MINUTES OF THE JOINT MEETING
OF THE
ASSEMBLY COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HUMAN SERVICES
AND THE
SENATE COMMITTEE ON FINANCE
SUBCOMMITTEE ON HUMAN SERVICES

Seventy-Seventh Session
April 9, 2013

A joint meeting of the Assembly Committee on Ways and Means' Subcommittee on Human Services and the Senate Committee on Finance's Subcommittee on Human Services was called to order by Chair Maggie Carlton at 8:12 a.m. on Tuesday, April 9, 2013, in Room 3137 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 nelis.leg.state.nv.us/77th2013. In addition, copies of the audio record may be purchased through the Legislative Counsel Bureau's Publications Office (email: publications@lcb.state.nv.us; telephone: 775-684-6835).

ASSEMBLY COMMITTEE MEMBERS PRESENT:

Assemblywoman Maggie Carlton, Chair
Assemblyman Michael Sprinkle, Vice Chair
Assemblyman David P. Bobzien
Assemblyman John Hambrick
Assemblyman Pat Hickey
Assemblyman William C. Horne
Assemblywoman Marilyn K. Kirkpatrick
Assemblyman Randy Kirner

SENATE COMMITTEE MEMBERS PRESENT:

Senator Debbie Smith, Chair
Senator Ben Kieckhefer
Senator David R. Parks

STAFF MEMBERS PRESENT:

Michael J. Chapman, Principal Deputy Fiscal Analyst
Alex Haartz, Principal Deputy Fiscal Analyst
Laura Freed, Senior Program Analyst
Catherine Crocket, Program Analyst
Mark Winebarger, Program Analyst
Linda Blevins, Committee Secretary
Cynthia Wyett, Committee Assistant

Chair Carlton opened the hearing for public comment. There being none, she advised the Subcommittees the work session would cover certain areas of the Department of Health and Human Services.

Catherine Crocket, Program Analyst, Fiscal Analysis Division, Legislative Counsel Bureau, stated the first item for discussion was the consolidation of disability services in the Aging and Disability Services Division (ADSD). Ms. Crocket said the areas to be covered included:

1. Current environment.
2. Purpose and structure of consolidation.
3. Fiscal impact of consolidation.
4. Suggested benefits of consolidation.
5. Problems with consolidation.
6. Consolidation measures of success.

Under item 1, current environment, Ms. Crocket explained the Governor recommended consolidating the majority of existing disability services within the ADSD. To accomplish this, Developmental Services would be transferred from the Division of Mental Health and Developmental Services (MHDS). Additionally, Nevada Early Intervention Services (NEIS) would be transferred from the Health Division.

Within the Division of Health Care Financing and Policy (DHCFP), the Waiver for Independent Nevadans (WIN) provided home- and community-based waiver services for individuals with physical disabilities. Ms. Crocket noted that the Governor did not recommend transferring the WIN to ADSD; however, the agency intended to transfer the WIN in fiscal year (FY) 2018.

The Department of Employment, Training and Rehabilitation (DETR) provided employment training-related services to persons with disabilities. Persons blind or with other visual impairments were provided services through the Bureau of Services to the Blind and Visually Impaired, Rehabilitation Division. The Governor did not recommend transferring those services to the ADSD; however, Senate Bill 349 was proposing to transfer the Rehabilitation Division of DETR to the ADSD.

Under item 2, the purpose and structure of consolidation, Ms. Crocket explained that the agency believed the consolidation of disability services within ADSD would create a continuum of disability services to serve persons at all stages of life within one state agency. The agency pointed out that programs operated by ADSD, Developmental Services, and NEIS shared similar provider types and advocacy groups. The agency further stated that locating programs with these similarities within one division would create operational and service delivery efficiencies that would benefit clients, their families, and the Division operations.

The consolidation required transferring estimated funding of $4.7 million to ADSD. According to Ms. Crocket, there would be 30.51 full-time-equivalent (FTE) administrative, fiscal, and information technology positions transferred to the ADSD Federal Programs and Administration account [budget account (BA) 3151] from various MHDS and Health Division accounts to strengthen ADSD's administrative support services. In addition, five budget accounts which contained the service delivery components of disability service programs would be transferred to ADSD, including the transfer of the NEIS budget from the Health Division. Other budgets transferred from MHDS included: Family Preservation Program (BA 3166), Rural Regional Center (BA 3167), Desert Regional Center (BA 3279), and Sierra Regional Center (BA 3280).

The consolidation increased the ADSD funding from approximately $117.8 million for the 2013-2015 biennium (excluding consolidation efforts) to approximately $497.3 million, a 322 percent increase. Authorized FTE positions were estimated to increase 252 percent from 241 FTE to 848.56 FTE. The agency estimated 12,000 clients would receive services under the new division; however, the agency noted that clients would notice no changes with the consolidation because the majority of changes would be internal.

