Legislative Counsel Bureau

Subcommittee to Conduct a Study of Postacute Care

Bulletin No. 17-3

The Subcommittee to Conduct a Study of Postacute Care (A.B. 242 [Chapter 306, *Statutes of Nevada 2015*]) is comprised of four legislators, two from each house.

January 2017

LEGISLATIVE COMMISSION'S SUBCOMMITTEE TO CONDUCT A STUDY OF POSTACUTE CARE

Bulletin No. 17-3

January 2017

TABLE OF CONTENTS

SUMMARY OF RECOMMENDATIONS

LEGISLATIVE COMMISSION'S SUBCOMMITTEE TO CONDUCT A STUDY OF POSTACUTE CARE

Assembly Bill 242
(Chapter 306, *Statutes of Nevada 2015*)

On July 6, 2016, during the fourth and final meeting of the Subcommittee to Conduct a Study of Postacute Care, the members conducted a work session and voted to forward five recommendations as bill draft requests (BDRs) to the 2017 Legislative Session. The Subcommittee members also voted to have one letter expressing their support for a specific issue and encouraging certain action. During the work session, the members also voted to include several statements of support for issues in the Subcommittee's final report. A summary of each BDR and letter follows, while the statements of support will appear in the Subcommittee's bulletin (interim study report).

During the drafting process, specific details of the following proposals for legislation and letters may be further clarified by staff in consultation with the Chair or others, as appropriate. If a proposal for legislation or the letter includes reference to specific chapters or statutes of *Nevada Revised Statutes* (NRS), as part of the drafting process, amendments to other related chapters or sections of NRS may be made to fully implement the proposals.

BILL DRAFT REQUESTS

1. **Submit a BDR** requiring the Division of Health Care Financing and Policy (DHCFP), Department of Health and Human Services (DHHS), to study the adequacy of the rates of reimbursement through Medicaid waiver programs for personal care services provided in assisted living facilities, facilities for the care of adults during the day, personal residences, and residential facilities for groups. In conducting the study, the DHCFP must consider reasonable cost of care assessments provided by personal care service providers in Nevada, the Medical Care in the Consumer Price Index, Nevada's rates in comparison to rates in other demographically similar states, and direct care staff labor costs. Upon completion of this study, the DHCFP shall prepare a report setting forth its findings and recommendations. In addition, if the rate is determined to be inadequate, the DHCFP must propose an adjusted Medicaid rate that adequately covers the cost for providing personal care services for consideration during the 80th Session of the Nevada Legislature in 2019. The report must be completed by March 1, 2018, and submitted to the Legislative Counsel Bureau (LCB) to be transmitted to the Legislative Committee on Health Care and the Interim Finance Committee. **(BDR S–368)**

2. **Submit a BDR** requiring the DHCFP to conduct a comparative analysis of the rates of reimbursement that cover the cost for personal care services and home- and

community-based services provided by residential facilities for groups (as defined by NRS 449.017); providers of supported living arrangement services (as defined by NRS 449.0159); and providers of community-based services for persons with physical disabilities, frail elderly persons, and persons with intellectual disabilities or related conditions to identify any disparities in the rates of reimbursement for equivalent services among these different types of providers. Upon the completion of its analysis, the DHCFP shall prepare a report setting forth its findings and recommendations. The report must be completed by March 1, 2018, and submitted to the LCB to be transmitted to the Legislative Committee on Health Care and the Interim Finance Committee. **(BDR S–369)**

3. **Submit a BDR** requiring the DHHS to establish by regulation standards for certain facilities providing 24-hour, long-term care for individuals who need supervision and assistance with personal care and medication management, including residential facilities for groups, supported living arrangements, and community-based living arrangements. Specifically, provide uniformity by establishing the following essential standards:

   a. Develop consistent authority to provide oversight for each regulating State agency;

   b. Require every facility or living arrangement to receive an annual State inspection or survey;

   c. Ensure that the penalties which may be imposed on a facility or living arrangement for violation of an applicable law or regulation are enforceable and consistent;

   d. Authorize each regulating agency to impose comparable fines; and

   Require clear notification of the State agency responsible for providing oversight for each facility or living arrangement; develop a "no wrong door" policy for reporting complaints among regulatory agencies; and ensure that residents are notified of the services that are authorized and the services that are required to be provided within that setting. **(BDR 40–370)**

