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

Eighty-Third Session
February 25, 2025

The joint meeting of the Assembly Committee on Ways and Means and Senate Committee on Finance Subcommittees on Human Services was called to order by Chair Erica Mosca at 8:03 a.m. on Tuesday, February 25, 2025, in Room 3137 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 2 of the Nevada Legislature Hearing Rooms, 7120 Amigo Street, Las Vegas, Nevada. Copies of the minutes, including the Agenda [Exhibit A], the Attendance Roster [Exhibit B], and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at www.leg.state.nv.us/App/NELIS/REL/83rd2025. Link to Executive Budget.

ASSEMBLY SUBCOMMITTEE MEMBERS PRESENT:

Assemblymember Erica Mosca, Chair
Assemblymember Daniele Monroe-Moreno, Vice Chair
Assemblymember Tracy Brown-May
Assemblymember Jill Dickman
Assemblymember Gregory T. Hafen II
Assemblymember Brian Hibbetts
Assemblymember Sandra Jauregui
Assemblymember Steve Yeager

SENATE SUBCOMMITTEE MEMBERS PRESENT:

Senator Rochelle T. Nguyen, Chair
Senator Nicole J. Cannizzaro
Senator Marilyn Dondero Loop
Senator Robin L. Titus
Senator Jeff Stone

SUBCOMMITTEE MEMBERS ABSENT:

None

GUEST LEGISLATORS PRESENT:

None

STAFF MEMBERS PRESENT:

Brody Leiser, Assembly Chief Principal Deputy Fiscal Analyst
Cathy Crocket, Senate Chief Principal Deputy Fiscal Analyst
Kimbra Ellsworth, Senior Program Analyst
Natalia Jordan, Committee Manager
Joi Guthrie, Committee Manager
Janice Wright, Committee Secretary
Lisa McAlister, Committee Assistant

OTHERS PRESENT:

Dena Schmidt, Administrator, Aging and Disability Services Division, Department of Health and Human Services
Carrie Embree, Governor's Consumer Health Advocate, Aging and Disability Services Division, Department of Health and Human Services
Rique Robb, Deputy Administrator, Aging and Disability Services Division, Department of Health and Human Services
Michael J. Willden, representing the Nevada Early Intervention Community Providers Association
Robert Burns, President, Nevada Early Intervention Community Providers Association
Julie Ortiz, Owner, Advanced Pediatric Therapies
Debra Stewart, Co-owner, MD Developmental Agency
Karen Wilkes, President, Family to Family Connection
Dana Aronson, Owner, Theraplay Solutions
Mark James, Owner and Speech Language Pathologist, Therapy Management Group
Patrick Santoro, Owner and Occupational Therapist, Therapy Management Group
Connie McMullen, representing Senior Coalition of Washoe County and Senior Spectrum Newspapers, Inc.
Lisa Manning, Chief Executive Officer, Capability Health and Human Services

Chair Mosca:
[Roll was called. Subcommittees' rules and protocols were explained.] We will hear five budgets this morning from the Aging and Disability Services Division, Department of Health and Human Services. Presenters, you may respond directly to the Members, and we will stop after every budget presentation for questions.

HEALTH AND HUMAN SERVICES
AGING AND DISABILITY SERVICES
DHS-ADSD - ADMINISTRATION (101-3151)
BUDGET PAGE DHHS-ADSD-13

Dena Schmidt, Administrator, Aging and Disability Services Division, Department of Health and Human Services:
With me today to my left is Carrie Embree, Governor's Consumer Health Advocate, Aging and Disability Services Division, Department of Health and Human Services. To my right is Rique Robb, Deputy Administrator, Aging and Disability Services Division, Department of Health and Human Services. Our mission and vision are on page 2 [Exhibit C]. Our mission is to empower individuals and their support systems by providing resources for disabilities and aging—connecting Nevadans to the services they need for improving their quality of life. Our organizational chart on page 3 shows the proposed IDEA [Individuals with Disabilities Education Act] Part C transition, which is the only major change to our organizational chart. We created page 4 to provide a visual of the populations that we serve and where our programs overlap among those populations. Several of our programs serve children, adults, and seniors. Some programs serve individual populations, and some programs serve all populations.

Our budgeted funding sources are on page 5. I would like to point out a couple of highlights. You will see a reduction in the federal funding resulting from the removal of the ARPA [American Rescue Plan Act of 2021] funds. These are not new funds going away; these are the ARPA funds that were removed or have been spent. In this chart, Medicaid is considered in the Other category. Our Medicaid funding does not show as federal fund sources.

What you will notice on this page is there is a significant increase in the State General Fund of approximately 45 percent. This is a $234 million increase in our General Fund recommendation. There are several factors leading to this change. One factor is the rate increases that were approved last session in our developmental services caseload. We will be talking more about those at our next budget hearing. Second, would be the Federal Medical Assistance Percentage (FMAP). The FMAP has been reducing as you have heard in other hearings. That is causing an increase in the General Fund recommendation. Third, is our caseload growth, which is the number one factor for us.

The demand for our services continues to rise year-over-year. I will give you some statistics to highlight that fact. In Nevada, there are an estimated 269,000 persons who are over the age of 5 who have some form of disability. Approximately 2.3 percent of the state's population experience difficulty with performing activities of daily living such as dressing, bathing, and getting in and out of their own homes. The over-60 population in Nevada is expected to reach 17 percent of the total population by the end of this year. Between the years of 2012 and 2022, Nevada's population of adults 60 and older increased by 42 percent. This population

growth continues to put pressure on all of our state resources including: our social service systems, transportation systems, medical systems, housing, and workforce. As this population ages, it increases the demand on our budgets, which is the majority of the caseload you will see throughout this presentation. Our budget is caseload. That is what we do in the Aging and Disability Services Division. As the population continues to get older, we have to find ways to solve the problems and address the demanding needs.

There are two reasons I bring this to your attention. One is to help this body understand that difficult decisions must be made when there are limited resources. Second, is that we need to work together to determine how to address this demand. It is expected that we will not see a slowdown in this increase any time soon. According to the report *Elders Count Nevada 2023*, we will continue to see an increase in the older population for the next 25 years. We are seeing a current growth in the older populations right now. There is also a swell of individuals in their late 30s now who will be the next generation of older adults in 20 years.

Our budget account summary is on page 6, and our budget presentation begins on page 7. Budget account (BA) 3151 is our Administration budget. It includes our HR [human resources], IT [information technology], and fiscal services. The budget includes positions that are cost allocated to manage programs across the Division.

The decision units related to BA 3151 are shown on page 8. Decision unit Enhancement (E) 259 is a recommendation for a medical epidemiologist. This position will focus on improving health outcomes and mitigating strategies to decrease the impact of substance abuse and opioids among older adults and adults with physical disabilities. In 2019, according to SAMHSA [Substance Abuse and Mental Health Services Administration], 1 in 50 individuals over the age of 60 years had an opioid use disorder. The purpose of this epidemiologist position is to focus on the impact on the older population. We need to learn how to intervene and produce effective treatments and interventions to reduce opioid abuse among older adults.

