Action plan proposal to begin re balancing the Long-Term Health Care system in Nevada

Problem

The problem is the dramatic increase in spending for "unlicensed" SLA / CBLA care has come at the expense of **ALL** Licensed Long-Term Care provider types including PCA, Big and Small RFFG, and Nursing Homes, the safety and quality of care for the disabled and mentally ill and the community.

Action Plan

We need to empanel a committee of provider experts to discuss a relative fair, free market cost / value for each service. Without a provider-based panel to fact check each other much is lost in the estimates and descriptions. It is difficult to see how a Nursing Home used for Long Term Care, which faces some of the heaviest state and federal monitoring of any business type and takes the most difficult cases who are unable to reside anywhere else cost effectively, can be paid $6000 / mo. and Transitional Living SLA / CBLA can be compensated at the same rate. Both offer activities, training, but the nursing home includes it in their underfunded daily rate. An example of the need for fact checking is to clarify for all parties when there are gross discrepancies in the use of common terms like Basic Skills Training (BST). Basic Skills Training which professionals would describe as teaching a developmentally disabled to tie their shoes or ride a bus similar to that offered at opportunity village is very different from the "BST" we commonly see in the Unlicensed SLA / CBLA area which can be coloring in a group session or going for a simple walk around the block. Moreover, BST requires some reasonable expectation that the individual can benefit. A mentally retarded/Developmentally Disabled person clearly can benefit with added training but a person with advanced dementia or mental illness who has already had that chronic illness for a long time *and the expectation is for that disease and other care needs to progress* are very different uses of BST. In this case the $37 price tag per person per hour likely has contributed to not having adequate funds to create an Opportunity Village based housing project which targets the needs of the Developmentally Disabled. I believe that the misguided goal of "giving everyone total freedom and independence" has contributed to the negative outcomes for the disabled this idea is attempting to protect. The clarification is that for anyone who needs ANY protective supervision they require some system of check and balances or structured care for their safety. When a Dementia expert tells an audience everyone in the memory care unit should be able to go out whenever they want that unquantified, inconsistent, statement can mislead those who are listening. If they are saying you need to provide 1-1 care to accomplish that the next issue is for a relative value analysis of how one is choosing to spend their limited resources and second, is it fair to the person who needs protective supervision to put them in a overly challenging setting that promotes negative outcomes for the very behaviors and issues they are receiving protection from? If everyone agrees to video cameras in the room to improve protective supervision in people who are not truly independent and who choose to live in a protective setting is that bad or intrusive? Or is that a mis use of the laudable goal of promoting freedom to deny them the needed set of proven safe, Olmstead compliant, regulations which keeps them safe AND helps them remain as independent as possible in the supported setting they choose? Indeed, the supports improve their independence while maintaining their safety.

Move all SLA / CBLA's that offer any combination of protective supervision, medication management, or caregiving into the same division of NRS 449 licensed RFFG. Merely moving them to NRS 449 and still keeping them in a separate regulation type seems to only perpetuate the problem. The issue is less NRS 449 and HCQC but the effect of the proven safe RFFG regulations that past legislators, regulators, industry providers, fire marshals and the community have developed over 20 years.

Re allocate funds from Unlicensed SLA / CBLA care to Licensed care and create a single, consistent, set of regulations for all similar types of care.

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Add personal responsibility to the qualifying criteria for new Medicaid patients.

We need to focus on the most difficult cases for providers to care for. *Those are new patients who are in crisis and are new applicants to Medicaid*. Also, those on Medicaid who face the annual review and the withholding of reimbursement when a resident is out of the home. This is accomplished by adding in an element of personal responsibly for families and responsible parties to provide the required banking information within a 1-2-month time frame. After that the state needs the legislated ability to move for temporary guardianship or co guardianship. Doing that will allow the state to monitor the safety and finances of the individual at high risk especially at a time of crisis. Moreover, it will add an element of trust back to all providers who now cannot take any Medicaid pending or Medicaid pending the recurring annual review at which time they might be cut off from any pay. Getting the underfunded current rate is clearly better than getting no pay and still being required to provide the care. Fixing this situation will go a long way to protect those most in need and improve the flow for the entire health care system while protecting families and individuals' rights to self-determination. I also would require an ongoing social work evaluation for anyone on state funds and a legislated permission that after that state agent noted two instances of any care choice not providing safe care for the disabled person that the state could move to temporary guardianship and require the family / individual move to a more structured care choice.

Initial suggested rate adjustments for Licensed care which have suffered on a relative basis with the over funding of "unlicensed" SLA / CBLA care.

Increase Medicaid rate for PCA's from $17/hr. to $25/hr.

Increase the F and E waiver from $1200 - $2000 to $3500/mo. and more for Dementia Endorsed care.

Increase the Long-Term Care Nursing home daily rate from $200 to $230/day. In this effort we also would suggest that residents have failed two community-based choices (PCA with family support to provide the difference in care, or Licensed care in a big or small RFFG) first before they try LTC SNF care. By making that a policy it improves individual choice while the need of the state health care system to protect the most disabled thus balancing reasonable safe care choices within the broader state LTC health care system.

