MEETING MINUTES

Name of Organization:	Nevada Commission on Aging: Policy Subcommittee (Nevada Revised Statute [NRS] 427A.034)
Date and Time of Meeting:	March 31, 2021 | 1:00 pm

1. **ROLL CALL**
   Mr. Duarte called the meeting to order at 1:03pm.

   Subcommittee Members Present
   Chuck Duarte, Chair
   Connie McMullen, Vice-Chair
   Mary Liveratti
   Barry Gold
   Donna Clontz

2. **PUBLIC COMMENT**
   No public comment was given.

3. **Approval of Minutes of the May 18, 2020 Meeting**

   Connie McMullen moved to approve the May 18, 2020 meeting minutes. Donna Clontz seconded the motion. The motion passed unanimously.

4. **Approval of Minutes of the August 17, 2020 Meeting**

   Connie McMullen moved to approve the August 17. 2020 meeting minutes. Donna Clontz seconded the motion. The motioned passed unanimously.

5. **Presentation of the following Medicaid policies. Discussion and approval of recommendations to the Commission on Aging for possible action to support policy changes. (For Possible Action)**

   Mr. Duarte stated The Commission on Aging met in February and put together policy priorities and submitted them to the Policy Subcommittee. As a part of the meeting, they prioritized list of potential policy items they would review during the interim. These policy recommendations don't preclude the subcommittee from coming up with their own policy recommendations as a part of their meetings, but at least they have some recommendations from the full Commission on Aging. Items included:
   1. Adding Home Delivered Meals to the Frail Elderly Waiver
   2. Fully funding Home and Community Based Services Waitlist
   3. Increasing the Nursing Homes Personal Needs Allowance

4. Increasing the Spousal Impoverishment Income Amount
5. Considering looking at nurse to resident ratios in Skilled Nursing Facilities
6. Work with ADSD on the Money Follows the Person (MFP) transition planning initiative.

Number 6, the MFP grant, is already moving forward with ADSD through a series of public workshops seeking input on how to move forward with $5 million. As such, this item will be dropped from the list of policy recommendations.

A. Adding Home Delivered Meals to the Frail Elderly (FE) Waiver
- Crystal Wren, Social Services Chief II, ADSD, DHHS
- Jeff Duncan, Social Services Chief II, ADSD, DHHS
- Kirsten Coulombe, Social Services Chief III, DHCFP, DHHS

Crystal Wren thanked the Committee for bringing this initiative forward and mentioned it's a continued collaborative effort with Division of Health Care Financing and Policy (DHCFP) during session and during the interim. ADSD is the operating agency where the initiative can move forward, and the funding and policy comes from the Division of Health Care Financing and Policy.

Mr. Duarte clarified the actions for each item is to do further research and make recommended policy changes to the full Commission.

Ms. Wren stated they met previously and discussed the general idea of adding meals to the Frail Elderly Waiver and what that looks like for each agency. There's a financial impact, an impact to the community, and to the providers and wanted to ensure that all areas were addressed. This population has access to meal delivery currently through grant funded programs or county funded programs. Meals from these programs are currently available to those on the FE Waiver. Looking at if it's feasible, what would the cost difference be, and would it promote more choice for recipients if they had an additional entity to seek meals through. Ms. Liveratti clarified it was her understanding that the Waiver for persons with disabilities included the meals? Ms. Wren and Ms. Coulombe confirmed that was correct. Ms. Liveratti commented there is experience with meals in a Waiver program. The Waiver was started for the aging population. They had meals in 1988 when they started the meals program, but utilization was low, and the Federal Government determined if there was no use, they would have to be taken out of the waiver.

