1 million Medicaid days of care to residents each year. About 60 percent of the care we provide is for Medicaid residents. Nursing facilities are an important part of the health care continuum, and when you do not have a healthy part of that continuum, it impacts everyone.

Nursing facilities have a delicate balancing act when they admit residents. They have to focus on the care, whether they can safely care for those residents. They also have to focus on the financial side. That is the side I am focusing on today, the reimbursement rates. When they admit a resident, they have to decide whether they can take a Medicare resident, a Medicaid resident or a private-pay resident. Medicaid is always the lowest payer.

There is a balancing act that happens in determining whether they can safely care for that resident. The balancing act sometimes creates bottlenecks in the system. As a result, other providers that want to admit someone to a nursing facility or hospitals that want to discharge someone to a nursing facility sometimes cannot do it quickly. They have to hustle around to try to find other places where they can admit those residents. This increases the costs in the system and slows quality of care for our residents. I encourage you to support having adequate reimbursement rates for nursing facilities.

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CHAIR NGUYEN:
There is no additional public comment. We are adjourned at 9:56 a.m.

RESPECTFULLY SUBMITTED:

_____
Marie Bell,
Committee Secretary

APPROVED BY:

_____
Senator Rochelle T. Nguyen, Chair

DATE: _____

_____
Assemblywoman Michelle Gorelow, Chair

DATE: _____

| EXHIBIT SUMMARY | | | | |
|---|---|---|---|---|
| **Bill** | **Exhibit Letter** | **Introduced on Minute Report Page No.** | **Witness / Entity** | **Description** |
| | A | 1 | | Agenda |
| | B | 1 | | Attendance Roster |
| | C | 2 | Richard Whitley / Nevada Department of Health and Human Services | Department of Health and Human Services Director's Office budget presentation |
| | D | 4 | Stacie Weeks / Nevada Division of Health Care Financing and Policy | Division of Health Care Financing and Policy budget presentation |