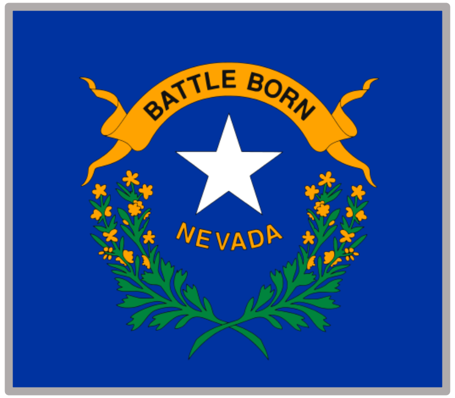
A Feasibility Study of a Combined License for Assisted Living Facilities, Adult Day, and Respite Care Services in Non-Urban Nevada:

Response to AB122

Prepared by:

University of Nevada, Reno Interdisciplinary Working Group

(in collaboration with External Working Group)



This presentation contains excerpts from the full report to the Nevada State Assembly. The citation to the full report is below:

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For more information about this presentation or the accompanying AB122 report, please contact Veronica Dahir (veronicad@unr.edu, 775-784-6272) or Jeanne Wendel (wendel@unr.edu, 775-815-2140).

Chapter 8 Summary: AB122 Questions
regarding facilities that would offer
Assisted Living, Adult Day and Respite Care services

1. Analysis of the feasibility of creating a single license for such a facility
2. Identification of the manner in which such a facility would receive reimbursements from Medicaid
3. Analysis of the feasibility of recruiting adequate staff to operate such a facility
4. Analysis of the economic viability of and payment structure of such a facility
5. Barriers to implementation
6. A possible timeline for creating a pilot program to establish such facilities

Question 1

Q1: Analysis of the Feasibility of Creating a Single License for Such a Facility

Current Licensure Requirements (Bureau of Health Care Quality & Compliance; HCQC)

- Assisted Living Facilities (ALFs)
  - Residential Facility for Groups
  - Special endorsement - Assisted Living Facility (ALF)
- Adult Day (AD) Centers
  - Personal care for adults
  - Supervised, protective, congregate setting
  - Portion of a 24-hour day
- Nevada does not currently license Respite Care (RC) facilities. Licensure requirements for ALFs and AD centers do not include provisions based on expected duration of stay or participation *(Ch. 2)*.

Benefit of a Combined License: potential efficiencies

Both types of facilities (ALF and AD) must have:

- A director/administrator,
- Staff trained in first aid and CPR,
- A first aid kit,
- Space and staff for activities,
- Space and staff for food planning, meal preparation, and serving and dietary consultants,
- Space and staff for laundry, and
- Systems to handle:
  - Medication administration and client health monitoring
  - Resident/client records, admissions, employee training
  - Facility maintenance, inspections, security

Issue #1: Current provisions in NRS & NAC may block combined license

Pertaining to the licensure Board: NRS 449.0302

2. The Board shall adopt separate regulations governing the licensing and operation of:
(a) Facilities for the care of adults during the day; and
(b) Residential facilities for groups, which provide care to persons with Alzheimer's disease or other severe dementia, as described in paragraph (a) of subsection 2 of NRS 449.1845.

Pertaining to ALFs: NAC 449.208

Restrictions on conducting other businesses or providing other services on premises. (NRS 449.0302)

No other business may be conducted or other services may be provided on the premises of a residential facility if the business or services would interfere with the operation of the facility or the care provided to the residents of the facility.

Pertaining to ADs: NAC 449.4067

Operation in combination with other medical facility or facility for the dependent. (NRS 449.0302)

A facility must not be operated in combination with any other medical facility or facility for the dependent unless it is licensed as a separate and distinct unit.

Issue #2: Differences in services offered in AD centers vs. ALFs

An AD center may offer nursing services, whereas an ALF may only offer the services (typically provided by layperson caregivers) described in the regulations at NAC 449.271 to 449.2738.

(AD center) NAC 449.4072

1. Each facility must have the number and kind of employees required by the physical characteristics of the facility, the number of clients and the services provided.

This language allows for provision of nursing services in an AD center.

(ALF) NAC 449.4081

1. If the facility accepts a client who cannot administer his or her own medication, an employee licensed to administer medications must administer the medication to the client.

This language requires an employee licensed to administer medications, such as a registered nurse, it does not authorize a layperson caregiver to administer medications.

Issue #3: Respite Care

<u>Under current law:</u>

A facility can offer both Assisted Living and overnight RC.

A facility can offer both Adult Day (AD) care and daytime Respite Care (RC) ***<u>if</u>*:**

- There is an available bed, and
- The individual meets the admission criteria for the facility.

If the respite care is to occur in the care recipient's home, the ALF would need a license to provide PCA or HH Aide services.

Issue #4: Consumer Protection and Rural Counties

If a combined license is created, it would be necessary to ensure that no program is operated at the expense of the others.

It may be advisable to consider:

- Training requirements for personnel that might staff ALF, AD centers, and RC programs.
- Restricting use of the new combined license to facilities operating in counties with fewer than 100,000 residents. (Requirement might be short-term or long-term)

Tennessee's Combined License Rule

The Rules of Tennessee Department of Human Services Community and Social Services Chapter 1240-07-10 Adult Day Services Standards' (2018) state:

> *When adult day services are co-located within other licensed settings such as nursing homes or assisted living facilities, states vary regarding licensure requirements. In* ***Tennessee****, if an ADC center is operated by a licensed facility such as a nursing home, the state may determine that its licensing provisions adequately regulate the ADC center's program and that a separate ADC license is not needed. But an ADC program, regardless of its affiliation or location, must comply with the program content requirements as detailed in the rules.*

Note:
- TN: Nursing homes (NH) & AD centers
- NV: ALF, AD centers, & RC (Settings Rule/Olmstead compliance)

Question 2

Q2: Identification of How Such a Facility Would Receive Medicaid Reimbursements

Medicaid payments for ALF for services:

- $23-$83 dollars per resident per day, depending on numbers of services*
- Average in non-urban counties: $46.65
- Compare to private pay average $111.48 (includes room and board charges)

Medicaid payments for AD for services: $42 per participant per day*

* These numbers are the rates prior to the 6% reduction as of July 2020. This is consistent with the assumption that the reduction is temporary, and the June 2020 rates will be restored when feasible.

Medicaid and Room & Board

By federal law, Medicaid cannot pay the room and board portion of ALF charges.

- If Medicaid is paying full cost of providing services, comparison of Medicaid rate and private pay charge implies room and board cost is $1,977 per month
- Implies room and board payments for Medicaid-eligible individual would be $23,726.