4. **Submit a BDR** expanding the authority of the long-term care ombudsmen to include the ability to advocate for residents of the following living arrangements and facility types:

   a. Living arrangements;

      (1) Supported living arrangements (NRS 435.3315), Aging and Disability Services Division, DHHS; and

      (2) Community-based living arrangements, Division of Public and Behavioral Health (DPBH), DHHS; and

   b. Facilities for the care of adults during the day. **(BDR 38–371)**

5. **Submit a BDR** requiring the adoption of regulations by the State Board of Health, DPBH, DHHS, and relevant professional licensing agencies that authorize any person: (1) who is employed by an agency to provide personal care services in the home (as defined by NRS 449.0021), a facility for the care of adults during the day (as defined by NRS 449.004), an intermediary service organization (as defined by NRS 449.4304), or a residential facility for groups; and (2) who has completed training in accordance with standards adopted by the State Board of Health and relevant professional licensing agencies to engage in the activities noted below.

   Such a person may, with the consent of the resident: (1) check, record, and report the apical heart rate, blood pressure, pulse, respiration or oxygen saturation, or temperature of a resident, or any combination of these; (2) administer insulin furnished by a registered pharmacist to a resident for the treatment of insulin-dependent diabetes as directed by a physician and using an auto-injection device approved by the United States Food and Drug Administration for use in the home; and (3) conduct a glucose test on a resident with diabetes using a device for monitoring that is approved as described above and used only on that resident. **(BDR 40–372)**

LETTER

6. **Submit a letter** to the Governor of the State of Nevada, the Director of the DHHS, and the Chairs of the Senate Committee on Finance and Assembly Committee on Ways and Means during the 2017 Legislative Session recommending and expressing support for:

   a. A review of the rate methodology for postacute care facilities and personal care and home health care services;

   b. Inclusion of an appropriation in the Governor's recommended budget and the legislatively approved budget that supports payment rates which are sufficient to ensure that Medicaid beneficiaries have access to covered Medicaid services; and

   c. Indexing the rate to increase with inflation in future biennia.

   Please see Appendix B.

REPORT TO THE 79TH SESSION OF THE NEVADA LEGISLATURE BY THE LEGISLATIVE COMMISSION'S SUBCOMMITTEE TO CONDUCT A STUDY OF POSTACUTE CARE

I. INTRODUCTION

The Subcommittee to Conduct a Study of Postacute Care is required to conduct a study relating to postacute care in Nevada, including a review of the quality and cost of postacute care; alternatives to institutionalization; cost savings of home- and community-based waiver programs; the impact of alternatives to institutionalization on the quality of life of a person receiving postacute care services; and State and national quality measures and funding methodologies for postacute care. The Subcommittee may recommend legislation to the 2017 Nevada Legislature concerning postacute care.

The Legislative Commission appointed four members to the Subcommittee, including:

Assemblywoman Robin L. Titus, M.D., Chair
Senator Joseph (Joe) P. Hardy, M.D., Vice Chair
Senator Joyce Woodhouse
Assemblywoman Teresa Benitez-Thompson

Legislative Counsel Bureau (LCB) staff services were provided by:

Marsheilah D. Lyons, Chief Principal Research Analyst, Research Division
James W. Penrose, Senior Principal Deputy Legislative Counsel, Legal Division
Gayle Nadeau, Senior Research Secretary, Research Division

II. SUBCOMMITTEE ACTIVITIES

During the course of the interim, representatives from State and local agencies, businesses, community groups, nonprofit and professional organizations, and the public provided testimony on a wide range of topics related to postacute care.

During the first meeting on November 17, 2015, the Subcommittee heard testimony related to the types of postacute care and quality measures, the quality of institutional and home- and community-based care, and the impact of alternatives to institutionalization on quality of life.

At the second meeting on February 17, 2016, the Subcommittee heard testimony related to State and federal funding for institutional and home- and community-based postacute care. In addition, the Subcommittee received information regarding funding by private insurance, self-funded care, and other funding sources for postacute care.

Testimony during the third meeting on April 6, 2016, included a review and evaluation of the quality and funding of postacute care in Nevada and a review of various recommendations submitted for the Subcommittee's consideration.

