

Steve Sisolak  
Governor

Richard Whitley, MS  
Director



# DEPARTMENT OF HEALTH AND HUMAN SERVICES

AGING AND DISABILITY SERVICES DIVISION  
*Helping people. It's who we are and what we do.*



Dena Schmidt  
Administrator

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## **DRAFT MEETING MINUTES**

of the Nevada Commission on Aging:  
Legislative and Policy Subcommittee (Nevada Revised Statute [NRS] 427A.034)

The Subcommittee held a public meeting on Friday, April 29, 2022 at 1:00 p.m. at the following location: **Virtual Microsoft Teams Meeting**

### **1. Roll Call**

Chair Duarte called the meeting to order at 1:01 p.m.

#### **Members Present:**

Barry Gold  
Connie McMullen  
Larry Weiss  
Diane Ross

#### **Members Absent:**

Donna Clontz

#### **Presenters:**

Crystal Wren, Social Services Chief 2, ADSD  
Neva Kaye, National Academy for State Health Policy

#### **Staff:**

Rebecca Ortiz, Administrative Assistant 3, ADSD  
Cynthia Maraven, Executive Assistant, ADSD  
Shannon Sprout, Health Program Manager 3, ADSD  
Richard McFeely, Social Services Program Spec 2, DHCFF

### **2. Public Comment**

No public comment.

### **3. Approval of Minutes of the January 27, 2022 Meeting**

Barry Gold moved to approve the January 27th, 2022 meeting minutes. Connie McMullen seconded the motion. The motion passed unanimously.

### **4. Discussion on Following Concepts and Approval of Recommendations to the Commission Aging**

#### **A. Medicaid Supports for Family Caregivers and Structured Family Caregiver Waivers**

Neva Kaye introduced herself and stated she really appreciated the chance to talk to the subcommittee. She started slightly broader than structured family caregiving because she wasn't sure about the background the subcommittee had. She expressed the importance of family caregivers to Medicaid and their important role in states' efforts to help Medicaid enrollees safely remain in their communities and their contributions also help offset the cost of personal care services, which can delay the need for more costly services such as hospital and nursing facility services. There's clear evidence that caregivers would benefit from both financial and skill building support. That would in turn benefit the Medicaid beneficiaries they care for and so recognizing both caregivers' importance and needs. All state Medicaid agencies already support caregivers in some fashion. They've implemented these supports in a variety of ways, including state plan amendments, various types of waivers, and managed care contracting.

However, since they operate their Medicaid programs within federal guidelines, there are constraints on what the program can offer. Within these constraints, there are four ways that state Medicaid programs have supported family caregivers generally. She would come back to these later in the presentation. First of all, they provide supports for the enrollee that also support the caregiver. Respite care is a really great example of that since it gives the primary caregiver a break from their caregiving duties. Care coordination, which is often provided to a person sent through their person-centered plan of care based on a formal assessment of the enrollee's needs and goals. They can seek to coordinate broad training and education to caregivers, helping them understand the needs of specific populations such as those with Alzheimer's, the likely progression of those needs, helping the caregivers assist recipients with functional needs, and finally payment to the caregivers.

One way that Medicaid can do that is through consumer-directed care in which the participant hires their own aid. Ms. Kaye focused on the model of structured family caregiving which is a service that more Medicaid agencies are starting to provide through their home and combining community-based services waivers.

Ms. Kaye introduced the document titled "Comparison of Medicaid-Covered Structured Family Caregiving in Three States" (Exhibit A).

Ms. Kaye discussed Exhibit A, a table that compares programs in three states. The model is in Georgia, Missouri, and South Dakota which are preliminary findings. She selected these states because their efforts were representative of the approaches used by states to deliver structured family caregiving to Medicaid beneficiaries that are older or living with a disability. Later this summer Ms. Kaye plans to conduct interviews with state officials from these states in order to round out information and find out more information such as lessons learned and

implementation from talking to people. She plans to release a complete report in the Fall. She thought the information would be useful for future discussions. Looking across these 3 structured family caregiving programs, she found consistent descriptions of the models and their purpose, approaches to administration, and consistent approaches to managing the cost of the services. She did find differences in payment rates.

