# MINUTES OF THE
# LEGISLATIVE SUBCOMMITTEE TO STUDY
# LONG-TERM CARE IN NEVADA
# March 9, 2000

A meeting of the Legislative Subcommittee to Study Long-Term Care in Nevada (created as a result of Senate Concurrent Resolution 4 – 1999) was held at 10:00 a.m. on March 9, 2000, at the Grant Sawyer State Office Building, 555 East Washington Avenue, Room 4401, Las Vegas, Nevada. The meeting was video-conferenced to Legislative Building, 401 South Carson Street, Room 3138, Carson City, Nevada. Exhibit A is the Meeting Notice and Agenda; Exhibit B is the Attendance Roster.

## COMMITTEE MEMBERS PRESENT IN LAS VEGAS:

Senator Mike McGinness, Chairman
Senator Raymond Rawson
Senator Terry Care
Assemblywoman Merle Berman
Assemblywoman Sheila Leslie
Assemblywoman Kathy McClain

## STAFF MEMBERS PRESENT:

Steve Abba, Senior Program Analyst, LCB Fiscal Division
Thomas Linden, Principal Deputy Legislative Counsel, LCB Legal Division
Ann Iverson, Deputy Legislative Counsel, LCB Legal Division
Sherie Silva, Secretary, LCB Fiscal Division

Chairman McGinness called the meeting to order at 10:25 a.m. and roll was called. He apologized for the meeting's late start. He alerted the audience the committee planned to work through the lunch hour in order to finish the day's business, noting that the committee had some very important issues before it.

Chairman McGinness asked for a motion to approve the minutes of the January 13, 2000 meeting. Senator Rawson so moved; Assemblywoman Leslie seconded the motion, and it was passed unanimously.

Senator McGinness noted that this was the third of five scheduled meetings. One more informational meeting will be held, after which a work session will be scheduled. He reviewed the purpose of the committee:

1. To identify alternatives to institutionalization;
2. To analyze the costs of those alternatives;
3. To determine the positive and negative effects and methods to provide long-term care services and quality of life to persons receiving those services;
4. To determine the personnel required for those services;
5. To determine realistic methods for funding;
6. To evaluate possible waivers from the federal government to integrate and coordinate acute care services through Medicare and Medicaid; and
7. To evaluate the possibility of waivers from the federal government to eliminate the requirement of

impoverishment as a condition of receiving assistance.

Chairman McGinness said it is important to review the charge of the committee each meeting. Moving to Item IV of the agenda, he introduced Jan Marie Reed, Executive Officer of the Public Employees' Benefits Program.

Ms. Reed said the Public Employees' Benefits Program is looking at long-term care for several reasons, one being that all of the programs in the benefits program are being reviewed and, beyond that, long-term care is clearly an issue. Long-term coverage was not offered on the voluntary program this year because the carrier that offers all of the state's voluntary products was revamping its product and it was not ready for the state's open enrollment. Ms. Reed said consideration is now being given to placing long-term care coverage back on the voluntary program. However, she believes that because of the number of issues involved in long-term care, it is important to know where the committee is going as well. She noted the education cycle in long-term care is very cumbersome and lengthy, and therefore the state does not want to start a program and then have to switch at a later date.

Ms. Reed stated the actuarial issue relative to long-term care is that it is a new product in the market as it currently stands. It has been around for a long time, but not as a much-used product. Long-term care is very conservatively underwritten, and therefore if the state chooses the option of self-funding, it will probably be the forerunner in the market. Ms. Reed said due to the fact long-term care is driven by age demographics, the feasibility of self-funding would involve a lot further evaluation and analysis. She said the state is open to the idea of self-funding, but she believes there needs to be very aggressive investing, which would be the key to success of self-funding the program. Self-funding will also require good claims management and a stable enrollment in order to build a fund over the long term with a reserve.

Continuing, Ms. Reed said a subsidy could be a valuable part of the long-term program, particularly as an incentive for participants to get involved. It would be possible to subsidize to the point of providing a base plan. She said the state's evaluation has resulted in between $10 million and $20 million for a base plan to be offered to everyone. The other possibility would be some sort of incentive subsidy to encourage participants to purchase, which could easily be handled through the Public Employees' Benefits Office since currently eligibility is done there. Ms. Reed stressed that aggressive education must be a part of the program if an incentive plan is offered. She said the state is also open to the piggy-backing idea; it would be feasible and easy to coordinate with the services already being provided through the Public Employees' Benefit plan.

Ms. Reed referred the committee to Exhibit "C" (original on file at Legislative Counsel Bureau Research Library), and she reviewed it briefly, remarking that long-term care is clearly the largest unfunded liability facing Americans:

- Long-term care supports physical and mental disabilities and includes custodial care, as well as bathing, cooking, and shopping, which can be provided at home or in a nursing home. Ms. Reed said long-term care is not the same care normally thought of as being provided in a hospital.

- The risk for needing homeowners' insurance is 1 in 88 and car insurance is 1 in 47, but the need for home or nursing home care is 1 in 4.

- With regard to who pays for long-term care, $26 billion is paid by the residents or families, and Medicaid and Medicare is available only when all other resources have been expended.

- Eighty percent of care is provided in the home or in a community-based facility, and most of it is being provided by family and friends. Ms. Reed said the program the state is considering will include the benefit for family and friends and will not require provider licensing.

- Sixty-four percent of the family caregivers are employed full- or part-time. The average caregiver provides about 18 hours of assistance a week, or a total of about $2 billion per month.

Ms. Reed outlined the features that should be included in a state program:

- Nursing home care with two types of home care, either in a facility by professionals, or by family and friends. The price of products for nursing care/home only is much less, but the reward is much less as well.
- The policy must be portable so that an employee leaving the state can take it with him.
- Extended eligibility is an important feature; coverage should be available for purchase for family members.
- Level premiums should be a benefit of the program. A young person should be able to lock in his/her rate for the life of the product. The average age of a state employee is 47 years, which means the premium will be high.
- There should be no offsets with Medicare. There are two products currently available — one requires receipts for all care in order to receive benefits. Ms. Reed recommended the indemnity type of policy, which does not include coordination with Medicare. Once an employee is certified to receive the benefit, receipts and claims are not required.
- Guarantee issue for employees would be an important feature.
- Inflation options are cost drivers in policy premiums; some kind of minimal simple-interest plan is anticipated in the state program.

Senator Rawson asked if retirees would be included in the guaranteed premium portion of the plan. Ms. Reed replied the guaranteed premium is anticipated to include only active employees.

Senator Rawson stated the committee would be interested in looking at a plan for state retirees also. Ms. Reed explained the age demographics that have been considered include the retirees; the $10 to $20 million figure does include retirees. However, as far as a voluntary product, a current employee can purchase coverage without any health survey or medical examination, while the retirees will be required to complete an application. The criteria would require certain procedures, conditions, and durable equipment to be needed based on age. Ms. Reed said these factors would be considered in the underwriting.

Ms. Reed explained the differentiations would include:

- A disability model, which provides freedom of choice as to who is going to provide the service and cost-effective delivery so that family and friends can be utilized without submitting claims.
- Total, informal-type care, which includes family and friends, and licensing is not an issue.
- Enrollment and communication services are an important key. The education cycle in this type of product is very long term, and includes several venues and continuous customer service.
- A large case implementation team, which is very important. Structured meetings should be required, as well as continued reinforcement. Enrollment will be key in the ability to fund the plan over the long term.
- Customer service, including telephone consultations and payroll deduction.
- Efficient and appropriate claims management.

Ms. Reed said she would be happy to spend more time with the committee and/or the actuaries; her purpose today was to provide an overview of the status of the long-term care plan. She emphasized the differentiations are extremely important in choosing a good product. She is also very interested in knowing the direction the committee is taking in order to know whether to move ahead quickly with a voluntary product, or whether to hold back.

Assemblywoman Leslie recalled the state had offered a voluntary program in the past, and she wondered what the percent of participation was at that time. Ms. Reed said she could not recall the participation percentage of the past plan, but over 200 people call about every three weeks to check on the status of the plan. Therefore, Ms. Reed reiterated, she is very interested in knowing what to do to move forward. She does not want to pursue a plan if it cannot be offered for six months, or if the committee decides on a different type of program.

In response to a question from Ms. Leslie, Ms. Reed said a very small percentage, less than 10 percent, of employees who had signed up for the previous product have indicated an interest in the new product. Ms. Leslie then asked Ms. Reed to explain the "piggyback effect" referred to earlier. Ms. Reed replied the plan would simply be added to the program currently available, and it would be offered through the current enrollment process, advertisement, education, etc., i.e., part of the insurance plan menu.

Senator Rawson said he was interested in knowing what the cost would be to cover all employees and retirees, as well as to provide optional coverage for family members. He feels the larger base and wider age demographics would reduce the premium considerably. Ms. Reed replied their study has indicated the cost would be $15 to $20 million to include the entire population. The large population base would help to drive the premiums down, but the plan is age-specific. She reiterated the workforce of Nevada is not a very young population (average 47 years) and does not include much of an offset with very young workers.

Senator Rawson observed it would be possible to craft the product to fit it into whatever price range is decided upon, although the benefits should not be degraded too much; Ms. Reed agreed. If funds were available to offer a long-term care plan as a product rather than a self-funded plan, he asked Ms. Reed if her office would be able to staff its implementation; she replied it would not be a problem.

Senator Rawson said he suspected it would be more costly to the state, but there is a known quantity when offering a product. He said the state may not be ready to create another major self-funded program without knowing all the eventualities. Ms. Reed reiterated the state would be a forerunner if it were to offer a self-funded program. She emphasized again the need for an education piece which must be considered in the funding. She advised the committee that her office is very willing to cooperate in any way toward making the program successful.

Senator Rawson affirmed the premium is anticipated to be $15 million a year; Ms. Reed concurred. He noted that would probably be less than one percent of the state payroll. In other words, instead of a salary increase, long-term coverage could be added for roughly what a one percent salary increase would cost. Ms. Reed added long-term coverage is often considered a retirement-type benefit—it really is protecting an employee's assets. She clarified that before she could commit to participating in the implementation of a program, she would need to obtain the approval of the Committee on Benefits; however, she believes the committee would be agreeable.

Assemblywoman Berman asked if it would be possible to self-fund the plan. Ms. Reed again noted that the actuary had indicated the state would be a forerunner in the field if it were to self-fund the plan. Because it is a new product as far as current design, there is no experience from which to draw results. However, the actuary has advised not to rule out the possibility, but more study will be required.

Ms. Berman asked if there is any model available which includes half self-funding and half employee contribution. Ms. Reed explained a self-funded plan is not truly an insurance product; it involves developing funds to pay for the plan. A plan involving self-funding and employee contributions would still be considered a self-funded product. Ms. Reed is not aware of any product of that sort.

Senator McGinness remarked if such a product were to be created, it would probably have to be made mandatory. Ms. Reed agreed, saying mandatory participation would be required in order to obtain the needed enrollment and the required enrollment mix to make the plan economically feasible to build reserves. If only the older population were to participate, the needed enrollment funds would not be available. Ms. Reed would consider such a plan adverse selection, i.e., the state would be paying the premium for only those who would be using the service, and there would be no chance to build a reserve.

Senator McGinness asked when the state's open enrollment period is scheduled. Ms. Reed replied open enrollment takes place from mid-October to mid-November. Because the long-term product will be offered through the current voluntary program, it will be possible to roll it into the market at any time; it will not be necessary to wait for the open enrollment period. However, if it is necessary to delay offering the plan, it can certainly be offered during open enrollment. Ms. Reed reiterated she has 200-plus people anxiously waiting for the plan to be offered. Since the carrier is ready to offer the plan, she would like to move ahead, albeit cautiously.

Obviously, Chairman McGinness observed, the Committee on Benefits is interested in what the long-term care committee will be doing. However, he noted that whatever is decided upon by the committee, legislation will not be proposed until the 2001 Legislative Session, and nothing will be effective until October of 2001. Therefore, he would hesitate to have the Benefits Committee wait on the results of the long-term care committee before moving forward.

Senator McGinness said he understands the state is going to offer the long-term plan on a voluntary basis, and he asked what the education component, which is the most important feature, will involve – will it entail something beyond people visiting the pay centers to promote the product? Ms. Reed said continuous meetings have been held with the carrier in order to keep the process active. The carrier has some very nice brochures which will be made available, and monthly workshops will be conducted for at least three months. She said most of the pay centers are very willing to provide a 15-minute block of time with employees, and it is hoped employees can be educated on the need for long-term care.