During the fourth and final meeting on July 6, 2016, the Subcommittee held a work session during which the members considered seven recommendations. The members voted to forward five recommendations as bill draft requests (BDRs) to the 79th Session of the Nevada Legislature and to write a letter to various entities expressing their support for a specific issue. The BDRs relate to the following topics:

1. Medicaid reimbursement rates for personal care services;

2. A comparative analysis of the rates of reimbursement that cover the cost for personal care services and home- and community-based services;

3. Establishing regulation standards for certain facilities providing 24-hour, long-term care for individuals who need supervision and assistance with personal care and medication management;

4. Authority of the long-term care ombudsmen; and

5. Authority for certain personal care and home health care workers to assist residents of certain facilities with checking certain vital signs, with the residents' consent.

III. DISCUSSION OF TESTIMONY AND RECOMMENDATIONS FOR THE STATE OF NEVADA

Several topics were reviewed and discussed at the meetings of the Subcommittee. Pursuant to Assembly Bill 242 (Chapter 306, *Statutes of Nevada 2015*), the Subcommittee deliberated over the following:

1. A review and evaluation of the quality and funding of postacute care in this State and alternatives to institutionalization for providing such care, including home- and community-based waiver programs;

2. An evaluation of the cost of such alternatives and potential savings from each alternative;

3. Consideration of the positive and negative effects of the various alternatives for providing postacute care services on the quality of life of persons receiving those services in this State;

4. A review of state and national quality measures for postacute care required to be reported by Medicare, Medicaid, and this State; and

5. A review of state and federal funding for postacute care, including the funding formula used in this State.

Following are two policy statements the Subcommittee agreed to include in this final report.

1. The Subcommittee supports enabling senior adults and individuals with disabilities to remain in their homes or in community-based settings.

2. The Subcommittee encourages the Department of Health and Human Services (DHHS) to establish a "no wrong door" philosophy as it relates to members of the public accessing information about postacute care services and supports.

The remainder of this section provides background information and discussion regarding the issues for which recommendations were made. These issues relate to:

A. Medicaid rates of reimbursement for certain personal care services, home and community-based services, and postacute care facilities;

B. Regulation standards for certain long-term care facilities;

C. Authority of the long-term care ombudsmen; and

D. Personal care and home health care workers assistance to certain residents.

All of the Subcommittee actions outlined below were approved unanimously by the members present at the final meeting and work session.

A. MEDICAID RATES OF REIMBURSEMENT

Postacute care includes a range of medical or health care services that support a patient's continuous recovery from illness or management of a chronic illness or disability. Postacute care is provided in a facility or within a home- or community-based setting. In Nevada postacute care facilities, such as facilities for the care of adults during the day (adult day care), homes for individual residential care, hospices, intermediate care facilities, rehabilitation hospitals, residential facilities for groups, and skilled nursing facilities are licensed by the State. Programs, agencies, and professionals that provide home-based care, such as a hospice, home health care, and personal care are also licensed or certified by the State. Additionally, family caregivers provide advocacy, care coordination, emotional support, financial assistance, and in many instances, direct care.

The Subcommittee received testimony regarding the importance of community-based and supportive services that make it possible for persons with disabilities to live in the most integrated setting possible. Long-term services and supports, such as those provided by the 1915(c) Medicaid waiver (known as the Home and Community-Based Services [HCBS]

waiver), offer assistance with a variety of services, including activities of daily living, assisted living accessibility adaptations, case management, residential support services, and specialized equipment and supplies. Providing these services helps people remain in their homes, avoiding higher cost institutional settings.

Advocates indicated that limited funding to support HCBS waivers and other programs that provide community-based services makes it difficult for the State to comply with certain court mandates. Two major court rulings in this area include: (1) the United States Supreme Court decision in *Olmstead v. L.C., 527 U.S. 581 (1999)*, which upheld the positon that people with disabilities have a right to receive state-funded services in the community rather than in institutional settings when certain conditions are met; and (2) the Americans with Disabilities Act's integration mandate, 28 C.F.R § 35.130(d), which requires public entities to "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities."

Consistently, the Subcommittee heard testimony from representatives of postacute care facilities, home- and community-based service providers, and advocates that the Medicaid rates of reimbursement have not kept up with inflation and the actual costs of providing certain services and care. Proponents for rate increases mentioned several rates that have not changed since 2002, including the rates for adult day care and personal care service. Currently, Medicaid reimbursement rates for adult day care services are $54.48 per day and $40 per day depending on the model of care. To account for a cost-of-living increase, advocates and service providers proposed a rate increase to $71.87 per day and $52.75 per day, respectively. Furthermore, the current rate of reimbursement for personal care services is $4.25 for 15 minutes or $17 per hour. The proposed rate increase to $5.25 for 15 minutes or $21 per hour considers the cost of living and a potential increase in the minimum wage at a state or federal level. Further testimony indicated confusion and frustration among personal care and home- and community-based service providers about perceived differences in the rate of reimbursement for equivalent or similar services that are performed in different settings.

