MINUTES OF THE MEETING
OF THE
ASSEMBLY COMMITTEE ON HEALTH AND HUMAN SERVICES

Eighty-Second Session
February 10, 2023

The Committee on Health and Human Services was called to order by Chair Sarah Peters at 1:32 p.m. on Friday, February 10, 2023, in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4406 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Copies of the minutes, including the Agenda [Exhibit A], the Attendance Roster [Exhibit B], and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at www.leg.state.nv.us/App/NELIS/REL/82nd2023.

COMMITTEE MEMBERS PRESENT:

Assemblywoman Sarah Peters, Chair
Assemblyman David Orentlicher, Vice Chair
Assemblywoman Cecelia González
Assemblyman Ken Gray
Assemblyman Gregory T. Hafen II
Assemblyman Brian Hibbetts
Assemblyman Gregory Koenig
Assemblywoman Sabra Newby
Assemblyman Duy Nguyen
Assemblywoman Angie Taylor
Assemblywoman Clara Thomas

COMMITTEE MEMBERS ABSENT:

Assemblywoman Michelle Gorelow (excused)

GUEST LEGISLATORS PRESENT:

None

STAFF MEMBERS PRESENT:

Patrick Ashton, Committee Policy Analyst
Nancy Davis, Committee Secretary
Ashley Torres, Committee Assistant

OTHERS PRESENT:

Stacie Weeks, Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services
Sandie Ruybalid, Deputy Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services
Kelly Cantrelle, Deputy Administrator, Division of Welfare and Supportive Services, Department of Health and Human Services
Kyra Morgan, Chief Biostatistician, Department of Health and Human Services

Chair Peters:
[Roll was called. Committee rules and protocol were reviewed.] We are going to start with an introduction of a bill draft request (BDR). Similar to our last meeting, your vote is to move this as an introduction and does not commit you to anything related to this bill; it just allows us to introduce it on the floor.

Bill Draft Request 40-331—Revises provisions relating to substance use disorders. (Later introduced as Assembly Bill 156.)

Do I have a motion to introduce BDR 40-331?

ASSEMBLYMAN ORENTLICHER MOVED FOR COMMITTEE INTRODUCTION OF BILL DRAFT REQUEST 40-331.

ASSEMBLYWOMAN GONZÁLEZ SECONDED THE MOTION.

Is there any discussion on the motion? Seeing none, we will vote.

THE MOTION PASSED. (ASSEMBLYWOMAN GORELOW WAS ABSENT FOR THE VOTE.)

Now, we will continue with our presentation, Overview of Medicaid and Social Services Programs in Nevada [Exhibit C]. Please welcome Stacie Weeks and Sandie Ruybalid. Thank you all so much for being here today. Please proceed when you are ready.

Stacie Weeks, Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services:
I have with me today, Deputy Administrator Kelly Cantrelle with the Division of Welfare and Supportive Services (DWSS) and Deputy Administrator Sandie Ruybalid who works with me at the Division of Health Care Financing and Policy (DHCFP); both divisions are under the Department of Health and Human Services (DHHS).

Today we want to give you an overview of Nevada Medicaid and talk about our role at the division as well as our sister agency, DWSS. We will talk a little bit about the federal public

health emergency and the unwind process, which has an impact on our program. At the end we will follow up with some updates from DWSS as well.

Page 3 [Exhibit C] sums up, at a high level, the impact of the Nevada Medicaid program. As you can see, about 920,000 people are currently covered by the program. In a previous presentation, I said one in four; it is actually one in three Nevadans who are covered today by Nevada Medicaid. Something that we often hear about is how much Medicaid pays and all the different elements of it. It is important to always remember, it is a taxpayer-funded program. We will talk a little bit later about the financing structure. In the last three years, since the pandemic, and because of the public health emergency and some of the continuous coverage requirements, we have seen about a 40 percent growth in the program in Nevada. This is similar across the country, but Nevada has definitely seen a large portion of growth. Deputy Administrator Sandie Ruybalid will talk about the public health emergency and unwind process later in the presentation. Also, something that is important to remember is that there is still about a 10 to 11 percent uninsured population in Nevada. We think about 37 percent of the uninsured are likely eligible for Medicaid coverage. This data comes from the Kenny Guinn Center for Policy Priorities, which was the last real study that looked at this portion of the uninsured population. That study was from 2019. We do think that number is probably different, but we expect a good portion of the uninsured to be eligible for the Medicaid program and not yet enrolled.

