Position Statement on Managed Medicaid
from the
Residential Care Home Community Alliance (RCHCAN)
Association of Homecare Operators of Northern Nevada (AHONN)

I am Dr Shawn McGivney. I am here on behalf of the two Residential Care Home trade associations – the **Association of Homecare Operators of Northern Nevada** representing the North and the **Residential Care Home Community Alliance of Nevada representing the south.**

Residential care homes or group homes currently represent more than half of all long term care beds in the state of Nevada. With over 3000 residents in the north and south

Residential care homes across the county are being utilized for long term care placement. In Nevada they have long been a vital part of Nevada's long term care solution. Nevada's Residential care homes (RCH) rank among the best in the nation compared to the other 49 states in regulatory standards of care. Moreover, RCH with dementia endorsement are the only care setting including SNF's with any staffing requirements in Nevada and have an awake person at night.

Rch's that participate in Medicaid waiver programs along with many other senior care providers that accept Medicaid payment have not received an increase in funding for over a decade. This is hurting providers and residents alike- many RCH's that used to be able to provide cost effective care to our most needy disabled seniors can no longer operate and are being forced to close. Thus continuing the decline in much needed long term care community based beds.

We oppose the switch to Managed Medicaid for 2 reasons

The first is that managed Medicaid has shown in many states that is **does not do** what it claims to do **which is save money**. See NYT Articles.

The second is managed Medicaid does not promote patient centered care and goes against the Olmsted act which goal is to increase community choice.

I have two articles from NYC that demonstrate how their attempts at managed Medicaid failed and cost more.

In addition right here in Nevada in our not so distant past, SLA's were exposed for overbilling at $12K/ per month/ per resident. Now again privatization with SLA using Medicaid funds still costs more than nursing homes at $6K/mo./resident for independent/ transitions type living. Many of these transitional type residents are also billed for BST training at $38/hr. I have personally witnessed 2 80 yr. old ladies with cognitive impairment doing BST in the form of "coloring' to reduce stress and blood pressure. (see attachment of what BST should be)

It is alarming that SLA'S receives **6000/month** from Medicaid for care of independent living / transitional living residents which is the **same** that nursing homes get paid for heavy care patients and **triple** the amount what residential care home get paid from Medicaid to provide care for chronically ill disabled seniors including those with dementia or $1800 to provide 24 hr care and supervision

Managed Medicaid clearly does not preserve patient centered care or choice. If you can only choose a single doctor who works for the HMO or is in the HMO managed care networks how you can get a second opinion. You give up a lot on checks and balances and a free market system.

Managed Medicaid will also likely force people to lose their traditional Medicare by lumping them into a managed care system if they have both Medicare and Medicaid.

Two examples confirm this. The article about the changes in Texas and the information on 1915 waivers where they say the goal of the waivers are to reduce choice in providers.

The reason managed Medicaid fails? Privatized or Managed Medicaid has far less monitoring and oversite and has a high risk of lack of accountability and over billing as has been shown in New York and here in Nevada with the over funding and billing in SLA's of 12,000/month or $ 6000/mo when these same services could be provided in a more structured and more highly monitored setting such as a RCH for half the price. Even if you increased the Dementia/heavy care waivers to $3000 month in RCH's this would save the state money and double the number of much needed long term care beds.

We bring this to your attention because only the state can add in the necessary checks and balances to protect not only disabled seniors but the tax payers as well. Privatization and managed Medicaid can't do it. Cherry picking and profit motives have repeatedly been shown to win. The good news is that RCH with some minimal supports do offer cost effective care and Nevada's hcqc and the two trade associations are always requesting changes to further improve the minimum standards of care.

RCH's will continue to work with our national leading regulators to continue to offer safe and cost effective care to Nevadans but we need the IFC and Governor to increase funding for **both** waivers and the HCQC regulatory staff to achieve those goals.

Shawn McGivney - Rchcan Jose Castillo – Ahonn

Two NYT articles on Managed Medicaid not achieving cost savings. Pg 1-6, pg 7-15

BST - What it should be to charge $38 or more / hr. pg 16

Edited slide on Waivers- pg 17

2 pgs on 1915 waivers and their goal to REDUCE patient choice in providers. Pg 18-19

Texas plan for managed Medicaid and how it comes with the loss of patients Medicare. pg 20-21

State to state comparison to prove Nevada RCH are the best in the nation. pg 22-23

LTC cost comparison table to show RCH are the most cost effective LTC choice for private pay and state Medicaid funds. Pg 24

**This is the exact same thing as happened with SLA in Mental Health.
Creative business owners and now big corporations are getting paid alot to do a little on the tax payer dime leaving those who need and benefit from LTC and other medicaid services holding the bag.**

Recall Developmentally Disabled SLA is very different from Mental health SLA and general Desert Regional "certified" SLA.

The New York Times | http://nyti.ms/XSdYnr

N.Y. / REGION

Day Centers Sprout Up, Luring Fit Elders and Costing Medicaid

By NINA BERNSTEIN APRIL 22, 2013

In NV Independent/ transitional living people are being housed in residential homes for very high prices to tax payers WHILE elderly severly disabeld residnets who have HEAVIER CARE NEEDS or Need DEMENTIA CARE, and AN AWAKE CAREGIVER GO UNCARED FOR.

Scores of elderly Russian immigrants played bingo under the chandeliers of a former funeral parlor in Brooklyn on a recent Monday, with a free dinner and door-to-door transportation from anywhere in the city.

Nearby, older people speaking Chinese filled a supermarket-size storefront with vigorous games of table tennis, billiards and mah-jongg, and ordered free lunch from a takeout menu featuring minced pork, beef and salty fish.

