Meeting Minutes

Nevada Commission on Aging
Policy Subcommittee
(Nevada Revised Statute [NRS] 427A.034)

Date and Time of Meeting:
August 17, 2020
1:00 pm until adjournment

1. Call to Order/Roll Call

Chuck Duarte called the meeting to order at 1:08 pm

Subcommittee Members Present:
Chuck Duarte
Connie McMullen

Subcommittee Members Absent:
Barry Gold
Mary Liveratti
Donna Clontz

No quorum – Action items tabled

Staff:
Shannon Sprout, Health Program Manager, ADSD
Jennifer Frischmann, Quality Assurance Manager, ADSD
Miles Terrasas, Executive Assistant, ADSD

Presenters:
Dr. Jeanne Wendell, University Nevada Reno
DuAne Young, Deputy Administrator DHCFP
Margot Chappel, Deputy Administrator, DPBH

2. Public Comment - None

(No action may be taken upon a matter raised under public comment period unless the matter itself has been specifically included on an agenda as an action item. Comments will be limited to three minutes per person. Persons making comment will be asked to begin by stating their name for the record and to spell their last name and provide the secretary with written comments.)

3. **Approval of Minutes of the May 27, 2020 meeting**

No quorum. Tabled for next meeting**.**

4. **Presentation on COVID-19 Requirements, Policies, Recommendations, and/or Guidance for Nursing Facilities, Residential Facilities for Groups and Adult Day Care Programs. - Margot Chappel, Deputy Administrator, Division of Public and Behavioral Health (DPBH**)

Mr. Duarte stated opening remarks and expressed the most pressing concern is family visits to regain momentum so they can see their loved ones. In most cases some have not seen their family members for months. That is the trajectory of where we want to go with the state.

Ms. Chappel, Deputy Administrator from DPBH oversees regulatory and planning, and Bureau of Health Care Quality and Compliance, Bureau of Health Protection and Preparedness, and Environmental Health Services and is primarily speaking to issues related to Bureau of Health Care Quality Compliance. When the Pandemic began CMS suspended certain non-emergency survey inspections allowing inspectors to prioritize the most serious health issues and threats including infectious disease and abuse. Right away they called skilled nursing facilities and walked through the self-assessment that CMS developed and added questions of their own to it. Inspectors started calling them and had the self-assessment done within the first two weeks of March when the Pandemic began. They began working with any facility that had an outbreak. Definition of an outbreak is defined as one or more cases residents or staff. Also working with assisted living facilities and created a document that was modeled after the infectious disease prevention document for skilled nursing facilities and personalized it to the assisted living facilities non-medical model and working with adult day cares as they started reopening. Published everything provided to them advisements, NV Health Response website, on the website for specific audiences the materials are separated out by skilled nursing facilities and assisted living facilities. Currently as it relates to visitation working with Nevada Public Health Foundation to get virtual communication equipment into every skilled nursing facility and efforts by ADSD for virtual access via tablets into assisted living facilities, both large and small for groups.

Mr. Duarte asked about the website publications. Mr. Chappel stated she would add it to the chat. One of the recovery documents shared by CMS in mid-May was a memo issued that described the phases of readiness for facilities being open to visitors. They looked at it extensively and determined as a state they could not be in one phase. They are having surveyors work with each facility to determine which phase they are in and many are in phase 1 and a few instituted outdoor visitations and have approved those on a case by case basis. Most facilities are not struggling. Last week 11 facilities were on the list: 2 of them being skilled nurses. The latest trend that is concerning is the smaller group homes are having the outbreaks and do not have the resources they need. An issue with complacency and are still engaging in social activities. Staff from facilities are being social and taking a risk and clarified she is making an observation and not stating a fact.