Kirsten Coulombe stated they have reviewed options to see if there would be a benefit to adding meals to the Frail Elderly Waiver. It is assumed that the population in the FE waiver are more often homebound, than individuals on the Physically Disabled Waiver who perhaps are still working or having a more active schedule. She continued Fiscal analysis for a potential decision unit was completed in the 2019 Legislative Session. When the Medicaid Rates Unit did the fiscal impact analysis, they base it on 2018 utilization data. It was fifty percent utilization at the time. Ms. Coulombe mentioned concerns they would not have a higher utilization, but the impact can only be based on available utilization data. They ran numbers in preparation for this meeting. It was surprising the number of individuals that access this service was twenty five percent. That's because there's access to meals at the county level or through the grants. That's not always the case with Waiver services that there's an alternative because typically there's not. It's not covered through Medicare and that's the point of the Wavier is to have the ability to offer these services. There are different criteria for that waitlist, they can certainly refresh the fiscal analysis and impact. The individuals that are utilizing the service that are non-Medicaid wouldn't have the match component which is always the benefit of the Waiver including paying less state general fund for a service that's offered through the Older Americans Act funding or through the county. So maybe there's a cost neutrality component by shifting those individuals that are Waiver recipients that are getting the services that don't have the match to a Medicaid Waiver Service and perhaps that can lessen the impact even though the utilization would then be on the Waiver side. Those are the initial conversations around which options are available. In terms of the process, it would be a decision unit in the Medicaid budget and the bureaucratic process of updating the Waiver

application which is done fairly frequently. It would have to be a prospective policy change to add a new service along with an implementation date and the necessary public notice of 30 days and then the Centers for Medicare & Medicaid Services (CMS) has 90 days to review.

Ms. Liveratti asked if there was an idea of how many other states utilize meals in their Frail Elderly waiver program if they have one?

Ms. Wren and Ms. Coulombe stated they have not had the opportunity to look at other states. The question came up last session, but that effort wasn't continued.

Ms. Liveratti stated she knows there was an issue paper on the Home Delivered Meals for the Waiver. That was the proposal when she spoke to Jill Bernston back in 2018 and wondered if that can be located and used for research.

Ms. Coulombe responded they can certainly look for it and they do have enough time to research.

Ms. Liveratti commented she would be very interested in what their experiences are in other states. How it works, what the utilization is, etc. There are some state dollars that come in and pay for meals and what they'd be looking at is shifting some of those dollars to be used as match to bring in the federal Medicaid funds. Freeing up those dollars that can be used for people that are on the Waiver that are participating in the meals program and freeing up those dollars to serve other clients that don't qualify for the waiver essentially maximizing dollars and revenue.

Ms. McMullen spoke of a grant received and stated Washoe county received money for the meals, and it has helped significantly. Will that still be available by next session and if it's not will it help the utilization rate?

Mr. Duncan asked for clarification on what grant she was referring to. He continued they haven't received any new grants for Home Delivered Meals or congregate meals. Back in the 2017 session they did receive funding to increase the home delivered meals rate from $2.65 to $3.15 and $1.089 million was awarded. The funding received was able to approve around 140 people. That money was continued in the 2019 session and received an additional $800,000 and increased the rate from $3.15 to $3.65. In addition, 100 individuals were removed from the waitlist. Regarding new funds and new allotments, they received emergency funds including a little over $2 million from the Families First Act and a little over $6 million in the CARES package and are waiting on the recent stimulus. The money was used to transition individuals that were going to congregate sites, transition to home delivered meals service or drive up. Additionally, there is an increase in the ability to take the meals to the individual's home and through other means outside of the traditional senior centers, home delivered meals through a vendor named Tivity, and many other one off initiatives. Their unit is currently looking at what's going to happen when the emergency funding run outs and does not have a response today but noted it's with the entire allotment of 8 million with all the emergency services. With the new funding they are anticipating it be better served and looking at the unmet need and infrastructure. It's difficult to sustain new direct services, the majority of money received went to the rapid response to get people nutrition services.

Ms. McMullen followed up and asked because of the special funding no maintenance of effort was required? Mr. Duncan responded no maintenance of effort was required.

Ms. McMullen stated it will be interesting because they got people involved who did not have the meals before and by the time the funds expire maybe the projection for need will be higher than the twenty percent utilization. Mr. Duncan responded they will be reviewing those data points for their service network because they'll have to work with their Community Partners to make sure they are targeting individuals most in need which could result in an entire reassessment on their existing clientele before the Pandemic and individuals who received new services due to the pandemic. Many of their services are different than the congregate.