Senator McGinness recalled the committee has received information on other states that offer incentives for participation in long-term care, some of which involve a credit on state income tax. Since Nevada does not have a state income tax, he wondered if Ms. Reed envisions any other types of incentives the state of Nevada could offer. She replied the possibility of offering a subsidy has been studied, but a lot of planning would be required for situations such as in the event an employee received the subsidy but then didn’t choose the product. Rather than subsidizing a full base program with some options, an incentive subsidy could be implemented, but a funding method would need to be worked out.

Chairman McGinness thanked Ms. Reed for her presentation, remarking that it was very helpful. Ms. Reed apologized for the fact she could not stay for the rest of the meeting, but stressed her interest in the committee’s activities.

Senator McGinness moved to Item V of the agenda, Presentation on Premium Costs for Long-Term Care Insurance. Guy Perkins, Chief Insurance Examiner for the Life and Health Section, Division of Insurance, said he would make a brief presentation on a state-sponsored long-term care program for state employees and retirees.

Ms. Perkins explained that prior to the January 13, 2000 meeting of the Subcommittee to Study Long-Term Care in Nevada, the Division of Insurance contacted the largest eleven long-term care insurers, which represents 84 percent of the total market share in the state, and asked for certain information. Eight companies responded to the survey, representing 74 percent of the long-term care premium in 1997. As a result of a request from the committee, Mr. Perkins contacted the Public Employees’ Health Benefits Committee for demographics on employees and retirees, and a listing of all employees and retirees by date of birth and sex was provided. The Insurance Division developed a chart with five-year age banding for each sex between the ages of 30 and 80, and one number for ages under 30 and one number for ages over 80. Mr. Perkins said the division then contacted the eight long-term care writers that had responded to the first survey, again representing 74 percent of the market share. The two largest writers are UNUM Life Insurance Company of America (25%) and GE Capital Assurance Company (22%). Several conversations have been held with GE Capital, and the company is genuinely interested in supplying some figures to the state on a group basis. Mr. Perkins noted that in conducting a survey such as this, companies are very careful to make sure that they are not under-pricing or over-pricing the numbers provided. However, GE’s figures have not yet been received. Only two companies have responded so far, and they did not provide any information; one company only writes individual coverage.

Mr. Perkins reviewed the seven assumptions, or pricing factors, that were asked for in the survey:

1. The group is composed of current employees and retirees of the state of Nevada.
   The group size is in excess of 25,000 people with the average age being 49.
2. Coverage for nursing home facility care and home care.
3. 20-day elimination period.

4. 3 years of coverage.
5. 5% compounded interest inflation protection.
6. Coverage of $100/day for nursing facility care and at least 50% for home care.
7. The policy would cover all eligible employees and retirees without any underwriting.

Mr. Perkins explained the last assumption was the major distinction of the plan, i.e., the state is interested primarily in a group plan because a group plan offers certain protections that individual policies do not. Most of the long-term coverage sold in the marketplace is individual, but there are some group plans available as well.

Senator Rawson recalled that during the 1999 Legislative Session, one of the things that led to this study of long-term care was a bill to provide long-term care insurance. At that time a request was made to New York Life Insurance Company to provide a premium, and it was a reasonable premium. Since New York Life was not included in the Insurance Division's last survey, he assumes the company must no longer have a significant part of the market share in Nevada. However, since New York Life had gone to significant effort to produce a very competitive figure, he wondered if there was a reason New York Life could not be asked to respond to the survey, since they had expressed an interest earlier.

Mr. Perkins replied the division has a copy of New York Life's plan. Senator Rawson remarked he was aware the plan was not as rich as the plan being proposed, but he was sure the company would respond if the new questionnaire was sent to them. Mr. Perkins explained there are two primary differences between the New York Life plan and the plan currently being considered:

1. The New York plan is individually underwritten, which means that someone age 70 who is in reasonably good health would have a $200/month premium, and another 70-year-old in poor health might have a significantly larger premium. Under a group plan with age banding, the employee would be locked in for the term of the contract, depending on his age when the policy was written.

2. Group plans do not usually limit themselves at the top end of the ages; they still have the ability to offer economies of scale in a single premium based on the population and overall health of the group.

Senator Rawson said some basic assumptions and decisions had been made when requesting the proposal from New York Life, and in looking back, he thought the state might want a better plan than what had been asked for then. However, since New York Life was willing to go to the effort to create a special plan, Senator Rawson thought the company would respond to whatever parameters were set. Since there does not appear to be a rush from other companies to provide a product and a price, he requested that Mr. Perkins include New York Life in the process.

Mr. Perkins referred to Exhibit "D", a chart depicting the Demographic Distribution for State of Nevada Employees and Retirees. He noted the total population, including current employees and retirees, is 25,153. The plan being requested by the Insurance Division is to include the entire population, not just current employees. The premium should cover all of the age groups, based on the weighting that an insurance company would use given the number of younger people that would apply as opposed to the number of older individuals.

Mr. Perkins observed the two largest age bands, which probably best represent the baby boomers, are the columns including ages 45-50 and 50-55. They are by far the largest group that any long-term care program would have to serve in the future.

Concluding his presentation, Mr. Perkins said he would provide the figures from GE Capital to Mr. Abba when they are received.

Assemblywoman McClain asked if long-term coverage would be limited to only three years of care. Mr. Perkins replied she was correct, and he explained that the shortest benefit period that can be offered in Nevada is two years, and the longest is five years. The Insurance Division has chosen three years based on the fact that the top end of an average stay in a nursing facility is three years; very few people stay beyond that time.

With regard to the $100 per day benefit, Ms. McClain asked if an inflation factor would be included. Mr. Perkins replied that would be true; there are numerous inflation factors offered in the marketplace. The Insurance Division has chosen a 5 percent compounded rate, which would be built-in on a yearly basis.

Ms. McClain asked if there are other programs that would take over if an individual's stay in a nursing home exceeds three years, or if the individual would have to become impoverished at that point. In other words, she wondered if the three-year period would be sufficient. Mr. Perkins said unless an individual qualifies for Medicaid, there is very little offered under Medicare benefits. Therefore, any expenses not paid by the long-term care policy would have to be paid from private sources.

Assemblywoman Berman asked what a stay in a nursing home costs per day, and how much coverage the $100 per day would provide. Mr. Perkins replied he has seen figures of about $3,500 per month, but the $100 per day would cover a large percentage of today's nursing facility costs. He reiterated a 5 percent compound interest has been added for inflation purposes.

Chairman McGinness asked Mr. Perkins to stay in touch with Steve Abba and provide him with any further information received. He thanked Mr. Perkins for his presentation, saying the information provided is exactly what the committee needs.

The next agenda item was a Presentation on the Feasibility of Pursuing a Medicaid Waiver Associated with Affordable Assisted Living and the "Coming Home" Initiative Sponsored by the Robert Wood Johnson Foundation. Charlotte Crawford, Director of the Department of Human Resources, introduced Janice Wright, Administrator of the Division of Health Care Financing and Policy, and Mary Liveratti, Administrator of Aging Services.

Ms. Crawford remarked Agenda Items VI, VII, and VIII will reveal how very connected Aging Services and Medicaid are—approximately 60 percent of the long-term care beds in the state of Nevada are paid for by Medicaid. Medicaid is the primary funding source for the majority of long-term care provided in Nevada. Aging Services is charged with constructing policies that are responsive to seniors and to try to create comprehensive care systems.

Ms. Crawford said for too long, long-term care has meant nursing care in Nevada. Attempts are now being made to try to create alternatives to the traditional nursing home, develop a continuum of services, construct services that meet a senior's need but do not exceed a senior's need, and allow them to be as independent as possible for as long as possible. She said the greatest challenge is how to continue to use Medicaid to develop alternative ways to propose to the federal government new ways to use Medicaid, which has traditionally been institutional support funding, into community support funding to precede entry into a nursing home. Ms. Crawford reiterated the funding source of Medicaid and the ability to create new solutions are very related, and because the cost of long-term care is extraordinary, the percentage of long-term care paid by Medicaid will probably grow as in other states. As baby boomers get older, growth is anticipated. The challenge to Medicaid is going to be increased in terms of the percentage of Medicaid dollars, so long-term care comprises the greater challenge of how to find creative alternatives to primarily institutional-based long-term care.

Chairman McGinness said Senate Bill 370 from the 1999 Legislative Session would allow seniors who had long-term care coverage for at least three years to not divest themselves of all assets. He asked Ms. Crawford to provide an update of the status of that proposal.

Ms. Crawford said the Department of Human Resources has prioritized its assignments, and senior pharmacy was above long-term care, not in importance, but in terms of timing. S.B. 370 indicated that individuals who exhausted three years of long-term care insurance benefits would be covered by Medicaid if their income was under $250,000. Ms. Crawford said in talking with Health Care Financing Administration (HCFA), the range was determined to be somewhat high, and other states have adopted use of asset adjustments rather than income as a determination of participation in the program. She said the department is still working on the proposal. Some modifications and work will have to be done in order to achieve the goal, which was clearly to incentivize individuals to carry long-term care insurance, and to have some assurance that Medicaid could be expanded to a broader population, as well as to not force individuals to completely reduce their assets and income in order to be eligible.

Senator McGinness asked if the program would have to be strictly a state program with no federal participation. Ms. Crawford replied the current language stipulates an income which may be too high for HCFA participation, so there may have to be adjustments. A lot of the dialogue will have to include whether the income range should be that broad, and whether there are other ways to address the income, such as asset adjustments. If different methodologies are used to adjust and/or reduce income and assets, Ms. Crawford believes HCFA will participate.

Janice Wright, Division of Health Care Financing and Policy, reiterated that the three agenda items referred to by Ms. Crawford are truly interrelated, and it would be difficult to isolate comments to just one aspect. She advised that she and Mary Liveratti would be making a joint presentation, with their comments covering agenda Items VI, VII, and VIII.

Ms. Wright recalled she had made a presentation at the committee's first meeting on Medicaid and its coverage of long-term care. She reminded the committee there are about 40 facilities statewide, with about two-thirds of the beds occupied by Medicaid-eligible clients. An amount in excess of $100 million per year is expended in just nursing facility costs.

With regard to Assemblywoman Berman's question regarding nursing home costs, Ms. Wright explained that Medicaid reimburses at different levels as follows:

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|---|---|
| Intermediate Care Levels I, II, & III | $ 54 to $ 84 per day |
| Skilled Care Levels I, II, & III | $103 to $235 per day |
| ICF/MR | $ 88 per day average |

Ms. Wright said most of the clients being served are at the Intermediate Care Level III, a total of 1,609 individuals. She noted it is important to understand what is currently being provided while considering alternatives. Medicaid is the only mechanism to provide for persons who are in a facility and cannot make payments; they do have to become impoverished and move into a Medicaid reimbursement system for their care.

With regard to whether there are alternatives and options the state can pursue, Ms. Wright said she would try to provide some basic information which may assist the committee in its deliberations. As a result of the January meeting of the Long-Term Care Committee, a meeting was held in February to investigate what resources can be used to develop alternatives. Representatives from Health Care Financing and Policy, the Division for Aging Services, Medicaid, Employment Training and Rehabilitation, Accessible Space Incorporated (ASI), and the private sector met to discuss various concerns with regard to long-term care. Ms. Wright acknowledged this type of planning has not been done in Nevada, but as a result of the meeting, the issues to be addressed are now being considered. She said the primary focus of the meeting was to look at the issues the Department of Human Resources would have to explore if other options were considered. Most of the information from the meeting is included in committee members' agenda packets (Exhibit "E", original on file with Legislative Counsel Bureau Research Library).

Ms. Wright said some of the specific issues to be addressed by DHR agencies include, but are not limited to:

- What is the population to be served? It is necessary to understand the population to be served in order to understand the services required.
- What recipients would fall into what categories?
- What options do those recipients currently have?
- How are those services currently being provided?

