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

Eighty-first Session
March 5, 2021

The joint meeting of the Subcommittees on Human Services of the Senate Committee on Finance and the Assembly Committee on Ways and Means was called to order by Chair Julia Ratti at 8:02 a.m. on Friday, March 5, 2021, Online. Exhibit A is the Agenda. All exhibits are available and on file in the Research Library of the Legislative Counsel Bureau.

SENATE SUBCOMMITTEE MEMBERS PRESENT:

Senator Julia Ratti, Chair
Senator Marilyn Dondero Loop
Senator Ben Kieckhefer
Senator Scott Hammond

ASSEMBLY SUBCOMMITTEE MEMBERS PRESENT:

Assemblywoman Daniele Monroe-Moreno, Chair
Assemblywoman Teresa Benitez-Thompson, Vice Chair
Assemblywoman Maggie Carlton
Assemblyman Jason Frierson
Assemblyman Tom Roberts
Assemblywoman Robin L. Titus
Assemblywoman Jill Tolles
Assemblyman Howard Watts

COMMITTEE MEMBERS ABSENT:

Senator Nicole J. Cannizzaro (Excused)

STAFF MEMBERS PRESENT:

Alex Haartz, Principal Deputy Fiscal Analyst
Brody Leiser, Principal Deputy Fiscal Analyst
Kimbra Ellsworth, Program Analyst

Tom Weber, Committee Secretary
Joko Cailles, Committee Secretary

OTHERS PRESENT:

Dena Schmidt, Administrator, Aging and Disability Services Division, Department of Health and Human Services
Sara Cholhagian, Executive Director, Patient Protection Commission, Office of the Governor
Jeff Haag, Deputy Administrator, Human Resources, Information Technology and Fiscal Services, Aging and Disability Services Division, Department of Health and Human Services
Rique Robb, Deputy Administrator, Aging, Physical Disabilities and Children's Services, Aging and Disability Services Division, Department of Health and Human Services
Robin Hager, Administrative Services Officer, Aging and Disability Services Division, Department of Health and Human Services
Jennifer Frischmann, Quality Assurance Manager, Aging and Disability Services Division, Department of Health and Human Services
Barry Gold, AARP Nevada
Kimberly Glass
Misty Grimmer, Nevada Alzheimer's Association
Robert Burns, President, Therapy Management Group; Early Intervention Community Providers Association
Lisa Foster, State of Nevada Association of Providers
Steven Cohen
Connie McMullen, Personal Care Association of Nevada
Mark Gibson
Deacon Tom Roberts, President and CEO, Catholic Charities of Southern Nevada
Lisa Allen

CHAIR RATTI:
We will hear budget accounts from the Aging and Disability Services Division (ADSD) of the Department of Health and Human Services (DHHS).

DENA SCHMIDT (Administrator, Aging and Disability Services Division, Department of Health and Human Services):
The Aging and Disability Services Division's presentation is (Exhibit B).

Page 1 of Exhibit B shows the ADSD's mission statement.

Page 2 of Exhibit B outlines the ADSD's goals.

In 1999, the United States Supreme Court handed down its *Olmstead v. L.C* (98-536) 527 U.S. 581 (1999), decision. The goals listed on page 2 of Exhibit B were established as part of the DHHS's *Olmstead v. L.C.* integration plan. The focus of the plan is on integration, quality of care, self-determination and dignity for the Nevadans who the ADSD serves and supports.

Page 3 of Exhibit B shows the ADSD's organizational chart. The green boxes on Page 3 of Exhibit B represent proposed changes to the ADSD's organization. The changes include the transition of the Office for Consumer Health Assistance, the Nevada 2-1-1 Program and the Patient Protection Commission (PPC) to the ADSD. These transitioned services would comprise a new Consumer Health Advocacy and Protection Unit within ADSD. More information on these changes is provided later in the presentation.

Page 4 of Exhibit B shows the number of total staff positions in the ADSD divided by budget accounts. The Executive Budget recommends the ADSD add 25 staff positions over the 2021-2023 biennium.

Page 5 of Exhibit B includes a summary of the ADSD's budget accounts. Our budget is mostly caseload-driven. We have 26 different programs within the ADSD with a variety of structures. Some programs provide direct services to communities. Other programs use a shared model where the DHHS provides services alongside community partners. There are also programs that are primarily run by community partners, but receive ADSD funding, oversight and technical assistance.

The largest programs in the ADSD are our Medicaid Home and Community-Based Waiver (HCBW) programs. Several of our direct service programs have federal mandates for waitlists and service delivery. Other programs are authorized by statute and allow for services to be provided as funds are available.

Page 6 of Exhibit B shows ADSD's budget by funding source.

Page 7 of Exhibit B summarizes the Patient Protection Commission's budget account (B/A) 101-3055.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

AGING AND DISABILITY SERVICES DIVISION

Patient Protection Commission — Budget Page DHHS-ADSD-91 (Volume II)
Budget Account 101-3055

Decision units E-500 and E-900 in B/A 101-3055 transfer the PPC to the ADSD from the Office of the Governor B/A 101-1000 and its reciprocal decision unit E-900.

E-500 Adjustments to Align Revenue Sources — Page DHHS-ASDS-91
E-900 Transfer from Governor's Office to ADSD — Page DHHS-ASDS-91

ELECTED OFFICIALS

GOVERNOR'S OFFICE

Office of the Governor — Budget Page ELECTED-8 (Volume I)
Budget Account 101-1000

E-900 Transfer from Governor's Office to ADSD — Page ELECTED-10

The transfer of the PPC to the DHHS is focused on aligning the PPC with other patient advocacy services in the State. Several programs related to patients' healthcare needs are provided by the ADSD. These include the Long-term Care Ombudsman program, Adult Protective Services (APS) program, the Office for Consumer Health Assistance, Community Advocates program, the HCBW programs and Nevada Care Connection Resource Centers.

The transfer is not intended to change the actual activities of the PPC. Rather, the transfer provides the PPC with a variety of resources and support structures to further its mission. These include access to national organizations that provide research and technical assistance, as well as resources in support of collaboration across DHHS. The ADSD is working to establish cross-divisional expertise to advance health outcomes and reduce health disparities in all areas.

ASSEMBLYWOMAN CARLTON:
Whenever we do something for the first time, we see what we put together and hope it works. I think the PPC has done a good job with the framework legislators established through Senate Bill (S.B.) No. 544 of the 80th Session. The PPC has been working hard.

I submitted Bill Draft Request (BDR) 40-497 in October 2020 because I anticipated PPC may require legislative changes.

BILL DRAFT REQUEST 40-497: Revises provisions governing the Patient Protection Commission.

After a program is initially implemented, we get to see what works and what needs improvement. Legislators can offer adjustments where needed. I am talking to stakeholders about possible changes to the PPC with BDR 40-497.

There have been several conversations about the Office of Data Analytics being under the DHHS Director's Office. The Office of Data Analytics and the PPC share the priorities of analyzing State healthcare data and addressing healthcare needs. Could there be conversations about the PPC possibly ending up in the Director's Office of the DHHS?

MS. SCHMIDT:
Yes, there is always room for those conversations. I would note the Director's Office of the DHHS provides administrative oversight. The ADSD can provide the PPC resources such as staffing and information technology (IT) support. Even though ADSD is one of the divisions within DHHS, the ADSD works across the DHHS on all issues. We have several committees and groups that work across the DHHS. Aligning the PPC with the ADSD does not change the PPC's focus on the whole State.

We are open to conversations on moving the PPC to the Director's Office. It is important to note the Director's Office sometimes has limited resources compared to other DHHS divisions.

ASSEMBLYWOMAN CARLTON:
This conversation stems from the fact the Office of Data Analytics is in the Director's Office. The Commission focuses on healthcare data in Nevada. Their functions mesh together well. We will continue these conversations.

I want to ensure we give the PPC the statutory authority it needs to perform its duties. No matter where the PPC ends up in the DHHS, it needs to be able to perform its functions. Is there anything that has arisen in the PPC that legislators need to be aware of? Are there changes that need to be made?

MS. SCHMIDT:
There is nothing I am aware of. Commission Executive Director Sara Cholhagian has spoken about how much support the DHHS has provided the PPC. This is one of the reasons the PPC is being transferred to the ADSD.

SARA CHOLHAGIAN (Executive Director, Patient Protection Commission, Office of the Governor):
I will always advocate for the PPC to receive more resources. The Covid-19 pandemic had unprecedented effects on Nevada, and the PPC has been particularly affected. Department Director Richard Whitley and his office provided much support for the PPC as it was being established. The PPC would not have been able to hit the ground running as fast as it did without the Director's Office's support.

The PPC was able to hold two meetings before the pandemic hit. The pandemic caused a hiring freeze. Due to the hiring freeze, the PPC was not able to fill the policy analyst position that will help facilitate its work. The Executive Budget recommends funding for the policy analyst position be maintained. I believe the PPC will be able to fill that position as soon as July 1, 2021.

The PPC received $25,000 for consulting services, which is not an insignificant amount of funding. That said, I could recommend more money be allocated for consulting services if possible. Extra funding would allow PPC to attain additional technical assistance that may not be immediately available to it through internal staff positions or the ADSD.

I will advocate for the PPC to receive as many resources as it can.

ASSEMBLYWOMAN CARLTON:
The PPC has done a wonderful job, considering what it faced during the pandemic.

The State has always made healthcare decisions based on anecdotes. That needs to stop. Nevada needs an entity that focuses on healthcare data. That is where the PPC really comes in. We might have misnamed the PPC; it may need to be renamed. We need healthcare data so we can reduce barriers to access and help patients get the health care they need.

I will be reaching out to the PPC's members. I am finalizing the points of BDR 40-497. For the record, we are working on changes. The PPC will do good things in the future. I want to make sure the PPC has all the resources it needs.

MS. CHOLHAGIAN:
I appreciate Assemblywoman Carlton mentioning patients. In the past year, the PPC has not seen as much active patient participation as it would like. That may be due to the pandemic environment.

Engaging patients takes a lot of work. It requires marketing to Nevadans. The PPC did the best it could during the past year. I encouraged the PPC's members to engage in patient outreach. The PPC included a patient portal on its website. All of the PPC's meetings were held publicly; 11 public meetings were held last year.

In my opinion, our patients' voices were limited due to lack of engagement and participation. If the PPC had more resources available for advocacy services, it would be better positioned to help the public know it exists and wants to hear from patients. I hope legislators consider that.

CHAIR RATTI:
Regardless of whether the PPC is located in the ADSD or the Director's Office, transitioning it to the DHHS could help connect it to patients and Nevada residents.

MS. SCHMIDT:
The ADSD hosts several independent commissions and boards. These include the Commission on Services for Persons with Disabilities, the Nevada Commission on Aging, the Nevada Statewide Independent Living Council and the Nevada Assistive Technology Council.