Ms. Kaye said in looking at these three programs, she saw significant commonalities which could be helpful reviewing options for Nevada's Family Caregiver program. Georgia and South Dakota both operate programs that cover older people and people with disabilities. Missouri developed a program focusing specifically on Medicaid beneficiaries with Alzheimer's. Because they made those decisions about how they wanted to use the program, the model resulted in some differences among the waiver, but still real consistencies. All 3 states emphasize that their intent of their programs is to help waiver participants, their 1915(c) waiver participants. Some community-based services and home services are provided in order to qualify for the waiver remain in their communities as long as safely possible by supporting their primary caregivers through a combination of payment, individualized training based on the needs of the waiver participant, coaching, and some form of backup or respite care and other supports. As she mentioned earlier, these types of supports can be put in place outside a structured family caregiving where several things can differentiate structured family caregiving from these other types of caregiver support.

First, the caregiving itself is centered in a private home where both the caregiver and the waiver participant live and all 3 of these states really emphasize that this is a home. It's the primary residence of both and it has all the comforts and controls of a home. The waiver participant could arrange the space to their own needs, all the things you would expect.

Secondly, the caregiver in these waivers is either a family member or someone who has a significant relationship to the participant. South Dakota calls these non-relative fictive kin. It's somebody who is really close and has a relationship to the waiver participant. All three states also imply in their policies that the caregivers already caring for the participant when he or she enters the program and Missouri has gone so far as to say that pre-existing relationship is a requirement that somebody cannot access structured family caregiving without.

Barry Gold asked if the relationship is self-declared, that they've already had that relationship?

Ms. Kaye answered there's usually an assessment. Several of the states have assessment forms that they then use the agencies to go in and look for signs of that. It is not just self-declared. They do look for some evidence.

Ms. Kaye continued when she gets to administration, she'll talk about how agencies are always involved and the role of the agency, which is important, and ensuring that the caregiving goes well. Caregiving is the primary job of the caregiver, and the caregiver provides a significant portion of the care of the participant needs. Georgia goes so far as they've established a policy that the caregiver and "must be unable to work outside the home due to caregiving responsibilities". It's really meant for a very specific support to a very specific type of caregiver relationship. The support includes payment and other supports that have been designed for both the caregiver and the participant.

For example, all three programs offer individualized support to help the caregiver meet the participants current needs, but they also help the caregiver anticipate and plan for changes in the participants needs and capabilities. That's particularly important in Missouri, which is focused solely on serving people with Alzheimer's. Interestingly enough South Dakota actually takes a further step and requires the agency to administer an assessment of the caregiver and to establish a support plan for every caregiver that is participating. It's very individually designed for the caregiver, particularly in those broader programs such as those in North Dakota and Georgia, where the caregiver might be serving a wide variety of people with different conditions and different caregivers would be serving different conditions. It's hard to come up with a general plan of care so it's very individualized training and coaching that is emphasized in these programs.

The final thing that is really important about this is that structured family caregiving includes an element of caregiver oversight. Caregivers are not employed by the waiver participant. In all three states, the caregiver is employed by an agency that is responsible for making sure that the caregiver is qualified and trained to succeed in completing their specific task. To make sure the tasks are completed as needed, and that the caregiver really pays attention to and knows what to look for as far as changes and participant needs. Often states require the agency to provide a web-based support for tracking things like daily notes and those notes are shared between the caregiver, the care coordinator, and others so that the caregiver becomes a very important part of the team. There are still those other functions in place of care coordination and the oversight necessary to make sure that the Medicaid beneficiaries are receiving high quality services.

Mr. Gold then stated the document answered his question. In two of the states, these services are within the current HCBS (Home and Community Based Services) Waiver and in one of them, it's an entirely separate waiver just for that.

Ms. Kaye continued this is actually her first administration point. All three of them (the states) did implement the program via 1915(c) waiver, but Georgia and South Dakota, as Mr. Gold pointed out, implemented the service within an existing 1915(c) waiver that also covered other services, and Missouri did it as a standalone waiver that only covered the caregiving. The advantage of the standalone waiver is that it's very targeted. It is does this specifically designed for caregivers who are supporting people with Alzheimer's, often the spouse. They are to make that very targeted design with that particular waiver. However, by having the broader waiver, one of the big advantages is that the participant can continue to access some of the other services like respite that are in the waiver which makes it relatively easy to fit that service within this broader range of service.