Finally, the Subcommittee heard testimony regarding the rates of reimbursement for institutional settings that provide care for individuals who require a higher level of care, such as a skilled nursing facility. Several key points emphasized by proponents for rate increases relate to: (1) the steady decline in the percent of State funding allocated to support skilled nursing facility care and services; (2) an acknowledgement that all of the rate increases that have been implemented since 2003 have been the result of provider taxes and increases in the Federal Medicaid Matching Rate; and (3) the impact of a payment methodology that disproportionately rewards providers who have high Medicaid occupancy.

Based upon the testimony received, the Subcommittee members recommended the following three actions—two BDRs and a letter:

1. **Submit a BDR** requiring the Division of Health Care Financing and Policy (DHCFP), Department of Health and Human Services (DHHS), to study the adequacy of the rates of

reimbursement through Medicaid waiver programs for personal care services provided in assisted living facilities, facilities for the care of adults during the day, personal residences, and residential facilities for groups. In conducting the study, the DHCFP must consider reasonable cost-of-care assessments provided by personal care service providers in Nevada, the Medical Care in the Consumer Price Index, Nevada's rates in comparison to rates in other demographically similar states, and direct care staff labor costs. Upon completion of this study, the DHCFP shall prepare a report setting forth its findings and recommendations. In addition, if the rate is determined to be inadequate, the DHCFP must propose an adjusted Medicaid rate that adequately covers the cost for providing personal care services for consideration during the 80th Session of the Nevada Legislature in 2019. The report must be completed by March 1, 2018, and submitted to the LCB to be transmitted to the Legislative Committee on Health Care and the Interim Finance Committee. **(BDR S–368)**

2. **Submit a BDR** requiring the DHCFP to conduct a comparative analysis of the rates of reimbursement that cover the cost for personal care services and home- and community-based services provided by residential facilities for groups (as defined by *Nevada Revised Statutes* [NRS] 449.017); providers of supported living arrangement services (as defined by NRS 449.0159); and providers of community-based services for persons with physical disabilities, frail elderly persons, and persons with intellectual disabilities or related conditions to identify any disparities in the rates of reimbursement for equivalent services among these different types of providers. Upon the completion of its analysis, the DHCFP shall prepare a report setting forth its findings and recommendations. The report must be completed by March 1, 2018, and submitted to the LCB to be transmitted to the Legislative Committee on Health Care and the Interim Finance Committee. **(BDR S–369)**

3. **Submit a letter** to the Governor of the State of Nevada, the Director of the DHHS, and the Chairs of the Senate Committee on Finance and Assembly Committee on Ways and Means during the 2017 Legislative Session recommending and expressing support for:

   a. Reviewing the rate methodology for postacute care facilities and personal care and home health care services;

   b. Including an appropriation in the Governor's recommended budget and the legislatively approved budget that supports payment rates that are sufficient to ensure that Medicaid beneficiaries have access to covered Medicaid services; and

   c. Indexing the rate to increase with inflation in future biennia.

B. REGULATION STANDARDS FOR CERTAIN LONG-TERM CARE FACILITIES

During the course of the postacute care study, the *Reno Gazette-Journal* published a series of investigative articles (http://www.rgj.com/story/news/2016/02/25/fragile-system-spotty-oversight-left-mentally-ill-living-squalid-home/80636366/) spotlighting deficiencies in certain supportive and community-based living arrangements in northern Nevada. The Subcommittee's charge to review issues related to the quality of postacute care and information regarding regulation and oversight differences in the articles encouraged the Subcommittee to review the DHHS's authority to regulate residential facilities for groups, homes for individual residential care, adult day care, supported living arrangements, and community-based living arrangements.

Testimony indicated that different agencies provide oversight and establish standards for these supportive and community-based living arrangements. Adult day care facilities, homes for individual residential care, and residential facilities for groups are each licensed as a facility by the Bureau of Health Care Quality and Compliance (HCQC) within the Division of Public and Behavioral Health (DPBH), DHHS. However, supported living arrangements are regulated by the Aging and Disability Services Division (ADSD), DHHS, and community-based living arrangements are regulated by Clinical Services within the DPBH. Neither type of living arrangement is licensed as a facility, but rather, contracts are developed to provide supportive services in the community for eligible individuals with a mental illness or an intellectual disability or related condition.

