Long Term Services and Supports in Rural Nevada

Study mandated by AB122

Preliminary Report

AB122 topics

a. Feasibility of creating a single license (ALF and AD)
b. Medicaid reimbursement for ALF and AD
c. Feasibility of recruiting staff
d. Economic viability and payment structure for the facility
e. Technical, economic and legal barriers to the establishment and operation of such a facility; and
f. Timeline for creating a pilot program

Feasibility of creating a single license (ALF /AD)

Licensure of combined ALF/AD facility

Pertaining to AD facilities:

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. (NAC)

Pertaining to ALFs:

•A residential facility may be licensed as more than one type of residential facility if … it complies with the requirements for each type of facility .. . (NRS)

•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 the licensure Board:

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 … (NRS)

Regulatory Review of Adult Day Services: 2014 Edition (O'Keeffe et al., 2014)

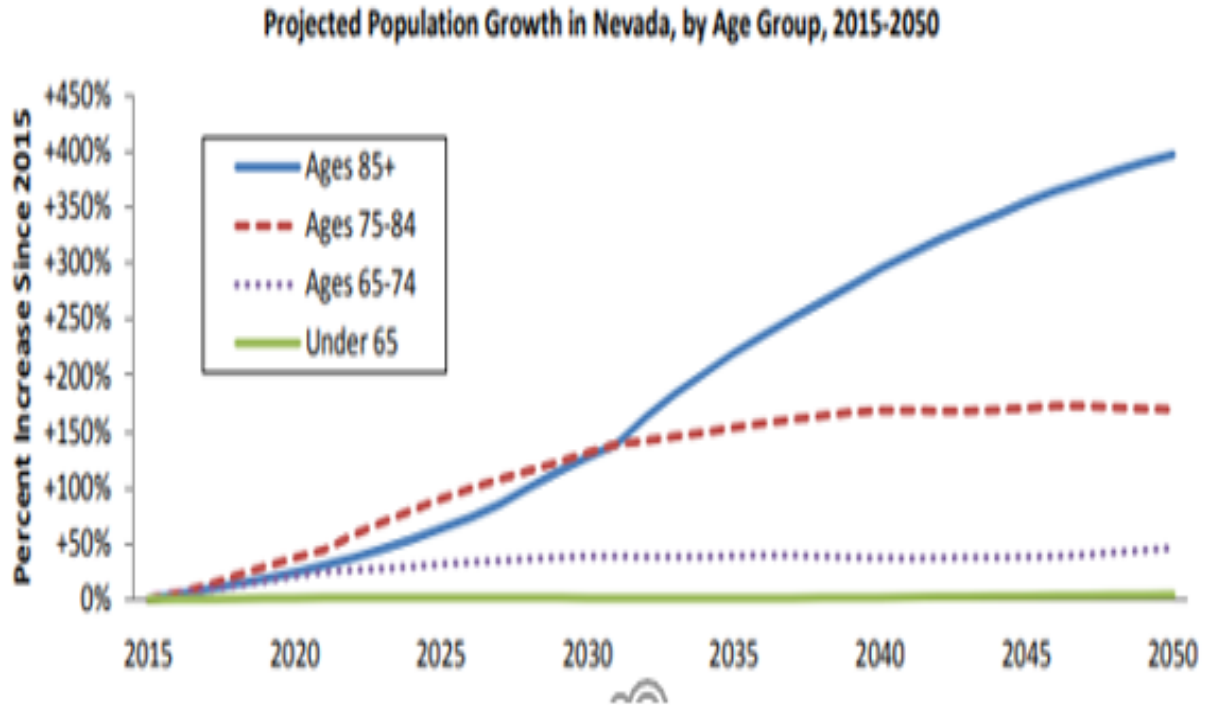
Tennessee:

AD center that operates in a licensed nursing home does not need to obtain a second license for the Adult Day Center. Tennessee regulations allow the nursing home licensing provisions to suffice. However, the Adult Day program must comply with state requirements.

Opportunity for flexibility:

Shift capacity ALF vs. AD

Figure 4-5: Projected population growth in Nevada by age group, 2015-2050



Source: Across the States 2018: profile of long-term services and supports in Nevada. AARP Public Policy Institute

Age 65-80: AD

Age 80+ : ALF

concerns

1. Quality assurance all services under the license
2. Settings Rule compliance
   - Cannot be owned by institution or co-located with institution
   - Cannot isolate clients from community: Must offer choice of service providers

   Would combined ALF/AD need to offer choice of service provider for activities? If so – what would this mean? How would this relate to the licensure requirement that ALF and AD must offer activities?

