

Suggested Changes to various DHHS budgets / programs

The following suggestions are based upon a preliminary review of the budget and program information submitted in support thereof. While there is general agreement with the overall DHHS budget, it has occurred to me and others, that this would be an opportune time to continue the efforts the Administration started in streamlining the various programs that impact seniors and disabled. The intent is to carry over into the program area the budget proposals to eliminate some of the silos that exist in the funding stream, notably in the Tobacco Settlement Funds.

Tobacco Settlement Funds

While the specifics of the proposal for this fund are not available yet, there is agreement that the various funding silos should be consolidated. The suggestion is, rather than leave the decision to the Director the allocation of these funds through a plan, that the funds be incorporated in the ADSD planning process, and be used to fund, in conjunction with the Federal funds they manage, community-based services, within priority areas established by the Legislature. Currently ADSD allocates the funds under its control to essential services defined in their plan. While there is considerable disagreement with the extent of the essential services incorporated in that plan (16 or 17), with direction from the legislature to limit the priority areas to say, 4, there will be more funds for programs that directly impact the ability of seniors to remain in their homes.

Waiver Program Eligibility Process

Currently, once a person gets with ADSD, they are screened, a preliminary care plan is developed, and eligibility is established for one or more of the waiver programs they administer. The application is then sent to Welfare which determines eligibility for Medicaid. The application is then sent to the Division of Health Care Financing and Policy (DHCFP) for final determination. DHCFP also develops a care plan for Medicaid services under the waiver. This process is replete with redundancies and overlap. It is proposed that for the various ADSD waiver programs, the first ADSD and Welfare division steps be eliminated, and DHCFP makes the eligibility and care plan decisions. Once this is done, the customer is shifted to ADSD for service delivery, or, DHCFP manages the waivers in the same way it does the regular PCA programs which serve as the basis for the waivers.

Consolidate all DHHS information and referral programs into one unit

Steps to bring some of these together were made in the Executive Budget, with the recommendation to combine the 2-1-1 program with the Consumer Health Assistance Office that is moving from the Governor's Office to DHHS. Further, ADSD has housed its latest ADRC with a rural FRC. There are at least two and probably more, information and referral databases in these programs, all of which

Suggested Changes to various DHHS budgets / programs

contain basically the same information. Bringing these programs together under one management structure, would allow the efforts currently underway to be expanded more quickly and with, in my opinion, some initial savings in administrative personnel costs, and mid and long term savings in support infrastructure, as well as a more accountable information and referral system for state residents.

It is interesting to me that the Consumer Health Assistance Office performs in the arena of health care the same role that the Family Resource Centers do for the entire state population and ADRCs perform for the elderly and disabled populations, and the 2-1-1 system is, or should be, an integral component of all of them.

It also would be much more efficient for those that need to access the federal, state, and local support system. This would truly establish the basis for the “no wrong door” system that has been talked about for at least the past 20 years.

Relocate all of the ADSD advocacy programs to a non-profit outside of State government

There are inherent conflicts with advocacy programs in agencies that are responsible for funding, regulating, or delivering services to the population that is served by the agency. The State recognized this several years ago when it disengaged from advocating for the disabled population. This would be an ideal time to make the same move for the senior population.

Remove the SURS unit from DHCQP

Under the current structure, DHCQP conducts audits of all providers, then sends the audit to the SURS unit to determine if there is a need for additional examination of the provider. While there is agreement that audits need to be evaluated, having the same division involved in the review process violates several basic rules of basic management as well as accounting. The current process is subject to abuse by the division that can be rectified by simply moving the SURS unit to say the Directors office, and using that unit to form the basis for the equivalent of an Inspector General function which in time would improve the accountability of the entire department.

Move forward with the various managed care and home-based programs for the Medicaid program

There are several proposals either in recently passed statutes, in the pilot program stage, or proposed. All of these efforts are designed to keep Medicaid eligible customers in the most economical health care environment which saves the state and local governments funds that otherwise would be required to

Suggested Changes to various DHHS budgets / programs

support this population in the more expensive alternatives such as hospitals, jails, and nursing homes.

Utilize contract services rather than employ 15 new EPS workers.

ADSD currently utilizes contract services for some of the EPS cases in the rural areas through the Maaverick Corporation. It is my understanding this is done for difficult to serve customers. While I am unaware of the per client cost of the services, it would be interesting to compare them to the costs of providing the services through state workers. If the costs are in fact lower, it is recommended that state not increase the social workers in the ADSD division, but transfer the funds to contract services.

Again, assuming the costs are lower, this approach would allow the program to expand and contract with the need, as well as delivering the services more cost effectively.

These suggestions were developed by Nevada Senior Advocates (NSA), on behalf of the Nevada Senior Corps Association, and are based upon a preliminary review of the Executive Budget for the Department of Health and Human Services. These suggestions will be further refined through discussions with Department staff as well as legislators.

For additional information, please contact:

Bruce Arkell
(702) 275-6530 (Cell)
(775) 829-0870 (Work)
brucea@nevadasenioradvocates.org