The Subcommittee received information regarding unlicensed group residences or other facility types that house three or more individuals receiving certain Medicaid services and how State authorities are notified and investigate complaints regarding licensed and unlicensed residential group homes.

The Subcommittee discussed the impact of establishing consistent standards in the following areas for all facilities providing 24-hour, long-term care for individuals who need supervision and assistance with personal care and medication management:

1. State ombudsmen;

2. State oversight;

3. Certified administrators;

4. Liability insurance;

5. A minimum high school diploma requirement;

6. Minimum staffing ratios;

7. Annual state inspections;

8. Internet access to view inspection dates and survey results;

9. Enforceable penalties;

10. The State's ability to impose fines;

11. Transparency and disclosure; and

12. Residential sprinklers.

Based upon Subcommittee discussion and testimony received regarding the unique roles of each living arrangement and potential costs to implement broader changes, the Subcommittee approved the following actions:

Submit a BDR requiring the DHHS to establish by regulation standards for certain facilities providing 24-hour, long-term care for individuals who need supervision and assistance with personal care and medication management, including residential facilities for groups, supported living arrangements, and community-based living arrangements. Specifically, provide uniformity by establishing the following essential standards:

a. Develop consistent authority to provide oversight for each regulating State agency;

b. Require every facility or living arrangement to receive an annual State inspection or survey;

c. Ensure that the penalties, which may be imposed on a facility or living arrangement for violation of an applicable law or regulation, are enforceable and consistent;

d. Authorize each regulating agency to impose comparable fines; and

e. Require clear notification of the State agency responsible for providing oversight for each facility or living arrangement, develop a "no wrong door" policy for reporting complaints among regulatory agencies, and ensure that residents are notified of the services that are authorized and the services that are required to be provided within that setting. **(BDR 40–370)**

C. AUTHORITY OF THE LONG-TERM CARE OMBUDSMEN

The Subcommittee heard testimony from the State Long-Term Care Ombudsman. The long-term care ombudsmen serve as advocates for residents of assisted living facilities, homes for individual residential care, nursing homes, and residential facilities for groups. Long-term care ombudsmen are trained to resolve problems and represent the perspective of residents in

monitoring laws, policies, and regulations. Advocates suggested that residents should be able to request the assistance of a long-term care ombudsman, no matter which facility type or living arrangement serves as their residence. The Subcommittee considered the effectiveness of a long-term care ombudsman in resolving residents' complaints and concerns and the additional level of oversight provided when they have access to a facility or living arrangement. Following deliberations, the Subcommittee agreed to:

Submit a BDR expanding the authority of the Office of the State Long-Term Care Ombudsman to include the ability to advocate for residents of the following living arrangements and facility types:

a. Living arrangements;

   (1) Supported living arrangements (NRS 435.3315), ADSD, DHHS; and

   (2) Community-based living arrangements, DPBH, DHHS; and

b. Facilities for the care of adults during the day. **(BDR 38–371)**

D. PERSONAL CARE AND HOME HEALTH CARE WORKERS ASSISTANCE TO CERTAIN RESIDENTS

In a residential setting, family members are frequently trained to help residents take and record certain defined vital signs, including taking a resident's apical heart rate, blood pressure, finger-stick glucose, oxygen saturation, pulse, respirations, and temperature, and to administer insulin and assist with the administration of insulin. The Subcommittee received testimony indicating that unlicensed assistive personnel (UAP) in a home- and community-based setting are not authorized to receive appropriate training in defined vital signs and to assist certain residents in a manner similar to the assistance that may be offered by a family member or friend when the patient is living in the patient's own home. This prohibition applies to UAPs working in: (1) a residential facility for groups; (2) an agency that provides personal care services in the home; (3) an intermediary service organization; and (4) a facility for the care of adults during the day.

The HCQC proposed regulatory changes that would only cover the finger-stick glucose testing—not the administration of insulin. The Subcommittee encouraged the HCQC to work toward regulatory changes that would allow UAPs to administer insulin and assist with the administration of insulin.

The Subcommittee received testimony regarding federal requirements for the Centers for Medicare and Medicaid Services Clinical Laboratory Improvement Amendments as it relates to blood glucose testing. However, it was acknowledged that other states may provide models that allow blood glucose testing by UAPs. In addition, stressing the need for oversight in these settings, the Subcommittee heard cautionary remarks regarding the possibility of

single-use injectable devices being used on multiple individuals and the need to ensure proper insulin dosage.

