HEALTH MANAGEMENT ASSOCIATES

Nevada Early Intervention System Evaluation

PRESENTED TO

NEVADA DEPARTMENT OF HEALTH AND HUMAN SERVICES

Research and Consulting in the Fields of Health and Human Services Policy, Health Economics and Finance, Program Evaluation, Data Analysis, and Health System Restructuring

Introduction

"There is an urgent and substantial need to identify as early as possible those infants and toddlers in need of services to ensure that intervention is provided when the developing brain is most capable of change."[1]

An infant's brain doubles in size during the first year of life and, by a toddler's third birthday, their brain will be 80 percent of its adult size.[2] The first three years of a child's life are pivotal because "sensory pathways such as hearing, language, and higher cognitive function all peak by the first three years of life" while the experience an infant or toddler has with their parents or caregivers "dramatically influences brain development, social-emotional and cognitive skills, and future health and success in school and life."[3] Experts estimate that between 16 and 18 percent of children under three years old have disabilities or developmental delays that may require early intervention (EI) or other supports such as services provided through maternal home visiting programs to limit or eliminate the impacts of such delays and disabilities.[4]

The federal government provides funding through Part C of the Individuals with Disabilities Education Act (IDEA).[5] The 1986 reauthorization of IDEA recognized "an urgent and substantial need:

1. To enhance the development of infants and toddlers with disabilities, to minimize their potential for developmental delay, and to recognize the significant brain development that occurs during a child's first 3 years of life;
2. To reduce the educational costs to our society, including our Nation's schools, by minimizing the need for special education and related services after infants and toddlers with disabilities reach school age;
3. To maximize the potential for individuals with disabilities to live independently in society;
4. To enhance the capacity of families to meet the special needs of their infants and toddlers with disabilities; and
5. To enhance the capacity of State and local agencies and service providers to identify, evaluate, and meet the needs of all children, particularly minority, low-income, inner city, and rural children, and infants and toddlers in foster care." [6]

IDEA Part C aims to promote a statewide multidisciplinary and interagency EI system that is continuously enhanced to provide higher quality EI services, and expanded and improved upon to ensure traditionally underserved children such as those who are racial or ethnic minorities or from low-income communities have the same level of access to services as all other children.[7]

Early intervention covers an expansive array of services to address the broad range of physical, cognitive, communication, social, emotional, and adaptive delays and disabilities among eligible children. Figure 1 describes each EI service as defined in federal regulation.

Figure 1: Early Intervention Services Required Under IDEA Part C[8]

Service	Select Service Provisions
Assistive technology device	Any device, piece of equipment, or system used to increase, maintain, or improve the functional capabilities of an infant or toddler with a disability.
Assistive technology service	Evaluation, acquisition, and training/ technical assistance for children and families, as well as providers, to utilize assistive technology.
Audiology services	Conduct hearing evaluations, provide auditory training, speech reading and listening device orientation and training, assistance in selecting, fitting, and dispensing appropriate listening and vibrotactile devices.
Family training, counseling, and home visits	Assist the family of the infant or toddler with a disability in understanding the special needs of the child and enhancing the child's development.
Health services	Services necessary to enable an otherwise eligible child to benefit from other EI services, which may include intermittent catheterization, tracheostomy care, tube feeding, consultation by physicians and other service providers concerning the special health care needs of children in the course of providing other EI services. Does not include surgical procedures, services that are purely medical in nature (unrelated to the provision of EI services specifically), or similar services.
Medical services	Services provided by a licensed physician for diagnostic or evaluation purposes to determine a child's developmental status and need for early intervention services.
Nursing services	Assessment of health status, provision of nursing care to prevent health problems or improve functioning, and the administration of medications, treatments, and other physician-prescribed regimens.
Nutrition services	Conducting assessments of nutritional history and dietary intake, feeding skills and challenges, and development of appropriate plans to address the nutritional needs of children.
Occupational therapy	Services that address the functional needs of children related to adaptive development, behavior, play, including sensory, motor, and postural development; includes adaptation of the environment and assistance with orthotic devices to facilitate development, promote acquisition of functional skills, and prevent or minimize the impact of future impairment, delay in development, or loss of functional ability.
Physical therapy	Services that address the sensorimotor function of children through enhancement of musculoskeletal status, perceptual and motor development, cardiopulmonary status; the service includes individual or group services and treatment to prevent, alleviate, or compensate for movement dysfunction and related functional problems.

Service	Select Service Provisions
Psychological services	Administers psychological and developmental tests, interprets assessment results, obtains and interprets information about child behavior and family conditions, and provides psychological counseling to children and families, as well as consultation on child development, parent training, and education programs.
Service coordination (case management)	Assists children and families to receive the services, rights, and procedural safeguards within IDEA Part C. Assists families in obtaining EI services, including making referrals, scheduling appointments, coordinating evaluations and assessments, facilitating and participating in the IFSP development and review, and other activities.
Sign language and cued language services	Includes teaching sign and cued language, auditory/ oral language, and providing oral transliteration services and interpretation.
Social work services	Makes home visits to evaluate a child's living conditions, prepares social and emotional development assessments, provides counseling with parents and other family members, and identifies and coordinates community resources to enable the child and their family to receive maximum benefit from EI services.
Special instruction	Designs learning activities to promote a child's acquisition of skills across developmental areas; designs curriculum, provides families with information, skills and other support needed to enhance the skill development of the child.
Speech language pathology	Diagnoses specific speech-related disorders and delays, provides or makes referrals for habilitation, rehabilitation, or prevention of communication or language disorders and delays in development of communication skills.
Transportation	Includes the cost of travel and other costs necessary to enable a child and their family to receive EI services.
Vision services	Evaluates and assesses visual functioning and diagnoses specific visual disorders and delays affecting early childhood development; makes referrals to other medical professionals necessary to habilitate or rehabilitate a child's visual functioning.

In Nevada, just four of these services – special instruction, physical therapy, occupational therapy, and speech language pathology – accounted for 90 percent of all authorized service hours based on active Individualized Family Service Plans (IFSPs) in July 2023.

As discussed in Part I of this report, federal regulations specify minimum components that must be present for states to receive federal Part C funds, including the designation of a lead agency that is the single line of authority for the system, a child find system that provides information about EI services and increases EI program awareness, a policy for how services will be delivered, and other requirements.[9] However, federal regulations give states broad authority in designing their EI program structure in terms of where the lead agency is housed, what type of entities (whether public, private, or a combination of both) will deliver EI services, and the eligibility standards for children to receive EI services.

