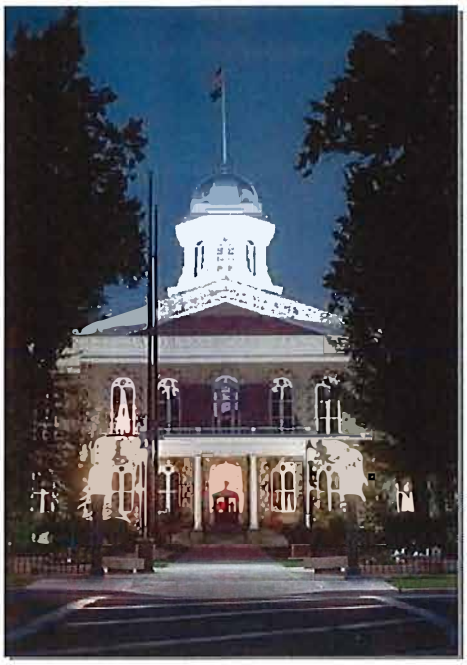


State of Nevada
Governor's Finance Office
Division of Internal Audits

Audit Report

Department of Health and Human Services

*****

Transportation Services

***

Improved and expanded transportation services will provide increased access to food for food insecure households and potentially reduce Medicaid program costs.

DIA Report No. 22-03
February 22, 2022

EXECUTIVE SUMMARY
Nevada Department of Health and Human Services
Transportation Services

Objective: Improve Transportation Services

Improving management of transportation services by actively managing contracts and standardizing internal processes will help the Nevada Department of Health and Human Services (DHHS) achieve efficiencies and ensure participants of Nevada's assistance programs receive consistent services. Improving management of transportation services will help DHHS understand the cost of providing medical transportation services. The state's non-emergency medical transportation services broker is contracted at a flat rate based on monthly Medicaid enrollment, not actual transportation provided, at a cost to the state of $20.4 million annually. DHHS does not analyze transportation costs and does not know the actual cost of providing transportation services. A better understanding of actual transportation costs can help DHHS manage current and future transportation services.

Expanding transportation services offered to Nevadans will increase access to affordable and nutritious food for individuals living in food deserts or food insecure households. There are 40 food deserts in Nevada and 367,000 Nevadans who are food insecure. Transportation is one of the greatest barriers to accessing nutritious food. The Nevada state plan addresses food insecurity through food programs but does not address transportation services to access food. Inadequate access to nutritious food increases health issues, yet not all Nevadans who are food insecure are eligible to receive food and nutrition assistance. Food insecurity affects children, minorities, and people of color to a greater degree. Providing increased access to nutritious food has the potential of reducing the state's Medicaid program costs.

INTRODUCTION

At the direction of the Executive Branch Audit Committee, the Division of Internal Audits (DIA) conducted an audit of the Nevada Department of Health and Human Services (DHHS). The audit focused on DHHS' provision of transportation services to Nevadans enrolled in one or more public assistance programs. The audit's scope and methodology, background, and acknowledgements are included in Appendix A.

DIA's audit objective was to develop recommendations to:

- ✓ Improve transportation services.

Nevada Department of Health and Human Services Response and Implementation Plan

DIA provided draft copies of this report to DHHS for review and comment. DIA considered DHHS' comments in the preparation of this report; DHHS' initial response is included in Appendix B. In its response, DHHS accepted the recommendations. Appendix C includes a timetable to implement the recommendations.

NRS 353A.090 requires within six months after the final report is issued to the Executive Branch Audit Committee, the Administrator of the Division of Internal Audits shall evaluate the steps DHHS has taken to implement the recommendations and shall determine whether the steps are achieving the desired results. The administrator shall report the six-month follow-up results to the committee and DHHS.

The following report (DIA Report No. 22-03) contains DIA's *findings, conclusions,* and *recommendations*.

Respectfully,

Warren Lowman
Administrator

Improve Transportation Services

The Nevada Department of Health and Human Services can improve transportation services by:

- Improving management of transportation services; and
- Expanding transportation services offered to Nevadans.

Improving transportation services will provide expanded options and increased access to transportation for households located in food deserts and food insecure households. Expanded options and increased access could reduce Medicaid program costs up to $541.4 million annually or 13% of the federal fiscal year 2020 $4.1 billion Medicaid program costs.[1]

Improve Management of Transportation Services

The Nevada Department of Health and Human Services (DHHS) should improve management of transportation services across the department. Improving management of transportation services will help DHHS achieve efficiencies through consistent practices related to: actively managing contracts, understanding the true costs of providing transportation services to Nevadans, and ensuring participants receive consistent services. Improving management of transportation services will also provide DHHS with the data necessary to expand transportation services for Nevadans where transportation continues to be a barrier for access to affordable and nutritious food.

State's Medical Transportation Services Contracted at Flat Rate Averaging $20.4 Million Annually

The contract with the state's sole non-emergency medical transportation (NEMT) services broker, Medical Transportation Management, Inc. (MTM) costs the state $20.4 million annually or $81.5 million over the term of the contract. Payments are based on a per member per month rate, regardless of actual transportation use. MTM brokers NEMT transportation services provided to Medicaid participants through bus passes, gas mileage reimbursement, taxi vouchers, and other modes of transportation at a rate of $2.29 per enrolled Medicaid member per month (PMPM).[2]

[1] Kaiser Family Foundation, Total Medicaid Spending, Nevada, Federal Fiscal Year 2020 data, https://www.kff.org/statedata/.
[2] Transportation service provided is dependent on the recipient's needs.

DHHS Does Not Actively Manage the MTM Contract

DHHS does not actively manage the MTM contract because payments are automatically issued monthly by the state's accounting system based on the Medicaid participant count for the month.[3] Although MTM submits encounter data and cost reports to DHHS on a monthly basis, DHHS could not confirm whether these reports are reviewed by program staff for accuracy, completeness, or compliance with contract terms.

DHHS Does Not Analyze Actual MTM Costs

DHHS does not analyze monthly MTM data to determine whether the MTM contract could be under or over-valued based on actual use. MTM is responsible for managing transportation requests and providing transportation services through the purchase of bus passes, reimbursement for gas mileage, and hiring third party providers to provide these and other transportation services.[4] MTM assumes the risk that more Medicaid recipients use NEMT services than anticipated, but financially benefits if participant use results in actual costs less than contracted rates.

OIG Audit of District of Columbia MTM Contract Found Issues Related to Not Understanding Costs

A 2017 audit conducted by the Office of the Inspector General (OIG) on the Non-Emergency Medical Transportation Program administered by the District of Columbia DHCFP found that like Nevada's MTM contract, MTM was paid on a flat rate basis regardless of the actual trips made by participants.[5] The audit identified multiple issues related to not understanding the actual cost of providing NEMT services.

Not understanding the actual cost of services can result in underutilization or overutilization of transportation services. Underutilization may lead to an overpayment of NEMT services by the state and overutilization would result in an underpayment to MTM.

---

[3] Medicaid participants are eligible for NEMT services as soon as they are enrolled in and are accounted for when determining MTM's monthly PMPM count for payment. The contract's four-year term began July 1, 2021.