Federal Poverty Level (FPL) 2020:

- Household with 1 member: $12,760
- Household with 2 members: $17,240
- Household with 3 members: $21,720

300% SSI (Supplemental Income and LTSS eligibility): $28,188

Medicaid is payer for small proportion of ALF residents:

- 17% nationwide
- **9% in NV**

Question 3

Q3: Analysis of Feasibility of Recruiting Adequate Staff to Operate Such a Facility

Older adults are an increasing proportion of Nevada's non-urban population, and growth of the number of LTSS workers is not keeping pace.

Proportion of non-urban Nevadans who are older adults (age 65 or older):

1990:	11%
2019:	21%

2015-2019:

- The number of people employed by LTSS providers did not grow as fast as the number of older adults.
- The number of LTSS workers per 100 older adults decreased.

LTSS Providers

LTSS providers employ individuals in an array of occupations:

- Personal care,
- Healthcare practitioners,
- Healthcare support, and
- Business occupations.

Home Health (HH) & Personal Care (PC) Aides are the majority of this workforce.

- 3/4 of the weekly hours of employees working in Residential Care Communities (RCCs)
- 40% of weekly hours in Adult Day (AD) programs.

NV training requirement for PC Aides = Federal minimum:

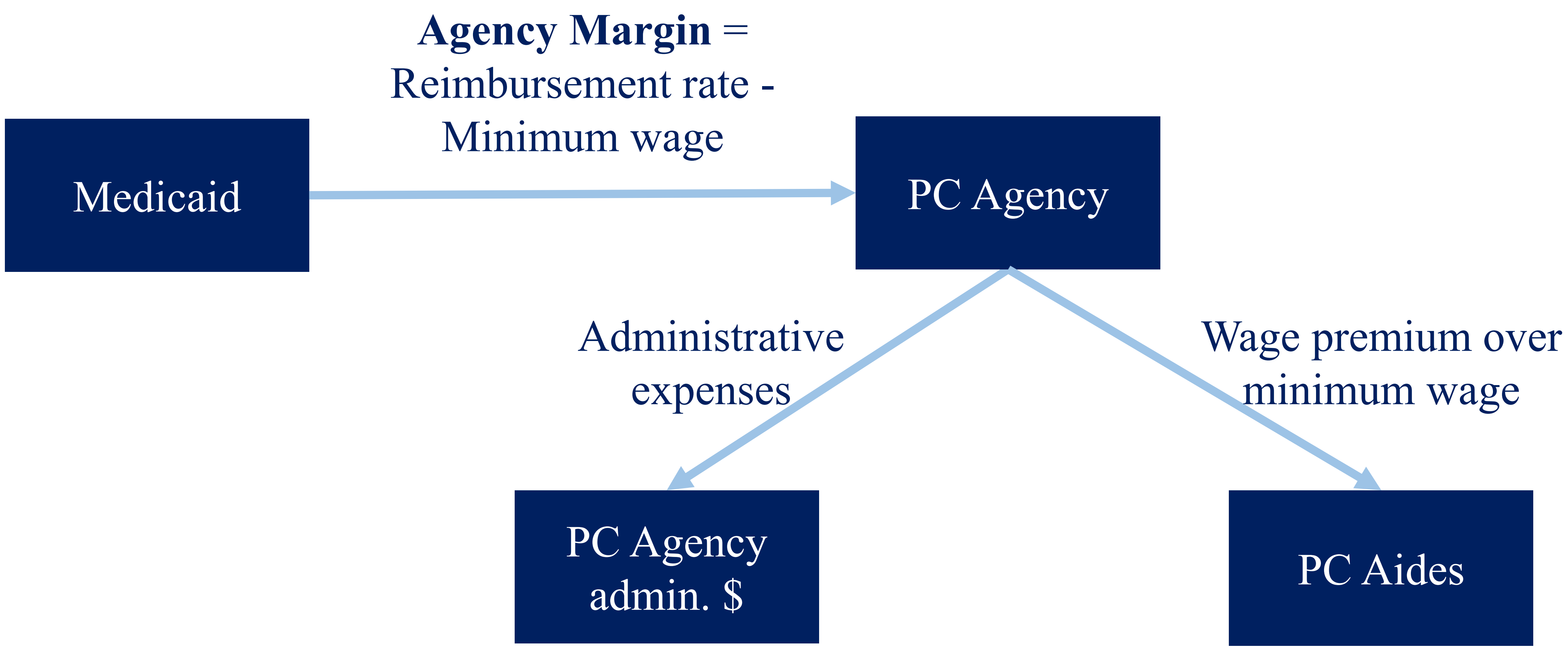
- 75 hours of initial training, including 16 hours of practical or clinical training.
- 12 hours of continuing education training each year.

Aides tend to have a high school degree or some college and be female and citizens.

PC Aide Shortage

- Nationwide concern
- 2 components
  - Supply of individuals willing to work as PC Aides (employed by PC agencies)
  - Supply of PC agencies willing to accept Medicaid payment