Part I: Nevada's Early Intervention System

"The primary focus of state monitoring activities is on improving educational results and functional outcomes for all children with disabilities; and ensuring that states meet the program requirements of IDEA"[29]

The Nevada Early Intervention Services system encompasses all aspects of early intervention service administration and delivery in Nevada, including intake and eligibility determinations, Individualized Family Service Plan development, service coordination, the full range of EI services, service monitoring, and transition supports and services before a child reaches the age of three. Federal statutes and regulations provide states with broad authority to design an EI system that complies with the minimum requirements of IDEA Part C. As a result, state programs vary in terms of program administration, eligibility standards, service delivery, and other system components.

This section describes the key administrative, supervisory, and service delivery structures and processes in place at the time of the evaluation. This section also discusses Nevada's eligibility policies and compares such policies and other system features to best practice recommendations from national authorities and advocacy organizations. The section concludes with recommendations designed to improve system efficiency and effectiveness.

NEIS Program Administration and General Supervision

Recent guidance issued by the U.S. Department of Education's Office of Special Education Programs (OSEP) reaffirmed "the importance of general supervision and the expectation that monitoring the implementation of IDEA will improve early intervention and educational results and functional outcomes for children with disabilities and their families."[30] According to OSEP's formal guidance, "each state has the flexibility to develop its own model of general supervision and may elect to address the underlying Federal requirements in other ways" while OSEP further emphasizes the importance of policies and practices that promote high-quality EI outcomes.[31]

Minimum IDEA Part C federal requirements for state EI programs include: [32]

- A designated lead agency that is the single line of authority in the state for its EI system. The lead agency is responsible for the general supervision and monitoring of the EI program, including monitoring child outcomes and other compliance requirements, as well as training, technical assistance, and enforcement actions as needed to ensure program compliance among EI Service programs (EIS programs) which deliver EI services to children and families.
- An Interagency Coordinating Council (ICC) comprised of parents, early childhood advocates, child care providers, EI service providers, state agency representatives, and others to strategically advise the lead agency on policies related to equitable access, child find strategies, training and workforce development, and other key strategic areas.
- A child find system that provides information about EI services to interested individuals and increases public awareness about EI services to ensure children with developmental delays or

other qualifying disabilities are identified and referred for EI services or other appropriate services.

- Eligibility criteria that clearly define the level of developmental delay that qualifies a child for EI services, and an evaluation and assessment process that is both timely and comprehensive in identifying the eligibility and service needs for each child referred to the system.
- A policy for how services will be delivered and the development of a sufficient network of EIS programs able to deliver EI services to children through a qualified workforce.
- A comprehensive system of personnel development that provides training and support to EIS programs and personnel while promoting standards that support a qualified and well-trained workforce that can best support high quality outcomes for children receiving services.
- Other policies and practices to support the EI system, including the establishment of interagency agreements that establish financial responsibility and service provision responsibilities of agencies across the state (for example, agreements between the IDEA Part C Office and the Part B office for handling the transition of children between programs as they age out of Part C).

Otherwise, federal regulations give states broad authority to structure their EI programs. Neither federal regulations nor nationally-endorsed best practices espouse a particular structure for housing a lead agency within a specific state department or coordinating the delivery of EI services with public and private organizations and individuals.

DHHS Early Intervention Support Structure

Nevada has designated its Department of Health and Human Services as the state's lead agency for IDEA Part C. Across the country, state health departments are the most common designated lead agency, reported by 18 out of 51 states (including the District of Columbia) participating in the IDEA Infant & Toddler Coordinators Association's 2022 Tipping Points Survey.[33] Other designated Part C lead agencies include the education department (reported by 11 states), human services departments (6 states), developmental disabilities departments (5 states), early childhood departments (2 states), and other arrangements and departments (9 states).

As referenced previously, the IDEA Part C Office and ADSD, both within DHHS, share responsibility for system administration, service delivery, and monitoring.

The responsibilities of the IDEA Part C Office include:

- Maintaining the Nevada IDEA Part C Manual and other policies and system directives consistent with federal IDEA Part C regulations and evidence-based best practices
- Applying for and providing oversight of federal IDEA Part C grant funding, assuring funds are used only for the purposes outlined in law
- Providing technical assistance and readiness activities prior to approving contracted EIS programs for service

- Facilitating dispute resolution requests, including investigating complaints from families, EI professionals, and other stakeholders; providing mediation; and conducting due process hearings
- Continuously monitoring all EIS programs for compliance with IDEA Part C requirements and issuing enforcement actions as needed, including comprehensive monitoring, complaint investigations, and focused monitoring. Monitoring activities also include verifying individual child records and overseeing implementation of corrective actions when issued
- Providing technical assistance and enforcement mechanisms through the sanctions matrix when EIS programs are noncompliant with IDEA Part C regulations
- Collecting and reporting system performance data at the EIS program and system levels to demonstrate compliance with federal regulatory requirements and to demonstrate the effectiveness of NEIS in achieving state targets for quality-based outcome measures
- Providing training, technical assistance, and other support and resources to EIS programs
- Conducting Community Partner billing reviews to identify potential billing errors and potential recoupment (an activity that was until recently performed by the Quality Assurance team within ADSD)
- Maintaining the state's CSPD, including the personnel qualification standards required to deliver EI services, and facilitating strategies that build and reinforce a workforce and provider network sufficiently staffed with qualified EI personnel with the training and experience needed to deliver high quality services.

Generally, states contract with providers to deliver services within an assigned catchment area. States may contract with private for-profit or nonprofit organizations; public entities such as state agencies, local school districts, special education schools (such as schools for the deaf and blind), and local county boards; or some combination of different provider types. Nevada has adopted a hybrid approach.–ADSD has responsibility for service delivery through its contracts with Community Partners while also directly managing three EIS programs. ADSD directly employs staff to provide service coordination and special instruction and contracts with Reliable Health Care Services (Reliable), a health services staffing agency, for the delivery of therapies and other EI services for the three programs it directly manages.