[4] Other transportation services include private vehicles, community non-professional drivers, commercial airlines, wheelchair vans, stretcher vehicles, paratransit services, Amtrak services, and transportation network companies.

[5] District of Columbia Office of the Inspector General (OIG): Department of Health Care Finance Inspection of the Non-Emergency Medical Transportation Program.

Better Understanding of Actual Costs Can Help DHHS Manage Current and Future Transportation Services

A better understanding of actual costs can help DHHS manage current and future transportation services. DHHS can improve its understanding of transportation costs by accessing MTM reports available to the state, analyzing raw data, comparing actual costs to contracted rates, and implementing agency-led quarterly audits. The contract requires MTM to deliver reports and data to DHHS by the 15th of each month via secured email and remote web access. DHHS may also request ad hoc reports or access program data as needed. See Exhibit I for MTM reports and data available to the state through contract provisions.

Exhibit I

MTM Reports and Data Available to the State

Report / Data Type	Description
Transportation Summary Report	Summarizes all adverse actions and authorizations for transportation services by type of transportation. Report must show utilization by Medicaid.
Call Center Report	Summarizes call volume, nature of calls abandoned, and other call center data.
Recipient Satisfaction Survey Report	Summarizes the results of the surveys conducted according to contract criteria.
Grievance Log	Summarizes complaints received and their resolution including any corrective action taken, along with any pending or unresolved grievances.
Annual Transportation Report	Describes the project and contracted services, major problems and issues and how they were addressed, and future plans. Includes a statistical summary of services provided and other pertinent information. Must be submitted within 60 business days after the closed of the calendar year.
High-Cost Users Report	Summarizes the monthly miles, level of service, costs, cost per mile, recipient ID number, location, and the name of the transportation provider. Must be submitted within 15 days after the end of each quarter.
Monthly Cost Report	Shows costs associated with providing NEMT by the type of transportation and an aggregated amount per recipient.
Fraud and Abuse Reporting	Detailed information for each fraud complaint warranting investigation must be provided to the state.
Encounter Data	Encounter data for all completed transaction services authorized by the vendor must be electronically transmitted monthly to DHHS.
Annual Independent Customer Satisfaction Survey	Vendor must perform and submit an annual customer service survey regarding Medicaid transportation services as part of its QA monitoring plan.

Source: Contract for Services of Independent Contractor between DHHS/DHCFP and MTM effective July 1, 2021.

MTM Data Indicate Participants Need Transportation for Access to Basic Needs

Review of MTM's post verification logs revealed one of the main reasons people use NEMT services for ineligible trip purposes is to meet basic transportation needs not covered by public assistance. Participants used transportation services for reasons such as dropping off prescriptions or picking up groceries indicating there is a need for transportation services that give participants access to basic needs. A better understanding of Nevadans' transportation needs may provide the building blocks for expanding or creating new transportation services.

DHHS Could Standardize Internal Processes to Improve Management of Transportation Services

DHHS could standardize internal processes to improve management of transportation services. Transportation services and eligibility requirements differ across DHHS programs, divisions, and units. DHHS does not have standardized departmental policies, procedures, or controls (P&P) for managing transportation services, with the exception of medical emergency and non-emergency services provided by the Medicaid program. The majority of existing P&P are documented at the division level and are inconsistent across the department. Review of P&P revealed they vary across and within programs and do not contain information sufficient for employees to consistently follow requirements.

Dissimilar Internal P&P Result in Conflicting Processes

Dissimilar internal P&P result in conflicting processes across DHHS, sometimes even within the same program. Conflicting processes may reduce quality of services, consistent eligibility determinations, and adequate program oversight. As a result, there may be underutilization, duplication, gaps, or incorrect usage of transportation services for Nevadans enrolled in more than one public assistance program. See Appendix D for DHHS transportation services by division for a detailed list.

Division-Level Bus Pass Logs Lack Critical Information

DHHS division-level bus pass logs lack information critical to inventory management and fraud deterrence. Bus passes are issued to Medicaid program participants at multiple fare levels on a monthly, daily, and single use basis. Daily and single use fares are loaded onto Bank of America card's two days prior to the participants appointment. Per MTM, monthly bus passes are assigned for recurring appointments dependent on the number of appointments per week. Inadequate bus pass inventory management increases the risk of fraud to the state because

of multiple types of passes issued and the number of participants enrolled in Medicaid.

All Bus Pass Logs Had One or More Inventory Control Issues

Review of division-level bus pass logs for fiscal years 2019 through 2021 revealed all logs had one or more inventory control issues, including:

- Logs did not track information P&P required, were incomplete, recorded inaccurate information, or had a combination of these issues;
- Inventory records were not maintained according to accounting standards and rules;
- There was no record of beginning inventory, purchases, bus passes issued, or ending inventory; and
- Inventory transactions were not supported by purchase documentation making it difficult to maintain accurate and validated inventory levels.

Additionally, some logs reviewed were electronically prefilled with information making it difficult to determine the validity of the information contained in the logs, including bus pass recipient, issuer, and approver. These pre-filled logs were used at state-run facilities, including Northern Nevada Adult Mental Health Services (NNAMHS) and Southern Nevada Adult Mental Health Services (SNAMHS).

Records Do Not Contain Sufficient Information for Adequate Inventory Control

Division accounting records for bus pass purchases varied across facilities and not all purchases contained sufficient information for adequate inventory control. DHHS agencies purchase bus passes by submitting a request to MTM. There are minimal inventory controls at the agency level once MTM issues bus passes.

Review of DHHS agency-level bus pass purchases showed there was no record of bus pass series purchased for multiple transactions. Of the 34 purchase transactions reviewed, only four (12%) documented the bus pass series purchased. Additionally, there is no documentation of who requested, approved, or took possession of the passes from MTM.

Some Bus Pass Inventory Records Do Not Match State Accounting Records

NNAMHS and SNAMHS provide residents with transportation services through taxi vouchers, employee-driven state vehicles, and Regional Transportation Commission (RTC) bus passes. Annual internal bus pass expenditure tracking provided by NNAMHS and SNAMHS matched official state accounting records. However, bus pass inventory numbers did not match official records for SNAMHS.

Total bus pass expenditures according to official state accounting records were $640 below what was expected given the inventory purchased for 2019, $1,800 below for fiscal year 2020, and there was no discrepancy in fiscal year 2021.[6]

Standardizing Internal Processes Could Improve Management of Transportation Services

Standardizing internal processes could help DHHS improve management of transportation services by:

- Ensuring consistent P&P across the department for managing transportation services;
- Providing employees with sufficient information to consistently follow requirements; and
- Helping maintain quality of services, consistent eligibility determinations, and adequate program oversight.

These improvements could help DHHS avoid underutilization, duplication, gaps, or incorrect usage of transportation services for Nevadans enrolled in more than one public assistance program. Moreover, improved management provides an opportunity to synergize transportation services to the benefit of Nevada's food insecure population.

[6] State accounting records had bus pass expenditures at $172,855. Inventory records show expenditures at $173,495.

Conclusion

The contract with the state's sole non-emergency medical transportation (NEMT) services broker, Medical Transportation Management, Inc. (MTM) costs the state $20.4 million annually to provide transportation to Medicaid participants through bus passes, gas mileage reimbursement, taxi vouchers, and other modes of transportation. Payments are based on a $2.29 per member per month rate, regardless of actual transportation use. The Nevada Department of Health and Human Services (DHHS) does not actively manage the MTM contract and does not analyze actual MTM costs. Consequently, MTM financially benefits if participant use results in actual costs less than contracted rates.