Medicaid → Aide Payment Model

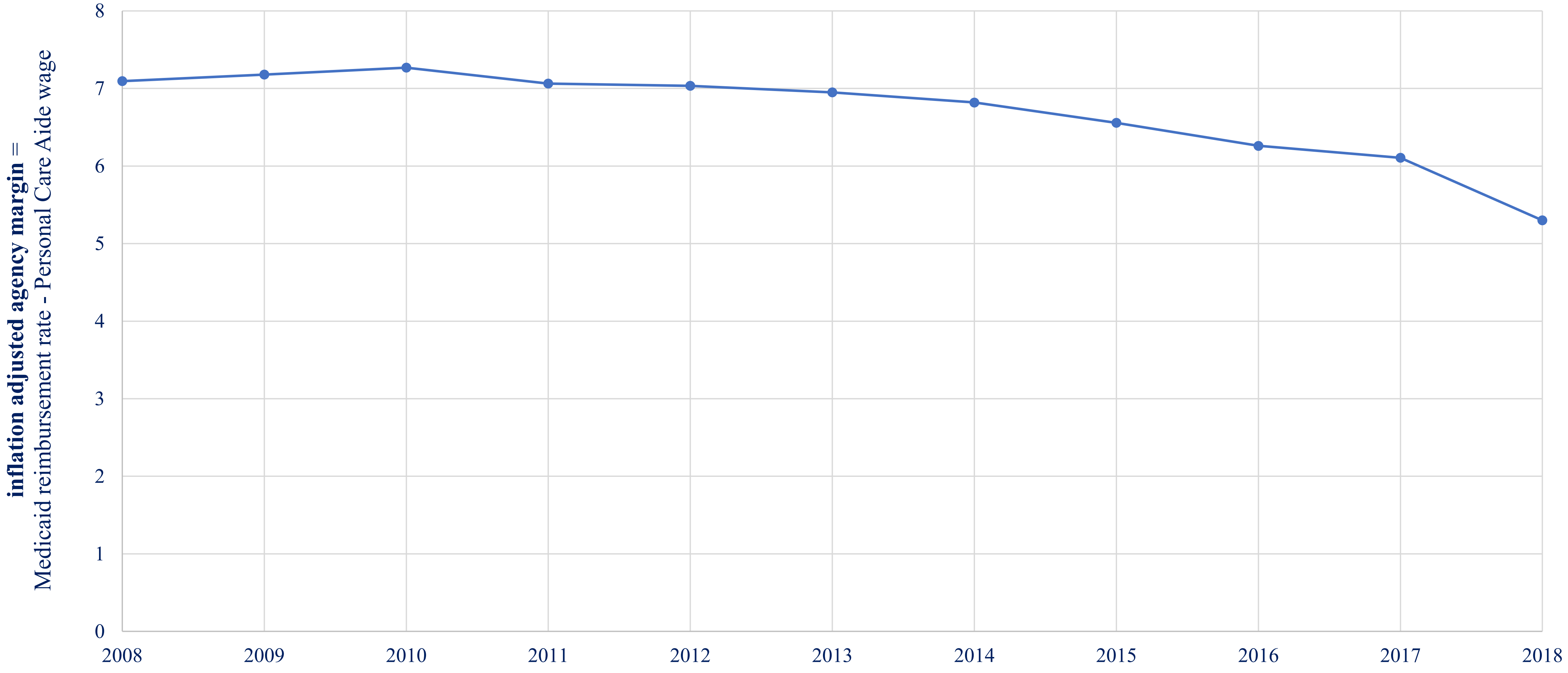


Aide Concerns (reported from national survey data)

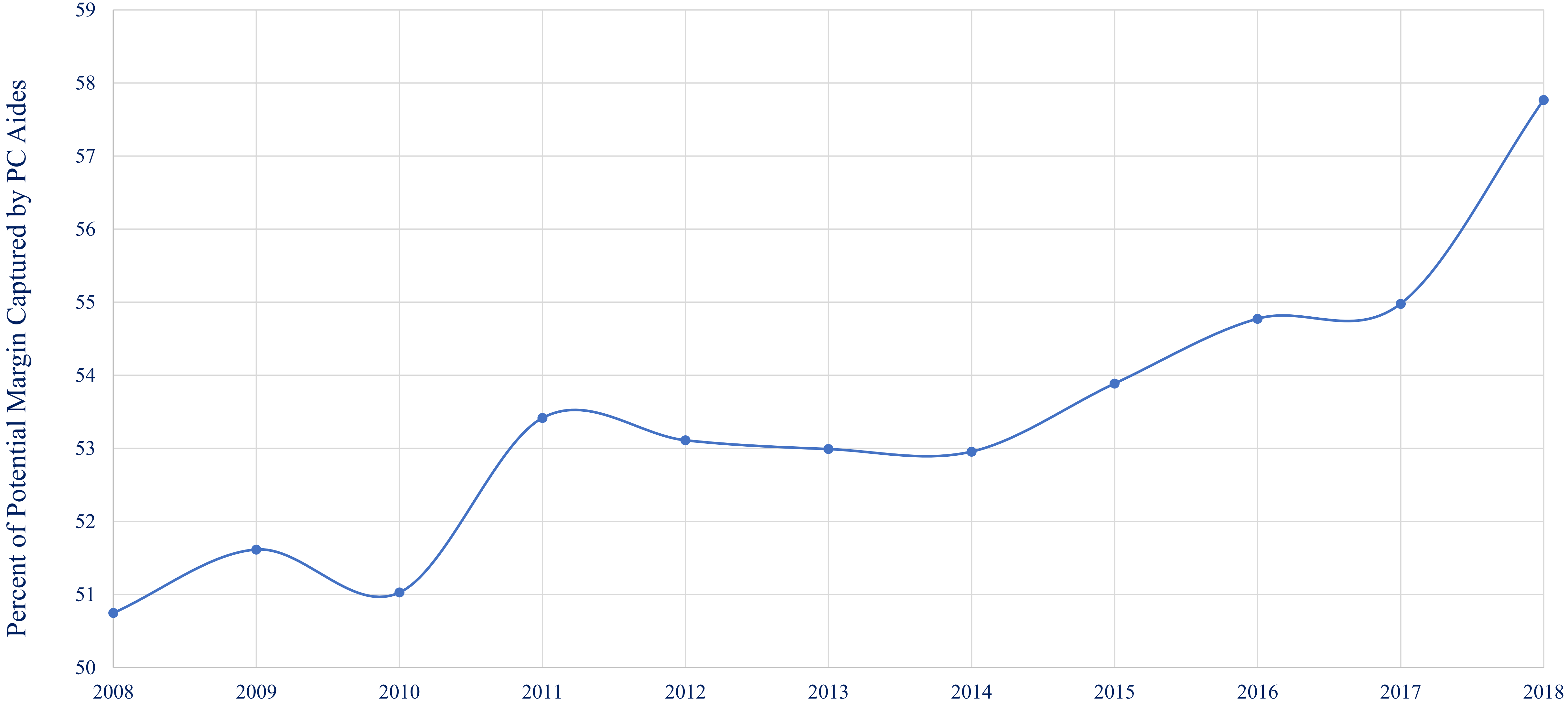
- Wage
  - Average hourly wages PC Aides in NV Nursing and Residential Care Facilities = $11.08 (*DETR*)
  - Alternate occupations are in retail, restaurants
  - Wage provides premium over minimum wage
- Worker injuries
- Insufficient work hours
- Communication with the "care team"
- Some job duties may be unpleasant

Inflation-Adjusted Agency Margins (Reported in 2018 dollars)

Inflation data: https://fred.stlouisfed.org/series/CPIAUCSL



Percent of Potential Margin Captured by PC Aides



PC Aide Agency Revenue & Costs

PC Aide Agency Rev. & Costs (Medicaid reimbursement)	Est. $ / PC Aide hour	
Medicaid reimbursement rate (assuming the rate is increased from its current level to $17.00/hour for 2021)		$17.00
Personal Care Aide wage		- $11.70
Other direct expenses for Aides other than wages including workers' compensation insurance, unemployment insurance, employer taxes, and reimbursements for travel and meals while PCAs are working	$1.79	
Caregiver recruitment and retention		
Agency Margin minus other direct expenses & recruitment/ retention		$2.89
Other agency expenses not yet considered:		
Operating costs (national survey PC agencies)		
Health insurance for employees (KFF)		

Aide travel time between clients is an agency administrative expense

- Payer Reimbursement Criteria
  - Each client is authorized to receive specific number of hours of care per day or per week
  - Most care recipients receive < 8 hours of care per day
  - Many Aides work at multiple homes or sites in a day with travel time between clients
- Nevada Medicaid
  - Reimburses PC agencies a 15-minute rate for care delivered
  - Does not specifically reimburse agencies for travel time
- Beginning in 2015, federal regulations mandate that agencies must reimburse PC aides for travel time between clients during the workday (*U.S. Wage and Hour Division, 2016*).