   Note: CMS: degree of choice must be similar to choices available to other people living in the same area

Opportunities for ALF/AD efficiencies:

Both types of facilities must have:

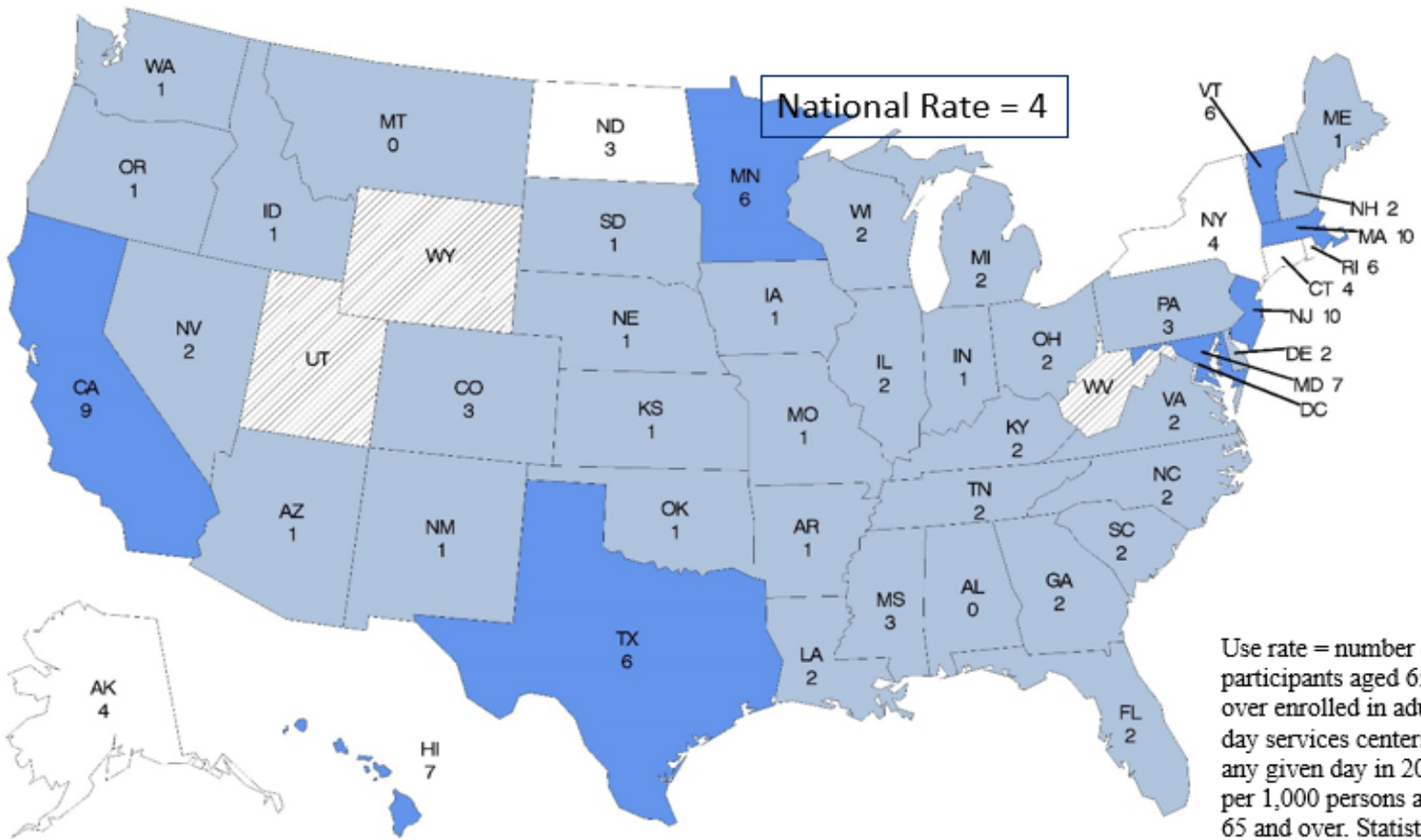
- director/administrator
- staff trained in first aid and CPR; first aid kit
- activities (space and staff)
- food planning, reparation and serving; dietary consultants
- laundry
- systems
  - health: administer medications; monitor client health
  - administration: resident/client records, admissions, employee training
  - building: facility maintenance, inspections, security