Missouri has put in place a requirement that the agency has to have essentially a backup caregiver that can help when the caregiver needs to do other things. If you went with a standalone way, you'd have to think about how you are going to provide all those things that sometimes support that dyad of caregiving and caregivers that are often already there in the broader waivers.

There are still some distinct advantages to being more targeted. All three only allow services to be delivered as part of the approved plan of care so they think big picture. How does this fit for this particular person? What are the persons needs as a whole and how does the family caregiver fit within them? All three states recognize that there are times when the caregiver may not be available to the waiver participant and have allowed for backup care either through respite or requiring a backup caregiver at the agency.

One place t there are differences is the amount of the stipend varies widely. It is important to view the caregiver payment as a stipend because it removes some of the requirements for reporting, wages, and all of that. If you go down this path, it is important to just remember that. Missouri and South Dakota both pegged the payment amount to the cost of nursing facility care because they think that this is really in many ways replacing nursing facility care. Georgia pegs it to the cost of providing extended personal support services because they explicitly designed the finances of their program to replace five hours of that particular service. It made sense that they would peg the cost of the structured family caregiving to the cost of the service that it was replacing.

This brings me to managing the cost of the service. States are often a little cautious when they enter into new thing, and they want to make sure that it's not going to exceed budget. By doing this under 1915c waiver, states can cap the number of people participating in the waiver. In Missouri's targeted waiver, that cap means that they know that each year only 300 people are going to receive that service. The other two states have a cap for their waiver participation; but since this is one of a number of services, it isn't really clear. They had to do estimates of how many of those waiver participants were going to actually need the service in order to do their financial estimates.

All three states, as part of managing the cost of service, have pegged their payment to the cost of the care they believe will not be needed due to the provision of structured family caregiving, nursing facility, or personal care. They put policies in place to prevent separate payment of other services that the caregiver is expected to provide such as homemaker and personal care services because they want to make sure they're not paying twice for the same service. Missouri actually goes the furthest in this. They say that Alzheimer's patients who choose the waiver will not be eligible for any other home and community-based services or long-term services and supports. It's the way they've structured their waiver.

In summary, states can and do support caregivers. Some states specifically support family caregivers through a structured family caregiving model. These programs really do differ in some areas, but all are focused on enabling the Medicaid beneficiary to receive the personal care they need in their home from someone they know, trust, and to support that caregiver in doing their job well. With that I'd really thank you and I hope this proves helpful and I want to see if you have any other questions about this, or anything for me about this material.

Mr. Gold stated that Ms. Kaye talked about the budgetary implications and the difference between having the strict waiver as a service in other waivers. Do the two that have it just as a service, that's Georgia and South Dakota looking at the document, are either of them a managed care state for their waiver programs?

Ms. Kaye answered not for the wavier programs.

Mr. Gold stated that managed care would also have an implication. He said he state of Nevada has discussed the idea of moving the waivers to managed care and the managed care agencies are hungry to do that because it's a cash cow.

Ms. Kaye stated there would be no bar to doing that in a managed care. As a matter of fact, she could potentially see giving the managed care company some of the roles that the

agencies currently have . Depending on how you structure the managed care program, that would actually be very interesting.

Chair Duarte asked in terms of reviews of similar states and how they are structured; maybe George is an example comparable to Nevada, what kind of incremental staffing does the state have to consider when they either add this to an existing waiver or develop a specific separate waiver? Are there separate staffing needs that have to be taken into consideration at the state level?

Ms. Kaye answered that she had not talked to Georgia yet so she is going to need to confirm this; but from reading their documents, they did not include any staffing in their cost estimates. Ms. Kaye assumed that they were then able to absorb this within the cost of administering the existing waiver, which is one of the benefits. In addition of adding it to an existing waiver, you already have a lot of the structures in place that you would need in order to accommodate that. There's no question there's still work that needs to be done, like the need to set up procedure codes, set up policy manuals and do training. As far as ongoing cost, she didn't see where they reported that it added anything to their work.