The Office for Consumer Health Assistance collects much data that provides perspectives on what patients are seeing and what their healthcare experiences are. The data helps us see in which counties patients are accessing health care. With the transition of the Office for Consumer Health Assistance and other organizations into the Consumer Health Advocacy and Protection Unit, I believe THE ADSD can help PPC by providing critical information.

CHAIR RATTI:
We need to look at patient perspectives with both data and voices. Is the PPC looking at actual human stories as well as numbers?

MS. SCHMIDT:
Yes. Both are critical.

ASSEMBLYWOMAN TITUS:
I am concerned about the actual interactions between these different boards and commissions. Are the boards and commissions all functioning in different silos? Is there an opportunity for us to put the boards and commissions under one section where they can effectively communicate with each other? We are trying to gather data. We are trying to ensure we have patient perspectives.

Is "Patient Protection Commission" the correct term for the PPC? Have you protected patients? Have you identified areas where patients are not being protected? That is what the name of the PPC suggests, in contrast to healthcare needs and accessibility.

I know you have four BDRs, and you have presented them to us. Could you remind me what those four BDRs involve? Do they involve actually protecting patients?

MS. CHOLHAGIAN:
The PPC submitted two bills, S.B. 5 and S.B. 40. The bills are scheduled to be heard by the Senate Committee on Health and Human Services on March 9, 2021.

SENATE BILL 5: Makes changes relating to telehealth. (BDR 40-416)

SENATE BILL 40: Provides for the collection of certain data relating to health care. (BDR 40-515)

These bills will benefit patients. They are based on the principles of increased access and quality. Senate Bill 40 deals with transparency. It is meant to enhance patients' healthcare experiences and improve outcomes by implementing transparency measures that help us understand data trends.

Senate Bill 5 is aimed at healthcare access. It deals with telehealth and codifies certain telehealth flexibility measures granted during the pandemic and its associated emergency declaration. Senate Bill 5 also focuses on equitable access to telehealth services. The bill is aimed at implementing data collection procedures that show how accessible telehealth services are for vulnerable populations. These measures are patient-driven initiatives.

ASSEMBLYWOMAN TITUS:
Would the bills allow the PPC to gather more data on patient access?

CHAIR RATTI:
I will allow questions on this topic to a point, but we will have hearings on these bills.

ASSEMBLYWOMAN TITUS:
How many bills did PPC the request for the Eighty-first Session?

MS. CHOLHAGIAN:
The PPC has the option to request up to three bills. It requested two bills.

ASSEMBLYWOMAN TITUS:
Did the PPC propose any bills related to workforce development?

MS. CHOLHAGIAN:
Workforce development is a priority for PPC. The PPC has not requested a workforce development bill for the Eighty-first Session.

SENATOR DONDERO LOOP:
Can you explain how the duties of the PPC align with the direct consumer services provided by the Office for Consumer Health Assistance? How do the PPC's duties align with the duties of the programs anticipated to be placed in the new Consumer Health Advocacy and Protection Unit?

MS. SCHMIDT:
The transfer of the PPC to the ADSD will not change the PPC's duties or activities. The transfer is intended to connect the boards and commissions under the ADSD that deal with patient advocacy with the PPC's work. We are not changing the duties of any programs under the ADSD. Although organizations such as the Office for Consumer Health Assistance will continue to perform the same tasks, having them housed in the ADSD allows for better cross-coordination.

There are many examples of cross-coordination in the ADSD. In the past year, different sections of the ADSD have hosted cross-committee meetings. The chairs of our boards and commissions come together for discussions. The ADSD hosted training and collaboration seminars. The seminars ensured the ADSD sections worked with each other on areas of common concern, rather than working separately.

Different sections of the ADSD are working together on shared policy initiatives. This helps move the policy initiatives forward.

SENATOR DONDERO LOOP:
It often takes us longer than we wish to get things in place.

ASSEMBLYWOMAN CARLTON:
The services are delivered through the ADSD, but the Director's Office provides the ADSD support and guidance. I see the PPC as fitting that support and guidance mission. This is one of the reasons moving the PPC to the Director's Office is justified. I want to put that on the record for transparency.

MS. SCHMIDT:
I will present the ADSD's B/A 101-3151.

HHS-ADSD - Federal Programs and Administration — Budget Page DHHS-ADSD-13 (Volume II)
Budget Account 101-3151

This budget account serves as the ADSD's primary administrative budget and contains functions related to the Division's operations. These operations include human resources, fiscal services, IT and administrative provisions. The Executive Budget recommends B/A 101-3151 contain 85.02 full-time staff positions by the end of the 2021-2023 biennium. Budget account 101-3151 now has fewer full-time equivalent (FTE) staff positions than it did before aging and disability services were merged into the ADSD in 2014.

The merger led to a 279 percent growth in the ADSD. The ADSD has grown another 35 percent since 2014. It is important for legislators and the public to understand that while we always focus our priorities on serving Nevadans, it is difficult to do so effectively and efficiently without the appropriate administrative resources.

Page 9 of Exhibit B lists decision units in B/A 101-3151. Decision unit E-680 in this budget account holds six positions vacant in FY 2021-2022. Decision unit E-911 transfers one management analyst position from B/A 101-3151 to the DHHS Director's Office Data Analytics B/A 101-3203.

E-680 Staffing and Operations — Page DHHS-ADSD-15
E-911 Transfer from ADSD Admin to Data Analytics — Page DHHS-ADSD-16

DHHS DIRECTOR'S OFFICE

DHHS DO - Data Analytics — Budget Page DHHS-DIRECTOR-29 (Volume II)
Budget Account 101-3203

E-911 Transfer from ADSD Admin to Data Analytics — Page DHHS-Director-40

CHAIR RATTI:
How will holding six positions in B/A 101-3151 impact the ADSD?

MS. SCHMIDT:
The lack of administrative positions affects our ability to onboard staff members who provide direct services in a timely manner and support program staff. It results in delays in service and reduces the quality of services.

CHAIR RATTI:
Will there be any impact on the ADSD's ability to hire vendors and perform related tasks?

MS. SCHMIDT:
Yes. The onboarding process is done through B/A 101-3151's human resources unit. In addition to hiring State personnel, THE ADSD onboards hundreds of contract staff. These processes are delayed when we lack adequate resources and staff positions.

ASSEMBLYWOMAN BENITEZ-THOMPSON:
I know in some budget accounts, staff positions are held vacant in the first fiscal year of the biennium and filled during the following fiscal year. The positions have probably been held vacant since the hiring freeze went into effect. Have staff members been laid off? If so, would we restart the hiring process and recruit new staff members once the hiring freeze is lifted?

Is the ADSD exiting staff members out of State service and onboarding new staff members when it is able to?

MS. SCHMIDT:
In order to not impact current staff members, we only held staff positions that were already vacant.

ASSEMBLYWOMAN BENITEZ-THOMPSON:
I am understanding the ADSD did not layoff any staff members. The positions were organically vacant. Does the ADSD anticipate any difficulties in filling the positions held vacant in fiscal year (FY) 2020-2021? Will issues such as pay concerns make it hard to fill these positions? Has the ADSD historically had difficulty filling these positions?

MS. SCHMIDT:
We do not anticipate hiring difficulties for a majority of those positions. The vacant positions in B/A 101-3151 are not hard to fill. We anticipate being able to hire staff members quickly.

The ADSD faces challenges in hiring staff for some of its direct service programs. We have to use contract staff when we are unable to fill positions internally.

ASSEMBLYWOMAN BENITEZ-THOMPSON:
Will the vacant IT professional position in B/A 101-3151 be difficult to fill? I remember we have had previous conversations about how hard it is for the State to compete with the private sector in terms of pay for IT staff.

JEFF HAAG (Deputy Administrator, Human Resources, Information Technology and Fiscal Services, Aging and Disability Services Division, Department of Health and Human Services):
The IT professional position has historically been difficult to recruit for. There are a lot of private sector companies the State competes with. Our pay is often lower compared to private companies making it harder to fill the ADSD IT staff positions.

We may have an easier time filling the IT professional position due to the existing job market. Historically, recruitment has been difficult.

ASSEMBLYWOMAN BENITEZ-THOMPSON:
It helps to know many of these staff positions were already vacant before the hiring freeze. There is a mix of vacancies. These are not necessarily positions the ADSD chose to vacate. The Division is just taking organic vacancies and holding them vacant.

CHAIR RATTI:
It is good when we can avoid layoffs by holding positions vacant. A potential unintended consequence is that critical positions that happened to be vacant when the hiring freeze went into effect may be left unfilled. Holding critical positions vacant might not be a good strategic choice for the ADSD.

I assume there is a process for the ADSD to fill critical positions, even with the hiring freeze. How would the ADSD fill these critical positions?

MS. SCHMIDT:
We originally identified vacant positions to freeze during the Thirty-first Special Session. Some of those positions will be fillable beginning in July 2021. When building the 2021-2023 biennium budget, we identified additional vacant staff positions to freeze.

The ADSD tried to avoid freezing critical positions. Because of the extensive budget cuts and the metrics we had to meet, certain critical positions were frozen. Some of our programs did not have supervision in certain areas. This created challenges for the ADSD.

We have identified critical vacant positions to refill as funding becomes available. We look forward to working with legislators to bring those staff positions back.

CHAIR RATTI:
The Subcommittees want to ensure the ADSD is thoughtful about staff positions that are critical for it to function. We want to avoid position vacancies resulting in higher long-term costs.

We will now move on to B/A 262-3156.

HHS-ADSD - Senior Rx and Disability Rx — Budget Page DHHS-ADSD-18 (Volume II)
Budget Account 262-3156

MS. SCHMIDT:
Budget account 262-3156 pertains to our Senior and Disability Prescription programs. These programs provide Medicare Part D premium subsidies to eligible individuals. Page 11 of Exhibit B describes decision unit E-225 which eliminates the pharmacy subsidy program funding.

E-225 Efficiency & Innovation — Page DHHS-ADSD-19

These funds were used to pay actual prescription costs for Medicare recipients. With the closure of the Medicare donut hole at the federal level, the need for this type of pharmacy coverage has ended. Due to the closure of the donut hole, the ADSD no longer has the need to subsidize and pay for prescription drugs. The funds were specific to those prescription drug contexts.

The Executive Budget continues funding to help individuals pay for Medicare Part D premiums. We currently pay a premium subsidy of up to $37 per month to help people offset the cost of their Medicare Part D plans.

ASSEMBLYMAN WATTS:
How was the premium subsidy of $37 per month determined? To what extent does the subsidy offset the cost of Medicare Part D premiums?

MS. SCHMIDT:
We looked at the amount of available funding and the number of potential recipients to determine the subsidy amount. We also took into account the average cost of Medicare Part D premium plans. While we offer up to $37 per month, the average subsidy is not that high. Not all recipients need that high a subsidy.

RIQUE ROBB (Deputy Administrator, Aging, Physical Disabilities and Children's Services, Aging and Disability Services Division, Department of Health and Human Services):
While individuals can receive up to $37 per month, the average premium subsidy for Medicare Part D plans was $27 per month in 2019. That was based on the subsidy programs available through the Medicare Part D program. The average was set based on funding and usage.