Page 4 shows some of the key statistics about the Nevada Medicaid program. As you can see, it plays a very significant role in Nevada's health care ecosystem and our state budget. In fiscal year 2022, the spending on medical expenditures in all the programs was about $5.5 billion. That is nearly 30 percent of all state expenditures in the state of Nevada. About half of births are covered by Nevada Medicaid. That is one of every two births in the state. About 78 percent of the people enrolled in Medicaid are served by one of four Medicaid managed care plans. We will talk later about what managed care is and why it is different than our fee-for-service program. About 44 percent of the population are children. We often forget a lot of our enrollees are youth and children up to the age of 18. Ten percent of our population are dually eligible, which means they are eligible for both Medicare and Medicaid, which is about 91,750 individuals. Eighty percent of the population live in Clark County. That may not be a surprise to many of you, but it is a very big portion of the program. Sixty-two percent of the nursing facility stays in the state are covered by our Medicaid program. Sixty-two percent is the percentage of adults enrolled in Medicaid who are employed. We often think of people being unemployed on the Medicaid program, but actually some data that Kaiser Family Foundation puts out shows about 62 percent in Nevada are employed. Sixty-four percent of the population are people of color.

Page 5 takes a little step back and looks at how Nevada Medicaid operates and some of the oversights and operations for the program. At the high level, we have our federal agency which is the U. S. Department of Health and Human Services. That agency has delegated its authority and function to the Centers for Medicare & Medicaid Services (CMS). Title XIX of the Social Security Act is what established Medicaid in the 1960s. This program has been run and overseen by CMS. They oversee our program and often audit us. We also have to

go through them for approvals for a federal share. Every state which elects a Medicaid program has to have a single state agency. In our state, under state law, that is the DHHS. State law has delegated, under the director of our department, the DHCFP, which is my division and also DWSS, our sister division. You can see the functions here laid out in front of you at a high level. I will say there are a lot of other things going on here, but these are the key core functions of each of our divisions. The Division of Welfare and Supportive Services mostly focuses on, for purposes of Medicaid, eligibility and enrollment. That is the function that they play for the state. Our division, DHCFP, focuses on the Medicaid budget. We are responsible for ensuring oversight and that we are good stewards of taxpayer dollars and following state and federal law. We are also responsible for payments to providers and ensuring that the payments are made on time to meet state and federal laws. We are responsible for enrolling providers in the program. It is different than licensing; we essentially enroll providers as long as they meet our Medicaid standards. There is also a program integrity that we are responsible for and those are essentially some of the items that the state and the federal government may ask us to do. We also administer the benefits, develop the benefits, and seek federal approval for federal funds.

Page 6 [Exhibit C] outlines the differences between the programs. My mom, still to this day, says that I work at Medicare. Medicare and Medicaid are two very different programs, and it is important to understand that distinction. As you can see, Medicare is managed by the federal government only. There is no state entity that an individual can call and ask about their Medicare benefits. We often get those calls, and we have to say, sorry, you have to call CMS. Medicare is also funded by the federal government and consumer premiums, in addition to some other funding streams, but there is no state share piece that you see in Medicare. It also covers a different population a little bit differently. It covers those 65 and older, which we do cover in Medicaid, but Medicare covers different services. For example, Medicare does not typically pay for long-term care, which Medicaid does pay for. Medicare also covers some younger individuals who have certain disabilities.

Medicaid is a joint program that is jointly managed and funded by the state and federal government; it is a partnership. It is funded at no cost to the consumer. The program is taxpayer-funded, and for the consumers covered by Medicaid, they do not have to pay a premium. In most states there is cost sharing, but not in Nevada. Medicaid covers all low-income individuals, regardless of age, and people with disabilities. As I mentioned earlier, Medicaid pays for long-term care services, which are important for our populations who are older as well as disabled. Medicaid is the payer of last resort, something that we often do not talk about, but that is an important piece. We do have, as I mentioned earlier, a dual-eligible population who are seniors which is served by both programs.

Page 7 gives you a high-level view of who is covered by Medicaid. These are mandatory populations by federal law. All states cover, to some extent, this population. We will look in a minute about what extent Nevada Medicaid covers in this population. It is all families and children who are low income, pregnant women and newborns, low-income adults up to the age 64, most seniors 65 and older, and people with disabilities, as well as children in foster care, guardianship, and adoption assistance.

Page 8 looks at what we consider low income in Nevada. We have different eligibility limits based on percentages of the federal poverty level. For example, under the Nevada Check Up program, children are covered by Medicaid. Children ages zero to five are covered up to 166 percent of the federal poverty level. The difference between that and the 205 percent that you see here is the check up program. We cover older children with the check up program, which is Children's Health Insurance Program (CHIP); families have to buy into that program. Children who are 6-18 are covered up to 139 percent of poverty by Medicaid, and then CHIP makes up the difference up to 205 percent of the federal poverty level. Pregnant women are covered up to 165 percent of poverty. I would note the Governor's recommended budget includes the proposal to expand this eligibility up to 200 percent of poverty, which is pretty consistent across the country. A lot of states are covering pregnant women similar to children, up to 200 percent. Nevada Medicaid covers parents up to 138 percent, which is the limit. If the state chooses to expand Medicaid, which Nevada did, they have to at least cover people up to 138 percent of poverty, so parents and childless adults are covered to 138 percent. For seniors and people with disabilities under the Affordable Care Act, the eligibility income limits were not impacted, so they are below the 138 percent poverty line. In Nevada Medicaid, that is 74 percent, but it varies by state.

