MINUTES OF THE MEETING

OF THE

SUBCOMMITTEE OF THE LEGISLATIVE COMMITTEE ON HEALTH

CARE TO ADDRESS MEDICAID AND OTHER ISSUES FOR

PERSONS WHO ARE AGED OR DISABLED

(*Nevada Revised Statutes* 439B.200)

September 2, 1998

Las Vegas, Nevada

The second meeting of the Subcommittee of the Legislative Committee on Health Care to Address Medicaid and Other Issues for Persons Who Are Aged or Disabled was held on Wednesday, September 2, 1998, at 10 a.m., in Room 4412 A, B, and C of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. This meeting was video conferenced to Room 4100 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. Pages 3 and 4 contain the "Meeting Notice and Agenda."

SUBCOMMITTEE MEMBERS PRESENT IN LAS VEGAS:

Assemblyman Jack D. Close, Sr., Chairman

Assemblywoman Barbara E. Buckley

SUBCOMMITTEE MEMBER PRESENT IN CARSON CITY:

Assemblywoman Vivian L. Freeman

OTHER LEGISLATORS PRESENT:

Senator Maurice E. Washington

OTHERS PRESENT IN LAS VEGAS:

Thelma Clark, Rulon Earl Resident Council, Inc.

Charlotte Crawford, Director, Nevada's Department of Human Resources (DHR)

Dr. James Kinard, D.D.S.

Donny L. Loux, Chief, Office of Community Based Services, Rehabilitation Division, Nevada's Department of Employment, Training and Rehabilitation

Larry Matheis, Executive Director, Nevada State Medical Association

Ruth Mills, Nevada Healthcare Reform Project

Carla Sloan, Administrator, Aging Services Division, DHR

Christopher Thompson, Administrator, Division of Health Care Financing and Policy, DHR

OTHERS PRESENT IN CARSON CITY:

Winthrop Cashdollar, Executive Director, Nevada Health Care Association

Alice Molasky-Arman, Commissioner of Insurance, Division of Insurance, Nevada's Department of Business and Industry

Jon L. Sasser, Washoe Legal Services

LEGISLATIVE COUNSEL BUREAU STAFF PRESENT:

H. Pepper Sturm, Chief Principal Research Analyst

Marla McDade Williams, Senior Research Analyst

Risa L. Lang, Principal Deputy Legislative Counsel

Leslie Hamner, Deputy Legislative Counsel

Jo Greenslate, Research Secretary

MEETING NOTICE AND AGENDA

Name of Organization: Subcommittee of the Legislative Committee on Health Care (*Nevada Revised Statutes* 439B.200) to Address Medicaid and Other Issues for Persons Who Are Aged or Disabled

Date and Time of Meeting: Wednesday, September 2, 1998

10 a.m.

Place of Meeting: Grant Sawyer State Office Building

Room 4412 A, B, and C

555 East Washington Avenue

Las Vegas, Nevada

Note: Some members of the subcommittee may be attending the meeting, and other persons may observe the meeting and provide testimony, through a simultaneous video conference conducted at the following location:

Legislative Building

Room 4100

401 South Carson Street

Carson City, Nevada

A G E N D A

1. Opening Remarks by the Chairman

   Assemblyman Jack D. Close, Sr.

*II. Approval of Minutes for the Committee's Meeting on July 14, 1998, in Las Vegas, Nevada

III. Discussion of Role of Certified Nursing Assistants, Personal Assistants, Personal Care Assistants, and Personal Care Assistants for the Dependent in Medicaid-Sponsored Programs

Donny Loux, Chief, Office of Community Based Services, Nevada's Department of Employment, Training and Rehabilitation (DETR)

Christopher Thompson, Administrator, Division of Health Care Financing and Policy (DHCFP), Nevada's Department of Human Resources (DHR)

*IV. Discussion of Alternatives to Evaluate the Satisfaction of Services for Medicaid Recipients and Health Care Providers

*V. Presentation of a Program to Supplement Commercial Health Insurance Plans and to Provide Health Insurance By Establishing a Medicaid Program "Buy-In"

Donny Loux, Chief, Office of Community Based Services, DETR

*VI. Presentation of and Solutions for Issues Surrounding Medicaid Waivers and Waiting Lists for Services

Christopher Thompson, Administrator, DHCFP

*VII. Presentation of the Need for Supplemental Nutrition Programs in Nevada

Kristin Alampi, Dietitian II, Aging Services Division, DHR

*VIII. Discussion of Future Topics for Consideration by the Subcommittee and the Legislative Committee on Health Care

1. Identifying Appropriate Levels of Care for Individuals Who Receive Medicaid Services, Including Medicaid Payment Rates and the Services That Are Expected From Residential Care Providers
2. Identifying Transportation Problems and Solutions

IX. Public Testimony

*X. Adjournment

*Denotes items on which the subcommittee may take action.

Note: We are pleased to make reasonable accommodations for members of the public who are disabled and wish to attend the meeting. If special arrangements for the meeting are necessary, please notify the Research Division of the Legislative Counsel Bureau, in writing, at the Legislative Building, 401 South Carson Street, Carson City, Nevada 89701-4747, or call Jo Greenslate or Roxanne Duer, at 684-6825, as soon as possible.

Notice of this meeting was posted in the following Carson City, Nevada, locations: Blasdel Building, 209 East Musser Street; Capitol Press Corps, Basement, Capitol Building; Carson City Courthouse, 198 North Carson Street; Legislative Building, Room 1214, 401 South Carson Street; and Nevada State Library, 100 Stewart Street. **Notice of this meeting was faxed for posting to the following Las Vegas, Nevada, locations:** Clark County Office, 500 South Grand Central Parkway; Grant Sawyer State Office Building, 555 East Washington Avenue.

OPENING REMARKS BY THE CHAIRMAN

Chairman Close called the meeting to order and noted that a quorum was present.