Under item 3, the fiscal impact of consolidation, the Governor recommended additional cost-allocation reimbursement funding totaling $437,002 in the 2013-2015 biennium to carry out the proposed consolidation. The increases were primarily related to unclassified salary increases, a position reclassification, moving costs, and additional office and computer equipment. Although the costs were included in the Governor's recommendation, Ms. Crocket noted the agency calculated the consolidation would generate a net General Fund savings of $196,501 in the 2013-2015 biennium as a result of cost-allocation adjustments. Although a net General Fund savings was anticipated, at the March 13, 2013, hearing the agency stated they were unable to project what the General Fund effect of the proposed consolidation would be in future biennia.

Under item 4, suggested benefits of consolidation, the agency believed the following benefits would be realized under the consolidated environment:

a. Creation of a continuum of care across the lifespan of clients. The agency believed this would promote easier access to services for clients and families and improve service coordination, service effectiveness, and improved access to community support and service information.

b. Creation of a single point of entry into the Division's disability service systems, called the "no-wrong-door" approach. The agency identified creation of an universal application for all aging services, NEIS, and developmental services to avoid client confusion and frustration with dissimilar application and eligibility processes. The universal application was projected to be in force by FY 2017. It was believed a single point of entry would lead to fewer transitions between programs, improve service coordination, provide timelier eligibility determinations, and increase customer satisfaction.

c. Development of a quality improvement program. The agency intended to develop a Divisionwide quality improvement program to align policies and procedures across programs, standardize intake and eligibility criteria, standardize data collection, and establish consistent provider and program oversight through standardized monitoring and service outcome evaluation.

d. Improvement of interagency communication. The agency suggested the current organizational structure of disability services within the DHHS divisions did not foster communication and data-sharing between ADSD, Developmental Services, and NEIS. The agency felt that transferring all programs into one division would remedy the problems.

Ms. Crocket described under item 5, issues with consolidation, the following problems associated with the consolidation:

a. It was uncertain whether consolidation was necessary to achieve stated benefits. It appeared to fiscal staff that many of the benefits could be achieved within the existing organization structure through improved interagency collaboration and communication. Given that ADSD, Developmental Services, and NEIS were all housed within one department under the governance of one director, it was not clear why the barriers identified could not be overcome.

b. The sufficiency of the current organization structure was a consideration. At the hearing on March 13, 2013, the Subcommittees requested the agency discuss any problems that could be resolved with the consolidation. The agency stated that the consolidation was not intended to solve problems but to create synergy to strengthen the program areas. The Subcommittees pointed out that constituents were generally happy with the disability services received.

c. The support of advocacy groups was discussed at the March 13, 2013, hearing. Testimony by the agency provided information that various commissions and stakeholders had been advised of the proposed consolidation. The agency said that the consolidation had been generally well received by the stakeholders.

d. At the March 13, 2013, hearing the agency provided a four-year consolidation time line that outlined milestones and dates for planned improvements for quality assurance programs, information technology, fiscal services, and human resources. The Subcommittees were concerned that the agency had not identified specific procedures to ensure that the consolidation time lines would be met.

e. There was a concern regarding the location of compliance and service delivery within one division. The proposed consolidation placed the Individuals with Disabilities Education Act (IDEA) Part C compliance office and the NEIS in the same division. The IDEA Part C performed compliance and monitoring of NEIS, while NEIS managed direct services and community provider contracts. Previously, the two functions were separated as a result of concerns regarding the lack of separation between the compliance and monitoring functions and the service-provision function. It was unclear what procedures would be put into place to ensure independence of the two functions.

f. The next concern was the information system compatibility. The ADSD, Developmental Services, and NEIS used a number of different information systems. In addition, the Governor recommended a one-shot General Fund appropriation of about $1.5 million to fund a new case-management system for Developmental Services. The agency stated that it intended to integrate their information systems in the future. It was unclear what the time line or associated cost would be for the integration.

Under item 6, the consolidation measures of success, the agency had not specified performance measures to provide information regarding the success and effectiveness of the consolidation. The ADSD had not indicated how agency-suggested benefits associated with the consolidation would be tracked and measured. According to Ms. Crocket, it was unclear what measurements could be used by the Legislature to evaluate whether the proposed consolidation was successful and could achieve the agency-suggested benefits associated with the consolidation.

Ms. Crocket pointed out there were four options the Subcommittees might consider at budget closings:

1. Approve the Governor's recommendation to consolidate Developmental Services and Early Intervention Services into the Aging and Disability Services Division.

2. Approve the Governor's recommendation to consolidate Developmental Services and Early Intervention Services into the Aging and Disability Services Division and transfer the IDEA Part C compliance office out of the Aging and Disability Services Division.

3. Approve part of the Governor's recommendation and transfer either Early Intervention Services or Developmental Services to the Aging and Disability Services Division.

4. Not approve the Governor's recommendation to consolidate Developmental Services and Early Intervention Services into the Aging and Disability Services Division.

It appeared to Chair Carlton that the consolidation did not resolve the problems. At the March 13, 2013, hearing the advocacy groups expressed concerns regarding consolidation of services.

Assemblyman Sprinkle voiced agreement with Chair Carlton. He believed that the problem was with communication throughout the ADSD. He did not see the need for consolidation but thought the communication barriers needed to be broken down. Several of his constituents had voiced disagreement with the consolidation.