Mr. Duarte stated that Ms. Kaye had talked about the structure of this in support of caregivers and that the caregivers become part of the care team which would include the agency staff, somebody at the state overseeing that beneficiary case, and beneficiary dyad. Is there any kind of other incremental costs, like technology costs, that need to be considered when you're making the caregiver part of that case management process?

Ms. Kaye answered all three states made it an agency requirement to supply the technology needed by the caregiver. The payment line which is on the 3rd page you'll note that there's a per diem in all three states that the Medicaid agency pays to the agencies that administer the service. Those agencies retain an amount of that for administration, but all three require the agency to pass on a significant amount of it to the caregiver as a per diem. Georgia says that the agency has to pass on at least 60% of its payment rate. Missouri says the agency has to pass on at least 65%. South Dakota says at least 50% so you know the amount of funding that's getting to the caregiver. That amount is really the agencies' amount for administering the program and what the states delegate to them is not just the technology but the qualification for the caregivers and the training requirements for the caregivers. When a caregiver gets individualized training and coaching, it's from the agency and not from the state so that amount is what the agency retained to cover all of those supports.

Mr. Duarte asked of the states that were highlighted in the report, which ones actually allow for legally responsible individuals to serve as paid caregivers at this point?

Ms. Kaye answered they all do. Georgia didn't but when COVID came and the public health emergency occurred, they said spouses can be caregivers. She did not know if that will go away once the public health emergency is done. That's one of the things she plans to ask them is what has been their experience now that they've been allowing that. Ms. Kaye thought that's really important in some ways for this kind of waiver and you do have to justify to the Centers for Medicare and Medicaid Services (CMS). You can't just check the box that we're going to allow it and then go ahead with it. You have to explain why in this case you're going to allow it. Given the nature of this particular kind of caregiving, it's probably most obvious in things like Alzheimer's. If you exclude that group, you're going to exclude a lot of potential caregivers who are already putting in a lot of care.

Diane Ross asked when you were talking about reimbursement for the caregiver, were you excluding any other kinds of assistance like respite care?

Ms. Kaye answered no. That is one of the things that is important to provide and that all three states have made some provision for its respite care. In Missouri, they say that the agency has to have a backup caregiver available because of the way their program is structured. There's always some aspect that allows for that. Now there are other services that somebody who participates in this type of caregiving cannot be paid for separately. The separate services are important because those are things like personal care and homemaker chores. The sort of thing that you would anticipate the caregiver is actually providing. There are usually policies in place preventing separate payment of those because they are already being paid for through the stipend to the caregiver.

Mr. Duarte thanked Ms. Kaye for taking the time on a Friday afternoon to be with the subcommittee and talk about the report. Mr. Duarte will make sure that we send out the full report that Neva and her colleagues put together on Medicaid supports for family caregivers. It's an excellent read and it will provide some good background for our discussions in the future and possible recommendations to the full Commission on Aging for legislation.

## **B. Respite, Caregiver Training, and other ADSD Programs Supporting Family Caregivers**

Mr. Duarte stated we're going to move on to the next agenda item and that's part of the agenda where we're going to hear from staff. One of the things discussed at the January meeting was getting updates on information regarding what's going on with ARPA funds. Kirsten Coulombe could not make it to the meeting. Therefore, we may not be able to hear what kind of actions are pending, but Crystal Wren is with us. "Crystal, are you able to give us any updates on what's going on with the enhanced 9817 HCBS funding out of CMS?"