The industry panel can assist state finance agencies in evaluating the relative value of existing "unlicensed" SLA / CBLA care. It is likely there is a lot of excess spending as the many State Audits, TV news and community complaints have illustrated.

Dr Shawn McGivney

Direct answers to posed questions

Areas of focus include, but are not limited to, the following:

• **Documented average operational costs for group homes and CBLAs by expense type.**

-Another presenter is doing this for Licensed Group Homes.

-It is impossible to follow the multi-level of reimbursement for SLA / CBLA. We offer what we can from Freedom of information act requests. We also can confirm the total revenues are close to $5-6000 from multiple billing sources including BST/ PST and other revenue streams

• **Input regarding what components of the current rate structure providers would like to see changed or improved.**

-Increase the payment for Licensed care choices of PCA from $17 to 25/hr, RFFG as described by other industry members but $3500 for the F and E waiver, and nursing home from $200 to $230/day. In all cases we need to consult with each individual industry.

-We need to get clear, complete, accurate financial data for the SLA / CBLA to begin to see where the $90 million is going.

• **In practice, how are services provided in a mental health group home different from those in a CBLA?**

They are not different. THEY ARE THE SAME NON-MEDICAL SERVICES OF PROTECTIVE SUPERVISION, MEDICATION MANAGEMENT AND CAREGIVING.

The medical services also are the same and are provided by medical care teams like SNAMH. Combining Medical care and Non-medical may be a goal for big insurance companies to bundle both services but it seems to come at a cost to ALL LICENSED Non-medical **and** Medical providers. It is unclear that any small business impact studies have been done for Doctors whose services are infringed upon, or any of the licensed providers who have seen their services negatively impacted by the creation of this second, Unlicensed SLA / CBLA industry.

-If you need BST / PST it makes sense to include the big players in the field of Developmental Disability like opportunity village. They remain under funded and do BST in most of their training but are not compensated at $111 per hour for a session with 3 clients. ($37 / hr @ 3)

• **What specific components of the current mental health housing models, within regulation or statute, are considered to be unreasonably restrictive, antiquated, or unnecessary?**

The Licensed industry, tax payers, and single-family residential home owners are deeply concerned with the growing data base of in effective use of state / tax payer funds and negative outcomes for those served under Unlicensed SLA / CBLA care.

Over reaching the intent of the idea of "total freedom" and unlimited ability to get a job for all individuals has put many WHO ARE NOT ABLE TO LIVE INDEPENDENTLY OR GET A JOB WITH ANY AMOUNT OF TRAINING at unnecessary risk. Those people who NEED protective supervision are done a dis service when you set the rules to dis allow required safety features like removing locks on doors, or camera's in the room when the family and individual agree that they have protective supervision needs that require that.

It is unreasonable and disingenuous to confuse these two. If you need protective supervision for safety it is difficult to at the same time say you should be "independent" with the expectation of getting a job especially for those with well established chronic illness WHOSE EXPECTATION IS TO GET NEEDIER. More reasonably and practically we want to use a structured care setting like Licensed care to improve independence in the structured setting.

-It seems unreasonable and contrary to free trade and fair business practice / commerce laws to have two systems of care to do the same thing. Clarifying how we ensure each professional, client, and the long time functioning licensed business are compensated or provided informed consent is needed.

-The Licensed group home industry with mental illness endorsement believes creating a new, Unlicensed, SLA and now CBLA industry which is more expensive and less monitored WHEN NEVADA HAD A NATION LEADING system of care with a well-established, multi-level, system of checks and balances is unnecessary and has caused unneeded negative outcomes for many.

• Do the current mental health housing models allow providers the opportunity to deliver an appropriate level of care, in the most independent environment possible, based on the needs of the individuals served?

The data from State Audits, TV news and other sources is clear. NO, current Unlicensed, SLA / CBLA Mental Health Housing has dramatically declined since the State moved most mentally ill residents from the safe, consistent, proven cost-effective Licensed group home with mental illness endorsement to the "unlicensed", state funded and certified SLA / CBLA system of care.

The underfunding of all Licensed care is causing providers to switch to the higher profit, less work, but unsafe for the client Unlicensed system of SLA / CBLA care. This comes at a time when there is a rapidly growing crisis for all with chronic illnesses in the LTC system state wide.

-The experiment of the 1915 and other waivers has its own track record of cost over runs, low quality care, which are proven by state audits, negative TV news stories and a decline in needed licensed care beds. SNF beds for LTC are reduced by half due to underfunding of SNF LTC beds. Yes, Half! 5000 before and now 2500 LTC beds and 2500 Short Term Rehab. Because it is re allocation of a fixed number of beds you can reduce the % quickly. When they say we are building new beds in fact they are building new short-term rehab beds WITH NO INTENTION OF PROVIDING LTC.

-The mis classification of people at "transitional living" or independent living when they are not limits the care they can get. This is reflected in all public data we have.

-We are concerned that a name changes from SLA (supported Living Arrangements) to CBLA (community-based Living arrangements) alone will not improve the care or fiscal efficiency. Indeed, if you change the name I would expect things to stay the same or get worse not better. We need to require all "unlicensed" care become licensed under the same NRS 449 regulations as current Licensed PCA's, RFFG.

- Shawn McGivney MD, RFA