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

Eighty-second Session
March 23, 2023

The joint meeting of the Subcommittees on Human Services of the Senate Committee on Finance and the Assembly Committee on Ways and Means was called to order by Chair Rochelle T. Nguyen at 8:06 a.m. on Thursday, March 23, 2023, in Room 3137 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to Room 4412 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Exhibit A is the Agenda. Exhibit B is the Attendance Roster. All exhibits are available and on file in the Research Library of the Legislative Counsel Bureau.

SENATE SUBCOMMITTEE MEMBERS PRESENT:

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

ASSEMBLY SUBCOMMITTEE MEMBERS PRESENT:

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

STAFF MEMBERS PRESENT:

Cathy Crocket, Chief Principal Deputy Fiscal Analyst
Brody Leiser, Chief Principal Deputy Fiscal Analyst
Kimbra Ellsworth, Senior Program Analyst

Paul Breen, Committee Assistant
Michelle Friedlander, Committee Secretary
Joko Cailles, Committee Secretary

OTHERS PRESENT:

Dena Schmidt, Administrator, Aging and Disability Services Division, Nevada Department of Health and Human Services
Jeff Duncan, Agency Manager, Aging and Disability Services Division, Nevada Department of Health and Human Services
Jessica Adams, Deputy Administrator, Aging and Disability Services Division, Nevada Department of Health and Human Services
Rique Robb, Deputy Administrator, Aging and Disability Services Division, Nevada Department of Health and Human Services
Marc Christensen, President, State of Nevada Association of Providers
Elyse Monroy-Marsala
Shelly Speck, Children's Advocacy Alliance

CHAIR NGUYEN:
We will hear from the Nevada Department of Health and Human Services (DHHS), Aging and Disability Services Division (ADSD).

DENA SCHMIDT (Administrator, Aging and Disability Services Division, Nevada Department of Health and Human Services):
I am presenting the ADSD budget presentation (Exhibit C). Page 2 of Exhibit C contains our mission and vision statement. Page 3 of Exhibit C contains our organization chart. Page 4 of Exhibit C compares our proposed budget by funding sources with the 2021-2023 biennium. Page 5 of Exhibit C is a summary of our budget requests by budget account (B/A) for the Eighty-second Session.

Budget account 101-3151 shown on page 6 of Exhibit C is for the general administration of the ADSD, and funds our fiscal services, IT, human resources and the chief elder rights position. It also includes program staff who oversee multiple ADSD programs in order for us to cost allocate their positions.

HEALTH AND HUMAN SERVICES

AGING AND DISABILITY SERVICES DIVISION

HHS - ADSD - Administration — Budget Page DHHS-ADSD-18 (Volume II)
Budget Account 101-3151

Page 7 of Exhibit C lists enhancement units for B/A 101-3151. Decision units E-225, E-226 and E-227 increase our human resources, IT and fiscal staff load. This will support ADSD's infrastructure and growth over time.

E-225 Efficiency & Innovation — Page DHHS-ADSD-20
E-226 Efficiency & Innovation — Page DHHS-ADSD-20
E-227 Efficiency & Innovation — Page DHHS-ADSD-21

Decision unit E-228 in B/A 101-3151 increases funding for executive team out-of-State travel.

E-228 Efficiency & Innovation — Page DHHS-ADSD-21

Decision unit E-230 in B/A 101-3151 funds software for electronic signature capabilities. This will help improve ADSD workflows. The pandemic taught us there are many technologies that can advance our ability to perform our work.

E-230 Efficiency & Innovation — Page DHHS-ADSD-22

Page 8 of Exhibit C lists two decision units for position reclassifications. Decision unit E-805 in B/A 101-3151 reclassifies an accounting assistant I position to a management analyst I position. This will provide oversight and guidance to the ADSD fiscal team. The team has grown and the complexities of managing several funding sources have increased.

E-805 Classified Position Changes — Page DHHS-ADSD-22

Decision unit E-816 in B/A 101-3151 aligns the salary of the chief elder rights attorney with other positions that require licensure. Several positions that will

be in the unclassified pay bill require licensure, but the chief elder rights attorney has not been paid at the same amount.

E-816 Unclassified Position Changes — Page DHHS-ADSD-23

CHAIR NGUYEN:
How has the ADSD managed its current IT needs, including any work orders or project backlogs?

MS. SCHMIDT:
We have 26 full-time IT staff members and 4 contractors. We worked with the agencies across the DHHS, including the Division of Welfare and Supportive Services, on calculating our needs and program alignment. It was found the ADSD needed 30 staff members. We have 15 staff members and are asking for 4 additional positions. Our calculations indicated we need to ask for more positions than requested in the Executive Budget.

Help desk tickets have increased for our field staff and help desk positions. The larger workload has caused these employees to fall behind. According to Gartner Research, a 1 to 70 workload ratio is ideal. The request in the Executive Budget would bring us to a 1 to 174 ratio. The current ratio in the ADSD is 1 to 196.

Our excessive workload ratio impedes our ability to perform tasks. Staff members have to wait hours or days to turn on their computers because of how behind we are.

CHAIR NGUYEN:
Do you have concerns about being able to fill those positions?

MS. SCHMIDT:
Several initiatives are being considered by lawmakers to support State employees. These may help with staffing issues.

One of the things we are cognizant of, especially for human resources staff, is people have to leave the ADSD for promotions. We have tried to create positions that facilitate an Agency career path, encouraging staff to stay with

the ADSD. A great human resources staff manager recently left the Agency because she did not have promotional opportunities. The ADSD aims to tier our staff positions to facilitate retention within our fiscal, IT and human resources teams.

ASSEMBLYWOMAN ANDERSON:
Can you discuss how the ADSD has been managing its human resources needs, and what benefits are expected if the four new positions in decision unit E-226 in B/A 101-3151 are approved? Do you have any recruits in mind?

MS. SCHMIDT:
We do the best with what we have and work hard. The ADSD has 18 human resources staff supporting over 1,200 employees. The 4 new positions will bring us to 22 human resources positions.

Our Executive Budget request reflects a 44 percent growth rate in our total full-time equivalent (FTE) positions. Historically, we have not had that same growth rate for our human resources staff. The new positions will help us retain enough human resources positions. For recruitment and retention, the ADSD is trying to build an Agency career path.

ASSEMBLYWOMAN ANDERSON:
Are you experiencing burnout with human resources staff? Are employees retiring earlier?

MS. SCHMIDT:
I do not have exact data on why people have left the human resources unit. Anecdotally, the people who have left, that I know of, did so because of promotional opportunities. I can provide follow up data.

ASSEMBLYWOMAN JAUREGUI:
For decision unit E-227 in B/A 101-3151, can you discuss how the ADSD has balanced its current human resources workload and how a new administrative services officer position would balance that out?

MS. SCHMIDT:
We have 25 State staff members in the ADSD fiscal team. They oversee eight budget accounts as well as contracts and grants we administer. Our requests add an additional five fiscal positions to the ADSD. The administrative services officer II position will support existing budget accounts, as well as new ones being proposed during the Eighty-second Session. Additional fiscal positions in the ADSD will allow for the appropriate workload distribution.

A staff member recently resigned. She was excellent at managing B/A 101-3266. This was a major loss. We are hopeful these additional positions will split workloads and support our fiscal employees.

HHS-ADSD - Home and Community-Based Services — Budget Page DHHS-ADSD-74 (Volume II)
Budget Account 101-3266

I will now present B/A 262-3156 for the ADSD Senior and Disability Prescription Program beginning on page 9 of Exhibit C.

HHS-ADSD - Senior Rx and Disability Rx — Budget Page DHHS-ADSD-27 (Volume II)
Budget Account 262-3156

The State Pharmaceutical Assistance Program (SPAP) provides low income seniors and people with disabilities who are Medicare eligible a subsidy towards their Medicare Part D premium.

Page 10 of Exhibit C shows our actual and projected caseloads. The decision units in B/A 262-3156 begin on page 11 of Exhibit C. Decision units M-200 and M-201 show a projected caseload decrease.

M-200 Demographics/Caseload Changes — Page DHHS-ADSD-28
M-201 Demographics/Caseload Changes — Page DHHS-ADSD-28

Decision unit E-229 in B/A 262-3156 combines the Senior Prescription Program and Disability Prescription Program expenditures into a new budget category.

This gives the ADSD the flexibility to serve our clients as they are. We have always divided these programs into two different budget accounts. The Executive Budget request eliminates the need to allocate these funds separately.

E-229 Efficiency & Innovation — Page DHHS-ADSD-29

ASSEMBLYMAN WATTS:
The ADSD Senior and Disability Prescription Program has seen shifts, particularly with changes in Medicare Part D. How many clients does the ADSD anticipate serving per month? What would the subsidy amount for those clients be? Is the ADSD using the average amount or aiming to provide clients the maximum amount?

JEFF DUNCAN (Agency Manager, Aging and Disability Services Division, Nevada Department of Health and Human Services):
Our caseload projection is 500 clients. We serve 400 clients now. In terms of the subsidy, we budget up to $37 per person as that is the maximum we can pay. The person may not choose or need to spend that maximum.