A better understanding of actual costs can help DHHS manage current and future transportation services. DHHS can improve its understanding of transportation costs by accessing MTM reports available to the state, analyzing raw data, comparing actual costs to contracted rates, and implementing agency-led quarterly audits.

Improving management of transportation services across the department will help DHHS achieve efficiencies through consistent practices related to: actively managing contracts, understanding the true costs of providing transportation services to Nevadans, and ensuring participants receive consistent services. Improving management of transportation services will also provide DHHS with the data necessary to expand transportation services for Nevadans where transportation continues to be a barrier for access to affordable and nutritious food.

Recommendation

1. Improve management of transportation services.

Expand Transportation Services Offered to Nevadans

The Nevada Department of Health and Human Services (DHHS) should expand transportation services offered to Nevadans by:

- Conducting a detailed review of existing programs;
- Coordinating with other state and local agencies; and
- Updating the state food security plan to reflect expanded services.

Expanding transportation services will increase access to healthier food options in food deserts and for food insecure households, which will improve Nevadans' health overall. The U.S. Department of Agriculture (USDA) defines a food desert as a neighborhood that is not located near larger grocery stores and does not have easily accessible transportation available to residents. Food-insecure households are those whose economic and social conditions do not provide household members with adequate quantities of food.[7]

Improved health for food insecure Nevadans could reduce Medicaid program costs up to $541.4 million annually for those already enrolled in the program. Potential savings represents approximately 13% of the federal fiscal year 2020 $4.1 billion Medicaid program costs.[8]

Transportation Services Increase Access to Affordable and Nutritious Food

Expanded transportation services increase access to affordable and nutritious food for those requiring transportation assistance. People who have the means to travel further pay lower prices for preferred or nutritious food. On average, Supplemental Nutrition Assistance Program (SNAP) participants lived 1.8 miles from the nearest grocery store but traveled 4.9 miles to the store they most often visited in cases where transportation was available.[9]

Research shows the distinction between individual-level and area-based food access has significant implications for how to address the problem of limited access. According to research, "if those people who have low incomes and limited access are scattered throughout areas with lower concentrations of poor people, then opening up a new supermarket may be less effective than policies that make individual or group transportation to stores less expensive (for example, bus/transit subsidies, store shuttle services, or improved bus routes)."[10]

---

[7] USDA Definitions of Food Security.
[8] Kaiser Family Foundation, Total Medicaid Spending, Nevada, Federal Fiscal Year 2020 data, https://www.kff.org/statedata/.
[9] Ibid.
[10] USDA 2009 Access to Affordable and Nutritious Food: Measuring and Understanding Food Deserts and Their Consequences.

DHHS Could Expand Transportation Services Available in Food Deserts and Reduce Food Insecurity

DHHS could expand transportation services available in food deserts and to food insecure households to reduce food insecurity overall in Nevada. Public assistance programs offer transportation services for limited purposes, including:

- Medicaid emergency and non-emergency transportation services;
- SNAP Employment and Training (E&T);
- NEON (New Employees of Nevada) E&T;
- Individuals who meet specific criteria, such as the elderly or disabled; and
- Recipients of other DHHS Services (out-patient, hospital, rural clinics).

SNAP E&T provides participants with job search training and supervision, job retention assistance, and other educational opportunities. SNAP E&T does not offer long-term transportation services to individuals who become employed while enrolled in the program but continue to need assistance more than 30 days following job placement.

Medicaid Provides Only Emergency and Non-Emergency Medical Transportation Services

The Medicaid program provides only emergency and non-emergency medical transportation (NEMT) services for program participants, including: bus passes; reimbursements for personal vehicle mileage; taxi services; and ride share services, such as Uber and Lyft. Medicaid participants may begin using NEMT services for medical appointments as soon as they receive a Medicaid card. These services cannot be used for food access according to federal program rules.

Some DHHS public assistance programs offer food access transportation services for the disabled or elderly. These services are not available for participants in the SNAP and Medicaid programs who do not meet the elderly or disabled criteria.

Conducting a Centralized Detailed Analysis of Existing Transportation Services Would Help DHHS Identify Gaps

Conducting a centralized detailed analysis of existing public assistance transportation services and updating the state plan would help DHHS identify gaps in transportation services offered to food deserts and food insecure households. Detailed review could include:

- Identifying public assistance programs where transportation services could be incorporated;
- Determining where program gaps exist and efficiencies can be gained;
- Identifying households in need of assistance, regardless of participation in public assistance programs;

- Coordinating with the Nevada Department of Agriculture (NDA) to increase transportation services to food insecure households or households located within food deserts;[11]
- Increasing coordination with local governments, charitable organizations, agencies within DHHS, and other non-NDA state agencies;
- Implementing identified improvements and expanding services;
- Updating the state plan to reflect expanded and new programs; and
- Monitoring program success.

NRS Requires DHHS to Address Food Insecurity through the Council on Food Security and a State Plan

NRS 232 addresses food insecurity through the Council on Food Security. The Council was created by executive order and later adopted into statute to implement Nevada's food security plan and effectively improve the quality of life and health of Nevadans by increasing food security throughout the state.[12] The Council must submit an annual report to the directors of DHHS and the Legislative Counsel Bureau detailing Council accomplishments and recommendations concerning food security.[13] The Council also developed a state plan to address regulatory requirements to develop, coordinate, and implement a food system that will:

- Partner with initiatives in economic development and social determinants of health;
- Increase access to improved food resource programs;
- Increase participation in federal nutrition programs by eligible households; and
- Increase capacity to produce, process, distribute, and purchase food in an affordable and sustainable manner.

The most recent state plan updated in November 2018 emphasizes strategies to increase participation in federal and state nutrition programs among the eligible population, including the National School Breakfast and Lunch Programs.[14] The state plan also focuses on supporting strategies to increase food banks' capacity to offer a variety of nutritious foods. A missing element of the plan is providing the ability to participate in these programs with more comprehensive transportation support.

[11] NDA administers multiple programs addressing food security and nutrition issues in Nevada, including some that already coordinate with DHHS.
[12] Executive order 2014-03.
[13] NRS 232.4968 Duties.
[14] 2018 Food Security in Nevada: Nevada's Plan for Action.

State Plan Does Not Address Transportation Services for Access to Food

Although the state plan addresses food insecurity through food availability and affordability, the plan does not address one of the greatest barriers to accessing nutritious food – transportation. SNAP and other public assistance programs are focused on supplying adequate food to food insecure individuals. Program benefits are minimized if participants are unable to physically get to where the food is located or if they must prioritize their limited resources to the detriment of food choice. Likewise, food insecure households not meeting program eligibility requirements face the same food insecurity issues. Providing adequate transportation services is a fundamental element in addressing food insecurity and improving the overall health of Nevadans.