In Bensonhurst, Brooklyn, at the new R & G Social Adult Day Care Center, known locally among elderly immigrants for luring clients with cash and grocery vouchers, most people there for lunch did not stay to eat. Instead, many walked briskly toward the subway carrying bags stuffed with takeout containers, and two elderly men rode away on bicycles with the free food.

Not a wheelchair or walker was in sight at these so-called social adult day care centers. Yet the cost of attendance was indirectly being paid by Medicaid, under Gov. Andrew M. Cuomo's sweeping redesign of $2 billion in spending on long-term care meant for the impaired elderly and those with disabilities.

Such centers have mushroomed, from storefronts and basements to a new development in the Bronx that recently figured in a corruption scandal. With little regulation and less oversight, they grew to at least 192 businesses across the city, from 40 in 2010, according to the Cuomo administration.

Managed care companies, financed by Medicaid, pay the centers to provide services to members. But the door swings both ways: Centers also refer new clients to the companies.

Managed care became mandatory last year for people receiving home services who are eligible for both Medicaid and Medicare. The idea is to try to control spending, but about a third of the 92,000 people so far enrolled in the system statewide are newcomers to such services, many responding to aggressive marketing by social day care centers.

Centers collected over $25 million from managed care plans in the first nine months of 2012, at roughly $93 per person per session, according to state figures. The managed care companies are paid by Medicaid; in New York City, the rate is about $3,800 a month per member.

"The whole thing is going to end up costing the state much more money," said Valerie Bogart, a lawyer with New York Legal Assistance Group who specializes in advocacy for frail elderly and disabled people. "It's really up to the managed care plans to be the watchdogs now, and it's like the fox watching the chicken coop, because they have an incentive to make money from these centers, too."

There is a clear reason no one wants to care for the Long Term Care residents. They cost alot! SLA and managed care is not the answer. The answer is RCH which have the proven ability to operate in a very cost effective,highly monitored, manner. They need some support but despite the current legislation, regulation and reimbursement they persist.

It was not supposed to play out this way. The bold Medicaid overhaul, part of a grand bargain with the state's most politically powerful health care players, has been promoted as a national model for curbing costs and reversing the incentives for fraud. It transferred tens of thousands of recipients of long-term care from a system in which providers billed Medicaid for each service to managed care, in which a capped monthly rate must cover all services to a company's enrollees.

With the largest Medicaid budget in the country, $54 billion, New York is trying not only to rein in runaway spending, but also to "rebalance" it, away from costly institutional care, like nursing homes and medical models known for overbilling, to inexpensive supports that keep people safely in their communities.

In that context, Jason Helgerson, the state's Medicaid chief, defended the rapid expansion of social-model adult day care, saying that without a chance to socialize and connect with others, Medicaid clients would suffer a decline in health that would

add costs. But when a reporter described some of the practices observed at centers, he expressed surprise and anger.

"The idea that people are bicycling home from managed long-term care is a complete misnomer," Mr. Helgerson said. "The idea that they're playing Ping-Pong — I guess they could be wheelchair-bound Ping-Pong players, but otherwise it's fraud and they are not eligible."

Beneficiaries are supposed to be impaired enough to need at least 120 days of help with tasks like walking, bathing or taking medication. But managed care companies, not government agencies, are now mainly in charge of determining eligibility, typically by using nurses to assess each potential member.

"It is being gamed," said an executive at a managed care company, speaking on the condition of anonymity. "There are just plums in the payment system. And the state will choose to be blind about this until something happens, which is what they did with nursing homes."

Mr. Helgerson said it made sense to rely on the companies to police the eligibility, since they were the ones responsible for the care. "The plans are better positioned than us to stamp out fraud and abuse," Mr. Helgerson said, adding that the office of the Medicaid inspector general would audit "on the back end."

For months, however, advocates for the elderly have been complaining to city and state officials that pop-up social day care centers were siphoning healthy clients from regular senior centers, sometimes with illegal inducements, and referring them to managed care plans that eagerly enrolled them.

After The New York Times raised questions about the centers, the Medicaid inspector general's office said in a statement on Monday that its investigators were "actively looking at adult day care services and will aggressively investigate any credible allegation."

"Any managed care plan found to be either directly or indirectly encouraging this behavior, or looking the other way, will see their new enrollment immediately suspended," the office said.

The office recently excluded four people from running adult social day care centers; the four were charged with bribing Assemblyman Eric A. Stevenson of the Bronx to help them open centers and to sponsor a bill that would block competing centers from opening for three years.

Competition for clients is intense. Warren Chan, the operator of two social adult day care centers in Bensonhurst, said he complained to no avail to an executive with VNS Choice, the largest managed care plan, that R & G, another of its contractors, was recruiting elderly clients with $10 grocery vouchers and cash payments. State officials confirmed that such inducements were illegal. But over all, the rules for the centers are skeletal or vague: No license is required, for example, and the minimum staff requirement is two people, one of whom can be a volunteer.

At Mr. Chan's Asian Senior Day Care center on 18th Avenue, around the corner from R & G, Liang Mei King, 77, was one of several clients who said they were offered financial inducements to join R & G.

"I went once to see," she said through an interpreter, interrupting her mah-jongg game. "If you get someone else, they give you $50. And each week, there's a certain amount of money. One day there's $5, a $10 grocery coupon, or an unlimited MetroCard. If you don't want the MetroCard, they offer $125 in cash."

Mr. Chan said other centers were resorting to the same tactics, and elderly immigrants who did not know better accused him of pocketing benefits himself. But when he pressed the executive, Brian Henry, the vice president of marketing for VNS Choice, to denounce the inducements, Mr. Chan said, Mr. Henry demurred, saying, " 'This could be kickbacks or this could be marketing.' " He told Mr. Chan to research the question, and when he grew upset, threatened to terminate his contract, Mr. Chan said.