Ms. Wright said it will be necessary to define "assisted living," which has not been done in the state of Nevada, and to focus on the unmet needs of the specific clients. It must also be determined whether there is an opportunity to expand an existing waiver. She explained there are currently four waivers in Medicaid, two of which are administered through the Division for Aging Services (CHIP and Group Home Care), one for the physically disabled, and a fourth for the developmentally disabled. Focusing on the two Aging Services waivers, Ms. Wright said the CHIP waiver may lend itself very nicely into being expanded to provide other options. A Medicaid waiver is approved for a three-year period, and then there is a five-year opportunity to renew the waiver. The CHIP waiver will be submitted in about a month for the next five-year period, and the Group Care waiver will be submitted in a year for another five-year period.

Chairman McGinness asked Ms. Wright to describe the process for developing a waiver. She explained anyone can submit an idea for a waiver, and then because of its understanding of the federal requirements, the Division of Health Care Financing and Policy prepares the language. Any waiver to be proposed must be supported by the Department of Human Resources, and the Director is the designated individual with authority. The Director approves or denies the waiver, and then upon approval it is sent to the federal Health Care Financing Administration (HCFA) for review. Ms. Wright's office then works with HCFA to ensure the proposal complies with all of HCFA's specific requirements.

Senator McGinness asked if a waiver is essentially a bending of the rules, and by bending the rules, a program can be cost-neutral or actually save money. Ms. Wright said Senator McGinness was correct, adding that HCFA has requirements with respect to cost neutrality, as well as limitations requiring evidence of how a benefit will be realized, not only to the individual but to HCFA as well. A waiver might be necessary to address other issues which may not apply to a population statewide, e.g., to provide a specific service to the senior population only would require a waiver because the service would not be offered to everyone on Medicaid.

Mary Liveratti explained the purpose of Medicaid dollars is to provide medical services. Waivers allow the state to provide services that are not necessarily medical, and allow supporting services that assist people in not utilizing the medical system as much as they might if the support systems were not in place. Under a waiver, the number and type of clients to be served can be designated, and a certain population can be targeted. Under the State Plan, services that are actually an entitlement must be provided to everyone who meets the eligibility requirements.

Janice Wright cited respite care as an example of a waiver situation, explaining that respite care is not a Medicaid State Plan service. If respite were to be offered through Medicaid, the state would have to pay for it with 100 percent General Fund dollars. However, if respite is used as a service in a waiver, federal participation is available. Ms. Wright said the reason respite care is viewed as a beneficial item is that if, rather than providing 24-hour continuous care, a caregiver can be given time to run errands or do other chores, ultimately there is an effective cost savings, because the patient is not forced into an institution. Therefore, the federal government recognizes the savings and allows the services through a waiver.

Continuing, Ms. Wright explained a variety of other non-waiver options were discussed in the DHR work group meeting, but the resulting information and conclusions were that it appears that expanding an existing waiver or proposing a new waiver would be the best way to proceed. She said it is very difficult to make a determination concerning cost neutrality, because DHR is not sure what the waiver or amendment will look like. Ms. Wright said it will be necessary to assure HCFA that the cost of the home- and community-based service is not going to be in excess of the cost that would be expended if that person were in an institution. She said it is important to note that while DHR does not have the answers, staff have started the research – they are looking at what other states do, what other Medicaid programs do, who else in the country has waivers that may provide some beneficial information. Ms. Wright said as a body of information is developed, DHR will share it with the committee. She apologized for not having the answers to all of the committee's questions, but she reiterated research is being conducted with other states and HCFA, and it is anticipated some options will be developed and submitted to the committee.

Ms. Wright said DHR currently does not have the ability to identify specific individual residents in a nursing facility who could be more appropriately placed in a community-based setting. There are the four existing waivers, and there are waiting lists for them, but it is not possible to determine how many individuals would qualify because the parameters of the waiver are unknown. Ms. Wright explained there obviously will have to be some type of cost savings associated with the waiver, but typically the savings are not an immediate dollar-for-dollar savings. Savings will result because people will not have to be put into an institutionalized setting if additional assistance in the home- and community-based setting is provided.

Responding to a question concerning whether existing staff and resources are available to develop the waiver, Ms.

Wright commented she does not believe the DHR currently has any staff who would volunteer to take on the project. However, information can be developed as to what the needs would be for the department if the waiver were proposed, whether it be a new waiver, an expansion, or an amendment to an existing waiver. Ms. Wright said the 1999 Legislature gave the Department of Human Resources a number of tasks to work on, and everyone is working hard to complete those tasks as expeditiously as possible. Quite honestly, she added, staff members are researching the waiver, but specific individuals are not assigned to the task 100 percent of the time.

Ms. Wright said there was consensus by the DHR work study group to examine the potential of expanding the CHIP waiver, which is through the Division for Aging Services. PCA Homemaker and Personal Emergency Response Systems are currently provided in a number of waivers, and those services would certainly have to be provided. However, Ms. Wright said some additional components of services need to be considered.

With regard to population and eligibility issues, Ms. Wright said the department does not have enough information from other states to be able to provide hard facts at this point. There is a gap in client services between the Department of Employment, Training, and Rehabilitation (DETR) program, and that information will be evaluated to determine what the best seamless process would be available when a person reaches the age of 65.

The department was also asked to look at the concept of a pilot study versus a full-scale program, but Ms. Wright said the department really doesn't know what types of medically necessary services could be offered and reimbursed by Medicaid. She said any proposal brought before the committee should show who would end up paying for the services. If a proposal is brought to the committee that is not a federally allowable expense through Medicaid, the committee needs to be aware. Based on initial evaluation, Ms. Wright said it appears a fair volume of clients would be necessary in order to draw down sufficient dollars and make it cost effective. The department is looking at these factors in order to provide the information to the committee.

Ms. Wright cited other issues that the DHR work study group considered:

1. Waiver budgets cannot provide for room and board. This is a concern for assisted-living facilities.

2. Sufficient providers must be available to offer services to the clients.

3. Income and eligibility guidelines for the recipients must be considered.

4. Specific costs will have to be developed for the service.

5. Cost neutrality.

Ms. Wright said it appears that a pilot study may be more appropriate than a full-scale program, or an expansion of an existing waiver may provide an opportunity to place some limits that will give some ability to project actual costs and services without it being a Medicaid program. She said that as Mary Liveratti explained, Medicaid is truly an entitlement program, and services must be provided to any person who qualifies through income eligibility, which makes it difficult to associate a cost with this kind of an option.

Assemblywoman McClain asked if the waiver expansion/amendment process is essentially an exercise in paperwork through the federal government, and she wondered how long the process would take. Ms. Wright replied Ms. McClain was correct. HCFA provides boilerplate forms to all states, which must be completed whether applying for a new waiver or an amended waiver. It takes staff several months to work through the requirements and to receive informal guidance from HCFA. Once the language is developed and approval obtained from the Director of the Department of Human Resources, the application is sent to HCFA, which has a 90-day period of time in which to review it and give the state an answer. If HCFA has questions or needs additional information, they have the authority to postpone the deadline.

Assemblywoman Leslie asked if an existing waiver such as the CHIP waiver can be used to reach a targeted population. Ms. Wright replied yes, that can be done.

Ms. Leslie asked if the committee should formally request the Director of Human Resources to make a decision on whether she would support a waiver—what would be the best process to go forward and learn whether the director would support a waiver? Ms. Wright replied if the committee believes a waiver should be pursued, a request should be submitted to Health Care Financing and Policy, and Ms. Wright will prepare the documentation needed to submit to the director. The question is not so much whether or not she will approve a waiver, but she should be able to ask Ms. Wright specific questions regarding timeframes, staffing, research, etc. Ms. Wright said if the committee directs her to pursue a specific kind of waiver, she will prepare the necessary documentation for the director. Ms. Leslie said the committee could certainly provide a formal request.

Assemblywoman Leslie noted Ms. Wright had mentioned conducting research in other states, and she wondered if she had contacted Dr. Mollica and Mr. Rimbach, who had made presentations to the committee at its January meeting. Ms. Wright replied both gentlemen have been contacted, and Mary Liveratti would be including that information in her presentation.

Ms. Leslie asked how the Olmstead Supreme Court decision will relate to the state of Nevada, and what steps will be taken to ensure compliance. Ms. Wright replied the Olmstead decision does have an impact on state services provided, not just through the Division of Health Financing and Policy, but through a number of other DHR divisions. She said the issue is foremost on every agenda for every meeting of state Medicaid directors. Stating that she is not an attorney, Ms. Wright said the elements which focus specifically on what states must do include states must develop plans, and the plans must include how to provide an opportunity for individuals to receive services in something other than an institutionalized setting. She noted that in his presentation to the committee at the January meeting, Dr. Mollica complimented the state of Nevada for providing options to institutionalization through four existing Medicaid waivers.

Ms. Wright said it was obvious during the 1999 Legislative Session that the legislature was concerned about Olmstead. Specifically, there were about 165 individuals on the waiting list for the physically disabled waiver, and about 125 people were being served. As a result of Olmstead and concerns brought before committees, the 1999 Legislature appropriated an additional $500,000 in the first year and slightly more in the second year of the biennium to expand the slots in the waiver from 125 to 185. Ms. Wright emphasized this plan eliminates the requirement that all people be served in an institutionalized setting; the plan is to continue to use waivers as an appropriate mechanism to provide services in the home-based setting.

In summary, Ms. Wright said all of the state Medicaid directors are working on having in place various plans and ways to continue to promote alternatives. She said the same discussion will likely be brought before the 2001 Legislature as a result of the biennial budgets currently being developed. DHR believes waivers do provide good services and allow individuals to receive services in a home- and community-based setting, and it can be demonstrated that there are associated cost savings, perhaps not immediately, but certainly in the long term. More importantly, Ms. Wright continued, a quality of life issue is being addressed by allowing individuals to receive services in their homes or community-based settings, and those elements are being built into the state plan to demonstrate that Nevada has the ability to offer clients something other than institutionalized care.

Assemblywoman Leslie asked where the state is in the HCFA process as far as applying Olmstead—she expressed some doubts as to whether the state will be okay. Ms. Wright replied she is not the best person to assure that everything is okay with Olmstead. However, the department is working on the issue and trying to learn how other states have addressed Olmstead. There are a number of lawsuits regarding other states' Medicaid programs, and Nevada is looking at the outcomes of those cases to determine what issues cause problems for other states. Ongoing meetings of Medicaid staff and counsel involve discussion of the issue, at least on a monthly basis. Ms. Wright emphasized Nevada does have a plan in that it does use waivers, and it has been viewed by the courts that as long as there is the ability to allow access to other than institutionalized settings, the state should be on the right track. The courts have indicated it is not appropriate to offer institutionalization as the only option. Although an institution might be the appropriate placement for some individuals, they cannot be forced to settle for that as the only option. The question for states is whether they have a mechanism in place to offer alternative care, and Nevada does.

Ms. Liveratti added Aging Services is sending a representative to a national meeting on the Olmstead decision in April, and the major discussion will be its impact on aging programs. She said she would share any further information with the committee at a later date.

Chairman McGinness noted that the Legislative Counsel Bureau Legal Division has developed a response to Olmstead, and he suggested a presentation be made at the next meeting.

In regard to the Robert Wood Johnson "Coming Home" affordable assisted living grant program, Ms. Liveratti said a letter of intent was submitted by the March 1 deadline, and proposals are due June 1. The DHR work group referred to by Ms. Wright will be working to develop a proposal, and if it is successful, those funds will be helpful in planning a pilot project to provide affordable assisted living services for those who cannot access them through the current private-pay system. Ms. Liveratti said one of the requirements to be considered for the funding was to guarantee that a demonstration project would be in place within one year of funding, and the proposal submitted by Ernie Nielsen at the January meeting is about two or three years out. However, Mr. Nielsen has been instrumental in looking at other housing projects that might be able to convert to assisted living and utilized as the demonstration project. If successful, the grant would provide $300,000 over a three-year period; Ms. Liveratti said she would keep the committee informed of the project's status.

Ms. Leslie thanked Ms. Liveratti for her cooperation and efforts in trying to position the state to take advantage of the grant. Ms. Liveratti said the situation portrays the difficulty with any one agency trying to work individually, but the collaborative effort is really making a difference. Aging Services is concentrating on the service piece; Jon Sasser, Ernie Nielsen, John Rimbach, and the Housing Division will focus on the housing part; and together, hopefully a good project proposal with a good chance of funding can be developed.