Crystal Wren answered the only thing that she was prepared to give an update on is adding the meals into the frail elderly waiver for the home delivered meals. The rest of the information, Kirsten has prepared she's been held up unfortunately with the other things. I will go ahead and provide that update. We did get the approval to add those meals to the frail elderly waiver. The approval is made for April. She are approaching the end of the month, so Medicaid is working to get the structure built into the payment schedule within MMIS. If anyone is aware of MMIS system, it's the Medicaid billing system that providers go through in order for claims to be submitted. There has to be some background routing done for the claims to match the provider type and the code. DHCFP is working with the business process unit to figure out the best way to do that, the quickest, and the easiest way with the least impact to our provider community to make sure that those meals can go through. She did anticipate getting some information in the next couple of weeks. She was working on some language for the recipients on the frail elderly waiver to allow them to choose if they would like the home delivered meal option through the waiver or continue the hot meal option through the congregate sites. It will still afford them that choice, but it will open that up to individuals who don't have access to the senior centers or the other sites that are offering those meals. Hopefully in the next couple weeks, she was hoping to have that wrapped up. It's just some background information then encoding that they have to do. That is not a quick fix unfortunately.

Mr. Duarte stated this goes back to our January discussion or maybe even precedes that. Jeff Duncan and you presented information. There is a discussion around concerns with community

partners being a part of Medicaid program and the challenges that that created for some of them who weren't prepared for example, Catholic Charities, who weren't necessarily prepared to handle the billing aspects of this. Has there been any issues that you folks have encountered with regards to the need for training or any hesitancy on the part of community partners to participate in these meal programs?

Ms. Wren answered yes and no. She said some of the hesitancy comes through the funding streams. A lot of our community partners receive funding through a grant and they may receive funding through other means. Some of that communication is deciding if they can have both funding streams work. On the ADSD side with the case managers, one of the main goals is to make sure that there's no duplication. We do not want to have an individual receiving federally funded meals through the waiver and also the grant funded meals. She wanted to make sure they don't have that duplication and so that's presented a little bit of hesitancy on the community partners. Just for that separation. She has not heard of any enrollment issues for this provider type for home delivered meals. It's a fairly simple process in comparison to some of the other entities that require a lot of licensure, training, and things like that. The home delivered meals and its enrollment checklist is a lot smaller. There are currently have four providers. That is adequate to meet the needs currently. It doesn't sound like a lot but two of them are out of state providers and are nationwide. The other two are within the state and currently she does not anticipate an issue with that. If any of the community partners would like to enroll, ADSD is open to help them with that process and connect them to Medicaid and make sure that there are no interruptions in service.

Mr. Duarte asked "How does that work? You've got four participating provider groups. Are they billing on like an individual meal basis or there's a code for that?"

Ms. Wren answered yes. There is a code and it's a monthly basis. ADSD authorizes meals. It's one a day or 2 a day depending on the nutritional risk that the individual presents so they can authorize those 30 meals or 60 and then they would bill that in bulk once a month.

Mr. Gold stated that agenda item was updated on the HCBS spending plan since our last meeting. The \$500.00 onetime payment to the workers and the restoring of the provider rate cuts has been approved, what we talked about. We were waiting for that to be approved and I don't know what the exact step in the implementation of it is, but I know that it's been approved, and they were working on getting it implemented

Mr. Gold he did have an email correspondence with Kirsten Coulombe regarding PCA rates. He asked whether a rate increase was being proposed in the agency budget request to the Governor. Ms. Coulombe could not confirm whether an increase was being proposed since the budget instructions were to keep the budgets flat.

Mr. Duarte moved to the next agenda item which dealt with an update on the Guinn Center report on PCA services. He said the report indicated that PCA rates have been almost flat since 2003.

Connie McMullen stated she did know that the IFC approved three studies on waivers for reimbursement. If they're going to do a study going forward in the state 's budget, that might set the reimbursement increase back in time. They'll do the study, obviously first.



Mr. Duarte stated one of the things he read was the Burns Group Report. They were recommending an \$18.00 and change, but that only applied to individuals with intellectual disabilities and that waiver. Unfortunately, it didn't go across the board.

Ms. McMullen stated she also has an update on the \$500.00 rollout there. A lot of the companies, and many of them did not participate, in accepting that because of the process of rolling out the payment. Some of their caregivers did not qualify. The ones that are doing that are completing the paperwork now but there was some concern because the state asked some questions about who was identified as taking the payment for their employees and who wasn't. There was a concern about those who were not participating maybe being blackballed or some negativity about them. She thought that they were also extending application of the \$500.00 by the companies a couple weeks, so they could give them a chance to do that. The burden falls on the state. They didn't make any indication or reimbursement for administration fees by the companies, so the companies had put that out themselves.