Mr. Duarte stated with the county funded meals, some which are congregate, the meal is a hot meal you can receive in a congregate and home delivered. With some of the waiver funded meals they would be frozen and then would need meal preparation for the recipient. Mr. Duncan stated prior to the pandemic they had a hybrid model, some partners do the seven frozen home delivered meal per week, but some partners really adhere to the intent of the Older American's Act funding to do five fresh hot meals during the week and an option of two frozen on the weekend and going to the premise of having someone in the home on daily basis, at least Monday through Friday to check on the wellbeing of that individual. Maybe looking at policy or funding to reward community partners with an accelerated rate to do home delivered hot meals almost like an incentive based, that way the individuals getting the daily check ins on their wellbeing. It's a hybrid model and in the new world, the definition of a homebound individual under the Older Americans Act is anybody who is traditionally homebound or those who are self-isolating and are anticipating when things return to normal that definition will go back to standard. They'll have to look at that the ability of the network and community partners to continue with potentially limited funding because of the county's ability to keep funding the programs. The fixed rate is a partial percentage of what the meal truly costs the community partners across the system. Rate studies were conducted and the cost for community partners is anywhere from five dollars, up to fourteen dollars. That's why there's been some constraints on the partners.

Ms. Liveratti stated under the Waiver they set the price whenever they want but they could be paying for the total cost of the meals?

Ms. Wren stated with the six percent reduction which is the normal rate for a meal is five dollars for the reimbursement which is a set rate and that is something to consider. With the Waiver, one of the main goals is that we offer choice. With current enrolled providers for the Physically Disabled that do home delivered meals it is a large number of frozen meals. It can be weekly, bi-weekly however they set it up with the provider based on their capacity. Currently, they do not have providers that offer hot meals that are enrolled with the Waiver, so that would be something they would need to expand and hope that providers would sign on for it. One of the options they had with the county was that they would still have that option to receive a hybrid model, a hot meal in person, they would still have that option based on that qualification but because of the choice they are afforded. One of the other areas of concern is if the current providers will be willing to become a Medicaid provider. Considering the overhead because they do not have that large infrastructure because county operations are smaller. There's a lot to consider and the choice is the number one goal. They do have some areas in the state where they are remote and do not have the opportunity to go to the community center or senior center to obtain the meal so this would offer that option to those who do not have access. There is an opportunity for community engagement to see what that looks like. Ms. Coulombe sated the current rate reduced by the 6% effective December 1st, 2020 is $4.70. Mr. Duarte stated some of the traditional providers, some that are providing county delivered meals and he assumed they would have to generate a Medicaid claim. That adds to their overhead and cost and they might not be willing to do that, and recruitment might become an issue for some of those providers to participate on the Medicaid side with Home Delivered Meals. Connie McMullen stated Amber Howell, Director of Washoe County Human Services, could not imagine her not wanting to participate. Ms. Coulombe added that she thinks it would not be difficult for the county to bill Medicaid because they actually bill Medicaid for other services such as county Day Break, the adult day health care program, juvenile justice services, etc. The challenge would be Catholic Charities and community providers that provide meals under the Older Americans Act grant and do not currently bill Medicaid. It would require enrolling with Nevada Medicaid which isn't always simple, learning the billing system, etc.

Mr. Duarte stated the other component is the County Match Program. Mr. Coulombe explained the County Match Program, which is for Long Term Services. The county of residence is responsible to provide the state match for Medicaid long-term care services including HCBS waiver services., Whenever Medicaid is contemplating an increase in services, they have to be cognizant of how that will increase the county's contribution. Those conversations also have to be had with the County.

Mr. Duarte added the county is essentially paying for the state share of Medicaid services for people that consider that particular county their county of residence.

Ms. Liveratti corrected they are paying for the non-federal match.

Mr. Duarte asked for a motion to receive the older version of the budget decision unit from a prior Legislative Session that could potentially be updated which would include the costs of Home Delivered Meals as an option for the Frail Elderly Waiver. As a part of that, potentially looking at what the impact might be for recruitment of providers, new providers of creating incentives as Jeff Duncan had described for increased meal payments through Medicaid as an incentive to provide Home Delivered Meals and also to look in on frail elders who are on the waiver. As part of any budget decision unit, what that might look like from the county's perspective and what the county match share might be for that.