Ms. McMullen stated it seems so difficult for families and the state must be doing a great job at monitoring all of it. Ms. Chappel built an infection prevention team led by Dr. Green former DPBH Chief Medical Officer along with two nurses hired full time. When they hear of an outbreak, they collaborate with the team to address issues and concerns and they talk with the facilities and have issues several chief medical officer directives by statute. Many facilities have been very receptive. Ms. McMullen still delivers to most of the facilities mainly independent and small group homes. Most of them are locked down and most residents seem to understand to acknowledge and follow the rules. Personal Care did not receive PPE and had to utilize other sources and stated it is interesting that state staff had the same problem. Ms. Chappel mentioned it was about two months ago that skilled nursing moved up on the list for prioritization for PPE and FEMA is still delivering it. It is their understanding as the end of July being able to purchase and access PPE was no longer having a shortage and hopefully it maintains itself. The Department of Emergency Management (DEM) is trying to create a stockpile in case of resurgence. Ms. McMullen asked what kind of communication equipment are you putting in these places? Ms. Chappel

responded ADSD is doing a different process, DPBH will allow the facilities to tell them what platform they work on such as Apple, Android and is purchased through Best Buy and allowing the facility to pick what they want. Some facilities had communication equipment already but did not have the support including stands and additional support equipment.

Ms. Frischmann clarified she is not on the agenda and stated the LTCO got $174,000 in CARES Relief Funds, it was not a grant it was one that was awarded. Working with HCQC they are in the process of purchasing 650 kindle fires through UNR Seniors in Service Program. The Seniors in Service Program will be utilizing some of the students that need volunteer hours loading different software applications onto the kindle fires to accommodate communication platforms and helping with distribution to take as much pressure off the facilities. They are also purchasing 72 visitation stations for their LTC facilities, they are plexi glass and have different backgrounds. It is a local company in Las Vegas with the allocation being 50 down in Las Vegas and 12 in the Reno area. Currently looking into the hugging stations and at this point do not feel it is very safe and working with HCQC to evaluate those facilities and trying to get LTCO in. Outreach is being done such as delivering activity books, games, puzzles, pens, and pencils.

Mr. Duarte stated the ombudsman staff are not designated as essential workers. Having to conduct interview/surveys externally. How is that working out? Are you using the tablets? How are you conducting that work right now?

Ms. Frischmann replied they are primarily doing everything by phone. The LTCO were not designated as essential staff and are different from APS and DPBH Staff. They have conducted interviews by the window in some cases. They have to coordinate efforts with the Bureau. State Long Term Care is working on a reentry plan which is due Friday and thanked Ms. Chappel and her team which allowed collaboration between ADSD and DPBH.

Mr. Duarte asked about the Dashboard and is confused by the data. A lot of conversation around the dashboard and asked for clarification on the definitions. There are relatively few facilities that are reporting cases. How may facilities have reported cases? Number of confirmed cases among residents and staff as confirmed covid cases. What does imported cases mean? Mr. Chappel replied that means that facility accepted a patient that was covid positive. Facility types and to remember that numbers are cumulative. He asked how do you define attack rates of COVID-19? She will get Miles Terrasas that information. One of the other things that came up has to do with testing. CMS in proves of sending out test instruments with starter kits. Has there been a discussion what happens after that? Does not look like there will be enough to do one or two runs of their staff? Is there a discussion on how to support the facilities to attain additional test kits to continue testing staff and residents? Ms. Chappel replied 12 of 14 have received them, each machine can only take up 3500 tests. It was a third-party piece of information. They were not involved in the discussion. Testing material have been federal to local intervention.

One of the things that concerns is they come out with 4 recommendations for Alzheimer's association. Testing is the route to establishing visits. Rapid testing and turn around. Both associations, the state of testing in the nation is not there yet to get those rapid results. Concerned these facilities need to get access to test and test kits and need to get access to PPE. Mr. Chappel responded started moving towards advising facilities to use time-based strategy if they are initiating the proper protocols, for lack of testing not finding facilities are short on PPE. Save PPE to work with cohort of suspected COVID. The dashboard shows no positive cases since May. How can we get paid enough to purchase tests necessary and PPE to maintain safety for residents and how to get reimbursed for the cost? Ms. Chappel applied to the Governor's Office for the supplemental rate. All of the SNPS should have got their own allocation from the CARES act. CARES funds to only be expended on covid related items. Nevada facilities received in total from CMS/HHS and will send expenditures to Miles Terrasas.