Senator Kieckhefer agreed that communication in the agency appeared to be a major concern. He thought there was logic in having mission consistency within the Division and, in the case of disability services, a trifurcated system with some services in the Health Division, some in ADSD, and some in MHDS. The system did not bring everyone together to strategize over the best avenues for service delivery for clients who needed to be served in a consistent manner over their lifespan. Senator Kieckhefer thought that having those services within the same house was useful from a strategic standpoint as well as a communication standpoint. Having all of the division heads answer to one director seemed logical. He was unclear why a single application process could not be developed without the consolidation.

Chair Carlton also wondered whether a single application process could be developed without the consolidation. She had not heard any testimony from the agency that suggested consolidations were necessary for certain tasks to be performed. It appeared that some of the items discussed could be accomplished with open communication. Without proven net benefit to the state, Chair Carlton thought it better to move forward slowly.

Senator Kieckhefer did not disagree with Chair Carlton; however, he felt it was possible some services should be bundled.

Chair Carlton pointed out that all of the services were together in the past but had been split because it was believed the Division was too big.

Assemblyman Sprinkle commented that constituents were concerned about how the continuum of care would work and whether an individual would become "lost in the mix." He understood that consolidation might be more efficient; however, constituents were skeptical.

Senator Kieckhefer agreed with Assemblyman Sprinkle from the perspective of aging services. He felt there was legitimate fear that the aging services component of the Division could become "lost."

Chair Carlton noted there were questions regarding the application process and whether the universal application for ADSD could be put into operation prior to the projected FY 2017 date.

Jane Gruner, Administrator, Aging and Disability Services Division, Department of Health and Human Services, explained that the universal application was not scheduled to be put in effect before FY 2017 because of the information system. The proposal was for the application to be completed online.

According to Ms. Gruner, the Strategic Plan Accountability Committee had stated that many agencies had attempted to develop a universal application in the past. Unfortunately, there were so many requirements for each division of ADSD that the program had been abandoned. Ms. Gruner assured the Subcommittees that the ADSD was committed to bringing about the universal application to provide easy access to services for consumers.

Chair Carlton was concerned that an application with multiple components would be too long and frustrating for the average consumer. The purpose of the universal application was to avoid answering the same questions multiple times and to provide a short, comprehensive application form. Chair Carlton questioned whether the technology was preventing the process from being in place prior to FY 2017.

In response to Chair Carlton, Ms. Gruner stated that the universal application was in the process of being developed. Ms. Gruner advised that the working group was creating a template that would be shared with consumers and advocacy groups for their input.

Chair Carlton asked Ms. Gruner how many committees there were in the ADSD. Ms. Gruner answered that there were five major committees and many subcommittees.

Chair Carlton voiced concern regarding outreach to advocacy groups. The normal regulatory process consisted of workshops, open meetings, submission of written and oral comments, and the taking of minutes. The advocacy groups had complained there was not an opportunity to have a voice in the process. Chair Carlton asked Ms. Gruner what could be provided to the Subcommittees to share conversations with advocacy groups, to identify the groups, and to show whether written comments were received from the groups.

Ms. Gruner replied that the process was informal with invited public comments. She would provide the minutes of those meetings to the Subcommittees.

Assemblyman Sprinkle commented that the budget would soon be closed and that it was disconcerting to hear at this late date there was a working commission that could provide minutes. He believed the minutes should have been provided to the Subcommittees earlier to allow time for review and questions. Ms. Gruner stated that the minutes were available online for review.

Assemblyman Sprinkle pointed out that performance standards were also needed to determine whether this new process would be successful. Ms. Gruner pointed out there were performance standards provided in each section of the proposed budget. The performance standards for the consolidation would be developed if the plan was approved.

Assemblyman Hickey requested that Michael J. Willden, Director, Department of Health and Human Services, provide the Subcommittees with information regarding the pros and cons of the proposed consolidation of Developmental Services and Nevada Early Intervention Services (NEIS) into the ADSD.

Mr. Willden felt that staff had appropriately listed the benefits of the consolidation. He explained that when budgets were built in early 2012, he decided there was too much "ping-ponging" through the system for the clients. As an example, a child born into the Developmental Services system would be required to exit NEIS at age 3 and apply for services in one of the three regional centers. As the child matured, he would have to connect with the adult disability services. Mr. Willden believed that was a fragmented and disjointed

system; therefore, he wanted to move all of those services under a single division so all services could be integrated. In looking at the aging population, the problem became disabilities acquired as the population aged. It made sense to consolidate the services to better serve the clients.

In Mr. Willden's opinion, if the Legislature did not approve the ADSD integration, there would be a problem with the mental health and public health integration because the Division would become too large if disability services were moved back to public health. The Department was trying to accomplish four goals: integrate suicide prevention into public health, integrate all of the eligibility functions into welfare, integrate disability services into aging services, and integrate public health and mental health.

Assemblyman Hickey inquired whether Mr. Willden would characterize the proposal to consolidate one of greater efficiency and coordination or more as a fiscal benefit to the budget.

Mr. Willden stated that the primary goal was to create more efficiency for the client. While the services provided were generally underfunded, this proposal was not made in an attempt to benefit the budget.