Food Deserts and Food Insecurity Restrict Access to Nutritious Food

Food deserts and food insecurity restrict access to nutritious food. As a result, food deserts restrict access to affordable, quality nutritious food.[15,16] The USDA estimates 10.5% of U.S. population census areas are food deserts affecting 13.8 million people in both urban and rural areas nationwide.[17] Compounding the issue of food deserts is that more than 35 million U.S. residents lived in food-insecure households in 2019, with approximately a third being children.

There are 687 census areas in Nevada and 40 (5.8%) are considered food deserts.[18] About 155,000 Nevadans live within food deserts and around 367,000 Nevadans are food insecure.[19,20]

Nevada Has Higher Food Insecurity Rate and Average Meal Cost than National Averages

Nevada's food insecurity rate is 12.8% and is higher than the national average of 11.5%. Food insecurity rates in all Nevada counties are higher than 9% with the highest rates in Mineral and Nye counties (17.2% and 16.2% respectively). According to Feed America, Nevada ranked 18th for overall food insecurity in 2019, 5th in 2020 and is projected to rank among the top 10 states in 2021.[21]

---

[15] USDA Interactive Web Tool Maps Food Deserts, Provides Key Data.
[16] According to the USDA, affordability refers to the price of a particular food and the relative price of alternative and substitute foods.
[17] USDA 2020 Key Statistics & Graphics.
[18] University of Nevada, Reno Extension College of Agriculture, Biotechnology & Natural Resource: What is a Food Desert?
[19] Ibid.
[20] Feeding America: 2018 Map the Meal Gap and auditor calculations. Feeding America is a charitable organization comprised of 200 food banks across the country.
[21] Projections for overall food insecurity in 2021 include COVID-19 impacts.

Additionally, Nevada has a higher average meal cost ($3.15) compared to the national average ($3.09), which further impacts the ability to purchase food.[22] Like food insecurity rates, average meal costs are higher when calculated at the county level. Higher food costs impact households with already limited income by forcing them to choose between nutritious foods or more affordable, less nutritious foods. See Exhibit II for food insecurity rates and average meal costs in Nevada by county.

Exhibit II

Food Insecurity Rates and Average Meal Costs in Nevada by County

County	Food-Insecure People	Food Insecurity Rate	Meal Cost *County Avg*	Meal Cost *% Above U.S. Avg*
Mineral	760	17.2%	$3.35	8.4%
Nye	7,070	16.2%	$3.15	1.9%
Carson City	8,020	14.7%	$3.24	4.9%
Lyon	6,980	13.1%	$3.38	9.4%
Clark	273,960	12.8%	$3.31	7.1%
Esmeralda	120	12.7%	$3.55	14.9%
Churchill	3,020	12.6%	$3.40	10.0%
Lincoln	630	12.2%	$3.26	5.5%
Pershing	810	12.2%	$3.40	10.0%
Storey	470	11.9%	$3.39	9.7%
White Pine	1,120	11.5%	$3.12	1.0%
Douglas	5,460	11.4%	$3.72	20.4%
Washoe	50,680	11.2%	$3.42	10.7%
Eureka	200	10.9%	$3.32	7.4%
Elko	5,240	10.0%	$3.35	8.4%
Humboldt	1,670	9.9%	$3.23	4.5%
Lander	560	9.8%	$3.41	10.4%
Total People:	**366,700**			

Source: Feeding America, 2018 Map the Meal Gap and auditor calculations.

Food Costs Affect Minorities and People of Color More

Data shows that household characteristics impact annual food expenditures, including demographics for the head of household, household regional location, and ethnicity. Median household food costs were higher for households with married couples with children than those headed by single women or other households with children.[23] Food expenditures for households headed by minorities or persons of color were lower than households headed by white non-Hispanics. Additionally, higher income households spend more on food per year than lower-income households. Consequently, food expenditures account for a higher percentage of low-income annual household expenditures than for high-income or white non-Hispanic households.

[22] Feeding America: 2018 Map the Meal Gap.
[23] USDA: Household Food Security in the United States in 2019.

Food and Nutrition Program Eligibility Requirements Restrict Assistance in Food Deserts and for Some Food Insecure Households

Nevada offers several food and nutrition programs to help low-income households.[24] SNAP is administered by the DHHS Division of Welfare and Supportive Services and helps low-income people buy the food they need for good health. The Nevada Department of Agriculture also administers multiple food and nutrition programs through its Child Nutrition, Commodity Food Distribution, and Dairy Commission Programs. However, eligibility requirements for food and nutrition programs restrict assistance in food deserts and for some food insecure households. See Appendix D for DHHS transportation services by division for a detailed list.

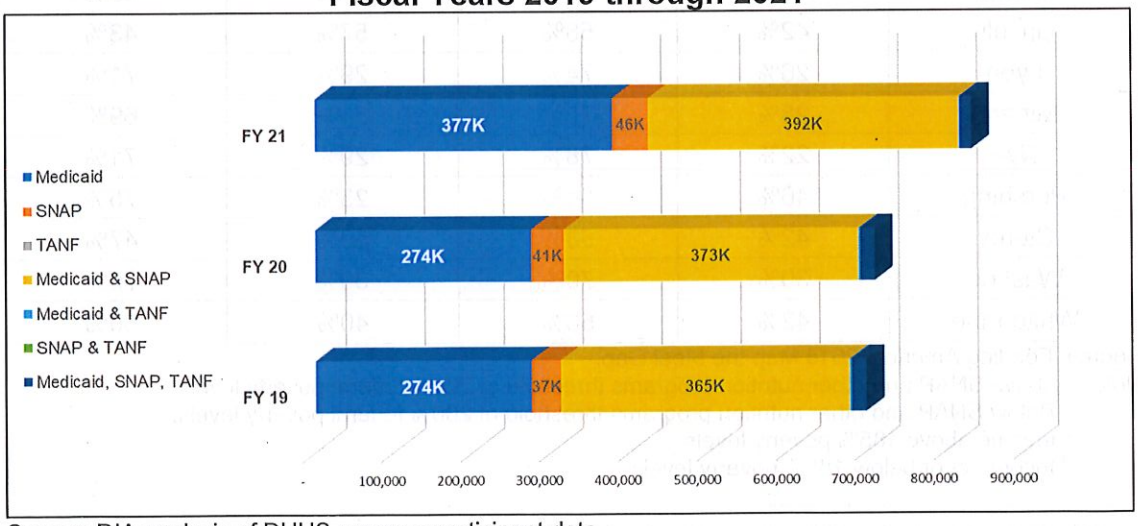
Nevada Had an Average of 750,000 Nevadans Enrolled in One or More Public Assistance Programs

Nevada had an average of more than 750,000 Nevadans enrolled in one or more public assistance programs during fiscal years 2019 through 2021. Enrollment consistently increased over the period with more Nevadans depending on public assistance programs to meet their basic needs. People below the age of 40 make up the bulk of program participants. Moreover, most individuals who receive public assistance are adults who do not qualify for child or elderly benefits.

See Exhibit III for average annual participants for the Medicaid, SNAP, and Temporary Assistance for Needy Families (TANF) public assistance programs during fiscal years 2019 through 2021.

Exhibit III

Average Annual Public Assistance Program Participants
Fiscal Years 2019 through 2021



Source: DIA analysis of DHHS program participant data.

[24] Of the various SNAP eligibility requirements, total household income must be at or below 200% of federal poverty guidelines to qualify for food and nutrition assistance.