Page 9 [Exhibit C] looks at who is enrolled and how many people are in the different categories. As you can see, more than half are parents and children—families—it is a big portion of our program. The second-largest portion is adults without children. And you might think of the Medicaid expansion population when you think of that population. The other two buckets, at 12 percent are the aged, blind, and disabled populations, and the smallest portion, 6 percent, are child welfare, individuals who are adopted or in foster care, and our waiver programs.

Page 10 asks how someone enrolls in Nevada Medicaid? There are several pathways to enrollment. Often most people do not want to go through that very long process. They just want to screen for eligibility. There are three different ways people can get into Medicaid enrollment. The first one is Access Nevada; the picture on page 10 shows the website. This website is maintained and the software is operated by DWSS. People can go on to this website and do a screening to see if they are eligible before they go through the long application process. Nevada Health Link, Silver State Health Insurance Exchange, also refers individuals who may be eligible for Medicaid to Access Nevada. That is another pathway. Some people can find their way to enrollment through a hospital or qualified provider through presumptive eligibility. That means that, for example, hospitals presume someone is eligible based on the information he reports, such as his income, what is going on, and how many people are in his family, and the hospital can presume eligibility. When the hospital does that, it submits an application to DWSS, and if presumptive eligibility is approved, then the hospital can get payment for the services provided to that individual even though he has not gone through the full application process. That enrollment is temporary, and the individual has to complete a full application within the deadline. If he does complete the application and is determined eligible, he will be fully enrolled into the program. There are three other official ways to enroll in Medicaid. Again, Access Nevada is our key site. Individuals can go on that site and enroll and go through the full application process. They

have to set up an online account. They can also still enroll by paper and by mail. They can enroll in various district offices in northern and southern Nevada in person.

Page 11 lists what Medicaid covers. We have two buckets of benefits. Under federal law, if states do not cover the mandatory benefits listed on the left side, they risk not receiving their federal share. This is a mandatory minimum set of benefits that Title XIX established for state Medicaid programs. We have to cover all of these services listed. On the right side are the optional benefits. Federal law does list out these benefits as being optional, and if states want to add them, they can seek a state plan amendment to add them and get approved. In that process we often define what is included, for example, under clinic services, what types of providers and what the reimbursement methodology would look like. There are other benefits not listed here that are available on the CMS website.

Page 12 [Exhibit C], I think you have probably heard we just need a waiver. We often hear a lot about waivers. I think it is important to step back and think about what the difference is between when we talk about a state plan benefit versus a waiver; they are really two different things. A state plan benefit, for example, for coverage, exists within federal law; it is either mandatory or optional, and it is listed that way. States can assume a benefit coverage, but they have to offer anything under the state plan statewide. It has to be available to everyone. It has to also be available in a comparable manner. We cannot give someone half the benefits we give others. We also have to offer it the same way to providers in terms of reimbursement. We cannot pay the same qualified providers differently. We have to be fair. The other piece of that is we have to allow freedom of choice for the enrollee and a qualified provider. If the provider is qualified and is enrolled, we have to pay for that service if it was covered and they were eligible. That is a state plan benefit. That has a lot of protections.

Waivers waive a lot of those things. When you think of a waiver, you are thinking, I want to offer this benefit perhaps in this region of the state because maybe we want to try it out and see if it works, or we only have one provider, or it is a budget risk. There are a lot of reasons states use waivers. That is when we are operating within federal law, but we are also seeking waivers of federal laws, there is a lot of flexibility. Nevada has several waivers; we have three home and community-based waivers. We also just recently submitted a waiver to add dental benefits for diabetic patients, only allowing those benefits to be available in a qualifying health coverage, for example. It is not statewide, it is not available to everyone, but it is allowing us to cover those services through a waiver, if approved.

Page 13 illustrates how Nevada Medicaid is delivered today. There are two systems that Nevada Medicaid uses that the state has chosen. The first one is our fee-for-service program. When you think of the fee-for-service program, it is your historical program and how services have been paid for years in Medicaid. The state sets the rate and pays the provider directly per service. It does not reward for anything but volume, essentially; that is the way it is operated. It can be a risk to the state budget because of that. It is a risk—sometimes the costs are hard to control because there is no utilization management in fee for service. In Nevada, individuals who live in rural areas of the state, our waiver population, our child

welfare populations, and the aged, blind, and disabled population are all in our fee-for-service program today. That is about 28 percent of our population.