Issues Faced By the State

- The current rate paid to agencies is lower than the rate set in 2002. Since that time:
  - Minimum wage increases:
    - NV minimum wage increased from $5.15 per hour to $8.00 per hour (if employer offers health insurance)
    - NV law: Minimum wage = $11 per hour in 2024 (employers offer health insurance)
  - Consumer Price Index (CPI) increased 41%

Options

- Set PC Agency reimbursement rates to cover the entire time needed to deliver the service, including both the direct care time and the travel time required to arrive at the care site.

- Analyze whether PC Agency administrative costs (including recruitment/retention and travel time) are higher in non-urban counties. If so, Medicaid could create a non-urban differential for PC Services. Medicaid reimbursement rates currently include a rural differential for in-home services provided by Physical Therapists, Speech Language Pathologists and Home Health Aides, but this differential is not currently available for PC Aides.

- Complete actuarial analysis of PC Agency administrative expenses and economic analysis of the wage premium (over the minimum wage) needed to recruit/retain PC Aides.
Set the reimbursement rate to cover these costs.

Which costs should the reimbursement rate cover?

Medicaid traditionally pays lower rates than private insurers to healthcare providers such as hospitals and physicians.

- Generally, Medicaid rates are sufficient to cover variable costs, but they do not cover the share of fixed costs associated with the number of patients covered by Medicaid.
- Rates paid by private insurers cover more than their "fair share" of fixed costs, to fill the gap create by low Medicaid reimbursement rates.

LTSS differs from traditional "health care" because the proportion of individuals covered by LTSS insurance is low. Instead most individuals who are not eligible for Medicaid LTSS assistance must pay out-of-pocket.

Workforce shortage is not unique to Nevada

In 2019 and 2020:

- 30 states increased the Medicaid hourly reimbursement rate.
- 17 states implemented new workforce development policies including recruiting, training, and credentialing.

Question 4

Q4: Economic Viability of, and Payment Structure of, Such a Facility

1. **Estimate number of (adjusted) potential ALF residents**: 2 strategies to consider population distribution and population size
   - Characteristics of counties in the 8 Mountain states that do (vs. do not) have at least one ALF
   - Proportions of older adults who live in an ALF at one point in time
     - Estimate using national data
     - Apply results to Nevada's non-urban counties
2. **Costs and revenues**

Population Distribution

Data on non-metropolitan counties 8 Mountain States:

- *P*(>= 1 ALF) is significantly affected by the presence of a town with at least 2,500 people.
- One county that does not have an ALF but is estimated to be relatively likely to have one is Eureka.

Counties with 1+ ALFs in Eight States

Characteristics of counties in the 8 Mountain states that do (vs. do not) have at least one ALF

Table 7.3 Impacts of County Characteristics on the Probability that at Least one ALF Operates in the County

Independent Variable	OLS Regression Coefficient	P-value
ADJACENT	0.128	-0.189
ADJACENT-SQUARED	-0.0412	-0.323
CORE	0.396***	-0.001
CORE-SQUARED	-0.0679	-0.242
AZ	0.101	-0.59
CO	0.248	-0.053
ID	0.352**	-0.008
NM	0.182	-0.189
MT	0.382**	-0.003
UT	0.509***	0
WY	0.271	-0.061
CONSTANT	0.12	-0.347
N	215	-
R-square	0.252	-

Dependent variable is binary variable equal to 0 if no ALF operates in the County, and 1 if the county has at least one ALF

County level data for non-metropolitan counties in the 8 Mountain states. Variable definitions based on the USDA ERS Urban Influence Codes.

One-tailed significance tests. *** p<=0.001, ** p<=0.00=1, ** p<0.05

Probability of 1+ ALFs in Nevada (Non-Urban) Counties

- *P*(ALF) <0.60; do not have a town with at least 2,500 residents

Carson City, Clark, Storey, and Washoe counties are not included because they are classified as metropolitan or micropolitan.

Table 7.4: Predicted Probability of at Least One Operating ALF in County

Non-urban Nevada counties

County	Predicted Probability
Churchill County, Nevada	0.73
Douglas County, Nevada	0.65
Elko County, Nevada	0.64
Esmeralda County, Nevada	0.21
Eureka County, Nevada	0.64
Humboldt County, Nevada	0.64
Lander County, Nevada	0.54
Lincoln County, Nevada	0.46
Lyon County, Nevada	0.73
Mineral County, Nevada	0.45
Nye County, Nevada	0.65
Pershing County, Nevada	0.21
White Pine County, Nevada	0.45

Population Size

Adjusted potential ALF residents (estimates based on analysis of national data)

- <=40 in 7 non-urban NV counties
  - 6 do not have an ALF
  - 7th has 10 ALF beds
- 40-99 in 2 non-urban NV counties
  - 1 does not have an ALF
  - 1 has 10 ALF beds
- >=100 in 8 non-urban NV counties
  - All have at least 57 ALF beds

Differences between adjusted potential ALF residents and existing ALF beds exceed 100: Elko, Douglas, Lyon, Nye, Clark and Washoe (all 6 of these counties have >= 50 beds)

ALFs & Licensed Beds in Nevada Counties

Table 7.6: Potential Older-Adult ALF Residents and Existing Numbers of Licensed Beds

Counties Grouped by Potential Older Adult ALF Residents

County	Number of Older Adults (2018)	Estimated Number of Potential Older-Adult ALF Residents	Adjusted Number of Potential Older-Adult ALF Residents (to reflect lower proportion of ALF residents with Medicaid as a payer in Nevada, compared to U.S.)	Existing Number of Licensed ALF Beds	Difference between Adjusted Number of Potential Older-Adult ALF Residents and Existing Number of Licensed ALF Beds
Counties with 39 or fewer potential ALF residents					
Esmeralda	269	8	8	0	8
Eureka	283	9	8	0	8
Lander	822	26	24	0	24
Lincoln	1,225	38	35	0	35
Mineral	1,099	34	32	0	32
Pershing	1,061	33	31	10	21
Storey	1,176	37	34	0	34
Counties with 40-99 potential residents					
Humboldt	2,083	65	60	10	50
White Pine	1,587	50	46	0	46

ALFs & Licensed Beds in Nevada Counties (continued)

Table 7.6: Potential Older-Adult ALF Residents and Existing Numbers of Licensed Beds

Counties Grouped by Potential Older Adult ALF Residents

County	Number of Older Adults (2018)	Estimated Number of Potential Older-Adult ALF Residents	Adjusted Number of Potential Older-Adult ALF Residents (to reflect lower proportion of ALF residents with Medicaid as a payer in Nevada, compared to U.S.)	Existing Number of Licensed ALF Beds	Difference between Adjusted Number of Potential Older-Adult ALF Residents and Existing Number of Licensed ALF Beds
Counties with 100-299 potential residents					
Carson City	10,018	313	289	382	-93
Churchill	4,446	139	128	112	16
Elko	5,477	171	158	57	101
Counties with 300-999 potential residents					
Douglas	12,611	394	364	236	128
Lyon	10,937	342	316	145	171
Nye	12,644	395	365	118	247
Counties with more than 1,000 potential residents					
Clark	301,845	9,441	8,714	6,153	2,561
Washoe	69,819	2,184	2,016	1,821	195

In Nevada, 9.3% of ALF residents have Medicaid as a payer. The comparable number for the U.S. is 17%.