Laura Freed, Senior Program Analyst, Fiscal Analysis Division, Legislative Counsel Bureau, provided information regarding the Nevada Early Intervention Services (NEIS) Governor-recommended budget and information gleaned since the hearing on March 7, 2013.

The Executive Budget recommended that the NEIS clinic expenditures be decreased by $102,124 in fiscal year (FY) 2014 and about $1.4 million in FY 2015. The community provider category would be increased by about $1.2 million and $5.6 million, respectively. According to Ms. Freed, the reason for the decrease was that in each month of the upcoming biennium, more caseload slots were to be transferred to community providers. By the end of FY 2014, the caseload split was expected to be 55 percent community providers and 45 percent NEIS clinics. By the end of FY 2015, the caseload split was anticipated to be 75 percent community providers and 25 percent NEIS clinics.

Ms. Freed reminded the Subcommittees that the state program would retain responsibility for the special children's clinics, the metabolic and genetic disorders clinics, vision clinics, child abuse referrals, and neonatal screening for

medically fragile children. Certain members of the NEIS staff would provide direct services predominately to the medically fragile portion of the caseload, while other staff members would provide quality assurance, standardization, and training for community providers. Community providers would conduct the majority of the specialized instruction and case management.

Ms. Freed noted that at the March 7, 2013, budget hearing, one of the discussion points was the cost to pay community providers versus the cost for NEIS clinics. The Governor-recommended budget was built on a capitated rate of $565 per slot per month, as opposed to $332.96 per slot per month for state-contracted therapists. The cost for community providers was different than for children served by state staff. The state rate included operating overhead and other services provided to children that were not part of the caseload for Individuals with Disabilities Education Act (IDEA) Part C. The other services provided by state staff that were not a part of the projected caseload included:

- 100 percent of all initial referral calls.
- Management of the community provider agreements.
- Approval of all invoices for Individualized Family Service Plan (IFSP) services provided by community providers.
- Special children's clinics for metabolic disorders and craniofacial genetics.
- Follow-up for newborn screening and for newborn hearing results.
- Vision clinics.
- Childcare facilities training on continuity of care to children so a child received the same intervention in both home and daycare environments.
- Review of child abuse referrals for children ages 0 to 3 to determine if they have intervention needs resulting from abuse.
- Hospital screening and monitoring for newborns in the neonatal units.

According to Ms. Freed, three separate rates could be considered; the $565 per slot per month rate paid to community providers; the $332.96 per slot per month rate for category 12 expenditures for state-contracted specialists; and the state personnel costs and other operating costs related to maintaining the NEIS clinics. Because of these overhead costs, the average monthly cost of serving children was budgeted significantly higher than the $565 capitated rate paid to community providers.

Ms. Freed explained that the Subcommittees were concerned that the developmental specialists employed by NEIS would be reassigned to quality assurance and measurement duties. In discussions with DHHS subsequent to the March 3, 2013, budget hearing, information was provided specifying 16.5 developmental specialist positions would be moved to the quality assurance role, while 86 developmental specialists 3 and 4 positions would continue to provide direct instruction for the family receiving services. The DHHS also advised staff that the developmental specialists performing quality assurance activities would continue to be a part of the multidisciplinary IFSP team and would evaluate the progress of the child and the family throughout the process, but would not provide direct instruction.

Ms. Freed advised the Subcommittees that the medically fragile caseload was broken into two subsets: the medically fragile children requiring critical care (1:12 caseload ratio) and the medically fragile children who did not require critical care (1:25 caseload ratio). For nonmedically fragile children, the ADSD believed the caseload ratio should be 1:50. Using the ratios provided by ADSD, Fiscal Analysis Division staff calculated the number of developmental specialists required in the base budget to provide direct services to children. Of the 88.51 full-time-equivalent (FTE) developmental specialist 3 positions authorized in BA 3208, Fiscal staff calculated that 75.68 FTEs were needed to handle the caseload projected for the three ratios when the caseload was split 50/50 by the end of FY 2013. The ADSD had advised there were 73 FTE developmental specialist 3 positions dedicated to clinic services, creating a deficit of 2.68 FTEs with the 50/50 split. The ADSD noted the goal was to improve the ability of community providers to serve medically fragile children so that NEIS clinics would not retain that portion of the caseload in future biennia.

Ms. Freed informed the Subcommittees that depending on the decision regarding the percentage of the total caseload to move to community providers, she would prepare closing documents with costs and staffing information. If the Subcommittees agreed with the 50/50 caseload split, there would be General Funds added for staffing.

When discussing the viability of changing the service model and future measures of success, Ms. Freed stated that it was difficult for the Fiscal Division to conclude whether shifting the caseload could be accomplished within the 2013-2015 biennium. Aging and Disability Services Division (ADSD) stated that provider capacity existed in "pockets." She believed ADSD had a well-developed plan showing both the time line for developing additional

capacity and the plans for standardizing quality of community provider services. Although the ADSD plans appeared well-established, development of qualified and willing community providers, especially in rural areas, might not occur quickly enough for the waitlist to be eliminated, even with sufficient funding to pay therapists.