With regard to the committee's concerns that persons on the Senior CHIP waiver have to pay a patient liability, which is a cost-sharing program, Ms. Liveratti said there are currently 850 individuals on the CHIP waiver program, and 101 of them have a patient liability. The annual revenue for this fiscal year is projected to be $89,000. She explained Aging Services does not determine patient liability; that is determined by the Welfare Division when Medicaid eligibility is established. Eligibility for Medicaid is determined first, and then a second calculation is done to determine if the individual is assessed a patient liability. The patient liability is paid on a monthly basis. The Division for Aging Services bills clients every month and collects that money and tracks payments made in order to reconcile. Ms. Liveratti said there is unpaid patient liability each year for a variety of reasons, and in 1999 approximately $10,000 was not collected. If money is not collected, it must be made up somehow, because when a billing is submitted to Medicaid, the patient liability is deducted out, i.e., the unpaid patient liability is money that has been paid out to service providers that the department is unable to collect through the reimbursement system. Ms. Liveratti said the state-funded CHIP program has to be used to offset the loss of revenue. She added the division tries very hard to collect all of the patient liability; every possible effort is made. There is a stipulation in the eligibility that failure to pay can result in termination from the program.

Ms. Liveratti explained one of the difficulties in the payment of patient liability is not only is patient liability determined at the time of application and eligibility determination, but many times patient liability notice of decisions are made retroactively, which creates a hardship on the clients. She said in those cases the division tries to accommodate the clients through a payment plan and write-offs; however, clients are also terminated.

If the patient liability were eliminated, Ms. Liveratti said the division would bill Medicaid for the full cost of services, so that out of the $89,000 currently collected for patient liability, approximately $44,500 would come from federal funds and the other $44,500 would have to come from state funds. She also wanted the committee to understand that the patient liability is deducted out of Medicaid Estate Recovery that occurs after a Medicaid recipient dies. The state will go back to the estate of the deceased client and try to collect the money that has been spent on services during his lifetime through the Medicaid program. Again, if the patient liability were eliminated from the CHIP waiver, those funds would be recovered in the Medicaid Estate Recovery process, which is administered by the Division of Health Care Financing and Policy.

Assemblywoman Leslie asked if the CHIP patient liability is a state option or a federal requirement. Ms. Liveratti said she was not sure; she had thought all waivers had patient liability, and she was surprised to learn that CHIP was the only waiver with patient liability.

Janice Wright explained there is no patient liability in Medicaid, which is a federal requirement for Medicaid. However, the waivers offer something different, so the same requirements do not apply.

Thus, Ms. Leslie asked, the state of Nevada decided to include patient liability as part of the CHIP waiver. Ms. Wright replied she was correct—the state created the waiver with the patient liability. If the CHIP waiver were a State Plan service, it could not include a patient liability.

Ms. Leslie asked if the patient liability could be eliminated. Ms. Wright said she would be willing to pursue that possibility. Assemblywoman Leslie remarked it seems to her the patient liability for one particular waiver is discriminatory; the disability waiver has no patient liability.

Ms. Liveratti said much confusion is created when individuals transfer from the disability waiver, a system with no patient liability, to the CHIP waiver, one with patient liability, when they turn 65 years old,. She said it is important to keep in mind that the disabled waiver targets a different population than the elderly waiver. The disabled waiver is only for those who are disabled and have a chronic disability for a long period of time, e.g., a 20-year-old who is permanently disabled from a car accident. The issues are different than those of the elderly. The elderly waiver applies to older individuals with chronic diseases which create a different type of disability. Ms. Liveratti speculated the CHIP patient liability may have been included as a result of different issues. Typically people coming from the disabled waiver have much more need for hands-on assistance on a regular daily basis, involving several hours a day, than many of the elderly on the CHIP waiver, most of whom require only one or two hours of service two or three times a week. Ms. Liveratti said the elderly population receives assistance from either a spouse, friend, adult children, etc., and Aging Services relies on that support system to provide services that the division cannot provide.

Continuing, Ms. Liveratti said at one time 50 percent of the CHIP clients were living alone, but that percentage has dropped to 45 percent at the present time. Because of the frailty and medical needs of the aged, the division now has a greater reliance on other support systems, whether it be family, friends, or other services. The Division for Aging Services alone cannot prevent institutionalization in most cases.

Ms. Liveratti said there have not been a lot of clients moving from the disabled waiver to the CHIP waiver; in fact there have been only ten people so far. She clarified that those individuals do not have to reapply for the CHIP waiver; case managers from Aging Services and Health Care Financing and Policy work together to assure there is continuity of care and services are not interrupted.

Responding to a question regarding the group care waiver and the differences in eligibility from CHIP and nursing homes, Ms. Liveratti explained that both CHIP and nursing homes have a 300 percent SSI level for the income level, and the group care waiver is at the SSI domiciliary rate, which is approximately $860. A CHIP client who has up to $1,536 of income a month and is over the $860 does not have the option of transferring into the group care waiver; the only option would be to enter a nursing home. Since July 1, 1999, there have been 29 individuals discharged from CHIP directly into nursing homes because of the inequity in income levels. Ms. Liveratti recalled that Dr. Mollica had mentioned this issue at the January meeting, and he had suggested raising the group waiver up to the $1,536 level, which would make the three programs equitable.

Ms. Liveratti said the group care waiver will be renewed next year, and five-year projections will be developed. She and Janice Wright have been discussing building the increase to a 300 percent SSI level into the five-year projections to analyze the impacts and ramifications. Ms. Liveratti said she is concerned that it may create a disincentive for group caregivers who may want to have clients at the higher income versus the SSI clients.

Assemblywoman Leslie said she had made note that this issue also needs to be addressed, and she encouraged Ms. Liveratti to pursue the matter. She said this is an obvious group for which a lot of extra money is paid, and perhaps they are not getting the quality of care they need or deserve. Ms. Leslie said she personally would love to see the increase.

Ms. Liveratti noted that the group care waiver is very limited. There are only about 70 individuals currently on it, and since July of 1999, 29 have moved into nursing homes; that number is estimated to be 50 or 60 by the end of the fiscal year. Without looking at each specific case, she could not say for sure that the group care program would have been appropriate, but the state is picking up the nursing home costs of these people because they are eligible under the 300 percent SSI.

Ms. Leslie remarked that potentially the state could realize a significant cost savings and, at the same time, provide better care and services. Ms. Liveratti replied she is very hopeful that will be the case.

Moving to the single point of entry system that Dr. Mollica had referred to at the January committee meeting, Ms. Liveratti explained that a single point of entry system was developed because of the fragmentation of services in the long-term care delivery system. When people need long-term care services, they often do not know where to start searching for help. Many states have designated a single point entry system so that an individual can go to a centralized location to receive information on long-term services that cover the entire spectrum, from the home to residential care to nursing home. Ms. Liveratti said the systems vary as to what they provide. In some states the single point entry system is actually a centralized information referral or a clearinghouse concept to ensure that anyone trying to access long-term care services is aware of all available services. Another version of the single point entry system covers the whole range of services which include not only referral, but screening, assessment, care plans, and oftentimes authorization of services and monitoring ongoing appropriateness of the services. This is often called the case management system, as is the case in Nevada. Ms. Liveratti explained that Nevada's case managers not only prescreen, they assess the individual's needs, develop a care plan, provide monthly monitoring services to ensure the client's condition is not changing and services do not need to be adjusted, and monitor the quality of services.

Ms. Liveratti reviewed the components of a single point of entry system:

- Information and Assistance
- Assessment of Needs
- Care Planning
- Case Management

Chairman McGinness asked if the centralized case management covers all elderly persons in the state. Ms. Liveratti replied no, it does not. She qualified that she is addressing the program from the perspective of the elderly who are trying to access long-term care services, and as mentioned earlier, there are other types of clients in long-term care systems, i.e., the physically disabled and developmentally disabled. Since the aging population is her area of expertise, and about two-thirds of those accessing long-term care services are elderly, she would be discussing this population only.

Ms. Liveratti explained that many other states utilize Area Agencies on Aging (AAA's), but Nevada does not have AAA's. She said many years ago the decision was made to disband the AAA's in the state and become a single source and service agency. The thinking behind the decision at the time was that AAA's are another level of administration, and because Nevada is such a small state, it was decided to not put more dollars towards administration. The AAA's were disbanded, and the State Division for Aging Services became a single state agency. However, Ms. Liveratti clarified, the division functions as an AAA, so when federal funds are received, the division is required to do everything an AAA would do, e.g., planning, disbursement, ongoing monitoring, etc.

In some states, Ms. Liveratti continued, there is one single point of entry statewide; others are regionalized by counties; some use AAA's; some use county social services or health departments. Massachusetts developed 27 non-profit Home Care Corporations, many of which are AAA's. In Nevada, the Division for Aging Services provides all four components of an AAA but, as Senator McGinness alluded to, they are not provided for everyone. Ms. Liveratti said information referral is provided to any older person and his/her family about long-term care services; information is available not only about community-based services under the division, but also about residential services, nursing homes, payment mechanisms, and a variety of other services. The division can do prescreening and assessment for anyone who applies for services under the division's home- and community-based services through the group care and CHIP waivers, but those services are not provided to private-pay clients. She said many states perform these services for private-pay clients, but Nevada typically refers private-pay clients to private case management agencies. There is not a centralized, comprehensive case management ongoing coordination mechanism for a person. If a family member or older person comes to the Division for Aging Services for information about services, the division provides the information and tries to send them in the right direction and assist them as much as possible. However, they are basically on their own once they receive that information; the division provides no follow-up to see that they are connected to the services. In some cases, however, follow-up is provided through the community ombudsmen, but typically this is not the case.

Ms. Liveratti said she had met with the Nevada Alzheimer's Association, both north and south chapters, and a centralized comprehensive case management system is a concern of theirs. It is difficult to find residential care facilities, and even nursing homes, that are willing to provide services to Alzheimer's patients. Ms. Liveratti explained these patients require additional care and oversight in order to properly care for them.

Ms. Liveratti announced there is some good news: A press release was received yesterday that the Administration on Aging is releasing funding for Alzheimer's demonstration projects. Grants of between $250,000 and $350,000 per year will be available to states that have not been able to access Alzheimer's demonstration grants in the past, and Nevada is one of those states. Ms. Liveratti said the division is working on a proposal to be submitted in April. She reiterated Janice Wright's concern about the lack of time and resources available for planning. However, it is hoped that additional funding through demonstration projects will enable the division to develop the planning piece. Instead of addressing systems in a piecemeal fashion, it is important to look at the system as a whole and make recommendations to bodies such as the Long-Term Care Subcommittee concerning what needs to be done to provide a comprehensive long-term care system, including payor sources, services, and clients to be served.

Senator McGinness asked if the fact that Nevada does not have a central case management system for all elderly has created a gap which people are falling through and, if so, what steps need to be taken toward creating a comprehensive system. Ms. Liveratti replied she thinks people in need of these services become overwhelmed, regardless of the assistance and information provided. They may receive assistance for their current problem, but the condition of a frail elderly client can change dramatically from one month to the next, and they may be in and out of the hospital before case management services are in place. Ms. Liveratti agreed that the fragmentation of the service delivery system is cause for concern, although case managers are able to coordinate services and assist families in providing care to keep elders at home for as long as possible. She remarked that she has worked in the social services field for 25 years, but when she had an uncle become very ill in Arizona, she became extremely frustrated, although she is a social worker working with social workers. Even knowing the systems it is very difficult, but the elderly person trying to access the systems and make sense of eligibility requirements becomes extremely frustrated. Ms. Liveratti said a central case management system needs to be able to provide coordination of all needed services, including meals, transportation, medical, etc. The goal is to keep the clients in optimum health in order to keep them out of the acute care system and institutional settings.

Ms. Liveratti said there is a need for nursing homes, and there are cases of people entering nursing homes and leaving them. Entering a nursing home is no longer a one-way street as it was many years ago; they are often used for rehabilitation. She said the case manager follows a client into the nursing home and helps to ensure that proper services are being provided in order to allow the client to return to the community.

Assemblywoman Berman asked when the division would expect to receive funds from the Alzheimer's grant. Ms. Liveratti said the proposal must be submitted by April 21, and she did not recall what date the funds would be awarded.

Ms. Berman asked if the Division for Aging Services was working with the Alzheimer's Association in developing the proposal. Ms. Liveratti said the division is working with the Alzheimer's chapters, and their proposals from the Legislative Health Care Committee are being reviewed; it definitely must be a collaborative effort. Another proposal for a support system and day care demonstration project may be a part of the proposal also.