With the closure of the "donut hole," the caseload has decreased. It continues to decrease as the need in Medicare Part D coverage has increased.

ASSEMBLYWOMAN WATTS:
What is the average monthly caseload projected for the 2021-2023 biennium?

MS. ROBB:
The caseload was 830 individuals in July 2020, 835 individuals in August 2020, 809 individuals in September 2020, 771 individuals in October 2020, 763 individuals in November 2020, 731 individuals in December 2020 and 598 individuals in January 2021. This is where we have seen the trend between open enrollment and the changes in the Medicare Part D subsidy supports. As individuals receive better coverage in Medicare Part D plans, there is less of a need for additional subsidies which is why we are seeing caseloads decrease.

I will follow up with the Subcommittees regarding our projected monthly caseloads for the 2021-2023 biennium. I can also provide information on our actual caseload for February 2021.

ASSEMBLYWOMAN BENITEZ-THOMPSON:
I know Assembly Bill (A.B.) 35 changes some of the eligibility requirements for the prescription programs. It looks like we really are shifting toward making sure the State is a payer of last resort.

ASSEMBLY BILL 35: Revises provisions governing certain programs to assist senior citizens and persons with disabilities with costs relating to health care. (BDR 40-288)

The application includes several important inquiries. It asks whether individuals have already applied for Medicare Extra Help or Medicaid. My understanding is this is a program where individuals need proper documentation. Individuals need to demonstrate they submitted applications for Medicaid and Medicare Extra Help. I have not done this process before, so I do not know if it takes one week, one month or four months.

People should not use this program for emergencies, such as when they need help paying for prescriptions in a given month. Is this a correct understanding? Is this how we are talking about this program with the public? Do we tell people the purpose of the subsidy is not for emergency prescription costs?

MS. ROBB:
This is truly a subsidy program. The monthly subsidies are not meant for direct prescription costs. Decision unit E-225 in B/A 262-3156 is based on the donut hole closure. It is important for Nevadans to understand that the subsidy is meant to ensure they have appropriate Medicare Part D coverage for their pharmacy benefits. The program has shifted based on changes at the federal level.

ASSEMBLYWOMAN BENITEZ-THOMPSON:
A growing number of applications require copies of individuals' Medicare cards. That can be hard to do for certain populations. This includes older individuals, especially if they have dementia. These individuals may misplace items such as wallets. It can be difficult to produce a copy of a Medicare card.

Do all applications require copies of Medicare cards? Can an individual provide his or her Medicare number in lieu of a card copy? Does the ADSD have the ability to verify Medicare numbers?

MS. SCHMIDT:
We require copies of Medicare cards. We do not have an electronic database to verify Medicare numbers without copies of the cards.

Other State agencies, including the DHHS Division of Welfare Supportive Services (DWSS), have that type of electronic database. We do not have that type of resource for this small program. One of the goals of A.B. 35 is to give the ADSD the ability to create a program that makes sense around prescription drug costs for individuals with disabilities and seniors. We want to spend the 2021-2023 biennium doing public outreach, understanding what the needs are and adopting regulations that build the program going forward to provide the needed support.

CHAIR RATTI:
At first glance, decision unit E-225 in B/A 262-3156 looks like a budget cut. It looks like a resource is being taken away. However, what I hear you saying is the closure of the donut hole at the federal level made it so we no longer need direct payments for prescriptions.

We need to help people purchase Medicare Part D plans so they have prescription coverage. I believe you said the subsidy assistance is provided on a sliding scale. I am thinking of a particular constituent I worked with who had an income of $835 per month. The constituent is a dual enrollee of Medicare and Medicaid and really does not have any money to pay for Medicare Part D coverage. Is this the program that is helping my constituent access Medicare Part D coverage? Is the sliding scale such that if an individual's income is extremely low, he or she will not be hurt?

Are there any low income seniors or people with disabilities who are not going to have the same level of resources they have today after decision unit E-225 in B/A 262-3156 is implemented?

MS. SCHMIDT:
For very low-income individuals, there are several federal assistance programs such as the Qualified Medicare Beneficiary and Extra Help programs.

The premium subsidy in B/A 262-3156 is intended to be for individuals who do not qualify for the federal assistance programs based on their incomes, but still need assistance. This includes seniors who are just about the federal poverty limit but need help due to high prescription costs.

The reduction in decision unit E-225 in B/A 262-3165 will not reduce benefits individuals receive from the federal assistance programs or the monthly premium subsidy.

CHAIR RATTI:
That is a helpful reminder of what the target population is for this specific program, and that there are other programs to assist low-income Nevadans.

We will move on to B/A 101-3266.

HHS-ADSD - Home and Community-based Services — Budget Page DHHS-ADSD-24 (Volume II)
Budget Account 101-3266

MS. SCHMIDT:
Budget account 101-3266 pertains to home and community-based services. This budget account contains several sections. These include the Planning, Advocacy and Community (PAC) Unit, the Community-Based Care (CBC) Unit, the Long-term Care Ombudsman program and Adult Protective Services.

Page 13 of Exhibit B explains the duties of the PAC unit. This program is responsible for the 13 programs and services listed on page 13 of Exhibit B. While there are no decision units, I would like to provide the Subcommittees with some information related to the work of the PAC Unit. The PAC Unit provides grant funding to community partners. It also operates several direct service programs.

The PAC Unit has a staff of five grant specialists who support all of its subgrant activities. Historically, each staff member handled an average of 45 subgrants. In FY 2019-2020, the ratio nearly doubled such that each staff member handled 83 subgrants. A lot of this increase has been related to additional funds received through the coronavirus relief fund. The PAC Unit has worked diligently to turn around federal dollars and get them out to the community. The PAC Unit created an expedited grant process so grantees could access those funds immediately. Much of the funding was used for food and nutrition services. The PAC Unit was able to get funds to the community so that could be delivered in a timely manner.

The PAC Unit also supported an additional 74 subgrants to support those emergency operations. Services range from home-delivered meals to in-home support services. We made a significant investment in technology and technology training. They were aimed at keeping people connected to their families and essential services. As part of the ADSD's response, we worked closely with the aging network to initiate a rapid response effort known as the Nevada Covid-19 Aging Network, also known as Nevada CAN. The PAC Unit helped coordinate this network and ensure older adults have access to critical services including food, medication, social support and telehealth services.

This effort partnered with Nevada Care Connection and the Nevada 2-1-1 program to help individuals explore services and support after their immediate needs are met. The effort was initially centered on rapid response, but has transitioned to help with long-term assistance. It helps families with both emergency needs and future planning.

The PAC Unit also took on the responsibility of creating the *Elders Count Nevada 2021* Report. This report provides data on key topics related to Nevada's aging population. We are in the process of having the reports delivered to each member of the Legislature. Each legislator should receive a hard copy. The report is aimed at providing a data-driven decision making tool. The data focuses on the State's senior population. We have made a commitment to continue this report on a biennial basis so the Legislature and the ADSD have the data necessary to make decisions for future legislative sessions.

The PAC Unit has also supported coordination of vaccination efforts for Nevada seniors. It has worked with community partners in getting individuals access to vaccinations. The PAC Unit is dedicated and has remained flexible during a difficult year. It has put the needs of seniors and the community first.

Page 14 of Exhibit B lists the duties of the CBC Unit. The CBC Unit is responsible for the Frail Elderly and Physically Disabled Waivers. It is also responsible for the Personal Assistance Service program, the Homemaker program and the Community Options Programs for the Elderly (COPE). These three services assist individuals who are not quite eligible for waivers based on their incomes, but still need assistance. The ADSD is responsible for eligibility and enrollment into waiver services, case management and service coordination and contracting and billing for direct services. It provides quality assurance activities and compliance with federally mandated requirements.

Page 15 of Exhibit B shows caseload projections for the PAS program, the Homemaker program and COPE.

Page 16 of Exhibit B lists two decision units for B/A 101-3266. Decision units M-202 and M-203 fund the caseload and waitlist projections for the PAS program.

M-202 Demographics/Caseload Changes — Page DHHS-ADSD-28
M-203 Demographics/Caseload Changes — Page DHHS-ADSD-28

Decision units M-204 and M-205 described on page 17 of Exhibit B fund the Homemaker program caseload and waitlist projections. Decision units M-206 and M-207 fund the COPE caseload and waitlist projections.

M-204 Demographic/Caseload Changes — Page DHHS-ADSD-29
M-205 Demographic/Caseload Changes — Page DHHS-ADSD-29
M-206 Demographics/Caseload Changes — Page DHHS-ADSD-29
M-207 Demographics/Caseload Changes — Page DHHS-ADSD-30

Page 18 of Exhibit B outlines decision unit M-208 in B/A 101-3266 which funds a decrease in projected CBC caseloads. The DWSS has an IT initiative to streamline enrollment during the application process. This budget account, because it handles eligibility and enrollment for waiver services, has to coordinate across three different agencies. That IT project will create efficiencies for this program.

M-208 Demographics/Caseload Changes — Page DHHS-ADSD-30

Under the existing system, one document has to be transferred three different times to three different agencies. Making processes electronic will allow us to render services more quickly. During the pandemic, we identified the need to expeditiously move people into services so they can remain in their homes. That is critical for this program.

Page 19 of Exhibit B summarizes the duties of the Long-term Care Ombudsman program. This program works to resolve problems for individual residents while providing advocacy for residents of nursing homes, residential facilities for groups and individual residential care facilities.

Page 20 of Exhibit B shows the caseload projection for the Long-term Care Ombudsman program.

Page 21 of Exhibit B lists the decision unit for the Long-term Care Ombudsman program. Decision unit M-209 of B/A 101-3266 represents a caseload staffing adjustment. It is seen in the reduction of staffing. The pandemic had a significant impact on the Long-term Care Ombudsman program, as staff members were not allowed in care facilities for several months. During the Eightieth Session, the facilities we visited were expanded. While we are concerned with the reduction in staffing proposed in decision unit M-209, we are hopeful the revised caseload projections in March 2021 will demonstrate we have returned to facility visits.

M-209 Demographics/Caseload Changes — Page DHHS-ADSD-31

Page 22 of Exhibit B summarizes the APS program. The APS program investigates abuse, neglect, self-neglect, exploitation, isolation, and abandonment of seniors and vulnerable adults from ages 18 to 59.

On July 1, 2019, the program was expanded to encompass vulnerable adults under the age of 60. The expansion was successful due to the planning and technical assistance the ADSD received from national experts. New vulnerable populations make up about 13 percent of cases within the APS program. That is in line with the projections the ADSD had at the time it was building the APS program budget.

Page 23 of Exhibit B shows the projected caseload for the APS program.

Page 24 of Exhibit B lists decision unit M-210 in B/A 101-3266. Decision unit M-210 increases staffing for the APS program by nine FTE positions based on current caseload projections.