Ms. Freed noted that from a fiscal perspective, it was less expensive on a per-child basis for community providers to perform specialized instruction than to have state staff provide instruction. Moving to a capitated rate provided budgetary stability. It was easier to budget for two years at a time if the agency knew how much it would spend on each child. However, if the NEIS clinics retained the medically fragile portion of the caseload at a lower client-to-staff ratio, there might not be any savings realized, and it could be difficult to develop the provider capacity to serve the medically fragile children over the 2013-2015 biennium.

Ms. Freed advised the Subcommittees there were three options for consideration in budget account 3208:

1. Approve the Governor's recommendation to transition 72 percent of the NEIS caseload to community providers by the end of FY 2015.

2. Amend the Governor's recommendation to slow the transition of caseload to community providers.

3. Amend the Governor's recommendation to continue with a 50/50 split of total caseload between the NEIS clinics and the community providers for the 2013-2015 biennium.

Chair Carlton asked for additional information regarding what the state provided versus what was provided by the community providers. She was concerned that if a community provider was unable to accept a child, the child was returned to the state's care.

Ms. Freed responded that a hypothetical example would be that when a child came into NEIS, a developmental specialist completed an intake evaluation looking for markers of developmental delays. If the child exhibited a delay, a multidisciplinary team was put together based on the developmental specialist's determination. The child would be evaluated by the early intervention doctor to ensure there were no medical problems causing the

developmental delays. The child must have a 50 percent delay in one area or a 25 percent delay in two or more areas to qualify for NEIS. Federal regulations required that the Individualized Family Service Plan (IFSP) must be completed within 45 days, and state policy required that all services should be commenced 30 days after the completion of the IFSP.

According to Ms. Freed, at this stage there was a waiting list. The child could receive one or more services within the 30-day window; however, they could not get all of the services completed within the 30-day window.

Once the multidisciplinary team finished its work, the family was given a choice of receiving services from NEIS clinics or from community providers. Ms. Freed said that if the family did not choose a provider, they would be assigned to an available slot. The state became the backup provider.

Senator Smith requested agency staff provide information regarding why there had been considerable input and involvement from the northern Nevada physicians but little from southern Nevada. She was also curious how processes were operationally different between northern and southern Nevada.

Tracey Green, M.D., Statewide Medical Program Coordinator, Mental Health and Developmental Services, State Health Officer, Department of Health and Human Services, answered that it seemed there had been more coordination with the physicians in southern Nevada in regard to the way the current staff physicians worked with the community physicians. There were more physicians in southern Nevada and more knowledge regarding working with staff physicians at NEIS. Dr. Green stated that DHHS was working on the lines of communication with the northern Nevada physicians.

Assemblyman Sprinkle liked the idea that with the transition to community-based services, DHHS was looking at the quality assurance positions and staff who could see the effects of not only what the state was providing but also what community services was providing. In his opinion, the decision was whether to increase the split of the NEIS caseload for community providers to 75 percent or continue with the 50/50 percent split.

Chair Carlton affirmed Assemblyman Sprinkle's statement. It would be a 50/50 split with an expansion on top. Her concerns were whether the community providers were capable of picking up the extra 25 percentage points of caseload. She was uncertain whether the state would have to come back in

two years and pull the medically fragile children out of their provider situation. She believed that it was important to ensure the 50/50 caseload split worked for the children and their families. The 25 percentage point increase was large considering that the state would still have to be there. Sustainability was always a problem, especially with nonprofit organizations, and the children must be protected. Chair Carlton was uncertain whether there were enough employees to monitor the programs and whether audit problems had been rectified.

There being no additional comments, Chair Carlton asked to move to the discussion of the Division of Mental Health and Developmental Services (MHDS) consolidation.

Mark Winebarger, Program Analyst, Fiscal Analysis Division, Legislative Counsel Bureau, presented an overview of the Mental Health/Public Health consolidation. The Mental Health section of MHDS provided inpatient services at the Rawson-Neal Psychiatric Hospital in Las Vegas and the Dini-Townsend Psychiatric Hospital in Sparks. Mental Health provided outpatient counseling services and various other related services throughout the state. Additionally, the Mental Health section was responsible for Lakes Crossing Center, the state's only facility for mentally disordered offenders and the Substance Abuse and Prevention Treatment Agency, which planned and coordinated statewide substance abuse services.

The Health Division had four bureaus designed to protect the health of Nevadans and visitors to the state. Mr. Winebarger explained that the Division was responsible for enforcing health laws and regulations promoting public health and education, investigating causes of diseases, and providing direct public health services in Nevada's rural counties. The Administrator of the MHDS was also acting as the Administrator of the Health Division, and the state medical director was acting as the State Health Officer.

Mr. Winebarger pointed out that the Governor recommended the consolidation of the mental health agencies of the Division of MHDS with the Health Division to create the Division of Public and Behavioral Health. Each mental health and Health Division budget account, except the Nevada Early Intervention Services (NEIS) budget account, would remain intact in the new division. The Department of Health and Human Services (DHHS) indicated that creation of the new division modeled a holistic healthcare approach that integrated services addressing both body and mind—treating an individual as a whole person.