The next decision unit is E-499. This is an extension of our ARPA funding to continue our system modernizations. We were granted ARPA funds to do IT projects, and those funds are continuing into the next biennium. Decision unit E-900 is a transfer of an Agency Manager from BA 3266, Home and Community Based Services. Decision unit E-901 transfers in a management analyst to BA 3151. These transfers allow those positions to be cost allocated across all of our programs because both positions serve multiple budgets. I will take any questions on this budget account.

Assemblymember Yeager:
I have a couple of questions on decision unit E-259. Looking at the underlying documentation, the epidemiologist position was originally proposed to be funded with Title X service grants in the Governor's recommended budget. I want to confirm that it should be funded through the use of the opioid money. Is that what you said?

Dena Schmidt:
You are correct. The intent is to fund this position with the opioid funding.

Assemblymember Yeager:
I have asked a number of questions about the use of the opioid money. You noted that it was 1 out of 50, or 2 percent of older individuals have had an opioid use disorder. What do you hope to accomplish through this position? Do you have any data around that 2 percent? Is that prescription drug abuse, or is that getting opioids off the street? Can you shed any light on that?

Dena Schmidt:
You made the point that we do not have the data on that, and that is the purpose of this position. We know that it is a problem among the older population. You highlighted the fact that we do not have a lot of Nevada-specific data. The intent of this position is to better understand substance abuse and opioid abuse among the older senior population. It is an area that we know exists, but it is not talked about often.

We received a federal grant in Adult Protective Services to focus on opioid abuse. We have seen either abuse among the individual seniors, or oftentimes among the caregivers, or the adult children who were stealing from, impacting, and not taking care of an older person. But there was no desire to talk about it. It was a voluntary program under that particular grant. The victim must volunteer the information. We found people do not want to talk about it. Often seniors do not want to get their adult-child caretaker in trouble. I am hopeful and would like to see how to create a system where we can intervene in that situation to help both individuals. We want to both protect the older adult, but also get the individual who might be abusing substances into treatment and remove the stigma from that situation because we do see that a lot.

The other concerning fact is Nevada ranks 48th for drug deaths in persons over the age of 65. How do we reduce that number? What are the appropriate interventions for this population? How do we make a difference, and bring that number down?

Chair Mosca:
Are there any other questions on the Administration budget? [There were none.] We will go to budget account 3204.

HEALTH AND HUMAN SERVICES
AGING AND DISABILITY SERVICES
DHS-ADSD - CONSUMER HEALTH ASSISTANCE (101-3204)
BUDGET PAGE DHHS-ADSD-40

Dena Schmidt, Administrator, Aging and Disability Services Division, Department of Health and Human Services:
The Office of Consumer Health Assistance provides ombudsmen who guide Nevadans through accessing their health care, insurance, and prescription drug assistance [page 9, Exhibit C]. This program also manages arbitrations for out-of-network emergency services under $5,000. Page 10 displays our caseload projections for this particular budget. This is the first time we have had caseload projections for this budget. We recently moved to a data system and are able to project the demand for these services. Page 11 shows the arbitration caseload is projected to start declining this year. The decline is because we are charging for the services now. People are starting to get the contacts, which was the intent of the program, so we are seeing a slight decline in arbitrations.

Page 12 shows the decision units for the Consumer Health Assistance program. Decision unit Maintenance (M) 201 is the projected increase in caseload. Decision unit Enhancement (E) 932 is the transfer of the management analyst position from the Data Analytics budget account 3203 to this budget account. That position involves programmatic duties, so we are transitioning it back to the Division. I will take any questions on this budget account.

Assemblymember Jauregui:
Please discuss the primary factors that are contributing to the increases in the Consumer Health Assistance caseloads. How are you managing the workload, and how will these new positions alleviate that?

Dena Schmidt:
We get a variety of calls in the Consumer Health Assistance program. Calls could result from Social Security difficulties with disability determinations, Medicaid eligibility concerns, prior authorizations, or specialty care. We know the demand for those services. The challenges around health insurance and accessing health care continue to grow even more now than before. We continue to see a demand. We have also done a lot of outreach in this program, which we had not done for quite some time. Our calls have leveled off. However, the outreach caused an increase in calls to our ombudsmen. These new positions will allow us to improve the quality of services, and cases will not stay open as long. People will get their situation remedied in a timelier manner.

Assemblymember Jauregui:
You mentioned cases would not stay open as long. Could you talk to us about how long people are currently waiting for services?

Carrie Embree, Governor's Consumer Health Advocate, Aging and Disability Services Division, Department of Health and Human Services:
Cases vary, but cases can stay open for up to approximately 90 days, and sometimes longer for the more complex cases. The time varies with the positions we have now. Sometimes we can take care of and move quickly on the less complex cases. The Social Security, Medicare, Bureau for Hospital Patients, and workers' compensation cases are complex cases. Sometimes those cases can stay open longer than 90 days.

Assemblymember Jauregui:
You mentioned that 90 days is the average time. With the increase in staffing, what will be the decrease in time? Is there a current waitlist for people who have not even been assigned a case worker?

Carrie Embree:
There is not a current waitlist. We have a policy to initiate cases within three working days. There is no wait now, but that may change as the cases increase. Once those cases are open and an ombudsman is working with an individual, sometimes there may be a delay in the ombudsman getting back to the individual. We can get those cases down to under 90 days, and anything under 90 days would be efficient and helpful for the consumers we serve.

Assemblymember Jauregui:
Would you walk us through what metrics you use? How do you determine what number of cases would be appropriate for each ombudsman to serve?

Carrie Embree:
Currently, this has been part of the new database. We have six ombudsmen total. As of January, the caseload is 1 ombudsman to 96 cases. We would like to reduce that to 45 cases per ombudsman.

Assemblymember Jauregui:
How did you determine that 45 cases was a good caseload number per ombudsman?

Carrie Embree:
That would reduce the caseload in order for the ombudsman to give the time necessary for each individual and the circumstances that were presented to them. We have one ombudsman vacancy right now. That is part of the 1:96 caseload ratio. The large caseload makes it more difficult for the ombudsman to do outreach, which is essential to keeping the public and our health care providers informed about what we do. That was all considered in the 1:45 ratio.

Dena Schmidt:
When we looked at the data and the time frames, we compared it across the other programs. We have two similar programs that carry similar caseloads. Our goal of getting down to the 1:45 ratio or 1:50 ratio range is based on those other two programs.

Chair Mosca:
Are there any other questions on this item? [There were none.] We will move to budget account 3208.

HEALTH AND HUMAN SERVICES
AGING AND DISABILITY SERVICES
DHS-ADSD - EARLY INTERVENTION SERVICES (101-3208)
BUDGET PAGE DHHS-ADSD-54

Dena Schmidt, Administrator, Aging and Disability Services Division, Department of Health and Human Services:
Our Early Intervention Services program is dedicated to helping infants and toddlers with developmental delays, thrive [page 13, Exhibit C]. The program supports families in addressing their child's needs by fostering growth in cognition, communication, physical development, social-emotional skills, and adaptive abilities. We cater to children under three. Oftentimes these services are provided in an in-home environment or community setting rather than a facility setting. On page 14, you can see the caseload projections for this budget account. We are seeing a growth projection of approximately 2 percent over the next biennium in this caseload.