M-210 Demographics/Caseload Changes — Page DHHS-ADSD-31

Page 25 of Exhibit B lists enhancement units for B/A 101-3266. Decision unit E-680 holds 21 positions vacant in B/A 101-3266 through FY 2021-2022. Decision unit E-908 transfers one contract management analyst position to the Data Analytics B/A 101-3203.

E-680 Staffing and Operations — Page DHHS-ADSD-34
E-908 Transfer from Home & Community to Data Analytics — Page DHHS-ADSD-35
E-908 Transfer from Home & Community to Data Analytics — Page DHHS-DIRECTOR-39

ASSEMBLYWOMAN MONROE-MORENO:
I was looking at waitlists for services from the PAS program, Homemaker program and COPE. The numbers of clients being served seem to be lower than legislatively approved for FY 2020-2021. Could you explain why that is, and why there continues to be waitlists despite availability? How has the pandemic affected the services you were able to provide?

MS. SCHMIDT:
Fewer individuals used Homemaker program services during the pandemic because they did not want people entering their homes. Many individuals who were eligible for homemaker services abstained from them. The ADSD also reached out to individuals on waitlists. Several of those individuals refused services due to Covid-19 concerns.

The reductions in some of these decision units are also based on decreased caseloads due to the pandemic. In addition, the cost per eligible client has been reduced for these groups. The cost per eligible client was originally around $613 during the Eightieth Session. The cost per eligible client is now $493.

We are working with the Legislative Counsel Bureau (LCB) Fiscal Analysis Division staff to make any technical adjustments needed. The numbers in these programs have fluctuated several times due to the pandemic.

ROBIN HAGER (Administrative Services Officer, Aging and Disability Services Division, Department of Health and Human Services):
We are working closely with LCB Fiscal staff to update caseload projections. Within two weeks, legislators will receive revised caseload projections for the programs in this budget account.

ASSEMBLYWOMAN MONROE-MORENO:
Could you discuss the intentions of the waitlist decisions in the Executive Budget? Does ADSD intend to serve all projected clients during the 2021-2023 biennium, including those who are waiting for service?

MS. SCHMIDT:
Yes. These decision units are intended to provide services to all individuals waiting for services in these programs.

ASSEMBLYWOMAN TITUS:
My question is on decision unit M-209 in B/A 101-3266. The Long-term Care Ombudsman program had lower staff levels than ADSD projected during the 2019-2021 biennium. Was the caseload number reduced because staff members were not allowed into long-term care facilities during the pandemic?

I believe the ADSD would have still been able to open cases and take calls, even as in-person entry was restricted. Can you clarify why caseload numbers decreased? Did the ADSD receive calls that it was not able to follow through on? My perception is that many families were calling the ADSD for assistance due to several concerns, including not being able to see loved ones.

MS. SCHMIDT:
A key function of the Long-term Care Ombudsman program is consistent residential facility visitation. We build caseloads based on activities performed. In a given facility visit, several activities may be performed.

A call from a family would constitute one activity. However, due to the lack of in-person visits during the pandemic, we were not able to go into facilities and talk to five other people about the situation. The inability to perform those activities reduced our numbers as caseloads are based on activities. This is why our caseload numbers have decreased, even though we still receive calls from families.

ASSEMBLYWOMAN TITUS:
To clarify, are caseload numbers based on interactions and activities as opposed to the number of patients?

JENNIFER FRISCHMANN (Quality Assurance Manager, Aging and Disability Services Division, Department of Health and Human Services):
The Long-term Care Ombudsman caseload is complicated. It is not a one-to-one figure. There are over 16,000 long-term care beds in Nevada. However, that does not equate to 16,000 visits. One case equals five activities. You have to make five calls during one case.

ASSEMBLYWOMAN TITUS:
Does that explain why the ADSD believes these case numbers are going to remain low, even though the long-term care units will be opening? How do you justify these caseload projections?

MS. SCHMIDT:
Over the past several weeks, the ADSD has returned to visits. We are hopeful the updated caseload projections reflect an increase due to the return of in-person visits.

Decision unit M-209 in B/A 101-3266 concerns us because we know we have not physically been in facilities. We do not have our eyes on staff members and residents. We are not getting many of the calls like we used to as those were often generated by us touching base with people during our visits.

The ADSD is concerned with losing staff positions. It is concerned about its ability to maintain its minimum number of visits on top of the additional complaints we receive. The projections will increase over the next couple of weeks.

ASSEMBLYWOMAN TITUS:
We can adjust decision unit M-209 based on what the updated caseload projections are.

CHAIR RATTI:
There is much concern surrounding long-term care facilities given what they faced during the pandemic. The magazine published by the AARP did a three-part series on some of the concerns we have with our long-term care facilities and our assisted living facilities.

During the Eightieth Session, legislators significantly increased the amount of staff positions in the Long-term Care Ombudsman program. The number of positions added is close to the number of positions being eliminated now. Families are distressed. Even in the best of times, family members often face difficulties visiting loved ones in long-term care facilities, especially if they live far away. Would the ADSD be able to provide the level of services it needs to if the Legislature accepts this budget recommendation?

MS. SCHMIDT:
The ADSD is concerned that it will not be able to do its minimum number of visits with staff reductions. The pandemic has taught us much about long-term care facilities and some of the issues and concerns surrounding them. As we move into the 2021-2023 biennium, one of the things the DHHS could improve on is looking at how it builds its caseload projections, the data that goes into the projections and whether activities are relying on accurate data. A single case often encompasses several activities, but that does not mean we should not be there for every individual who needs our support. There is some planning we can do during the 2021-2023 biennium to ensure our numbers and our data support the staffing needs in this program.

ASSEMBLYMAN ROBERTS:
How long have the 21 FTE staff positions you are recommending be held vacant in FY 2020-2021 been unfilled? How have the vacancies affected the ADSD's ability to provide services? Is the ADSD being affected? Why do you feel the need to keep the positions instead of eliminating them?

MS. SCHMIDT:
Those 21 staff positions have been vacant since the implementation of the Statewide hiring freeze. Services have been affected. The effects are not limited to the 2021-2023 biennium. We have seen the impacts over the past year. Our ability to provide timely services was reduced.

ASSEMBLYMAN ROBERTS:
When did the hiring freeze go into effect?

MS. SCHMIDT:
The hiring freeze went into effect March 16, 2020.

ASSEMBLYWOMAN BENITEZ-THOMPSON:
I want to speak more about the potential staff reduction in the Long-term Care Ombudsman program. During the Eightieth Session, legislators approved ten additional staff positions for the Long-term Care Ombudsman program. I want those positions to remain in B/A 101-3266.

As we look at the data, I imagine that the minimum data set and several quality measures in skilled nursing facilities have decreased. When long-term facilities were closed to families and outside providers, only staff members were present to monitor facility conditions. The Long-term Care Ombudsman had trouble entering facilities and communicating with staff members. It is important the State closely monitors congregate care settings, whether the settings are for children or adults. Without close monitoring, people may file lawsuits against the State if malpractice occurs.

I know the federal coronavirus relief bill allocated funding to skilled nursing facilities. I do not believe the ADSD HCBW program programs received any funding from the coronavirus relief bill. I remember there was funding for isolated seniors to receive iPads. Other than that, no coronavirus relief funding went to the waiver programs. Is that correct?

MS. SCHMIDT:
It is true that emergency funds approved by the coronavirus relief bill, under the Older Americans Act, went directly to the Long-term Care Ombudsman program. That funding is where the iPads came from. We also had Older Americans Act funds that were delivered directly to community providers through the PAC Unit. There was no additional funding for the HCBW programs.

We saw an increased percentage in federal Medicaid assistance. That offset some of the costs for the HCBW program. The dollars from the percentage increase are located in the Division of Health Care Financing & Policy (DHCFP), not in ADSD's budget.

ASSEMBLYWOMAN BENITEZ-THOMPSON:
The DHHS provides a dashboard showing Covid-19 cases by residential facility. It seems like elderly and medically fragile individuals fare better in smaller congregate care settings such as residential group homes compared to skilled nursing facilities, though the dashboard does not separate group homes and assisted living centers.

Are these observations correct? Do we know what types of settings fared best for our seniors?

MS. SCHMIDT:
We have not formally parsed that data out. I agree it is important to look at how seniors fared in different types of facilities and what the issues were. We need to reach out to providers to gather input. In a smaller setting, it is easier to isolate individuals than it is in skilled nursing facilities.

One of the issues seen in skilled nursing facilities is that staff members often work in more than one facility. In group homes and smaller congregate settings, the staff tends to remain consistent. I do not have a direct answer for your question based on data. This is based on anecdotal observations.

This is a worthy discussion to have. We can work with the DHHS Office of Data Analytics to provide more information now that we have a year's worth of data.

ASSEMBLYWOMAN BENITEZ-THOMPSON:
I would appreciate that data. There were a number of trends before the pandemic. We saw skilled nursing facilities switching their client set to Medicare rehab beds because those pay more. Fewer nursing facilities take long-term Medicaid patients.

We also see fewer individuals who want to reside in nursing homes. No one plans to check themselves into a nursing home and spend several years there anymore.

As we plan the future of HCBW program services and supporting people living at home, we want to ensure the ADSD staff members can help individuals get off waitlists. We want to expand services for people on waitlists. The long-term trend may be for people to prefer staying in their own homes instead of moving to care facilities. Based on that, it is important the ADSD's HCBW program services are properly staffed. If fewer people are in congregate care facilities, they will be safer from infections. This is not limited to Covid-19. They will be safer from other infections that are common in group settings. We should support that trend.

MS. SCHMIDT:
We will work with the Office of Data Analytics to study some of those numbers. The ADSD advocates community-based care in all settings. We emphasize that individuals should have the ability to remain in their community, in care settings of their choice. This is also cost-effective. It is more efficient to provide services at home than it is in skilled nursing facilities.

ASSEMBLYWOMAN BENITEZ-THOMPSON:
I have a question on APS. There seem to be several vacancies in that program. It is new, so it is important for us to get the funding model right. We need to look at how things have been going in the past several years.

Can you tell us more about those vacancies? Are those vacancies happening more in one area than another? Can you give us insight on the number of staff vacancies in APS?

MS. SCHMIDT:
We have a difficult time recruiting staff for APS, which is our biggest problem in terms of vacancies. Our established caseload ratio is normally 1 staff member for 40 cases. The current average caseload is about 1 staff member for 93 cases. Staff members are working overtime. They are overwhelmed. Their ability to render timely responses is being impacted by excess vacancies.

The vacancy rate for social workers and adult care specialists is about 51 percent. Statewide, the vacancy rate is around 50 percent. In the Las Vegas area, our APS social worker vacancy rate exceeds 60 percent. When you consider the activities of APS staff members, you can see it is very difficult for them to sustain workloads under the current caseload ratio. We are concerned about burnout.

Difficulties in recruitment represent our biggest problem. We see much turnover. People can get hired in our APS Unit as social workers and then move to other agencies for higher pay. We often train social workers who move from our program to other programs.