ASSEMBLYMAN WATTS:
We have seen different figures in various places and want to ensure the data aligns. Do you project the caseload will continue to decline due to some other changes reducing the need for the Program? If so, what does the ADSD see coming as far as changes to the Program in the future?

MR. DUNCAN:
Based on how the Program works today, we do not see the caseload increasing because of how competitive Medicare Part D plans are that do not have premiums. Potential clients under those plans would not be eligible for our Program.

Senate Bill 4 may give us the ability to expand the population and service delivery if it passes.

SENATE BILL 4: Revises provisions governing certain programs to pay for prescription drugs, pharmaceutical services and other benefits. (BDR 40-220)

SENATOR DONDERO LOOP:
Can you provide more information as to how consolidation of the Senior Prescription Program and Disability Prescription Program will benefit clients?

MR. DUNCAN:
Combining categories will allow us to better meet client needs. When we have excess dollars in one program and not enough dollars in another program, the ADSD has to go before the Interim Finance Committee (IFC) to transfer funds around. Consolidation provides flexibility to address where demand is.

SENATOR TITUS:
Federally, Medicare Part D expanded, which addresses pharmacy benefit plans for Medicare recipients. More people use that program, decreasing the number of users of the State programs. It is not that there are fewer seniors in Nevada. New programs are covering the need. Is the ADSD requesting better use of State program funds?

MR. DUNCAN:
Yes.

MS. SCHMIDT:
We will now present the Rural Regional Center (RRC) B/A 101-3167, the Desert Regional Center (DRC) B/A 101-3297 and the Sierra Regional Center (SRC) B/A 101-3280.

HHS-ADSD - Rural Regional Center — Budget Page DHHS-ADSD-35 (Volume II)
Budget Account 101-3167

HHS-ADSD - Desert Regional Center — Budget Page DHHS-ADSD-115 (Volume II)
Budget Account 101-3279

HHS-ADSD - Sierra Regional Center — Budget Page DHHS-ADSD-126 (Volume II)
Budget Account 101-3280

Regional centers support individuals with intellectual and developmental disabilities across the State, helping them live in the least restrictive settings. Page 16 of Exhibit C shows the caseload projections for the regional centers. Decision units M-200 and M-201 in B/A 101-3167, B/A 101-3279 and B/A 101-3280 represent the combined caseload increases in the three regional centers.

M-200 Demographics/Caseload Changes — Page DHHS-ADSD-36
M-201 Demographics/Caseload Changes — Page DHHS-ADSD-37
M-200 Demographics/Caseload Changes — Page DHHS-ADSD-117
M-201 Demographics/Caseload Changes — Page DHHS-ADSD-118
M-200 Demographics/Caseload Changes — Page DHHS-ADSD-127
M-201 Demographics/Caseload Changes — Page DHHS-ADSD-128

Decision unit M-202 in B/A 101-3167, B/A 101-3279 and B/A 101-3280 would fund nine new positions for our Youth Intensive Services Support (YISS) program. Staff members focus on helping children with intellectual and developmental disabilities. We are seeing an increase in behavioral health needs and the need to support children with more than one diagnosis through YISS. We historically had YISS in Las Vegas but have not created it in other State regions.

M-202 Demographics/Caseload Changes — Page DHHS-ADSD-38
M-202 Demographics/Caseload Changes — Page DHHS-ADSD-119
M-202 Demographics/Caseload Changes — Page DHHS-ADSD-129

These requests change staffing ratios. Our normal staff ratios are 1 to 45. For YISS, it is 1 to 15, allowing employees to focus on the intensive needs of the families.

Decision unit M-510 in B/A 101-3279 and B/A 101-3280 reflect a reduction in our projected waitlists for the DRC and SRC.

M-510 Mandates — Page DHHS-ADSD-120
M-510 Mandates — Page DHHS-ADSD-130

Page 17 of Exhibit C shows decision unit E-252 in B/A 101-3167, B/A 101-3279 and B/A 101-3280, which increases the monthly allotment for our Fiscal Intermediary Program (FIP) from $450 to $650. The program is available to families with children under age 18. It provides funding that allows them to self-direct money for specialty services that may not be covered by typical health insurance.

E-252 Infrastructure, Energy & Environment — Page DHHS-ADSD-39
E-252 Infrastructure, Energy & Environment — Page DHHS-ADSD-123
E-252 Infrastructure, Energy & Environment — Page DHHS-ADSD-131

Decision unit E-250 in B/A 101-3167, B/A 101-3279 and B/A 101-3280 shown on page 17 of Exhibit C funds an increase in provider rates based on a study we conducted with Burns and Associates. We anticipate this will reduce waitlists. Providers and the State have struggled to hire and retain staff to provide critical services.

E-250 Infrastructure, Energy & Environment — Page DHHS-ADSD-39
E-250 Infrastructure, Energy & Environment — Page DHHS-ADSD-123
E-250 Infrastructure, Energy & Environment — Page DHHS-ADSD-130

Decision unit E-255 in B/A 101-3167 and B/A 101-3280 on page 17 of Exhibit C funds contracts with board-certified behavior analysts to support people with high behavioral and complex needs. Behavioral health needs across the State are increasing, and the clients we serve are not immune to that. Having board-certified behavior analysts on hand will be helpful for our teams and families.

E-255 Infrastructure, Energy & Environment — Page DHHS-ADSD-40
E-255 Infrastructure, Energy & Environment — Page DHHS-ADSD-131

Budget account 101-3166 for our Family Preservation Program (FPP) on page 18 of Exhibit C provides financial assistance on a monthly basis to low-income families providing care in their homes for family members with profound or severe intellectual disabilities.

HHS-ADSD - Family Preservation Program — Budget Page DHHS-ADSD-32 (Volume II)
Budget Account 101-3166

Page 19 of Exhibit C shows caseload projections for the FPP. Page 20 of Exhibit C shows associated decision units. Decision unit M-201 in B/A 101-3166 shows a projected caseload increase. Decision unit E-240 funds an increase in the monthly allotment from $374 to $486.

M-201 Demographics/Caseload Changes — Page DHHS-ADSD-33
E-240 Efficiency & Innovation — Page DHHS-ADSD-33

Page 21 of Exhibit C addresses enhancement units specific to B/A 101-3279 for the DRC and does not pertain to B/A 101-3166. Decision unit E-233 in B/A 101-3279 funds a two-grade increase for developmental technicians at our intermediate care facility. These team members provide direct support to people residing in intermediate care facilities.

Our wages do not even compete with fast food and retail establishments. Support staff at intermediate care facilities have harder jobs without comparable pay. The current pay grade for a developmental technician I is Grade 23, at $15.19 per hour. That is what we pay to staff working with behaviorally complex individuals. The ADSD is seeing the highest turnover and vacancy rates recorded at our intermediate care facilities. We hope pay increases will resolve some of these issues, so we can be competitive in the job market.

E-233 Efficiency & Innovation — Page DHHS-ADSD-122

Decision unit E-226 in B/A 101-3279 on page 21 of Exhibit C funds the continuation of one agency manager position for the DRC intermediate care facility. The needs there for community-based services have grown. Historically, we only had one agency manager, but that workload is too much for one person. We created another agency manager position with the approval of the IFC. The position is filled, and we would like to continue it moving forward.

E-226 Efficiency & Innovation — Page DHHS-ADSD-121

Page 21 of Exhibit C shows decision unit E-225 in B/A 101-3279 funds an additional accounting assistant for payroll. The number of FTEs in the ADSD has increased significantly, but there has not been a corresponding increase in the number of payroll staff processing the transactions.

E-225 Efficiency & Innovation — Page DHHS-ADSD-120

Decision unit E-248 in B/A 101-3279 on page 21 of Exhibit C funds a fleet van for the intermediate care facility.

E-248 Efficiency & Innovation — Page DHHS-ADSD-122

Page 22 of Exhibit C covers specific enhancement units in B/A 101-3280 for the SRC and does not encompass B/A 101-3279. Decision unit E-257 in B/A 101-3280 funds a contract for a security guard to provide a secured environment for both visitors and staff.

E-257 Infrastructure, Energy & Environment — Page DHHS-ADSD-132

Decision unit E-720 in B/A 101-3280 funds a new fleet vehicle.

E-720 New Equipment — Page DHHS-ADSD-132

Page 23 of Exhibit C contains text that we request be put into the Appropriations Act. Historically, this language has always been in the Act to allow funds to be transferred between the three regional centers based on need. We want that authority to continue.

ASSEMBLYWOMAN MONROE-MORENO:
Could you discuss provider capacity and how that capacity impacts the ability to serve people with more complex needs?

JESSICA ADAMS (Deputy Administrator, Aging and Disability Services Division, Nevada Department of Health and Human Services):
The waitlist has increased over the past two years, mostly due to provider capacity. Providers have had difficulty in hiring staff. We have a process, called a vendor call, when someone needs a service. Providers are called to gauge

interest in whether they want to serve a given client. During fiscal year (FY) 2022-2023, we received 2,100 responses to vendor calls. This does not represent 2,100 people. It represents 2,100 different instances in which providers responded to vendor calls. Our findings show 75.2 percent of these responses indicated a provider was not interested in serving a given individual. Of this 75.2 percent, 65 percent of providers have indicated they said no because they lacked adequate staff. We have a dire situation where people cannot be served.