Not All Affected Households Qualify for Food and Nutrition Assistance

Eligibility requirements for food and nutrition public assistance programs may restrict program participation for food insecure households or households located within food deserts because of income limitations.[25] Consequently, not everyone who needs help with accessing nutritious food is getting the help they need. For example, 35% of Nevada's food insecure children are ineligible for food and nutrition programs, almost 30% higher than the national average. Nevada children experience more food insecurity compared to the rest of the nation and experience higher levels of ineligibility for food and nutrition assistance programs. See Exhibit IV for federal food assistance program eligibility rates among food insecure Nevadans for the federal Supplemental Nutrition Assistance Program (SNAP) and child nutrition programs.[26]

Exhibit IV
Food Assistance Program Eligibility Rates Among Food Insecure Nevadans

County	Ineligible for SNAP[a]	Eligible for SNAP[b]	Children Likely Ineligible for Nutrition Programs[c]	Children Eligible for Nutrition Programs[d]
Carson City	25%	75%	19%	81%
Churchill	33%	67%	28%	72%
Clark	25%	75%	34%	66%
Douglas	41%	59%	40%	60%
Elko	40%	60%	45%	55%
Esmeralda	0%	100%	0%	100%
Eureka	57%	43%	73%	27%
Humboldt	32%	68%	31%	69%
Lander	38%	62%	37%	63%
Lincoln	42%	58%	57%	43%
Lyon	26%	74%	29%	71%
Mineral	28%	72%	31%	69%
Nye	22%	78%	29%	71%
Pershing	46%	54%	25%	75%
Storey	42%	58%	53%	47%
Washoe	30%	70%	30%	70%
White Pine	42%	58%	40%	60%

Source: Feeding America, 2018 Map the Meal Gap.
Note: [a] Above SNAP and other nutrition programs threshold of 200% federal poverty levels.
[b] Below SNAP and other nutrition programs threshold of 200% federal poverty levels.
[c] Income above 185% poverty levels.
[d] Income at or below 185% poverty levels.

[25] Evaluation of food and nutrition programs administered by the Nevada Department of Agriculture is outside the scope of this audit.
[26] SNAP and child nutrition program eligibility data was derived from the most recent surveys available, which were completed for calendar year 2018.

Inadequate Access to Nutritious Food Increases Health Issues and May Increase Nevada Medicaid Costs up to $541.4 Million Annually

Inadequate access to nutritious food increases health issues and may increase Nevada Medicaid costs up to $541.4 million annually. How much a household spends on food indicates how adequately it is meeting the food needs of household members. Food insecurity (food quantity) and food deserts (food quality) result from a lack of resources necessary to purchase nutritious food, such as income, nearby grocery stores, and transportation. These factors reduce quality of life and increase health costs overall.

More than Half of Nevada's Medicaid Enrollees Also Enrolled in SNAP

Analysis of data provided by DHHS revealed approximately half the participants enrolled in the Nevada Medicaid program are also enrolled in SNAP for an average of six or more months. The number of participants enrolled in these programs for the period of November 2018 through June 2021 increased by an average of 9% for Medicaid and 4% for SNAP year-over-year. Increases in program enrollment will result in additional food and nutrition assistance costs for the state.

Of the participants enrolled in both the Medicaid and SNAP programs, approximately 270,000 (72%) are food insecure when adjusted for 2021 estimates. Increases in food insecure households alone may result in higher Medicaid medical costs estimated at an additional $541.4 million annually.[27]

Food Deserts Do Not Provide Reliable Access to Nutritious Food

Food deserts do not provide reliable access to nutritious food. Households located in food deserts with limited access to large grocery stores rely on small grocery or convenience stores that may not carry a variety of nutritious foods. When basic nutritious foods are offered, they are often sold at a higher price. These circumstances decrease purchasing power and place greater demand on already strained resources for the household. This is especially true for households receiving government food and nutrition assistance.

Food Deserts Are Often Located in Areas with Predominantly Unhealthy Foods

Food deserts are often found within or near food swamps. A food swamp is an area with access to food, but the food is unhealthy.[28] Studies show food swamps increase the likelihood of obesity more than food deserts alone because of the

[27] Estimated average number of Nevadans enrolled in both SNAP and Medicaid * average annual increased medical costs for food insecure people, adjusted for inflation: 269,995 * $2,005 = $541,339,975.

[28] USDA 2009 Access to Affordable and Nutritious Food: Measuring and Understanding Food Deserts and Their Consequences.

greater availability of unhealthy food from fast food restaurants, convenience stores, and grocery stores.[29] While food swamps and individual food choices play a critical role in potential health issues, a lack of access to healthier food options worsens the potential for future health issues.

Stores Meeting Minimal SNAP Requirements May Offer Largely Unhealthy Food

Stores must meet minimal requirements to be eligible to accept SNAP benefits. A store may be authorized to sell a variety of staple foods, frozen and fresh, within the following four categories:

- Breads, cereals, rice, pasta, crackers, pastries, flour, and other dry goods;
- Dairy products, meat, poultry, and fish;
- Fruit and vegetables; and
- Fruit trees, plants, and seeds to grow food.

Consequently, stores qualifying as eligible to accept SNAP benefits may not offer a wide variety of nutritious food. For example, a convenience store may offer bread, milk, and bananas while most other food options are largely unhealthy. These unhealthy options have a negative effect on the health of members of food insecure households.

Food Insecurity is Associated with Developing Chronic Disease

Studies show that greater food insecurity is associated with a higher probability of developing chronic disease, including hypertension, coronary heart disease, and diabetes.[30] Adults in a food insecure household were 15.3% more likely to have a chronic illness compared to adults in food secure households.[31] The number of diagnosed chronic conditions is also 18% higher for food insecure households.[32]

For example, diabetes is one of the most common illnesses found in adults and is more prevalent among food insecure adults. A study conducted by the USDA determined that 6.7% of the population suffers from diabetes. However, the prevalence of diabetes for adults with high, marginal, low, and very low food security is 6.8%, 8.7%, 11.1% and 14% respectively. For individuals with diabetes, annual medical costs are higher and continue to increase over the course of their lives.

---

[29] International Journal of Environmental Research and Public Health: Food Swamps Predict Obesity Rates Better Than Food Deserts in the United States.

[30] According to the USDA, chronic diseases are conditions that last for a year or more, result in limitations to mobility or functions and/or require ongoing medical treatment. Full list of chronic diseases examined by the study were hypertension, coronary heart disease (CHD), hepatitis, stroke, cancer, asthma, diabetes, arthritis, chronic obstructive pulmonary disease (COPD), and kidney disease.

[31] USDA 2017 Food Insecurity, Chronic Disease, and Health Among Working-Age Adults.

[32] The Institute for Functional Medicine: Food Insecurity and Chronic Disease.

Food Insecurity and Chronic Disease
Increase Healthcare Costs

Food insecurity increases chronic disease, which results in higher healthcare costs for food insecure households. A 2018 study estimated that food-insecure adults individually spend an additional $1,863 annually in healthcare costs, or $2,005 in 2021 when adjusted for inflation.[33] Using diabetes as an example, individuals with diabetes incur average medical costs of $16,752 per year. More than half of these annual medical costs are directly related to treating diabetes.[34] Total diabetes medical costs in the U.S. increased to $327 billion in 2017 from $245 billion in 2012.[35] The majority of the cost, 67.3%, is paid for through government medical assistance and insurance programs.