Ms. McMullen asked if the Home Delivered Meals drivers stopped looking in on the elderly? Did we resume that during the crisis?

Ms. Clontz responded as far as she knows, in Washoe County they are looking in on the Seniors once a week. They are also calling them ahead of time and to make sure of their health situation.

Ms. Coulombe clarified for the fiscal impact he wouldn't need to request the County impact separately as it would be included in the fiscal impact.

Ms. Liveratti moved to approve to proceed with investigating the possibilities of adding home delivered meals to the Waiver program. Ms. McMullen seconded the motion. The motion passed unanimously.

B. Funding for Home and Community Based Services to eliminate the waitlist.
- Kirsten Coulombe, Social Services Chief III, DHCFP, DHHS
- Crystal Wren, Social Services Chief

Ms. Wren explained what it would look like to eliminate the waitlist. The waitlist is defined by the agency and is created for those who apply for services and are presumptively eligible for service but do not have an opening or slot until one becomes available. Every Legislative Session, Medicaid and ADSD and Data Analytics come together and help project anticipated slots they will need for the next biennium which covers normal population growth as well as to eliminate those who are waiting over 90 days on the waitlist. The legislature looks at both of those areas and comes to a consensus to see how many slots are needed to meet those numbers. Every session, they are always awarded slots, but there is always a waitlist. Even though it's important to eliminate the waitlist, it's also a real factor that the waitlist is inevitable. When someone applies for services, they are never automatically approved, there is always a process to get them onto a service. Looking at servicing people within allotted time frames is more realistic for the agency. Ms. Liveratti stated she is not interested in getting rid of the waitlist, she is interested in the time to service. It's the wait time that is the driving factor, not the waitlist. She would rather look at getting the wait time down to the 90 day that's set under the Olmstead decision. It would have to be funded to a level of saturation. Ms. McMullen asked if the wait time is significant? Mr. Duarte stated that he agrees and had discussed with Ms. Wren and Ms. Coulombe it is the time to service. Some of it will hopefully be addressed through the budget process if the Division of Welfare and Supportive Services (DWSS) receive funding for an IT project that they are initiating to help Medicaid and ADSD with waiver application processing. It's a $995k decision unit and its 90% federally funded. Ms. Liveratti shared a story of a client with an amount of paperwork and the length of time it took to process. Mr. Duarte stated another aspect of time to service is provider saturation and the ability to have sufficient provider capacity to render service which becomes another issue along with staffing. He continued, the point is how long is it taking particularly on the FE waiver from the point of application for MAABD, and how long does it take to get to services in general? Mr. Duarte asked where we are right now with the FE waiver? Ms. Wren stated she will

have to pull the average wait times but thinks it was close to 120 days on average for wait times. From the time they apply, and receive a complete application, then have them apply for MAABD and then send that to Medicaid for the final steps. There are many factors that go into it. A lot of it is staffing on all sides with all agencies. Occasionally clients run into situations where DWSS must pend the case for trusts and other verifications, which can add additional time. While people are waiting for services, they are not ignored. Intake Social Workers do routine check-ins to make sure nothing's changed, see if they are still interested in the programs while they wait and provide them any additional resources. Ms. McMullen commented it's better now, but in the past the wait had been a year or more.

Ms. Coulombe stated one aspect is the system would need to be updated to make the antiquated paper process improved, two, availability of Social Workers in general to hire that staff to do those assessments. Third, the workforce of providers, especially in the rural to do those services. We talked about the AB122 study that Dr. Jean Wendell and Dr. Ronnie Dahir had presented that landscape and what that looks like in Nevada and trying to look at those recommendations and its far more complicated.