APPROVAL OF MINUTES FOR THE COMMITTEE'S MEETING

ON JULY 14, 1998, IN LAS VEGAS, NEVADA

ASSEMBLYWOMAN BUCKLEY MOVED FOR APPROVAL OF THE MINUTES OF THE JULY 14, 1998, MEETING OF THE SUBCOMMITTEE OF THE LEGISLATIVE COMMITTEE ON HEALTH CARE TO ADDRESS MEDICAID MANAGED CARE ISSUES FOR PERSONS WITH DISABILITIES. THE MOTION WAS SECONDED BY ASSEMBLYWOMAN FREEMAN AND PASSED UNANIMOUSLY.

DISCUSSION OF ALTERNATIVES TO EVALUATE THE SATISFACTION

OF SERVICES FOR MEDICAID RECIPIENTS AND

HEALTH CARE PROVIDERS

Sue Hockenson

Sue Hockenson, Director of Government Programs, testified that she was attending the meeting on behalf of Marie H. Soldo, Vice President,

Government Affairs, Sierra Health Services Inc. She advised that Ms. Soldo suggested that as the committee evaluates what can be done to improve care delivery to the disabled population through Medicaid and other existing programs, it review the actual services delivered in the program and the participants' perceptions of how well those services are being delivered. Ms. Hockenson advised that her company studied the procedures currently followed by managed care with the idea that some of the methods used to evaluate care delivery can be adapted to the disabled population with existing data sources.

Specifically, Ms. Hockenson suggested examining the following areas:

- The current structure of care delivery.
- The services being delivered.
- The existing barriers to services. (For example, patients who do not have adequate access normally do not obtain preventative care services.)
- Whether the appropriate types of services are delivered in a timely manner.
- Determination of the sources of problems.
- Solutions to existing problems.

Ms. Hockenson pointed out there are many alternative methodologies to evaluate patient satisfaction. An example is the Health Plan Employer Data Information Set (HEDIS) used by health maintenance organizations. She suggested that the following be done with existing data systems:

- Use current claims information which is periodically augmented with record review.
- Review readmission rates for people who have been discharged from long-term care facilities as well as those who have received care at acute care facilities.
- Evaluate admission rates for ambulatory sensitive conditions such as asthma or diabetes. Ideally, if good ambulatory care is delivered, many admissions could be avoided.
- Compare the overall inpatient admission rates of the disabled population with a standard population.
- Identify satisfaction with services by using such techniques as focus group methodology or member satisfaction surveys. An example is the Consumer Assessment of Health Plan Study, an instrument developed by the Health Care Financing Administration (HCFA) of the United States Department of Health and Human Services.
- Evaluate the types of services provided during emergency room visits.

Another useful avenue suggested by Ms. Hockenson is analysis of primary care services, which is often overlooked when evaluating care delivery for the disabled population.

In response to a question from Assemblywoman Freeman regarding preventative care for the chronically ill, Ms. Hockenson replied that typically the benchmarks that exist in the current literature are clear as to appropriate preventative care measures. She added, however, that several preventative measures need to be evaluated such as the use of beta blockers in the senior population. She suggested a community effort is necessary to determine which measures are most appropriate for Nevada's population.

Responding to Chairman Close's inquiry as to what is being done presently within the Medicaid program to evaluate care provided to recipients, Christopher Thompson, Administrator, Division of Health Care Financing and Policy, Nevada's Department of Human Resources (DHR), explained that:

> 1. With regard to the fee-for-service program, there is no information system enabling the DHR to determine those quality indicators. The DHR's current data gathering system does not distinguish between a primary care physician and a specialty physician. The department is undergoing a business process reengineering (BPR) study that addresses the need for a data system that will allow it to evaluate the care that is being delivered.
>
> 2. The managed care program has an encounter data reporting system which allows analysis of the satisfaction of care delivery. The program has been operating for approximately 16 months, and the first set of information is being reviewed by an outside contractor to determine its accuracy.

Mr. Thompson remarked that HEDIS is a good system to build upon because it is used in the general population as well as with Medicaid recipients. He advised that at the federal level, HCFA, which has responsibility for both Medicare and Medicaid, has been moving forward with its Quality Improvement Strategies for Managed Care approach, which is also a program designed to measure the quality of health care delivery. Mr. Thompson pointed out that Medicaid recipients are somewhat dissimilar to the standard, commercial population, because Medicaid serves primarily children and pregnant women.

Referring to Mrs. Freeman's question regarding how tracking of the handling of chronic health conditions can be accomplished, Mr. Thompson offered an example using diabetes. He asserted the single most important test to determine the onset of diabetes, and its significance in terms of long-term health problems, is the glyco hemoglobin test. He advised that a reasonably good encounter system enables the checking of laboratory tests to determine how often a physician performs a glyco hemoglobin test on a diabetic patient.

A second, more useful measure may be to track those glyco hemoglobin levels, and after receiving the information, determine if actions have been taken to address the problem. He remarked that at this point, he is not suggesting that the State begin full health profiling of individuals, but asserted that this type of information gathering would aid in evaluation of the system.

Responding to a question from Mrs. Freeman, Mr. Thompson advised that there is significant federal money available to develop a Medicaid management information system. In order to obtain federal funding, however, the system must be designed, and an advance planning document submitted, before the system is actually developed. He predicted that the BPR study will facilitate the advance planning document. Mr. Thompson concluded by indicating that the DHR anticipates receiving a report from its BPR consultants by the end of October 1998, with specific recommendations in this area.

Winthrop Cashdollar (previously identified on page 2) testified that Nevada's nursing facilities are evaluated at least once a year, however, the evaluation information is written in a format that is not easily understood by the consumer. He suggested establishment of a parallel system for evaluating nursing facilities that focuses on practical matters of resident well-being and satisfaction as reported by residents and family members, and that the evaluation be performed on an ongoing basis rather than only once a year. Further, Mr. Cashdollar recommended that such evaluation be in a format that is readily understood by consumers.