5. Update: Dual-eligible Special Needs Plan (D-SNP), Impact on Aging Services - DuAne Young, Deputy Administrator, Division of Health Care Financing & Policy (DHCFP)

DuAne Young reported 75,000 duals are in the Medicaid program, truly eligible that are part of a supplemental plan, maximizing potential opportunity combining Medicare/Medicaid funding from the care of dual eligible.

Mr. Young stated they have been working dual eligible programs this year and it became a reality of what can be accomplished. The dual programs information was disseminated back in March. Plans who registered each year for potential markets. There were 4 plans who registered including United Health Plan, Centime Corporation, Anthem, and Aetna. 3 of those are current managed care vendors. 3 plans have reached out for next year in 2022. 139 different Medicare advantage plans and operating in that space in various capacities. Nevada has become an all comer state. Since it is new for Medicaid, they pulled resources where they could and thanked ADSD's help with implementation. Focused on contract and did not use the standard state Medicaid agreement and changed to reflect unique to Nevada. Quality measures that require to report to the percentage of members that actually had a primary care visit, not those assigned to primary care and were able to push for supplemental packages; things that are not covered in the Medicaid state plan but would be required to be covered through the program such as adult dental, vision and others with budget cut backs and the looming crisis because of covid will be more important to have for this population. The dual population is a high cost population and is often underserved. Neither of the agencies have the full capacity to reach them. It is a plan to grow operations. One plan operating in Washoe and the other three out of Clark and Nye. Letting potential plans know the requirements to be registered in both Washoe and Clark county and covering the rural.

The long-term vision is to have statewide coverage among the DSNP plans and that is the reason they went with all comers because they focus more in the rural than the urbans. The plans have submitted their signed contracts to CMS and what their capitation rate is and will define their services through DHCFP. They also put in place the ombudsman contract that where they need to notify every time, they go into a LTC facility or extended hospital stay and to manage that information. Working with plans to set up data connections to be ready by January 1st. The contract will still need to go to Boards of Examiners. Finished another round of questions from LCB and GFO explaining it is a new concept to Nevada and making sure they are prepared and have all the information needed and go to September BOE. CMS has given the plans conditional approval. The plans should know what services they are offering and what their capitation is by October 31st. They will have all that information by November 1st. In addition they will be working with ADSD to put general information out on DSNPS so they know they don't have to change their MA plan and they may seem some recruiting material and advertisements and it's an added benefit to them and get neutral education out. Any information that comes from the Department will come from a neutral basis.

Ms. McMullen asked does this have to with just health care or in-home care as well? Will the managed companies be doing their own contracts with personal care or other services, home health or hospice or health care like the exchange?

Mr. Young responded they did ask for personal care services and home health within the contract if money if is available, they would provide those services through the Medicare advantage plan. It is savings to the state and to expand the capacity of those services performed for that population. That is our hope. Year 1 and 2 felt ambitious but looking at the scale it is not as comprehensive as other states. The goal is those services would expand and personal cares services being allowed through Medicaid managed care. They have not seen a big uptick of Medicare advantage plans offering those services. It was put that into the agreement as a value added and the recognized need for those services.

Mr. Young stated there is a gap that is paid and other factors that fit into that gap like the upper payment limit. The recent public hearing backs further away from the Medicaid rate. The DNSP as it grows to get providers back to Medicaid if they are serving those duals. The Medicaid caseload continues to grow,

and the private insurance market continues to shrink. Continuing to see that trend in Nevada and other states but more so Nevada because of the tourism-based economy. Moving to that trend, a lot of providers will have to reassess their business models and look at the percentage and come back to take a greater percentage to Medicaid because the private insurance will lower. Ms. McMullen expressed how Mr. Young has been a great addition to the Medicaid division.