ADSD also assists in the collection of provider performance data, approves payments to Community Partners, provides training and technical assistance to EIS programs, and participates in general NEIS planning. The IDEA Part C Manual further describes ADSD's activities, including:

- Collaborating and coordinating with the IDEA Part C Office to ensure implementation of the statewide system of early intervention services
- Implementing procedures to ensure the statewide availability of early intervention services for Part C eligible children and families and that those services are provided in a timely manner in accordance with IDEA Part C regulations and state policy

- Identifying and coordinating all available resources to ensure compliance with payor of last resort requirements
- Collaborating with other divisions and agencies to assign financial responsibility

The Quality Assurance team within ADSD provides several supports for NEIS. The QA team members assigned to NEIS include experienced developmental specialists who are responsible for the following tasks:

- Performing home visit observations of EI professionals to monitor fidelity to evidence-based practices
- Providing coaching and training to developmental specialists in implementing evidence-based EI practices
- Hosting trainings
- Monitoring Plans of Improvement as needed
- Collaborating in the development and implementation of policies and procedures related to quality assurance
- Attending ICC meetings and participating on subcommittees

The DHHS Management Analyst (MA) team within ADSD provides support to multiple DHHS divisions, but does not have a dedicated team or position specific to NEIS. Supports provided to NEIS by the MA team include:

- Compiling and analyzing EI program data about caseloads and financial data
- Supporting ADSD and the IDEA Part C Office with contract oversight and fiscal monitoring
- Providing analysis of state and federal regulations that may impact NEIS and preparing reports to summarize findings
- Overseeing data entry and data collection about EIS programs, and providing technical assistance that support program and fiscal integrity
- Collaborating with NEIS stakeholders to build data-driven reports that support compliance and programmatic improvements

The IDEA Part C Manual lists overlapping responsibilities across these units that at times results in a lack of clarity. For example, the IDEA Part C Manual notes that the IDEA Part C Office provides training and technical assistance regarding research-based EI service and compliance practices, which is also an emphasis of the QA team within ADSD. Due in part to these ambiguities, in 2022, the IDEA Part C Office, ADSD (including the Children's Services office, the QA team, and the MA Team) were tasked with identifying their key roles and responsibilities within NEIS. Figure 9 summarizes the activities each unit identified in their self-assessments, although these roles and responsibilities were not further documented or adopted into a formal policy or other agreement.

Figure 9: EI Roles and Responsibilities Documented by DHHS Divisions

EI Role/ Activity	IDEA Part C Office	ADSD	Mgmt Analyst Team	Quality Assurance Team
Monitoring EIS programs	✓	✓		✓
Developing policy for EIS programs	✓	✓		✓
Compiling, analyzing, and reporting EI program data	✓	✓	✓	✓
Enforcing policies and obligations on EIS programs (including supporting roles)	✓	✓	✓	
Working with EIS programs to correct non-compliance if identified	✓			✓
Surveying families for satisfaction	✓			✓
Providing training and technical assistance/ training to EIS programs (including state-facilitated service staff)	✓	✓	✓	✓
Policy development	✓			
Maintaining the Central Directory (Project ASSIST)	✓			
Supporting the ICC	✓			
Overseeing system funding	✓	✓		
Providing services directly		✓		
Overseeing timelines for DS endorsement obtainment and the EIS program level		✓		
Performing contract oversight of Community Partner EIS programs		✓		

As the figure illustrates, certain functions, such as monitoring EIS programs, policy development, and providing training and technical assistance to EIS programs are shared across DHHS divisions and teams. DHHS staff interviewed as part of this evaluation expressed an ongoing lack of certainty about the scope of their various shared responsibilities while also expressing a desire for improved clarity in the objectives of certain activities and improved collaboration across DHHS divisions and teams in documenting and carrying out their responsibilities.

The lack of clearly articulated roles and responsibilities has created some confusion, system inefficiencies, and the perception that collaboration across DHHS units needs to be improved. For example, Community Partners interviewed as part of the evaluation reported that they did not generally differentiate between DHHS divisions, especially when receiving requests for information related to their EIS programs for compliance and performance reporting. They also reported an observable lack of coordination and collaboration across DHHS units that has resulted in duplicative information requests and sometimes conflicting technical assistance or training.

Other NEIS Partners with Administrative Support Roles

A key responsibility of the IDEA Part C Office is to establish and maintain agreements with state and local agencies, delineating the roles and responsibilities of each agency with respect to coordinating payments and funding for EI services, and sharing information and resources to support children identified as having a developmental delay or disability who may require early intervention services. Figure 10 highlights the primary agreements in place at the time of the evaluation.

Figure 10: System Partnerships and Agreements

Partnership	Description of Agreement
Nevada Department of Education (NDE), Part B Office[34]	• Supports broad collaboration and communication between the Part C and Part B Offices, especially in ensuring the effective transition of eligible children from Part C into Part B through transition planning activities and joint participation by Part C and Part B in development of transition plans and Individual Education Plans as appropriate. • Requires Part C EIS programs to comply with the EI conditional licensing contract created by NDE's teacher licensure requirements and the accompanying endorsement requirement for early intervention personnel.
DHHS' Division of Health Care Financing & Policy (DHCFP) [35]	• Provides for Medicaid reimbursement for service coordination (targeted case management) provided by NEIS. • Provides for Medicaid reimbursement for ADSD for providing community outreach, such as educating individuals or groups regarding the eligibility criteria for EI services and identifying and providing guidance to individuals who are potentially eligible for Medicaid services.
Early Hearing and Detection Intervention (EHDI) [36]	• Supports collaboration between EHDI and NEIS to reduce the number of hearing screened infants who are lost to follow-up and/or lost to documentation. • Ensures that information is collected regarding the eligibility of children with hearing loss as well as their referral to appropriate services. • Specifies information sharing and response time requirements to ensure families identified as having a child with hearing loss are contacted and provided with screening services.

The IDEA Part C Office holds additional agreements with the DHHS Division of Welfare and Supportive Services for coordination of care and with the DHHS Division of Child and Family Services (DCFS) for service provision and coordination of care.

NEIS is further supported by the Interagency Coordinating Council (ICC), which includes 28 membership slots across multiple stakeholder groups. Figure 11 reports the type of stakeholders that compose the ICC as well as the number of vacancies as of December 2023.[37]

Figure 11: ICC Composition and Number of Vacancies (as of December 2023)

Stakeholder Type	Number of Slots	Vacancies
State Legislature	1	0
Personnel Preparation	2	0
Head Start Agency	1	0
Parent Representatives	7	2
Private/Public Provider	5	3
State Education Agency for Preschool Services	1	1
State Agency Involved in the Provision of, or Payment for Early Intervention Services	1	1
State Medicaid Agency	1	1
State Child Care Agency	1	0
State Foster Care Agency	1	1
State Health Insurance Agency	1	1
State Mental Health Agency	1	0
Office of the Coordinator of Education of Homeless Children	1	1
Native American Representative	1	0
Advocacy	3	0
Total	**28**	**11**

As the figure suggests, the ICC includes an array of EI system stakeholders who offer a broad array of perspectives, including parents, providers, Head Start delegates, representatives from multiple state agencies, advocacy group representatives, and others. However, at the time of the evaluation, 11 of the 28 available ICC slots were vacant, mostly resulting in a lack of representation of parents, providers, and key state agency representatives.