Asked about the conversation, Mr. Henry said, "I'm not aware of anything you're talking about." He then referred all questions to the public relations department of the Visiting Nurse Service of New York. It had already declined to comment for this article.

At R & G, two young men who seemed to be in charge said they were only receptionists, and referred questions about payments to "the boss," giving the name "Betsy" and a Long Island telephone number.

The number led to Elizabeth Geary, president of the New York State Adult Day Services Association, a 25-year-old group now deluged with inquiries.

"I am not the boss of that program or any other program in New York," she said. "It alarms me that they would give my name, and it is also a huge concern that they are calling themselves social adult day and not providing core services."

In a center, she said: "I would expect to see people eating together, having a lunch that is nutritionally well balanced. There might be participants who would have a vision impairment or who might have had a stroke who would need assistance in cutting the food up. It is not a takeout program by any means."

The new social day care centers usually can afford to pay higher rent than traditional senior centers run by the city, religious groups or other nonprofits. In one recent case, the private management of a federally subsidized senior housing development in Coney Island sent an eviction notice to the longstanding Ocean Parkway Senior Center on its ground floor, and moved to replace it with a social day care center company offering higher rent.

"They are draining well-elderly out of the regular centers in every part of the city where they exist," said Joan Pastore, the director of AMICO, a center in Borough Park, Brooklyn, that runs on about $4 a person per day. "How many frail old ladies do you know who play Ping-Pong, do computer and go dancing?"

Correction: May 17, 2013

An article on April 23 about the growth in so-called social adult day care centers in New York City misstated the number of centers two years ago and referred incompletely to the people they served. Besides eight centers financed by the city for people with dementia, there were at least 40 more social-model adult day centers, according to a list provided Tuesday by the Cuomo administration, and some of those centers served people with a variety of impairments. There were not just eight centers for people only with dementia.

Mei-Yu Liu contributed reporting.

A version of this article appears in print on April 23, 2013, on page A1 of the New York edition with the headline: Day Centers Sprout Up, Luring Fit Elders and Costing Medicaid.

See comments on first few pages to get a sense of how this applies as a good comparison for Nevada.

The New York Times | http://nyti.ms/1ihqJ79

N.Y. / REGION

Pitfalls Seen in a Turn to Privately Run Long-Term Care

By NINA BERNSTEIN MARCH 6, 2014

NASHVILLE — Even as public attention is focused on the Affordable Care Act, another health care overhaul is underway in many states: an ambitious effort to restrain the ballooning Medicaid cost of long-term care as people live longer and survive more disabling conditions.

In-home care the most expensive choice by far! See LTC cost comp tbl.

At least 26 states, including California, Florida, Illinois and New York, are rolling out mandatory programs that put billions of public dollars into privately managed long-term care plans, in hopes of keeping people in their homes longer, and expanding alternatives to nursing homes.

Nevada already has a safe, cost effective model of RCH that we can build on to improve quality and standards of care model.

Subway advertisements and highway billboards feature smiling old people as plans jockey for shares of this vast new market. Companies promise profits for investors and taxpayer savings, too. And some states say the new system is already working.

"It's a success story," said Patti Killingsworth, director of long-term services and supports in Tennessee, pointing out that the state was serving a quarter more people with inexpensive home and community services.

But a closer look at Tennessee, widely cited as a model, reveals hidden pitfalls as the system of caring for the frail comes under the twin pressures of cost containment and profit motive. In many cases, care was denied after needs grew costlier — including care that people would have received under the old system.

"The notion of prevention saving money in the long run only works if you actually provide care in the long run," said Gordon Bonnyman, former director of the Tennessee Justice Center, a patient advocacy group. "Tennessee is probably as good as it gets in terms of oversight and financial regulation, and thus I think it is a cautionary tale."

Exactly what we see. Independent living / transitional living getting paid $12K and now 6k a month and are not saving money as expected.

Like many advocates, he originally supported managed long-term care, seeing it as a way to break the stranglehold of nursing home lobbies that opposed shifting more Medicaid money to home and community-based care. But now he says too high a price is being paid by very debilitated people denied care when they need it most — people like Billy Scarlett II, who was 33 in 2005 when he sustained severe brain injuries in an A.T.V. accident, and Glenn McClanahan, who is 79.

Mr. McClanahan's case illustrates both the appeal and the perils of the new system. Once a high school quarterback, a successful car salesman and a ladies' man, he was living alone on Social Security, already hobbled by arthritis and emphysema, when at 75 he abruptly lost nearly all of his sight. For years, Tennessee residents like him had to move to nursing homes, with Medicaid paying the bills from a mix of state and federal money.

But in 2010 the new program gave Mr. McClanahan another choice: Stay at home with daily help, and go to a nursing home later if he needed it. Medicaid paid a fixed monthly sum to an insurance company to cover and coordinate his future care. For about 30 months, Mr. McClanahan was happy to manage at home with four hours of help daily. The government and the insurance company benefited, too, because his care cost much less than the monthly Medicaid sum paid to the plan — $3,820, which was less than the $4,583 a nursing home would have cost.

But when he developed dementia and his health fell apart in the fall of 2012, the state and the insurer denied his application for nursing home placement and told him he would lose his home care, too. Under tighter rules adopted by the state to serve more people without spending more, Mr. McClanahan was one of thousands of applicants deemed not disabled enough for Medicaid to pay for any help.

The change was new scoring that sharply raised the disability threshold required to get into a nursing home, or to get equivalent care at home. Such thresholds vary

from state to state. But in Tennessee, 41 percent of 34,000 applications for care were denied over the 13 months after the change, compared with under 10 percent previously.