Discussion between Mr. Duarte and Mr. Young ensured on the following:

- Materials will be handled at the federal level completely in terms of enrollment. District offices will be available to answer questions and anything Medicaid related.
- Duals are in fee for service Medicaid.
- HCBS waiver eligible and DSNP can be eligible at the same time and coordination of benefits language added to the contract.
- In previous years data integration was a significant barrier.
- Coordination of benefits for MA and SNP benefits and continuity of coverage. It is being done now. Someone in the MA program will need to notify the Ombudsman and LTSS for a trigger notification and to monitor point of transfer.
- Conversion for billing DSNP to Medicaid the costs will shift to the county match program in some instances. The costs are already bearing in the county match program.
- Transition to facilities in short term instances if there is a better placement, the MA plan will move them out of that facility. People past the 100-day mark who need that continued care may experience shifting and delay but not a greater cost.

Mr. Duarte asked after data is collected for DSNP the division has some experience to possibly have another update. Mr. Young stated he will be able to provide information and mentioned DSNP are shorter term contracts, so they have time to adjust.

6. Budget Overview – Aging and Disability Services Division - Dena Schmidt, Administrator, Aging and Disability Services Division (ADSD)

Ms. Schmidt stated the following updates:

- Special Session proposed reductions were not accepted or put forward. Results that go us through was large reversions in ATAP FMAP, reduction of travel and training dollars, deferred maintenance projects and no programmatic cuts.
  - Programs are continuing and monitoring budgets through FY21. Finalizing budgets for 22/23 and working with Director's Office to get them submitted and finalized and to build within cap.
  - Anticipating a further reduction if cap changes. Review those same reduction areas that were put forward for Special Session
  - Looking at gaining savings with telecommuting. Create savings with leases and save direct impact to direct services.
  - A workgroup issued client survey results that stated 90% are already contacted by phone. They indicated they would rather us come to them. Constituents were very satisfied. They completed a staff survey 10% staff prefer not to telecommute and ADSD is considering space for them during the evaluation.

Mr. Duarte stated the proposal access the board rate reductions for HCBS and health provider positions. How can you do an across the broad cut? Will CMS allow that? Federal regulations precluded in each category had to be justified you have to show services are still accessible. Will access to services comply with what is in existing federal regulations? Kirsten Coulombe stated her understanding of the rates unit is CMS requested them to update the ARPPR and show they are meeting access to care. They are submitting that report earlier than usual because they are aware those rate cuts are coming. Separate from then the state plans that were submitted to CMS at the August 13 public hearing an submitted updated to those reports so CMS can review those cuts. Mr. Duarte asked if it will it be posted to access

to care once it is updated? Ms. Coulombe stated she is not sure but will follow up with the rates unit. He also asked if it has to be submitted prior to the submission of state plan amendments? She responded it is a separate process. The state plans that were presented and approved last Thursday are on their way to CMS to start the 90-day time limit in order to have the assumed retro approval for the rates. The reason for the report to be updated would be for CMS to review the rates pages and take it into consideration.

Ms. McMullen asked if the waiver cuts were put back in place?

Ms. Schmidt clarified the FE/PD waiver are in Medicaid budget. IDD waiver is in ADSD budget. IDD was not cut because the language in the bills talks about the Medicaid appropriations. Ms. Coulombe stated her understanding is FE/PD are included . They pulled from public hearing. CMS requires a strict posting guideline including a draft of the waiver application which was not presented at the public hearing in detail in terms of the 30-day notice. The tribal notice that was posted in advance are a process to give public notice on state plan services. It had an expedited date because of 1135 and the disaster notice and allowed to not do a 30-day notice which is her understanding for the public hearing which is not applicable to the waivers. Change to that process would have to be done through the Appendix K Two separate processes for state plan versus waivers. There is a link to the public notice letter that includes to both elder and disability waivers until September 14 for the proposed cuts. The FE/PD there are still proposed cuts like the state plan services it has a different mechanism to do the public notice and was not able to be aligned with the state plan cuts.