Mr. Duarte asked whether the companies have to pay the net of taxes on that, or they had to gross up to the \$500.00?

Ms. McMullen answered they have to pay taxes at the end of the year on that payment as well. There's some concerned about it. They didn't build in any of that structure.

Mr. Duarte thanked, Connie. He knows it is never simple when you're talking about state money.

Ms. McMullen agreed. She forgot the name of that legislative board, but they were meeting regularly now. It's complicated. It's not as simple as just giving the caregivers more money and that's going to be a heavy lift. If that comes about there, it will be recommended probably out of this committee and going into the next session. That will set it back away. They said that they would subpoena the companies because it's in Section 16 of the bill, which is kind of heavy handed. They're requesting that they fork up their records to show how much profit they make and such information. At least the association that I'm connected with is trying to put that together. Some of the members and some people that are not Medicaid providers were a little upset by it. The people who are contractors and that are on that committee board are making efforts to move forward and provide that information.

Mr. Gold stated he did have an email I'm looking at from Kirsten Coulombe. I asked her about the ARPA funding approval. I can tell you what it says. I cannot answer a single question so I will not be making any good points related to this, but what she said was adding home delivered meals to the frail elderly, adding an assessment for our environmental adaptation services in the PD waiver. This was what was approved this month, supplemental payments for PCs. They will conduct the rate study that Connie mentioned for the Fe and PD waivers, which also added PCAs in the 1915(c) waiver services including adult day health care, residential habilitation, four contract positions with three for fiscal to handle ARPA activities and one for LTSS to help implement, self-directed budget authority option, subscription to the Center for evidence-based policy at Oregon Health and Science University, activities related to electronic visit verification system, adding our 4th MCO and annual security audits, and an agency manager position in ADSD.

Mr. Duarte asked Mr. Gold if there was an increase approved for the frail elderly waiver.

Mr. Gold answered no. He said it just included supplemental payments

Ms. McMullen stated the supplemental is that federal money that's just coming through and it's like a onetime thing.

Mr. Duarte asked is that the \$500.00?

Ms. McMullen answered yes that's \$500.00 and some extra money for the agencies.

Mr. Gold stated at the governor 's conference on health care providers, one of the questions that he because Suzanne Bierman was there as well as the Mr. DuAne Young, the Governor's health policy advisor, was about providers and payment rates for providers. Mr. Gold said he was hoping for that extra money for the provider rate restoration will be added to the Medicaid Governor recommended budget. His question was really for the governor 's office and he asked, "Will the governor's office be including that extra money for the rate restoration?" Mr. Young did not answer the question but discussed education being the Governor's priority.

Ms. McMullen stated she wanted to make this point to the supplemental that went to the personal care agencies. That was to reimburse them for back bill payment that they were not getting a paid at some point before the session ended or the budget cycle ended.

Mr. Duarte asked if that that was for claims recycling and payment?

Ms. McMullen answered yes.

Larry Weiss asked Mr. Gold if all he just described, was that ARPA funds?

Mr. Gold answered that's all ARPA funding. That's what was approved from the ARPA fund OK.

Mr. Duarte stated sort of the bottom line of this discussion is that we don't know what's necessarily going to be happening in the upcoming agency request budget nor the governor 's budget, especially if it's going to be held flat. That could be a problem given the concerns that we've heard from not only providers but people who need in home services and supports. It's a challenge for us and probably something that we ought to be looking towards in terms of our recommendations to the full COA.

## **5. Discussion and possible approval of recommendations on updates to the American Rescue Plan Act (ARPA) Section 9817 (HCBS) Spending Plan**

Inadvertently added to agenda. No presentation given or discussion made.