In the real world of budget cuts, state officials say, this was the only way to double the proportion of Medicaid recipients served outside nursing homes, to 40 percent. "Yes," Ms. Killingsworth said, "sometimes that means that not everybody is going to get everything that they think they need."

In Mr. McClanahan's case, the day after an official letter scored his need for care at zero, he fell from his short-stay convalescent bed, gashing his face and breaking his nose.

"It's all about the money," his son, David McClanahan, said. "I wouldn't want anybody to have to go through what I went through with my dad."

Changes, and Audits

For years, efforts to curb fast-rising Medicaid costs centered on welfare mothers and children, even though Medicaid spends more than five times as much on an aged or severely disabled person in long-term care as it does on a poor child.

Long-term care cases traditionally were considered too vulnerable and politically sensitive to be assigned to a managed care company. But between recession-starved budgets and the looming costs of an aging population, many states have decided the old system is unsustainable. About 4.2 million people receive long-term services paid by Medicaid, representing only 6 percent of Medicaid beneficiaries, but about $136 billion, or one-third of all Medicaid spending. They include many formerly well-off people in nursing homes who have "spent down" their "countable" assets — the primary home is the major exclusion — to less than $2,000, the maximum for Medicaid eligibility in many states.

Under the old system, providers bill Medicaid directly, a model plagued by perverse incentives for expensive, unnecessary and even fraudulent care. Despite arguments that people should not have to enter high-priced institutions to get help with activities of daily life like bathing and eating, relatively little Medicaid money

was available for cheaper alternatives. Nursing homes have often used political muscle to keep it that way.

Managed care promises more predictable, controlled spending. From a fixed sum per enrollee, plans pay networks of providers to deliver care, which could be as cheap as a recorded medication reminder, or as costly as a nursing home stay.

Like the rationale behind health maintenance organizations, the idea is that plans will benefit financially by keeping costs lower and people healthier, and that the expense of customers who need more care will be counterbalanced by those who need less.

But now, as the formula is applied to a more fragile population, some states have already run into problems that marred the early history of H.M.O.s.

In New York, enrollment in the largest plan, VNSNY-Choice, was suspended for several months last year over the cherry-picking of able-bodied seniors, lured into the system by new adult day care centers offering free takeout food, casino trips and games of table tennis. An audit, undertaken after an article in The New York Times documented the problem, found hundreds of enrollees who were not impaired enough to be eligible, but who cost Medicaid $3,800 a month each, or nearly $34 million in all. Meanwhile, advocates for the elderly and disabled complained, plans were shunning the most impaired, including bed-bound seniors with dementia.

In Wisconsin, which Gov. Andrew M. Cuomo of New York has called a model for his Medicaid reforms, the price of expanding managed long-term care rose by 43 percent in three years, as more people signed up than expected. Further expansion was suspended. The program, which relies on homegrown nonprofits, saw two of nine plans go broke; others cut caregivers' hours and pay, shifting burdens to relatives.

Still, Kitty Rhoades, Wisconsin's Medicaid chief, said, "We're closer to getting it right than most other states."

Even Minnesota, a pioneer of the system, came under congressional fire for shifting state costs to Medicaid, which is federally subsidized. And a 2011 audit

found that it had overpaid at least $207 million since 2003 to insurers, including high executive salaries and expenses like a luxury box at a sports stadium.

Helped at Home

Northeast of Nashville, in the house on his father's farm where he grew up, Mr. Scarlett, who was severely injured in an A.T.V. accident nine years ago, is living proof that high-quality care at home can be better than care in a nursing home. But his family has had to struggle to keep it, under the financial pressures inherent in the shift to managed long-term care.

In 2005, Tennessee shrank Medicaid from one of the most expansive versions in the country to one of the most restrictive. That bitterly contested move, made amid spiraling costs in a state without an income tax, eliminated coverage for more than 170,000 people, many with severe chronic illnesses.

Though the state had experienced more than its share of managed care scandals in the 1990s, it embraced that approach for long-term care, under tight rules and a governor who had been a managed care executive. Officials say it helped keep increases in the state's Medicaid budget to half the national trend line.

Before his family signed him up for the new program, Mr. Scarlett spent a year in a nursing home, with relatives keeping vigil. Whenever a mucous plug threatened to choke him, his sister, Kimberly Maynard, recalls, she dashed to the nurse's station to beg for someone to suction the tracheostomy tubing. He was sent to the hospital six times with pneumonia and battled two antibiotic-resistant infections linked to institutional health care. At home, he has been tended 24 hours a day, mostly by licensed practical nurses, and had to go to the hospital only once.

One weekday last fall, propped in a recliner with tubes linking him to life, he struggled to raise a thumb so his father could kiss it, and moved one bare foot against a beach ball that his sister had gently aimed there. "Attaboy," said his father, Billy Scarlett, 75, who still hopes his son will emerge from what doctors call a persistent vegetative state. "Knock it over here to Daddy!"

But since 2010, when the state expanded the program, called TennCare Choices, and AmeriGroup, a major insurer, took over the case, the program has been trying to drop Mr. Scarlett. The form letters began with a mistaken claim that the family had asked to quit. A letter last fall ordered him "disenrolled" on Dec. 1 and added, "You can't appeal again."

The problem: His home care, while it served him best, cost $330,000 a year. If he were dropped from TennCare Choices, he would most likely end up in a nursing home, at an average annual tracheostomy rate of $144,000, potentially a big savings.

In a nursing home "he'd have been gone a long time ago," Billy's sister said.

"I just can't do that," she added, "because now if you were to do that, you'd actually be murdering him."

The program offered an alternative: Instead of paying an agency $37 an hour for 24-hour care, AmeriGroup would pay the family about $15 an hour to hire caregivers earning less than agency employees, without benefits like health insurance.