The decision units for this caseload are on page 15. Decision units Maintenance (M) 201 and M-202 are the caseload projections. Decision unit Enhancement (E) 266 recommends transitioning to a fee-for-service model for our community providers. This decision unit ensures our compliance with the payer-of-last-resort requirements, and it ensures the maximization of federal funding is being used. Decision unit E-260 is a medical epidemiologist position to help develop health interventions to mitigate negative impacts of opioid and substance abuse. This position is also funded through the opioid funds and is focused on the population 0 to 3 years. We know that 12 percent of the children born in Nevada have been exposed to substance abuse. How do we create interventions and identify services that will help those children develop and grow? Decision unit E-264 replaces audiology equipment as well as funds the ongoing maintenance and calibration.

Page 16 has the additional decision units for this budget account. Decision unit E-253 funds the annual purchase of protocols. We know that 12 percent of newborns are affected by gestational exposure. Protocols are needed to identify developmental delays to ensure that children receive the necessary services. These protocols are critical to the Early Intervention Services. Decision unit E-680 recommends the elimination of five positions that have been vacant for more than two years. Decision unit E-901 is the transfer of a management analyst position from Early Intervention Services, budget account (BA) 3208 to BA 3151 so we can cost allocate across programs. That particular position works in more than one budget. I am happy to answer any questions on this budget account.

Assemblymember Brown-May:
There are lots of questions. I would love to catch up with you offline about many of these, but I will stick with caseload growth and staffing adjustments for decision unit M-201. Please discuss the current capacity throughout all regions of the state to provide children services through the EIS [Early Intervention Services] program for both community providers and through state services. What is our current capacity to provide services?

Dena Schmidt:
One of the challenges you will see in the caseload growth is that it has been adjusting. We break it out by community providers and state clinic staff. The original projections have changed. Over the three months, you will see a difference. Originally, it was projected that the community providers were going to serve more children. Then the projections changed to reflect that the state was going to serve more children. That was due to a couple of community providers being out of rotation for a couple of months. They go out of rotation for various reasons, but that will change the projection. We try to look at the overall projections. Right now, everybody has the capacity to grow at the growth rate, but probably not as fast as we would all like.

Rique Robb, Deputy Administrator, Aging and Disability Services Division, Department of Health and Human Services:
The challenge is that in the last legislative session we went from a 50:50 model to that required split. It was our hope that we would see the shift, but because we had a large provider out of rotation, it made a significant shift to the state providers versus the community providers. We are happy to supply the actual breakdown of those percentages. That is what our challenge is this year. When we have a provider out of rotation, it shifts the actual caseload.

Assemblymember Brown-May:
Thank you for bringing up the provider/state split. In the documentation that I have, it looks like the state is working to become more of a provider as opposed to supporting the organizations that are the independents outside of the state's purview. You have talked a bit about why that happened. You had a provider out of circulation. I want to be clear about that. Is it the state's intent to grow as a provider, or is it the state's intent from your Division to foster relationships with outside agencies that can deliver this service? This is from the perspective of the Interagency Coordinating Council on Early Intervention Services. How are we growing supports for these 0 to 3 populations? I am curious to know—is it going to rely on the state and our delivery of services, or is it going to rely on growing the network in our community?

Rique Robb:
No, the state would not like to be the main source of services. My hope at this stage of where we are, compared to last legislative session, was within the two years I was hoping we would be at a 70:30 ratio, with 70 percent being the community providers and 30 percent being the

state. That was my hope with that change. Unfortunately, when you have providers out of rotation due to noncompliance on a long term, it impacts the entire system. It impacts every single one of these community providers as well as the state.

The state providers are the only providers who currently provide rural early intervention services. There is no percentage that goes to the community providers at this point in the rural areas. We have been in communication with them. They submit a monthly capacity that states how many they can take during that month to bring more children into the community provider services. The goal would be for them to be taking more children. We will have more discussions today. We will talk about what that looks like. The goal would be that we have more community providers. At some point, the discussion has been that in seven-to-ten years from now, the state provider will look different and provide technical assistance and training. Then the majority, if not all our children, would be with community providers.

Senator Nguyen:
You have used this term a couple of times about a provider being out of rotation. I know that there are only five community providers. When you say out of rotation, are you saying they are not accepting clients? Do they no longer have licensure? What are the circumstances?

Rique Robb:
Typically, when a provider is out of rotation, it is due to compliance issues. It could be a state provider or a community provider. These two particular providers were out of rotation, and that was two out of the five providers that were out of compliance and out of rotation. That is based on IDEA [Individuals with Disabilities Education Act] Part C. They make those recommendations, and every child who would have gone to those community providers either goes to the state or to the other community providers.

Keep in mind, not all community providers provide statewide supports and services. We have a provider in the northern region that just serves the northern area, and we have two providers in the south that only provide services in the south. That causes a significant impact to the program. We have seen the Las Vegas caseload grow due to having two providers out of rotation. When they go back into rotation, we look at various things in regard to—can we return—a child exits, then we would maintain those numbers.

It comes together with Aging and Disability Services Division, as well as the IDEA Part C office. We work collaboratively in determining what that looks like. Please know it is one of those tough decisions. We never want a provider to go out of rotation. That is the last thing we want. We have also seen providers go out of business in those scenarios as well. Our goal is for them to get into compliance as quickly as possible, ensure they are providing quality services to those children and families, and move forward. It impacts the entire system. The state staff is asking when we can get a break on this as well.

Senator Nguyen:
You indicated it is not the state's intention to take over these services from community providers. I have spoken with community providers. You have heard some of the testimony that began early during our presession meetings from public testimony and public comments. We are getting a lot of feedback from community providers, which were under the impression there was going to be a move more toward these community providers and supporting these resources. They planned accordingly to be able to take on those increased caseloads. The shift in the payment model caused a lot of concerns from the same community providers. They worry they will be unable to maintain their business model, unable to take on these additional cases, and unable to afford their existing caseloads, let alone take on a projected increase up to 70 percent. Would the state be able to take on these added people if come July 1, these community providers realize that this is an untenable situation, and we had to shift all of those resources over to the state?

Rique Robb:
This is another one of those difficult decisions in this budget process. With caseload, the state would have to take on the cases because the state is required federally to not have a waitlist. Everyone we work with understands that Nevada is facing the same national critical shortages that everyone else is. Nevada gets hit in different ways. Would we like to take on these additional children? No, we would not. We would like to ensure that they are able to stay in the community with these current community providers. We have other interested providers as well. But no, we will make capacity because we must—we are the safety net. As the safety net, we have requirements that we need to meet. We will do everything that we need to do to ensure that those children are receiving the best services that they can. Will that be an impact on the system? Absolutely. We would prefer to find a way to maintain all of our community providers, grow that network for them, and ensure those children are in the community.

Senator Nguyen:
I am hoping I can get some further clarification. During one of these initial presentations, there was an indication on the record that only 6 percent of the community providers were billing in this situation. It should be restated for clarification. Would you clarify what you meant about 6 percent of these providers billing on these children? That would be helpful.

Dena Schmidt:
Since I am the one who made that statement, I will be the one to clarify. We track billables and the claims in three different ways. The state and community providers all bill private insurance, Medicaid, and managed care. We track it by all three of those. The percentage of reimbursement varies across each of those. The lowest is the fee-for-service Medicaid. That is where the 6 percent comes in. The average is 6 percent return on fee-for-service. What I did not state on the record, which I would like to clarify now, is that 6 percent only represents approximately 4 percent of the total caseload. The majority of the caseload is managed care, but we are still not seeing anywhere near the goal, which is a 98 percent

reimbursement rate for services under managed care as well as private insurance. We have provided staff with a breakdown of those percentages across every program. I do not want to go into detail, but we have provided staff clarification of exactly what those numbers are.