Source: Project team analysis of NHATS and ACS 2018 data.

Accompanying Spreadsheet Tool

A spreadsheet to facilitate preliminary analyses of proposed projects accompanies this chapter.

- Financial analysis focuses on revenues, fixed and variable operating costs
  - Net operating income (NOI: Is NOI sufficient to cover Reserves and Debt Service?
  - Sensitivity to underlying assumptions
  - Business risk

The example analysis uses secondary data on costs.

- Wages: DETR
- Staffing: NSLTCP
- Other operating costs: 2019 State of Senior Housing Cost Report (*ASHA*)
- Construction costs:
  - Average: State of Senior Housing Cost Report (*ASHA*)
  - New construction: RS Means
- Revenues: Genworth Financial and DHCFP

Conclusion

Small facilities (10 beds) NOI < 0

Mid-size facilities (>= 20 beds) NOI > 0

- NOI sufficient to cover Reserves and Debt Service at level indicated in ASHA survey
- This Debt Service amount does not reflect new construction costs.

Costs and Revenues

A. Estimate the average number of residents each month		
	Number of Residents (=number of **Occupied Beds**)	**20**
	B.1. ASHA: occupancy rates typically average 91%.	
	Number of **Built Beds**	**22**
	B.2. ASHA: average number of square feet of personal space per built bed is 541 ft^2; average non-private space for every 100 ft^2 of personal space is 73 ft^2.	
	Total Facility Square Footage	**20,570**

Revenues

- Median monthly charge for an individual in an ALF in NV is $3400 (*Genworth Financial*)
- The average daily Medicaid reimbursement rate: $46.65 in Nevada's non-urban counties

- In the example constructed in the Excel template, we assume ALF receives $3400 per month from each resident.

Estimate Revenues

Step 2: Estimate revenues. Assume number of built beds = 22				
Payer Type	**Residents with Each Payment Source**		**Monthly Payment Rates**	**Revenue**
	Proportion NSLTCP	***Number of Residents (rounded)***		
Medicaid	9.3%	2	$3,400	$6,800
Private Pay	90.7%	18	$3,400	$61,200
Revenues			**TOTAL**	**$68,000**

Fixed Costs

Fixed Costs			
		Monthly Cost	
Facility Director **($66,800 salary + 30% benefits)**	$87,000	$7,250	$363
Executive Chef **($44,500 Salary + 30% Benefits)**	$58,000	$4,833	$242
Annual License Renewal Fee		$99	$5
		$12,183	**$609**

Costs that Vary with the Number of Residents

Costs that Vary with the Number of Residents

Registered Nurse	0.01	$35.96	$43.87	$0.44	$267	$13
Licensed Practical Nurse	0.02	$26.24	$32.01	$0.64	$389	$19
Personal Care Aide	1.59	$11.08	$13.52	$21.49	$13,075	$654
Social Worker					$253	$13
						$699

Other Variant Costs

Other costs that Vary by the Number of Residents	Total	Per Resident
Annual License Renewal Fee per Bed	$167	$8
Other Labor (admin, food prep, activities, housekeeping, marketing)	$15,185	$759
Other Non-Labor Costs (raw food, activities, supplies, marketing)	$7,584	$379
Workers Compensation	$875	$44
Total Other costs that Vary by the Number of Residents	**$23,810**	**$1,191**

Costs that Vary with Space

Costs that Vary with the Number of Square Feet			
	Monthly Cost per Ft^2	Monthly Cost	
		Total	*Per Resident*
			$256

Net Operating Income (NOI)

Net Operating Income	Total	Average per Resident
Total Monthly Revenues	$68,000	$3,400
Total Monthly Operating Costs	$55,103	$2,755
Net Operating Income	$12,897	$645

Step 5-7 Estimates

Step 5: Capital Costs and Replacement Reserves (Per Resident)		
Replacement Reserve (ASHA participants)	$1,321	$110
Step 6: Compute Net Operating Income - Replacement Reserve and Debt Service		
Step 7: Compute (NOI -Replacement Reserve -Debt Service)		
		$535
		$436

New Construction Costs & Considerations

National cost estimate (2013):

- New construction
- 22,500 sq. ft. apartment building, 1-3 stories
- Open shop
- No land acquisition or site work

https://www.rsmeans.com/model-pages/apartment-1-3-story

Debt Service

- 100% loan
- 2% interest, 30 years
- Monthly debt service = **$540**

NOI would barely cover Replacement Reserve and Debt Service for 20-resident facility with new construction, without considering:

- Costs associated with licensure requirements to cause ALF construction cost to exceed the cost of building an apartment building, or
- Reduced revenue from individuals with Medicaid coverage.

Seven NV counties have fewer than 40 potential adjusted ALF residents.

Sensitivity Analysis

			$609	$305	
		$36	$645	$949	
		($74)	$535	$839	

Business Risk Considerations

Business Risk: Actual number of residents < Expected number

1. 20% drop in occupancy is more likely in smaller facilities, if individual decisions to live in ALF are independent
2. Below-expected occupancy has greater impact on Net Operating Income in smaller facilities.

Facility Size & Business Risk

Impact of Facility Size on Business Risk		
	$12,897	$88,136
Net Operating Income if actual residents = 80% of expected residents (monthly)	$ 6,856	$63,972
		-27%

Question 4 Summary

- Small facilities (20 beds or fewer):
  - Can generate revenue to cover operating costs
    - Are not likely to generate sufficient net operating income (NOI) to also cover capital costs associated with new construction
    - Fixed costs represent a higher monthly cost per resident in small facilities than in larger facilities
  - Smaller facilities face greater risk regarding occupancy than larger facilities:
    - If occupancy is only 80% of expected, greater percentage reduction in monthly NOI
    - If occupancy reflects decisions made by individuals, probability of a 20% reduction in demand is larger for small facility than for larger facility.
- In NV counties with fewer than 40 potential adjusted ALF residents, creative project design may be needed.