The second program that we have is our managed care program. This program operates in Washoe and Clark Counties as well as Carson City. In this program, the state contracts with health insurance companies to manage the cost utilization and quality of care for these enrollees. They develop a provider network, they negotiate the rates, and they pay the providers directly. I would just note that when you look at these two populations, even though the managed care program is 72 percent, it is a very large portion of the program, but it represents a very small portion of the cost compared to the per member per month. When you look at the cost of the per member per month, between these two programs, fee for service is a lot more expensive at about $800 per member per month with the last data that we looked at in 2020, versus about $250 per member per month for the managed care program. The difference is, the fee-for-service program is often our higher cost population, and it is hard to do risk utilization and control for those costs in the managed care program. Another thing I would note is that something a lot of states use you might hear about is value-based payment design. That can be a way of delivering services, but in Nevada Medicaid we are implementing some of that delivery into our managed care system today. We currently have targets for value-based payments with providers. Essentially, that is allowing us to pay providers and reward them for improving care, meeting certain quality metrics, and getting the outcomes that we want to see. We are hopeful that will start to change some of the payment models in the program.

Page 14, how is Medicaid paid for? It is a state and federal partnership, as I mentioned earlier. The state shares in the cost to the federal government if something is matchable. The Federal Medical Assistance Percentages (FMAP) are the federal share. The FMAP are based on a formula, and it typically represents the per capita income of the state. Some states get more than 61 percent, and some get less. No state can get less than 50 percent. Nevada Medicaid is currently at the 61 percent FMAP. That is how much the federal government is willing to pitch in for the cost of the program and the state's share is at 39 percent. As you can see, together those make the provider payment.

Page 15 [Exhibit C]—will Medicaid pay for a service? We get this question a lot and there are really four helpful questions to answer. If you answer yes to all of them, then the services are paid for. The first one is, is the individual enrolled in the program? If that is yes, great. Is it a Medicaid-covered service? Is it a Medicaid-enrolled provider? Is the service medically necessary? If all those four things are yes, then it should be paid for, and we can draw down federal share to match for that service. I am now going to turn the presentation over to Sandie Ruybalid.

Sandie Ruybalid, Deputy Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services:

I have the pleasure of being put in charge of the public health "unwind" statewide. As you can imagine, it is very complex to coordinate something across three different entities. This has been a definite learning experience. Over the past three years, states have been under

what is called the federal public health emergency (PHE) declaration due to the pandemic. That afforded states flexibilities in coverage and a continuous coverage requirement under Medicaid which also afforded a 6 percent FMAP increase. That was definitely a benefit to the state. Telehealth was one of the flexibilities that we do intend on continuing if approved by CMS. We did submit that request to CMS and we are awaiting their approval. Some of the administrative flexibilities we have gotten approval for during this process include using the U.S. Postal Service notice of change of address database and managed care organizations as trusted data points to change someone's contact information without having to reach out to the member and verify the information. We are allowed to eliminate that step and ensure that we have good address and contact information for members.

Under the Families First Coronavirus Response Act, the continuous coverage requirement was tied to the expiration of the PHE. That was ended under the Consolidated Appropriations Act, and we actually got a firm date to end the continuous coverage requirement. Previously, we were operating under a 60-day notice that it is going to be extended. It is now ending on March 31. We will begin what is called the unwind process on April 1. What that means is, we will start doing redetermination for Medicaid eligibility. That process will transpire over a 12-month period. It starts April 1, and it will end May 31, 2024. Part of the unwind reduces that enhanced FMAP over time, and it will be back to normal—as we call it—on January 1, 2024, but it is a gradual step down, quarter by quarter.

Page 18 graphs the projected Medicaid caseload. We anticipate, to the best of our ability, that 200,000 members might be impacted by the unwind.

Page 19 [Exhibit C] is a visual of how the unwind cycle will occur. It is important to note that we did not stop doing redeterminations as part of this continuous eligibility. We continue to mail determination packets. We just did not take a negative action; or if someone was not eligible, we continued their eligibility. It is not like we have this big pile of members waiting to be redetermined; it is going to be based on their due date for redetermination. That helps spread out the workload.

Month One, April 1, 2023, approval notices and renewal packets are going to be mailed out Day One, Month One. Then we go through to Month Three, which is June. The first negative action will not occur until June as part of this unwind. At that point, members also have 90 days to submit for reconsideration. If they did not realize they needed to return paperwork or anything like that, they do have that 90-day period.

Page 20—for the past 10 months, we have been doing some extensive planning because the goal is to avoid loss of coverage. I think that is really the key factor here. If members are no longer eligible for Medicaid, then they need to have a soft landing place. That is why the Silver State Health Insurance Exchange is a really important partner with us. We have been working very closely with all three agencies to make sure that we have had that covered. We also have a great partnership with the DHHS Office of Analytics. They have been instrumental in helping us with analytics and helping develop dashboards we will be posting

publicly so anyone can monitor what we are doing. Application status, telephone statistics—all of those different unwind data points will be available publicly for all stakeholders.