Medicaid reimbursement

LTSS Scorecard	
AARP Foundation, Commonwealth Fund, SCAN Foundation	
Indicator	**Nevada Rank**
Affordability and Access	50
Choice of Setting and Provider	47
Quality of Life & Quality of Care	23
Support for Family Caregivers	25
Effective Transitions	29

Chapter 4: Demand

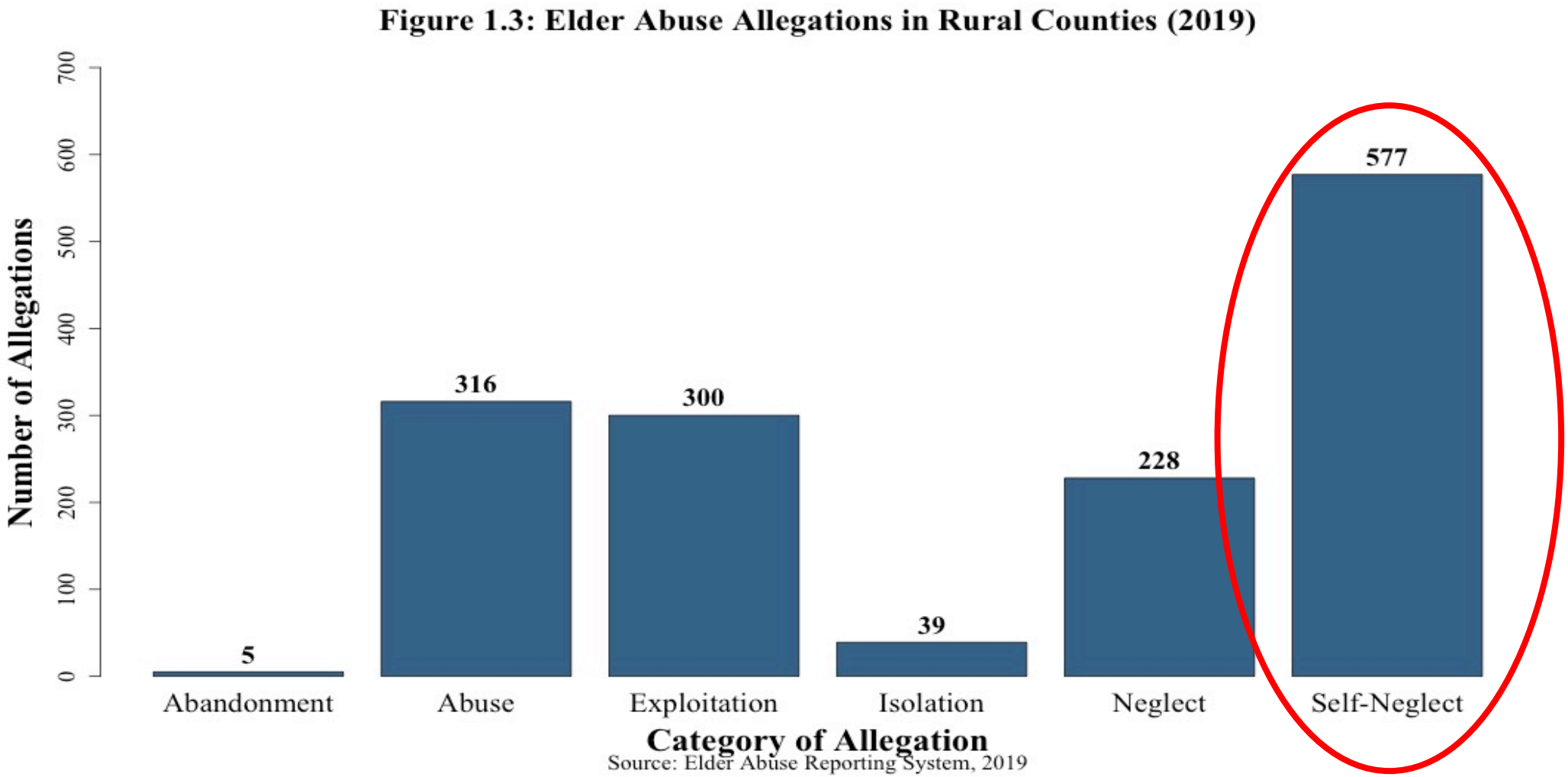
Figure 4-1a: Use rate of adult day services center participants aged 65 and over: United States, 2016



Use rate = number of participants aged 65 and over enrolled in adult day services centers on any given day in 2016 per 1,000 persons aged 65 and over. Statistical significance tested at $p < .05$.