Assemblywoman Buckley pointed out that there are existing indicators of quality issues, both in the existing fee-for-service system and in the managed care system, from the consumers themselves. For example, an alleged problem with Medicaid is that there are not enough providers or waiver programs to enable disabled persons to work and remain in their own homes. Some of the problems Ms. Buckley is aware of regarding managed care are benefit denials, lack of referrals, the "gatekeeper" system, and untimely payments.

Donny Loux (previously identified on page 1) asked Mr. Cashdollar if it was his intention, in studying the evaluation of nursing homes, that consumers and their families be involved in the design of more usable evaluations. Mr. Cashdollar affirmed that would be helpful.

Chairman Close suggested that the subcommittee make a definitive request to the full Legislative Committee on Health Care to recommend to the 1999 Legislature an interim study dealing with the items discussed thus far in the meeting, which include: (1) a satisfaction evaluation; (2) a performance evaluation of the services provided under Nevada's Medicaid program; (3) the claims based analysis; (4) the barriers to care; (5) the timeliness of services; (6) readmission rates; and (7) the personal satisfaction areas.

ASSEMBLYWOMAN BUCKLEY MOVED THAT THE SUBCOMMITTEE RECOMMEND TO THE LEGISLATIVE COMMITTEE ON HEALTH CARE THAT A BILL DRAFT REQUEST BE PRESENTED TO THE 1999 LEGISLATURE FOR AN INTERIM STUDY DEALING WITH THE ISSUES MENTIONED BY CHAIRMAN CLOSE. THE MOTION WAS SECONDED BY ASSEMBLYWOMAN FREEMAN AND PASSED UNANIMOUSLY.

DISCUSSION OF ROLE OF CERTIFIED NURSING ASSISTANTS, PERSONAL

ASSISTANTS, PERSONAL CARE ASSISTANTS, AND PERSONAL CARE ASSISTANTS FOR THE DEPENDENT IN

MEDICAID-SPONSORED PROGRAMS

Senator Washington introduced Rick Cline of Reno, Nevada, who was in attendance to discuss personal care assistants for the disabled (PCA-D).

Mr. Cline, who is a quadriplegic, testified that he has been "struggling" with the PCA-D issue for several years. He maintains there was a "subtle undermining" surrounding the conception of the PCA-D program which continues to hamper its success.

According to Mr. Cline, after investigating institutional care he decided that he wanted to live at home. He petitioned Medicaid to provide him home health care and was told that the personal care assistant (PCA) program, as it existed, would only allow three and one-half to four hours of home care per day, which would make it impossible for him to live at home. During his "battle" with Medicaid to obtain additional home health care assistance, he learned of a court case which had parallel components to his situation. As a result of the decision in that case, Assembly Bill 645 (Chapter 301, *Statutes of Nevada 1995)* was enacted, which "Authorizes unlicensed personal assistant to perform certain services for person with physical disability under certain circumstances." Mr. Cline finally prevailed in receiving the home health care he required with the only limitation being that his home health assistance expense not exceed the amount allocated to his nursing home residency.

Mr. Cline advised that a PCA-D program was created to include the new legally-required concessions, however, it lacked the practical necessities to allow its functionality. According to Mr. Cline, the crux of the problem is that the existing PCA program which contained all of the practical elements necessary to make it work was denied the benefits of the concessions in the court case. In order to correct the problem,

Mr. Cline proposes integrating the benefits of both the PCA and PCA-D programs into one and eliminating the "needless infringements."

Mary Jean Thomsen, Community Advocacy Coordinator, Northern Nevada Center for Independent Living, advised that she has been working with Mr. Cline on this issue for approximately four months. Ms. Thomsen stated that she is a member of a coalition consisting of approximately 30 agencies in Reno and suggested the respective state agencies form such a group to either combine the PCA and PCA-D programs or to develop a PCA-D program. Ms. Thomsen mentioned the requirement of PCAs and PCA-Ds wishing to participate in the PCA-D program to purchase insurance through the State Industrial Insurance System (SIIS), which reduces their income to just above minimum wage. She maintains the process of purchasing insurance through SIIS further delays the benefits of the PCA-D program to disabled individuals.

Continuing, Ms. Thomsen commented that the Employment Security Division (ESD), Nevada's Department of Employment, Training and Rehabilitation (DETR), refuses to post job opportunities for the PCA-D program. She also mentioned the need for a backup system for this program. Ms. Thomsen recommended cross-training individuals so they could fill in as backup PCA-Ds. She concluded by urging the ESD and Medicaid to work together to develop a more effective PCA-D program.

Senator Washington recommended that:

1. The DHR and Medicaid make a policy change regarding the PCA-D program. He requested the subcommittee to recommend that the full Legislative Committee on Health Care consider such a collaboration as soon as possible.

2. A case management philosophy concerning disabled Medicaid recipients be adopted. He suggested that this proposal could be accomplished by a joint effort of Mr. Cashdollar, the Nevada nursing organizations, the Northern Nevada Center for Independent Living and PCAs, along with involvement by DHR and SIIS.

Chairman Close clarified that Senator Washington addressed two separate issues: (1) personal care assistance problems that Mr. Cline has brought forth; and (2) assurance that health care recipients receive care appropriate to their condition. He advised that the second issue will be discussed at a future meeting and requested that Mr. Thompson address the concerns of cross-training, a backup system, and job postings.