The number of people on waitlists is increasing. People who received services prior to the pandemic may not be able to access services now because they stopped treatments due to COVID-19. This is the worst situation we have ever seen as far as providers not being able to hire staff and people who need services having to wait.

ASSEMBLYWOMAN MONROE-MORENO:
We hear about the State not being able to hire staff. We have to contract with vendors, and we think it is easier for them to onboard staff because they pay more. Now, they say they cannot hire enough employees either.

The Executive Budget reduces the waiver waitlist for supportive living arrangements, and jobs and day training (JDT) programs. Do you anticipate being able to serve all projected clients waiting more than 90 days for waiver services during the 2023-2025 biennium?

MS. ADAMS:
That is the goal, which is why legislators see the rate requests. If we can increase rates, the hope is providers can properly pay staff and encourage employees to make this line of work a career instead of a job they spend some time at before moving to something else. If we are able to increase the number of staff providers can hire, we will serve more people on our waitlist.

CHAIR NGUYEN:
Can you discuss whether the ADSD has observed any notable changes in the use of services for supportive living arrangements, family support, respite programs or JDT training?

MS. ADAMS:
There are several components to my answer. We still have people who were receiving JDT training prior to the pandemic who have not been able to resume training. This service has been hit harder than others.

We have been able to add more people to supportive living, but we have not met the levels we hoped for. This has to do with staffing issues. Not as many people have lost services in that realm.

With family support programs, we have seen a significant uptick in need for the FIP. So far in FY 2022-2023, another 100 clients were added. Our Executive Budget request reflects that this is a self-directed program for minors to attain services that their families think they need. This program has purchased music therapy, horseback riding therapy, art classes and similar services. This gives children things to do and gives parents a break.

CHAIR NGUYEN:
What factors have contributed to the increase in the projected family support caseload, especially at the DRC? This is in comparison to the FY 2021-2022 actual caseload.

MS. ADAMS:
Do you refer to children overall or an individual program in particular?

CHAIR NGUYEN:
I refer to children overall.

MS. ADAMS:
I cannot tell you why more kids are coming in. We do a significant amount of outreach to schools. There was a lull in our intake because of COVID-19. Most people were not going to school or participating in outreach events. People have since returned to in-person attendance. They can learn about our services through events and visiting schools. We are witnessing intakes increase. This is a natural flow. People are starting to learn about us again.

ASSEMBLYMAN YEAGER:
How has the RRC managed its fiscal needs? How will the proposed administrative services officer help with that management?

MS. ADAMS:
A lone administrative services officer III working out of the SRC prepares the budgets for both the SRC and RRC. That has been the case since developmental services funding switched into the ADSD several years ago. As caseloads have grown, money involved has increased. It has become more difficult for a sole administrative services officer to cover the need.

ASSEMBLYWOMAN JAUREGUI:
The rate increases in decision units E-250 in B/A 101-3167, B/A 101-3279 and B/A 101-3280 appear to be 43 percent. When was the last time there was a provider rate increase? Did some of that rate increase go to increasing employee hourly wages?

MS. ADAMS:
We had a small rate increase of 4.35 percent in FY 2021-2022, beginning September 1, 2021. We can provide you with a full history of our rates. The Burns and Associates study was the first official rate study since 2002 for developmental services. Our rates have been based on an old study we have incrementally been giving more money to.

When it comes to the amount of funds going to staff, the rate study and rates put forward are based on several assumptions. We wanted direct support staff to be paid $18 an hour. They would also receive benefits such as health insurance and paid time off, items which current rates do not allow for. When we asked Burns and Associates to do the study, we asked them to keep those items in the rate, so we could make this a career instead of a job to be held for a short time.

ASSEMBLYWOMAN JAUREGUI:
I want it on the record that the ADSD will get a 44 percent rate increase for staff. It is important that hourly wages and benefits for staff will be impacted in a positive way. If the rate increase is approved, what is the anticipated timeframe increases in provider capacity that would be realized?

MS. ADAMS:
The increases should be realized quickly and are accomplished in two steps. The first step would be realized July 1, 2023, based on our existing structure. This would be a rate increase across-the-board to close gaps and pay people better. The big rate study would be implemented April 1, 2024. The reason there is a delay is because the new rate structure comes with new mechanisms of providing and authorizing services. The way we have authorized services has not changed in at least 25 years. We will update and improve our processes. This requires us to hold several meetings and analyze how to effect positive changes for our thousands of clients.

ASSEMBLYWOMAN JAUREGUI:
You indicated the service authorization mechanism has not changed in at least 25 years. What will this administrative workload look like?

MS. ADAMS:
The nine-month period between July 2023 and April 2024 will encompass an intensive amount of work. We onboarded a program manager with our existing budget authority who will help us with the computer aspects of the mechanism update. We have dedicated staff who will lead the project. Providers will also assist.

ASSEMBLYWOMAN JAUREGUI:
If the provider rate increase is approved, how will wait times and waitlists be affected?

MS. ADAMS:
I cannot say for sure. Conversations with providers indicate they are confident once this is rolled out, they will be able to hire staff. We have a commitment from our extensive provider network that they will be ready to go once they can pay staff properly.

ASSEMBLYWOMAN JAUREGUI:
What does the waitlist look like right now? How long do people wait until they are provided services? How many people are on the waitlist? These are vulnerable populations, so it is important to get this information on the record.

MS. ADAMS:
As of February 2023, 434 people were waiting for residential supportive living across the State. Of these 434 people, 389 people were waiting for more than 90 days. There was an average wait time of 439 days—a little over a year.

Our JDT training services had a waitlist of 493 people. Of those 493 people, 462 had a wait time of more than 90 days, with the average wait being 485 days.

CHAIR NGUYEN:
The big rate study increase is set for April 2024. Other provider rate increases throughout the Executive Budget begin as soon as January 1, 2024. Is there a particular reason for the start date difference? Is it just the magnitude of the 43 percent increase that does not allow for the change to take effect in January 2024?

MS. ADAMS:
The magnitude of work requires the nine-month period between July 2023 and April 2024. This is why we asked for an interim increase in July 2023, so we would at least be able to get some additional money out. This is a large change.

ASSEMBLYMAN WATTS:
In decision units E-252 in B/A 101-3167, B/A 101-3279 and B/A 101-3280 for the FIP, there will be a $200 increase. How was that figure determined? Will that be enough for families to get the supports they need?

MS. ADAMS:
The $200 figure was derived from discussions with families. Families are always willing to accept additional help. The $200 increase reflected similar changes to other rates we administer.

The ADSD looked at historical data to determine if the rate had ever been increased from $450. We do not believe it was ever increased. I do not have an exact timeframe for when the FIP started, but it has been a long time.

ASSEMBLYMAN WATTS:
I want additional background information. Clearly, the rate has not kept up with inflation. What will the impact of the additional $200 be? What additional services will families be able to attain?

MS. ADAMS:
I cannot speak for every family as all families use this resource differently. Prices continue to increase for all services. The $450 rate will probably not pay for the same number of services it would have two years ago. This increase will at least allow families to retain services they have already been using. I am not sure families will be able to get more services, but they should at least be able to keep what they have.

ASSEMBLYMAN WATTS:
Not only is the additional $200 needed, but families probably need the ability to harness additional services. Please provide follow-up information.

SENATOR SEEVERS GANSERT:
We hear about 440-day waitlists for our most vulnerable families. Increasing provider rates by 43 percent is a huge bump. We have not been able to do that before. Hiring a board-certified behavior analyst makes sense to serve the many children affected with autism.

ASSEMBLYWOMAN ANDERSON:
How many residents with high behavioral and complex needs are receiving institutional care out of State?

MS. ADAMS:
We have seven children and eight adults living out of State who are open to regional center services.

ASSEMBLYWOMAN ANDERSON:
Will the additional staffing in the Executive Budget bring them back to Nevada and allow for an increase in the number of people getting services?

MS. ADAMS:
It may be possible to bring some of them—particularly the adults in intermediate care facilities—back to Nevada with the increase in the Executive Budget. It would be good if we were able to add higher-level supportive living homes in the State. The out-of-state children are typically receiving behavioral health services. It is more difficult for us to address that. If we are able to get some of our services provided in homes, we might be able to stabilize a child earlier, before they require out-of-State placements.

ASSEMBLYWOMAN ANDERSON:
Would the pay increase in the Executive Budget reflect $15 per hour for workers?

MS. ADAMS:
The amount is $18 per hour.

ASSEMBLYWOMAN ANDERSON:
Would some employees receive $15 per hour and others receive $18 per hour?

MS. ADAMS:
Right now, it is all based on $18 per hour. We can request additional increases in the future.

ASSEMBLYWOMAN ANDERSON:
I appreciate the increases. I wish we could do more, and sooner. Could you discuss how staff turnover affects children receiving services?