Restricted Access to Food Affects Children Significantly

Restricted access to food affects children significantly and has long-term health effects. Studies show that food insecurity is linked with a poorer physical quality of life and food insecure children are at risk for developing:

- Stunted physical development and/or mental health disorders;
- Anemia and asthma; and
- Oral health issues.

Food insecurity is also linked to low nutrition intake, lower grades, and lower cognitive skills. Food insecure children are more likely to exhibit behavioral problems and run the risk of falling behind their peers developmentally and educationally.[36]

Nevada Has Child Food Insecurity Rate
Higher than National Average

Nevada has an average food insecurity rate that is 30% higher than the national average, with one Nevada county (Mineral) double the national average. Nevada has 128,160 children who are food insecure representing 19.5% of all Nevada children. Nationwide, there are 11,174,000 children who are food insecure or 15.2% of children in the U.S. See Exhibit V for child food insecurity rates in Nevada by county.

[33] USDA 2017 Food Insecurity, Chronic Disease, and Health Among Working-Age Adults.
[34] Source: American Diabetes Association.
[35] Ibid.
[36] Feeding America: Map the Meal Gap 2020: A Report on County and Congressional District Food Insecurity and County Food Cost in the United States in 2018.

Exhibit V

Child Food Insecurity Rates in Nevada by County

County	Food Insecure Children	Food Insecurity Rate
Mineral	240	31.3%
Nye	1,930	25.9%
Storey	140	23.0%
Carson City	2,580	22.9%
Lincoln	180	21.5%
Lyon	2,440	21.1%
Pershing	230	20.9%
Eureka	90	20.3%
Clark	97,140	19.3%
Esmeralda	40	19.3%
White Pine	390	19.3%
Douglas	1,590	19.1%
Lander	310	18.8%
Churchill	990	18.1%
Elko	2,440	16.9%
Washoe	16,700	16.8%
Humboldt	730	15.8%
Total People:	**128,160**	

Source: Feeding America, 2018 Map the Meal Gap.

Clark County has the highest number of food insecure children; however, almost a third of the child population in Mineral and Nye County, who are geographically isolated, are food insecure.

Conclusion

Expanding transportation services offered to Nevadans can be achieved by: conducting a detailed review of existing programs; coordinating with other state and local agencies; and updating the state food security plan to reflect expanded services. Expanded transportation services will increase access to healthier food options in food deserts and for food insecure households, which will improve Nevadans' health overall.

Food deserts and food insecurity restrict access to nutritious food. There are around 155,000 Nevadans living within food deserts; around 367,000 Nevadans are food insecure. Nevada's food insecurity rates and average meals costs are higher than the national average. Food costs affect minorities and people of color to a greater degree. Improved health for food insecure Nevadans could reduce Medicaid program costs up to $541.4 million annually.

Food and nutrition program eligibility requirements restrict assistance in food deserts and for some food insecure households, with only 74% of food insecure people qualifying for program participation due to income limitations. Inadequate access to nutritious food increases health issues and may increase Nevada Medicaid costs.

Recommendation

2. Expand transportation services offered to Nevadans.

Appendix A

Scope and Methodology, Background, Acknowledgements

Scope and Methodology

We began the audit in March 2021. In the course of our work, we interviewed members of management and staff from the Nevada Department of Health and Human Services (DHHS) to discuss processes inherent to DHHS' transportation services. We reviewed DHHS records and researched legislative history, applicable Nevada Revised Statutes, Nevada Administrative Code, Nevada State Administrative Manual, governmental generally accepted accounting principles, and other state guidelines. We concluded fieldwork in November 2021.

We conducted our audit in conformance with the *International Standards for the Professional Practice of Internal Auditing.*

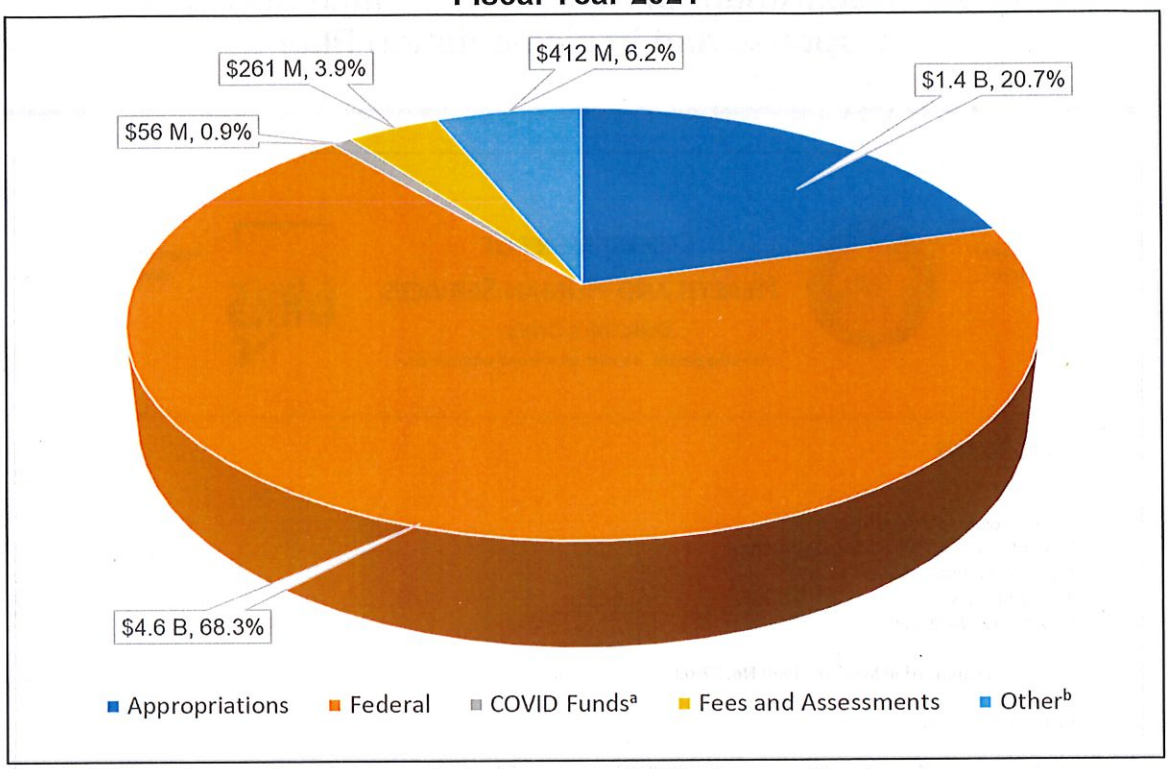
Background

The mission of the Nevada Department of Health and Human Services (DHHS) is to promote the health and well-being of its residents through the delivery of facilitation of a multitude of essential services to ensure families are strengthened, public health is protected, and individuals achieve their highest level of self-sufficiency. DHHS is the largest department in state government, comprised of five divisions along with additional programs and offices overseen by the DHHS' Director's Office.