Assemblywoman Berman said she hears from her constituents that a voucher program is needed, and she hopes one will be included. Caregivers get burned out, and there is no one to turn to; this was a large piece of the four-page resolution heard by the Legislative Health Committee, and she expressed the hope that some relief can be given to caregivers.

Assemblywoman Leslie said she had recently attended a national legislative conference where she heard a presentation from California about a community-based information referral and case management system funded by the state. She had asked Mr. Abba to possibly arrange for a presentation to the committee at the next meeting. She wondered if Ms. Liveratti was familiar with the California information referral option, and if she thought it would work in Nevada. Ms. Leslie noted the program appears to be similar to Nevada's family resource centers, and she thought it might be attached to the existing senior centers. It is currently very difficult for the elderly to find resources within the state, but everyone should be able to find their senior center. Ms. Leslie thought in a local community, the senior center would be the first place to look for services.

Ms. Liveratti said a listing of all the different ways information is disseminated could be found on a later page in the meeting packet. Although she is not really familiar with what California is doing as this time, she would be more than happy to hear what they are suggesting. Some of the ways Nevada has tried to increase the information is implementation of an 800 number called the Eldercare Health Line. Ms. Liveratti explained the number is not a hotline—it's a health line that is only open the hours the department is open, Monday through Friday, 8:00 to 5:00 p.m., and it is staffed by community ombudsmen. The health line was set up originally to assist individuals trying to access services and information, especially homebound seniors and their family members. The community ombudsmen then follow-up, and if more than just information is needed, sometimes it takes a number of calls to make sure people get connected to those services. Ms. Liveratti noted there are only three community ombudsmen statewide, so their time is limited in what they can do.

Ms. Liveratti continued, saying the division has also created two websites during the last year. One is www.nevadaaging.net, which is in conjunction with the State Health Insurance Advisory Program (SHIP), and the Nevada Elder Caregivers website deals directly with caregivers. She said it is hoped that baby boomers using the Internet might use it as a way to help grandma, grandpa, mom, or dad access information about Aging Division services. Ms. Liveratti explained the Elder Caregivers site is under construction; it started in the north and is being expanded statewide this year. It will not only provide information, but will have a chat room where people can chat with experts about caregiving concerns, including subjects such as upcoming caregiver training. Ms. Liveratti said the division hopes this might be another way to reach out to the public to get information into their hands.

The Aging Services Division also has 34 project NEON sites where either computers or web t.v.'s are provided in a variety of settings such as senior centers, community centers, and family resource centers. People can visit the sites and access information, and trained volunteers are available to help them if they are not familiar with how to access the Internet. Ms. Liveratti also noted that the National Elder Care Locator has a nationwide toll free number, 1-800-677-1116, and if someone has a concern about an elderly person living in another state, he/she can call the number and access information about services in that area.

Ms. Liveratti said she cannot emphasize enough the need to develop a comprehensive plan for long-term care. The issues are currently being addressed in a piecemeal fashion, and a lot of time, energy, and funds are wasted. With the tobacco settlement money providing independent living grants, the state has an opportunity to look at some demonstration and pilot projects that may be useful toward maximizing resources through Medicaid or other sources.

Chairman McGinness said the committee is looking for direction, and he asked if there would be a positive response to seeking an additional waiver. Janice Wright said the DHR work study group had determined the best way to proceed would be through expanding the CHIP waiver. She added the work group plans to continue developing information to be provided to the committee for its review if that would be appropriate.

Senator McGinness replied the committee will have only one more meeting in which to gather information; the final meeting will be a work session to actually develop legislation if there is interest in putting legislation forward. He asked that all information be submitted by the end of April, the tentative date for the next meeting. He emphasized that the DHR staff are the experts, and the committee needs to receive specific direction from them.

Assemblywoman McClain asked if it is possible to utilize waiver funding for case management costs, or if it must be used strictly for payment to group homes, etc. Ms. Wright replied there are case management services in nearly every current waiver, and those are federally allowable Medicaid expenses.

Ms. McClain asked if federal dollars would be available to support across-the-board single point entry case management. Ms. Wright responded the waiver would have to be crafted in such a way that the purpose of it would be to provide case management services for all seniors in order to ensure there will be federal match dollars available.

Charlotte Crawford said the Department of Human Resources would be glad to provide assistance and guidance to the committee. She explained sometimes the term "waiver" is used as something slightly different than what it is, i.e., a waiver of some rule in Medicaid statewide, rather than an actual program expansion or addition. In other words, she said, all changes are not waivers. Ms. Crawford explained the long-term care program is the only Medicaid program at the maximum federally allowable income. However, she added, the component that has not been discussed is who puts up the matching dollars for long-term care – there is another partner not at the table today. The state puts up the match dollars if the income is between 0 and 157 percent Social Security; however, above that (up to 300 percent of SSI) the county pays the match dollars, which is a very important issue. Ms. Crawford said as people are shifted into waiver programs, one of the issues that needs to be addressed is that they are shifted away from a county match on to a state match, and in time that amount will add up. She said she is getting a sense of the need to provide the committee with more assistance and guidance of Medicaid and what Medicaid does, as well as what other states have done.

Chairman McGinness introduced Carla Sloan, Nevada State Director of the American Association of Retired People (AARP), who was present to provide Recommendations on Improving the Quality of Care for 2000 and Beyond.

Ms. Sloan thanked Chairman McGinness and the committee for the opportunity to present a briefing on the AARP Invitational Conference, Long-Term Care 2000 and Beyond, that was conducted in Las Vegas on February 7, 2000. She said the purpose of convening the long-term care conference was to provide an informal atmosphere for focused discussion on three critical components of the long-term care continuum:

- Home- and community-based services;
- Residential living; and
- Nursing homes.

Referring to a hand-out from the AARP conference (Exhibit "F"), Ms. Sloan noted some basic definitions were provided at the conference to establish some common ground for participants. Conference opening remarks were provided by the chairman of AARP's Health and Long-Term Care Action Team, Dr. William Hausman, who gave a brief summary of the work of the Legislative Subcommittee to Study Long-Term Care. Ms. Sloan said Dr. Hausman had said among the important issues confronting the members of the committee are:

- The enormous amount of data on the subject to be digested;

- The cost of implementing each of the various approaches to dealing with long-term care in Nevada;

- The need for flexibility and creativity in establishing cost-effective long-term care;

- The critical importance of waivers in the search for more humane and less costly options to traditional nursing home care; and

- The importance of separating out the issues of privately funded and state employees from those dealing with the large population of individuals that fall under the umbrella of Medicaid and other public support.

Continuing, Ms. Sloan said Dr. Hausman had observed that each of these issues merit close attention from the state, but the solutions will differ and will require different legislative, fiscal, and administrative remedies. She said it is the hope and expectation of AARP that today's dialogue will serve as a useful step in the process that yields legislation and administrative strategies aimed at the resolution of this very complex and important problem affecting many citizens in the state. It was the goal of the conference that through the gathering of people, the resources, discussions, and facilitated group exercises, AARP might be of some assistance to the committee in bringing back some information, which was part of the reason for Ms. Sloan's appearance at the meeting.

Following Dr. Hausman’s introductory remarks at the conference, about thirty minutes were devoted to the subject of Nevada’s long-term care landscape. Ms. Sloan said much of the information covered was drawn from the Long-term Care Committee’s records. She commended the committee for the work completed to date, adding that she believes the minutes and background material from the committee meetings comprise the most current and comprehensive collection of information on long-term care available in Nevada. The information was of great assistance in preparing her remarks for the conference.

Referring to another handout that had been distributed (Exhibit “G”), Ms. Sloan explained it provides Census population data for the one-year period from July 1, 1997 to July 1, 1998 by county. She emphasized it is important to remember that Nevada’s growing population does not exist in all counties of the state. There are four counties with declining population, and the funding of a long-term care system with a voluntary county match program is vulnerable—if one county fails to meet its obligation, the whole system falls apart. Ms. Sloan said AARP is mindful of how vulnerable the program is and how important those counties are as stakeholders.

Other issues of significance to AARP, Ms. Sloan continued, were gleaned from the Utilization Report Chart found on page 3 of Exhibit “G”. Referring committee members to the data for calendar year 1998, she pointed out that from an occupancy perspective, skilled nursing accounted for 29.4 percent of the inpatient care days. Intermediate care, which is non-medical care, accounted for 70.6 percent of the inpatient days. The chart found on the last page of Exhibit “G” reflects the distribution of patients among the different types of facilities. Ms. Sloan noted that during 1998, 27 percent were discharged to acute care or a hospital setting, 29 percent went home or to stay with family members or friends, 16 percent died, and 28 percent went to other settings.

Ms. Sloan said one of the assumptions that can be made from the information is that there is a potential for the provision of care in settings other than nursing homes. She believes the numbers also reflect the institutional bias of the Medicaid Program, which is a major barrier to the provision of care in alternative settings such as the home. Ms. Sloan said institutional bias results from longstanding Medicaid methodologies and an antiquated medical model for the provision of long-term care services. She emphasized that non-medical custodial care is not funded at the same level as institutional care. Public policy that recognizes the need for non-medical services in the home and community that are essential for maintaining health and independence is critically needed.

Ms. Sloan explained the AARP conference was a working meeting. Following the introductory remarks, three participant groups were formed around the topics of home- and community-based care, residential care services, and nursing home care. The work groups only had two hours to answer four specific questions:

1. What is the need for the services, and who needs them?
2. What are the barriers?
3. How can the barriers be broken down?
4. What makes sense for Nevada?

Ms. Sloan reiterated that the work groups had only two hours in which to work, and therefore the recommendations were not intended to be final—they were intended to be brought forward for further consideration, discussion, debate, and information. However, everyone at the workshop was struck by the fact that each of the three work groups came forward with very similar issues, and the one that really stood out was the single entry point. Ms. Sloan thanked Chairman McGinness for inviting the Department of Human Resources staff to address the issue at this meeting; AARP representatives have gained much valuable information on which to build. She said the single point of entry meant something different to each work group, but the main point is that the long-term care system is so big and so confusing, everyone enters it at a different point in time, and there is no coordination at even the community level, much less the state level, as to how people access services, particularly long-term care services.

In referring to long-term care services, a definition was needed so that all conference participants understood what was being discussed. Ms. Sloan said an individual consumer of long-term care services does not use the same terminology, e.g., someone may call and ask about assisted living or a rest home. She noted there has not been a formal bureaucratic definition of a rest home in a very long time. However, there is the notion on the part of the consumer that a skilled nursing facility is a rest home that might be run by a non-profit organization that will provide care and support in a caring and loving environment for someone who is alone. Ms. Sloan emphasized that is not what nursing homes do; it may be what assisted living or group care facilities do, but there are no common definitions and there is no common point of entry—it is confusing. She said good services are provided to those who qualify for state services, as described earlier by Mary Liveratti. Ms. Sloan believes committee members can feel good about the state dollars being allocated for people who qualify for state services. However, people who do not qualify for state services have access to the information and assistance piece, but there are only three community ombudsmen statewide; they cannot serve the number of people who need a guide through the maze. The notion of a single point of entry, whether it is called that or care navigation or case management, is people first need information and then they need guidance through the confusing system. A list of group care facilities is given to a client, but there is no definition, no idea of who regulates, what kind of oversight takes place, or how to find out what regulatory findings have been made. Clients are not provided with the needed tools to make good decisions for themselves and their loved ones.

Ms. Sloan said it would be wonderful if a single point of entry system could be created under a waiver, but after listening to the earlier discussion, she would want to be sure that everyone, regardless of income, would qualify. Currently she does not know what funding source would provide that.

Reviewing the notes of the three conference work groups, Ms. Sloan highlighted some of the concerns brought forth from the Residential Services group:

- Very broad definitions for an array of facilities, e.g., assisted living is licensed under residential care (no definition);

- Various degrees of supervision in residential care facilities;

- Different regulations for different sized facilities;

- Training mandates, initially and ongoing;

- Language barriers;

- Low salaries and wages;

- Etc.

In reply to the question “What makes sense for Nevada?”, the Residential Services group’s response was to develop a single entry point with care managers to:

- Prescreen,
- Assess,
- Determine financial eligibility,
- Place,
- Monitor, and
- Check on quality.

Ms. Sloan noted all of the listed activities are performed by CHIP workers for their clients. The nursing home unit in the Clark County Social Services Senior Program and Washoe County Seniors Program have similar systems, but the rural communities have nothing. Since people are not qualifying for government assistance, they do not have access to these types of services.