MS. ADAMS:
The impact depends on the person. Some face destabilization with constant staff turnover. We may see increases in behavioral issues, hospitalizations and suicidal ideations.

ASSEMBLYWOMAN GORELOW:
For decision unit M-201 in B/A 101-3166, could you explain the factors contributing to the decrease in the FPP caseload?

MS. ADAMS:
The FPP exists for a specific population. It serves people with profound intellectual disabilities or corresponding developmental disabilities. As such, it constitutes the lowest amount of diagnoses we see in regional centers.

We try to make sure everyone who is eligible submits an application for the FPP. Case closure data indicates some people move out of State. Other people may get paid to convert into shared-living homes in which the family is actually getting paid to provide services with staff, as opposed to getting a monthly supplement. These paid services provide more than the FPP, so the ADSD has seen clients shift towards shared-living homes.

Over the past few years, we have seen a different population come into our service system. The ADSD has seen more clients diagnosed with developmental disabilities as opposed to intellectual disabilities.

ASSEMBLYWOMAN GORELOW:
Do you see that trend continuing to decrease?

MS. ADAMS:
I do not know if the trend will continue to decrease. It may be stable, as it has been for the past several years. There are some months when we see slight increases or decreases, but, we have not seen the same number coming in with severe or profound intellectual disabilities as we used to.

SENATOR DONDERO LOOP:
If I am the relative of someone who needs services, what marketing or outreach would I see to know if we are eligible for services? Where would I find that information?

MS. ADAMS:
We try to attend many outreach events, including senior services and community occasions. The ADSD markets its services to schools. Once people know about our services, we have intake teams across our three regional centers that are able to give information to applicants. They explain eligibility to potential clients. Once someone is determined to be eligible, they are referred to a service coordinator.

CHAIR DONDERO LOOP:
Are clients born with these severe and profound disabilities? Can disabilities form throughout one's life?

MS. ADAMS:
I cannot speak to when disabilities form as I am not a clinician. The vast majority of clients are born with their conditions. People who develop conditions, due to events such as a traumatic brain injury, may qualify for our services if the event occurs before 22 years of age.

ASSEMBLYWOMAN JAUREGUI:
For decision units E-225 and E-226 in B/A 101-3279 for the DRC, can you discuss what the DRC payroll and oversight workload is without the proposed accounting assistant and agency manager positions? How will the addition of these positions benefit the DRC?

MS. ADAMS:
We have a hardworking team of accounting assistants. They sometimes need to work overtime to perform their duties. An additional position would be helpful to ease workloads.

For the agency manager, we had funds to start the position. The IFC gave us authorization to hire for it. We have two agency managers at the DRC. One of them oversees the intermediate care facility for intellectual or developmental disabilities, our 48-bed State-run facility, and the other oversees our community services program with a clientele of about 5,300 people.

ASSEMBLYWOMAN JAUREGUI:
Are accounting assistants at the DRC overworked? We do not want to lose more staff because they are being overworked. Will the new position allow accounting assistants to work normal hours instead of working overtime?

MS. ADAMS:
Yes.

ASSEMBLYWOMAN ANDERSON:
Can you provide an update on the $8.5 million approved during the October 2022 IFC meeting to fund providers through the University of Nevada, Las Vegas, Ackerman Autism Center? How much does the ADSD anticipate spending before the funds expire on December 31, 2026?

RIQUE ROBB (Deputy Administrator, Aging and Disability Services Division, Nevada Department of Health and Human Services):
We are evaluating that information. The grant award was disbursed in January 2023. We are working with the Ackerman Autism Center on these expenditures. The Center is in the process of hiring clinicians to reduce the autism caseload, including in diagnostics, and for fetal alcohol syndrome cases. We expect to have more information by July 2023.

ASSEMBLYMAN WATTS:
Can you provide an update on the $14.5 million approved during the October 2022 IFC meeting to support intensive behavioral support homes?

MS. ADAMS:
Our staff is meeting with potential vendors for the contractor piece of that appropriation, which is $520,000. We hope the vendor will be in our master services agreement group so we can contract with them quickly. As of now, no funds have been expended, but we should start rolling them out soon.

ASSEMBLYMAN WATTS:
We had several conversations about disbursing funds the Legislature authorized. It sounds like things are moving forward. Have there been any difficulties in rolling out those funds?

MS. ADAMS:
No, there have not been difficulties for the $14.5 million appropriation for intensive behavioral support homes.

ASSEMBLYMAN YEAGER:
It has been five months since the IFC authorized the Ackerman Autism Center grant. I am concerned because, based on the information I have seen, only about $80,000 of the $8.5 million grant has been obligated.

Can you update legislators if the ADSD believes it will not expend all funds by December 31, 2026? If so, we might be able to redirect some of the funds.

MS. ROBB:
Yes. We are working with the Ackerman Center to gather information. This is a large amount of money, and there has been a significant delay in setting up diagnostics and services. We will update legislators as often as you wish.

MS. SCHMIDT:
I will now present Home and Community Based Services (HCBS) in B/A 101-3266 beginning on page 24 of Exhibit C. This budget account contains multiple programs aimed at helping older adults and people with disabilities receive community-based services and remain as independent as possible.

Pages 25 through 30 of Exhibit C contain caseload projections for B/A 101-3266, including for our Personal Assistant Services program (PAS), Community Options Program for the Elderly (COPE), HCBS Waiver for the Frail Elderly, Adult Protective Services (APS) and our Long-term Care Ombudsman (LTCO) program.

Decision units for B/A 101-3266 begin on page 31 of Exhibit C. Decision units M-200, M-201, M-203 and M-205 pertain to projected caseload growth for PAS, COPE and HCBS Waivers.

M-200 Demographics/Caseload Changes — Page DHHS-ADSD-78
M-201 Demographics/Caseload Changes — Page DHHS-ADSD-79
M-203 Demographics/Caseload Changes — Page DHHS-ADSD-79
M-205 Demographics/Caseload Changes — Page DHHS-ADSD-80

Decision units M-202 and M-204 in B/A 101-3266 on page 31 of Exhibit C address a reduction in projected waitlists for PAS and COPE.

M-202 Demographics/Caseload Changes — Page DHHS-ADSD-79
M-204 Demographics/Caseload Changes — Page DHHS-ADSD-80

Decision units M-206 and M-207 in B/A 101-3266 are for the projected increase in the APS and LTCO caseloads.

M-206 Demographics/Caseload Changes – Page DHHS-ADSD-81
M-207 Demographics/Caseload Changes – Page DHHS-ADSD-81

Page 32 of Exhibit C shows enhancement decision units for B/A 101-3266. Decision units E-226, E-228 and E-490 fund a continuation of seven positions in both our Fiscal Unit, and the Planning, Advocacy and Community Grants (PACG) Unit. These positions were funded through federal American Rescue Plan Act of 2021 and Older Americans Act of 1965 dollars. We are asking for them to be continued because their work has not stopped. Caseloads continue to increase, as has the complexity of our grant funding. The number of funding sources we have for our programs has grown.

E-226 Efficiency & Innovation — Page DHHS-ADSD-83
E-228 Efficiency & Innovation — Page DHHS-ADSD-84
E-490 Expiring Grant/Program — Page DHHS-ADSD-87

We saw a 23 percent increase in the number of subawards we manage. This is a good thing. It means more community partners are providing services, but the ADSD has to process their funding requests.

Decision units E-227 and E-492 in B/A 101-3266 on page 32 of Exhibit C fund the continuation of three regional coordinator positions now funded by grants. The requests would carry the positions past the expiration of grant funding. Positions were modeled after the regional behavioral health coordinator program in the DHHS Division of Public and Behavioral Health. Their role is to serve as a convener of ADSD services within communities. They promote public knowledge of, and access to, our services by meeting with individuals, families and community leaders.

E-227 Efficiency & Innovation — Page DHHS-ADSD-84
E-492 Expiring Grant/Program — Page DHHS-ADSD-88

Decision units E-237 and E-491 in B/A 101-3266 on page 32 of Exhibit C change the funding source of one agency manager. The agency manager was initially funded through the American Rescue Plan Act of 2021. We want funding to be continued. The position oversees our PACG unit, which

administers grants. It also oversees community-based care, which is our PAS and COPE waivers.

E-237 Efficiency & Innovation — Page DHHS-ADSD-86
E-491 Expiring Grant/Program — Page DHHS-ADSD-87

Page 33 of Exhibit C shows more enhancement decision units in B/A 101-3266. Decision unit E-234 funds a rate increase for COPE and PAS providers. This aligns COPE and PAS with the Medicaid rate increase for the same services. The programs for COPE and PAS are State-funded and mirror some services in the Medicaid program. They are provided to individuals who are not necessarily qualified for Medicaid.

E-234 Efficiency & Innovation — Page DHHS-ADSD-85

Decision unit E-231 in B/A 101-3266 on page 33 of Exhibit C adds a program officer to support our Guardianship Program. In certain situations, the ADSD is required to be the petitioner for guardianship. We are seeing an increase in the number of these situations. The position will help address the workload.