Source: NCHS, National Study of Long-Term Care Providers, 2016

Human costs of absence of services



IMPACTS OF CAREGIVING

		significant impacts
HEALTH AT AGE 50 vs. AGE 40		
	Physical Health	-3 on 100 pt. scale
	Mental Health	-2 on 100 pt. scale
EMPLOYMENT		
	Whether Employed	lower probability by 0.02
	Hours Worked	74 fewer hours per year
INCOME		
	Caregiver earnings	lower by $1900
	Total Net Family Income	lower by $2400

Health regression is OLS; n=6107. Employment and income regressions are FE; n=29,785)

OLS regressions controlled for health at age 40, race, gender, family size, region of the country, marital status, years of education, and age and age-squared. All FE regressions controlled for family size, region of the country, marital status, years of education, and age and age-squared.

National Longitudinal Survey of Youth 1979; all survey waves through 2016.

	capacity per 1000 adults age 65+	
	ALF beds	AD slots
Nevada	20.1	7
U.S.	19	5.7

	capacity per 1000 older adults (65+)	
	ALF	AD
ABOVE-AVERAGE # ALF BEDS		
Carson	33	-
Churchill	28	-
Washoe	25	2
Clark	20	10
BELOW-AVERAGE # ALF BEDS		
Douglas	18	2
Lyon	13	-
Pershing	10	-
Nye	9	-
Elko	8	-
Humboldt	5	-

NO ALF BEDS; NO AD
Eureka
Lander
Lincoln
Mineral
White Pine
Esmeralda
Storey

Federal law requires state Medicaid program to establish methods and procedures to ensure that Fee for Service (FFS) Medicaid beneficiaries can access services to at least the same extent as the general population in the same geographic area.

http://dhcfp.nv.gov/Resources/AccesstoCare/NevadaAccesstoCareMonitoringReviewPlan/

Current system in NV: FFS
Medicaid reimburses for services, not facilities

question

Is there flexibility in current rate structures to add or enhance adjustment for potentially higher costs in rural areas?

- Diseconomies of small scale
  - Requirement that staff must be present when clients are present
  - Nutritionist must review menus periodically
- Distance
  - Fire alarm inspectors drive from urban counties
- Higher prices/wages

Key limitation of Medicaid reimbursement system

Federal law: Medicaid cannot make direct payments for housing

This restricts demand for ALF:

- LTSS eligibility: 3*SSI. Upper end of this income range may be able to pay for room and board charges at ALF. Lower end?

Medicaid does not pay for the room and board portion of ALF

Medicaid assistance with LTSS

Social Determinants of Health

Housing subsidies

1. CMS approved North Carolina's Section 1115 Waiver application in 2019.
    - Healthy Opportunities pilot programs.
    - may use Medicaid funds to pay for non-medical services, including payments for short term (up to six months) of housing (post-hospital-discharge) for individuals at risk of homelessness.

A KFF report on this waiver explains:

"Generally, states have not been able to use federal Medicaid funds to pay the direct costs of nonmedical services like housing and food. Under federal Medicaid managed care rules, managed care plans have some limited flexibility to pay for non-medical services.

… This waiver allows the state to use Medicaid to pay directly for non-medical interventions that target the social determinants of health, although the program scope is restricted by its limited funding"

2. As of 2019, 27 states were contracting with managed care companies to administer LTSS (MLTSS).

Of these, MLTSS is mandatory for:

- Seniors and Persons with Physical Disabilities in 15 states
- Persons with I/DD in 6 states

<u>two potential benefits:</u>

- Improved coordination of care, and
- Program design flexibility to address social determinants of health.

footnote 2 in the KFF report:

"Under federal Medicaid managed care rules, Medicaid MCOs may have flexibility to pay for non-medical services through "in-lieu-of" authority …. "In-lieu-of" services are a substitute for covered services and may qualify as a covered service for the purposes of capitation rate setting."

"Some Medicaid managed care organizations have recognized this need and are testing ways to provide rental assistance. For example, Health Plan of San Mateo in California pairs health care services with ongoing housing assistance for over 120 people to avoid nursing home care costs. As of 2017, the plan's costs for these members had fallen by 50 percent".

3. State Medicaid programs are exploring options for addressing the housing affordability by collaborating with Housing and Urban Development (HUD) programs.