## **6. Discussion and possible approval of recommendations on updates to 2020 Guinn Institute policy report**

Mr. Duarte stated item number 6 is one that Mr. Weiss requested during the January meeting. This was to see if there were any updates to the Guinn Center's September 2020 report Helping Hands: An Assessment of the Personal Care Aid Workforce in Nevada. The subcommittee heard a presentation from Meredith Levine from the Guinn Center Mr. Duarte said that several things stood out to him from the report. Currently Nevada has approximately 13,000 PCAs that we have information on through federal reporting as of

2020. The Guinn Center suggests that by 2025 we are going to need an additional 5,300 additional workers. The Alzheimer's Association published report for Nevada that by 2025 we might need even more than that.

Mr. Duarte said one of the things he asked Ms. Levine two weeks prior was if she had an update on that report. Ms. Levine said over the next 5 years the demand for PCA services will be the 4th highest demanded service of any professional service. Whether that's restaurant hospitality or anything, it'll be the 4th highest in demanded service.

Mr. Duarte stated that the report they put out in 2020 really speaks to the care gap that's developing where the demand is going to strip our ability to provide services. That's one of the reasons he asked Neva Kaye to present on the NASHP report regarding support for family caregivers because we have to make do with what we have. Mr. Duarte said there is a structural problem that we're dealing with, and that's going to be a big issue. Something that policy-wise or legislation-wise we may need to advocate for the COA to take up.

Mr. Duarte did speak to Miss Levine about any updates to the report. Unfortunately, they weren't able to do that. They looked into doing an update, but she told him that the data that they used for the 2020 report was gathered from Bureau of Labor Statistics (BLS). That was the data for 2018 that they used in their 2020 report. However, she said that beginning in 2019, BLS began to group home health aides and personal care aids into a single occupational Group. They were unable to separate them from one another which presented a challenge in terms of data analysis. They couldn't accurately determine the number of PCS workers nor their accurate wage because they were all lumped in with higher wage workers like home health aides. That was one reason. She said that there is also a lot of attention paid to the workforce demographic composition in that report because the census data for 2020 is still apparently experimental, according to Ms. Levine. They were unable to reliably depend on that data for demographic information. She was very interested to find out what's going on because she said that the \$17.56 an hour that is currently being paid by Nevada Medicaid was at the time insufficient. If it remains at that level the care gap that we're facing is going to get worse.

Ms. McMullen stated there is a huge caregiver shortage. And when there's a caregiver shortage, people can't get care. On that Labor Relations Board, the SEIU representative lobbyist has a great deal of control over the input and what happens in those meetings and how they're structured. She did not agree with it. She thought it should be a neutral 3rd party body. Anyway, they keep pushing forward, even with the minimum wage increases which if you work overtime 8 hours in a 24 hour period is time and a half, to higher rates for the caregiver. It's gone up in recommendations to almost 80% of what the agencies budgets are. If they keep pushing like this, they're going to push some of those companies out of doing Medicaid work. There's only so many companies that are doing this and it's a frail system. They assumed that the companies are making a lot more money than what they're reporting. She did know that those companies that are part of the association pay less to the caregivers down South than they do up North. They seem to have a better a better way of paying people. I don't know what's going to come out of this, but they better start making efforts to enhance those people out there that are doing this kind of great work. The need, as Ms. Levine put in her report, is going to be there.

Mr. Weiss asked how does Nevada compare to other states for PCA wages?

Mr. Duarte answered did not know but said it was in the Guinn Center report.

Ms. McMullen answered I don't know. They've requested that in this study as well because at the time of the past legislative Suzanne Bierman gave a presentation before one of the committees that the PCAs in surrounding states really didn't make that much more than Nevada. Ms. McMullen disagreed with Ms. Bierman's assessment. Ms. McMullen said they were going to make that part of the recommendations because nobody really knows. The administrator is on record as saying that she thought her data shows it's pretty similar, but she was going off of Kaiser data.

Mr. Duarte stated "Mr. Weiss, you're you ask a really good question because that's public record. I've done this before, even more recently with the Alzheimer's Association. I went to 50 state Medicaid sites websites, and I was able to find specific rates for specific services. It's there. The question that you ask is something that we ought to put forward to the full Commission to request from the Division of Health Care Financing and Policy, the Medicaid Agency."

Ms. McMullen stated if we do request that, and I think it's a great idea, we should take into consideration the demographics of Nevada. How spread out Nevada is and who's receiving services in the state and what areas are not?