Senator Nguyen:
The 6 percent was really of that 4 percent. It is a small proportion. While we are not at 98 percent, it is my understanding that we are closer to 60 percent in billing at this point.

Dena Schmidt:
We might be closer to 60 percent, but keep in mind that the $794.88 per-child per-month, for an open IFSP [Individualized Family Service Plan], is State General Funds going out the door. We are not receiving any match of federal dollars on those funds, which is really the intent of this transition.

The purpose of this transition is to get us into compliance. It is not to do harm. If we need to work through what this looks like, we are willing to work with this body to make sure that we are not doing harm. We have to make sure that we are being compliant with the payer-of-last-resort rule that requires us to ensure that billable services have been reimbursed before we pay any supplemental or additional payments.

Senator Nguyen:
What type of resources are we providing these community providers? When you talk about having to submit for reimbursement or payment for services to these MCOs [Managed Care Organizations]—much like I would have to do—there is a lot of denying of these services. There is a lot of denying of these processes. We have unrealistic expectations on our community providers to be able to provide these services for our 0- to 3-year-old population; then also to navigate the insurance world of denials and repeated submissions of services. There is a realistic possibility that a service that is submitted for reimbursement in six months will not even be paid by the time that child ages out of the program at three years of age. What kind of services is your agency taking into consideration as you are proposing to transition to this model where they are completely dependent on insurance companies approving every single claim that they make?

Rique Robb:
We have gone through multiple iterations of trying to build a comprehensive billing and data system. We are currently in what we call the NEIDS or Nevada Early Intervention Data System, and it went live on December 1, 2023, with challenges. We have been working through that process. We had to build a system that was appropriate for Nevada because our billing processes are different; and, because Nevada has a structure of having community providers and state providers. That also added an additional opportunity for us to work through. Within that system, community providers as well as state providers are all billing in NEIDS. We have worked to find the best way possible. It is not perfect, but we are working through it every day.

With that system, we did multiple iterations of training in person, and we do ongoing supports on that. They have what we call an open office, where they bring their questions, and we work through those. They work one-on-one with our fiscal staff when a program has concerns. We are currently having biweekly meetings with Medicaid for them to ask specific questions. We have also done those introductions to ensure that they are working directly with Nevada Medicaid and are able to get those questions answered directly.

I would say that one of the bigger challenges is private insurance. We have been able to support somewhat, but I would say that all of it is going to be ongoing. This is not a one-time fix that we can give an answer and move on. It is going to be something that the system has to do together forever, no matter what we are doing. Some of the opportunities that we have had with the system is we keep a record of all of the tickets, tracking, and issues that come in from any provider. Then we work ongoing with the vendor. In my experience in doing vendor projects, they are not fun. Typically, when you are a year away from the start date, you no longer have weekly meetings with that vendor. We continue to have those weekly meetings based on ensuring that when those issues come up, we can have those conversations. I am the person who has the tough conversations if that vendor is not meeting what we need. Support will be ongoing.

When the $794.88 was determined through the Burns and Associates [A Division of Health Management Associates] study in 2022, the amount was inclusive if a child received all services. We want to keep in mind that $794.88 is if a child is receiving speech, OT [occupational therapy], SI [sensory integration] therapy, and all of the proposed services for a child with early intervention. Some of these children might be seen once a month or they might only be receiving service coordination. We have to keep in mind that there is the potential for—not overpayment—but for a lack of a better word—some months that are going to get maxed out with the child. Some months it is going to be less if they only are being seen once a month. Keep that in mind with that $794.88 figure. The main piece for this is compliance—compliance with Medicaid, as well as compliance with the payer-of-last-resort rule. We have been working with federal experts. They stated to us, we are surprised Nevada has not had a finding on your payer-of-last-resort rule. Our goal is to not have a finding on the payer-of-last-resort rule or Medicaid payments.

Senator Dondero Loop:
The caseload staffing ratios would result in the elimination of two administrative supervisors and five administrative support staff positions. However, both supervisor positions, and two of the five administrative support staff positions, are currently filled. Decision unit M-201 would not eliminate the two filled supervisor positions, but it would eliminate the two filled administrative support staff. What is the rationale for retaining the supervisor positions and eliminating the two front-line administrative support positions that are currently filled?

Rique Robb:
Keep in mind those particular positions are based on caseload. At the time of the November caseload projections, it looked as though our caseload was going down. If our caseload continues to increase—as you saw we are looking at a 2 percent increase in the next biennium—we are seeing that increase right now, especially with those providers being out of rotation. The caseload could increase, and then those positions would not be eliminated. However, if that caseload does not change, and we still have to eliminate positions, we would look within the Division to find another position that we could put them in. The positions would not be able to be maintained within budget account 3208. If we cannot find them a position, then they would go on the layoff list. Very seldom do we have them go on the layoff list because caseload maintains or because we are able to put them in another position within the Division or the Department.

Senator Dondero Loop:
With that being said, will that continue to fit in the budget?

Rique Robb:
Only if our caseload shows that we will have the increase and that we need those positions. As of right now, it is not in the budget because it is not projected in our caseload.

Senator Dondero Loop:
Please discuss how the addition of psychological development counselors and health program managers to the caseload staffing ratios would benefit children served by Early Intervention Services?

Rique Robb:
We do caseload ratios, and within the caseload ratios that we have for early intervention—we have been doing this for several years—it now shows us when we need additional management, supervision, or developmental specialists. Based on our caseload and supervision that we currently have, it shows that we need additional support within the northern region based on growth. The northern region supervises the entire rural northern region. Only the state provides services to the rural areas. It only supports the actual cases.

Senator Dondero Loop:
What impacts does the agency anticipate on state capacity to provide service as a result of the recommended caseload positions?

Rique Robb:
We would shift duties on those administrative tasks. When we get in those situations, sometimes a developmental specialist would help take over some of those duties or supervision depending on what the actual position is and what they are doing. We would shift duties.

Assemblymember Yeager:
I have a few questions on the community provider payment model changes in decision unit E-266, and specifically about the add-on payment that is coming from the Fund for a Resilient Nevada. Does the agency anticipate the add-on payments would be continued into future biennia as part of the budget for the community providers caseload, or are the add-on payments intended to be temporary for the transition during the 2025-2027 biennium?

Rique Robb:
An add-on payment of $199 is funded by the State General Fund. An additional $88.94 in fiscal year (FY) 2026 and $120.72 in FY 2027 represents temporary payments from the Fund for a Resilient Nevada opioid settlement funds. Those are set to be temporary transitional payments from the Fund for a Resilient Nevada. The other part is currently in the budget and would be ongoing.

Assemblymember Yeager:
That makes sense. I understand that the temporary part is from opioid settlement funds. How would the use of opioid settlement funds from the Fund for a Resilient Nevada for an increased add-on payment for community providers align with the goals of the Opioid Needs Assessment and Statewide Plan?