The ICC's purpose is to "advise and assist the Nevada Department of Health and Human Services in the development of and implementation of a statewide system of early intervention services" for children with developmental delays or disabilities and their families.[38] The ICC's primary function is to advise the IDEA Part C Office in the performance of its responsibilities, including: [39]

- Identifying fiscal resources and other supports for EI services
- Assisting with the assignment of financial responsibility to appropriate agencies
- Promoting the use of intra- and inter-agency agreements for child find, program monitoring, and transition-related activities
- Assisting with the preparation and submission of the Part C application and amendments

- Advising and assisting Nevada's Department of Education's Part B office regarding the transition of toddlers with disabilities to Part B services or other supports (such as special education preschool)
- Creating and disseminating accessible information about the EI system to stakeholders, including legislators, medical practitioners, families, child care providers, businesses, and communities
- Supporting a system where all providers and stakeholders at the state and local levels are able to participate in partnerships that maximize outcomes for children and families
- Providing input to the Annual Performance Report (APR) submitted to the Governor and the U.S. Department Education about the status of EI Service Programs in Nevada
- Coordinating and collaborating with the State Advisory Council on Early Childhood Education and Care for Children and other state interagency early learning initiatives, as appropriate

Additionally, the ICC holds a triennial strategic planning summit to create a three-year plan and meets every year in between to review and update strategies from each summit. In its December 2023 meeting, the ICC began a five-year strategic planning process that includes subcommittees responsible for evaluating strategies for equity, child find, and family supports.[40] Although federal regulations do not require a strategic plan, such an endeavor aligns with national ECTA Center's recommendations to use a written plan to drive ongoing system improvement and to base such plans on data and stakeholder input.[41]

Given the flexibility federal regulations offer states in designing their early intervention systems, state structures vary. A summary of EI system structures among the seven benchmark states included for comparison purposes in the evaluation follow:[42]

- **Arizona:** The Arizona Department of Economic Security (DES) is the state's lead agency through the Arizona Early Intervention Program (AzEIP). DES is the state's human services authority, administering programs such as home and community-based services for individuals with developmental disabilities, Adult Protective Services, the state's child care subsidy, and various other benefit programs such as the Supplemental Assistance Nutrition Program (SNAP). AzEIP oversees EIS programs across Arizona's 22 catchment areas that may be served by one or more EIS programs. EIS programs include privately-contracted community-based providers and two public programs operated by the Arizona Schools for the Deaf and the Blind and the DES Division of Developmental Disabilities. Service coordination is performed by EIS programs.
- **California:** The Department of Developmental Services (DDS) is California's lead agency through its Early Start program and additionally oversees the state's services for individuals with intellectual and developmental disabilities. Early Start services are provided through 21 community-based non-profit agencies known as Regional Centers that are responsible for a defined geographic catchment area. Regional Centers provide assessments, determine eligibility for services, provide support coordination, and contract with community-based providers to deliver EI services.

- **Colorado:** Early Intervention Colorado oversees contracts with twenty private non-profit organizations that perform all EI service-related functions, including service coordination. Early Intervention Colorado was reorganized in 2022 within a newly-established cabinet-level agency, the Department of Early Childhood, which also administers Colorado's universal preschool program, home visiting programs, and child care subsidies. Early Intervention Colorado is facilitated through 20 county-based catchment areas containing one or more counties. Each catchment area is served by a single EIS program.
- **Georgia:** The Georgia Department of Public Health (DPH) is the state's lead agency through its Babies Can't Wait (BCW) EI program. BCW supervises 18 local health care districts comprised of one or more counties. Services are delivered and coordinated within each region by private community providers and independent contractors. Three regional offices are responsible for providing supervision and technical assistance and training.
- **New Mexico:** The New Mexico Early Childhood Education & Care Department (ECECD) is the lead agency of the state's Family Infant Toddler (FIT) EI program. FIT was formerly part of the New Mexico Developmental Disabilities Supports Division (DDSD) but was reorganized under ECECD when it was created as a cabinet-level agency in 2020. The creation of the new department was intended to "create a more cohesive, equitable, and effective early childhood system" to improve coordination across a "continuum of programs from prenatal to five." EIS programs supporting FIT are private providers and a public program operated by its statewide school for the deaf and blind, and are monitored by three regional coordinators who oversee a county-based regional catchment area.
- **Oregon:** The Oregon Department of Education is Oregon's lead agency through its Early Intervention/ Early Childhood Special Education (EI/ECSE) program. EI/ECSE supervises nine EIS programs that provide EI services in a county-based catchment area of one or more counties. Across the nine regions, one EIS program is a school district, one is operated by a university, and the remaining regions are operated by educational service districts.
- **Utah:** The state recently combined its Department of Health, where its Baby Watch Early Intervention Program (BWEIP) was housed, with its Department of Human Services. Within this reorganization, a new Office of Early Childhood was established to administer BWEIP as well as maternal home visiting and other early childhood programs. BWEIP delivers EI services through 15 local EI programs that serve a geographic catchment area, including one program facilitated directly by the lead agency with state staff. Other EIS programs include private providers and some school districts serving children within their boundaries. The Utah Schools for the Deaf and the Blind's Parent Infant Program also operates an EIS program.

As described above, benchmark states locate their lead agencies within a range of state departments, including health, human services, and education departments. Three benchmark state EI programs (Colorado, New Mexico, and Utah) recently reorganized within early childhood-focused departments or divisions. These states report that co-locating EI with other early childhood programs – such as maternal

and child home visiting programs and child care subsidies – will improve coordination and access across programs that support young children and their families.

All benchmark states manage EIS programs through regional service areas usually comprised of on one or more counties. Services are delivered through a combination of private community-based providers (like Community Partners in Nevada), school districts, local health districts, and other public entities. Some states designate a single program for each regional service area. Like Nevada, Utah manages an in-house EIS program with a reporting line to the Part C Coordinator. According to Utah's Part C leadership, the monitoring and supervisory practices are the same for the EIS program managed by their office as they are for contracted programs. They additionally noted that the direct operation of an EIS program ensures they maintain firsthand experience and knowledge of service delivery, allowing them to better support other contracted EIS programs across the state.

Nevada's Early Intervention Service Programs

Federal regulations define EIS programs as entities designated by the lead agency for reporting outcomes for the children they serve.[43] An EIS program may be a public agency (including the lead agency or another public body) or a private organization or individual.[44] All of Nevada's EIS programs:

- Receive and evaluate referrals and determine eligibility
- Develop goals and service plans within the IFSP and periodically revise IFSPs as appropriate
- Consult with parents, other service providers, and community organizations to ensure the effective provision of services in the child's community
- Coordinate and deliver services as identified in the IFSP
- Train parents and others regarding the provision of EI services
- Respond to requests for data and other information from the IDEA Part C Office and ADSD through its Children's Services office and QA team
- Participate in technical assistance training, receive coaching and feedback from the IDEA Part C Office and ADSD, and carry out corrective actions as needed to bring programs into compliance

At the time of the evaluation, there were ten EIS programs in the state, including three programs operated by ADSD and seven programs operated by private Community Partners contracted by ADSD as illustrated in Figure 12.