Mr. Duarte agreed with Connie's comments. He continued that the Olmstead decision required a 90 day turnaround for waiver slots and was denied by the Attorney General's office at the time and they would not allow budget decision units, so-called legal "mandates," into the budget. We could project caseload growth but one of the positive things is now during the budget build, Medicaid puts in a Waiver caseload growth projection which is the normal inflation of caseload and then puts in an M decision unit or mandate which is the legal requirements of Olmstead and there are additional waiver slots funded above the normal caseload growth projection in order to meet the Olmstead mandate.

The Committee discussed mandates and decision units. Ms. Liveratti clarified there is no 90 day mandate. It's a reasonable rate of time but we as a state decided we would use 90 days as what we considered reasonable. Mr. Duarte stated the 90 days is based around case law in Olmstead, there were court decisions that considered reasonable time frames to be 90 days and that was one of the reasons why it was started.

Mr. Duarte asked how the Committee would like to move this forward. He continued we all agree there will be wait times, but we want to try and minimize the wait time to service and a lot of it sounds like they are operational issues but not necessarily solely funding slots. Any suggestions to how you want to proceed with it or change it.

Ms. Liveratti stated as the Policy Subcommittee we should focus on wait times rather than the waitlist. When we focus on wait times it allows the Legislature to look at what is causing the wait time and all the factors Kirsten discussed.

Mr. Duarte asked if they would like to make a recommendation to change the terminology from wait list to wait times?

Ms. McMullen moved to approve the recommendation to change the terminology from wait list to wait times. Mr. Duarte clarified because wait times are impacted by several operational issues that have policy implications such as staffing, IT initiatives, so forth. Do we want to change how we monitor or want us to be involved in looking at potential operation administrative issues that can be where the agencies would need support to improve wait time to service? Ms. Liveratti clarified we want a policy that states we support the 90 day time to service and it's not changing the tracking. Mr. Duarte clarified it would be how the Commission tracks the information. Ms. Liveratti responded the Commission has the information available regularly. The committee clarified the motion and discussed the Commission on Aging's focus to put an emphasis on the wait time. Ms. Liveratti stated we need to go to the Legislative Subcommittee to ensure they are going to the legislature and that's something they are focusing on.

Ms. McMullen moved to approve that the Commission on Aging monitor on the waitlist the wait time as it progresses as caseload progresses as a priority and a consideration of the 90 day goal as well as waitlist as a secondary measure. Mr. Duarte clarified the motion is the monitoring wait times to service. Ms. McMullen added with an emphasis on 90 days. Ms. Liveratti seconded the motion. Mr. Gold asked if they are not going to be monitoring waitlist and only wait times there's a need to look at both. If the wait times are x number of days. Ms. Liveratti briefed Mr. Gold on previous discussion regarding waitlist versus time to service and clarified the Commission would still be monitoring waitlist. Mr. Duarte added they will use wait time as a priority metric to talk with legislators about the need to move people onto services. Both agencies will be providing waitlist numbers but really want to focus on wait times for operational efficiency and getting people onto service. The motion passed unanimously.

C. Increasing the Personal Needs Allowance
- Sheri Rasmussen, Social Services Program Specialist III, DWSS, DHHS

Ms. Coulombe provided an update on the Money Follows the Person (MFP) Grant. Last week, we held a public workshop to solicit feedback on ideas of ways to improve HCBS and increase capacity which is the intent of the supplemental Money Follows the Person Grant which is up to 5 million dollars. They had a lot of great ideas. Some of them are related to discussion today or related to policy and not sure they would apply for the grant to do those activities. One of the things to mention, there is a required match to the $5 million. That will most likely be a consideration. The supplemental funding grant because it's related to increasing HCBS capacity, it has a lot of flexibility, but it is separate and aside from the traditional MFP grant that is transitioning individuals out the nursing facilities. The next step is summarizing the notes and suggested ideas and post them to the Medicaid website. She will send to Miles or the appropriate person to inform the group. The grant is due to be submitted this June which is a quick turnaround. The solicitation would ideally be requesting information within a 2-3 week period. ADSD and Medicaid are meeting weekly to identify what would be feasible and what it would be utilized and where the match would come from. Ms. Liveratti asked if it is a hard match or soft match?
Ms. Coulombe yes, it would be the non federal share so the state match. It wouldn't necessarily have come from DHCFP since they have zero money. One area they are looking at is what DWSS has, their initiative in terms of the systems have the systems work together, is there other things to use this grant for that could be used for in later phases that could help expedite the process. One of the areas they lack, and struggle is the manual process of once someone gone through the whole process, Medicaid has the manual process to add their benefit line to make them eligible. That is one thing they review, regarding what is the system component that can help expedite getting services to individuals.