Ms. Sloan reminded the committee that about one-third of the clients in long-term care are disabled, not aged, and a long-term care system starts with living independently at home to institutional placement.

The Home- and Community-Based Care group came to similar conclusions, and there was a lot of discussion regarding caregiver needs. Concerns included:

- Burn-out,
- The need for respite,
- The need for support for family and caregivers,
- Homemaker services,
- Personal case,
- Case management,
- Early intervention,
- Adult day care,
- Transportation,
- etc.

Ms. Sloan recalled that Mary Liveratti had stated earlier that services provided under the CHIP program rely on the fact that there are support services in addition to those that can be bought. Services are purchased under CHIP from private vendors, home health agencies, adult care centers, Meals on Wheels programs, etc., but those alone are not enough to enable people to stay at home. Without parents and family members, the CHIP program cannot maintain people independently. Ms. Sloan emphasized that caregivers are critical and seldom acknowledged.

When the Home- and Community-Based Care group was asked to prioritize recommendations, the first was for the state to commit to the concept that care costs, that health care be determined to be a priority, and that all entities involved should work together to find the resources to fund it. The next recommendation was that service should be based on need rather than availability, i.e., people should be able to receive care in their homes rather than have to enter a nursing home to receive intermediate level of care. The third recommendation was to implement a single point of entry system.

The third group, Nursing Home Care, also recommended a statewide long-term care case management system. Ms. Sloan said many of the care providers in attendance expressed their frustration at having people placed in a long-term care facility who perhaps did not need to be there. However, at the time they were placed there were no family members or neighbors available to support them, and they could not afford to pay someone to come in and provide the care. Thus, they were placed in a nursing home not for rehabilitation, but with the notion that they would probably not be returning home. Ms. Sloan explained patients who enter nursing homes are those who have been placed there for rehabilitation or who have no hope of leaving. However, with good intervention at the beginning, a good assessment and health evaluation of the individual's status now and into the future, and a single point of entry, it might be possible to bring services to those folks at home or help to find resources to avoid nursing home placement in the first place.

Ms. Sloan said it was heard during some of the work sessions that Senator McGinness should be told to take people out of nursing homes and use the money for care in the home. Being the voice of doom, she would ask, "Do you think you can bring many people out of nursing homes?" Once individuals have been institutionalized for six months, a year, or two years, their homes have probably been sold, their furniture is gone, their clothing is gone, and they have developed a dependency on the system. However, Ms. Sloan reiterated, they can be prevented from being placed there in the first place with good assessment, case management, and a single point of entry.

The other piece of the dilemma is to have the services to provide to people at home. Ms. Sloan said the tobacco settlement funds and the Aging Services Independence for Seniors grants alluded to earlier are very exciting prospects toward enhancing the current waiting lists and opportunities at the community level to provide adequate services, e.g., day care, respite, friendly visitor, and home companion. She remarked that although the tobacco settlement funds are not going to be the answer to all of the problems, they will certainly make a difference during the next couple of years when baby boomers reach retirement age and as their health begins to diminish.

In summary, Ms. Sloan said she hoped she had presented a fair representation of the conference discussion. She was personally appearing before the committee out of responsibility to those who attended the conference who are hesitant to testify, as well as to share the informal experience of the conference with committee members. Ms. Sloan stated her presentation did not represent formal recommendations, but rather conference participant observations and an accounting of the dialogue that took place on February 7, 2000.

On February 8, 2000, AARP volunteers took the recommendations from the conference and spent the day trying to answer the question, "What can we do that will make a difference?" Ms. Sloan said one of the outcomes of the discussion was a commitment to improving the quality of care and, most importantly, the quality of life for recipients of long-term care throughout the service continuum. Recognizing that front-line professionals such as homemakers, home health aids, and certified nursing assistants provide the majority of care, the volunteers were very concerned about the severely limited training requirements for workers. Ms. Sloan said the AARP volunteers believe that in forming the long-term care system, a short-term goal should be to increase the training requirements for paraprofessionals in long-term care environments. Federal law requires a minimum of 75 hours of training for nursing assistants in nursing homes. Nevada statute requires just 8 hours of training annually for persons employed by residential facilities for groups. AARP feels this is insufficient to provide worker safety, client safety, or to provide an adequate understanding of the aging process and related care issues.

Ms. Sloan continued, saying that research has confirmed the key to satisfaction with the quality of long-term care is the personal relationship between the care recipient and the front-line professional. Front-line workers provide between 75 and 95 percent of all hands-on care, providing assistance with instrumental activities of daily living, monitoring vital signs, and assisting with rehabilitation treatment, such as range-of-motion exercises. Ms. Sloan said her intention in discussing paraprofessionals in long-term care is to raise awareness of the needs of the caregivers and the vulnerability of the disabled and elderly persons they serve. Policy discussions of long-term care seldom consider the needs of these workers, who are primarily female and receive limited training and earn low wages. Limited training and low wages often result in high worker turnover, and continuity of care is important to fully dependent or cognitively disoriented people. Clients need to be supported emotionally, not just medically, over extended periods of time.

Ms. Sloan cited the following as being essential to caregivers in order to improve the quality of long-term care:

- Adequate wages and benefits,
- Appropriate and ongoing training,
- Opportunities for upgrading job skills,
- Good supervision,
- Safe working conditions, and
- Recognition of the critical role of the paraprofessional in providing quality care.

Referring to Exhibit "H", *Paraprofessionals on the Front Lines: Improving their Jobs—Improving the Quality of Long-term Care* (original on file with Legislative Counsel Bureau Research Library), Ms. Sloan explained the report is from a national AARP invitational conference that was structured somewhat like the Nevada conference. Because of time constraints, she would not make a formal presentation on the document, but she asked committee members to review the report and consider the included recommendations. Ms. Sloan asked for questions prior to viewing a short video presentation.

Assemblywoman Leslie noted the single point of entry was mentioned in every AARP conference discussion group, and it had been mentioned several times during the current meeting. She asked Ms. Sloan if the conference participants had any thoughts as to whether the state should be providing the single point entry system, or whether it should be in the community, a senior center, etc. Ms. Sloan replied there was no opportunity or time to design solutions. All that could be done in the two hours was to look at the issues and develop some prioritized concerns. Although there was not a specific recommendation, she feels all of the groups believe there should be strengths throughout the continuum—there is no one best way to do it. She thinks what is crafted in Nevada will be unique to Nevada, and by taking a look at other states' programs, a good program can be developed.

Ms. Leslie asked if AARP would be prepared to make recommendations in terms of the service delivery model by the time of the committee's work session the end of June. Ms. Sloan said AARP is conducting further research on the paraprofessional issue and will be prepared to make some recommendations concerning a training program. She added she would be happy to work with staff from the Department of Human Resources, but it was not a priority issue for AARP's volunteers. She also recommended that the Committee on Long-Term Care be continued into the future, and to draw further from subject matter experts to work together to find specific solutions. Ms. Sloan reiterated she would be happy to pledge her assistance to the issue of a single point of entry system if it is to be included in the committee's recommendations for the upcoming legislative session. She added the AARP work group could be of valuable assistance, and she would be willing to bring them together again to make a recommendation concerning a single point of entry system. Ms. Leslie replied she would very much like to hear AARP's opinions and recommendations.

Assemblywoman Berman said she shares Ms. Sloan's concern with the paraprofessional training only consisting of 8 hours, but she feels the problem of inadequate numbers of paraprofessionals should be considered before training needs are decided. She asked if AARP conference participants had discussed the lack of caretakers. Ms. Sloan replied there was discussion in each of the work groups about shortages of personnel, which is a very real concern at all levels, whether it is at the paraprofessional level or the nursing level. It is often difficult to attract people into long-term care professions at any level, and Ms. Sloan noted one of the recommendations from the national AARP conference is that people will be retained longer if they are provided with good training, supervision, support, and a career ladder, as well as be involved in care planning and receive respect and recognition for the work that they do. Workers who burnout most likely do so because there is no career advancement available. Ms. Sloan said the issue of workforce development is going to require some additional collaboration, and it is being discussed in a great many areas.

Assemblywoman Berman asked what the AARP group had recommended as far as training hours, and she wondered if it had recommended licensing. Ms. Sloan said currently licensure requirements exist at some levels, such as the certified nursing assistant level, which would be regarded as paraprofessional. Home health aids and homemakers are not licensed. She said AARP does not have specific recommendations at this point, but research is being done, and she will return to the committee with specific recommendations on training.

Ms. Berman assumed more licensure and training will be recommended. Ms. Sloan said she could not speak to licensure, but more training will definitely be recommended.

At this point, Ms. Sloan presented a six-minute video which highlighted the various issues confronting long-term care aids and paraprofessionals.

Concluding her presentation, Ms. Sloan read the following statement:

> The AARP volunteers and staff urge the committee to make increased training for paraprofessionals in all long-term care settings a legislative mandate in Nevada. Disabled and elderly Nevadans and their families who rely on supportive services to maintain their independence will benefit from your leadership on this critical issue. Workers who provide the care with such compassion and dedication will benefit from your action. AARP volunteers and staff further urge the committee members to recommend to the 2001 Nevada Legislature that the work of the committee be continued, at least through the year 2002. Further study and dialogue are necessary to improve the long-term care system in Nevada. It was clear to us from the response in the open exchange of information from the subject matter experts in attendance at our conference that there is a sincere interest in finding new and innovative ways of providing care for persons with chronic and disabling conditions. Legislation providing for both the resources and the authorization for continued study of the Nevada long-term care system is needed and will make a difference.

Ms. Sloan thanked the committee for the opportunity to testify. Chairman McGinness thanked her for an excellent presentation. He also noted the presence of Kathy Apple from the State Board of Nursing, and he expressed the committee's appreciation for her attendance at the meeting.

Moving to Item X of the agenda, Presentation and Recommendations Concerning Improving and Expanding Respite Care for Lay Persons who Provide Care for Individuals with Alzheimer's Disease, Chairman McGinness asked Susan Livak to address the committee from Carson City.

Ms. Livak introduced herself as the Alzheimer's Family Advocate for the Northern Nevada Public Policy Committee of the State Alzheimer's Association. She explained the actual presentation would be made by the Southern Nevada Public Policy Committee, but she wanted to express the Northern Public Policy Committee's support of the recommendations included in the presentation. The northern committee is eager to assist in the process toward implementing the recommendations, including the formation of an Alzheimer's advisory council and provisions for support and respite for family caregivers. Ms. Livak said she would be happy to answer any questions from the committee following the presentation. She added that she has been a family caregiver for her mother through her first seven years of Alzheimer's disease. She thanked the committee for the opportunity to speak.

Donald Hauth, Public Policy Chair for the Alzheimer's Association, was accompanied at the testimony table by Phyllis Montavon, Executive Director of the Alzheimer's Association, and Lorraine Krasner, a staff member of the association. He explained the purpose of his presentation was to look at addressing the needs for expanding respite care for caregivers, particularly Alzheimer's caregivers, and the needs of Nevada's rapidly increasing Alzheimer's population. In conjunction with a slide presentation, Mr. Hauth presented the following information:

- Nevada, between 1990 and 1995, was number one in senior growth according to the U.S. Census. Of the 25 top counties in the United States with a population over 65, Nye County was number one with 122 percent growth during that time period, and Clark County had a 46 percent growth of the 65-and-over population between 1990 and 1995.

- The typical age of a Nevada's Alzheimer's patient is anywhere from 57 to 93, but can be as low as 40.

- Of the 55 and older population, current and projected year 2000, an overall 87 percent increase is expected between 1993 and the year 2003.

- Research has found that because of the explosive senior population growth and the corresponding Alzheimer's patient growth, resources have not kept pace with the growth. The National Chapter of the Alzheimer's Association conducted a study of caregivers. A control group was provided with respite care and compared with a group that had no respite care available; the group with respite care delayed nursing home entry by an average of 329 days.

- According to a survey by the Nevada Silver Haired Congress, which has representatives from all over the state, 44 percent said that Alzheimer's care is a major issue.

- In a poll of the Nevada Silver Haired Congress, Carson City representatives reported that a major issue is expanded home care; Elko representatives said home-care cutbacks were a major concern; and in Tonopah, home health care was a major concern.