Figure 12: NEIS Programs by Region (as of December 2023)

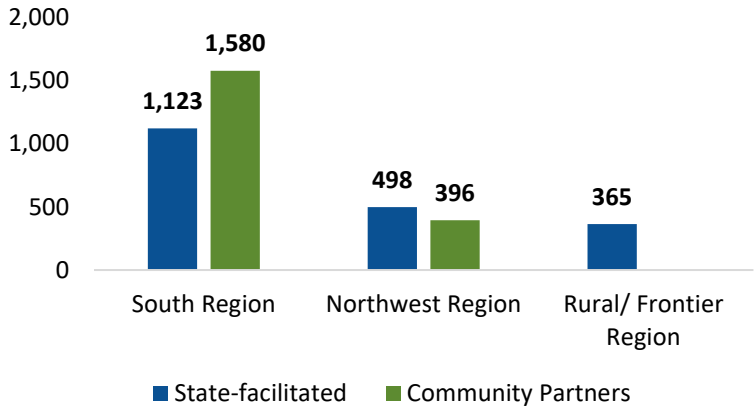
Provider Type/ Name	South	Northwest	Rural/ Frontier
State-Facilitated EIS Programs			
NEIS-South	✓		
NEIS-Northwest (Reno)		✓	

Provider Type/ Name	South	Northwest	Rural/ Frontier
NEIS- Rural/Frontier			✓
Community Partner-Facilitated EIS Programs			
Advanced Pediatric Therapies, LLC		✓	
Capability Health and Human Services	✓	✓	
Theraplay Solutions	✓		
MD Developmental Agency	✓		
Therapy Management Group	✓	✓	
Total EIS Programs	**5**	**4**	**1**

As the figure shows, five Community Partner organizations deliver services in the south and northwest regions. Two of these organizations have EIS programs in both regions. Two additional Community Partners ended their contract with ADSD in late 2022 and early 2023 with their caseloads (totaling about 330 children) redistributed among the other programs. Loss of EI providers is not uncommon nationally, as one-in-four states participating in the IDEA Infant & Toddler Coordinators Association's (ITCA's) 2022 Tipping Points Survey reported losing EI providers in the previous three fiscal years due to fiscal constraints.[45]

As described previously, NEIS is divided into three regions that broadly encompass the Las Vegas metropolitan area as well as Esmeralda, southern Nye, and Lincoln counties in the south region, Reno in the northwest region, and Carson City and all other counties in the rural/ frontier region. Figure 13 presents the distribution of the state's caseload as of October 2023.

Figure 13: Distribution of Overall Caseload as of October 2023 by Region and Provider Type



As the figure shows, Community Partners have a greater proportion of the caseload in the urban south region (58.4 percent) and a smaller proportion of the caseload in the northwest region (44.3 percent). At the time of the evaluation, Community Partners did not provide services in the rural/ frontier region, but some expressed a willingness to do so.

System Funding

Although federal Part C regulations place a wide array of requirements on state early intervention programs, federal Part C funds cover only a fraction of the cost of administering these programs, shifting

primary funding responsibility to the states.[46] As a result, "states continually struggle with the need to adjust or expand the array of resources to support an integrated early intervention system" and "are faced with financing systems that are unstable, inadequate, and complex."[47] As described in this section, annual service costs range from $9,500 to $13,000 per child. Although the total federal Part C grant amount has increased nationally from $375 million in 2000 to $496 million in 2022, per child funding decreased over the same period, from $1,819 to $1,222 per child as illustrated in Figure 14.[48]

Figure 14: Total Federal Part C Grant and Average per Child Served Nationally (2000 - 2022)

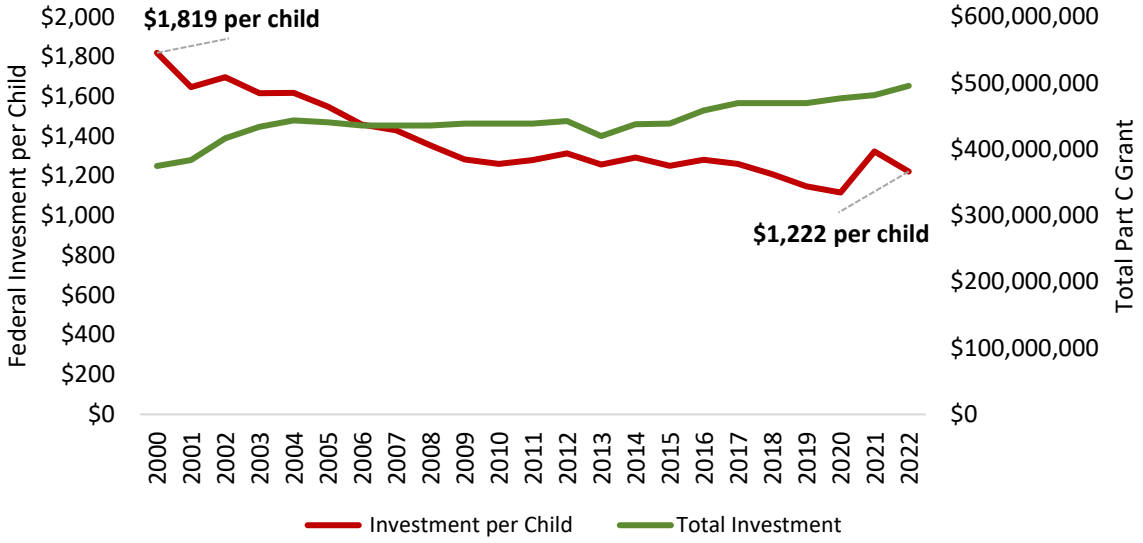


Figure 15 reports national early intervention funding based on a 2023 survey administered by the IDEA Infant and Toddler Coordinators Association (ITCA).[49] Nationally, the Part C grant represents only about 11 percent of all EI system funding, while state funds (which may include state general funds, state special education funds, and other state funding streams) represent close to half of all EI spending. Medicaid provides 16.8 percent of EI spending through payment for covered services (such as therapies and service coordination) provided to children enrolled in the state Medicaid program. Other funds from local sources (such as school districts or municipal, tribal, and county governments) account for almost five percent of EI spending.