Mr. Duarte stated benefit line issue is they have to go into the Medicaid Management Information System (MMI system), add the person as eligible and list their services as part of the data entry process. Ms. Coulombe stated once DWSS is finished they would like to have the systems work together to automatically give them that benefit line in the MMI system so providers can be billed.

Mr. Duarte asked of the Department is looking one shot projects? You're not looking to start new programs with this? Ms. Coulombe replied someone asked if it would be a pilot. Medicaid does not really do pilots except for the 1115 C waiver. Anything ongoing after the grant would require a budget imitative. So, it would be appropriate to think of it as a one shot funding to try and increase it. She attached examples including caregiver training, increasing providers in the network, etc.

Ms. Rasmussen stated the Code of Federal Regulation mandates states to allow a personal needs allowance that leaves $30 per month to institutionalized individuals and that's for their clothing or other personal needs. Nevada allows $35 per month. From records and research everything goes back to 1991 when the PNA has been in place. She couldn't find any documentation that the State tried to increase that PNA. She reviewed what all 50 states and the District of Columbia are allowing and only 7 allow a PNA of less than $40. 33 of the states have it between $44 and $69 and the other 11 allow anywhere up from $70 to $200. The inflation calculators showed that inflation has increased about 2.2% since 1991. She provided examples of haircuts, smoking, and

personal snacks. Ms. McMullen asked if the PNA covered prescriptions. Ms. Coulombe responded it outside the per diem but it is a Medicaid service so the recipient would be able to have those medications billed through the Pharmacy service. Ms. Liveratti asked if they had Medicare, wouldn't they cover the costs? Ms. Coulombe responded yes if they had both Medicaid would be the payor of last resort.

Mr. Duarte stated this item has been needing updating for a long time. There is a couple of ways to look at it. One might be to take an average of the lows and highs or as Sheri described, there seems to be a middle tier of states that have a range between $40 and $69. Another way to look at is to take the middle tier and take an average and the third way would be to take the $35 that was back in 1991 and inflate it. Ms. Liveratti asked if there would be a cost impact? Ms. Coulombe stated Medicaid would be responsible. Ms. Rasmussen stated she came up with a random number of $50 a month and if Nevada were to increase the PNA but its within what the 33 states are allowing. Talking about approximately 4,066 institutional cases right now and she subtracted the 695 cases who are SSI recipients because when an SSI recipient goes into a nursing facility, their payment is reduced to $30. The new amount is 3371 individuals who might benefit from this. It would be less patient liability collected by about a little over $600,000 per year. Mr. Duarte asked if that was totally computable costs? Ms. Rasmussen replied she's coming from here's what we allow for them we would subtract an additional $15 from their patient liability and doesn't know if those costs are completely accurate because they were counted from the system and subtracted based off the aid code who are SSI recipients. She continued and stated Kirsten mentioned they would have to conduct a fiscal analysis. After adding to what is countable now, it would be about $2,239,000; almost $2,240,000 a year. Mr. Duarte stated what the general fund share would be approximately 35% or 32% of that. Ms. Coulombe explained if the patient liability was increased then the recipient retains more. Then the provider would get less, and Medicaid would be billed more. The fiscal impact would be most likely $600,000 plus per year. It would definability be a decisions unit. She continued she could have the Rates Unit and fiscal staff run more definite numbers after session. Mr. Duarte clarified this would be an interim analysis. Another thing to consider the nursing home provider tax funds 40% of the per diems' reimbursement of skilled nursing homes. The fiscal impact in terms of state general fund would be lessened by the fact that a significant portion of the reimbursement rate is funded by nursing home provider tax payments and not state general fund. Mr. Gold stated there was an issue with personal needs and it got put into an account and people that never spent it. They would go over the maximum and it would get them in trouble. He was wondering what the affect would be and what is the process for doing that, and what would be an unintended consequence in our state that were not thinking of? Ms. Rasmussen replied the resource limit for institutional individuals is $2,000. Even increasing it would take a while to get there and they do a redetermination and reassess resources. Most clients do not get thrown off because they use it and they have the guardians make sure they use it. Ms. McMullen asked if the questions Mr. Gold spoke of could be included in the interim analysis? Ms. Rasmussen responded she could not answer that but stated they can purchase anything they would like if it for their needs and they cannot give it away. Mr. Gold added $20 dollars a month is only 200 dollars a year and it would take them awhile to accumulate over their maximum. Ms. Coulombe stated they do have in the MSM chapter 500 which is the Nursing Facilities policy. Each nursing facility provider must have a patient trust fund which is where that money is deposited and so it does reference in terms of the routine personal hygiene items, the $35 or any money that would accumulate in that patient trust fund could not be used for that because it's included in the per diem so that would be something that's part of the facilities rate. In terms of the pharmacy, she does not see anything related to over the counter. Drugs that are prescription only, compound prescriptions, TPN, solutions and additives are not included in the per diem so perhaps over the counter is. Ms. Liveratti stated surely, they have to buy personal items every year and could spend it down that way.