Mr. Thompson prefaced his remarks by saying he would like to meet with Ms. Thomsen to begin a dialog regarding her concerns. With regard to the specific issues raised by Ms. Thomsen, he advised that the requirement to purchase insurance from SIIS applies to any employed individual for workers' compensation insurance purposes. As far as cross-training PCA-Ds and the ability to provide backups, the DHCFP is studying the possibility of contracting with an agency to assure its ability to meet overall PCA demands. He pointed out that using an agency to provide PCAs would add to the cost of the service. Continuing, he said Nevada currently pays $9.25 for PCA services which includes the SIIS contribution. Conversely, for homemaker services, the hourly rate paid is $12 to $13, even though PCA services include a broader set of responsibilities such as direct contact with the patient. Mr. Thompson explained that the rate differential is being considered in the upcoming budget, especially in light of the anticipated expansion of waivers, which will increase the demand for PCA services.

Ms. Thomsen added that the PCA-Ds also perform homemaker services.

Chairman Close asked Ms. Thomsen what her agency has to pay on a quarterly basis for SIIS benefits. Mr. Cline answered that the PCA-Ds that work for him pay monthly fees of just under $48.

Jon L. Sasser (previously identified on page 2) remarked that it is his understanding that the problem with the SIIS payments is not the monthly payment but the up-front fee of $120 to $125. These individuals may not recover these expenses for three months until they receive their first paycheck. He also stated that it is the independent contractor nature of the PCA-D position that has caused the ESD to refuse to post it; however this practice causes undue hardship to disabled persons recruiting PCA-Ds. Mr. Sasser told of a suggestion by Mr. Cline that the ESD be involved in the overall recruitment of a pool of applicants from which the person in need could choose, as well as participation by the ESD in the initial orientation of potential PCA-Ds. He also suggested that the home health agencies maintain a backup pool of PCA-Ds and provide cross-training to that pool.

Ms. Loux informed Senator Washington that there are three personal assistant programs in Nevada: (1) one that is operated by Medicaid; (2) the Community Home-Based Initiatives Program (CHIP) operated by the Aging Services Division; and (3) a program operated by the DETR. She said there is a great deal of cooperation among the plans' case workers to ensure that people are appropriately placed in one of the three, and that if one program's hours are expended, one of the other two will supply hours to it. She advised that representatives of each program meet regularly to try to find solutions to their common problems.

In response to Mr. Sasser's earlier question as to why there are so few participants in the PCA-D program when it has been in effect for over two years, Mr. Thompson stated that he was not certain, but he suspects that in large part it has to do with the low wages currently being paid for their services.

Responding to Chairman Close's question regarding PCA training, Mr. Thompson replied there are currently three options: (1) an existing contractor relationship which places the training responsibility on the contractor; (2) an agency relationship under which the services are contracted through an independent third party who is responsible for recruitment, training, and maintenance of a sufficient pool of individuals; and (3) direct employment with the State, which affords the greatest degree of control over the PCAs. The third option costs an additional 10 percent over what is paid in a contract relationship plus additional employer-related costs.

In response to a question by Assemblywoman Buckley regarding the types of relationships that exist in the three programs, Mr. Thompson replied they are all different. The Medicaid program contracts directly with independent contractors for PCAs, PCA-Ds, and Certified Nurse Assistants (CNAs). In the area of direct employment, under which Mr. Thompson makes no distinction between the PCA and homemaker services program, the work is done through direct employees working variable schedules at a cost to the state of $1.4 million.

Carla Sloan (previously identified on page 1) addressed the question of how services are delivered under the CHIP program. She advised that the Aging Services Division contracts primarily with agencies, including home health and other such entities for homemaker and attendant services. Additionally, they have individual contractors that are typically in the rural areas where there may not be an available agency. She stated that working with the agencies provides the advantage of having backup employees. Ms. Sloan advised that this program is nonmedical and is overseen by the case manager who works closely with the physician and others who provide input for the patients' plan of care. Continuing, she added they have no direct employees, and division staff provides case management services.

Responding to additional questions from Ms. Buckley, Ms. Sloan informed the subcommittee that the division requires background and fingerprint checks on individual contractors. Individual contractors are required to view a videotaped training series and complete a brief post-training test. The videotapes are available at the division's regional offices. Further, Ms. Sloan advised that the division has a process for verification of the hours worked by the employees that is signed on a weekly basis by the client. Finally, the division collects a client satisfaction evaluation from its clients on an annual basis.

Ms. Loux stated that the DETR's program contracts with an agency to provide PCAs. It uses a nonprofit agency that provides other services to disabled persons as opposed to one limited to home health. She advised the cost is $13.31 per hour which includes recruitment, screening, training, backup, and case managers who wear pagers so they are available on a 24-hour basis. Ms. Loux remarked that the agency's employees are evaluated by a team of consumers, providers, and an occupational therapist (OT). The OT determines the number of hours needed by the disabled person, which is then approved by the consumer/provider board. The workers must pass a test before they are eligible to work. Employees who work 40 hours per week receive full medical benefits. Part-time workers are eligible for a wellness rebate, time off for additional training, and so forth. The client is able to hire and fire his own assistant; however, the agency mediates any disputes between a client and his assistant.

According to Ms. Loux, in 1993, the interim Legislative Task Force on Personal Assistant Services was formed by Senate Concurrent Resolution 17, which "Urges Governor to establish task force to examine programs for providing personal assistance services for persons with disabilities." The results of that task force are included in an "Executive Summary" (please see Exhibit A). In-home interviews of all clients and assistants in the program are conducted. (The survey results are included as Exhibit B.)

Alice Molasky-Arman, Commissioner of Insurance, Division of Insurance, Nevada's Department of Business and Industry, requested that her office and the Division of Industrial Relations, Department of Business and Industry, be included in any dialogue between SIIS and Mr. Thompson. She mentioned that three-way workers' compensation in Nevada will commence on July 1, 1999, and there are currently over 100 insurance companies that will be marketing for workers' compensation insurance along with SIIS. Ms. Molasky-Arman stated that the rates and classification of employees will change, and she is holding a meeting next month to educate those involved about the new contract, which will be approved or disapproved before the end of 1998.