Figure 15: ITCA 2023 Finance Survey – Reported Revenues by Major Fund Source

Fund Source	Reported Revenues	Percent of Total Reported Revenue
State Only Funds	$1,864,541,807	45.7%
Medicaid	$682,978,397	16.8%
Federal Part C	$454,549,975	11.2%
Local Government	$197,597,089	4.8%
Part C ARPA	$188,015,398	4.6%

Fund Source	Reported Revenues	Percent of Total Reported Revenue
All Other Sources	$687,832,544	16.9%
Total	**$4,075,515,210**	

Nevada's 2023-2025 legislatively-approved budget for NEIS reports actual spending of $32.1 million in fiscal year 2022 and an approved budget of $36.6 million in fiscal year 2024, as reflected in Figure 16. Similar to the national totals presented in Figure 15, federal IDEA Part C grant dollars in Nevada represent only about 11 percent of NEIS' funding for the 2024-2025 budget period.

Figure 16: 2021-2025 Legislatively-Approved Budget Details for NEIS (IDEA Part C Office and ADSD) [50]

Fund Source	2021-2022 Actual	2022-2023 Work Program	2023-2024 Leg. Approved	2024-2025 Leg. Approved
IDEA Part C Office				
Federal Part C Grant	$3,438,814	$4,226,703	$4,326,843	$4,007,958
Fed. IDEA Amer. Rescue Plan Act	$90,265	$1,766,652	$540,600	$16,800
Transfer in ARPA	$0	$378,368	$324,450	$0
Sub-Total IDEA Part C Office	**$3,529,079**	**$6,371,723**	**$5,191,893**	**$4,024,758**
ADSD				
State General Funds	$31,905,219	$34,819,097	$32,214,543	$32,775,115
Reversions	($3,615,775)	$0	$0	$0
Medicaid Medical Services	$293,137	$497,973	$367,021	$367,606
Medical Services – Private	$88,737	$208,339	$140,168	$140,273
Medicaid Targeted Case Mgt.	$436,343	$628,234	$653,890	$653,890
Medicaid Admin. Charges	$2,624,881	$2,618,654	$2,689,012	$2,702,369
Prior Year Refunds	$13,876	$0	$0	$0
Transfer in ARPA	$415,393	$425,268	$0	$0
Transfer from Education	$0	$246,268	$0	$0
Transfer from IDEA Part C Compliance	$2,491,695	$2,869,501	$2,500,582	$2,510,942
Sub-Total ADSD	**$34,653,506**	**$42,313,334**	**$38,565,216**	**$39,150,195**
Less: Intra-agency transfer from Part C to ADSD for Compliance	($2,491,695)	($2,869,501)	($2,500,582)	($2,510,942)
Total Part C and ADSD Funding	**$32,161,811**	**$39,443,833**	**$36,064,634**	**$36,639,253**
Part C Grant as Percent of Total	**10.7%**	**10.7%**	**12.0%**	**10.9%**

National research notes that "one of the most important funding sources for EI services is Medicaid, and states vary in the extent to which they take advantage of Medicaid funding."[51] In Nevada, Medicaid funding in the 2023-2024 legislatively-approved budget accounts for only $3.7 million of the $36.6 million total budget. At 10.3 percent of the total NEIS budget, the Medicaid contribution is 6.5 percentage points lower than the national average. Of this total, nearly $3.3 million represents funding to support the following activities: [52]

- Performing Medicaid administrative duties which may include monitoring providers for compliance with the Nevada Medicaid Services Manual, informing Medicaid recipients about their Medicaid appeal rights and procedures, and similar activities.
- Medicaid outreach for potentially eligible populations that NEIS may encounter through its child find and service delivery activities, which may include dissemination of information regarding eligibility for Medicaid waiver programs.
- Providing targeted case management (support coordination) for children receiving services through NEIS who are Medicaid eligible.
- The funding also pays for other Medicaid-related administrative duties carried out by ADSD, such as monitoring providers for compliance with the Medicaid Services Manual, identifying and reporting to DHCFP issues that may impair service access or quality, and informing Medicaid recipients about their Medicaid appeal rights and related procedures.
- Additional Medicaid funding of approximately $367,021 in the 2023-2024 legislatively-approved budget pays for Medicaid-allowable services delivered through NEIS, such as therapies, audiology services, and similar services. Nearly half of the children with active IFSPs as of July 2023 were Medicaid eligible (48.4 percent), and of these, 94.4 percent had consents to bill Medicaid for NEIS services approved by their families.

Unlike Medicaid services that generally require recipients to have household income and assets below set thresholds, early intervention programs do not have income limits.[53] Federal regulations therefore allow states to institute family cost participation policies requiring families to contribute to the cost of services (excluding service coordination) based on a sliding fee schedule tied to family income.[54] For example, Utah charges a flat monthly fee (when not covered by a family's private insurance) based on family size and income. Figure 17 illustrates Utah's monthly family cost participation charges for a family of four in state fiscal year 2024.[55]

Figure 17: Utah's Family Cost Participation Requirements for a Family of Four

Annual Income	Monthly Fee	Annual Income	Family Cost
<$55,800	Exempt	$180,000 - $209,999	$80
$55,800 - $55,999	$10	$210,000 - $239,999	$100
$60,000 - $74,999	$20	$240,000 - $269,999	$120
$75,000 – 89,999	$30	$270,000 - $299,999	$140

Annual Income	Monthly Fee	Annual Income	Family Cost
$90,000 - $119,999	$40	$300,000 - $329,999	$160
$120,000 - $149,999	$50	$330,000 - $359,999	$180
$150,000 - $179,999	$60	>$359,999	$200

Although three of the benchmark states considered as part of this evaluation – California and Utah in addition to Georgia – have family cost participation requirements, the majority of states – including Nevada – do not charge families for services. Among the 43 states participating in ITCA's 2023 Finance Survey, 31 states (72 percent) do not have family cost participation requirements.[56] Ten of the 12 states with family cost participation requirements reported cost participation revenues averaging $1.37 million in 2023.

Commercial insurance plans may cover some of the services, such as therapies, delivered through early intervention programs. Since federal regulations make Part C the payor of last resort and state early intervention systems often have limited resources, states frequently require providers to first seek payment from a child's commercial insurance before billing the state program. However, states and providers must first seek consent from the family before attempting to bill their insurance.[57] In Nevada, ADSD seeks this consent from families receiving state-facilitated services while Community Partners seek consent from the families they serve. Families may decline to provide consent without any impact on their access to services. For children and families with active IFSPs as of July 2023, more than 97 percent provided insurance information for state-facilitated EIS programs, and of these, 91.1 percent provided consent to bill their public or private insurance for EI services. Rates of insurance disclosures to Community Partners were somewhat lower, with 92.4 percent of their IFSPs reporting insurance, and 88.5 percent consenting to bill their public and private insurance.