Ms. Rasmussen stated if they wanted diapers other than what's provided by the facility, is that included? Ms. Coulombe replied it does say if they wanted any brand name (lotions, underwear), they could purchase that. Mr. Duarte asked if incontinence supplies is part of the per diem. Ms. Coulombe replied yes.

Mr. Gold moved to move this forward for increasing the personal needs allowance forward for an evaluation. Ms. McMullen seconded the motion. Ms. Rasmussen asked about the evaluation time frame. Mr. Duarte explained the evaluation work will depend on numbers the Rate Unit at Medicaid can develop around this and the potential implications around assets and limits around assets. The motion passed unanimously.

6. Review, discuss and approve tentative agenda for the next meeting (For Possible Action)
- **Chuck Duarte, Chair**

Mr. Duarte stated we've tabled a number of items because they are not particularly relevant as they are being dealt with right now. Are there any agenda items the subcommittee would like to study, independent of those the Commission has assigned? Connie McMullen stated she is concerned after talking with representatives from the SEIU Chapter in Las Vegas and they want to have that employment board and thinks it's an excuse to unionize the caregivers in a year or so. She continued she's a little concerned because Senator Neal personally asked the Senators on the Health and Human Services side to support her on this bill and is concerned with what it will do to the state. When we received a 3.3% increase in the Waiver to make the FE Waiver cost equal to the WIN waiver costs, it was 6.6 million dollars. So, if they're looking to increase the costs, the reimbursement, minimum wage outside of the current, what's that going to do the state for the Caregivers that are on Medicaid? Mr. Duarte stated its late to be weighing in on current legislative actions but the discussion around provider reimbursement rates would be pertinent. One of things we didn't talk about is the American Recovery Act and some of the provisions there to protect home and community rates for waiver providers. That would require us to continue to fund those rates in the future which will be an ongoing budget item after the recovery act funding goes away.

- Review of HCBS providers reimbursement rates and what changes have occurred over a period of time over the last 7-8 years. That impacts getting people timely service. Ms. McMullen discussed the provider tax legislation and expressed her nervousness.
- Mr. Gold suggested a review of legislation during the session that will affect a variety of things.
- Consider nurse-to-resident ratios.
  Increase the spousal impoverishment limit.
  Mr. Duarte clarified the motion for the next agenda. The review of legislation, increasing the spousal impoverishment amount, consideration of nurse to resident ratios for SNPs, increasing the monthly personal needs allowance for nursing facility resident. He added to keep in mind we will have additional presentations on the items discussed today.

Ms. McMullen moved to approve. Barry Gold seconded the motion. The motion passed unanimously.

7. Next Meeting Date – Tentative Meeting Date, June 2021

8. PUBLIC COMMENT
No public comment.

9. ADJOURNMENT –
The meeting adjourned at 2:48pm.