Rique Robb:
We are seeing that 12 percent of Nevada's infants are born exposed to opioids. This payment helps us in that transition because it identifies that we have a population that we have not been supporting as well as we have in the past. We know our populations have changed significantly over the years. It is important for us to ensure that we are hitting that goal to reduce harm. That is one of the main pieces of early intervention; we are trying to reduce harm to these children who were prenatally exposed. The goal would be to reduce harm, and that goes into all of the opioid settlement funds that we have requested. We want to ensure that we are supporting those children, those babies, those in utero who did not have a choice. We want to support them in finding resources and adequate and appropriate services.

Assemblymember Yeager:
You explained the rationale. I am curious, and could be mistaken, but I did not see that particular funding reflected in the Early Intervention Services budget account. Should it be reflected there?

Dena Schmidt:
Are you talking about the supplemental temporary payment?

Assemblymember Yeager:
Yes, the add-on supplemental payment is $88.94 in 2026 and $120.72 in 2027.

Dena Schmidt:
Yes, that is not intended to come through the Aging and Disability Services Division because of its temporary nature. It will come directly from the Director's Office, Department of Health and Human Services.

Assemblymember Yeager:
Please explain the process for providers to request and receive the add-on payments recommended to be funded with the opioid settlement funds. How is that going to work? Is it going to happen automatically, or is there going to be a process in place where they request that?

Rique Robb:
It will be similar to what they currently do. We are still in the process of making sure what that looks like going through the Director's Office. Our goal is to have it streamlined through us when they submit their other invoicing for either the $794.88 for the uninsured or for their monthly unbillables and the $199 on our side. Our goal is to do it the same way, but we will work with providers, so they do not have to submit it in multiple places. Our hope is to streamline that and ensure that we work with them closely, and it does not add another administrative burden to the providers. We will work directly with the Director's Office to get that.

Chair Mosca:
I understand you are saying it is compliance driven. Do you anticipate any adverse impacts on the community provider capacity, client services, or wait times as a result of the recommended payment model change?

Rique Robb:
There could be an impact. I know they are concerned about this. We have had these conversations. In all transparency, the challenge is we knew this would be coming at some point. The unfortunate part is the planning part was not there for all of us. It is an impact, not only to them, but also to the state; we have to work through finding a process.

In my career, this is one of the toughest decisions I have had to make in working through this. Please know we have empathy and compassion for them as business owners and the highest of respect. This system is reliant on the community providers who provide services; they provide quality; they are good at what they do. Our hope is to find a way to support them.

I would love to look at a potential insurance assistance type model that we have similar to the Autism Treatment Assistance Program. If our finance body had the funding somewhere, we would like to do a high-deductible plan. Obviously, it would be stringent. We would have to determine what their deductible would be. I will not get into those details, but I will ensure that we have a process. If we worked with the providers, we could find some process with

a high-deductible plan—that would be something. We would make sure that if someone does not have insurance . . . The goal is to do limited harm and to work with the program.

Chair Mosca:
I appreciate your perspective. It is important for all the community providers we are hearing from to know how you plan to continue to work with them in this transition.

Rique Robb:
First is communication. We understand people are frustrated, but they also have to continue to communicate with us. We are out there, we are talking with them, and we need to keep that going. Without that, we will not succeed in any opportunity that we have before us. Our goal is to continue that communication; we are meeting biweekly with them; we have Medicaid that joins us as well. That communication and collaboration is going to be key on both sides.

Dena Schmidt:
I want to clarify that we are working closely with Medicaid. They have been a great partner in coming to the table to work with and listen to these providers regarding the payment rates as well as any of the challenges that they might be having with managed care. They are stepping up to the plate to assist us as well. It is not just the Aging and Disability Services Division, it is Medicaid [Division of Health Care Financing and Policy, Department of Health and Human Services] also assisting along the way.

Assemblymember Monroe-Moreno:
I would like to ask about decision unit E-260. Please explain how the addition of a medical epidemiologist to study the impact of opioids might contribute to the overall improvement of health outcomes for newborns and developing children and discuss the nexus to early intervention services.

Chair Mosca:
We will take a one-minute recess to see if we can fix the microphone problems.

[The meeting was recessed at 9:01 a.m.]
[The meeting reconvened at 9:02 a.m.]

Chair Mosca:
For our presenters, staff is working on the microphone problems right now. We do not have an update, so it may be a good time for a break, but do not go far.

[The meeting was recessed at 9:02 a.m.]
[The meeting reconvened at 9:03 a.m.]

Chair Mosca:
Thank you everybody for your patience. It is not just our room; it is all the committees right now that are having problems. We are going to take a 15-minute recess. We are going to come back at 9:15 a.m. They are going to reboot all the systems and hopefully that will solve it. So please come back by 9:15 a.m.

[The meeting was recessed at 9:03 a.m.
[The meeting reconvened at 9:28 a.m.]

Chair Mosca:
Thank you everybody for your patience. We are about ready. We will give the members about a minute to return, and we will begin. We will continue on and make sure we have the time we need.

Senator Nguyen:
I am going to switch over to some of the maintenance of effort (MOE) requirements as a part of the federal IDEA [Individuals with Disabilities Education Act] Part C program. Can you provide an update? We need to maintain certain levels of funding, and it looks like we are not. Can you provide an update on the guidance received from the federal Office of Special Education Programs regarding the Early Intervention Services program's ability to meet the federal MOE requirements while becoming compliant with the federal billing rules and regulations?

Dena Schmidt:
Yes. We met with the Office of Special Education Programs. They referred us to a national expert who was able to answer some of our questions and give us guidance on how to comply with the MOE requirements. They provided us a clarifying document explaining that one of the things that the state of Nevada has not done previously is claimed the state share of Medicaid, and you can claim the state share of administrative expenditures. There is a large portion of funding that we have been leaving on the table for years that we are able to claim.

As some of these payments transition to the Medicaid program—while the Medicaid payment itself from the federal government is not countable—the state share of that payment is countable. That is something we have never been utilizing or claiming. We can start to look at those claims as well as all the administrative costs in the Aging and Disability Services Division. Historically, we have only calculated the service dollars. We have quality assurance teams, management teams, and fiscal teams. The administrative costs to operate the program are all allowable expenditures. We believe counting those additional costs will allow us to meet the MOE requirements.

We did ask the worst question of all. What if we fail to meet the MOE? What if we miss it by a few? She told us if we failed to meet the MOE, the Office of Special Education Programs would give us a finding, a corrective action plan, and work with us to resolve the issues. She

said this is not the first time states have had to go through this transition. She anticipated that we would not get a penalty right off the bat.

Senator Nguyen:
I do not know if that gives me comfort. We would not get a penalty right off the bat. Do you have an idea when that new calculation could be used, and when those previously unused numbers could be included in the calculation of the MOE funding required? Will you have a better idea of what that means? How will that change? How much is required?

Dena Schmidt:
The requirement is that we calculate the final MOE calculation when our budgets are closed, and all costs have been accounted for. That is usually about a two-year lag. We use those two years. We do not know what this budget looks like yet. Once the final determination is made on our current budget, it is hard to say . . . We know what that number is, but we do not know what this number looks like yet. We can start to run those numbers and project additional costs, but it is difficult at this point to project the state share of the Medicaid payments because they have not been coming in historically. We do not have a lot of data on that. We are trying to work together to figure out how we calculate this. There are a lot of unknowns at this point until the budget is finalized with State General Fund appropriations for this program.