Policies related to families' consent to bill their insurance are somewhat more common than family cost participation policies. Of the 43 states participating in ITCA's 2023 Finance Survey, 18 states (42 percent) reported having policies related to private insurance. The details of these policies vary and a number of states impose stricter requirements than Nevada's standards. For example, in Georgia, families that decline consent are responsible for 100 percent of the cost of their services.

Service Costs

Nevada's Community Partners cited low pay and high caseloads as the most common causes of staff turnover. The challenges faced by Community Partners were exacerbated by payment rates that had not been adjusted since 2012, resulting in funding differences between Community Partner programs and state-facilitated programs. In response, DHHS commissioned HMA-Burns to perform an evaluation of the monthly Community Partner case rate in 2022 to establish a payment rate that would reflect current costs. The rate study was funded by DHHS through federal American Rescue Plan Act (ARPA) grant funds (the rate models produced during the rate study are included as Attachment 6). The increased payment rate was implemented in July 2023 concurrently with a contract change that requires Community

Partners to enhance their efforts to seek reimbursement from private and public insurance programs when families provide consent to do so.

Community Partners are paid through a monthly per-child case rate designed to cover all direct services as well as program support costs (such as the cost of supervising EI professionals, providing training, travel expenses between EI families visited by EI professionals, and similar activities) and administrative costs (such as the payroll costs of Community Partners' management and support functions, facility costs, and similar expenses). This payment model offers flexibility to providers to design IFSPs to best meet the needs of the child and family without needing to achieve a specific billing target and reduces administrative requirements related to billing. However, this model can also result in under-delivery of services as providers are paid the same amount regardless of the amount of service authorized or delivered. Nationally, this payment model is uncommon. Among the seven benchmark states selected for comparison during the evaluation, at least six of the seven utilize a fee-for-service payment structure as opposed to a monthly per-child case rate as with NEIS.

Community Partners were surveyed as part of the rate study to collect information about their personnel costs, operating and administrative costs, and service details (such as caseloads, mileage, and service lengths). Recognizing that provider costs are, in large measure, a function of the rates they are paid, the rate study also included supplemental research to identify independent published data sources to estimate key cost drivers. For example, the U.S. Department of Labor's Bureau of Labor Statistics (BLS) provides Nevada-specific wage estimates for hundreds of occupations. The rate models developed as part of the rate study used these BLS wage estimates to ensure that the wage assumptions reflect actual market costs. The rate models incorporated other independent data sources to estimate the costs of health insurance, worker's compensation, vehicles, and other factors.

Separate rate models were developed for the more urban parts of the state currently served by Community Partners as well as the rural/ frontier region. The rate model for the rural/ frontier region recognizes the greater distances traveled in rural areas and the consequent smaller caseloads (as more time spent traveling means less time available to serve families).

Prior to the rate study, ADSD paid providers $565 per child per month. Additionally, providers were contractually required to bill Medicaid and children's private insurance for eligible services when granted consent from children's parents. Any revenues received from these other payors were retained by providers in addition to the case rate. In short, the $565 payment was designed to be the *net* cost to ADSD after accounting for other revenues. Community Partners reported receiving an additional 9 percent of their revenues through Medicaid or private insurance, resulting in effective average revenue of $621 per child per month.

The rate study recommended increasing ADSD's payment rate to about $795 per month, representing an approximate 28 percent rate increase over the effective prior rate of $621 per child per month after considering private and Medicaid insurance collections. However, this payment is meant to represent the *gross* cost of service delivery. That is, the rate study recommended that providers be required to offset revenues received from other payors from the rate billed to ADSD. For example, if a provider

receives $100 in payments from a child's private insurance, they would bill ADSD $695 (the $795 rate less the $100 receipt). Thus, the increased payment rate was coupled with contractual changes specifying how providers seek reimbursement from other payors, requiring Community Partners to document the results of these attempts, and adjust claims submitted to ADSD.

This evaluation also analyzed the costs of state-facilitated programs administered directly by ADSD. NEIS is supported by a robust administrative support structure, including personnel in the IDEA Part C Office, ADSD, and other units that contribute administratively or programmatically to the entire EI system, including activities that benefit Community Partners. This analysis therefore considered only costs limited to the state-facilitated services, including the costs of developmental specialists employed by the state, their supervisors, and professional staff contracted with the state as well as administrative functions and related operating costs that directly support the state-facilitated services. Specifically, this analysis considered:

- Fiscal year 2023 ADSD personnel, program support, and administrative costs directly benefitting ADSD's state-facilitated services.
- Reliable Health Care Services (Reliable) invoice data and staff rosters to calculate total wages, benefit costs, payroll taxes, travel-related expenses, and administrative expenses for Reliable's fiscal year 2023 contract. Reliable holds a statewide contract to provide personnel for nearly all state-facilitated EI services, excluding developmental specialists who are employed directly by ADSD.
- Fiscal year 2023 independent contractor invoices for specialists contracted directly by ADSD outside of the Reliable contract.

Figure 18 reports the total cost per member per month for state-facilitated services compared to the results of the Community Partner rate study.

Figure 18: Comparison of Cost Components Across EIS Programs (Per Child, Per Month)

Service Cost	State Facilitated	Community Partner Rate Model – Urban	Community Partner Rate Model – Rural/ Frontier
Therapists (OTs, PTs, and SLPs)	$620.64	$516.67	$665.91
Other Services and Program Support	$265.22	$158.98	$204.90
Administration	$194.19	$119.23	$153.67
Totals	**$1,080.05**	**$794.88**	**$1,024.48**

As the figure shows, the calculated cost of state-facilitated EIS programs are 36 percent higher than the rate model established for Community Partner services delivered in urban areas, but only about five percent higher than the rate model developed for the rural/ frontier region. However, most state-facilitated services are delivered in the more densely populated regions in the south and northwest which collectively comprise 96.1 percent of the October 2023 state-facilitated caseload. After

accounting for this mix of urban and rural cases, state-facilitated services in fiscal year 2023 are 35.8 percent higher than Community Partner-facilitated services. The cost difference is primarily attributed to higher program support and administrative costs in state-facilitated programs and lower caseloads among developmental specialists employed by state-facilitated programs. As detailed below, the rate model resulting from the 2022 rate study included wage assumptions for developmental specialists, physical therapists, and occupational therapists similar to the wages paid by state-facilitated programs today, but somewhat lower than the wages paid to speech language pathologist by state-facilitated programs.