ASSEMBLYWOMAN BENITEZ-THOMPSON:
We need to remember why the APS program was established. It was not because legislators said we needed the program. It was established due to an audit by the Department of Justice and DHHS's Division of Child and Family Services Victims of Crime program staff. The push for APS came from higher up. Nevada was told it was not providing services it was obligated to.

We established the program to ensure we complied with the audit's recommendations. We need to ensure this program is established correctly. Otherwise, we might be forced to do so at a later time.

SENATOR KIECKHEFER:
You mentioned earlier that the cost per eligible client was $613 during the Eightieth Session, but is now $493 per eligible client. Is that correct? With the new projections coming for caseload numbers, will you return to a cost per eligible of $613 or use a different number?

MS. SCHMIDT:
Those numbers were related to the COPE and Homemaker program where the actual costs for clients have been reduced. Part of the decrease is because individuals asked for less time in their homes. When projections are updated, we will look at average costs for determining 2021-2023 costs. In our methodology, we use average actual costs when projecting costs for an upcoming biennium.

MS. HAGER:
We would typically take FY 2019-2020 actual costs as the basis for projected costs during the 2021-2023 biennium. Because of the pandemic, FY 2019-2020 was a unique year. The reduction in individuals using services

drove costs down, potentially in an artificial manner. This might be an opportunity for us to perform what we consider a post-model adjustment.

The ADSD will work with the LCB Fiscal staff to determine a sound rate number. We know projected caseloads based on FY 2019-2020 numbers, even within the Long-term Care Ombudsman program, will be artificially deflated. There is still much work to be done. In fact, there is probably even more work to be done now compared to the previous biennium. The ADSD will work with LCB Fiscal staff to determine what a cost per eligible rate is.

SENATOR KIECKHEFER:
I look forward to reviewing the updated projections to learn more about how you came up with these numbers.

It looks like decision unit M-208 reduces staff positions. We may need to add staff positions as more people sign up for these programs. Could you elaborate on decision unit M-208?

MS. HAGER:
This represents differences in how staff positions are used. Some social workers focus on intake, while others are actual caseworkers. Based on the caseworker numbers we saw, some shifting took place. We needed fewer intake workers and more social workers. We will see changes over the next couple of weeks because we believe caseload projections will increase. We will not see as many reductions.

There are also some instances where Medicaid funded services for people on waitlists for us. I missed that when building this budget, so I did not include the staff numbers needed to fund service expansions. All of this will be fixed over the next couple of weeks. We will see changes, and the numbers will begin to even out.

ASSEMBLYWOMAN CARLTON:
When we expanded elder protective services to include adults from ages 18 to 59, we did so with grant funding provided by the Victims of Crime Act. I know there have been changes to that funding stream. With the funding switch being

proposed, what alternatives did the ADSD look at for APS? Should legislators be aware of a potential loss of grant funds from the Victims of Crime Act?

MS. SCHMIDT:
We had technical assistance from national experts when we expanded the Elder Protective Services program into APS. We looked at the ways other states are funding similar programs. Many states fund programs the way we have been doing, which is through a combination of Medicaid administration funding, general fund dollars, funding from the federal Victims of Crime Office and Title XX funding.

We continue to apply for grant dollars under the Victims of Crimes Act, but those funds have been limited. The funding has not been available at the levels we originally anticipated and hoped for.

Nevada's APS program was recently awarded direct federal funding for the first time. We received a little over $700,000 in a recent federal measure. We will soon receive the first amount of that funding. The funding is restricted in terms of timeframes, but we are hopeful as it is the first time the federal government has ever identified funding for APS.

In the American Rescue Plan Act of 2021, there is a potential for APS to receive long-term funding from the federal government. We do not know for certain whether those dollars will arrive, and we cannot plan based on that assumption. However, we are hopeful. Adult protective services programs from several states are pushing for that funding. Historically, this funding stream has not been available for states. If it were to come, it would help offset any costs related to this program.

ASSEMBLYWOMAN CARLTON:
I am glad to hear that. I was hoping we would hear there were dollars out there. We hope to know about the status of the potential federal grant funding in time to make the necessary technical adjustments.

CHAIR RATTI:
The PAC Unit performed several important functions during the pandemic. Conversations revolve around social workers, case workers and frontline staff

members. It is also good to hear about the work grant workers are performing. They helped ensure extra money was used for critical services.

The Nevada CAN project has done important work. I am glad to hear that it shifted from only focusing on immediate needs to focusing on long-term planning as well.

An administrative assistant III position was assigned to the PAC Unit, but was identified as no longer being needed. Can it be eliminated rather than held vacant? Is the ADSD planning to fill that position when resources become available?

MS. SCHMIDT:
That position was previously funded through a federal grant. We shifted the administration of that grant to community partners. It used to be the State that operated that grant. It was for some of the Medicare assistance programs. With the grant's transfer to community partners, the administrative assistant III position was no longer needed. We certainly could use that position on staff, but it would take General Fund appropriations.

CHAIR RATTI:
We will move on to B/A 101-3208.

HHS-ADSD - Early Intervention Services — Budget Page DHHS-ADSD-45 (Volume II)
Budget Account 101-3208

MS. SCHMIDT:
The presentation for B/A 101-3208 begins on page 26 of Exhibit B. This budget account pertains to the Nevada Early Intervention Services (EIS) program. The EIS program provides specialized support and services to children from birth to age 3 who have developmental delays or disabilities. The program helps these children and their families meet individualized developmental and learning needs.

The EIS program uses a shared model, with community partners and the ADSD both providing services. We have to follow regulations outlined in Part C of the federal Individuals with Disabilities Education Act (IDEA). These regulations prohibit waitlists in EIS services.

Page 27 of Exhibit B shows the projected caseload for the EIS program.

Page 28 of Exhibit B shows decision unit M-201 in B/A 101-3208 which funds a caseload increase and the staff levels to support that caseload increase.

M-201 Demographics/Caseload Changes — Page DHHS-ADSD-47

Page 29 of Exhibit B shows decision units E-680, E-698 and E-699. Decision unit E-680 holds 29 positions vacant through FY 2021-2022 with reinstatement in FY 2022-2023. Decision units E-698 and E-699 reduces monthly per child funding for community providers from $565 to $500. This monthly payment is made for every child with an active individualized family services plan (IFSP). It is paid over and above what providers can obtain through billable services through insurance and Medicaid.

E-680 Staffing and Operations — Page DHHS-ADSD-49
E-698 Program Reserves — Page DHHS-ADSD-49
E-699 Program Reserves — Page DHHS-ADSD-50

We know the Affordable Care Act (ACA) increased billable services across many of these programs, especially as it pertains to children's services. Additionally, the federal flexibilities during the pandemic have also allowed telehealth services to be provided for many of the services within the EIS program. That has reduced the costs associated with transportation for both the providers and the State.

SENATOR DONDERO LOOP:
Please explain both the need to and the benefits of replacing caseworker positions with supervisors and administrative support staff members.

MS. SCHMIDT:
When building this budget, we took time to look at and identify staff duties. Historically, we used caseloads to determine staffing needs. We would conduct administrative duties such as single point of entry (SPOE) activities, which are

required under federal Part C regulations of the IDEA. These activities are needed, along with associated staffing, regardless of caseload. Historically, we did not have this need identified. Our caseload kept growing, and we did not have the appropriate staff levels. Our ratios were out of alignment.

This budget build identifies those administrative activities, pulls them out of caseload numbers and identifies the caseload ratios that are appropriate. We are noticing there are too many staff members and not enough supervisors, or too many supervisors and not enough staff members. Those ratios were out of alignment. That is why you see the adjustment here. The adjustment ensures our staff ratios are effective.

SENATOR DONDERO LOOP:
How was the ratio of 1 supervisor for 19 staff members determined to be ideal?

MS. ROBB:
We looked at staff ratios across the ADSD, compliance and quality assurance. The ratio is currently around 1 supervisor for every 25 staff members. Once you exceed 1 supervisor for 19 staff members, quality decreases and compliance becomes an issue. It is important to establish appropriate caseload ratios and ensure compliance with quality being the top priority. The ADSD has implemented performance matrices for all caseload staff members. We have been able to analyze data.

During the Eightieth Session, legislators approved a management analyst team for ADSD. The management analyst team has helped us analyze data, and we have gained an understanding of what works and what does not work. The team showed us how staff ratios have affected quality and compliance. The ratio of 1 supervisor to 19 staff members has been shown to be the most appropriate caseload ratio.

SENATOR DONDERO LOOP:
Could you discuss whether there may be an increase in the cost per eligible client during the 2021-2023 biennium as service usage and how services are delivered return to pre-pandemic norms?

MS. SCHMIDT:
Yes, there is a potential for an increase in the cost per eligible client. We take that potential into account. Program usage has been down. The use of telehealth services has reduced costs. While telehealth is a wonderful alternative, it is not always the best approach for individuals. There is a potential for cost per eligible increases as the ADSD returns to direct services rendered in homes. Many families have been hesitant to allow the ADSD staff to enter their homes. As vaccinations expand in Nevada and our reentry program goes into effect, we may have a plan that impacts our cost per eligible client.

MS. ROBB:
The EIS program uses a natural environment model, per federal mandate. That means we must operate programs within a child's natural environment; specifically, services are rendered in children's homes. The pandemic rendered us unable to perform services in homes. Federal flexibility gave us the ability to implement telehealth measures.

We are currently looking at a phased-in reentry approach. We are in phases 1 and 2 of reentry with clinical environments being provided based on the needs of the child. Higher need individuals are able to see physicians, developmental specialists, therapists and other providers. These services are provided within clinics. Once the State reopens more, we will look into phase 3. Phase 3 encompasses assisting children in their natural environments once it is appropriate for staff members to enter homes.

SENATOR DONDERO LOOP:
What impacts does the ADSD anticipate on community providers' capacities as the recommended rate reduction is implemented?

MS. ROBB:
Community providers for IFSPs have received a rate of $565 per child on a monthly basis. The rate has not been reviewed since the ACA was implemented earlier in the decade. It is important to know we are working directly with the trade association and EIS community providers to determine what the actual impact will be. There has been a revenue increase resulting from an executive audit and the ACA. Community providers have the ability to bill both private insurance plans and Medicaid, increasing their revenues.

Anecdotally, community providers have said the rate reduction will impact them. Based on the data, we note they have received an increase over the years. Deciding whether community providers will continue providing the same level of services after the rate reduction is a business model decision for them.

A moratorium was put in place by EIS physicians which has not allowed for face-to-face visits and natural home environment visits. It is important for that to be on the record. The moratorium put in place on March 15, 2020, is still active for the EIS program.

SENATOR KIECKHEFER:
Can State providers also bill private insurance? If so, how successful is the State at getting permission to bill private insurance?

MS. ROBB:
Yes, the ADSD can and does bill private insurance. The management analyst team has been very supportive in providing us data and support in actually increasing those revenues based on Medicaid, Targeted Case Management billing and private insurance. The revenue actually offsets the supports to the overall system, not just for State providers.

SENATOR KIECKHEFER:
In terms of a revenue line in your budget, where would I see those reimbursements?