Mr. Duarte clarified the FE/PD waiver cuts is the inclusion of 6% rate reduction. The personal care rates were basically rolled back prior to the 2019 legislature. The 2019 legislature approved and then basically rescinded them. Ms. Coulombe responded there was increase in the 2019 session so that stayed but they are subjected to the 6%.
Ms. Schmidt clarified the net reduction is less than 6% but its still a reduction.

7. **Assembly Bill 122 Update: Requires the Department of Health and Human Services (DHHS) to seek a feasibility study on a single license for Adult Day Care, respite services, and assisted living facilities in rural Nevada. - Jeanne Wendell, Ph.D., University of Nevada, Reno**

Dr. Wendell presented updates on AB122 (See Attachment A)

Discussion ensued on the following:

- 8 hours within a 24-hour period vs 12 hour shifts and if labor laws do not apply to industry specific
- Hourly restrictions imposed by Medicaid. Medicaid hours would be dictated on the prior authorization and ideally in the system if the individual needed high hours and multiple personal care attendants. The PA's would not allow crossing of hours and duplication of services. Ms. Coulombe can look in the historical records to see if there's information on that. Mr. Duarte asked is it based off the Medicaid regulation or labor laws? Ms. Coulombe will look to see what the edits were. The EVV specific to PCS to try and review individuals that are submitting fraudulent time sheets and to ensure the individual is getting the care they need. EVV is an inherent safeguard to see the recipient and how many individuals they have. Discussion that NV and California are the only states required to do the 8 hour and 24-hour period.
- Companion rate below eight dollars which is below minimum wage. Ms. Coulombe mentioned in the 2017 session it required Medicaid to review their rates every 4 years and is not certain how the rates unit will take the approach to the recent rate increase done in July. She will follow up with rates unit.
- Advisory Committee – two areas related to Medicaid. The settings rule , in relation to rural and frontier program and facilities. Is there was facility, a critical access hospital or nursing facility in a rural community. Do you see a stop in that happening or is there flexibility in the setting rules

to develop those types of services? Ms. Coulombe provided an example on the Fallon campus and spoke to CMS visits along with the CMS feedback and settings requirements and the extended deadline for the state transition plan.

- The settings rule is applicable per service. A confirmation each recipient for each service was offered a choice.
- 2002 Rates Commission. Variety of provider rates including personal care. Cost base established for rate settings. Agencies were surveyed for cost of labor. One of special considerations to rural agencies for distance and travel. Ms. Coulombe stated cost studies when updated and renewed FE/PD waivers. There was cost studies that rate units did. Doing a cost study to the ID waivers. ADSD Marilyn Hesterly from DPBH is a good resource related to licensure.
- AB 122 group will finish up questions with Medicaid to help finalize AB122 report

8. **Review, discuss and approve tentative agenda for the next meeting**
   - Chuck Duarte, Chair
   - Approval of May 18, 2020 Meeting Minutes
   - Discussion of Potential Impact of Budget Reductions on Nursing Facility Provider Rates
   - Discussion Provider Reimbursement

9. **Tentative Meeting Date, November 16, 2020**

10. **Public Comment** (No action may be taken upon a matter raised under public comment period unless the matter itself has
    Been specifically included on an agenda as an action item. Comments will be limited to three minutes per person. Persons making comment will be asked to begin by stating their name for the record and to spell
    their last name and provide the secretary with written comments.)

11. **Adjournment** – Meeting adjourned

Attachments:

A: Long Term Services and Supports in Rural Nevada