Question 5

Q5: Identification of Technical, Economic and Legal Barriers to the Establishment and Operation of Such a Facility

Technical Barrier: Broadband services in some of Nevada's non-urban counties

Coordination between LTSS providers and health care providers (EMR/HIE):

- Substantial proportions of ALF residents have diagnosed medical conditions,
- 6% of ALF residents had an overnight hospital visit during the ALF stay, and
- 13% had an emergency room visit (*Ch. 4*).

Telemedicine and/or remote monitoring of patient biometrics.

- Require broadband
- Could generate efficiencies (*Ch. 2*).

Economic Barriers

1. The lack of ALFs in some of Nevada's rural counties suggests that these facilities are not financially viable at the scale likely to be useful in areas with small populations and low population density. This is consistent with the ROM financial analysis.

2. The current Medicaid reimbursement rate for PC Aides may exacerbate the workforce shortage issue facing all states (*Q3 & Ch. 3*).

Legal Barriers

1. A combined ALF/AD license is not currently permitted (*Ch. 2*).

2. The number of slots available for accessing waiver services creates waitlists for ALF and AD services. July 2020:
   - 98 individuals waitlisted for the People with Intellectual Disabilities waiver
   - 666 waitlisted for the Frail Elderly waiver
   - 175 waitlisted for the Adults with Physical Disabilities waiver.

Reducing or eliminating the WLs could have two fiscal effects:

- Increased access to HCBS may postpone or eliminate costlier NH stays.
- Providing HCBS to an expanded number of eligible individuals could increase total cost if these services are utilized by individuals who would not have needed NHs in the absence of the HCBS.

Lack of Transportation

Lack of transportation is a barrier to AD services.

- DHCFP contracts with MTM to manage non-emergency transportation to Medicaid-covered services.
- Medicaid pays a fixed amount per-Medicaid-member per-month (PMPM) to MTM.
- MTM reimburses transportation vendors for covered transportation.
- Vendors do not operate in all areas. Entities offering AD services can apply to operate a transportation service.
- MTM also reviews applications to determine whether the applicant will be permitted to offer the transportation service.
- Anecdotal evidence suggests the application process can be lengthy and inefficient.

Separating the function of evaluating applicants from the function of administering payment for transportation services could produce better alignment between the policy goal of providing transportation and the incentives facing the entity that administers transportation payments.

Question 6

Q6: Possible Timelines for Creating Pilot Programs

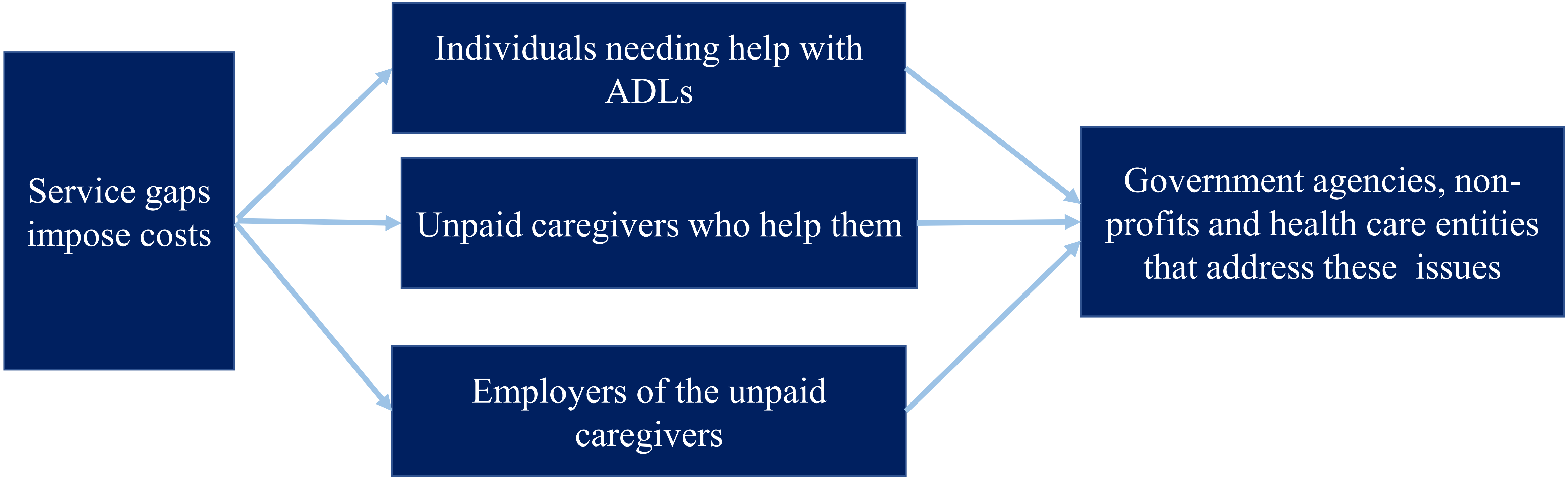
Nevada’s non-urban counties may pursue a variety of strategies to strengthen the local availability of LTSS.

For any specific project, the timeline will depend on project details and the timing of relevant state policy changes.

This section provides information about:

- Key background information
  - Costs of current service gaps
  - Support for informal caregivers
  - Additional background information
- Potential project types
- Government action to facilitate each project type that could shape project timelines

Background Information: Costs of Current Service Gaps



Background Information: Costs of Current Service Gaps - Self-Neglect

Self-neglect cases: 39% of elder abuse cases in NV non-urban counties.

Nevada’s non-urban counties:

- 11% of the state’s population
- 19% of the state’s cases of self-neglect

Background Information: Costs of Current Service Gaps - Coping Strategies

Stakeholder Interviewees on Coping Strategies

- Elders receive assistance from family, friends, and neighbors,
- Elders are dropped off and abandoned at the local hospital
  - national news: "pop drop events"
  - One hospital staff member: *This doesn't happen frequently, but it happens more often that you would think*, and
- Elders move to another county or urban area to receive needed services.

Background Information: Costs of Current Service Gaps – unpaid caregivers

Caregiving

Adverse impacts

Caregiver health

Caregiver employment

National survey: 871 employed C.G.S.
15% missed work preceding month due to caregiving

Background Information: Support for Informal (Unpaid) Caregivers & Care Recipients

Approximately 330,000 individuals provide unpaid care in Nevada.