E-231 Efficiency & Innovation — Page DHHS-ADSD-85

Decision unit E-225 in B/A 101-3266 on page 33 of Exhibit C funds a reinstatement of crisis support services funding. These funds are used to ensure safety of adults in APS.

E-225 Efficiency & Innovation — Page DHHS-ADSD-83

Decision unit E-809 in B/A 101-3266 on page 33 of Exhibit C reclassifies 48 social worker II positions to social work III positions. Nine social worker supervisor I positions are reclassified to social work supervisor II positions. These changes are for APS, a program that has had a historically high vacancy rate. We have had a 40 to 50 percent vacancy rate since before COVID-19. Staff in APS investigates cases and allegations of abuse, neglect and exploitation. These are crucial services.

E-809 Classified Position Changes — Page DHHS-ADSD-93

We have seen APS struggle to compete with other programs where social workers exist. The Child Protective Services workers in the DHHS Division of Child and Family Services have a higher pay grade. Decision unit E-809 aligns support for our social workers with those in other agencies.

Page 34 of Exhibit C visually represents the movement of funding out of B/A 101-3266 to B/A 101-3278, B/A 101-3282 and B/A 101-3283.

HHS-ADSD - Planning, Advocacy and Community Grants — Budget Page DHHS-ADSD-107 (Volume II)
Budget Account 101-3278

HHS-ADSD - Adult Protective Servs & Long-Term Care — Budget Page DHHS-ADSD-135 (Volume II)
Budget Account 101-3282

HHS-ADSD - State Independent Living Council — Budget Page DHHS-ADSD-139 (Volume II)
Budget Account 101-3283

Budget account 101-3266 will retain HCBS programs for PAS and COPE. Budget account 101-3278 establishes a separate section for the PACG Unit. The Unit will cover Older Americans Act of 1965 funding, discretionary grants and community services programs. Budget account 101-3282 will contain APS and our LTCO program. Budget account 101-3283 funds the Statewide Independent Living Council. Page 35 of Exhibit C shows the FTE positions being transferred between these four budget accounts.

SENATOR DONDERO LOOP:
Why are there waitlists for PAS and COPE when the number of patients being served in FY 2021-2022 has actually decreased?

MR. DUNCAN:
This goes back to our vacancy rate, which varies by program. The average social worker vacancy rate—whether on Waiver, COPE or PAS—was approximately 30 percent.

SENATOR DONDERO LOOP:
Is this just a caseload management piece?

MR. DUNCAN:
Yes. We need social workers to place people in programs.

SENATOR DONDERO LOOP:
How many people do we believe are not being served? If we have a vulnerable elderly population that needs help, and we cannot provide services, that is concerning. Are there 20 people we cannot serve? Is it 200 people?

MR. DUNCAN:
If we were fully staffed, we could serve our full projected and funded caseload. We are not able to do so with a 30 percent vacancy rate. We need people to apply for our jobs at the ADSD. Slots cannot be filled without the corresponding team members to provide services.

SENATOR DONDERO LOOP:
How many people are not being served? These are older people who may need help.

MR. DUNCAN:
The HCBS Physical Disabilities Waiver program had a waitlist of 319 people. For the HCBS Frail and Elderly Waiver, the waitlist was 1,087 people. For PAS, the waitlist was six people. For COPE, it was six people. These numbers fluctuate as we hire and lose staff members.

SENATOR DONDERO LOOP:
These waitlists are daunting. As someone who has cared for elderly people, I cannot imagine that the people on the waitlists are not getting the services they need.

CHAIR NGUYEN:
How has the ADSD managed the growing caseload for the APS program? There is a need for additional staffing, including program, administrative and supervisory staff. How has the Agency been dealing with that?

MS. SCHMIDT:
We have supervisors who take caseloads. Over time, we made authorizations as the budget authority has become available. We aim to maintain caseloads.

We successfully conducted emergency reclassifications to change some of our social work positions to adult rights specialist positions. We brought these people in to help with investigations and support our social work staff. The ADSD continues to struggle with meeting our timeframe of investigating all cases within three days.

ASSEMBLYWOMAN GORELOW:
Can you elaborate on how much overtime staff has been putting in? Are we looking at an additional 10 or 20 hours per staff member weekly?

MS. SCHMIDT:
I do not have specific numbers on hand. When the ADSD has projected savings, we determine how many hours can be paid for. We then allow employees to voluntarily work overtime up to the budgeted authority for pay.

We track this information and can follow up with legislators.

ASSEMBLYWOMAN MONROE-MORENO:
In decision unit E-234 in B/A 101-3266, do you have an update of the caseload projections for COPE? Are they the same for PAS?

MR. DUNCAN:
Exhibit C contains the most up-to-date information from the DHHS Office of Analytics.

ASSEMBLYWOMAN MONROE-MORENO:
You said an increase will allow the rates to be more competitive. Is pay currently $13.12 per hour? Are we looking to increase that to $25 per hour?

MR. DUNCAN:
It varies by service. I cannot provide that information for each specific worker. For our average rate increases, there would be a 42 percent increase for attendant care, 66.7 percent increase for Homemaker Program care,

66.7 percent increase for chore services, 212 percent increase for adult companion care and 150 percent increase for respite care.

ASSEMBLYWOMAN MONROE-MORENO:
Is the $13.12 rate at the low end of what that group is being paid? Are some employees making more than that?

MR. DUNCAN:
Yes.

ASSEMBLYWOMAN MONROE-MORENO:
These are significant rate increases. You say it will make us more competitive. Will we be close to what private agencies pay? Will there still be a large margin between the State rates and private industry?

MS. SCHMIDT:
The rate increase aligns with the Medicaid rate increase. This was done at the recommendation of the Nevada Home Care Employment Standards Board. The industry aligned with this recommendation. We are hopeful this increase will make us competitive.

I do not have details on how they got to the particular rate increase figure. We just want to ensure we are in alignment with the Medicaid rate. The providers we use also provide Medicaid services. We do not want to pay significantly less than Medicaid. Medicaid homes and non-Medicaid homes should be paid the same rate.

ASSEMBLYWOMAN MONROE-MORENO:
Do we know how long ago the survey was conducted?

MS. SCHMIDT:
We can follow up with that information. The ADSD's goal was to ensure we were aligned with the Medicaid rates. We were not directly involved with the recommendation.

ASSEMBLYWOMAN MONROE-MORENO:
What impacts do you anticipate on provider capacity as a result of the recommended increases? Will we address provider shortages?

MR. DUNCAN:
I cannot say with certainty. We hope the rate increase provides equity for our providers so they can address their capacity issues.

ASSEMBLYWOMAN JAUREGUI:
In decision unit E-809 in B/A 101-3266, are the reclassifications of social worker positions for retention so you can be competitive with other State agencies and the private sector?

MS. SCHMIDT:
The reclassification is to address both retention and the way APS has changed by becoming more complex. During the Eightieth Session, the Elder Protective Services program was changed to Adult Protective Services. We provide services to a spectrum of clients and their cases have greater complexity. Within elder protection, there is increased complexity from issues like financial exploitation. We want to properly align pay for protective services staff and retain our workers.

ASSEMBLYWOMAN JAUREGUI:
The caseload-to-caseworker ratio is higher than it should be. What is the consequence of this?

MS. SCHMIDT:
Our staff deals with turnover, burnout and overtime. The people who do this work care deeply. They work hard to manage their caseloads. The ADSD internally tries its best to manage and use overtime when it is available.

Our supervisors are taking caseloads. Some of our tasks do not get done as supervisors have to handle cases themselves. There is an impact to overall quality when everyone is doing the job and no one is doing the oversight.

ASSEMBLYMAN WATTS:
I want to ask about the continuation of positions approved by IFC and funded with American Rescue Plan Act of 2021 dollars. The ADSD attested to its increased workload, necessitating maintenance of these positions with subawards. Can you provide additional information as to how these positions will increase or maintain the ADSD's capacity? Will the community benefit from keeping these positions going?

MR. DUNCAN:
For years, the ADSD struggled with the need to address the complexity of our funding sources and oversight requirements at both the State and federal levels.

We have almost 50 different funding sources, each with different rules, complications and reports. The benefits of continuing the positions are to remain in compliance, conduct quality assurance and provide technical assistance for our robust community partner network.

ASSEMBLYWOMAN GORELOW:
For the new program officer position in decision unit E-231 in B/A 101-3266, our understanding is that guardianship cases are addressed on an ad hoc basis. Can you provide more information on how the ADSD is managing guardianship cases and how the new position will help with the workload?

MS. SCHMIDT:
Adult Protective Services has to file documentation. Social work supervisors are doing the work proposed for this position, pulling them away from cases.

Adult Protective Services has recently seen a historically unusual figure of 40 filings. The ADSD has also had to implement monthly case staffing meetings to screen potential guardianships. These meetings take three to four hours as we are going through cases to determine whether guardianship is the appropriate path. We work with the whole team to identify other resources and the least restrictive options possible. The program officer position would guide that process, ensure consistency, collaborate with our team and relieve social workers and their supervisors from filing duties. Field staff would be able to focus on their investigation duties.