Mr. Winebarger said that by using a public health model for mental health matters, the agency believed it could provide services and identify needs that would aid in preventing negative and costly outcomes. As an example, the agency noted the approach was used in jails to initiate follow-up mental health treatments and medications while the client was incarcerated. Prior practices of waiting for the individual to be released before initiating contact often resulted in delays in receiving medication and follow-up services.

According to the agency, a benefit of reorganization was colocating public health and mental health services in rural areas creating a single point of entry in the community. Mr. Winebarger stated that currently there were colocated services available in Carson City and they would be available in Dayton. The agency indicated that it would evaluate all public health nursing clinics and mental health clinics in rural Nevada to determine if the communities would benefit from this model. Because efforts were underway for colocating services, it was unclear to staff why this could only be achieved through the proposed reorganization.

Mr. Winebarger added that the agency stated that standardization of services and practices was a significant benefit of integrating public and mental health. As examples of standardization, the agency noted that the redesign of policies and procedures in the following areas had already begun: medical clearance needed prior to providing mental health services; caseload management; and mental health courts. It was unclear to Fiscal Analysis Division staff why standardization of services could only be achieved through the proposed reorganization.

Should the consolidation be approved, the agency proposed fiscal management standardization. According to Mr. Winebarger, consolidation would result in a centrally located fiscal grants-management team led by a management analyst 4 position requested in budget account (BA) 3168, decision unit Enhancement (E) 225, the MHDS Administration account. The fiscal grants-management team appeared to be the only organizational change in the consolidation effort.

Mr. Winebarger further noted that the four positions recommended for the Health Division (BA 3223) added cost-allocation revenues of $117,074 over the 2013-2015 biennium. The two positions recommended in the MHDS Administration account (BA 3168) added $221,730 in General Funds over the biennium. Several reclassifications in the Health Division resulted in

General Fund savings of $131,405 over the biennium with a net increase of $90,325 over the biennium. No other costs or savings related to the reorganization had been identified.

Mr. Winebarger pointed out that it was difficult for Fiscal Analysis Division staff to evaluate the Department of Health and Human Services' proposal to consolidate public health services and mental health services within one division. First, there were no apparent cost savings directly attributable to the consolidation. The new grants-management positions for the MHDS Administration account (BA 3168) were primarily recommended for public health grants management. It appeared that regardless of the recommendation for consolidation, those positions would have been recommended to address the Health Division's workload.

Mr. Winebarger stated that while the client service benefits of consolidation previously stated may be realized, the Fiscal Analysis Division did not see reorganization as a necessary condition for achieving those benefits.

Mr. Winebarger noted that the option for the Subcommittees to consider at budget closing would be:

1. Approve the Governor's recommendation to eliminate the Health Division and the Division of Mental Health and Developmental Services and approve the creation of the Division of Public and Behavioral Health within the Department of Health and Human Services.

2. Do not approve the Governor's recommendations and maintain the current Department of Health and Human Services structure with mental health budget accounts housed in a different division than the public health budget accounts.

Chair Carlton commented that earlier discussions on the consolidation of disability services within the Aging and Disability Services Division were also relevant to this proposed reorganization. She likened the reorganization and consolidation to a "double jump" in checkers. If the state did not take the "double jump" and some options were approved but other options were not, she was uncertain how the reorganization would work for the state. Chair Carlton was certain more information was needed to explore the variables of the options available and how everything would fit together.

Senator Kieckhefer pointed out that it appeared logical that the services should be housed together. A leadership team with a consistent mission would more effectively and efficiently steer an organization.

Assemblyman Sprinkle was uncertain why the standardizations could not be accomplished without completely reworking the structure of DHHS. He did not believe all of the changes were necessary to accomplish the goals. He suggested that the changes could be instituted incrementally rather than all at once. The legislators could work during the interim to develop a plan of action.

Senator Smith was concerned that the Legislature was not involved in the proposed reorganization and consolidation until the DHHS had the plan in place. The legislators were put into an awkward position. If the legislators did not agree with the proposal, the DHHS would have to "dial back" and undo some of the options that had been put into place. The legislators should have had the information in advance to review the criteria, goals, and performance measures. Senator Smith had been given information from agency staff that the proposal was a "done deal" and a "forgone conclusion." It was troubling to Senator Smith for the Legislature to have been left out of the decision-making process. The "domino effect" was concerning because she felt it was not possible to make one decision without affecting other areas of the proposal.

Chair Carlton wondered whether some of the decisions regarding the consolidation and reorganization should have been made at the policy committee level. Many of the problems appeared to be policy-driven. Agreeing with Senator Smith, Chair Carlton was uncomfortable with allowing the rearrangement and having a massive effect on the clients. The task for these Subcommittees was to examine the service and health issues within the policy jurisdiction.

Senator Smith was empathetic with the agencies. The Legislature was in session for a short time and she understood that was a problem for the agencies; however, she felt the decision-making process in this case was backwards.

Assemblyman Hambrick believed that some of the committees thought the term "Gov Rec" meant the Governor was the author of the proposal. He suggested that the term be changed to "Governor's Buy-In" because the Executive Branch staff prepared the documents. Assemblyman Hambrick commented that it was

difficult when partisanship labels were put on issues. He believed rather than referencing "The Governor," documents should reference "A Governor" to remove any partisanship. He agreed that the decisions should have been made at the policy committee level.