DHHS is funded mostly by $4.6 billion in federal funds representing 69.2% of fiscal year 2021 funding. The remainder is provided by state appropriations, and other funding. DHHS' funding was $6.7 billion for the most recently completed state fiscal year, 2021. Exhibit VII summarizes DHHS' budget by funding source for fiscal year 2021.

Exhibit VII

DHHS' Budget by Funding Source
Fiscal Year 2021



Source: Derived from state accounting records.

Notes: [a] COVID Funds denotes federal coronavirus assistance from a variety of sources received by DHHS in fiscal year 2021.

[b] Other includes the following funding sources: cash balances; fines and penalties; gifts and donations; reimbursements; tobacco settlement funds; transfers from other state agencies; the Treasurer's interest distribution; and other state allocations.

Acknowledgments

We express appreciation to the Nevada Department of Health and Human Services' management and staff for their cooperation and assistance throughout the audit.

Contributors to this report included:

Heather Domenici, MAcc, CPA
Executive Branch Audit Manager

Beatriz Mena-Ortiz, MAcc, MBA
Executive Branch Auditor

Appendix B

Nevada Department of Health and Human Services Response and Implementation Plan

Steve Sisolak
Governor

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIRECTOR'S OFFICE
Helping people. It's who we are and what we do.

Richard Whitley, MS
Director

January 31, 2022

Warren Lowman, Administrator
State of Nevada Governor's Finance Office
Division of Internal Audits
209 E Musser St
Carson City, NV 89701

RE: Transportation Services Audit No. 22-03

Dear Mr. Lowman:

The Department of Health and Human Services (DHHS) has reviewed the audit recommendations for the recent audit of Transportation Services and respectfully submits the following final comments and response for the two recommendations.

Recommendation No. 1
Improve management of transportation services

Response
RE: Improving management of contract with Medical Transportation Management, Inc.
Federal law (the Consolidated Appropriations Act of 2021, P.L. 116-260) requires state Medicaid agencies to provide emergency and non-emergency medical transportation (NEMT) services for eligible Medicaid recipients to access medically necessary covered services. States have the flexibility and discretion in the payment methods and service delivery models used to provide non-emergency medical transportation services. Nevada uses a transportation broker model to manage the benefit and a capitated model, which pays on a per member per month (PMPM) basis. Research found that "the brokerage model is cost effective for some states, primarily because it may ensure that Medicaid only pays for rides for eligible individuals and for appropriate trips, which could be a deterrent to fraud and abuse."[i] Also, the service delivery model of a capitated payment system creates stability in state funding and places the risk on the vendor to assume any costs higher than the set contracted amount. The NEMT benefit includes a wide range of transportation services and is available to all full-benefit beneficiaries. States vary in their delivery models for providing NEMT and may manage the benefit directly, contract with a third-party broker, as Nevada does, or include these services under their Medicaid managed care contracts. Nationally, two-thirds of NEMT rides are paid for under capitated models (either the broker model Nevada uses or through managed care)[ii].

The contract with the state's sole NEMT services broker, Medical Transportation Management, Inc. (MTM) is managed by the Division of Health Care Financing and Policy (DHCFP). DHCFP actively manages the contract with MTM and reviews contract reports received to analyze modes of transportation used to ensure that cost-effectiveness requirements are met. While the NEMT benefit is offered to eligible recipients, the Division cannot require Medicaid recipients to utilize a service. Both MTM and the DHCFP continually engage stakeholder groups to educate potential members on the NEMT service to increase utilization. The service delivery model of a capitated payment system creates stability in state funding and places the risk on the vendor to assume any costs higher than the set contracted amount.

400 West King Street, Suite 300 • Carson City, Nevada 89703
775-684-4000 • Fax 775-684-4010 • dhhs.nv.gov

The DHCFP will look at the feasibility of contracting with an actuarial vendor to perform a study to determine a PMPM that would be based on actual costs versus contracted rates used by the NEMT broker. In addition, the DHCFP will evaluate the means to conduct a quarterly audit of monthly reports submitted by MTM to identify areas of program improvement.

Anticipated Implementation Date: June 2022

RE: Standardize Internal Processes to Improve Management of Transportation Services
The Department agrees with this recommendation and supports efforts to identify areas of improvement to standardize internal processes. Efforts will ensure consistent practices are implemented to manage transportation services. Transportation services and eligibility requirements differ across DHHS programs due to program and funding restrictions/requirements.

The DHCFP maintains purchase orders for each respective Regional Transit Commission (RTC) where MTM purchases bus passes in bulk as needed as well as the blank bus trip log which is part of all MTMs bus pass procedures. Other agencies such as the Division of Public and Behavioral Health (DPBH), the Division of Welfare and Supportive Services (DWSS), Southern Nevada Adult Mental Health Services (SNAMHS), and Northern Nevada Adult Mental Health Services (NNAMHS) do not request, purchase, or receive bus passes from MTM. DWSS offices provide an accessible place for MTM staff to distribute monthly bus passes to qualified Medicaid recipients. DWSS, SNAMHS and NNAMHS have an internal process for reviewing and auditing transportation services. There are two audit cycles for quality assurance purposes and all policies related to Internal Controls are reviewed in the agency's Executive Leadership meetings. Divisions will continue to use these audit cycles and leadership forums to improve transportation services provided by existing programs. DHHS will work with each division to review and identify potential standardization opportunities to improve management of transportation services.

Anticipated Implementation Date: January 2023

Recommendation No. 2
Expand transportation services offered to Nevadans

Response
RE: Conduct a detailed review of existing programs
The DHHS agrees with the intent of this recommendation. Sister agencies will work together to conduct a detailed review of existing programs that offer transportation services to Nevadans. Appendix D, DHHS Transportation Services by Division, will be updated to reflect all current services provided by division and program. The updated table will help DHHS identify gaps in transportation services by providing details of services provided to participants by program.

Anticipated Implementation Date: December 2022

RE: Coordinate with other state and local agencies
The DHHS is committed to partnering with public health stakeholders and sister agencies to improve overall health and reduce longstanding disparities in health care and expand transportation services offered to Nevadans. While federal limitations exist that limit Medicaid from providing transportation to non-covered Medicaid services, Medicaid does address barriers to accessible food by offering Home Delivered Meals through its 1915(c) Home and Community Based Services Waiver for Persons with Disabilities. The DHCFP is also expanding Home Delivered Meals to recipients under the Waiver for the Frail Elderly through the American Rescue Plan Act. Work will continue to support these efforts as well as link back to nutrition and transportation services managed by sister agencies.

DHHS actively works with the Nevada Department of Transportation (NDOT) related to transportation around social services. Julia Peek, Deputy Administrator for DPBH, serves as the DHHS representative on the statewide Transportation

Planning Advisory Committee (TPAC). The TPAC is intended to advise, solicit input, and interact with NDOT's Planning management team and staff on issues that affect transportation planning in Nevada. This advisement/interaction may include review, comment and making recommendations on NDOT planning studies, plans and guidance, as well as special duties such as serving as the Steering Committee for the One Nevada Transportation Plan. Additionally, the purpose of the committee is to help NDOT with its public outreach efforts by providing valued input into the transportation planning decision-making process. The DHHS representative will discuss the audit recommendations at the July TPAC meeting.