Recent Health Affairs blog post: Medicaid should **not** pay for housing:

(i) Medicaid should focus its limited resources on healthcare, and

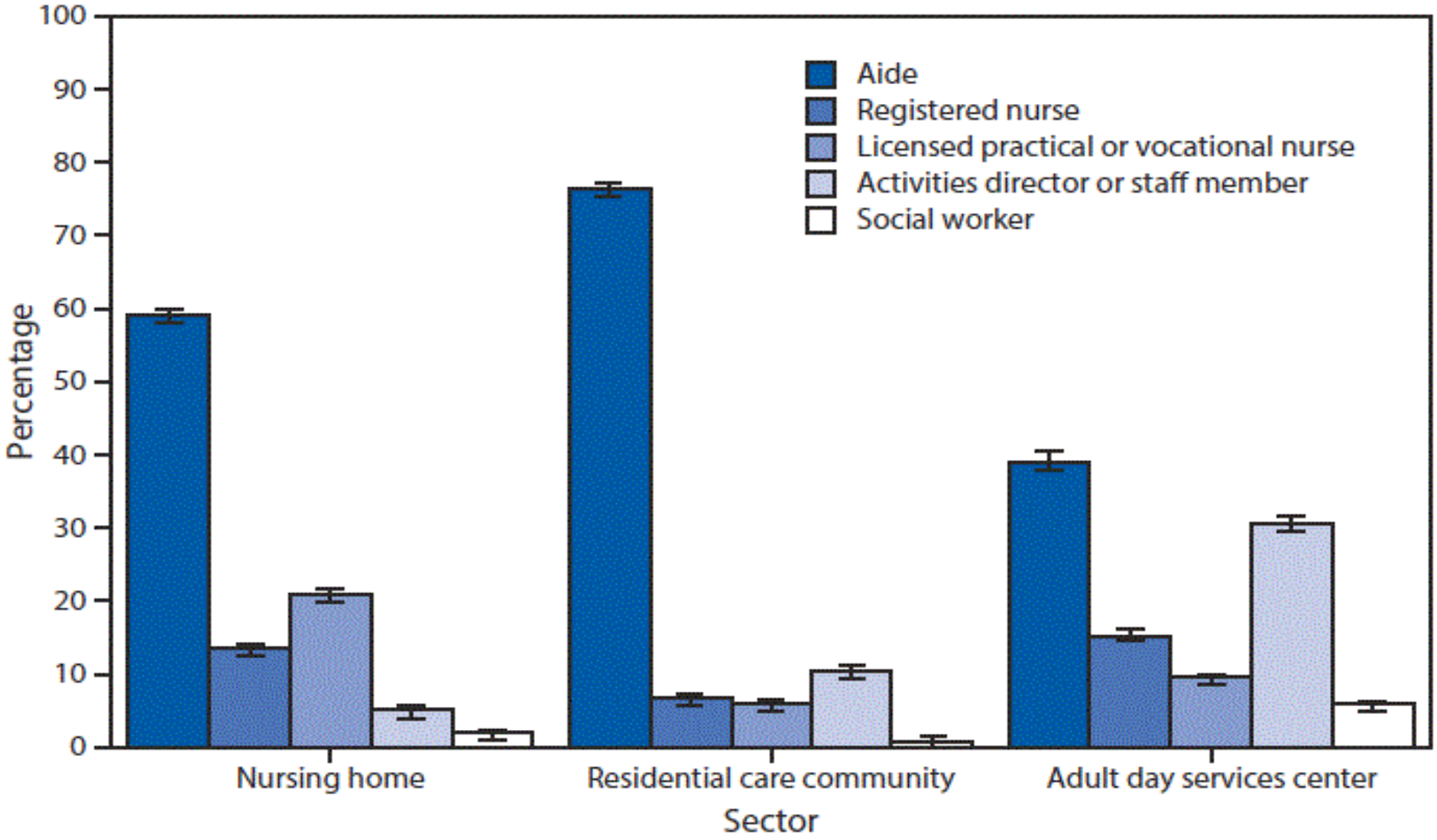
(ii) Medicaid lacks administrative capacity and expertise to run housing programs

Feasibility of recruiting staff

Workforce

- ALF and AD workforces include:
  - Health care support (home health aides)
  - Health care professionals (nurses)
  - Personal care aides
  - Other
    - Social workers
    - Food service
    - Building maintenance
    - Administrative

Percentage of weekly hours



Training required for aides (NV = federal minimum)

- initial training = 75 hours, which must include 16 hours of practical or clinical training
- 12 hours of continuing education training each year
- HH aides must not be evaluated as unsatisfactory in any task