ASSEMBLYWOMAN GORELOW:
What factors are contributing to the increase in these caseloads? What is the projected caseload for the 2023-2025 biennium?

MS. SCHMIDT:
We have not historically tracked the guardianship caseload. We have seen a large increase in the number of cases, but we do not have a projection at this time.

Multiple factors contribute to the increased need for guardianship. One is that APS expanded, and we identified more individuals who need guardianship. We are seeing more complex needs of people in developmental services programs. We see parents getting older and no longer being able to care for their loved ones.

SENATOR TITUS:
We sit in many hearings where the ADSD justifies the need for new positions. The sentiment that everyone is doing the work, and no one is doing oversight exemplifies the need for supervisory roles. No one is looking, from above, at whether things are being done correctly.

SENATOR DONDERO LOOP:
In B/A 101-3278, why does the PACG Unit require its own budget account?

MS. SCHMIDT:
Mr. Duncan said we have nearly 50 funding sources for the ADSD. When you consider federal funding through Medicaid waiver programs, having individual budget accounts gives us the ability to isolate those dollars. We will do a better job tracking and monitoring of the funding of our grants.

CHAIR NGUYEN:
Why is funding for APS and the LTCO program being transferred to B/A 101-3278?

MS. SCHMIDT:
As the ADSD looked at how to categorize funding, we considered transparency from a fiscal perspective. Our LTCO program and APS are funded through the

same federal source. Various procedures and processes are more aligned between these two programs. It made sense for them to share a budget account. This change is not programmatic. It is more about ensuring fiscal transparency.

CHAIR NGUYEN:
Did the ADSD struggle with fiscal management or transparency previously?

MS. SCHMIDT:
This is an incredibly complex budget. The HCBS B/A 101-3266 has several moving parts. Previously, we only had one fiscal person overseeing it. Being able to break it up, with a fiscal team looking at the funding streams, would provide better oversight.

ASSEMBLYMAN WATTS:
My question pertains to B/A 101-3204 for the Consumer Health Assistance (CHA) program. How has the shift of staff towards arbitration activities impacted the ADSD since it began receiving arbitration requests under A.B. No. 469 of the 80th Session?

HHS-ADSD - Consumer Health Assistance — Budget Page DHHS-ADSD-43 (Volume II)
Budget Account 101-3204

MS. SCHMIDT:
I will address that as I present B/A 101-3204 beginning on page 36 of Exhibit C. The decision units for B/A 101-3204 are on page 37 of Exhibit C.

Decision unit E-226 in B/A 101-3204 on page 37 of Exhibit C is a request for one-shot funding to contract with staff to finish, improve and maintain our case management system.

E-226 Efficiency & Innovation — Page DHHS-ADSD-46

Decision units E-490 and E-491 in B/A 101-3204 on page 37 of Exhibit C align funds and funding activities based on time tracking. We are replacing previous fund sources with General Fund appropriations as we are no longer tracking the

time associated with CHA activities. This change is based on the need of community members and the types of calls we receive.

E-490 Expiring Grant/Program — Page DHHS-ADSD-46
E-491 Expiring Grant/Program — Page DHHS-ADSD-47

ASSEMBLYMAN WATTS:
How has the shift of staff resources to arbitration impacted the ADSD?

MS. SCHMIDT:
When the arbitration process came to the CHA, we did not have a reference for how many cases we would address or how much time would be spent on them. Around 20 percent to 25 percent of our staff time is spent on arbitrations, with 64 percent spent on other activities. Medicaid program activities constitute 17 percent of staff time. Arbitration required more work from staff than we anticipated.

ASSEMBLYMAN WATTS:
Could you provide an update on cost recovery efforts associated with medical balance billing disputes?

MS. SCHMIDT:
As of March 14, 2023, we invoiced a total amount of $138,341. Of our invoices, 90 percent have been paid. We are projecting revenue of $172,631 by the end of June 2023.

ASSEMBLYMAN WATTS:
The proposal is for lawmakers to authorize General Fund dollars for CHA B/A 101-3204. Does the ADSD have a plan to support CHA's personnel costs for the long term if staff time shifts to nonbillable activities?

MS. SCHMIDT:
Historically, CHA ombudsman positions have been funded through the General Fund. Other grant funding was available at different times. Ombudsman activities are General Fund activities. When arbitration work is done, it is a billable activity.

The shortfall and issues seen in B/A 101-3204 can be addressed through two options. We can fund activities through the General Fund and then set the revenue back. Lawmakers can also allow us to keep the revenue and offset ongoing costs.

CHAIR NGUYEN:
With respect to case management system improvements, the ADSD testified it had been managing the associated workflows. You mentioned 25 percent of staff time was spent on arbitration activities. How will this recommended case management system improve efficiency?

MS. SCHMIDT:
As we learn more about arbitration, we learn more about data we need to collect. The proposed case management system would allow us to complete the arbitration process and ensure both arbitration and ombudsman activities are appropriately tracked.

These are one-time contract funds to complete system implementation. This is an in-house system which would be handled by internal positions proposed in the Executive Budget. Our IT Unit would take over the maintenance and management if any future enhancements were needed.

The Early Intervention Services (EIS) B/A 101-3208 begins on page 38 of Exhibit C.

HHS-ADSD - Early Intervention Services — Budget Page DHHS-ADSD-58 (Volume II)
Budget Account 101-3208

The EIS program provides services for infants and toddlers who have or are at risk for, developmental delays. Supports are also provided for their families. Caseload data and projections are on page 39 of Exhibit C.

Decision units for B/A 101-3208 begin on page 40 of Exhibit C. Decision units M-200 and M-201 in B/A 101-3208 pertain to a decreased caseload projection for EIS.

M-200 Demographics/Caseload Changes — Page DHHS-ADSD-60
M-201 Demographics/Caseload Changes — Page DHHS-ADSD-60

Decision unit E-226 in B/A 101-3208 on page 40 of Exhibit C funds a cost-per-eligible rate to increase access to care.

E-226 Efficiency & Innovation — Page DHHS-ADSD-62

Decision unit E-231 in B/A 101-3208 on page 40 of Exhibit C funds a rate increase for community partners. This is based on a comprehensive provider rate review conducted by Burns and Associates.

E-231 Efficiency & Innovation — Page DHHS-ADSD-64

Decision unit E-240 in B/A 101-3208 on page 40 of Exhibit C combines different service categories. The ADSD wants to try to combine State services with community partner services. The purpose of this is to ensure parental choice and allow the money to follow the individual child rather than us delegating which budget account families have to work out of. This better aligns our activities.

E-240 Efficiency & Innovation — Page DHHS-ADSD-65

Page 41 of Exhibit C lists more enhancement units. Decision unit E-227 in B/A 101-3208 funds an expansion of telehealth capacity and remote access. During the pandemic, we learned we are able to do much work in remote areas through telehealth. We need the equipment to continue that work.

E-227 Efficiency & Innovation — Page DHHS-ADSD-62

Decision unit E-225 in B/A 101-3208 on page 41 of Exhibit C funds ongoing maintenance, equipment and repairs for our audiometer equipment.

E-225 Efficiency & Innovation — Page DHHS-ADSD-62

Decision unit E-228 in B/A 101-3208 on page 41 of Exhibit C funds ongoing costs of a new case management system.

E-228 Efficiency & Innovation — Page DHHS-ADSD-63

The bottom of page 40 of Exhibit C shows two reclassification decision units. We eliminated positions we felt were not needed and redirected the funds to create one program manager II in decision unit E-229 and one social services manager II in decision unit E-230. These positions are both needed for program oversight and management. These are higher-level positions, considered essential as the EIS program is becoming more complex; Managers are needed to oversee activities.

E-229 Efficiency & Innovation — Page DHHS-ADSD-63
E-230 Efficiency & Innovation — Page DHHS-ADSD-64

ASSEMBLYWOMAN GORELOW:
You testified to some of the factors contributing to the caseload shift toward community providers to help ensure parental choice. This is appreciated. I heard of cases where parent requests for community providers were rejected.

How will this caseload shift affect community providers? Some of them are not meeting the 45-day requirement to assess clients. Will this timeframe be extended?

MS. ROBB:
It is an issue when providers do not meet the 45-day window for assessments. The problem is found in EIS programs throughout the Nation, not just in Nevada. The system is facing shortages in both State-provided services and services from our community providers which negatively affects our State.

We work with community partners to help ensure the capacity they are able to provide. The State will continue to be a safety net. Unfortunately, the system is not meeting timelines due to critical shortages.

Therapeutic services also have capacity issues. Nevada has shortages of physical, occupational and speech therapist services. Our hope is that eliminating the 50/50 split between State services and community provider services will help us not have to compete for therapists, who often work for both the State and community providers.

If 60 percent of parents choose a community provider, that means 60 percent of therapists will be working through community providers. The goal is to allow families to have a choice while helping therapists render much-needed services in a timely manner.

ASSEMBLYWOMAN GORELOW:
There are provider shortages across the board, especially with therapists. How will staff reductions affect the caseload for those who choose to work for the State?

