RCHCAN and AHHONN

Public Comment on concern push toward SLA's

10/23/15

We want to voice our concern about several factors contributing to the accelerated decline of long term care beds for our chronically ill Nevadans, especially those with Alzheimer's, Dementia & Mental Illness.

Decline in SNF and RCH beds with various endorsements that target care for those with mental illness and Dementia care.

There are approximately 5000 nursing home beds and 3000 RCHs in Nevada. We are concerned about the new trend in SNF facilities to take beds that previously were used for long term/ chronic & Dementia care that received $200/day reimbursement from state Medicaid are now being reallocated for the higher pay, short term rehab at reimbursement rate of $600/day from Medicare and the new Mental illness/behavioral rate of up to $500/day from Medicaid. These changes will leave the chronically ill long term care cases including those with Alzheimer's and Dementia with even fewer care options. Even if more nursing home beds are built, we are concerned they will also be allocated for the higher paying reimbursement rates, leaving us with a bigger problem of where to place long term dementia care cases. We concede that nursing home beds are needed and they can provide a higher level of skilled care that other facilities cannot, but there are thousands of people who could be cared for in the highly monitored RCH with various endorsement and do not require skilled nursing home care. We are concerned these low ADL, Dementia and chronic care cases will have no place to go if these trends continue.

Heightened concern over push toward SLA's (NRS 435) and away from RFFG (NRS 449)

There has been a shift in state funding away from Medicaid funds for waivers for Residential Care Homes (RCH's) with dementia or mental illness endorsements toward Supported Living Arrangements (SLA's) for independent living/ transitional living. This adds strain and uncertainty for the RCH industry in Nevada, which has been a proven community based care option and resource for middle to low income senior and disabled who wish to remain in the same residential communities as the non-disabled and not be forced to be institutionalized.

RCH's have been providing highly monitored, safe cost effective, 24hr care to residents with mental illness and Dementia for the last 17 years and are among the best in the nation. (see state by state comparison table) A small number of RCH's receive up to $1,500 per month from Medicaid waivers to cover all their costs; housing, food, insurance, licensing fees, fire monitoring, payroll etc. These providers are not in this business to make a lot of money they do it because they know it is needed and the residents they serve would be lost without them. Even though there are a small portion of RCH's who accept medicated waiver, 90% are private pay and are the only option for low to middle income seniors and disabled Nevadans who are not on Medicaid and do not want to be forced on to Medicaid because their one viable option of Cost effective RCH's are legislated out of business. Other options such as in home care, adult day care and assisted living are not viable care options for middle to low income Nevadans because they are too costly and do not provide an adequate amount of care and service.

RCH's are clearly the most cost effective for the residents and the tax payers. (See Long term care comparison table) So we ask why RCH's not are being considered or included in the long term care continuum when it comes to state Medicaid dollars.

SLA's on the other hand, have seen over spending of Medicaid dollars and faced scandal with rates reaching $5,000-$6,000 dollars per month, per person compared to $1,000 – 1,500 per month in a fully licensed RCH with Dementia or Mental illness endorsement. In addition to the base rate for housing, caregiving & medication management SLA's also bill separately for BST (basic skills training) & PST (psychological skills training) for additional state funds. While these services are often needed and effective in many cases, we wonder how much benefit they give to a 70 year old person with several chronic illnesses like arthritis, limited mobility & dementia. It is very unlikely that a person with these issues will transition to independent living or go back into the work force. This appears to be an ineffective use of tax payer dollars.

We have found very little information on the rules and regulations of SLA's. What type of residents they are allowed to serve and what type of services are provided. In general, our understanding is that SLA's are designed for transitional living to help an individual transition to independent living. We wonder how long some can continue to receive state funding and reside in a transitional living setting? Is there are any age restrictions on who is an appropriate candidate to utilize transitional living? Are there limitations on an individual's physical or mental health conditions? Who is appropriate to reside in these settings and how are the individuals monitored and supervised? Does the public have access to any of this information? If not, why?

If these entities get state Medicaid funds we believe they should be held to the same high standard of transparency and monitoring as similar types of disabled residents who live in RCH with dementia and mental illness endorsements under NRS 449.

Moreover, the community, home owners, HOA's should be entitled to know where these houses are just as they do for RCH. Instead there is no public list of the SLA homes and only a list of the big companies that are certified under Desert Regional. One might ask why SLA is entitled to this privacy protection and lack of transparency when RCH are not. We have heard that some SLA's have prison contracts for released prisoners and wonder if the secrecy is to protect their animity?

It is not clear who monitors and over sees the safety of these entities? Why is the state ombudsman not allowed to investigate these entities when they receive complaints as they do for all other long term care entitles? If SLA's are for independent / transitional living then the residents living there should transition in some amount of time or be moved to a LTC residential care home. Contrarily, if SLA's are in fact offering long term care services equivalent to RCH with various endorsements then those patients deserve all of the safety and monitoring protections that RCH offer as well.

We have done a significant amount of research and have deep concerns about the seeming lack of information, monitoring, supervision and transparency to the public surrounding this entity type. We are noticing more and older chronically ill people with chronic mental illness and other co morbidities residing in the less monitored and regulated SLA entities and are greatly concern for their well-being and safety.

The change in direction of funding to these entities and away from RCH's may be to try to comply with CMS /strategic planning committee guidelines to provide "patient centered" care, but to lump all people into one group is troubling. People who have potential to transition and go back to work or live independently in the community are very different from older chronically ill people with long standing cognitive loss, mental illness and co morbid medical illnesses who are not likely to transition to independent living or back into the work force. We want to ensure all people are receiving the same high level of monitoring and supervision.

One must wonder, at a time when the state passes a large tax increase, if this is an efficient use of tax payer dollars and state funds? Have the decision makers even considered giving a slight increase in

the payment for the safer, highly monitored, regulated care and more transparent setting of RCH's to help ensure the existence and growth of this well developed and highly utilized care option? If not, why?

The 3000 RCH's beds are a very large portion of the long term care continuum and heavily relied upon as safe, cost effective, discharge options for hospitals, nursing homes and assisted livings, yet sadly they are not represented on the panel here today or on other planning committees. The only voice of our industry is through public comment.

We request to be added to the agenda to make a formal presentation of our concerns at a future meeting and ask to be included in state planning meetings as we are interested and well informed stakeholders in the long term care continuum.

Thank you,

Shawn McGivney, President of the RCHCAN

Jose Castillo, President of AHONN

Attachments:

LTC cost comparison table shows decline in RCH and SNF LTC beds
State by state comparison of RCH – Nevada RCH best in the nation.
We reference the materials submitted to 8/21/15 Alzheimer's task force meeting.