Ms. Buckley commented that the current system of only using independent contractors with Medicaid may not yield the most effective service for people who do not have the resources to arrange a contract with workers' compensation, recruit, train, and ensure that they are being provided good services. Ms. Buckley suggested that perhaps Medicaid could additionally contract with either a nonprofit or a for-profit home health service to have a pool of recommended and qualified employees for those who cannot find their own PCA. She indicated that would improve services and increase the number of people using the service. Further, Ms. Buckley recommended that the committee offer consumers an opportunity to provide input and conduct a hearing to determine what improvements would make the program more "user friendly" to the consumer and ensure that the disabled population can live in the least restrictive environment and gain independence.

Chairman Close mentioned the importance of distinguishing between the services provided by the personal care assistant and those provided by licensed practitioners in the State of Nevada such as nurses, nurses aides, and so forth. He emphasized the importance of ensuring that the proper person is providing the proper care, and that those who are licensed to practice in other areas are not being "usurped." In that regard, Chairman Close requested that a letter from John D. Busse, Executive Director, Home Health Care Association of Nevada, dated August 26, 1998, be included in the record (see Exhibit C).

Ms. Loux requested that the report of the Legislative Task Force on Personal Assistant Services and a copy of A.B. 645 be included in the minutes of this meeting. (The full report of the Legislative Task Force on Personal Assistant Services may be found in the minutes of the Assembly Committee on Health and Human Services dated May 29, 1995, in the Research Library. A copy of A.B. 645 may also be obtained from the Research Library.)

Ms. Buckley suggested that the subcommittee recommend to the full Legislative Committee on Health Care that it direct the DHCFP to conduct a hearing concerning possible revisions to the program that explores the possibility of contracting with a nonprofit or for-profit home health organization, to create a pool of people who are available to provide personal care assistant services. Regarding such a pool, the division should take into account such things as ensuring consumer choice, consumer ability to hire and fire, and inclusion of the safeguards that are already in the existing programs. Further, the division should report to the Legislative Committee on Health Care the findings of those public hearings by December 1, 1998, to allow enough time to request a bill draft, if necessary, to determine if the program can be improved.

Chairman Close proposed directing the subcommittee's report to the Legislative Committee on Health Care including the following recommendations:

1. The subcommittee is in support of a PCA program.

2. A hearing should be conducted that addresses establishment of a pool of PCAs in adequate time to request a bill draft, if necessary, for the 1999 Legislative Session.

3. The subcommittee would support the concept of the system being a client-driven case management system versus an agency-driven system.

4. The division should promote the PCA program for all people including those in hospitals and nursing homes.

Additionally, Chairman Close added that a report be made to the subcommittee by the Commissioner of Insurance about possible recommendations to resolve the PCA and PCA-D independent contractor problem.

ASSEMBLYWOMAN BUCKLEY MOVED TO INCLUDE THE RECOMMENDATIONS MADE BY ASSEMBLYMAN CLOSE IN A REPORT TO THE LEGISLATIVE COMMITTEE ON HEALTH CARE. THE MOTION WAS SECONDED BY ASSEMBLYWOMAN FREEMAN.

Paul Gowins, a member of Nevada's Independent Living Advisory Council, testified that he has been using PCAs for approximately 19 years. He stated that Medicaid is providing several PCA services through home health agencies. Mr. Gowins asserted that when services are contracted through a home health agency, Nevada Medicaid has no power to ensure that the organization meets its contractual obligations. For example, if a PCA notifies a client on Friday night that he/she will not be able to provide assistance all weekend, there is no way for Medicaid to penalize the home health agency it is contracting with other than to not use that service. According to Mr. Gowins, this issue arises continually, and he requested that this problem be discussed by the subcommittee.

Larry Matheis (previously identified on page 1) was of the impression that Medicaid does not contract with home health agencies. In his opinion, if a licensed home health agency fails to fulfill a contract, the appropriate action would be to report it to the Bureau of Licensure and Certification, DHR, for investigation.

Mr. Thompson remarked that Medicaid uses home health agencies, but not for personal care assistant services. However, there are times when they are unable to locate available PCAs which then necessitates the use of CNAs employed by home health agencies at approximately twice the cost of PCAs. Mr. Thompson indicated that the Medicaid program is considering contracting with PCAs, which are not health care licensed individuals, through a home health or other independent agency.

Ms. Thomsen called attention to the fact that there is a cost involved with the level of care a patient receives. She urged the subcommittee to keep in mind when considering utilization of different agencies to provide PCAs that some patients have more severe conditions which require a higher level of care than others. On another issue, Ms. Thomsen asked if the recommendation made by Chairman Close that the committee support the PCA program included the PCA-D program.

Chairman Close confirmed that the recommendation does include the PCA-D program.

James Wisman, a consumer, asserted that people are unable to obtain the assistance they need because Nevada has slot requirements, and if the individual is not eligible for any of the slots, he will not be able to participate in any of the other programs offered. He gave an example of the main supporter of a family being involved in an automobile accident that is not a work-related injury. That individual, after waiting two years before receiving medical coverage through the State, may still not be availed of personal assistant services.

Chairman Close informed Mr. Wisman that the two-year waiting period and the waiver situation is an issue the committee is addressing.

The Chairman called for a vote on Ms. Buckley's motion and asked if there were any other relevant comments.

Ms. Buckley stated that she would like to amend her motion to include a discussion of imposing contract penalties against home health agencies who fail to meet their contractual obligations, and that independent contractors may be utilized if that is the choice of the consumer.

THE MOTION CARRIED UNANIMOUSLY.

PRESENTATION OF A PROGRAM TO SUPPLEMENT COMMERCIAL HEALTH INSURANCE PLANS AND TO PROVIDE HEALTH INSURANCE BY ESTABLISHING A MEDICAID PROGRAM "BUY-IN"

Donny Loux

Ms. Loux testified that the United States General Accounting Office stated in a report of people with disabilities and their return to work:

Fewer than one-half of 1 percent of all Social Security beneficiaries ever leave Social Security because of a return to work, and further, if that same one-half of 1 percent should return to work, it would save the taxpayers $3 billion.