MS. ROBB:
The staff reductions are for State employees—developmental specialists and supervisors. Our caseloads are starting to trend upwards as we recover from the pandemic. There could be an issue as the positions are eliminated but, based on projections from the DHHS Director's Office, Office of Analytics, we will be able to keep a few staff members.

Eliminating the 50/50 split will allow community providers to fill in the gap as they can hire staff more easily in comparison to the State's hiring process. This will help us balance things out. We will not know the full impact on caseloads until we implement this model and give families the ability to choose.

ASSEMBLYWOMAN GORELOW:
The pandemic required providers to develop a hybrid model, with services being rendered mostly online at first. Now some families are being seen online and others are using in-person services. Do you expect to fully revert to an in-home model? Will some services be kept virtual?

MS. ROBB:
A majority of services provided are in the natural, in-home environment. That is the first preference. The wonderful thing about having a remote option is we can still provide services if family members or even specialists are feeling ill. Services can still be provided, even though not in person. We can meet clients' needs timely and not have to do makeup sessions.

This is also a good benefit for rural areas if families or staff are unable to travel due to circumstances such as weather. We can provide services that we would otherwise be unable to render.

ASSEMBLYWOMAN JAUREGUI:
Regarding decision unit E-240 in B/A 101-3208, this service model has been used for almost a decade. How has the ADSD managed its caseload under the 50/50 split? There are concerns as to how you will manage staff levels if there are substantial shifts to and from State clinics.

MS. ROBB:
This is something the ADSD has been working on. The challenge has been that the 50/50 provider split was arbitrary. It added more challenges compared to the proposal in the Executive Budget. Mandating a 50/50 split means we have to either put the State program on hold or do so with our community providers. Families lose their choice. They do not have the ability to determine what program they would like to go to.

That program then had to wait until we went through a work program process, which is there for accountability. It did not support the family's choice. We put a hardship on one or the other of the programs because we then covered additional children having to join either State services or community providers, depending on which mechanism we put on hold. This was detrimental to the EIS program.

We will monitor the changes carefully, on a monthly basis. We do referrals and work closely with community partners. We communicate with each other. Community providers let us know if they feel there may be an issue with the budget and holds must be implemented. With the proposals in the Executive Budget, we can hopefully avoid holds, which impact our community providers as businesses and the State. We will continue to monitor EIS caseloads to ensure the State and community providers have adequate staff.

The ADSD is working with Burns and Associates to continue studying rates. We want to make sure the way we are modeling the EIS program is appropriate and

reflects best practices. This is one more step we are taking to ensure we work with the community and State providers.

The State providers will continue to maintain care for children and the medically fragile. We will be the safety net. If there is an issue, we make sure children are cared for by the State if need be.

ASSEMBLYWOMAN JAUREGUI:
It sounds like this will be a more efficient system, and children who receive EIS support will have shorter wait times.

MS. ROBB:
The Executive Budget requests will make us more efficient. We will still deal with wait times due to provider shortages. Combining service categories and eliminating the 50/50 provider split will allow the ADSD to determine what the true level of need is. The rotation holds that the 50/50 split forced us to implement were arbitrary. They did not accurately show what parents' choices would be. That violated federal regulations. Parents were upset. They want to choose who provides care for their children and where they receive care.

ASSEMBLYWOMAN JAUREGUI:
If there is a shift to community providers over the 2023-2025 biennium, how will the ADSD address the associated costs?

MS. ROBB:
We will continue to monitor costs as they are combined. If there is a significant cost, the good news is, we will not have to go through the work program process and hold children from going to community providers. We will be able to closely monitor budgets and project costs sooner rather than later.

We will need to communicate with community providers if there is a budget issue. Based on experience, it will be wise to monitor similar funds in one budget category.

CHAIR NGUYEN:
I am glad we are raising provider rates. It seems we are asking providers to return money they receive from billings. Have we discussed the additional burden of billing and how that affects community providers?

MS. ROBB:
We have had multiple conversations on the burden of billing. Our service agreements require money received from billing to be returned. Unfortunately, we did not have the data or mechanisms to manage that properly. We have collected that data for the past several years. We can now see exactly what has been billed through Medicaid, based on information we received from the DHHS Director's Office, Office of Analytics. This will eliminate duplication of payments because they receive a monthly rate per child per active Individual Family Service Plan.

This rate was originally all encompassing, but providers now bill for private and Medicaid insurance coverage. This eliminates the duplication of payment. We do not use a fee-for-service model. Providers receive the comprehensive rate. When we conducted our review with Burns and Associates that ended in June 2022, it was determined we are in the appropriate model as we are not fee-for-service. If we were using the fee-for-service mode, providers would have to bill for all these services in lieu of having a comprehensive billing rate.

Federal dollars and General Fund dollars will not be paid in duplication. We will be fiscally responsible.

ASSEMBLYWOMAN GORELOW:
Do you have a system that tracks how many hours of physical, occupational or speech therapy are administered? This would give an idea of which areas of EIS are trending higher. You would understand which areas you need more professionals in.

MS. ROBB:
We do not have a thorough system. We are in contract with a vendor to build a comprehensive reporting, case management and billing system for EIS. We tried implementing this previously without success. My hope is to have a consistent

mechanism to report that data to legislators in the future. The ADSD uses matrices, but this is not the best way to report this information.

ASSEMBLYWOMAN GORELOW:
Having the data can justify expansion. If we were talking about an education budget, information on class sizes and programs would be useful when making a decision on how much money to appropriate.

SENATOR DONDERO LOOP:
For decision unit E-231 in B/A 101-3208, what impacts are anticipated on provider capacity as a result of the community provider rate increases?

MS. ROBB:
We often receive inquiries about being a comprehensive provider. We have two new providers, including one in southern Nevada that started February 1, 2023. The other provider came in about two years ago. Inquiries are high, but the volume of enrollment in comprehensive services is relatively low.

This past week, someone in Fallon asked about becoming a provider. I will be happy to share the news if we get that rural provider. We do not have providers in rural areas. They are only providing services in urban areas. We want to increase provider reach. Whether that increase is effectuated depends on caseload. Regardless, we are excited to give providers a rate increase.

SENATOR DONDERO LOOP:
What impacts does the ADSD anticipate on provider capacity as a result of the recommended adjustment of the State clinic cost per child?

MS. ROBB:
That is a piece we will receive in our next analysis. Provider capacity may decrease. Historically, we had a 60/40 split between State and community providers in southern Nevada. We are consistent at a 50/50 split in northern Nevada. Being able to eliminate gaps will help the ADSD, which will closely monitor impacts.

MS. SCHMIDT:
Budget account 101-3209 for the Autism Treatment Assistance Program (ATAP) begins on page 42 of Exhibit C.

HHS - ADSD - Autism Treatment Assistance Program — Budget Page DHHS-ADSD-67 (Volume II)
Budget Account 101-3209

Page 43 of Exhibit C shows the ATAP caseload projection. Page 44 of Exhibit C begins the decision units for B/A 101-3209. Decision units M-200 and M-201 in B/A 101-3209 fund the projected caseload increase in ATAP.

M-200 Demographics/Caseload Changes — Page DHHS-ADSD-68
M-201 Demographics/Caseload Changes — Page DHHS-ADSD-69

Decision unit M-203 in B/A 101-3209 funds a reduction in the projected ATAP waitlist.

M-203 Demographics/Caseload Changes — Page DHHS-ADSD-69

Decision unit E-225 in B/A 101-3209 on page 44 of Exhibit C funds one psychological development counselor to reduce ATAP wait times for eligibility and decrease costs to outside providers.

E-225 Efficiency & Innovation — Page DHHS-ADSD-71

Decision unit E-230 in B/A 101-3209 on page 40 of Exhibit C funds an increase for in-State travel for ATAP home visits.

E-230 Efficiency & Innovation — Page DHHS-ADSD-71

ASSEMBLYWOMAN GORELOW:
What factors contribute to the number of children on the ATAP waitlist? How long are they waiting? How many children are on the waitlist?

MS. ROBB:
The program serves 979 children. Over 900 children were on our waitlist in the past. Based on the support the ADSD has been given for waitlist reduction, we have 122 children in referral status as of February 1, 2023. Referral status is a process of eligibility in which paperwork is collected, and we work through the intake process. There are 11 children on the waitlist.

The previous wait time had been 9 to 12 months. It is now 51 days, depending on eligibility. The ADSD has seen the previous 9- to 12-month waiting period reduce to a 17- to 51-day waiting period.

ASSEMBLYWOMAN GORELOW:
Will there be sufficient capacity in the 2023-2025 biennium to keep that waitlist down?

MS. ROBB:
I cannot say for certain. Provider capacity is an issue. We have made great gains in bringing providers to the State, but we are not at an ideal level yet. Provider capacity depends on several factors: location, child behavior, age, familial availability and insurance coverage.

The ADSD has a mandate to serve children. Unfortunately, one of the largest insurance plans in the State only covers children until six years old. While that early intervention is key, it is only diagnostic. It is difficult to take a six-year old, change providers, find new providers and ensure treatment continues.