- In a 1990 research paper sanctioned by UNLV on Alzheimer's caregivers in Southern Nevada, the major priority was the availability of adult day care. With both husbands and wives working, this is an important service.

- The National Alzheimer's Association contracted to have a professional agency conduct research into the amount of money that employers and businesses lose. On the average, employers lose about $26 billion in lost productivity, time away from work, counseling, increased insurance costs, etc.

- Alzheimer's patients are unique in that they require more extensive care than normal patients. On average, an Alzheimer's patient entering a hospital will incur 75 percent higher costs than a normal patient. In addition, Alzheimer's patients have a 400 percent longer hospital stay.

- Another study conducted by the National Chapter revealed that on average, $1,863 of savings per month is realized if institutionalization is delayed.

- The State Division for Aging Services projects that $14 million in savings could be realized through delay of institutional placement through their program.

- National estimates are that it costs an average of $41,000 a year to institutionalize an Alzheimer's patient.

In summary, Mr. Hauth remarked, home care saves taxpayers money. He explained Alzheimer's patients are unique in the fact that they require 24-hour-a-day care due to their wandering and sleeplessness, versus someone with a normal disability.

Caregivers are very diverse—they are not homogenous, Mr. Hauth continued. One of the studies reported that 21 percent of the caregivers have teenagers at home. An average of 69 to 100 hours a week are spent in direct care, e.g., feeding, bathing. He reiterated that Alzheimer's patients require more care than normal because of their unique needs, and they are oftentimes combative.

Because of the need for 24-hour care, 99 percent of caregivers experience occasional or frequent depression, which Mr. Hauth noted is usually the result of the lack of respite services. Thirty-six percent of caregivers reported lost income; many family members find they have to either quit their jobs or work only part-time in order to care for their loved one.

According to Mr. Hauth, fifteen home health agencies have closed or stopped accepting Medicaid. The Division for Aging Services had estimated an 18 percent increase in their caseloads by the year 2000. Mr. Hauth noted this is just another indication of increasing population.

The last U.S. Census had predicted the number of nursing home facility residents will increase 400 percent in the year 2020 compared to 1990 levels, a four-time increase in placement. Mr. Hauth said this staggering figure is due to the baby boomers reaching the upper 60s and 70s.

Mr. Hauth said the Alzheimer's Association would like to propose the following recommendations for the committee's consideration:

1. Look at expanding eligibility for programs. Most of the current programs require an individual to be 65 or older, and many Alzheimer's patients are under the age of 65. Many states have eliminated the age waiver. Mr. Hauth explained that persons with Down's Syndrome will eventually get Alzheimer's or develop the neurological pathology of an Alzheimer's patient. A large number of mentally retarded persons will also develop the neurological pathology of an Alzheimer's patient. Alzheimer's can also be an episode of Parkinson's disease.

2. There is a tremendous variety of caregivers, including a large number of elder caregivers—those elderly spouses who are caring for their elderly mate. These caregivers have totally different needs than the younger caregivers, i.e., they require more assistance with the physical aspects of care rather than adult day care. Mr. Hauth said one of the problems with home health aids is that many are not trained to deal with Alzheimer's patients, and it is difficult for caregivers to find competent respite care. He added that many times the Alzheimer's patient outlives the caregiver because of the stress and strain of the 24-hour care.

   Mr. Hauth said many states have adopted a voucher system which allows the caregiver to obtain the specific kind of assistance needed, e.g., housecleaning, adult day care, respite leave, etc. The voucher system is a consumer-driven program in which the caregivers make the choice of program.

3. Look at providing a flexible program for relatives who provide care. There are a large number of relatives who either quit their jobs or reduce to part-time in order to care for the patient, which places a

tremendous financial strain on them. In many cases, rather than respite care, the relatives would prefer compensation in order to enable them to stay home. Instead of paying strangers to provide respite care, the money can be paid to the relatives in order to allow them to stay home.

4. Authorize a technical advisory committee to look into the many issues associated with caregivers and Alzheimer's. Mr. Hauth remarked that the more advanced programs which provide a wide variety of services, including respite care, started with an advisory committee to gather statistics and analyze the needs and solutions. He said it is estimated there are 40,000 Alzheimer's patients in the state of Nevada, and a 400 percent increase is expected. Some of the following goals of an advisory committee would be:

   a. To recommend the delivery of services in the most effective and efficient manner possible;
   b. To identify additional sources of federal and private sector funding;
   c. To promote public and professional awareness and education relative to Alzheimer's;
   d. To identify service delivery mechanisms that enhance the quality of life for people with Alzheimer's and their caregivers;
   e. To evaluate and coordinate implementation of recommendations by the committee; and
   f. To evaluate models from other states.

Mr. Hauth stressed that the programs proposed would be very cost effective and would save money, thereby allowing either future expansion of programs at no cost or additional money for other programs, while at the same time allowing people to stay at home for increased periods of time. It's a win-win for the individual, it's a win-win for the families of Nevada, it's a win-win for the businesses and employers, and it's a win-win for the taxpayers of the state.

Assemblywoman Berman asked how funds are obtained for a voucher system, who gets them, and how many are disbursed each month?

Phyllis Montavon, Executive Director of the Southern Nevada Nevada's Alzheimer's Association (SNNAA), replied there is a voucher system in place at the SNNAA, and an increasing number of requests are being received. If the money is available, vouchers are not denied. One of the primary requirements for eligibility is that the caregiver is at home with the Alzheimer's patient, and the patient is living with the individual 24 hours a day. There are no eligibility restrictions in terms of age or financial resources. She explained not all people with Alzheimer's fall under the waiver system of 65 years and older. As stated earlier, Alzheimer's patients can range from as young as 40 through the 50s and upward. From Ms. Montavon's experience working with patients and families for the past ten years, when a family calls for help, she knows they need it. As long as funding is available, no one is denied. Unfortunately, she added, the amount of money given to each family is only $250. With the exploding senior population in southern Nevada, more and more requests for vouchers are being received.

Ms. Montavon explained the voucher system was first set up by contacting the home health agencies and asking if they would participate in the program. Those who were willing were placed on a respite care listing, so when an Alzheimer's family calls, they are provided with a list of appropriate services available, e.g., home health aid, adult day care, respite care, and those services can be accessed immediately through the voucher system.

Assemblywoman Berman asked how much adult day care costs for one person. Ms. Montavon replied adult day care for an Alzheimer's patient ranges from $40 and $80 per day, typically from 8:00 a.m. until 5:00 p.m.
Ms. Berman asked if there are any other resources to help pay the cost, noting that many working people don't even make $80 a day. She wondered if there were any less expensive options. Ms. Montavon replied that unfortunately, the funds available to help the families are restricted. The CHIP program is available through Medicaid. It is also the Alzheimer's Association's recommendation that the waiver be expanded to include younger people and to allow middle-income families to access services.

Ms. Berman asked if the grant funds referred to earlier by Mary Liveratti of the Division for Aging Services could be used to provide vouchers for day care or implement a day care program. Ms. Montavon said the association is currently trying to work with other organizations and agencies, because a coordinated effort will be required to resolve the problem at hand. She has spoken with Ms. Liveratti, but the Alzheimer's Association is not really in the position of providing direct care services such as adult day care. The costs of running an adult day care program are high, and it would be very expensive to operate.

Don Hauth said it was learned from one of the studies that in 1989 in Medicaid District IX, which includes Hawaii, Arizona, California, and Nevada, there were 433 licensed day care facilities, with only six in the state of Nevada. Today, even with the tremendous growth in the elderly population, there are only eight facilities in Nevada. He said there must be a reason behind the lack of growth, and he believes one of the problems is licensing of adult day care—is it modern, is it up to date, is it conducive to allowing day care to come into business and encourage competition, which would lower prices? Mr. Hauth said this is another issue that definitely needs to be looked at. The voucher system allows family members to access adult day care at a much lower cost. He agreed with Assemblywoman Berman that the lack of adult day care facilities leads to higher prices and lack of availability.

Assemblywoman McClain asked if the voucher system should be included in an expanded waiver system, or if it should be set up as a separate program. She wondered whether the Alzheimer's Association had any recommendations on how to fund these projects. Ms. Montavon replied she believes the voucher system should be a separate system, probably administered by the state. Although the CHIP program is a wonderful program, Ms. Montavon stressed the accessibility of a voucher program must be immediate—most persons are in a crisis situation by the time they request assistance. Many times she will recommend that an individual call the state to get on the respite care list because the service would be continuous, but they will be placed on a waiting list, which she believes is currently at about 800 individuals. Ms. Montavon reiterated the voucher system must be capable of providing a quick response to caregivers.

Mr. Hauth added that as far as funding is concerned, the tobacco money may be an excellent source. It is his understanding a portion of the tobacco funds will be allocated to seniors and given to the Division for Aging Services specifically for respite care. He said many states use General Fund monies supplemented by tobacco funds in order to provide stability and flexibility to the respite program. He also emphasized the need for an immediate response system to requests for respite care.

Assemblywoman McClain asked how Mr. Hauth envisioned the proposed technical advisory committee would be structured. He replied it would be a subcommittee of the legislature's standing Committee on Health Care. Although the membership has not been finalized, it would typically consist of state legislators, representatives from AARP, the Alzheimer's Association, the Division for Aging Services, the Governor's Office, the Nevada Association of Counties, the Division of Health Care Financing and Policy, nursing homes, assisted living facilities, and a professional psychiatrist. The request would also include staff to research the needs and problems, both current and future. He said most of the successful programs in other states have expanded year after year, having added money, expanded programs, and reduced eligibility. The goal is to look at servicing the needs of Nevada in the best manner possible.

Senator McGinness thanked Mr. Hauth and Ms. Montavon for their testimony. He then asked for public testimony.

Ed Guthrie, Executive Director of Opportunity Village in Las Vegas, testified that Opportunity Village is a not-for-profit organization that provides advocacy and family support, as well as habilitation training and pre-employment services for people with mental retardation and developmental disabilities throughout southern Nevada. It is the largest community training center in the state, but there are similar programs throughout Nevada in Elko, Tonopah, Ely, Reno, Carson City, etc.

Mr. Guthrie said the population served by Opportunity Village primarily lives with their caregivers, usually families. Of the people who live at home with families, 40 percent of the clients served live with caregivers who are 60 years of age or older; 25 percent live with caregivers who are 70 years of age or older; and 15 percent live with caregivers who are 80 years of age or older. He noted that 40 percent of the adults who apply for mental retardation or developmental services in southern Nevada are 35 years of age or older, which means that most of their families are in the 65-70 age group. Mr. Guthrie explained this is the result of Las Vegas being a retirement community. All different types of people retire to southern Nevada, including those with adult sons or daughters with developmental disabilities.

Continuing, Mr. Guthrie stated that approximately 60 percent of the services provided by community training centers are funded through the home- and community-based services waiver. The Community Training Center (CTC) budget for FY 2000 is approximately $7.7 million. He recalled that during the last committee meeting, Charlotte Crawford had referred to the home- and community-based services program for people with mental retardation and developmental services as a model program and one that should be emulated in other areas. Mr. Guthrie agreed it is a wonderful program, but he believes it has some serious flaws as it now stands. He explained the program is a public-private partnership between the community training centers in the state, and it has saved Nevada taxpayers hundreds of millions of dollars throughout the years. In 1988, an economic impact statement done by Dr. John Dobra of the University of Nevada, Reno, stated that just Opportunity Village alone was saving Nevada taxpayers $20 million per year through the services provided.

Mr. Guthrie then went on to discuss two of the flaws in the program as he perceives them: The first is that nursing homes are closing and there is a lack of adult day care centers in the state. Mr. Guthrie maintains one of the reasons is that there have been no rate increases in the state for a substantial period of time. For the last four years, Opportunity Village has received no rate increase for the services it provides. No increase has been received for six out of the last eight years; in fact, Mr. Guthrie continued, during the last eight years, a cumulative rate increase of just 6 percent has been received.

Assemblywoman Berman asked how much costs have gone up during the last six years. Mr. Guthrie replied costs have increased at least 2 to 3 percent per year, and they are rising dramatically at the present time because of the rising cost of gasoline. He said another problem has been the inability to pass along wage increases to staff, resulting in a turnover rate of 40 percent per year, which is actually a good rate for direct service workers. Some of the residential providers of home- and community-based services have an annual turnover rate of over 100 percent per year. Consequently, the state has agreed to fund care for a certain number of individuals, but providers cannot staff the facilities to run the programs, whether it be for adult services, day services, or residential services for mental retardation and other developmental disabilities. Mr. Guthrie emphasized high turnover is a major issue that needs to be resolved.