The family withdrew its appeal after the state's lawyer warned at a hearing, "By trying to get something better, they could get nothing."

Still, AmeriGroup said late last year that the rules had changed again: A nursing home was now the only choice — an ultimatum withdrawn eight hours later, after The Times inquired about it.

WellPoint, which recently acquired AmeriGroup for $4.9 billion, referred questions to TennCare, where officials said privacy laws did not allow discussion of the case. But Kelly Gunderson, a TennCare spokeswoman, added that in any long-term care program, "difficult public policy decisions must be made, including whether to provide an unlimited array of benefits to a few, or a reasonable package of benefits sufficient to safely serve individuals in the community to many."

Tennessee has chosen to be as cost-effective as possible, she said, and that has allowed the state to eliminate waiting lists for community-based services, which now serve nearly 13,000 people, up from 5,000, while keeping the number of nursing home residents flat at 19,200.

Beneficiaries include Sara West, 64, a former medical records worker who was in rehabilitation centers for months after infections from operations left her in a wheelchair. "I would be in a nursing home if it wasn't for this program," she said, calling it a godsend.

Through UnitedHealthcare, TennCare provided a roll-in-shower and pays for about five hours of daily help by aides Ms. West hires herself. Despite having recent amputations and needing nightly bedpan help, Ms. West, a diabetic, has stayed within a $55,000 annual cap for three years, she said, by relying first on her husband, a retiree with dementia, and now on cousins who take turns spending the night.

Assisted Living

Last spring, Mr. McClanahan, in his late 70s and nearly blind, had already cycled through hospitals, rehab centers and geriatric-psychiatric units when he became one of 5,283 people who were told that they did not qualify even for a new, temporary category of home services limited to $15,000 a year — one-third of the state's Medicaid rate for a nursing home.

Officials acknowledge that among the 1,451 of those denials that were appealed, more than a third turned out to be based on inadequate information and were later reversed. Members have 30 days to appeal denials.

When David McClanahan threatened to publicize a gruesome photo of his father's face after his fall, UnitedHealthcare, the managed care company, offered placement in an assisted living center, costing a third of the nursing home rate. Such centers are not regulated or equipped for people with serious impairments.

The McClanahans were unaware that the center, Elmcroft of Twin Hills, had been under state investigation for resident deaths linked to neglect, and for complaints that it kept residents who needed more care than it could deliver.

Elmcroft, acquired by a 19-state chain in 2011, said it had fixed the problems by last spring, when it passed a state inspection. But relatives noticed unwashed sheets and pills scattered on Mr. McClanahan's floor, and said the center demanded $460

more a month from Mr. McClanahan because he needed more care than expected. It settled for his full Social Security income. "He remained a viable assisted living resident" under state rules, Bob Goyette, a spokesman for Elmcroft, said, "even though he required more care."

Mr. McClanahan soon ended up back in a hospital, and the whole process began again. Eventually, after his son threatened to sue the state, another denial was reversed and Mr. McClanahan secured a nursing home bed. "They're trying to see what they can get by with," his son said.

Alice Ferreira, a spokeswoman for the insurer, said, "UnitedHealthcare has worked very closely with the family and the TennCare to ensure the member has the appropriate care."

Ms. Gunderson, the state spokeswoman, said: "The due process procedures we have in place work effectively to ensure that members are able to receive the appropriate level of services in the appropriate setting."

For raising the level of impairment required to qualify for nursing home-level care, Ms. Killingsworth said, "I make no apology."

She called the previous threshold — a significant deficiency in one activity of daily life — one of the lowest in the country, while the new threshold is based on a weighted point system that typically requires serious deficiencies in three activities.

Nationwide, publicly traded companies like UnitedHealthcare are replacing nonprofits. There are trade-offs, said Michael J. McCue, a professor of health administration at Virginia Commonwealth University, whose comparative study found that publicly traded plans focusing primarily on Medicaid enrollees reported the highest percentage of administrative expenses, and received lower scores for quality of care.

"They have to make sure that they meet earnings expectations to help improve their stockholders' wealth," Professor McCue said. "They could argue that, hey, maybe we have a more effective way of managing the care or cost. And one can ask, hey, are they denying care?

"We'll have to collect the data on that and see."

Correction: March 20, 2014

An article on March 7 about problems that states have encountered in shifting to privately managed long-term care programs misstated one reason Minnesota was criticized for its handling of the transition. The state came under congressional fire for shifting state costs to Medicaid, which has partial federal funding — not for shifting Medicaid costs to federal Medicare.

A version of this article appears in print on March 7, 2014, on page A1 of the New York edition with the headline: Pitfalls Seen in a State's Turn to Privately Run Long-Term Care.

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Basic Skills Training

Basic Skills Training (BST) services are rehabilitative mental health services interventions designed to reduce cognitive and behavioral impairments and restore recipients to their highest level of functioning. BST services are provided to recipients with age and developmentally inappropriate cognitive and behavioral skills. BST services help recipients acquire (learn) constructive cognitive and behavioral skills.

- If the goal of BST services are to help recipients "Learn" and then apply what they have learned to various life situations for purposes of rehabilitation than the recipient must have enough cognitive awareness or ability to understand the therapy they are receiving.

- Clearly seniors with long standing mental illness and or varying levels of dementia lack the insight, judgment to understand the therapy or gain any benefit.

- the 38/hr paid for activities like Coloring & playing simple games might be more effectively used to pay for more protective supervision in RCH's with national leading regulation and protective supervision where activities are included.