We also spent a significant amount of time developing our operational unwinding plan, which is a beautiful document. If you would like to go see it, it is posted on our website. It is about 52 pages, and is a very comprehensive, detailed document of every step that we have taken along the way. One of the things I would like to highlight as part of this process is what is called ex parte renewals. Ex parte is Latin for by one for one party. What that means is, we have the ability to hit different databases to automatically determine if someone is eligible for Medicaid, and if so, we can then automatically renew them and send them a notice and tell them they have been renewed for 12 months. That is key in this process because it is mandatory by CMS, so that is a big factor. We did start that process in December, and we were able to renew just over 16,000 households without their having to do anything, without a caseworker having to touch their case. That is a huge improvement for our state to simplify things for members and ensure continuous coverage. Some exclusions from ex parte redeterminations are based on the Nevada Check Up program, and also there are scenarios where folks might have a pseudo social security number and we cannot hit a database if we do not have a valid social security number. Another thing I would like to highlight as part of this project is Georgetown University has a 50-state tracker posted online of the five key documents that are posted publicly. Nevada is one of 10 states that hit all of these five points. It is always nice to highlight when we are in the top 10 for anything. Those five items are having a state plan or summary, an alert to update contact information, unwinding frequently asked questions, a communications toolkit, and an unwinding data dashboard being posted publicly, which we do plan to start once we have data after unwinding. That concludes our unwind efforts, and I will turn it over to Deputy Administrator Cantrelle.

Kelly Cantrelle, Deputy Administrator, Division of Welfare and Supportive Services, Department of Health and Human Services

I am happy to be here today to talk to you about the Division of Welfare and Supportive Services (DWSS) part in the unwinding and collaboration that we have had, and then about some of our programs and things that are updating and happening within Welfare.

Page 22 [Exhibit C], Sandie Ruybalid did a great job touching on the fact that we received a waiver to use the national change of address database and the managed care organization addresses that they received and were verified on receipt. We put a team together that we dedicated specifically to the address changes; the team does nothing but update the eligibility system with these verified addresses we receive. The team will also reach out to customers if we need to do that. If they receive an out-of-state address or return mail with a forwarding address, they will reach out to the customer to see if they can verify the address that we have received. In 2022, we were able to update nearly 267,000 addresses, which will go a long way to helping the unwinding process. One of the things we are really afraid of is not being able to reach the folks to let them know that this is happening or that their Medicaid needs to be redetermined because it has just been rolling along now for over three years. Another thing that is a notable mention is the State of Nevada DWSS did not make any system

updates to provide continuous coverage. We were able to do it with staff and supervisors doing overrides so people stayed eligible for what they were eligible for. As we start to unwind, we do not have any system updates to unwind, so that will make it a little easier as we move into this.

As you heard, there are over 900,000 Medicaid recipients. That sounds like a daunting task to certify everybody or redetermine everybody in a year. But DWSS works with cases, not necessarily individuals. Over 900,000 individuals translate to 535 cases, which will then be worked over the coming 12 months. The majority of those cases have Supplemental Nutrition Assistance Program (SNAP) and are renewed every six months. For the cases that have a combination, which is about 50 percent of our Medicaid cases, we have not lost touch with those individuals—we have been seeing them, talking to them, and getting updates from them every six months with that program. Ms. Ruybalid did a great job covering all the various ways customers can access Medicaid, so I will not reiterate that.

Page 23 [Exhibit C] addresses the DWSS programs. The first one is Temporary Assistance for Needy Families (TANF). It is designed to provide assistance to care for dependent children in their own homes with their own parents, relative caregivers, fictive kin, which is like close family relations or friends who can care for the child instead of placing them in a random foster care system. Temporary Assistance for Needy Families provides financial support and supportive services such as transportation, vocational training, work permits, tools, anything work-related or related to getting a job.

The next program I would like to talk to you about is the Energy Assistance Program (EAP), which provides a supplement to assist qualifying Nevadans with the cost of energy. It reduces the burden of those high electric bills and, sometimes, those gas bills. It helps residents get through the hot summers down in Las Vegas and those cold winters up here in Reno and Carson City. That is a program I am excited that we have.

The Child Care and Development Fund (CCDF) assists income-eligible families with the cost of child care so that they can go to work. It also helps them find quality child care out in the community.

Child Support Enforcement (CSE) aims to make child support a reliable source of income. The program wants children to have financial and medical support from both parents and not just one, and they strive to see that that happens. It emphasizes the need that children have. Children have to have both parents involved in their lives and all at the same time. It helps reduce welfare costs.

Page 24 reviews SNAP, which was formerly known as food stamps, which is a term that a lot of people are familiar with. Food stamps help qualifying Nevadans buy food. For some Nevadans, after paying rent and utilities, oftentimes they have very little money left to buy food. This program helps them buy nutritious food. Thousands of families across Nevada receive SNAP benefits every month to help feed their families.