Reasons to provide support:

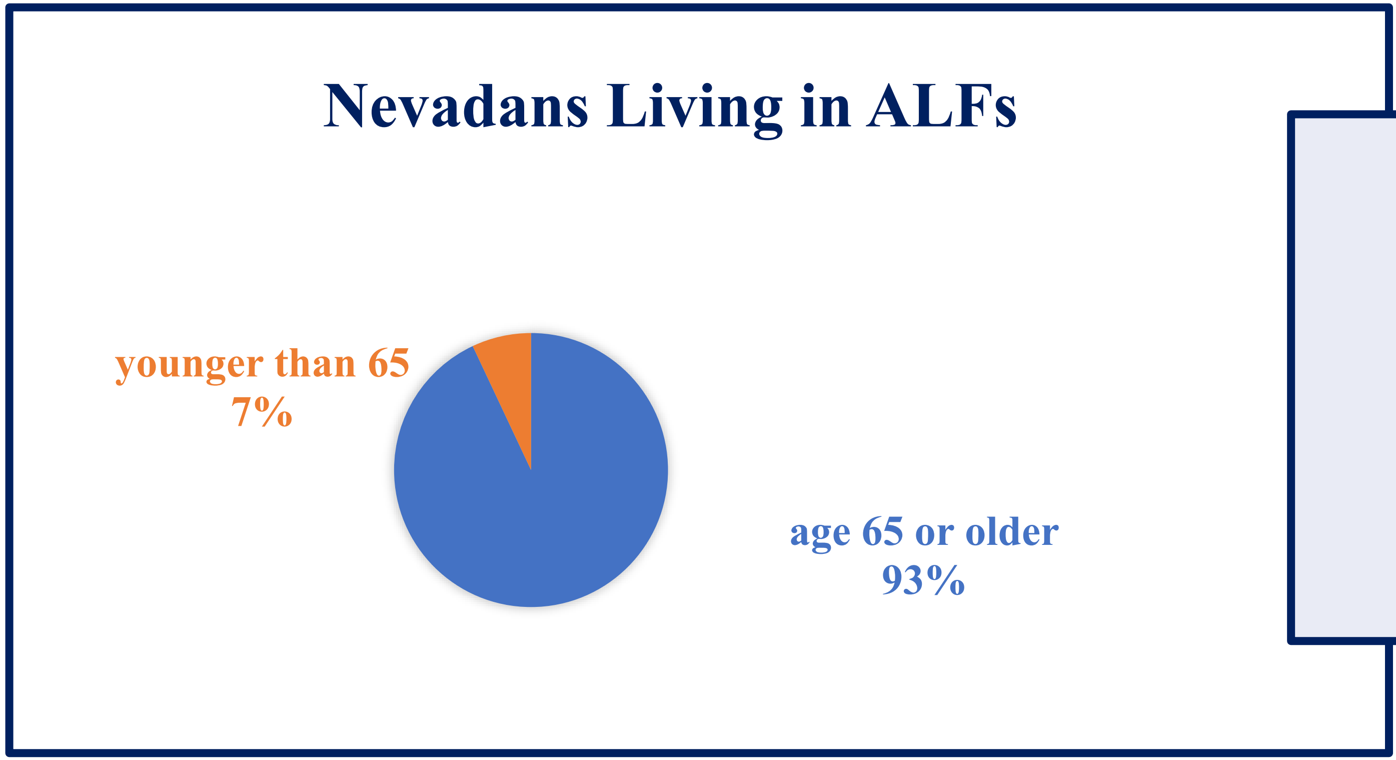
1. Equity: Individuals with incomes below the federal poverty level are more likely to be caregivers than individuals with higher incomes.
2. Financial: Unpaid care delays the need for paid care.

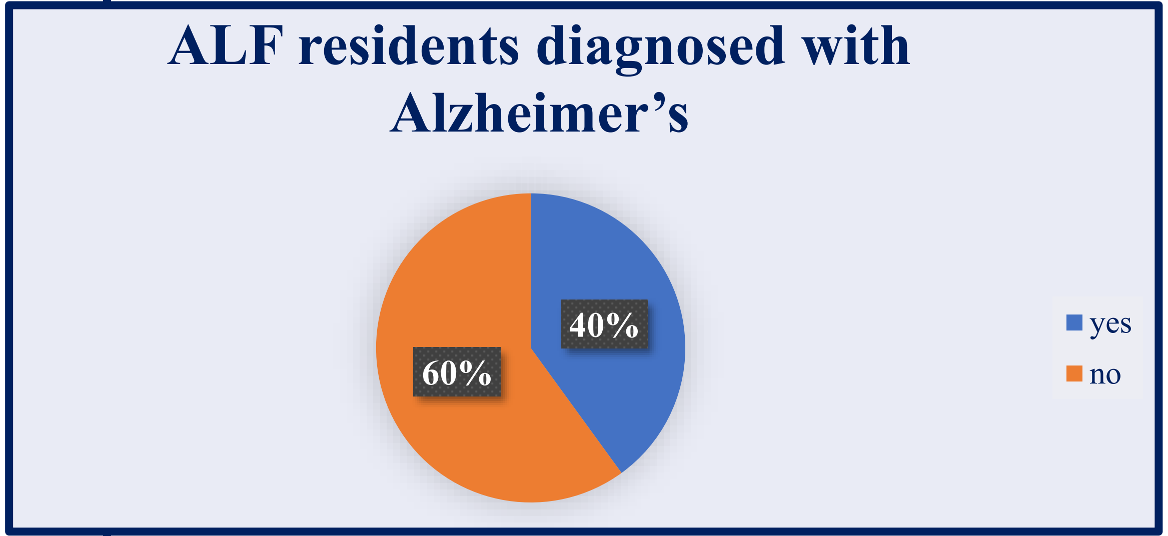
In Nevada (2020), private sector employers with >=50 employees…

- must provide a minimum amount of paid leave,
- cannot require the employee to provide a reason (gives employees flexibility to use the leave time to carry out caregiving duties).