- BST is a needed service but there need to be clearer definitions on the types of residnets allowed and the expected time table one can take to obtain maximum benetfit of BST

Basic Skills Training Services

Basic Living and Self-Care Skills

Recipients learn how to manage their interpersonal, emotional, cognitive and behavioral responses to various situations. They learn how to positively reflect anger, manage conflicts and express their frustrations verbally. They learn the dynamic relationship between actions and consequences.

Social Skills +

Communication Skills +

Parental Training +

Organization and Time Management Skills +

Transitional Living Skills +

What is a Waiver?

We believe that all small business providers and the community need to be actively involved to ensure we do not "waive" government mandates for choice, safety, and cost effectivness. If SLA is any indication the recurring issue of over billing, lack of transparency, reduced senior safety regulations like no sprinklers in congregate care settings are worrisome.

- Under the Social Security Act, several sections allow states to waive government-mandated requirements which pertain to Medicaid under certain circumstances

- Medicaid waivers are designed to allow states to be more flexible in providing health care options to their citizens. They promote the use of community-based services as an alternative to institution

In doing so they appear to reduce choice in providers and create a one size fits all system of waivers when there are at least two very different groups of people.

- Medicaid costs for Home and Community based services provided in a waiver program must be less than Medicaid costs for institutionalization if the waiver programs were not in operation.

Clearly the goal is to save money but we believe you can save money and promote choice with existing options!! SNF is $6K / mo, SLA is $6K / mo, fully licensed RCH are much cheaper and promote choice and safety.

- There must be an application for a waiver program with specific details and processes outlined that is approved by the Centers for Medicare & Medicaid Services (CMS)

This process is under way and could benefit from small business provider and community input. Many providers and community groups are asking to be allowed greater participatoin

http://www.leg.state.nj.us/2013/Committee/StatCom/SeniorVetSpecial/Other/15-January-2014/AgendaIVAAiello.pdf

Notice for the move toward Managed Medicaid in NV.

Please follow the links below and see what questions or concerns you may have. We wonder what they mean when they say "the goal of the program is to reduce choice and restrict providers" Also we suggest more clarification to waiving needed senior care safety and monitoring system as potential dis benefits of the program.

As providers, consumers and members of the community we need to be aware of what is going on and be actively involved.

Demonstration and Waivers

Demonstration and waivers are vehicles states can use to test new or existing ways to deliver and pay for health care services in Medicaid and CHIP. The primary types of waivers and demonstration projects include section 1115 demonstrations, section 1915(b) managed care waivers, and section 1915(c) home and community-based services waivers. More information about waivers is available on the Waivers page.

- State of Nevada Approved Waivers

http://www.medicaid.gov/medicaid-chip-program-information/by-state/nevada.html

Waivers

Waivers are vehicles states can use to test new or existing ways to deliver and pay for health care services in Medicaid and the Children's Health Insurance Program (CHIP). There are four primary types of waivers and demonstration projects:

Section 1115 Research & Demonstration Projects: States can apply for program flexibility to test new or existing approaches to financing and delivering Medicaid and CHIP. In September 2014, the Centers for Medicare & Medicaid Services initiated a national, cross-state evaluation of four types of Medicaid section 1115 demonstrations. See the evaluation design.

Section 1915(b) Managed Care Waivers: States can apply for waivers to provide services through managed care delivery systems or otherwise limit people's choice of providers.

Section 1915(c) Home and Community-Based Services Waivers: States can apply for waivers to provide long-term care services in home and community settings rather than institutional settings.

Concurrent Section 1915(b) and 1915(c) Waivers: States can apply to simultaneously implement two types of waivers to provide a continuum of services to the elderly and people with disabilities, as long as all Federal requirements for both programs are met.

View demonstrations and waivers list

http://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/waivers.html

1915(b) Managed Care Waivers

Restricts choice.

1915(b) Waivers are one of several options available to states that allow the use of Managed Care in the Medicaid Program. When using 1915(b), states have four different options:

- **[1915(b)(1)]** - Implement a managed care delivery system that restricts the types of providers that people can use to get Medicaid benefits
- **[1915(b)(2)]** - Allow a county or local government to act as a choice counselor or enrollment broker) in order to help people pick a managed care plan
- **[1915(b)(3)]** - Use the savings that the state gets from a managed care delivery system to provide additional services
- **[1915(b)(4)]** - Restrict the number or type of providers who can provide specific Medicaid services (such as disease management or transportation)

Does "streamline' and "selectively contract" like they do with SLA corporations mean reduced choice?

CMS has begun the process of "modularizing" its current 1915(b) waiver application to separate the various statutory authorities. First in this process is a streamlined application for States to selectively contract with providers under their fee-for-service delivery system. It simplifies the process for documenting the cost-effectiveness of the waiver but requires that States demonstrate maintenance of beneficiary access. Below are links to both the fillable PDF application as well as the technical guide for completing the application.

- 1915(b)(4) Waiver Fillable Application
- Technical Guide for the 1915(b)(4) Application

More information on approved 1915(b) waivers is available.

While simplify documentation for cost effectiveness sounds good in fact we are waiting to see any cost savings and already have examples of overbilling in SLA's and growing questions of maintained access especially for heavy care, LTC cases who need nursing home or heavier care

1915(c) Home & Community-Based Waivers

The 1915(c) waivers are one of many options available to states to allow the provision of long term care services in home and community based settings under the Medicaid Program. States can offer a variety of services under an HCBS Waiver program. Programs can provide a combination of standard medical services and non-medical services. Standard services include but are not limited to: case management (i.e. supports and service coordination), homemaker, home health aide, personal care, adult day health services, habilitation (both day and residential), and respite care. States can also propose "other" types of services that may assist in diverting and/or transitioning individuals from institutional settings into their homes and community.

Is SLA the pilot study for this?