Next is Supplemental Emergency Allotments (SEA). There have been several news articles recently about SEA, so I want to talk to you about this. The DWSS implemented SEA for recipients of SNAP due to the impacts of COVID-19. What SEA did was increase SNAP benefits. The increase started in March of 2020. From March of 2020 through January of 2023, we have issued over $1.2 billion in SEA benefits to over 450,000 Nevadans. Those are huge numbers. In 2022 we issued $43 million a month. That served over 230,000 SNAP households. Supplemental Emergency Allotments payments are ending; they end this month and the last payment that will issue an SEA is next month. What does this look like? I have a little scenario that will give you an idea of what is happening to these folks starting April 1. A single-person household, which is about 140,000 of our SNAP households, has been receiving the maximum allotment of $280. After SEA ends, starting in April the amount that will be received by a single-person household will be reduced to $149 a month. That is a 47 percent reduction in SNAP benefits that they have been living on for the last three years and that is just going to come to an end. It does not unwind; it is just ending next month. We are working with community partners, food banks, and the Retailers Association to get the word out. We have our own people in the field notifying customers. We are trying to get the word out so that people at least know that this is coming.

Page 25 [Exhibit C] shows the last program I am going to touch on today, which is known as Targeted Outreach Partnerships (TOP), which basically connects people to DWSS services throughout the community. We all recognize sometimes there is a stigma with applying for welfare, being on welfare, or walking into a welfare office. Mobilizing and putting our people in places where you would not normally find them allows us to reach underserved members of our community who may not walk in. Members of the TOP team take applications, make changes, make eligibility determinations, issue the SNAP card, and more. The team has what is called an office in a box. They basically pick up their laptop, a scanner, and a printer, and they travel. They travel from place to place out into the community, and it allows them a lot of efficiency and it allows them to be very productive without having to be in a traditional brick-and-mortar welfare building. We have 48 family services specialists who are eligibility staff on the TOP team who serve 182 community sites every month throughout the entire state of Nevada. We service some of them in person. Some have asked us to come virtually, phone calls—all different ways. This team services rural areas all over.

An example of some of the sites that we have are social services sites such as county social services offices, libraries, counseling centers, schools, and homeless shelters. We have medical sites, such as hospitals and rural tribal behavioral health clinics. We have a lot of justice-related sites, such as correctional facilities, sheriff's offices, courthouses. In Las Vegas, for example, we have three of the TOP team stationed right in the Clark County Detention Center; that is their home office. They go there every day. They report to work there. That is what they do every day. In 2022 the TOP team attended 132 specialized events, and that was a slow year because we were just coming out of COVID-19. We anticipate a lot more this year, but they go to things like the city jail inmate resource fairs, Reinvent Schools, and Safe Summer Nights celebrations; they attended the Black HIV/AIDS Awareness Day event, U.S. veterans job fairs and community fests, the Washoe tribal health festivals, a myriad of other health fairs, and the Elko Veterans Roadshow, just to name a very

few. We have even gone to grocery stores and have set up right outside the markets so that we could be there for anybody walking into the market who may have an interest in some of our programs. It is very flexible. Currently, we have 89 community-based organizations on our wait list that are requesting TOP staff to utilize these outreach services in their facilities. That is the last of our presentation and we are all available to take any questions that you may have.

Chair Peters:
Thank you so much for the information sharing. I think several of us are new to this area and we are unaware of many of your programs. We do have quite a few questions.

Assemblyman Hafen:
I have to begin by saying thank you for all that you do. It is a lot of work, just looking at page 3 [Exhibit C], 920,000 people that are on Medicaid. I am a numbers geek, so I am writing down the numbers and looking at where we are at. It looks like about a 250,000-person increase since 2019 and the pandemic. That is just an amazing feat. I believe you said that in 2019 there was about a 10 percent uninsured rate, which was roughly about 300,000 people. I know the addition of the 250,000 is not one for one because people lost their jobs and businesses went under during the pandemic. Do we know when we will actually have an update of what the percentage is of the uninsured? It is somewhere between 9.5 percent and 10 percent. I am curious if we will have that information this session, or if that is something that we will have to wait to get in the interim.

Stacie Weeks:
Honestly, that is hard to find that out. I think the entity that probably can give us that update will be the Division of Insurance, Department of Business and Industry. We can follow up with our sister department. I will say the latest data online from the Kaiser Family Foundation was from 2021; it is behind a year. I think even once you do get that update, it is still not really going to reflect all the gains that have been made in the last year. It is a very hard number to pin down, but we can definitely follow up with our Division of Insurance colleagues and try to get an answer for you.

Chair Peters:
Mr. Ashton has offered to give some input on this. I am going to let Mr. Ashton go ahead and answer.

Patrick Ashton, Committee Policy Analyst:
According to the 2023 Insurance Market Report from the Division of Insurance, Department of Business and Industry, the current uninsured estimate is 10.6 percent. An estimated account of 333,000 Nevadans without insurance.

Chair Peters:
Thank you. As a side note, I think as we see the unwinding happen, we are trying to capture all those folks, so we do not have an increase in that number. That is really the feat right

now, making sure we have all the right things in place. It is amazing that we have gotten to a place where we have a plan to do that.