Stakeholder Interviewees: Respite Care and Adult Day programs are important, and they are not available in all areas

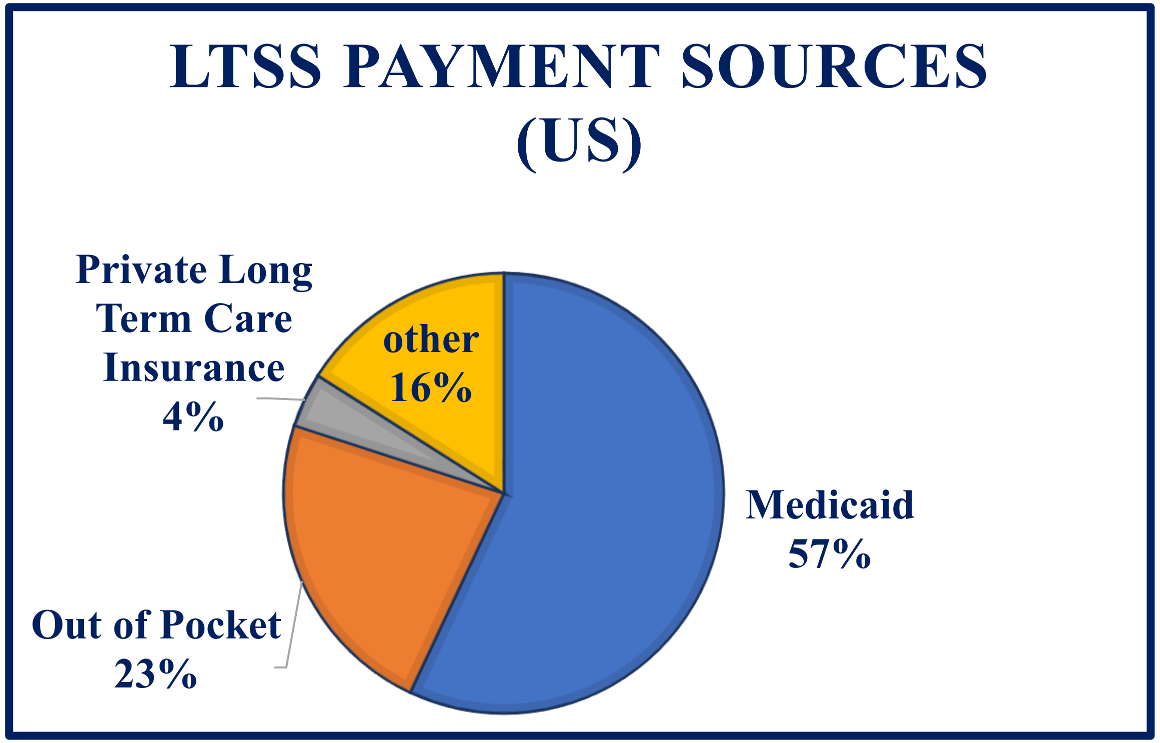
Background Information: Diverse Individuals Utilize ALFs





Individuals over age 80 are more likely to live in ALFs than individuals age 65-80.

Background Information: LTSS Payment Sources and Current NV Capacity



ALF beds per 1,000 older adults & AD capacity: NV is similar to the US overall

However:

- No licensed ALFs in 7 NV counties
- No licensed AD facilities in 14 NV counties

Background Information: Additional Considerations

Emerging technologies may make it possible for facilities and LTSS workers to assist and monitor patients in new, more efficient and effective ways than current strategies.

- could alter ALF and AD cost structures.
- could require new strategies for consumer protection.

  Example: licensed professional dispenses medication vs. licensed professional organizes medication in electronic dispensing machine.

All Home and Community Based Services (HCBS) reimbursed by Medicaid must comply with the CMS “Settings Rule.”

All LTSS providers must comply with the 1999 U.S. Supreme Court decision in *Olmstead v. L.C.*, regardless of the entity that will pay for the service.

Background Information: Additional Considerations

Medicaid cannot reimburse ALFs for the room and board portion of the monthly charge.

Individuals who are otherwise eligible for SNAP benefits:

- cannot receive SNAP benefits while living in an ALF
- can receive SNAP while living in federally-subsidized housing for the elderly.

https://www.fns.usda.gov/snap/eligibility/residents-assisted-living-facilities-meal-options

Medicaid LTSS | **SNAP** | **Housing assistance**

Individual with low income

Background Information: Additional Considerations

Medicaid LTSS

SNAP

Housing assistance

Individual with low income
lives in subsidized housing with Medicaid reimbursed HCBS

Medicaid LTSS

SNAP

Housing assistance

Individual with low income
lives in licensed ALF with placed based or person based housing voucher

Medicaid LTSS

SNAP

Housing assistance

Individual with low income
lives in traditional licensed ALF

Four Potential Models for Medicaid-Covered Assisted Living

- Federally-subsidized housing with supportive services (not licensed ALF),
- Combined-License ALF with AD,
- Tiny House Villages or Pocket Neighborhoods (Licensed facility),
- Rural PACE (Program of All-Inclusive Care for the Elderly).

Broader Options

Broader perspective: assist individuals needing help with ADLs/IADLs:

- Build and operate a facility that offers ALF, AD and RC services under a combined license
  - Without housing assistance (green boxes, previous slide)
  - Provide housing vouchers, or other assistance, for individuals living in licensed ALF (blue boxes, previous slide)
- Develop systems to coordinate LTSS services to individuals living in subsidized housing units or receiving housing vouchers (gray boxes, previous slide)
- Develop mechanism to increase the PCA and HH Aide workforce to increase availability of HCBS
- Strengthen AD and RC supports for unpaid caregivers

State Actions to Provide Framework

State actions to provide framework supporting range of project options:

- Create combined license
- Set reimbursement rate for PC Agencies that covers total costs in non-urban and urban counties
- Increase the number of waiver slots to minimize or eliminate wait lists
- Increase the availability of housing and energy assistance
- Strengthen transportation services in rural counties
- Strengthen coordination between NV DHHS and NV Housing Division to facilitate development and implementation of programs such as Section 811 housing vouchers
- Increase broadband service availability in non-urban counties

Potential Project #1

A facility to offer ALF, AD, and RC services under a combined license

State actions to facilitate this project:

- Create combined license
- Increase the number of waiver slots
- Set reimbursement rates for ALF and AD services that cover total cost
- Increase the availability of transportation services
- Increase broadband service availability

Potential Project #2

Strengthen the package of services provided to low-income individuals currently living in small houses near a primary care clinic, to possibly include:

- In-home visits by physicians, community health workers, and/or medical assistants,
- Improved coordination of health care services and LTSS, and
- Assistance with applications for services such as energy assistance or SNAP.

State actions to facilitate this project:

- Increase the number of waiver slots
- Establish reimbursement rates for Personal Care services and AD that cover total cost
- Increase the availability of transportation services
- Increase broadband availability
- Increase housing assistance

Potential Project #3

Create a system that allows low-income individuals to receive housing subsidies while living in an ALF.

State actions to facilitate this project:

- Increased availability of place-based or person-based housing vouchers, or other housing assistance
- Implement the Section 811 program
- Create combined license
- Increase the number of waiver slots
- Set reimbursement rates for ALF and AD services that cover total cost
- Increase availability of transportation services

Low Income Housing Tax Credit (LIHTC) financing has limited usefulness for helping individuals with low incomes afford the room & board portion of ALF charges. Projects financed with LIHTCs screen renters to ensure they have enough income to be able to afford the rent payments, while Medicaid LTSS assistance is available to qualifying individuals who have low incomes. The set of people who can meet both criteria is a small subset people with low and moderate incomes who cannot afford ALF room & board charges.

Thank you!

Questions?