Part I Conclusions and Recommendations

NEIS' system structure and the roles and responsibilities of key DHHS divisions should be clarified through formal written policies based on broad stakeholder input

The ECTA Center's *System Framework* provides recommended practices and attributes of high-quality EI systems designed to answer one question: "what does a state need to put into place in order to encourage/support/require local implementation of evidence-based practices that result in positive outcomes for young children with disabilities and their families?"[58] Within the ECTA Center's System Framework, several key attributes of a high-quality EI system are described, including:

- State staff or representatives use and promote strategies that facilitate clear communication and collaboration and build and maintain relationships between and among Part C stakeholders and partners.
- Lead agencies evaluate the structure of entities assigned for state, regional, and local implementation on an ongoing basis and revise as needed to ensure equitable delivery of services.
- There is an ongoing process for reviewing and revising, as necessary, the designation of roles and responsibilities.

As described previously, federal regulations provide states broad authority to design an EI system structure that best meets the needs of the children and families within the state and this evaluation does not recommend any specific changes to NEIS' organization. However, in keeping with the ECTA Center's recommendations, Nevada should review its operating structure to ensure it supports effective and efficient operations that create the conditions for high-quality EI services for the nearly 4,000 children enrolled in NEIS. Nevada's Community Partners surveyed as part of the evaluation reported confidence in leadership within the IDEA Part C Office and ADSD in their intentions and efforts to build a stronger EI system, specifically noting the high degree of responsiveness and technical assistance they receive from all DHHS divisions.

However, Community Partners also identified areas they feel should be addressed to improve coordination across DHHS divisions. Specifically, although there is some awareness among Community Partners of the general roles, responsibilities, and separation of duties of the IDEA Part C Office, ADSD (including its Children's Services office), ADSD's QA team, and ADSD's MA team, Community Partners do

not generally distinguish between supervision and monitoring activities imposed by different DHHS divisions. They reported sometimes receiving duplicate requests for the same type of information from different DHHS personnel, while also at times receiving conflicting guidance that may be difficult to resolve in the absence of a clear single line of authority. Some Community Partners also noted an observable lack of collaboration between DHHS divisions that they find to be a barrier to system improvement.

DHHS staff expressed similar concerns about the relative lack of clarity in key administrative and oversight responsibilities. For example, compliance reviews conducted by the IDEA Part C Office and reviews conducted by ADSD through its QA team share some areas of focus, but are distinct enough to necessitate improved written policies to fully address the objectives of these divisions and the scope of these reviews for each. Although the IDEA Part C Office maintains various agreements as described previously and has differentiated its roles and responsibilities from ADSD's within the IDEA Part C Manual, more recent efforts by the DHHS teams that support NEIS to document their roles and responsibilities yielded a connected but not particularly well-coordinated system where several key responsibilities were identified as overlapping.

Therefore, DHHS should re-evaluate the NEIS system structure, including the roles and responsibilities of each DHHS division or team supporting NEIS with respect to compliance monitoring, quality oversight, training and technical assistance, and similar administrative and oversight responsibilities shared by DHHS divisions and teams today. In doing so, DHHS should:

- Ensure roles and responsibilities are appropriately grouped when activities are similar. For example, the Part C Office and ADSD jointly provide compliance oversight of Community Partner programs through compliance and quality monitoring and contract oversight. Additionally, training and technical assistance activities are performed jointly by the Part C Office and ADSD and Community Partners reported sometimes receiving conflicting guidance. Given the importance of compliance monitoring, training, and technical assistance to supporting service quality, DHHS should identify opportunities to ensure such activities are not unnecessarily duplicated across operating units.
- Establish roles and responsibilities that are agreed upon by responsible administrators and DHHS staff, and clearly documented within written policies (such as the IDEA Part C Manual) or other written agreements shared across NEIS, including with Community Partners.

ADSD should ensure the regional service delivery structure and caseload distributions are optimized in providing children and families with provider choice

As described previously, Nevada is one of a small number of states that have state-facilitated early intervention programs. One state that also administers a state-facilitated program noted a key benefit of directly facilitating service is that they have a first-hand understanding of the rules and requirements imposed on contracted providers. The ADSD-administered program is the only option in the rural/frontier region and is the primary provider in the northwest region. However, some Community Partners interviewed as part of the evaluation expressed a willingness to expand services to rural parts

of the state, though they would require additional information about potential caseloads and related factors to adequately analyze a potential expansion.

Outside of the rural/frontier region, families have multiple options. The ADSD-administered program is the primary provider in the northwest region, but there are also three contracted Community Partners serving this area. In the south region, there is an ADSD-administered program serving more than 40 percent of enrolled children as well as four contracted Community Partners. In other states reviewed as part of this evaluation, there are typically one or two contractors serving a given geographic region.

Therefore, ADSD should evaluate the extent to which the existing provider network structure is optimal, including whether to continue administering programs directly and whether to maintain the number of contractors. Such an evaluation should consider the benefits and tradeoffs between providers' financial stability (that is, a larger number of providers results in lower organizational caseloads and consequently smaller budgets), family choice (for example, offering options to families given them an opportunity to find a provider that best meets their needs), the need for quality control and service monitoring, and if changes may facilitate efficiencies or broaden access and provider choice in regions served by only one provider type today.

ADSD should explore options to increase funding from other sources to supplement state funds

State and local funds account for more than half of NEIS' spending while the federal Part C grant provides only 10 to 12 percent of the program's funding. To support the growing demand for services and ensure long-term program sustainability, the state should consider opportunities to increase funding from other sources, including:

- Adopting a family cost participation policy in which families contribute to the cost of the services received by their child. Family cost participation should only apply to higher-income families. For example, some states with family cost participation policies exempt families earning less than 250 or 300 percent of the federal poverty level. Although most states with family cost participation policies charge families a percentage of the cost of services (usually on a sliding scale), Nevada should consider a fixed amount (or amounts on a sliding scale) because providers are paid a fixed monthly amount that is not tied to the specific services an individual child receives. Key policy considerations would include whether ADSD or the early intervention program serving the family would be responsible for collections and how to address non-payment.
- Requiring families to provide permission to bill any other insurance plan that the child has. Such a policy should be crafted to protect families from negative consequences due to lifetime benefit limits and increased out-of-pocket expenses due to deductibles or copayments. Families that do not cooperate with this requirement would be responsible for paying the entire cost of services (based on the monthly case rate for Community Partners).
- Evaluating options for maximizing use of Medicaid dollars for service delivery. As noted above, Medicaid accounts for only 9.1 percent of NEIS funding compared to a national average of 16.8 percent. The change in Community Partners' contracts that increases accountability for billing

other responsible payers, including Medicaid, may increase Medicaid payments. If, however, Medicaid collections continue to lag the national average, a thorough analysis should be undertaken to determine whether there are any structural barriers to seeking Medicaid reimbursement.