Senator Nguyen:
There are some vacant position eliminations in decision unit E-680. I know that there is a recommendation to eliminate a vacant developmental specialist position. I do not know how long it has been vacant. You can answer that. Please discuss whether the recommended elimination of vacant developmental specialist positions would impact the agency's ability to provide early intervention services to all children in the projected caseload for the upcoming biennium.

Rique Robb:
Those positions that are slated to be eliminated at this time are ones that have been vacant for more than two years.

Dena Schmidt:
The two positions you asked specifically about were the developmental specialist positions. There were two positions that we understood were eliminated last session. We had not attempted to fill them, and that is why they are slated for elimination.

Rique Robb:
I would love to keep the positions.

Senator Nguyen:
You would love to fill them is really what it is. It sounds like there is capacity; there is work to be done by those positions, but you have had difficulty filling those positions. There is a recommendation for elimination because the positions have not been filled during the past two years. What are the barriers in filling this position?

Rique Robb:
Currently, we have the caseload for it. We do not have a barrier. The reason those particular positions were not filled was because we understood the positions were to be eliminated, so we did not recruit. I believe if we recruited, we would be able to fill the positions.

Chair Mosca:
Members, are there any other questions on this budget item? [There were none.] We will move to budget account 3209.

HEALTH AND HUMAN SERVICES
AGING AND DISABILITY SERVICES
DHS-ADSD -AUTISM TREATMENT ASSISTANCE PROGRAM (101-3209)
BUDGET PAGE DHHS - ADSD-69

Dena Schmidt, Administrator, Aging and Disability Services Division, Department of Health and Human Services:
We are now going to talk about budget account (BA) 3209, which is our Autism Treatment Assistance Program [page 17, Exhibit C]. This program supports essential therapies like applied behavioral analysis, social skills development, intensive parent training, and speech, physical, and occupational therapies to children under the age of 18 who have a diagnosis of autism spectrum disorder.

The caseload for our autism program is on page 18. We project approximately a 12 percent increase over the next biennium for this program. There are two caseload decision units on page 19 for this program—decision units Maintenance (M) 201 and M-202. I am happy to answer any questions with this budget account.

Senator Dondero Loop:
Please discuss whether the agency anticipates sufficient autism service provider capacity in the upcoming biennium to support the projected caseload.

Rique Robb:
We are continually working to increase provider capacity for all services, autism included. We do have some wait times for providers. We are increasing provider capacity at all times. Can I tell you that it will meet the need based on a 12 percent projected increase? I am not sure at this time, but we continue to increase providers.

Senator Dondero Loop:
Please discuss how the additional caseload staff might help reduce the number of children waiting for services as well as the wait time for children to begin receiving autism services. I know that we have a village out there, but can you bring that in for us and talk about that?

Rique Robb:
Yes, additional staffing supports the families on the case management side and gives them that service coordination. They support those families in finding appropriate providers. As new providers come on, they are able to identify what would fit for that child and that family. Yes, the staffing is key to ensuring that we are able to connect those families to services.

Senator Dondero Loop:
Do you have an estimate or number of how many families we are currently serving and how many might be waiting?

Rique Robb:
Yes, currently we have 1,077 families who are active, and then we have 334 who are waiting.

Chair Mosca:
Members, are there any other questions on this budget? [There were none.] We will move to budget account 3282.

HEALTH AND HUMAN SERVICES
AGING AND DISABILITY SERVICES
DHS-ADSD - ADULT PROTECTIVE SERVS & LONG-TERM CARE (101-3282)
BUDGET PAGE DHHS-ADSD-124

Dena Schmidt, Administrator, Aging and Disability Services Division, Department of Health and Human Services:
Budget account (BA) 3282 is for our Adult Protective Services and our Long-Term Care Ombudsman programs [page 20, Exhibit C]. In our Adult Protective Services programs, we safeguard vulnerable adults from abuse, neglect, and exploitation. In our Long-Term Care Ombudsman program, we champion for the rights of residents in long-term care facilities.

We provided the Adult Protective Services caseload on page 21. We anticipate a 5 percent caseload growth over the next biennium in Adult Protective Services. Page 22 is our Long-Term Care Ombudsman projections. We projected an increase of 16 percent over the next biennium. Page 23 has the decision units. These are related to caseload. We know the Aging and Disability Services Division budget is all caseloads. Decision unit Maintenance (M) 201 is the projected caseload for Adult Protective Services. Decision unit M-202 is the projected caseload increase for the Long-Term Care Ombudsman program. I am happy to answer any questions regarding these programs.

Assemblymember Jauregui:
Please discuss the primary factors that are contributing to the increases in the caseloads for Adult Protective Services and the Long-Term Care Ombudsman program.

Dena Schmidt:
Adult Protective Services is based on complaints. We have seen an increase in complaints of or allegations of abuse, neglect, and exploitation; this is the same as our Long-Term Care Ombudsman program. Staff goes out to facilities on a regular basis—not with the intent of doing an investigation. What happens sometimes when they go to visit a facility—in educating clients and residents of those facilities—they may get issues that arise. A resident may say that they do not get to eat at 9 p.m. when they are hungry, or whatever the issue might be. We get the referrals for long-term care ombudsmen in multiple ways. Sometimes it is just going into a facility; sometimes it is an individual calling us; sometimes it is a family member calling to make a complaint about their loved one in a facility.

We have seen a rise. I do not know what the indicators are, or whether it is low staffing in facilities, or what. We do not correlate that to what the issues are. I do not know what caused the rise for the Long-Term Care Ombudsman program. Carrie Embree, Governor's Consumer Health Advocate, Aging and Disability Services Division, Department of Health and Human Services, knows more about the Adult Protective Services program.

Carrie Embree, Governor's Consumer Health Advocate, Aging and Disability Services Division, Department of Health and Human Services:
Part of the increase is that our Nevadans continue to age. We have a high number of cases in the age group of 74 to either 80 or 84. There is a high number of seniors in that group. Also, we have completed a media campaign in Adult Protective Services—we have been getting the messaging out. What are the signs of abuse? How do you report it? I think that has been part of it too for Adult Protective Services.

Assemblymember Jauregui:
How were the staffing ratios for managers, supervisors, quality assurance staff, and administrative staff determined to be appropriate? Why are the legislatively approved staffing ratios not working?

Rique Robb:
We are seeing caseload increases in numbers across the board anywhere from developmental services to early intervention. The Autism Treatment Assistance Program received 96 referrals, which is much higher than we have seen in the past. The legislatively approved ratios are based on projections, but actuals are coming in higher.

Assemblymember Monroe-Moreno:
Please discuss how the agency has managed the growing caseloads with its existing vacancies for Adult Protective Services and the Long-Term Care Ombudsman program?

Dena Schmidt:
In our Adult Protective Services, our current vacancy rate is 30 percent; social workers are 37 percent of that breakdown and adult rights specialists are 17 percent. In our Long-Term Care Ombudsman program, our current vacancy rate is 21 percent.

Assemblymember Monroe-Moreno:
How are you managing the growing caseloads with those existing vacancies?

Carrie Embree:
For Adult Protective Services, we are doing a number of things related to recruitment of those vacancies. We are working closely with our universities: the University of Nevada, Reno; and the University of Nevada, Las Vegas. We are going into their classes and talking with the social work students. We are participating in any type of job fair that they have at the universities as well as in the communities. Adult Protective Services takes in practicum students at the Aging and Disability Services Division. These are some of the things that we are doing, and it is helping to make a difference.