Anticipated Implementation Date: July 2022

RE: Update the state food security plan to reflect expanded services
The Department agrees that there is a need to expand transportation services. There is also a need to evaluate other critical success factors to improving the health and well-being of Nevadans, including efforts to address other social determinants of health and methods to support better eating habits. DHHS has been collaborating closely with the Nevada Department of Agriculture (NDA) to improve food security efforts since 2014 when the Governor's Council on Food Security and the Office of Food Security (OFS) were created. DHHS and NDA have been working on analyzing gaps in programming and initiatives for food security to not only find ways to collaborate and expand programing but to also improve efficiency of current programs and avoid duplication of efforts.

The OFS has been in a strategic planning process since September 2021, this strategic plan will assist with updating the Food Action Plan (the last installment was in 2018). This strategic plan will conclude in July 2022 and a new report will follow by the end of 2022. The Food Action Plan also helps to advise the Nevada Governor's Council on Food Security (CFS) reports. The 2021 CFS report received final approval from the Council during the January 18, 2022, CFS meeting and is going through the final routing process now. Additionally, the OFS put out three food security reports in 2020 which focused on the impact of COVID-19 on food security in Nevada (*Combatting the Statewide Hunger Crisis*). An additional report was developed highlighting *Hunger Among Older Nevadans Amidst the COVID-19 Pandemic*. These reports analyzed and highlighted existing and new programs who worked to feed Nevadans throughout the first year of the pandemic. Program reach, service areas, types, access, and other data points were documented throughout these reports to inform efforts across the state in the wake of COVID-19.

Before COVID-19, during and ongoing, efforts to increase food security have focused on not only having enough foods to offer but also combatting the various access barriers. Recently, the focus on improving access has been around finding ways to bring food to people not people to food. Barriers in shopping and accessing foods go beyond proximity to stores and transportation. Specifically in relation to nutrition security (nutrient dense foods chosen/available), people with disabilities, language barriers, families with small children and working families.

OFS recently received the State Partnerships Improving Nutrition Equity (SPINE) grant which is on the list for February IFC. Once IFC approval is obtained, the OFS will use this grant to pilot a program that will increase access of nutrient-dense fresh foods in rural, frontier and underserved communities. OFS will collaborate with Catholic Charities of Northern Nevada who will purchase equipment allowing them to deliver more fresh food options to underserved communities and homes of those in-need.

DPBH is also discussing further collaboration strategies with NDA through a Local Food Purchasing Program grant NDA will be applying for. This grant would help local farmers, as well as food insecure community members gain additional access to local fresh foods.

The Department is committed to reviewing and updating the state food security plan to include expanded transportation services.

Anticipated Implementation Date: January 2023

The Department would like to thank the Division of Internal Audit staff for their professionalism and dedication in assisting the Department with valuable information to improve services. Please contact Marla McDade Williams at mmcdadewilliams@dhhs.nv.gov if you have any questions.

Regards,

Richard Whitley
Director

cc: Heather Domenici, Executive Branch Auditor
Marla McDade Williams, Deputy Director, Department of Health and Human Services
Suzanne Bierman, Administrator, DHCFP
Lisa Sherych, Administrator, DPBH
Steve H. Fisher, Administrator, DWSS

[i] MACPAC, "Medicaid Coverage of Non-Emergency Medical Transportation", Issue Brief, May 2019, page 2. https://www.macpac.gov/wp-content/uploads/2019/05/Medicaid-Coverage-of-Non-Emergency-Medical-Transportation.pdf

[ii] MACPAC, Mandated Report on Non-Emergency Medical Transportation, June 2021, pg. 169. https://www.macpac.gov/wp-content/uploads/2021/06/Chapter-5-Mandated-Report-on-Non-Emergency-Medical-Transportation.pdf

Appendix C

Timetable for Implementing Audit Recommendations

In consultation with the Nevada Department of Health and Human Services (DHHS), the Division of Internal Audits categorized the recommendations contained within this report into two separate implementation time frames (i.e., *Category 1* – less than six months; *Category 2* – more than six months). DHHS should begin taking steps to implement all recommendations as soon as possible. The target completion dates are incorporated from Appendix B.

Category 2: Recommendations with an anticipated implementation period exceeding six months.

Recommendation	Time Frame
1. Improve management of transportation services. (page 2)	Jan 2023
2. Expand transportation services offered to Nevadans. (page 9)	Jan 2023

The Division of Internal Audits shall evaluate the action taken by DHHS concerning the report recommendations within six months from the issuance of this report. The Division of Internal Audits must report the results of its evaluation to the Executive Branch Audit Committee and DHHS.

Appendix D

DHHS Transportation Services by Division

Division	Program	Transportation Service	Description of Transportation Services
DWSS	SNAP E&T	Participants receive support services which are reasonably necessary and directly related to program participation and/or to support 30 days of employment if a job is obtained during participation.	Car repairs up to $500 per year per participant for employment, bus passes, gas reimbursement up to $25 twice a month, and vouchers for the purchase of gas.
DWSS	TANF	Training for Elder Healthcare Professionals	The Division assists TANF work eligible individuals to train for, seek, and maintain employment in health care occupations. The assistance the division may provide includes tuition, payment of course fees, books, instructional materials, special equipment, and supportive services such as childcare and transportation services.
		Supportive Services to TANF-NEON Participants.	To ensure success in job search, NEON program activities, and job placement, the Division may provide necessary bus passes, gas vouchers, or transportation reimbursements.
		Aging and Disability & Other Divisions	Services coordination assists individuals in gaining access to needed support services and consists of arranging services and providing transportation to services. Transportation is offered to enable individuals to gain access to other community services, leisure activities and resources, and to enable them to participate in community life specified by the plan of care.
		Work Supports	TANF and State MOE expenditures that provide benefits to reduce or eliminate barriers that may interfere with a family's ability to obtain, retain, or advance in employment, or participate in other work activities. Benefits include transportation benefits including gas reimbursement, auto repair and insurance, and bus tokens.
		Non-Recurrent Short-Term Benefits	The Tahoe Family Solutions Community Support Team time-limited cash assistance program provides emergency financial assistance for families in need under 200% of the FPL[a], to assist them in becoming financially stable. The assistance may include rent, utilities, transportation, and relocation.
		Child Welfare Adoption Services - Family Support/Family Preservation/Reunification Services	Personal Assistant Services (PAS)[b] provided through the Aging and Disability Services Division (ADSD) for parents with disabilities to aid in daily living so that parents may remain in their home with their children. Services may include assistance with the household, personal hygiene, transportation, etc.

Division	Program	Transportation Service	Description of Transportation Services
ADSD		Senior Companion	Provides companionship activities for individuals in their home. Companions may also accompany the client and provide transportation to access services outside of their home.
		Transportation Services	Provides safe transportation for access to needed services including meals, medical appointments, social services, adult day care, shopping, and socialization
		Taxi Assistance Program (TAP) in Southern Nevada	Allows Nevada residents aged 60 and older and persons less than age 60 with permanent disabilities, who meet income criteria, to purchase coupon books to pay for taxicab rides at a discounted rate.

Source: Auditor compilation of DHHS division and department-level data.
Note: [a] FPL = Federal Poverty Level
[b] PAS serves families below 800% of poverty.