Assemblyman Nguyen:
Before I get to my question, I just want to reiterate what I said at our last meeting: I have utmost respect for the Health and Human Services staff. You all have so much to do and so little time, and it is always endless things. I appreciate that you are still here with a smile and ready to take on the challenges—so much respect. With that said, I am a data guy. I always want to see how we can be helpful with data in terms of what we can do on this side of the aisle. You mentioned earlier that there is a dashboard that you are working on that put in real-time information that everybody can look at from the public standpoint and even the Legislature. Looking at these big projects you are taking on with the unwind, with the SNAP changes, and with the SEA changes, are there plans or perhaps an existing data profile that we can look at as members in our respective Assembly districts? Let us just say, if you know I represent District 8 and the number is this much, and my colleague in District 16, her number is this much. Are there data available for all these programs across the department that we can see and then we can truly help you all in terms of outreach and be able to bring more attention to it?

Stacie Weeks:
I would like to call up Kyra Morgan, our Office of Analytics Director.

Kyra Morgan, Chief Biostatistician, Department of Health and Human Services:
In the public health unwind dashboard, we are adding a live mapping feature where you will be able to look at these individuals who are losing coverage. I do have a static report that I can provide to the Committee that looks at the individuals who we already know are more likely to lose coverage because, for example, they have submitted income under staff redetermination. We have a lens into people who are more likely to lose coverage. We have that mapped by zip code currently, so you can see where those folks are living. We also have the legislative health profiles on our website. Those allow you to look at a breadth of information, including eligibility for Medicaid, SNAP, and TANF, as well as just general health indicators, such as cancer rates, mortality rates, drug use rates, a wide array of things. Those are all available on the website, and I can provide those links.

Assemblyman Nguyen:
The next thing we talked about earlier was the targeted outreach partnership. My question is in terms of that funding source and where that comes from for the execution of that program, because I think it is a great program. I just did not know about it. Also, can you provide to me the definition of nontraditional communities?

Kelly Cantrelle:
The majority of the funding for the targeted outreach partnership team is federal funding through the SNAP program. The types of nontraditional places would be jails, correctional facilities, hospitals, schools, libraries, sheriff's offices, and anywhere that we have people asking for us; that is where we put our folks. It is all types of different places such as the

homeless shelters. In Las Vegas we are in the Courtyard Homeless Resources Center, which is an entire homeless "courtyard," for lack of a better word. We have 10 outreach members who are stationed there. We are even at the dental school. All the places that, outside of a welfare office, you would not necessarily expect one of our eligibility staff to be, those are the places that we are trying to get into.

Assemblywoman Newby:
I have two questions. First on page 11 [Exhibit C], I did not see any mention of mental health or behavioral health on that list. Question number one: Is that covered by Medicaid? On page 14, when you speak of the state share at 39 percent, where does that money come from?

Stacie Weeks:
To answer your first question, yes, behavioral health is covered. It is written into federal law; it is usually listed by provider types. The services of behavioral health are essential benefits that are required to be covered. In answer to your second question, the source is the state budget. That is the appropriation that the state has made for the state share that we pay. When we add a benefit, we need to get legislative and budget authority to pay for that service or we cannot fund it.

Assemblywoman Newby:
My understanding is that, at least in the past, Clark County had an agreement with the state to contribute funds. Is that still the case?

Stacie Weeks:
Yes. Those are intergovernmental transfers. There are other smaller sources of state share that we can get from local governments if they would like to front the state share. Typically, it is a state general budget.

Chair Peters:
Those are only considered under waiver programs, right?

Stacie Weeks:
No, the federal law allows us to do intergovernmental transfers from a local government to fund the state share. In that example, it allows for us to pay a supplemental payment to the hospital in addition to our base rate, so it does not have to be through a waiver.

Assemblywoman Thomas:
Thank you for the information you are giving because there are so many questions that I had as far as Medicaid. I think your clear and concise way of explaining it brought it home for me, and I do appreciate that because I am a layman in this area. When you say the federal share is 61 percent, you gave a minimum and I think the minimum was 50 percent. What is the maximum?

Stacie Weeks:
I am not sure there is a maximum. I cannot imagine that it would ever be 100 percent because that would violate federal law which says there has to be some state share, but no state can get less than 50 percent from the federal government.

Assemblywoman Thomas:
Can we ask our federal delegation to see whether we can get an increase? I have heard from so many different Committee members that this is the problem, that if we had more money for Medicaid, we could service our growing population that needs or requests Medicaid services.

Stacie Weeks:
Now you are singing my song. There is always a need for more money. Unfortunately, the FMAP is set by federal law and there is a formula that spits out a number. Right now, our number is 61 percent. It went down because our per capita income went up for families. It fluctuates based on poverty in the state and per capita income. For example, Mississippi, which is one of our more impoverished states in the country, has a much higher FMAP than we do.

Chair Peters:
I think several of us are wondering how that fluctuates, especially looking at the cost-of-living increase that we have seen in this state. How is that incorporated into the FMAP funding formula? Do you know if it is even considered?