Since July, the vacancy rate for Adult Protective Services has come down 15 percent. We feel like the recruitment activities that we are doing with our universities and in the communities is making a difference in beginning to bring the vacancy rates down.

Assemblymember Monroe-Moreno:
You spoke about recruitment. Are you doing anything for retention?

Carrie Embree:
Yes. Adult Protective Services is focusing on retention. We do this in a number of ways. One is supporting our staff through training. Another thing we are doing as well is we are onboarding our new staff and working with them, and we have a social work academy that both the social workers and adult rights specialists go through. We work to train them so that they go out in the field with confidence, knowing what their role is and what they need to do. Hopefully, that will help them to stay and enjoy their job. They know what to do, how to do it, and have the support of their supervisors.

Assemblymember Monroe-Moreno:
Having the 15 percent decrease is great. What is the actual ratio knowing that you still have the vacancies, and they have a caseload. What is that ratio?

Carrie Embree:
The ratio is currently 1 position to 54 cases.

Chair Mosca:
Members, are there any other questions? [There were none.] Thank you for all that you do for our state. Now we will close the budget hearing, and we are on our last item on the agenda, which is public comment.

Michael J. Willden, representing the Early Intervention Community Providers Association:
I want to make sure from the testimony that we all understand Nevada has what we call a "gross case rate" system. The $794.88 has been paid at different rates for years, but we have had the gross case rate system in place for decades. Hearing testimony that it needs to change, yes, it may need to. There have been two Burns and Associates [A Division of Health Management Associates] studies that have been done in the last three or four years. They have recommended things, but they have said to stay with the gross case rate study until there is a plan to move to a fee-for-service model. I do not think there is a plan, and I think from the testimony today, there is not a plan.

The $794.88 should be considered as a managed care payment. Some children cost a lot more than $794.88. Some children cost less than $794.88. It is not that every kid costs less than $794.88; some children or many more may need those services. Billing, it sounds like there is an impression that the community providers are not billing. They bill every day. They bill Medicaid, they bill the MCOs [managed care organizations], they bill private insurance, and when they get payments, it is netted out of their $794.88 payment. They do not get to keep that. It is netted out.

Currently, if we go to the other model, the fee-for-service model, and they get paid $199, there is a roughly $600 gap between $794.88 and $199. You will not see insurance collectibles at $600 per month per child. That is not going to happen. If you look in the Burns and Associates study, it says the national average is 16 percent.

Robert Burns, President, Nevada Early Intervention Community Providers Association:
[Read from written testimony, Exhibit D.] I am a pediatric occupational therapist. I have served as such for the state of Nevada since 2005. I worked for the state's NEIS [Nevada Early Intervention Services] program for five years before leaving to start Therapy Management Group (TMG) with my other two co-owners whom I met while working at NEIS. We saw firsthand many of the challenges NEIS faced, for example: staff shortages, increased bureaucracy, and a waitlist with over 500 children.

Nevada Disability Advocacy and Law Center filed a systemwide complaint due to the lack of timely initiation of services. In response, the state contracted with a community provider. But it was expensive. In 2007, TMG presented a proposal to HHS [Department of Health and Human Services] that suggested all EI [early intervention] services be delivered by community partners with the state retaining management oversight and quality assurance. In

2009 we were awarded a contract to become a community partner. At that time, the community partners' rate was $767 per child plus insurance revenue. That worked. The waitlist was eliminated, and more children were seen.

During the last biennium, an independent rate study was conducted. The rate study found the community partners should be paid a $795 per-child per-month rate minus insurance revenue. The Legislature approved the new rate, but now, despite that study's findings and the Legislature's rate approval, a drastic rate decrease is being proposed, which would make it impossible for community partners to keep their doors open. Over 1,800 children would be returned to the state and waitlisted for services.

In closing, to avoid that, we humbly suggest these three solutions:

1. Return $12 million annually to budget account 3208, Category 14.
2. Continue to make changes to NEIDS [Nevada Early Intervention Data System] software to enhance billing, reporting, and efficiency.
3. Fund an additional study before changing to a fee-for-service model to assess cost, viability, and impact to families.

Julie Ortiz, Owner, Advanced Pediatric Therapies:
I am a member of the Nevada Early Intervention Community Providers Association as well. I am a speech pathologist, but I am also a business owner of Advanced Pediatric Therapies. I have been in business for 22 years. We do speech, PT [physical therapy], OT [occupational therapy], autism services, behavioral health, and now early intervention services for the past 16 years. I have been with this program a long time. I have seen a lot of positive changes. We have worked through a lot of growth and challenges as well. This is the biggest challenge that we have had to think about adjusting to because this rate—without changing a service model—cannot work. This rate of $199 is more of a clinical-based model, where we would see children back-to-back in a facility. This does not support a home-health model.

The other challenge that we are faced with is the majority of the services we provide as early intervention providers are not billable. We have those federal unfunded mandates that we provide to the families to ensure quality and that they are receiving all of their rights of care. We cannot assume we can run a position just with insurance billing. There has been talk about noncompliance with billing. As a provider, we understand the payer-of-last-resort rules.

As Michael Willden and Robert Burns said, we bill the insurance; we pay that back fully to the state program; then we receive their payment for that payment of last resort. We are following that model already. What they are proposing is a drastic cut to what we will be getting paid back in return.

Debra Stewart, Co-Owner, MD Developmental Agency:
This issue is important. I am from Chicago, Illinois. We have programs in Illinois and Nevada. I am also a developmental specialist and a psychological counseling behavior certified specialist as well. [Presented Exhibit E.] I would like to talk about challenges with NEIDS [Nevada Early Intervention Data System]. The statewide system has been in place for 15 months and still has a full-time project manager and weekly meetings with state administrators to work on ongoing errors and limitations in the system. Community partners are giving feedback and engaging in the process of improving NEIDS. The ADSD [Aging and Disability Services Division, Department of Health and Human Services] is providing a framework for the community partners to report errors and glitches in the system. Some improvement recommendations include:

1. The capacity to rebill denials, or bill secondary insurance without manual submission in order to decrease denials.
2. Track private insurance deductibles.
3. Create standard insurance reports and private insurance remittances integrated to improve tracking of claims, authorizations, and payments.

Karen Wilkes, President, Family to Family Connection:
I am a graduate of all Nevada schools including UNR [University of Nevada, Reno]. Currently, I am the President of the local nonprofit, Family to Family Connection. Family to Family Connection was founded in 1998 by First Lady Sandy Miller. The program provides education to children ages zero through five via the concept of family engagement. The parents must help their own child with prescribed activities, therefore becoming the child's first teacher. We are teaching parents appropriate ways to interact with the child, working with approximately 200 families per year.

We are currently partnering with UNLV [University of Nevada, Las Vegas] and Touro University Nevada to take their early childhood development advanced students as interns in our program, providing them with their practicum hours. Our employees are trained to spot medical and psychological problems and to make referrals. We rely on philanthropy, fundraising, and county funds. If we can reach 99,000 children in Las Vegas who are not in daycare prior to kindergarten, it will change the graduation rates and the abilities of our workforce in Nevada.