Chair Carlton opined that she saw no partisanship in the plan. The term "Gov Rec" was used to specify documents. When she heard "Gov Rec" she knew to reference the Governor's budget. She did not associate the budget with a person or a party. The term was used for clarity purposes. The discussions regarding the consolidation and reorganization were to ensure the clients received the best and most efficient services.

Assemblyman Hickey appreciated the discussions that had occurred on the proposed reorganization and consolidation in DHHS. He agreed with Senator Smith that the legislators only being in session every two years could be a problem for the agencies. The agencies had to prepare proposals during the interim to present to the Legislature, then wait two more years to carry out the plan. He appreciated how difficult it was for the agencies.

Senator Kieckhefer suggested that if agencies did not plan during the interim, the legislators would tell the agencies the plan was not well thought out. Not all agency plans could wait four years for approval.

Chair Carlton understood the predicament of the agencies, but serving on the Committee on Assembly Health and Human Services, she would have been interested to know the reorganization and consolidation discussions were occurring. She agreed that being in session for four months every two years was difficult for the agencies. Although the position of a legislator was called "part-time" the members worked on problems every day and were available to the agencies and the constituency.

There being no additional comments, Chair Carlton asked Mr. Winebarger to move to the next item.

Mark Winebarger, Program Analyst, Fiscal Analysis Division, Legislative Counsel Bureau, explained the next item for discussion was the closing of the downtown Las Vegas outpatient clinic and the establishment of a 24-hour urgent care mental health center at Southern Nevada Adult Mental Health Services (SNAMHS) (BA 3161, decision unit Enhancement (E) 226 and E-227) as recommended by the Governor. The move would allow SNAMHS to provide

medical clearance and urgent care mental health services to divert individuals from emergency rooms. It would also provide quicker access to inpatient and outpatient psychiatric services by colocating medical clearance and urgent care programs. The Governor recommended approximately $1 million over the 2013-2015 biennium for two senior psychiatrists and two accounting assistants to help with increased caseload and expanded operating hours. Closing the downtown clinic was projected to offset the costs by $721,174 over the biennium.

In addition to transferring the 13 current downtown clinic staff to the SNAMHS West Charleston campus, Mr. Winebarger stated the agency intended to transfer positions from other clinics and fill current vacant positions as additional shifts and weekend services were added. The agency projected transfer of the downtown clinic staff to SNAMHS before August 31, 2013. The agency anticipated weekend services would begin by December 2013, evening hours by March 2014, and 24-hour operation by March 2015.

To operate a 24-hour urgent care mental health center, the Governor recommended additional General Fund appropriations of $600,000 for the 2013-2015 biennium to allow SNAMHS to contract additional psychiatric services (budget account 3161, decision unit E-227). Mr. Winebarger noted that after determining a 24-hour urgent care mental health center was needed, SNAMHS conducted an analysis and concluded that the downtown clinic was the best choice for closure. The Southern Nevada Adult Mental Health Services (SNAMHS) met with stakeholders to solicit feedback relating to the closure of the downtown clinic.

According to Mr. Winebarger, the agency stated that the overall feedback was positive, although some individuals who received services from the downtown clinic, family members, and advocacy organizations expressed concern. The agency noted it was committed to collaboration with community stakeholders and employees and that a weekly implementation meeting would be held to allow stakeholders ongoing input and feedback.

The two options for the Subcommittees' consideration at budget closing were:

1. Approve the closure of the downtown clinic and approve the relocation of its staff to the SNAMHS campus on West Charleston Boulevard in Las Vegas and operate a 24-hour urgent care mental health center.

2. Do not approve the closure of the downtown clinic, the relocation of the staff to the SNAMHS campus on West Charleston Boulevard in Las Vegas, and the operation of a 24-hour urgent care mental health center.

Assemblyman Horne was unconvinced the closure of the downtown clinic would be beneficial. He requested additional information from the Department of Health and Human Services (DHHS). It seemed that the 24-hour urgent care mental health clinic was physically located a significant distance from hospital services.

Tracey Green, M.D., Statewide Medical Program Coordinator, Mental Health and Developmental Services, State Health Officer, Department of Health and Human Services, explained there were a number of criteria used to determine which of the clinics to move. When the downtown clinic was selected, the primary consideration was the number of clients who resided in the area. This was determined by zip code. There were 664 clients who were served at the downtown clinic on a walk-in basis. When the zip codes of those clients were studied, less than 100 of the clients lived in the area. The clinic was used by the clients because of the walk-in service, not the location. The walk-in service was available in all of the DHHS clinics. The second criterion was accessibility to University Medical Center (UMC) of Southern Nevada. It was hoped that with the opening of the mental health urgent care center, the clients that would have received services from UMC would use the Rawson-Neal Psychiatric Hospital. There was 24-hour bus service from the downtown clinic to the Rawson-Neal Psychiatric Hospital. Additionally, there was fiscal criteria including the ability to lease on a month-to-month basis and the availability of physicians trained in urgent care.

Assemblyman Horne inquired whether the physicians at the downtown clinic were trained in urgent care rather than psychiatric services. Dr. Green responded that the physicians were psychiatrists, but the primary way they had been seeing clients was on a walk-in basis similar to an urgent care model. The other clinics were run on an appointment basis.