Continuing, Ms. Loux advised that the National Organization of Disabilities combined with the polling company of Louis Harris and Associates to poll disabled persons to determine whether they were interested in returning to work. She said they did want to return to work, but had the following concerns:

- Disabled persons lose Medicaid benefits if their wages are higher than $20,000.
- Entry-level wages are inadequate due to the high costs incurred by disabled persons for such things as:

    1. PCA services, which is generally a minimum of four hours per day;

    2. Housekeeping and chore services (such as mowing the lawn); and

    3. Purchase of a van which will accommodate a wheelchair to travel to and from work. Further, the van requires a wheelchair lift and expensive maintenance.

The overriding issue, according to Ms. Loux, is the disabled population's fear of losing health care insurance after returning to work. She asserted that most private insurance companies do not provide the benefits needed by severely disabled persons. She mentioned that some states allow people to buy into Medicaid for its benefits or to obtain a policy that supplements the private insurance plan. Premium payments are made to Medicaid to cover additional medical expenses. Ms. Loux discussed recent changes in Medicaid laws that enable states to allow this buy-in, and through a series of new incentives and disregards, it would cover people up to 250 percent of poverty, which is $20,000 in income per year for one person. Some of the disregards include:

- $4,000 in individual assets or $6,000 per couple;
- A person's home regardless of the value;
- A vehicle regardless of its value;
- Small business equity up to $6,000; and
- $1,500 for burial expenses.

Any income spent on medically necessary items to enable a person to work are covered, according to Ms. Loux. Costs of PCAs and assisted technology would be deducted from one's income before Medicaid determines the individual's eligibility to remain on Medicaid. It is Ms. Loux's understanding that premiums are paid on a sliding-fee basis.

Ms. Loux referred to a Massachusetts plan that has been in effect for six years. She said this plan provides the same opportunities for families with severely disabled children; parents may purchase wraparound policies to ensure their children receive needed services. Massachusetts also has a provision for drug rebates for prescription drugs. Ms. Loux advised that the person in charge of this program is willing to present details of the plan to the committee at no cost.

Discussion ensued regarding the cost of a Medicaid buy-in program and whether a presentation of the buy-in program in Massachusetts would be beneficial in addressing issues faced by Nevada.

Chairman Close asked the committee if it would like to invite the speaker from Massachusetts to make a presentation and at the same time, have Mr. Thompson present to the committee the financial impact of this program to the State of Nevada.

Mr. Sasser clarified that the subcommittee was discussing two separate proposals: (1) to take advantage of the new option in the Medicaid program to cover disabled persons up to 250 percent of poverty; and (2) the Massachusetts buy-in program which goes above and beyond the medically needy program, which Nevada does not have.

Mr. Thompson stated that the 250 percent buy-in is separate and apart from the medically needy issue. He said it was unclear whether they could have a medically needy determination just with regard to the 250 percent of poverty program without covering the disabled population or the overall Medicaid population of the State. Mr. Thompson remarked that the medically needy option represents a price tag of at least $50 million to Nevada. He advised that the question of whether the medically needy issue could be addressed specifically to this population becomes critical in determining both the cost and the equity of this program as it relates to other nondisabled, low-income individuals who would otherwise benefit from such a plan.

Ms. Buckley recommended two presentations to the committee: (1) the buy-in program and its potential cost; and (2) the Medicaid waiver program. She expressed that incremental reform of Medicaid was more likely to occur rather than the costly medically needy program at a cost of $50 million. Ms. Buckley suggested scheduling the presentations after Mr. Thompson has more information about the cost and has coordinated with a representative of the Massachusetts program.

Chairman Close requested that Ms. Loux coordinate the scheduling of the presentations with Mr. Thompson.

PRESENTATION OF AND SOLUTIONS FOR ISSUES SURROUNDING MEDICAID WAIVERS AND WAITING LISTS FOR SERVICES

Christopher Thompson

Mr. Thompson testified that the State of Nevada currently has four separate home- and community-based waivers that have the same general purpose of allowing for a greater degree of independence for individuals who might otherwise be in nursing facilities. He described them as follows:

1. One for the physically disabled to allow them to live in the community;

2. Another for the elderly, which is similar to the one for the disabled;

3. A third for the elderly and disabled both to live in group care homes as an alternative to nursing facilities; and

4. One specific to individuals who would otherwise be in an intermediate care facility for the mentally retarded (ICFMR).

Continuing, Mr. Thompson stated that the elderly program is referred to as CHIP, and it is operated through the Aging Services Division, which provides homemaker and related services to individuals who would otherwise be at risk of being in a nursing facility.

Mr. Thompson said there is a dichotomy in federal law and the state approach. He said the concept of waivers is that they will always be at least cost neutral or save money on the basis that the state would otherwise have to make payments to nursing facilities for the full cost of care. However, most individuals that apply for waiver services would rather remain independent and not live in a nursing facility even though they are eligible for nursing home care and to receive Medicaid as a result of being in an institution. Mr. Thompson advised that the waivers enable some people to delay going into nursing facilities, and a few are actually taken out of nursing facilities and put on to waivers. Those who are eligible to go into a nursing facility and choose not to, allows the Medicaid program the opportunity to use 50 percent federal dollars and provide certain services that allow those individuals to maintain their independence.

Mr. Thompson stated there are currently 107 individuals on the waiver for persons with physical disabilities; an additional 162 have expressed an interest in being on the waiver. Of those 162, a determination has not been made as to their eligibility for the waiver. He said that history has shown that once slots have opened up, approximately one in three individuals waiting for waivers are determined to be eligible. Mr. Thompson indicated that over the last year, 15 individuals have come off the waiting list and gone onto the waiver. The actual waiting time is approximately one and one-half to two years. Due to the long waiting period, some people choose to go into a nursing facility, which causes them a loss of independence that is difficult to regain.