In an effort to give UAPs in these residential community settings authority that is similar to what is authorized for a friend or family member in a resident's home, the Subcommittee directed the following action:

Submit a BDR requiring the adoption of regulations by the State Board of Health, DPBH, DHHS, and relevant professional licensing agencies that authorize any person: (1) who is employed by an agency to provide personal care services in the home (as defined by NRS 449.0021), a facility for the care of adults during the day (as defined by NRS 449.004), an intermediary service organization (as defined by NRS 449.4304), or a residential facility for groups; and (2) who has completed training in accordance with standards adopted by the State Board of Health and relevant professional licensing agencies to engage in the activities noted below.

Such a person may, with the consent of the resident: (1) check, record, and report the apical heart rate, blood pressure, pulse, respiration or oxygen saturation, or temperature of a resident, or any combination of these; (2) administer insulin furnished by a registered pharmacist to a resident for the treatment of insulin-dependent diabetes as directed by a physician and using an auto-injection device approved by the U.S. Food and Drug Administration, U.S. Department of Health and Human Services, for use in the home; and (3) conduct a glucose test on a resident with diabetes using a device for monitoring that is approved as described above and used only on that resident. **(BDR 40–372)**

IV. CONCLUSION

This report presents a summary of the bill drafts requested by the Subcommittee for discussion before the 2017 Nevada Legislature and other actions to express its position on important matters related to postacute care. Persons wishing to have information that is more specific concerning these issues may find it useful to review the "Summary Minutes and Action Report" and related exhibits for each of the Subcommittee meetings at: https://www.leg.state.nv.us/App/InterimCommittee/REL/Interim2015/Committee/274.

The Subcommittee wishes to thank the many testifiers, including citizens, stakeholders, and subject-matter experts who generously gave of their time and expertise to make this interim study productive.

V. APPENDICES

APPENDIX A

Assembly Bill 242 (Chapter 306, *Statutes of Nevada 2015*)

Assembly Bill No. 242–Committee on
Health and Human Services

CHAPTER.....

AN ACT relating to public health; requiring the Legislative Commission to appoint a subcommittee to conduct a study relating to postacute care in Nevada; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

This bill requires the Legislative Commission to appoint a subcommittee to conduct a study relating to postacute care in Nevada, including alternatives to institutionalization, cost savings of home- and community-based waiver programs, the impact of postacute care services on the quality of life of a person receiving such services and a review of the state and national quality measures and funding methodologies for postacute care.

EXPLANATION – Matter in ***bolded italics*** is new; matter between brackets [~~omitted material~~] is material to be omitted.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Sections 1-11. (Deleted by amendment.)

Sec. 12. 1. The Legislative Commission shall appoint a subcommittee to conduct an interim study of postacute care in this State.

2. The subcommittee must be composed of four Legislators as follows:

(a) One member appointed by the Majority Leader of the Senate from the membership of the Senate Standing Committee on Health and Human Services;

(b) One member appointed by the Minority Leader of the Senate from the membership of the Senate Standing Committee on Health and Human Services;

(c) One member appointed by the Speaker of the Assembly from the membership of the Assembly Standing Committee on Health and Human Services; and

(d) One member appointed by the Minority Leader of the Assembly from the membership of the Assembly Standing Committee on Health and Human Services.

3. The study must include, without limitation:

(a) A review and evaluation of the quality and funding of postacute care in this State and alternatives to institutionalization for providing such care, including home- and community-based waiver programs;

(b) An evaluation of the cost of such alternatives and potential savings from each alternative;

(c) Consideration of the positive and negative effects of the various alternatives for providing postacute care services on the quality of life of persons receiving those services in this State;

(d) A review of state and national quality measures for postacute care required to be reported by Medicare, Medicaid and this State; and

(e) A review of state and federal funding for postacute care, including the funding formula used in this State.

4. Any recommended legislation proposed by the subcommittee must be approved by a majority of the members of the subcommittee.

5. The Legislative Commission shall submit a report of the results of the study and any recommendations for legislation to the Director of the Legislative Counsel Bureau for transmittal to the 79th Session of the Nevada Legislature.

Sec. 13. This act becomes effective on July 1, 2015.