The Culinary Health Fund insurance plan is a great plan and does good work. Unfortunately, since coverage ends at six years old, families are left desperate to find services. Families hope the education system could provide supports, but that is not the case. Schools do not provide applied behavioral analysis (ABA) either on campus or in the child's natural environment. Provider capacity continues to be an issue. Great gains have been made, but due to factors such as insurance coverage and Medicaid rates, capacity will continue to be an issue.

ASSEMBLYWOMAN GORELOW:
What levels of providers are needed for registered behavioral technicians, psychologists and psychiatrists?

MS. ROBB:
The majority would be registered behavior technicians, board-certified behavior analysts and board-certified assistant behavior analysts who all provide a level of ABA therapy. This is a spectrum of roles within the therapeutic model.

ASSEMBLYMAN WATTS:
There are caseload adjustments and requests for the addition of caseworker positions. Will those additional positions ensure we keep timelines and the waitlist where they are? Where are trends heading? Is the ADSD in a position to maintain or improve where we are?

MS. ROBB:
Based on how the ADSD has modified ATAP to ensure we meet families' needs, we plan for the downward trend to continue. Things can change. Some families have moved out of Nevada due to service issues. That explains some of the fluctuations where caseloads drop then increase again.

Provider capacity will play a role in future trends. We have two employees whose goal is to recruit providers, support them through the request for proposal and request for quote processes, and move organizations through to become Nevada providers.

SENATOR DONDERO LOOP:
What will the benefits of the new psychological development counselor position be? Will it reduce wait times for children? The earlier kids get diagnosed, the better off they are. It is critical to address wait times.

MS. ROBB:
Diagnostics is a challenge the ADSD has across Nevada. This is why American Rescue Plan Act of 2021 dollars were directed to the Ackerman Autism Center. The psychological development counselor will be able to support us on multiple pieces.

The ADSD has psychological development counselors in EIS who use the Autism Diagnostic Observation Schedule to diagnose children under three years old. The Executive Budget request expands this so they can work across children's services in early intervention and ATAP. The new psychological

development counselor will provide an additional layer of information on diagnostics. We have not had this internal layer in the past. The position will work with ATAP and EIS staff. It will work on adaptive scoring and the intake process. Families may need a diagnosis or updated adaptive scores.

We hope the new psychological development counselor will help bridge communication gaps with others doing diagnostics in the community. We have extensive waitlists. Our hope is the Ackerman Autism Center and other community providers will be able to reduce that. The psychological development counselor will bridge communication gaps, but not necessarily in the clinician piece of it.

SENATOR DONDERO LOOP:
I see kids who have been diagnosed early and those who have not been. There is a difference. To know families, especially if they lack resources, can go to a place like the Ackerman Autism Center is important.

MS. ROBB:
The ADSD has an excellent team. We have much work ahead of us. For EIS and ATAP, we have combined those two categories into children's services. We have psychological development counselors and individuals trained in the Autism Diagnostic Observation Schedule working in early intervention.

The earlier we can attain diagnostics for someone, the more they and their family will be helped on a lifelong basis. We are working on these services across the board. Collaborations with the Ackerman Autism Center and the University of Nevada, Las Vegas will help us.

SENATOR SEEVERS GANSERT:
We need to provide services as early as possible. Moving wait times from 9 to 12 months, down to 17 to 51 days, makes a significant difference when we are talking about 2- or 3-year-old children.

Registered behavior technicians are critical providers. When we changed the statute in the Seventy-ninth Session, we only had 40 of them in Nevada. How many registered behavior technicians do we have now?

MS. ROBB:
I can provide that information offline. We have increased the number of registered behavior technicians. We had challenges during the pandemic and staff levels decreased, but the numbers have trended back up.

SENATOR SEEVERS GANSERT:
Services for EIS and ATAP have much crossover. Many of the same kids are in those two programs. We discussed changes in rates, but it was mentioned the Executive Budget was going to keep the rates as they are now. Will rates be continued or do you see drops in certain types of work being done for children with autism?

MS. ROBB:
The rates you refer to are Medicaid rates. Stacie Weeks, the administrator for the DHHS Division of Health Care Financing and Policy (DHCFP), discussed that with legislators.

Once the ATAP budget is approved by legislators, we will review rates closely and determine, if there was a decrease, what that will look like in terms of service delivery. We do not wish to be in competition with Medicaid rates. We also provide an array of different services through ATAP. At a minimum, we will be at the Medicaid rate or higher.

SENATOR SEEVERS GANSERT:
We have made so much progress and do not want to go backwards. The key here is ensuring we have a robust number of providers and continue to increase capacity.

MS. SCHMIDT:
Budget account 101-3271 for the Facility Outreach and Community Integration Services (FOCIS) and Money Follows the Person (MFP) programs begins on page 45 of Exhibit C.

HHS-ADSD - FOCIS and MFP — Budget Page DHHS-ADSD-103 (Volume II)
Budget Account 101-3271

The program for FOCIS resides in the DHCFP and is meant to provide alternatives to institutional settings for Medicaid recipients.

The program for MFP is a demonstration grant with the federal Centers for Medicare and Medicaid Services. The funding is aimed at assisting states in balancing spending on long-term care and shifting costs from nursing homes to community-based services.

Page 46 of Exhibit C shows transfer decision units for B/A 101-3271, pertaining to the transfer of the program from the DHCFP to our Division. The intent of the transfer is to better align the work of FOCIS and MFP with our programs. Medicaid has its hands full with handling payer services.

The two programs in B/A 101-3271 are focused on transitioning and supporting individuals to remain in the community, which is the ADSD's focus. Staff worked together to identify where these programs best fit. The request to move programs to the ADSD is for management and alignment purposes. Our LTCO program often identifies individuals who want to move out of facilities and into communities. The funds in B/A 101-3271 could be used to help those individuals.

ASSEMBLYWOMAN JAUREGUI:
Are you combining FOCIS and MFP into the ADSD? If so, why? What challenges were the programs experiencing? How will the transfer benefit the populations the programs serve?

MS. SCHMIDT:
We have an entire community network of service providers and staff that focuses on keeping people in their homes in the most independent settings possible. The programs for FOCIS and MFP are connected to this mission. The programs were on an island of their own in Medicaid. They worked hard, but, they did not have the same coordination with other community resources as they will under the ADSD.

Often, funding for FOCIS and MFP is restrictive. The programs might find a person who needs community services but did not meet current FOCIS or

MFP criteria. The ADSD would have alternative funding sources and work with those programs to move as many people back to the community as possible.

CHAIR NGUYEN:
We will now hear public comment.

MARC CHRISTENSEN (President, State of Nevada Association of Providers):
The State of Nevada Association of Providers represents 22 disability providers that contract with the ADSD and regional centers to provide services. We appreciate all the work the ADSD and the regional centers have done to help support us in serving some of Nevada's most vulnerable citizens. We support the Executive Budget and would appreciate any efforts that would allow our providers to pay their employees an average wage of $18 per hour in July 2023 instead of having to wait until April 2024.

ELYSE MONROY-MARSALA:
I am on the Board of Directors with a nonprofit called the Community Food Pantry in Sparks. We are subrecipients of ADSD grant funds. I know you did not hear about nutrition assistance programs today, but I was excited to see the ADSD in the building and I wanted to make public comment.

The Community Food Pantry has been a subrecipient of the ADSD since about 2018. There has been much discussion about the challenges agencies have faced, including reimbursements and contracts. That has not been our experience with the ADSD. We receive contracts and reimbursements in a timely manner. Staff is knowledgeable and helpful. The Community Food Pantry is thrilled that we get to support this program. We provide a mobile support program where we take food to seniors living in weekly motels. We get funding to provide products and help get food out. We are primarily a volunteer-run organization. Since 2018, we have had the same six people going to serve seniors living in dire straits. We take them food, but we also take them fellowship. We know about these seniors' families, situations and lives.

We helped a man in severe distress while delivering food to him. He was having a medical emergency, and we ensured he got critical life support. We are able to take food out to people in the direst straits. I cannot tell you how sad some

situations are. We provide food and fellowship. The ability we have to check in with someone is vital. I am grateful for our ability to support this program.

SHELLY SPECK (Children's Advocacy Alliance):
I support Early Intervention Services B/A 101-3208. I will read my written testimony (Exhibit D).

Remainder of page intentionally left blank; signature page to follow.

CHAIR NGUYEN:
Seeing no further public comment, I adjourn this meeting at 10:26 a.m.

RESPECTFULLY SUBMITTED:

_____
Joko Cailles,
Committee Secretary

APPROVED BY:

_____
Senator Rochelle T. Nguyen, Chair

DATE: _____

_____
Assemblywoman Michelle Gorelow, Chair

DATE: _____

EXHIBIT SUMMARY				
Bill	**Exhibit Letter**	**Introduced on Minute Report Page No.**	**Witness / Entity**	**Description**
	A	1		Agenda
	B	1		Attendance Roster
	C	2	Dena Schmidt / Nevada Department of Health and Human Services, Aging and Disability Services Division	Aging and Disability Services Division Budget Presentation
	D	50	Shelly Speck / Children's Advocacy Alliance	Letter of Support for B/A 101-3208