Assemblyman Horne asked the hours of operation for the urgent care mental health clinic. Dr. Green noted that the urgent care mental health clinic would begin operations with the same hours as the downtown clinic. Based on the hiring process, the hours would be expanded over a year to a 24-hour urgent care mental health clinic.

In response to Assemblyman Horne's question regarding decreasing the service hours, Dr. Green explained that there were no downtown clinic hours in the evening hours; therefore, the clients would receive the same level of service as when the downtown clinic was open. The downtown clinic was an 8 a.m. to 5 p.m. clinic. Clients needing service prior to the closure of the downtown clinic would receive the same level of service they were receiving currently. If the client went to UMC for services and required transfer to Rawson-Neal Psychiatric Hospital, with or without the closing of the clinic, the client would receive the same level of services.

Chair Carlton confirmed with Dr. Green that this was for the medical clearance portion. The goal was to keep people out of the emergency room for medical clearances before they went to Rawson-Neal Psychiatric Hospital.

Assemblyman Sprinkle believed in the concept of keeping the psychiatric clients out of the emergency rooms. He asked whether the 24-hour urgent care mental health clinic would be a receiving facility for emergency medical services.

Dr. Green confirmed there would be an ambulance bay and a secured area. The facility could receive both ambulance and police transport.

There being no further questions or comments from the Subcommittees, Chair Carlton opened the work session for public comment.

Dan Musgrove, representing West Care of Nevada, the Valley Health System, and the City of North Las Vegas, expressed support for the consolidation plan. He testified that the consolidation had been discussed in many sessions. It was difficult to wait for the legislative sessions every two years to discuss consolidating or reorganizing programs. He was aware that it was difficult for the Legislature to understand the agency moving forward with planning during the interim. He believed it was important for the integration to be approved.

Barry Gold, representing AARP Nevada, expressed concern regarding the possibility of aging services being lost in the reorganization. He was hopeful there was opportunity for the older Nevadans to provide input. While it was not directly related to the integration, AARP Nevada was pleased that in the Governor-recommended budget there was money for increases in the number of Home- and Community-Based Services (HCBS) waivers.

Keith Uriarte, representing American Federation of State, County and Municipal Employees (AFSCME) -Local 4041, referenced Exhibit C, email from Jane Gruner dated April 4, 2013, regarding Nevada Early Intervention Services. He believed there were many questions to be answered before moving forward with the reorganization. He asked the Subcommittees to remember that the children were at stake.

Ed Guthrie, Executive Director, Opportunity Village, stated that the integration of developmental services was not a good fit with mental health services. The needs of clients receiving mental health services were different from the clients with intellectual disabilities. The existing arrangement was not necessarily the best arrangement for individuals with developmental disabilities.

Mary Liveratti, member of the Nevada Commission on Autism Spectrum Disorders, Department of Health and Human Services (DHHS), testified that the Commission supported the consolidation of disability services within the Aging and Disability Services Division. She stated that the autism families struggled between the three agencies. There had been autism programs under Disability Services, under Early Intervention Services, and under the Autism Treatment and Assistance Program (ATAP) at Aging and Disability Services. She was aware there had not been consistency with the services. Therefore, she believed there was a benefit in bringing the services together to better serve clients and their families.

Ms. Liveratti also expressed concern that there was not sufficient administrative staff for the ATAP. The Commission was dependent on the data collected by ATAP but there was not staff available to analyze and oversee the data. There needed to be more focus on quality assurance in the autism programs.

Connie McMullen, Chair, Strategic Plan Accountability Subcommittee, Nevada Commission on Aging, stated that there were concerns regarding the senior community not being given full attention with the proposed consolidation. Because of the growing senior population there was a greater need for services.

Bruce Arkell, representing Nevada Senior Advocates, was involved when mental health and developmental services were integrated in the 1970s. According to Mr. Arkell, concerns expressed at that time were similar to those expressed at this work session. Mr. Arkell suggested that legislators should be involved in the strategic planning process during the interim.

Assemblyman Hickey said that staff had indicated that there had been buy-in for the consolidation by various advocacy groups and stakeholders. He believed the advocacy groups testified in support. He asked Mr. Arkell if that was also his belief.

Mr. Arkell felt there was agreement with the concept, but concern with the process and the effect on the constituent groups. In his opinion, it would be up to the legislators to develop the budget and the policies. The next two years were critical to shaping the proposal.

There being no additional comments or questions, Chair Carlton adjourned the hearing at 10:11 a.m.

RESPECTFULLY SUBMITTED:

_____
Linda Blevins
Committee Secretary

APPROVED BY:

_____
Assemblywoman Maggie Carlton, Chair

DATE: _____

_____
Senator Debbie Smith, Chair

DATE: _____

EXHIBITS

Committee Name: Committee on Ways and Means

Date: April 9, 2013 **Time of Meeting: 8:12 a.m.**

Bill	Exhibit	Witness / Agency	Description
	A		Agenda
	B		Attendance Roster
	C	Keith Uriarte, AFSCME, Local 4041	Email from Jane Gruner