MS. HAGER:
Are you referring to Medicaid reimbursements?

SENATOR KIECKHEFER:
No. I am referring to private insurance paying State providers.

MS. HAGER:
We have State providers and private community providers. That is probably what you are looking for. It can be found in Revenue General Ledger 3819 (medical services – private).

SENATOR KIECKHEFER:
You said changing payment mixes is going to be a business decision for community providers. Are you concerned that the rate reduction will lead to an influx of families who request State providers? The Division may not have appropriate staff levels to handle that influx. Have you anticipated some movement of families from community providers to State providers?

MS. ROBB:
There are multiple factors to consider in answering that question. We have discussed the flexibility between our State and private provider programs. There are fluctuations when it comes to referrals.

Between families choosing community providers and families entering what we call rotations, the numbers fluctuate up to 10 percent. We anticipate those fluctuations. We look at fluctuations on a daily to weekly basis. On a weekly basis, we let community providers know what is available.

We look at what proportion of clients community providers can take based on our budget authority. Then, we look at the proportion for State providers. We operate based on that data. This is another area where the management analyst team has been a true benefit to us over the past year.

SENATOR KIECKHEFER:
I worry this level of rate reductions will reduce the capacity of community providers, pushing more people into services provided directly by the ADSD. We have used this program to bolster community providers so these services are available to people. This is done in multiple programs, not just for EIS. If people need support, they can find them in their communities. I am concerned this is going to have a significant impact on people's ability to access care in their communities.

Something providers have looked at is whether funds from the Temporary Assistance for Needy Families (TANF) program can be used in the EIS program. The EIS program provides various medical services.

The Autism Treatment Assistance Program (ATAP) B/A 101-3209 allows for TANF dollars. Why has the ADSD not used TANF funds for the EIS program?

HHS-ADSD- Autism Treatment Assistance Program — Budget Page DHHS - ADSD-53 (Volume II)
Budget Account 101-3209

MS. ROBB:
We explored using TANF funding with the DWSS funding. Although EIS programs use an education model, the actual services provided are medical in nature. They are excluded from using TANF dollars as a result. Federal partners and a Nevada deputy attorney general gave us guidance as well. The Autism Treatment Assistance Program fits in many different service categories, but it is mainly a behavioral program. It is only billed medically based on Nevada's determination for applied behavioral analysis (ABA) services, but it is not styled as a medical service.

SENATOR KIECKHEFER:
Is ABA medical?

MS. ROBB:
Applied Behavioral Analysis encompasses several categories. It sits in the educational, behavioral and medical categories. It is not styled as a medical service.

ASSEMBLYWOMAN TITUS:
You talk about business models and how you function as a business. At the same time, you talk about how you use a medical model. How are we morphing those two approaches when it comes to access to care for Nevadans using EIS? I have concerns the delineation is not clear.

I hear you say you are decreasing the reimbursement for providers. I need clarification on that. The State has its own group of providers. You are talking about State caseworkers. You also mention this is a mandatory no waitlist program. Does that mean families that request assistance are referred to caseworkers immediately? Is there no waitlist on that? Could you clarify what it means to have no waitlists?

MS. SCHMIDT:
Having no waitlists means we are required by federal statute to provide timely services. There are timeframes established under Part C of IDEA for each service rendered and each step of the process. There is a timeframe for families when they call to request assessments. There is a timeframe for the first delivery of services.

We use a shared model where the same services can be rendered by State and community providers. Families are taken in through SPOE. Evaluations are done for eligibility. Families can choose a community provider to be referred to. If they do not have preferences, their assignments are based on a rotation. A family can choose to be referred to a community provider the family has a relationship with.

ASSEMBLYWOMAN TITUS:
What is the actual timeframe for the provision of services? Families call and receive assessments. After the assessments, a determination is made on their potential needs, and a plan is made for services. My concern is we have a limited number of EIS specialists. Access to community providers is very limited throughout Nevada. How long does it take for services to be rendered to children? What is the average time spent on waitlists? Is it two weeks or two months? I am not talking about just an assessment. I am talking about actual care.

MS. ROBB:
When families call, they enter a SPOE. That step of the process is not where assessments take place. That step is where they choose which provider to attain services from. The ADSD has three days to refer families to service providers. Once the referral takes place, service providers have 45 days to perform assessments and determine needed services. Services are attained from community providers or State providers, depending on who families choose or who families are paired with based on the rotation.

Community providers do good work. There are times, depending on administrative factors such as hiring, when they can perform services faster than what is required under the timeframes. Losing capacity in the realm of community providers would be detrimental for the entire system. It is important for us to maintain that capacity. We are not speaking to their business decisions. Community providers are integral and the system could not do its work without them.

ASSEMBLYWOMAN TITUS:
I am looking for a specific metric. I am concerned about that capacity. You said providers have up to 45 days after families call and enter rotations. If families simply ask for the earliest possible assessment or intervention, what is the average time for that to happen?

MS. ROBB:
They have 45 days to establish the IFSP. Within 30 days of the IFSP being established, a service delivery must be set and received.

MS. SCHMIDT:
We do not have the actual average on hand. We track and monitor that data on a regular basis. The ADSD can follow up with the Subcommittees and provide the actual average that you are asking for.

ASSEMBLYWOMAN TITUS:
That information is important to have. If it takes 45 days to develop an IFSP and another 30 days before actual services are rendered, that means months can pass before care or solutions are provided for families. How long does it take for a family to have their child's needs assessed by a provider?

ASSEMBLYWOMAN CARLTON:
For several sessions, many parents have been in this building to discuss EIS. Much work has been done to ensure the needs of these children are addressed. Work has been done on making sure medically fragile children are taken care of.

The debate has been whether ADSD uses State providers or community providers. Currently, a mixture of those providers are used. Nevada tries to get the best of both worlds. I have always been struck by the cost differences between State providers and community providers. When State providers provide EIS services, the cost is approximately $290 per month per child. With respect to community providers, that number increases. There might have been a number of miscalculations. I believe the number is close to $550 per month per child for private providers. Parents had a choice on which provider to use.

There were times when parents told legislators it was taking four to five months for their children to receive services. We are on the right track. We are trying to meet all of these children's needs, but I still have concerns. I understand the community providers' concerns about a rate decrease, but I think it is important we compare that amount to the approximate rate State providers charge. We need an apples to apples comparison on what is being done here.

If the ADSD has updated rate figures, I ask it to put the correct figures on the record.

MS. SCHMIDT:
The ADSD can work with the LCB Fiscal staff to verify the figures you are looking at, ensuring we have the most accurate information moving forward.

CHAIR RATTI:
Are any of the changes we are making, particularly the rate reduction, going to affect our maintenance of effort?

MS. SCHMIDT:
Based on calculations performed by the ADSD, we will still meet our maintenance of effort with the rate reduction.

CHAIR RATTI:
We will move on to B/A 101-3209 which pertains to ATAP.

MS. SCHMIDT:
Parents and caregivers are assisted by ATAP with the cost of providing autism-specific treatments for their children who have been diagnosed with autism spectrum disorder. There are several plan types within ATAP. We have comprehensive plans, insurance assistance plans, social skill plans, targeted plans that support individuals and family needs, and transitional services. It is important to understand there is not just one service in ATAP. Families have multiple options when accessing ATAP services.

Page 31 of Exhibit B shows the projected caseload for ATAP.

Page 32 of Exhibit B shows decision units M-201 and M-203 in B/A 101-3209. Decision unit M-201 provides funding for the caseload increase. Decision unit M-203 funds the elimination of the waitlist. The waitlist is projected to include 148 children in the 2021-2023 biennium. Decision unit M-203 would provide services to all of those children and includes four developmental specialist positions to help provide those services.

M-201 Demographics/Caseload Changes — Page DHHS-ADSD-55
M-203 Demographics/Caseload Changes — Page DHHS-ADSD-55

Page 33 of Exhibit B shows decision unit E-680 in B/A 101-3209 which holds eight developmental specialist positions vacant in FY 2021-2022.

E-680 Staffing and Operations — Page DHHS-ADSD-56

SENATOR DONDERO LOOP:
Budget account 101-3209 is of utmost concern. How has the pandemic affected ATAP's ability to provide services? Has it impacted whether families are seeking services? What have ATAP staff members observed?

MS. SCHMIDT:
Like other ADSD programs, there have been impacts to ATAP. At some point, we were not providing services to many families. If there are in-person services or high-touch services, usage of the programs was restricted during the pandemic. Ms. Robb can explain what our implementation plan is and where we are going.

MS. ROBB:
While ATAP's caseload may seem steady, there has been a reduction in service delivery during the pandemic. From March 2020 to May 2020, insurance providers and Medicaid had restrictions on telehealth for ABA. Applied Behavior Analysis is a face-to-face therapeutic service for many individuals. This caused a moratorium in services as well as a loss of registered behavioral technicians (RBT). Since the restrictions were removed, we have slowly seen service delivery come back.

Although telehealth is approved, it is not clinically appropriate for all children on the autism spectrum. It is very important we provide face-to-face services. We have slowly been resuming face-to-face ABA services, but we are also addressing the loss of RBTs in ATAP. We have seen capacity reduced during the pandemic.

We are continually working with all ABA providers to get back into homes with families. They are going to parks, and they are going to individual support programs to allow those individuals to receive services. We are using a slow and phased-in approach as we move forward.

SENATOR DONDERO LOOP:
I understand there are more children waiting for services than the waitlist numbers reflect, even in the University of Nevada, Las Vegas Ackerman Autism Center. What are the primary factors contributing to the number of children waiting? Does ADSD anticipate ATAP service providers will support projected caseload growth and eliminate the waitlist during the 2021-2023 biennium? I worry about children having to wait for services. We know early intervention and immediate therapies lead to success for many children with autism.

MS. ROBB:
The waitlist for ATAP is based on current program staff levels. We have been under a hiring freeze since March 2020. Service delivery funds are available, but the ADSD does not have the level of staffing needed to provide services using those dollars.

The Ackerman Autism Center has a diagnosing waitlist. That waitlist has several components. People are on the waitlist for ABA services. People are also on the waitlist for diagnosing fetal alcohol syndrome. The Ackerman Autism Center is looking at diagnosing fetal alcohol syndrome as a new best practice, but that has not yet been covered by insurance plans. From the ADSD's perspective, these are completely different waitlists. We have a postdoctoral fellow, funded through service delivery dollars, who works with the Ackerman Autism Center for diagnosing autism cases.

There are multiple factors for the Ackerman Autism Center's waitlist. It is for diagnosis.

SENATOR DONDERO LOOP:
How will Governor Steve Sisolak's recommendation to add staff positions reduce both the number of children waiting for services and the wait times to begin receiving ATAP services?

MS. ROBB:
The ability to add staff members will allow us to use the service delivery dollars that are budgeted for ATAP. That will be significant. We currently have a ratio of 1 case manager to 40 children. Increasing staff levels would positively impact ATAP.