Stacie Weeks:
I would have to give you the exact formula, if that is helpful. The per capita income does look at that poverty impact. I hear what you are saying, but I want to follow up before I try to answer that question.

Assemblywoman González:
I did not see it on the page about services. Does Medicaid cover mental health and what does that look like?

Stacie Weeks:
Yes, we do cover mental health, substance use disorder treatment, behavioral health—a variety of services. We can follow up with a full list.

Assemblywoman González:
Something that I hear often from my constituents is about the quality of care. What is your organization doing when it comes to having diverse, quality care for constituents who utilize the service?

Stacie Weeks:
That is a concern for us. I will say in our fee-for-service program, we do not really have any tools to implement or really require quality like we can with the managed care program. We

do measure our managed care plans on a lot of different quality metrics that are required by federal law. I will say our recent procurement, for this last contract period, includes a lot more quality strategies, population health management strategies. They are also required to look at their workforce and make sure that it is diverse. There are a lot more tools there for us, and that is 78 percent of the population. But as you know, it is not everyone, and it is an area where we can grow.

Assemblywoman González:
I try my best to bring the concerns of my constituents forward, and quality of care concerns are something that I hear a lot, so thank you so much and I look forward to working on this with you.

Assemblyman Gray:
I represent a portion of the rural counties, and you do a fantastic job. It is a very altruistic job. You do a great job of tracking how many people you enroll and assist. Is there another side of that coin where you are identifying the underlying problems, why these people are not self-sustaining and self-supporting? Also, do you track when people get off of assistance whether they have moved on to a self-sustaining kind of lifestyle? Personally, I think that should be the goal so there are more resources that are freed up for other people who need it.

Stacie Weeks:
To the point about tracking individuals when they leave the program, we do not currently track them as far as I know. I know it is not part of our requirements to do so. I would just note that there are different components, especially in a managed care program, which really focus on some of those employment services and trying to help wrap around people some of those social services that help provide more stability in their lives and help improve their income so they can move out of Medicaid. It should be a ladder up, not down. I think your points are important. At this time, we do not necessarily track. Also, coming into the program, we do not assess what the issue is and why people are in poverty. I think it is a broader question for maybe a different department than ours.

Chair Peters:
I have a couple of base-level questions around Medicaid coverage and the relationship with managed care organizations. You mentioned recently the quality assurance metrics from the new contracts with the managed care organizations. Do you anticipate having a report of that or something you can share with our body on what you are finding?

Stacie Weeks:
Yes, in fact, we have a quality strategy plan, we have an updated version I can send to you, as well as a report on the organizations' performance.

Chair Peters:
If you would send that to staff, they will send it out to the rest of us. You mentioned that Medicaid is at no cost to the consumer. Does that include copays in Nevada?

Stacie Weeks:
Yes, Medicaid has no copays and no premiums in Nevada.

Chair Peters:
You mentioned buying into CHIP. Will you talk a little bit more about what you meant by that?

Stacie Weeks:
Under CHIP, which is our check up program, it is for children who are not eligible for Medicaid, whose household incomes are above the 165 percent or 139 percent of the federal poverty level. Their families can pay a quarterly premium to enroll into the program. That is currently how it is structured.

Chair Peters:
Is that a set rate or is that on a sliding scale?

Stacie Weeks:
I have to follow up with you on that.

Chair Peters:
Are there any other questions from the Committee? Seeing none, I want to reiterate what my colleagues have said, thank you so much for the work you do in our state. We appreciate your making sure that some of the most vulnerable populations are captured and taken care of in our state. We look forward to working with you to make sure you have the resources you need and that our state keeps moving forward to ensure we have a healthy community.

We are going to move on with our agenda items. I believe our last agenda item for today is public comment. I am going to open up public comment. [Public comment rules and protocol were reviewed.] Is there anyone in Carson City wishing to provide public comment? Seeing no one, I will go to Clark County. Is there anyone in Las Vegas who would like to provide public comment? Seeing no one, is there anyone calling in to provide public comment? Hearing no one, I will close public comment for today.

Before we adjourn, are there any comments from the Committee? Seeing none, thank you all for being here today and thank you to those folks who attended in the audience and who presented today. Our next meeting will be on Monday, February 13, at 1:30 p.m. With that, the meeting is adjourned [at 2:36 p.m.].

RESPECTFULLY SUBMITTED:

_____
Nancy Davis
Committee Secretary

APPROVED BY:

_____
Assemblywoman Sarah Peters, Chair

DATE: _____

EXHIBITS

Exhibit A is the Agenda.

Exhibit B is the Attendance Roster.

Exhibit C is a copy of a PowerPoint presentation titled "Overview of Medicaid and Social Services Programs in Nevada" provided by Stacie Weeks, Administrator, Division of Health Care Financing and Policy, Sandie Ruybalid, Deputy Administrator, Division of Health Care Financing and Policy, and Kelly Cantrelle, Deputy Administrator, Division of Welfare and Supportive Services.