Mr. Duarte stated this is more anecdotal than everything but over the last few months, he's been asked to do presentations to some of the Alzheimer's Association caregiver support groups. Talking with them was very interesting. A couple of them are paid caregivers. They are friends of the beneficiary. They're on Medicaid and they get paid through an agency. What was interesting was that two of them that spoke up said that the Medicaid agency only approves 5 hours a day but they're providing between 7 and 10 hours a day of service. Taking into consideration things like IADL 's and homemaker cooking, they're on call as in-home caregiver 24/7 and might provide anywhere from 10 to 12 hours of service in a day. They're only authorized to get paid for 5 so that's another issue.

Ms. McMullen stated that if they work for an agency, they have to legally be paid the time and a half.

Mr. Duarte stated "I don't know what's going on with that. I didn't ask that question. They might be assuming since they're only authorized for 5 that's all they can get paid for. You're right. That's an issue too because that'll just increase agency costs as we get try to squeeze more out of each caregiver. Especially out of a family caregiver."

## **7. Selection of a subcommittee member to present on behalf of the Legislative and Policy Subcommittee at the Commission on Aging meeting on May 17, 2022.**

Mr. Duarte shared his plans have changed and he can present at the May 17th Commission on Aging meeting.

## 8. Agenda items for next meeting

Mr. Duarte stated that the subcommittee discussed a couple of items for the next agenda already but would like to hear from the subcommittee members as to any new agenda items that you'd like to hear to learn more about where we could possibly invite not only state staff but others from the community to give us information. "Any particular agenda items that you folks would like to see for the next meeting?"

Mr. Gold answered he would like an update on Medicaid Redeterminations. The Medicaid agency has a new website with information regarding this that is both for providers and for beneficiaries. It's about having the correct address and what the process was going to be, and they did that in anticipation of the ending of the public health emergency which just got extended for 90 days. When he asked Medicaid do you know when the public health emergency would end, before they extended it, they said we only know we're going to get 60 days' notice. He knew a few people that have already been told that disenrollment is pending. They've already been redetermined but they're kicking the can down the road until the public health emergency ends. We need to know what's happening with that. What their plans are, how they're going to be doing that, and what the process is significant of what's going to happen to people here in our state.

Ms. Wren stated it would probably be best to reach out to DWSS for that agenda item. They can present on it.

Mr. Duarte stated the discussion we had today was good to hear from and the email we got from Kirsten. We still need to hear about how the use of those ARPA funds are proceeding, who they're helping, and, even if we don't get an answer, how the Medicaid agency plan to extend the funding for those services into the next biennium. That's still an important issue for us to hear about.

Mr. Gold stated he agreed with Mr. Duarte. We can ask them directly if the restoration of the provider cuts will be included in your recommended budget. What he was told in terms of a lot of the spending plan, the spending plan was all completely approved but they're taking it to IFC month by month by month. Having an ongoing discussion on that for when they're rolling those out is helpful.

Mr. Duarte asked is the agency request budget still top secret or is that something that can be publicly accessed before it goes to the Governor for review?

Mr. Gold answered that is top secret.

Mr. Duarte stated this is for possible action but did not think we need a motion or approval for these agenda items. If anything else comes up that the subcommittee please don't hesitate to contact Rebecca or Cynthia, who are on this call today, and they'll communicate with me as to what members are interested in hearing about. I hope the presentation today by Neva Kaye from The National Academy of State Health Policy was helpful. That's something I'm hoping that we can get the state to consider as a change to the current waiver for the frail elderly or maybe even more broadly to all the waivers.

## **9. Next meeting date**

Tentative meeting scheduled for July 22, 2022.

## **10. Public Comment**

Shannon Sprout stated Connie was asking about some data sources. There is an organization out there called Phi Quality Care (?) through quality jobs. They have a workforce data center that focuses solely on personal care and they've also done a recent policy report about caring for the future. She would be happy to send that information to Cynthia and Rebecca. They can pass it along to you. I think it definitely shows you can drill down on that data across the nation about the rates and everything else as well.

## **11. Adjournment** – The meeting adjourned at 2:15 p.m.