Is SLA saving money or have we already seen over billing with the reduced monitoring?

More information on approved 1915(c) waivers in each state is available.

View the 1915(c) Waiver Application and Technical Guidance here.

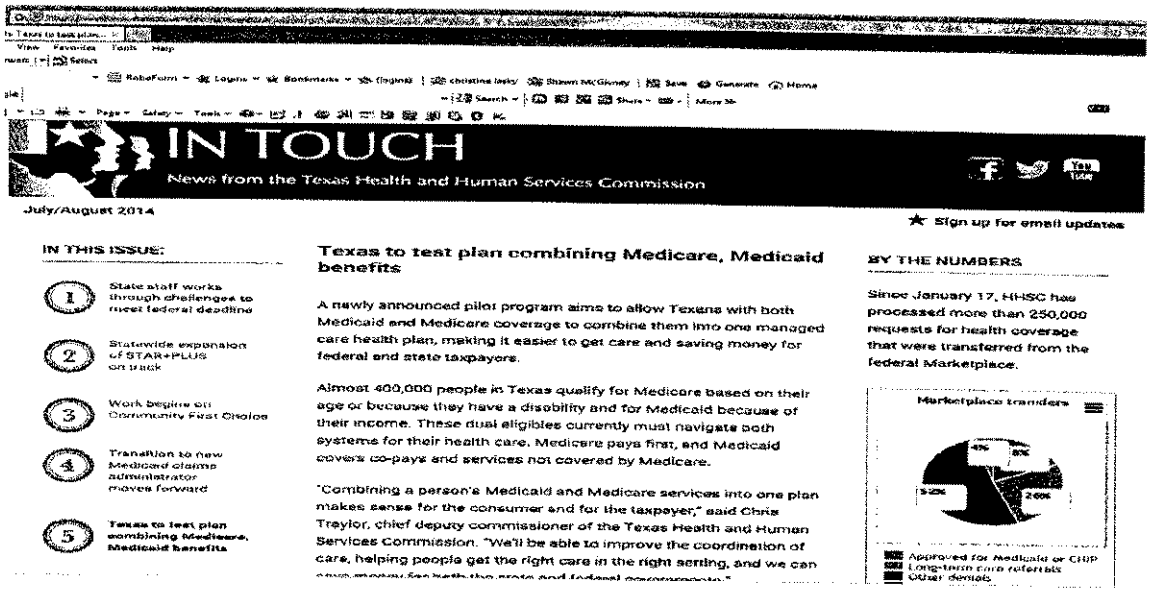
View the Modifications to Quality Measures and Reporting in §1915(c) Home and Community-Based Waivers here.

Is SLA and Managed Medicaid / Medicare expanding the community based LTC beds or putting the existing system of care and beds at risk of collapse?

Are less monitored private businesses really offering to take responsibility for the heaviest care residents for low pay? What penalties and monitoring are there when there are Medicaid clients or poor people who the managed care system cannot afford to care for safely?

http://www.hhsc.state.tx.us/stakeholder/2014/july-aug/5.shtml

Texas plan to combine Medicare and Medicaid.



IN TOUCH

News from the Texas Health and Human Services Commission

July/August 2014

★ Sign up for email updates

IN THIS ISSUE:

1. State staff works through challenges to meet federal deadline
2. Statewide expansion of STAR+PLUS on track
3. Work begins on Community First Choice
4. Transition to new Medicaid claims administrator moves forward
5. Texas to test plan combining Medicare, Medicaid benefits

Texas to test plan combining Medicare, Medicaid benefits

A newly announced pilot program aims to allow Texans with both Medicaid and Medicare coverage to combine them into one managed care health plan, making it easier to get care and saving money for federal and state taxpayers.

Almost 400,000 people in Texas qualify for Medicare based on their age or because they have a disability and for Medicaid because of their income. These dual eligibles currently must navigate both systems for their health care. Medicare pays first, and Medicaid covers co-pays and services not covered by Medicare.

"Combining a person's Medicaid and Medicare services into one plan makes sense for the consumer and for the taxpayer," said Chris Traylor, chief deputy commissioner of the Texas Health and Human Services Commission. "We'll be able to improve the coordination of care, helping people get the right care in the right setting, and we can

BY THE NUMBERS

Since January 17, HHSC has processed more than 250,000 requests for health coverage that were transferred from the federal Marketplace.

Marketplace transfers

Approved for Medicaid or CHIP
Long-term care referrals
Other denials

Texas to test plan combining Medicare, Medicaid benefits

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Right care as defined by the one in network provider. With few options for second opinions.

In addition, to improving a person's coordination of care, the pilot is expected to save money by reducing the need for in-patient hospital care and institutional care. That's because combining

acute and long-term care services into one managed care plan increases the plan's incentive to support policies and services that reduce the need for hospitalization and other expensive services.

In today's fragmented system, a state agency or Medicaid health plan that spends money to help reduce hospital stays among dual eligible clients wouldn't see any of the savings from that effort because Medicare pays for the hospital stay. Likewise, Medicare wouldn't benefit from federal efforts to expand medical services to help people stay in their homes longer and reduce the need for expensive long-term care services, which are covered by the state Medicaid program.

Texas is planning to pilot the new program in six of the state's most populous counties and expects to combine coverage for 168,000 dual eligible clients, starting March 1, 2015. People in the pilot areas age 21 or older who get Medicare and full Medicaid benefits will be able to enroll **(or forced / strongly encouraged/guided by state benefit consultants to enroll?)** in the newly combined health plans. The pilot is scheduled to begin March 1, 2015.

The pilot is based on a managed care arrangement where the state and federal government contract with a health plan to provide the full array of Medicare and Medicaid services to the consumer. The state and federal governments will each pay a portion of the monthly premiums the health plan gets to provide the services and will share in the savings achieved by the integrated model.