According to Mr. Thompson, the CHIP waiver for the elderly currently has approximately 745 individuals on the program with a waiting list of approximately 700. The same issues apply to the CHIP waiver, but due to the rapid growth in southern Nevada and a lack of proportionate growth in the number of case managers, there is a six-month waiting period to obtain waiver services versus a two- to three-month waiting period for the remainder of the State. Mr. Thompson advised that the issue of providing more case managers has been addressed through the budget.

For both the physically disabled and the CHIP waiver, Mr. Thompson indicated that there is a cost savings to the extent that a person is prevented from moving into a nursing facility. Therefore, one of his division's goals is to spend additional money up-front to enhance the independent living operations to save more money in the long run.

Regarding group care waivers, Mr. Thompson stated there are 55 individuals currently on the group care waiver, with no waiting list.

Finally, in regard to the waiver for persons with mental retardation (MR) and related conditions, there are 694 individuals currently on the waiver program, with a waiting list of approximately 130 people. He advised that the waiting list is budget-driven through the Division of Mental Health and Mental Retardation, DHR.

Mr. Thompson concluded that, at this time, approximately 1,500 individuals are covered under all the waivers. The greatest need for addressing the waiting lists is in the area of people with physical disabilities, which is a major focus in the budget his division is proposing.

An additional comment by Mr. Thompson was that, in general, the services provided by the waiver programs are fairly standard, including personal care services and case management. The CHIP program includes certain related services such as day care, homemaker, some respite and chore services. A personal emergency response system is common for all the programs. He said in the area of MR and related conditions, his division has been more expansive in allowing for alternative supported living arrangements. The MR waiver also includes additional state plan services such as dental care. He explained that currently the Medicaid State Plan for adults only covers dental services on an emergency basis; preventative dental care is not covered. An expanded dental program will enable mentally retarded persons to live more independently

once they leave an ICFMR. Mr. Thompson mentioned that dental services would be beneficial to the elderly and disabled as well, but would not afford them greater independence. Even though it is an expensive benefit, it is one that to the degree that it enables individuals to live in their own homes and not be institutionalized, will save Nevada money overall.

One final problem Mr. Thompson addressed was that as waivers are expanded, there will be greater demand for homemakers, PCAs, and so forth, to provide these services. He said in its effort to increase salaries for these service providers, the division will need to monitor the cost of providing services that enable individuals to live independently to ensure it does not exceed that of institutionalization.

Responding to questions from the committee, Mr. Thompson made the following comments:

- The MR waiver program is for residential care when people move out of institutions rather than an outpatient mental illness program.
- The Medicaid program is to provide medical care to individuals and not nonmedical services. The Federal Government allows for waivers of various sorts to offer alternative services to assure that what would otherwise be higher medical costs, such as long-term care services, can be avoided.
- Under the general Medicaid program, people are only eligible up to 100 percent of poverty if they are living outside an institution. If they are institutionalized as an aged or disabled individual, their income level may be up to 300 percent of Supplemental Security Income (SSI), which is just under $1,500 a month. An individual with an income of $1,000 a month is not eligible for Medicaid but would have his medical costs covered if in an institution.
- While it is true that there have been savings as a result of lower than expected waiver recipients, the division does not have adequate staff to expand the caseloads on waivers at this point because they are associated with case managers as well as dollars. There are two solutions to this problem:

    1. Each biennium, additional case managers can be built into the budget to enable the programs to handle more clients.
    2. Flexibility could be built into the division’s budget to permit it to move money mid-session to meet this type of crisis.

Ms. Sloan proposed, as a solution, the addition of "program assistants." She said currently, each case manager in the Aging Services Division is assigned 44 cases. This is an increase of four cases per manager from the last biennium. In Ms. Sloan’s opinion, the division can increase that number to 50 cases per case manager with program assistants to handle the paperwork.

In response to Chairman Close’s comment regarding the lengthy waiting period to get into the waiver programs, Mr. Thompson remarked that in addition to a shortage of dollars and staff, the program administrators need to do a better job up-front of evaluating the individuals that are potentially eligible for a waiver. He advised that the financial aspects of waivers are handled through the Welfare Division which does not determine eligibility of an individual until a slot is open. Therefore, there are people on waiting lists that ultimately are not eligible for the program.

Additionally, Mr. Thompson asserts that an evaluation of a person’s needs upon application would enable the program administrator to more directly determine how quickly that individual could be moved onto a waiver. Mr. Thompson maintains it would be much easier to convince the legislative committee or the Interim Finance Committee of a need for additional staff and funds if he could present them with specific figures and report to them something to the effect:

> There are 20 people that if not moved into a waiver within the next six months, are going to have to be housed in a long-term care facility. With an additional staff person and an additional $10,000 for waiver services some of the other costs that would otherwise be incurred could be reduced by $150,000.

In response to questions by Paula Berkley, representing EduCare, regarding waivers for mentally retarded persons, Mr. Thompson answered:

- There is no federal timeframe requirement for waivers. However, Medicaid would be required to make an ICFMR placement within 90 days.
- During the last several years, the Mental Hygiene and Mental Retardation Division, DHR, has been successful in placing people in the most appropriate level of care. Many MR patients will be in state institutions for the remainder of their lives, and there are no plans to close the state mental health institutions.

Chairman Close suggested that the subcommittee continue to endorse the elimination of the waiting period for waivers, evaluate the reasons why there is a waiting list, and recommend to the Legislative Committee on Health Care that recommendations be made to the Governor that staffing be allotted to improve the entry into the waiver program to ensure a better outcome from that process.