APPENDIX B

July 8, 2016, Letter to the Honorable Brian Sandoval, Governor of Nevada

ROBIN L. TITUS
ASSEMBLYWOMAN
District No. 38

COMMITTEES:
Chairwoman
Natural Resources, Agriculture, and Mining
Vice Chairwoman
Health and Human Services
Member
Ways and Means

State of Nevada Assembly

Seventy-Eighth Session

DISTRICT OFFICE:
P.O. Box 377
Wellington, Nevada 89444-0377
Office: (775) 465-2587
Fax No.: (775) 465-2676
Email: rltitus@earthlink.net

LEGISLATIVE BUILDING:
401 South Carson Street
Carson City, Nevada 89701-4747
Office: (775) 684-8507
Fax No.: (775) 684-8533
Email: Robin.Titus@asm.state.nv.us
www.leg.state.nv.us

July 8, 2016

The Honorable Brian Sandoval
Governor of Nevada
State Capitol Building
101 North Carson Street, Suite 1
Carson City, Nevada 89701-4786

Dear Governor Sandoval:

At the July 6, 2016, final meeting of the Subcommittee to Conduct a Study of Postacute Care (Assembly Bill 242 [Chapter 306, *Statutes of Nevada 2015*]) the Subcommittee members unanimously agreed to request your support for:

1. A review of the Medicaid rate and methodology for reimbursing postacute care facilities and personal and home health care services;

2. Inclusion of an enhancement in the Governor's recommended budget that supports payment reimbursement rates that are sufficient to ensure that Medicaid beneficiaries have access to covered Medicaid services; and

3. Indexing the reimbursement rate to increase with inflation in future biennia.

The Subcommittee was charged with examining postacute care in Nevada, including a review of the quality and cost of postacute care; alternatives to institutionalization; cost savings of home- and community-based waiver programs; the impact of alternatives to institutionalization on the quality of life of a person receiving postacute care services; and State and national quality measures and funding methodologies for postacute care. The following facilities provide postacute care in Nevada: rehabilitation hospitals, skilled nursing facilities, intermediate care facilities, hospice facilities, residential facilities for groups, homes for individual residential care, and adult day care facilities. In addition, the Subcommittee considered home and community services such as hospice, home health, and personal care.

Testimony received regarding Medicaid reimbursement rates for postacute care facilities and personal and home health care services indicated that the rate for many of these providers and services has not been adjusted since 2002. Industry representatives indicated that the rates do not cover the cost of providing the necessary care and service and emphasized the impact this has had on the health of the industry, pointing to facility closures and limited access to services that help individuals remain in their home and community.

Numerous studies support the benefits of home-based care in helping patients maintain and achieve optimal health outcomes. In addition, care provided in the home is less expensive than institutional care. As the Nevada population continues to expand and age, these services will be in higher demand. However, current reimbursement levels do not support the expansion of services to meet the demand. According to testimony, without rate increases, it is anticipated that even more facilities will close and services will be inaccessible.

For these reasons, I ask respectfully for your support of a rate review and subsequent budget enhancements to increase the Medicaid reimbursement rates for postacute care facilities and home- and community-based postacute care services. I thank you kindly for your consideration and for assisting all the constituents that would benefit from increased access to these important services in Nevada.

Respectfully,

Robin L. Titus, M.D.
Nevada State Assemblywoman
Chair, Subcommittee to Conduct a Study of
Postacute Care

RLT/gn:W162560

APPENDIX C

Suggested Legislation

APPENDIX C

Suggested Legislation

The following Bill Draft Requests will be available during the 2017 Legislative Session or can be accessed after "introduction" at the following website: https://www.leg.state.nv.us/Session/79th2017/BDRList/page.cfm?showAll=1.

BDR S–368 Requires analysis of adequacy of rates of reimbursement paid through Medicaid waiver programs for personal care services.

BDR S–369 Requires comparative analysis of rates of reimbursement paid for personal care services and home- and community-based services furnished by certain providers.

BDR 40–370 Requires establishment of minimum standards of operation for provision of long-term care for certain persons.

BDR 38–371 Expands authority of Office of the State Long-Term Care Ombudsman.

BDR 40–372 Authorizes employees of certain facilities and organizations to check vital signs and provide related services to residents.

The following explains the numbers or letter preceding the dash in the BDR number:

40–370 A number designates the NRS Title (i.e., Title 40), which encompasses the main subject of the bill draft.

S–368 The letter "S" denotes the bill draft is a special act.