ASSEMBLYWOMAN CARLTON:
During my time in the Legislature, I have been very protective of TANF funds. This is a very limited source of dollars. It is meant to support families during times of need with the basics. It is about family survival. I want to have a further discussion about using TANF dollars in ATAP. If they are used here, will they be taken out of Pre-K services? Are they going to be taken out of the work and supportive systems we have? Are they going to be taken out of childcare? This is a limited pot of money, and it is not a very big pot. It has not changed since 1999. We have received the same amount of money for TANF since then. I have concerns about using TANF dollars for ATAP.

MS. SCHMIDT:
When we were building budgets, we were looking for any opportunities to offset reductions from the General Fund. We worked with the DWSS partners and identified TANF reserve funds. The Division has worked with the DWSS and federal partners to clarify what TANF funds can be used for. One of the functions of TANF is maintaining intact families. It is important to understand, especially during the pandemic, that ATAP services help keep families together. Families are often overwhelmed with the behavior of their children. The Autism Training Assistance Program provides training for parents. The training helps parents build the skills they need to support their kids.

There are four purposes of TANF funding. One of those purposes is maintaining intact families. The Autism Treatment Assistance Program provides family trainings. It helps family members reinforce positive behaviors for children when staff members are not around to assist them. That is a key reason the ADSD identified TANF as appropriate to rely on.

There are always concerns with using TANF dollars to fund programs long-term. Because of the pandemic, this was a unique year when it came to money being available to provide services. We wanted to ensure autism treatment services are continued. We did not want to reduce caseloads and create larger waitlists. We have made so much progress in ATAP in providing services. We did not want to stop that progress.

ASSEMBLYWOMAN CARLTON:
I appreciate that. I have watched the treatment of autism evolve over the last decade. There was a time we did not even talk about the condition. There was no funding available for these children. We are going in the right direction. I have concerns about accessing a limited pot of money that can be used for so many different things. I also understand making sure these children have treatment is at the top of our priority list. I will look at the TANF budget further. I would like to convince the federal government to increase TANF dollars. I do not think that is an easy fix for the near future.

CHAIR RATTI:
Can we discuss the cost per eligible client? Several factors have impacted that cost recently, including the pandemic. I want to make sure we are thinking about the cost per eligible client as we move into the 2021-2023 biennium.

MS. SCHMIDT:
The pandemic is one factor, but so too is the history of the program. We are the payer of last resort. The implementation of ATAP and the ACA were factors. The ACA required insurers to cover ABA services. We have transitioned much of the cost we had incurred as a State agency. Much of the cost was transitioned to DHCFP.

In the past, we paid providers for services and were reimbursed by Medicaid. We did not always do a good job of receiving Medicare reimbursements. We were not always successful at getting the revenues we needed to offset costs. We no longer took this approach over the course of the 2019-2021 biennium. We work to help community providers build the capacity they need to bill directly for services on their own. Community providers are now very successful at doing that. This improvement lowered our costs.

Since the pandemic began, many families eligible for ATAP services have not used them. There was a timeframe when ATAP was not providing any services. These factors have also impacted the cost per eligible client.

CHAIR RATTI:
There are a lot of moving pieces. How did you project costs for the 2021-2023 biennium?

MS. SCHMIDT:
There are several factors that go into projections. Each service plan type has a maximum benefit amount. Historically, the ADSD has built ATAP's budget based on that maximum benefit amount. This practice has over-projected the costs needed for ATAP.

We modified this practice. The budget constraints caused by the pandemic incentivized the ADSD to ensure all money is properly used. The ADSD is now projecting based on actual costs instead of maximum benefit amounts in each plan type.

ASSEMBLYWOMAN MONROE-MORENO:
My question is on the budget reduction in decision unit E-680 in B/A 101-3209. How will holding eight developmental specialist positions vacant impact ATAP?

MS. ROBB:
It will impact the program. Even though we have service delivery dollars, we do not have enough staff to provide services and handle case management. We do not have enough staff to work directly with children and providers to ensure appropriate services are being rendered.

The other piece for us is provider capacity. That part has been a significant issue. The program has done a good job working with providers and supporting them through the process. The provider capacity issue continues. Especially after the pandemic, losing RBTs and their ability to provide services has impacted children, families and providers.

MS. SCHMIDT:
Page 34 of Exhibit B briefly mentions the transfer of the Office for Consumer Health Assistance from the Director's Office to the ADSD. I want to make sure we answer any questions related to the transfer of B/A 101-3204 in decision unit E-900 to ADSD B/A 101-3150 in the reciprocal decision unit E-900. We can answer legislators' questions on the transition of the Office for Consumer Health Assistance and the Nevada 2-1-1 program to ADSD.

HHS-DO - Consumer Health Assistance — Budget Page DHHS-DIRECTOR-46 (Volume II)
Budget Account 101-3204

E-900 Transfer From Consumer Health to Grants Mgmt Unit — Page DHHS-DIRECTOR-50

HHS-DO - Administration — Budget Page DHHS-DIRECTOR-10 (Volume II)
Budget Account 101-3150

E-900 Transfer From Consumer Health To DHHS Do — Page DHHS-DIRECTOR-10

CHAIR RATTI:
Legislators have had questions around the transfer. My understanding is the PPC, the Nevada 2-1-1 program and the Office for Consumer Health Assistance will compose a group in the ADSD that is meant to help Nevadans navigate the DHHS system. Is that correct? Is there anything you want to elaborate on there?

MS. SCHMIDT:
Yes, that is correct. Bringing these programs under one roof allows us to build on our No Wrong Door strategy. It allows us to build on the collaboration we have seen across DHHS.

As we transitioned the Nevada CAN program into the Nevada Care Connection, we coordinated with the Division of Public and Behavioral Health (DPBH). Individuals can come through Nevada Care Connection and be referred to DPBH through the No Wrong Door strategy. Efforts to build a No Wrong Door strategy are not limited to the ADSD. They are intended to be Department-wide. We are continuing to work across the DHHS on these types of activities.

The transfer of the Office for Consumer Health Assistance is not intended to change its name or duties. The Governor's Consumer Health Advocate, Carrie Embree, is with us today. She was previously employed at the ADSD as our chief of what was the Elder Protective Services Unit, which is now APS. With her transition, we identified many areas of crossover and ways we can support one another between the ADSD and the Office for Consumer Health Assistance. We have cases where having access to our subject matter experts and our programs' staff have really helped Ms. Embree get people connected in a timelier manner.

The Director's Office is administrative. The Office for Consumer Health Assistance is a direct service provider. It provides direct hands-on service. Staff would not have as many resources and as much support from the Director's Office. By bringing the Office for Consumer Health Assistance to the ADSD, the Division has the ability to support that team. Tools the ADSD can provide include access to national level information, technical assistance and training opportunities. We have many social workers in the ADSD. We have all of the tools to support the Office for Consumer Health Assistance. This is a good fit, based on our experience. We work closely with the Office for Consumer Health Assistance now, and we want to continue doing that.

CHAIR RATTI:
We will move to public comment.

BARRY GOLD (AARP Nevada):
My comments refer to B/A 101-3266. The programs in that budget account are critical for helping older adults and adults with disabilities live independently and in the community as much as they can and with dignity. Legislators asked good questions.

When the ADSD proposes budget changes, it brings them before the Nevada Commission on Aging for review. I have the pleasure of serving on the Commission. Legislators know other members of the Commission, including Mary Liveratti and Jeffrey Klein. We ask probing questions when the ADSD proposes budget changes to see what the impacts will be on the community and those families that are going to be affected by them.

I would like to discuss the waiver programs. I know legislators have looked at HCBWs, including the Frail Elderly and Disability Waivers. During the Senate Committee on Finance and Assembly Committee on Ways and Means Joint Human Services Subcommittees' meeting on February 26, 2021, legislators heard from the DHCFP. We heard about increasing the funding for slot availability. That is important because, in addition to addressing caseload increases, we want to eliminate waitlists. It is important anyone on waitlists who is eligible for a slot position receive nursing home levels of care. If they do not get access to a waiver slot, they will enter nursing homes. Aside from being the right thing to do, it is fiscally prudent for some seniors to be cared for in community settings.

I have previously discussed waitlists. The Commission on Aging has a standing agenda item to receive updates on the status of waitlists. I saw a report saying that approximately 200 people who had dropped off the waitlist for the waiver programs either passed away or entered nursing homes. That is not a good thing. Funding the waitlist would make a difference.

I want to discuss the Long-term Care Ombudsman program. People at AARP have strong concerns about what is going on in nursing homes and in the Ombudsman program. We sent two letters to Governor Sisolak and DHHS Director Richard Whitley about testing, personal protective equipment (PPE) staffing and virtual visitation. These were important topics, and many things happened. The National Guard delivered one million pieces of PPE to nursing homes and long-term care facilities. Later, AARP sent a letter about planning for the Ombudsman program representatives to again enter facilities safely. Some states have started planning for that. I want Nevada to do that.

I thank Assemblywoman Benitez-Thompson for saying we need inspections to take place in long-term care facilities. People at AARP have advocated for those inspections. I was glad to see a public announcement saying the Ombudsman program would be entering facilities to inspect conditions.

I know terrible things are happening in nursing homes. People at AARP have been collecting that information. I thank Senator Ratti for looking at AARP information on long-term care facilities and skilled nursing facilities. Nevada has done much better than other states with respect to nursing homes. In some states, more than 40 percent of the total number of Covid-19 deaths have been in nursing homes. In Nevada, the rate is closer to 20 percent. We are moving in the right direction. This is important for helping people off the waitlists. I appreciate how Assemblywoman Benitez-Thompson discussed having the adequate staff levels to eliminate waitlists. It is not just about funding slots. It is important that funding and staff positions from ADSD fit together.

KIMBERLY GLASS:
I am a disabled person who lives in Reno, Nevada. I also have a disabled 4-year-old daughter. Without the EIS program, I would have been lost with a newborn baby who has the rare condition of brittle bone disease. I did not know what to do and was unaware of any resources that could help.

The EIS program provided physical therapy and in-home services. Because I am disabled myself and cannot drive, their help was imperative for the care and development of my daughter who suffered many bone fractures during her first six months of life. The EIS program also helped with issues we faced in feeding.

At the time, funding was already scare for the program. Because I am a disabled consumer, I know how imperative funding is. I have performed human resources services for agencies that rely on funding like this to hire their employees. Any budget cuts that are implemented when programs are already deeply underfunded is detrimental. This time, we are not only affecting disabled consumers, but disabled children who are already born with a disadvantage in life. These children have capabilities. I know that because I was a disabled child, and am now a thriving and productive adult member of society.

Disabled children need support from their community. I am begging legislators to consider how important funding is for children with special needs. These resources assist parents who are at a loss when it comes to helping their children. Even as a disabled person, I had no idea how to help my daughter find the services she needed. I am thankful for the EIS program because it provided the support I needed to determine what was needed for my child.