Mr. Guthrie said staff of Opportunity Village recently compiled some information from other states such as Utah, Oregon, and New Mexico, in order to compare what Opportunity Village would have received for providing similar services in those states last year. He said in 1999 Opportunity Village received about $1.7 in state funds for services out of an $8 million budget; the balance of the funds is raised through community fundraising, charitable donations, and contracts for services with federal or private groups. Mr. Guthrie said the state of Utah would have paid Opportunity Village nearly $2.4 million for the same services, $600,000 more than received in Nevada. In Oregon, the amount would have been over $3 million, and in New Mexico it would have been nearly $3.6 million.

The second major issue to be addressed, according to Mr. Guthrie, is transportation to services. Day services provide two major purposes: to provide people with disabilities to be as productive as they can be in order to give back to their family and their community, and to provide respite services for adult family caregivers. However, Mr. Guthrie pointed out, providing transportation to the adult day services is a real issue with a substantial effect on the families. In southern Nevada there is a two-year waiting list for regular transportation to adult day services. Transportation is provided through the ADA Para-transit system, which is run by the Regional Transportation Commission (RTC). Therefore, Mr. Guthrie explained, an individual who is not on regularly scheduled services must get up at 6:00 a.m. every morning to start calling the RTC to find out what time transportation to the adult day services will be available for the following day, and this must be done every day of every week that services are needed until placement on the regular services schedule.

Mr. Guthrie said Opportunity Village had worked with legislators on the problem of transportation during the 1999 Legislative Session. Assemblywoman Vonne Chowning sponsored a bill to enable regional transportation commissions to provide non-emergency medical transportation to adult day services and other human service agencies, such as kidney dialysis, that could be funded under Medicaid. He said Opportunity Village had worked with the Regional Transportation Commission to try to develop alternative funding to expand services so that regularly scheduled services can be funded by Medicaid. Mr. Guthrie said the RTC thinks it is such a good idea that they have agreed to put up the state’s share of Medicaid, as well as to help pay the state’s share of administrative costs for the program through Medicaid.

Mr. Guthrie said the Regional Transportation Committee has agreed to entirely fund the state’s share of costs for a pilot project, but they have not received a response from the state on whether a waiver or State Plan amendment is necessary to be able to access federal Medicaid funds. RTC is waiting for a response from the Department of Human Resources to determine the feasibility of implementing a Medicaid transportation program for adult day services.

With regard to the impacts of Olmstead, Mr. Guthrie admitted he is a layman, but it seems to him that Olmstead appears to be about access to community services—access not just for people who are currently institutionalized and receiving institutional services, but also access for people who are eligible for those institutional services so that they do not have to enter an institution to receive those services. He added that Charlotte Crawford and Carlos Brandenburg have received a letter from Health Care Financing Administration confirming that is the correct federal interpretation of the impacts of Olmstead. If the state does not guarantee access to community services, then it is not complying with Olmstead. If access is guaranteed, the state is in compliance.

Mr. Guthrie noted that Olmstead is not a Medicaid-only decision; it applies to all services provided, regardless of source of funding. If people cannot access community services because providers cannot recruit and retain staff, Mr. Guthrie expressed concern that Nevada would be deemed in violation of the Olmstead decision. If people cannot access community services because they cannot access reliable transportation to services that are available, even though the money is there and people are willing to provide their share of funding, then he worries that Nevada would again be deemed in violation of the Olmstead decision.

On behalf of Opportunity Village, Mr. Guthrie requested from the committee that:

1. A group of advocates and providers of services be formed to develop a concept paper for the Division of Mental Retardation and Developmental Services to be presented at the next committee meeting.

2. It be determined if the Department of Human Resources' budget requests address the fact that providers cannot pay and retain staff in order to provide services. Are there plans to ask for funding?

3. The Department of Human Resources be asked what is being done about the agreements with the Regional Transportation Committees, both in Reno-Tahoe and in Southern Nevada, to fund a Medicaid-based alternative for non-emergency medical transportation to human service agencies, adult day care, and other medical transportation.

Mr. Guthrie concluded his presentation, thanking the committee for the opportunity to speak.

Chairman McGinness asked for public testimony from Carson City. Ed Fend, representing AARP, said he had attended a program on long-term care a few days earlier which he thought was outstanding. The program was put on by Carolyn Ford, University of Nevada School of Medicine, Office of Rural Health. Mr. Fend said the presentation established the fact that Nevada has an urban, rural, and frontier population. He noted there are two counties that have absolutely no facilities for providing health care or mental health care, Lincoln and Esmeralda Counties. In addition, there are lots of areas where everything is running scarce. Mr. Fend said one of the biggest problems in the rural areas is the extremely high cost of transporting a patient from the rural area to a hospital in Reno. Ms. Ford had indicated that something needs to be done about the situation so that the problems can be resolved at minimal cost. One issue of significance to Mr. Fend was that there is no helicopter service in the state other than medical helicopters. The Nevada Guard flies "130" airplanes, which are capable of landing at any small airport in the state, which would allow them to be incorporated into the medical response program. The pilots are required to log so many hours, and Mr. Fend believes they could be utilized to support emergency medical needs in the rural areas.

Mr. Fend recommended the committee schedule Ms. Ford's presentation. He added he had brought copies of *Profiles of Long-Term Care Systems Across America,* as well as the latest edition of *The Idaho Circuit Breaker* for distribution to committee members.

Senator Care introduced one of his constituents, Brucine Saifer, who had previously invited him to attend an Alzheimer's support group meeting at a local facility, Willow Creek. Senator Care had listened to spouses and adult children of Alzheimer's victims and found it to be very compelling. As a result, he had asked Ms. Saifer to make a short statement to the committee.

Brucine Saifer remarked that after listening to the committee's proceedings, she appreciates everything being done to help. She said the biggest concern with regard to Alzheimer's patients is the stress on the family caregivers, who have nowhere to take their Alzheimer's patient. Many must go to work, leaving the patient at home. She cited the case of a 53-year-old woman with a 56-year-old husband who has had Alzheimer's for several years. Although the husband appears to be very socially acceptable, he was fired from his job because he could no longer do the work. He has taken apart their swimming pool, hot tub, sprinkler system, computer, and the garbage disposal—he's very mechanically inclined. Unfortunately, Ms. Saifer added, he cannot remember how to put anything back together.

Ms. Saifer explained Alzheimer victims' family members are shunned by other people who do not understand the disease. Alzheimer's is not over in three or four years; in fact, three or four years can pass before the disease is obvious. In the beginning, excuses are made for forgetfulness, and before long, the individual is unable to do anything. Oftentimes it is co-workers who recognize the illness rather than family members – most people are very good at being in denial of the illness. Ms. Saifer lost her mother to dementia in December, and she has suffered from high blood pressure for years. The Alzheimer's patient is probably the least affected because he has nothing to worry about anymore; the caregiver is the one to worry about finances and patient care.

Ms. Saifer presented some recommendations from her Alzheimer's group:

- Regular nursing homes are not the answer for Alzheimer's patients and their families. Alzheimer's victims need to be placed in a locked-down facility—licensed, Alzheimer's care. However, they need a lot of room to wander, regardless of the size of facility.

- Alzheimer's patients need loving caregivers to take care of them; they do not need nursing care. A nurse should be on staff, but custodial care is the type of care necessary, and there are no methods to pay for custodial care.

- Custodial care is needed in 8-hour shifts. If an Alzheimer's patient is placed in a 24-hour facility, it is no different than if he were to remain at home. Incidents of abuse increase when there are 24-hour caregivers—this is a major topic of discussion in support groups.

- Alzheimer patients must be around someone at all times; if they cannot see another individual, they may think they do not exist any more. Therefore, they "shadow" their caretakers.

- Caregivers have absolutely no private time when caring for an Alzheimer's patient. The hardest decision a caregiver has to make is to place the Alzheimer's patient in a facility. Unfortunately, Ms. Saifer added, several members of her Alzheimer's support group have died before their Alzheimer's patients.

Ms. Saifer emphasized that respite care must be provided to these caregivers; if it is not, the number of sick people will increase because the caregiver will also become very ill and possibly die before the Alzheimer's victim. The bottom line is that a place is needed where Alzheimer's patients can be treated with the dignity and love owed to the older generation, as well as to assist the younger generation who are lovingly trying to care for them.

Returning to Carson City, Jon Sasser of Washoe Legal Services testified he would like to provide a brief postscript to the testimony offered by Ms. Crawford, Ms. Liveratti, and Ms. Wright regarding Medicaid waivers for assisted living. Mr. Sasser recalled that he and a group of others had made a presentation at the last committee meeting proposing that Nevada develop a program where two funding streams could be matched to create affordable assisted living to lower-income seniors. The proposal involved matching federal money which is currently used to create affordable housing opportunities with Medicaid money which would then pay for the services to the persons living in the assisted living facilities. Mr. Sasser said the group to be served would be those who are income eligible, i.e., below $1,500 per month, for long-term care, yet who could survive outside of long-term care if assisted living were available to them. The group would include persons who cannot manage with the more limited services available under the CHIP waiver because those services do not offer the opportunity for 24-hour care.

As was reported earlier, on February 14, 2000, Mr. Sasser met with Mary Liveratti, Mary Wherry, the Deputy

Administrator of Medicaid, and a number of Medicaid staff members. He said he felt very positive about the meeting, although a fair amount of time was spent explaining the concept and how it might work. However, a productive problem-solving session then followed. At the end of the meeting there were some unanswered questions, and Mr. Sasser had suggested that Medicaid staff talk to John Rimbach, the expert from California. It is Mr. Sasser's hope and belief that once Mr. Rimbach is able to explain the specifics of how the program works in the states of Colorado, Connecticut, Minnesota, and Illinois, it will be possible to resolve the concerns in Nevada.

Mr. Sasser said with some guidance from the committee to the Department of Human Resources encouraging them to focus on studying the four states where the program has been tried rather than studying waivers all over the United States, it might be possible to return to the committee with recommendations as to what changes need to be made in Nevada, either in amending the current CHIP waiver or in adopting a new waiver. However, it is Mr. Sasser's belief that the CHIP waiver can be amended. Admitting there are a few problems to be worked out, he is optimistic that with the prompting of the committee, the group will be able to submit some very concrete answers and proposals prior to the committee's work session.

Chairman McGinness thanked Mr. Sasser for the update on the project. He asked for further public testimony.

Susan Livak, Alzheimer's Family Advocate for the Northern Nevada Chapter of the Alzheimer's Association, said she had recently spoken by telephone with a 75-year-old Alzheimer's caregiver. She had told Ms. Livak that when she goes to the grocery store, she has to tie her husband into a wheelchair and wedge the chair between the couch and an easy chair so that he cannot move. The wife is a heart patient herself, and her nightmare is that as she rushes to the store, she will have a heart attack and her husband will be helplessly tied in his chair at home. Ms. Livak said she could not help the woman because she would not reveal her name or address for fear of prosecution for elder abuse. Ms. Livak told committee members once they have the image clearly in mind, they need to multiply it by several thousand. She thanked the committee for listening to the stories of desperate need.

Chairman McGinness announced the next meeting will be held on Thursday of either the last week in April or first week of May. He thanked everyone, including staff, for their attendance and participation.

The meeting was adjourned at 3:50 p.m.

Respectfully submitted,

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Sherie Silva, Secretary

APPROVED:

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Senator Mike McGinness, Chairman

Date:________________________________

**Exhibits:**

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| Exhibit "A" | Meeting Notice and Agenda |
| Exhibit "B" | Attendance Rosters |
| Exhibit "C" | State of Nevada Public Employees' Benefits Presentation Document (Original on file at LCB Research Library) |
| Exhibit "D" | Chart – Demographic Distribution of State of Nevada Employees and Retirees |
| Exhibit "E" | March 9, 2000 Meeting Packet - Committee to Study Long-Term Care in Nevada (Original on file at LCB Research Library) |

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| Exhibit “F” | AARP Conference Synopsis |
| Exhibit “G” | U.S. Bureau of the Census Nevada County Population Estimates |
| Exhibit “H” | *Paraprofessionals on the Front Lines: Improving their Jobs—Improving the Quality of Long-Term Care* (Original on file at LCB Research Library) |