Family to Family Connection would like to help by expanding to eight locations around the valley, potentially reaching 1,600 or more families per year. Those eight locations could be accomplished for under $1 million per year. And think of the impact to our community. We are supporters of this bill of moving funds to community partners. That would be good for all of us. Thank you for the opportunity today to speak about our growing community-based services.

Dana Aronson, Owner, Theraplay Solutions:
I am one of the owners of Theraplay Solutions, an early intervention community provider serving over 200 families. I am a member of the Nevada Early Intervention Community Providers Association. [Read from prepared testimony Exhibit F.] Thank you for the opportunity to be here today. As you consider the budget, you will hear compelling information about why the proposed drastic funding cuts are unsustainable for the early intervention system. Today, I want to provide you with specific funding data that highlights just how unsustainable these reductions would be.

Our analysis, based on 182 active children shows the following:

- Current funding at the capitation rate of almost $795 costs the state $144,668 per month.
- With the proposed decrease to $199 per child, Theraplay Solutions would receive $48,252 per month.

To put this in perspective, the proposed model would not cover payroll for our providers before taxes, not to mention employee benefits, administrative expenses, and other operational overhead. Additionally, if this budget cut is implemented, children enrolled with community EI [early intervention] providers would be forced back into the state-run program at an increased cost of almost $51,000 more per month compared to simply maintaining current community provider funding.

This is not just a funding issue; it is a fiscal and human impact issue. The proposed cuts will:

- Push children back onto waitlists, delaying essential services during their most critical developmental years.
- Eliminate parent choice, forcing families to rely on a strained state system.
- Cost taxpayers significantly more in the long run.

I urge you to prioritize the wellbeing of Nevada's children and families by rejecting these cuts and ensuring sustainable funding for our community providers.

Mark James, Owner and Speech Pathologist, Therapy Management Group:
I appreciate this opportunity to speak with you today. [Read from prepared testimony Exhibit G.] We have been around a long time and wanted to give a bit of history. Since 2006, a gross capitated rate has been used in early intervention to reduce and contain the cost of early intervention services. Whether a child receives 1 service or 20 services per month, the cost to the state is the same.

Over the past 16 years, community partners have received reductions in the gross capitated rate with no reduction to required services provided to families. The gross capitated rate has been adjusted from $857 per-child per-month to $695 to $565 to a prorated $565. With all

these reductions in payments, it became difficult to be competitive in retaining and hiring staff. Thanks to the legislators' efforts during the last biennium, a rate and service model study was commissioned. The study found that the state's cost to provide services was over $1,000 per child. The authors recommended that the community partner's rate should be adjusted to $795.

With that rate adjustment, we have been able to serve more children, hire staff, and retain staff. We have been excited about the direction of early intervention. This was quite a hit with the news to this current budget. In closing, over the last 15 years the state has never made a change without doing a study first to assess the proposed changes' impact on families, costs, and any other unintended consequences that might affect the early intervention program's viability.

Patrick Santoro, Owner and Occupational Therapist, Therapy Management Group:
Previously, community partners were paid $565 as a supplemental rate per month and allowed to bill insurance to recoup therapy costs. In 2022, a Burns & Associates [A Division of Health Management Associates] study stated that a $565 rate was not a viable number moving forward. The rate study recommended a comprehensive rate of $795 with insurance reimbursement netted out each month. In a perfect world where 100 percent of insurance reimbursement is received, and no family cancels appointments, the proposed supplemental rate of $199 or $287 along with insurance reimbursement still would not cover the cost of payroll, let alone the full cost of the program.

Connie McMullen, representing Senior Coalition of Washoe County and Senior Spectrum Newspapers, Inc.:
I am here on behalf of the Senior Coalition of Washoe County and *Senior Spectrum* newspaper. We support the budget for the Aging and Disability Services Division, Department of Health and Human Services for the upcoming biennium for the Adult Protective Services and Long-Term Care Ombudsman program. These are extremely valuable programs in safeguarding our aging population. Our membership supports spending in caseload growth, and bringing down the waitlist and the time spent waiting for assistance. Administrator Dena Schmidt reported there will be continued growth over the next 25 years in the vulnerable and aging populations. Now is the time to get ahead of this expanding need. We thank you for your consideration.

Lisa Manning, Chief Executive Officer, Capability Health and Human Services:
We are one of the first community providers to provide early intervention services in the state of Nevada [Presented Exhibit H]. We are concerned that the proposed funding cut coupled with the shift to a fee-for-service model will create untenable financial and operational conditions for community providers. If the community providers are forced to close, families will be left without access to critical early intervention services. This will lead to large waiting lists for NEIS, which is a burden the state program is not equipped to handle.

There is a lack of evidence supporting the fee-for-service model. The fee-for-service model's efficacy and viability have not been studied or substantiated as a better way to move forward. We propose that rather than reducing funding and further straining the system, we urge you to adopt the agency request for budget account 3208, which restores the necessary funds and maintains the current capitated rate for CPs [community providers].

Additionally, we propose that funding be sustained at the current levels until a comprehensive study can be conducted to evaluate a viable operational and financial model for delivering these services. This study would provide data-driven recommendations to optimize service delivery while ensuring fiscal responsibility. The early years of a child's life are critical for their development, and reducing access to EI [early intervention] services contradicts the goal of providing children with the best possible start in life. I respectfully urge you to consider the long-term impact of this on Nevada's children.

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

[Exhibit I and Exhibit J were submitted but not discussed and are included as exhibits for the hearing.]

Chair Mosca:
There being no others for public comment and no other business before the Subcommittees, this meeting is adjourned [at 10:08 a.m.].

RESPECTFULLY SUBMITTED:

_____
Janice Wright
Committee Secretary

APPROVED BY:

_____
Assemblymember Erica Mosca, Chair

DATE: _____

_____
Senator Rochelle T. Nguyen, Chair

DATE: _____

EXHIBITS

Bill	Exhibit	Witness / Agency	Description
	A		Agenda
	B		Attendance Roster
	C	Dena Schmidt, Administrator, Aging and Disability Services Division, Department of Health and Human Services	PowerPoint presentation titled "2025-2027 Governor's Recommended Budget Aging and Disability Services Division, dated February 25, 2025."
	D	Robert Burns, President, Nevada Early Intervention Community Providers Association	Email dated February 25, 2025, regarding rate cuts for community providers of early intervention services.
	E	Debra Stewart, Co-Owner, MD Developmental Agency	Letter dated February 25,2025, regarding rate cuts for community providers of early intervention services.
	F	Dana Aronson, Owner, Theraplay Solutions	Prepared testimony regarding rate cuts to community providers of early intervention services.
	G	Mark James, Owner and Speech Language Pathologist, Therapy Management Group	Prepared testimony regarding rate cuts to community providers of early intervention services.
	H	Lisa Manning, Chief Executive Officer, Capability Health and Human Services	Letter dated February 24, 2025, regarding rate cuts to community providers of early intervention services.
	I	Ashley DeSouza, Private Citizen, Henderson, Nevada	Letter dated February 24, 2025, regarding rate cuts to community providers of early intervention services.
	J	Shannon Garner and Kyle Tyler, Private Citizens, Las Vegas, Nevada	Letter dated February 25, 2025, regarding rate cuts to community providers of early intervention services.