> ASSEMBLYWOMAN BUCKLEY MOVED TO SUPPORT THE SUGGESTIONS MADE BY CHAIRMAN CLOSE. ASSEMBLYWOMAN FREEMAN SECONDED THE MOTION WHICH PASSED UNANIMOUSLY.

PRESENTATION OF THE NEED FOR SUPPLEMENTAL NUTRITION PROGRAMS IN NEVADA

Kristin Alampi

Ms. Alampi, Dietitian II, Aging Services Division, DHR. made a presentation on nutritional health from her written testimony (please see Exhibit D for details).

Generally, Ms. Alampi covered the importance of good nutrition to optimal health, nutrition programs for the elderly, and malnutrition among the elderly. She also talked about the Nutrition Screening Initiative and the unmet nutritional needs of the physically disabled population. Ms. Alampi described a survey conducted by her division of senior centers in Nevada to determine the need for meal service to the physically disabled population. The results of that survey are contained in Exhibit E.

Chairman Close suggested that Ms. Alampi also make her presentation before the entire Legislature, perhaps during March 1999 which is national "Nutrition Month."

DISCUSSION OF FUTURE TOPICS FOR CONSIDERATION BY THE SUBCOMMITTEE AND THE LEGISLATIVE COMMITTEE ON HEALTH CARE

The next item, according to Chairman Close, is to make the committee aware of what topics will be discussed in future meetings. He mentioned testimony by Theresa Brushfield of the Adult Care Association of Nevada at the last meeting who was concerned about issues concerning housing of the disabled and elderly. Therefore, the next agenda will include discussion regarding placement of individuals to receive the appropriate level of care, the role of assisted living, the rates for the services in that area, and other related issues.

Chairman Close stated that another problem area that needs to be addressed is transportation for the disabled population. He remarked that he would like a representative of the paratransit system to attend a meeting to educate the committee on its criteria for transportation of the disabled community.

Mr. Matheis suggested that a report from Mr. Cline as to whether his PCA-D problem has been resolved be added to the next subcommittee meeting agenda.

Two agenda items recommended by Mr. Cashdollar are: (1) the possible conversion of the State's four Medicaid waivers into one "super waiver"; and (2) a discussion of manpower issues relating to long-term care of the aged and disabled.

Ms. Buckley urged the committee to try to reach closure on the main topics discussed during the interim. She expressed concern that the committee may not have enough time to address the paratransit issue during this interim.

Chairman Close clarified that the subcommittee could report to the full committee that the transportation problem needs further investigation, but the subcommittee does not need to look for solutions to the problem at this time. In Chairman Close's opinion, the problem does need oversight, especially for the disabled community which does not currently have recourse.

PUBLIC TESTIMONY

Paul Gowins

Mr. Gowins advised that he was asked to deliver a document to the subcommittee by Herb Perry, Chairman of the Board, Title II Community Aids National Network (see Exhibit F). The document includes a report on eligibility for Medicaid and related programs and a list of advocacy groups.

From a personal viewpoint as a disabled person, Mr. Gowins urged the committee to keep in mind that persons with disabilities are already receiving financial aid, and if they can obtain insurance and return to work, it would enable them to participate in society and pay back some of their benefits.

Lou Clark

Lou Clark, Nevada Disability Advocacy and Law Center, advised regarding Mr. Thompson's remarks about the waiting list for the mentally retarded population in Las Vegas, that she received an interoffice memorandum from a person with knowledge of the situation from Desert Regional Center that indicated the waiting list is currently 167, rather than 130. Additionally, Ms. Clark is aware of a parent who was told the

waiting list for community-based services is two to five years. Further, Ms. Clark refuted Mr. Thompson's suggestion that the reason the waiting list has increased since allocation of funds to address this issue during the 1997 Legislature is that people with less needy situations may be seeking services since the waiting list is shorter. She asserted that people are moving into the community with a need as high as it has ever been, and that in her opinion, the issue should be readdressed during the 1999 Legislative Session.

Chairman Close announced that the next meeting of the Subcommittee of the Legislative Committee on Health Care to Address Medicaid and Other Issues for Persons Who Are Aged or Disabled is tentatively scheduled for October 5, 1998, at 10 a.m.

ADJOURNMENT

There being no further subcommittee business, the Chairman adjourned the meeting at 3:30 p.m.

Respectfully submitted,

Jo Greenslate

Research Secretary

APPROVED BY:

_____

Assemblyman Jack D. Close, Chairman

Date: _____

LIST OF EXHIBITS

Exhibit A is a document titled "Executive Summary," presented by Donny Loux, Chief, Office of Community Based Services, Rehabilitation Division, Nevada's Department of Employment, Training and Rehabilitation.

Exhibit B is a document dated March-April, 1997, titled "Personal Assistance Services (PAS) — Client Satisfaction," presented by Ms. Loux.

Exhibit C is a letter dated August 26, 1998, from John D. Busse, Executive Director, Home Health Care Association of Nevada addressed to Marla L. McDade, Senior Research Analyst, Research Division, Legislative Counsel Bureau, "Re: Assemblyman Jack Close, Chairman, Legislative Health Care Subcommittee on Disability."

Exhibit D is the written testimony of Kristin Alampi, Dietitian II, Aging Services Division, Nevada's Department of Human Resources.

Exhibit E is a memorandum dated September 1, 1998, from Kristin Alampi addressed to Donny Loux, "Subject: Survey Results," presented by Ms. Alampi.

Exhibit F is a letter dated August 19, 1998, from Thomas P. McCormack, Technical Advisor, addressed to Mr. Herb Perry, Chairman of the Board, Title II Community Aids National Network, delivered to the subcommittee by Paul Gowins, a member of Nevada's Independent Living Advisory Council.

Exhibit G is the "Attendance Record" for this meeting.

Copies of the materials distributed in the meeting are on file in the Research Library of the Legislative Counsel Bureau, Carson City, Nevada. You may contact the library at (702) 684-6827.