Aide turnover is high: wages

DETR (2018) average hourly wages

Home Health Aide hourly wages

- $13.77 in Nursing and Residential Care Facilities
- $14.56 in Community Care Facilities for the Elderly
- $17.60 Home Health Care Services

Personal Care Aide hourly wages

- $11.08 in Nursing and Residential Care Facilities
- $11.99 in Community Care Facilities for the Elderly

- Anecdotal information: ~$10.00 agency serving Medicaid patients

Other job issues (national survey)

- On-the-job injuries
- Lack of smooth communication with health care providers (home care)
- Inadequate work hours
  - Payers authorize number of care hours for each patient (< 8 hours/day for most patients).
  - Aides must piece together schedule that includes travel time between patients.
  - Medicaid does not reimburse agencies for aide travel time.

30 states raised rates for aides 2019-2020

AL, AR, AZ, CA, CO, CT, DC, DE, HI, IL, LA, MA, MI, MT, NC, NH, NJ, NY, OH, OK, OR, PA, TN, TX, UT, VA, VT, WA, WI, and WV

Some tied increased rate to completion of increased training.

TN:

- creating additional training,
- collecting additional workforce data,
- helping providers improve recruitment and retention, and
- offering wage incentives to complete additional training.

NV

- Increased Medicaid reimbursement rate to agency 1/1/2020 to $17
  - First increase since 2002
  - Rescinded 2020 Special Session

- Reimbursement rate not increasing with:
  - Increases in minimum wage
  - Increases in CPI

	CPI	
July	urban	% increase
2002	180.1	
2020	259.1	0.44

Minimum wage

July 2020: NV minimum wage increased:

- $8/hour if health insurance
- $9/hour if not

Current law:

Increase $0.75/hour each year until $11 if health insurance/ $12 if not

Staffing issue: 2 components

- Can agency or facility hire enough aides?

- Can agencies break-even on Medicaid reimbursement rates?

agency

Revenue = Medicaid reimbursement rate per hour

Minus Costs

- wages + fringe benefits for aides
- administrative costs
  - billing
  - HR = hiring, training
  - IT system
- buy/maintain or rent office

3 additional perspectives

- Healthypeople.gov (2020): goals:
  - Person-centered care planning that includes caregivers, and
  - Fair compensation formal and informal caregivers.

- Ross et al. (2014) recommend redesigning the role of aides to include higher levels of training and greater responsibilities (which might support wage increases.

- Emerging technologies could potentially support the redesign discussed by Ross et al.

Economic viability and payment structure for the facility

Template: allow people to assess costs and revenues for facilities or programs

If Revenues < Costs: 2 policy options

Increase Revenue per day /per client	Reduce average costs
Increase Medicaid reimbursement rates	Housing subsidy (increase number clients, reduce diseconomies of small scale)
Additional sources of revenue:	Reduce regulatory burden while maintaining quality
state and/or county	alternative to nutritionist review menu?
employer, managed care company, Accountable Care Org, hospital?	combined license
	can technology reduce total cost?

Feasibility Analysis: whose costs and whose benefits?

Facility
costs vs revenue

State residents:
quality of life, &
fairness across income
groups

Taxpayers: Medicaid and Social Services Expenditures vs. economic development issues

Technical, economic and legal barriers to the establishment and operation of such a facility

Technical: broadband

Legal: NRS/NAC prohibitions on combined license

Economic

- Rural costs high (e.g. fire alarm inspector)
- Small scale
- Travel times
- Availability of transportation and health care services (ALF must facilitate access to dental care)

Table 4.17: Genworth 2019 Cost of Care

Nevada, 2019

	Monthly Charges			
Service	Nevada	Carson City	Las Vegas	Reno
Home Health Aide (44 hrs / week)	$4,290	$4,767	$4,242	$4,957
Adult Day Health Care (5 days/ week)	$1,733	n/a	$1,733	$1,560
Residential Care Facility, Private Room	$3,400	$3,645	$3,300	$3,250
Semi-Private Room	$7,604	$9,095	$7,498	$9,437
Private Room	$9,277	$9,520	$8,821	$10,615

Source: Genworth 2019 Cost of Care

Timeline for creating a pilot program

IF Medicaid partner with Housing: form collaboration, form non-profit, state create combined license, new entity obtain license, verify compliance with settings rule

IF Medicaid rate adjust: public process if new rate structure; shorter if within existing regulations

IF increase rates: ALF, AD, RC, Personal Care – legislative session

IF aide job redesign: wage, scope of practice, create and implement training

Discussion:
What do you think?