It does take time to get services because they are underfunded. I do not think the numbers presented in the meeting are accurate because I have friends with children who have been waiting for services for months. It is not just because of Covid-19. It is because the EIS program does not have the money and resources it needs to provide services for its consumers. There are so many of them. People who can get paid more working at a department store than serving their community doing a job that is emotionally taxing will do so, unless they have a passion to assist the disabled community. Please consider that. Please consider these programs that serve children. These children have the means to be great members of the community, but need support. The support is barely there as it is. Please do not cut anymore funding. I would have been lost without the EIS program.

MISTY GRIMMER (Nevada Alzheimer's Association):
The Nevada Alzheimer's Association expresses its support for all of the work that Ms. Schmidt and her team does at the ADSD. The work they put in for our community is important. Mr. Gold mentioned much of what I wanted on the record. I want to encourage continued support of Ms. Schmidt, her staff and all of the programs the ADSD runs. I think we have several meetings scheduled with legislators next Tuesday, which is Alzheimer's Awareness Day at the Legislature. The Association looks forward to continuing to work with you on these programs.

ROBERT BURNS (President, Therapy Management Group; Early Intervention Community Providers Association):
I have written testimony, (Exhibit C).

I am a co-owner of Therapy Management Group, and we provide early intervention services to children from birth to three years old throughout Nevada. I am also the president of Early Intervention Community Providers Association (EICPA), which is the trade organization that represents the majority of early intervention community providers. The 12 percent rate reduction from $565 per child per month to $500 per child per month concerns the EICPA. We would also like to call your attention to the possible continuation of the rule that has the State providing 50 percent of services to children and families in need. Community partners see the other 50 percent of the children, but approximately 25 percent of the total EIS budget. Per an executive audit, it costs community partners 30 percent less to provide EIS compared to State providers.

From 2005 through 2011, restrictions and legal actions were levied against the State due to large waitlists and noncompliance with the IDEA. The public-private partnership service delivery model was created as a solution and resulted in elimination of the waitlist in compliance with the IDEA for the first time. A rate decrease to $500 per child per month would result in a negative service delivery model change, with community providers possibly going out of business. This potentially opens the State up to legal action with the return of waitlists and noncompliance with federal mandates.

I have a number of possible solutions. Tenant funds could be used to eliminate the cuts and holds of the biennium as the economy continues to recover. The 50-50 split could be modified to a 60-40 split or 70-30 split, ensuring parent choice and the elimination of rotation holds. Both State providers and community providers acting in concert as a system-wide early intervention safety net.

LISA FOSTER (State of Nevada Association of Providers):
I am representing the State of Nevada Association of Providers (SNAP). We want to express support for the ADSD budget items being considered today. Our members partner with the State to provide services to adults with intellectual disabilities to meet their housing, transportation, medical, social and employment related needs. The Association appreciates the ability to constructively work with the ADSD to help those we serve reach the goal of meeting the client's potential. We appreciate the work of the Subcommittees and the great efforts of those at the ADSD and the DHHS.

STEVEN COHEN:
I agree with what has been said.

CONNIE MCMULLEN (Personal Care Association of Nevada):
I have written testimony (Exhibit D).

I support ADSD budget accounts. I am particularly interested in B/A 101-3266, and items in the HCBW program. This includes the Homemaker program services and COPE services.

I understand why there is a limited number of slots when the need is so high. I caution that, as the pandemic stabilizes, seniors and people with disabilities will want to engage with life again. Personal care at all levels, including for children, will be needed. The caseload will be restored and the waitlist will grow. I am concerned about the budget cuts made in A.B. No. 3 of the 31st Special Session. I understand why they were made, and thank legislators for the efforts they took to stabilize the State. The rates have been a constant problem. They are too low.

The reduction of services is a huge frustration for people and the industry. We should revisit some of these services. Maybe we can make them more efficient instead of doing away with them.

No one wants to go into a nursing home. There is not enough nursing home capacity in Nevada as it is. In many cases, people would rather die than go to nursing homes. I mean no offense to nursing homes, but many individuals would prefer to die in their own homes.

Your ideas about small residential homes are great. When my mother was no longer acute, she was asked to leave a skilled nursing home and moved to a small group home where she eventually passed away on hospice care. The one-on-one service was great. It was more affordable, my mother got better care and the family was able to visit more easily.

MARK GIBSON:
My daughter was diagnosed with autism spectrum level II, a developmental disability. She is 2.5 years old. She is in the EIS program. I want to express opposition to the rate reduction in B/A 101-3208. My daughter receives ABA therapy under ATAP, and services are calculated at an average rate of $120 per hour.

The cost totals $187,500 for a noninsured person. My family has insurance, and we are able to cover a majority of costs. The remaining balance is $37,500.

I am unemployed, as I had to leave my job to take care of my daughter. The caregivers, who were nonspecialized and hired through a nanny agency, were not able to give my daughter what she needs. My daughter was referred to the EIS program by a physician who rarely refers patients to EIS.

My daughter is unable to speak. She is unable to communicate the needs she has. She hands me a sippy cup when she wants something to drink. She cannot say "cup." She cannot say "mom." She cannot say "dad."

The EIS program and ABA services are crucial to the development of Nevada's future. I understand the pandemic has restricted in-home services. I understand costs were lower because of the use of virtual services. But virtual services, via Zoom, have not benefitted my daughter as well as in-home services. She cannot focus as well on a monitor, compared to direct interaction. We have been approved for 30 hours a week for ABA services. That is a large amount of time, even for people who do not face autism. I have a history of being in group homes that have now designated themselves as autism group homes.

With the benefits, I am worried about being able to go back into the working field to be able to help support our financial need. The money I would be making would allow me to break even, but I could not unable to provide my daughters with the consistency they need. The EIS program has been able to help us get ATAP and ABA services. The program helped us through Social Security, Medicaid and other resources such as the Sierra Regional Center in northern Nevada and Desert Regional Center in Las Vegas.

People tend not to use resources available to them because they are not informed. Specialists gravitate to people who actually seek resources. I believe a 12 percent reduction in rates will hinder service provision to the community. We have seen an increase in the rate of autism over the years. If I read the numbers correctly, 1 out of 54 kids in Nevada have autism. That is a high rate for a State with 3 million people. That is many kids who have autism.

I want to give my child, who is really gifted in music, a future. She needs resources to be available. As I speak to you, my daughter is in this room. I keep on flipping her and trying to communicate with her. This is relevant because ABA services help provide direction and consistency to my daughter. I cannot always do this because I have other children to raise. These challenges do not affect just my daughter, or the others who speak during public comment today. These are challenges that face children everyday. To touch up the future, we need to focus on the present. This reduction hurts the community. We end up spending more in the future because we do not make investments in the present. Why not assist children in need now instead of later?

DEACON TOM ROBERTS (President and CEO, Catholic Charities of Southern Nevada):
My concern is B/A 101-3266. I supported the home delivered meals budget the Governor submitted. Our budget will be kept flat. I want to give you some statistics about the southern Nevada market we serve. Thanks to State and private funding, we are able to serve almost 2,400 seniors in this State and 2,188 of those seniors are partially funded through the ADSD's funding model. Through the donations of private support and Agency efficiencies, we have been able to grow that number by almost 200 during the pandemic. We now serve nearly 2,400 seniors.

Our waitlist is large. It costs $1.3 million per year just to be able to serve the existing 2,188 clients and seniors we have taken off the waitlist on our own. The funding mechanisms need to increase by at least $2 million to $3 million if we are to successfully continue reducing the waitlist. I know legislators are aware food insecurity among Nevada's seniors is high. The ability to keep seniors in their homes with direct service is a matter of dignity and compassion. It is also efficient, as it keeps seniors out of assisted living and out of nursing facilities.

Thank you for keeping our budget flat this year. My hope is that there will be additional dollars dedicated to home delivered meals. That is important if we are going to continue caring for homebound seniors and continue reducing the number of people on the waitlist.

LISA ALLEN:
I am a mother of a child in the early intervention program. I would like to share his story to illustrate how the EIS program has positively affected our lives. When our son, Britton, was six months old, he endured a tragic accident. He suffocated under a pillow due to the propping of pillows around our bed during

an impromptu naptime. We did not want to move him to his crib, but we did not want him to roll off the bed.

Prior to this accident, Britton was developing normally and was a healthy child. As the result of oxygen loss while my husband was in the shower, our lives completely changed. At the time, I was in shock. I believed Britton would be fine when he came home from the hospital. I learned during the months we would spend in our local hospital and even at an out-of-state children's hospital this was not the case. I had no preparation and no experience with what our new normal would look like. Advanced Pediatrics' early intervention services have been a godsend. Britton received many types of therapy. The EIS program helped us learn how to take care of Britton the very best we can and improve his quality of life. Therapy is almost a daily occurrence, giving us the guidance we need to help Britton long-term.

Britton was diagnosed with spastic quadriplegic cerebral palsy, meaning control of all four of his limbs and his head are affected. He also has a cortical vision impairment, which makes it difficult for him to focus visually. Britton cannot eat by mouth on his own, and requires use of a feeding tube to give him the nutrition he needs to live and grow. The EIS program has been able to assist him by providing him with a developmental specialist, a physical therapist, a speech therapist, an occupational therapist, a nutritionist and a vision specialist. With the help of these incredible people, we are able to learn how to help ourselves do everyday activities with our son, including spoon feeding, brushing teeth, learning how to track objects with eyes, making sounds, playing with developmentally appropriate toys, movement with his joints and ultimately enjoying his life as we work towards the goal we pray will come as we continue to put forth the effort.

I want to note the simple things which are unsafe for us to teach Britton on our own, without EIS assistance. Activities like eating and brushing teeth represent choking hazards. As we learned through experience, exercising his arms and legs can be risky. His bones are easily broken as they are less dense. This is a result of lack of independent movement.

I do not know where we would be without Advanced Pediatrics. We never expected our lives to take this turn. The EIS program has been with us every step of the way since Britton's accident, and I know they are there for many families across northern Nevada. They help families get on their feet, figuratively and literally. They gave families the confidence needed to move forward on their individual journeys. Britton cannot do the things we once thought he would do, but it is with the help of EIS that we are hopeful he will eventually learn the extraordinary skills that the rest of us often take for granted, like seeing, eating, playing and walking. I hope you will give EIS the chance they deserve.

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CHAIR RATTI:
I adjourn this meeting at 10:45 a.m.

RESPECTFULLY SUBMITTED:

Joko Cailles,
Committee Secretary

APPROVED BY:

Senator Julia Ratti, Chair

DATE:

Assemblywoman Daniele Monroe-Moreno, Chair

DATE:

EXHIBIT SUMMARY

Bill	Exhibit Letter	Begins on Page	Witness / Entity	Description
	A	1		Agenda
	B	1	Dena Schmidt / Aging and Disability Services Division, Department of Health and Human Services	Aging and Disability Services Division Presentation
	C	1	Robert Burns / Early Intervention Community Providers Association	Early Intervention Community Providers Association Public Comment
	D	1	Connie McMullen / Personal Care Association of Nevada	Personal Care Association of Nevada Public Comment