Starting in January, HHSC will begin sending information on the new program to people who can take advantage of the integrated coverage.

STAKEHOLDER FORUM

TEXAS
Health and Human
Services Commission

HHSC will host its next stakeholder forum on **Monday, July 14**, from 2:30 to 4:30 p.m.

http://www.hhsc.state.tx.us/stakeholder/2014/july-aug/5.shtml

http://projects.propublica.org/tables/assisted-living-regulations#data-explainer

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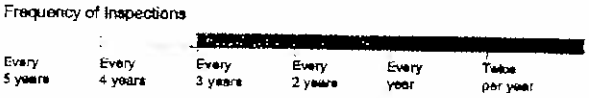
Life and Death in Assisted Living

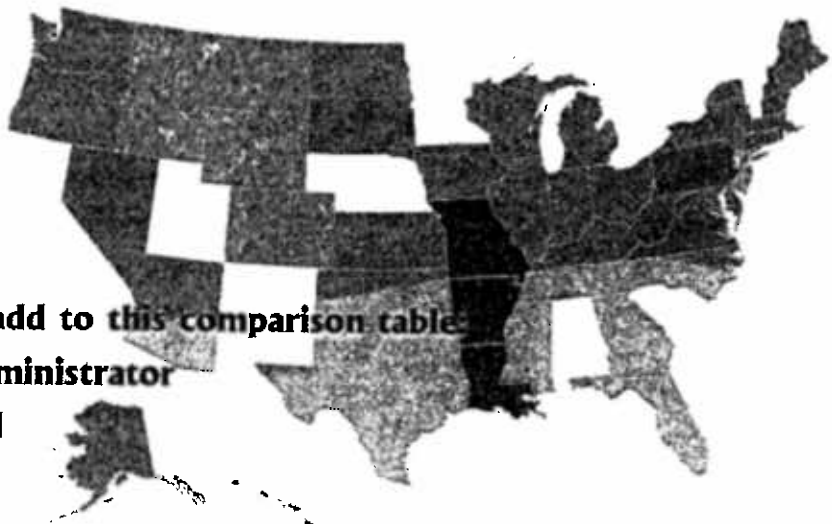
State-by-State: Assisted Living Regulations

by Hanna Trudo, Jonathan Jones and A.C. Thompson, ProPublica - October 29, 2013

ProPublica set out to compile the key rules and regulations governing assisted living in all 50 states and the District of Columbia. This information was gathered from state regulatory agencies, an examination of state codes and other records, and a 2013 review prepared by the National Center for Assisted Living, an industry trade group.

These are the categories included here: the qualifications required for those who run assisted living facilities; the frequency of inspections; fines for problem facilities; staffing requirements, and whether states offer performance records of the facilities to the public online. *See more about the data.* » | Related Story »





Other columns to add to this comparison table:
-Beltca certified administrator
-sprinklers required
-liability insurance
-FBI finger print screen

State	State Can Fine Facilities?	State Posts Inspection Data Online?	Administrators Required to Have High School Diploma, GED, or College Education?	Minimum Staffing Ratios?	Frequency of Inspections
Alabama B	Yes	Yes	Yes	Yes	No requirement for periodic inspections
Alaska A	Yes	No	No	No	Every two years
Arizona D	Yes	Yes	Yes	No	Every two years
Arkansas C	Yes	No	Yes	Yes	Every year
California E	Yes	No	Yes	No	Every five years
Colorado F	Yes	Yes	No	Yes	Every three years
Connecticut G	No	No	Yes	No	Every two years
Delaware H	Yes	Yes	Yes	No	Every year
Florida I	Yes	Yes	Yes	Yes	Every two years
Georgia J	Yes	Yes	No	Yes	Every two years

State	State Can Fine Facilities?	State Posts Inspection Data Online?	Administrators Required to Have High School Diploma, GED, or College Education?	Minimum Staffing Ratios?	Frequency of Inspections
Hawaii K	Yes	No	No	No	Every two years
Idaho M	Yes	Yes	Yes	No	Every three years
Illinois N	Yes	No	Yes	No	Every two years
Indiana O	Yes	Yes	Yes	No	Every 15 months
Iowa L	Yes	Yes	No	No	Every two years
Kansas P	Yes	No	Yes	No	Every 15 months
Kentucky Q	Yes	No	Yes	No	Every two years
Louisiana R	Yes	No	No	No	Every year
Maine U	Yes	No	No	Yes	Every two years
Maryland T	Yes	Yes	Yes	No	Every 15 months
Massachusetts S	Yes	No	Yes	No	Every two years
Michigan V	Yes	No	No	Yes	Every two years
Minnesota W	Yes	Yes	No	No	No requirement for periodic inspections
Mississippi Y	No	No	Yes	Yes	Every two years
Missouri X	Yes	Yes	Yes	Yes	Twice per year
Montana Z	No	No	Yes	No	Every three years
Nebraska c	Yes	Yes	No	No	Every five years
Nevada g	Yes	Yes	Yes	Yes	Every year
New Hampshire d	Yes	No	Yes	No	Every year
New Jersey e	Yes	Yes	Yes	No	Every three years
New Mexico f	Yes	Yes	Yes	Yes	No requirement for periodic inspections
New York h	Yes	Yes	Yes	No	Every 18 months
North Carolina a	Yes	Yes	Yes	Yes	Every two years
North Dakota b	Yes	No	No	No	Every two years
Ohio i	No	Yes	Yes	No	Every 15 months
Oklahoma j	Yes	Yes	No	No	Every 15 months
Oregon k	Yes	Yes	Yes	No	Every two years
Pennsylvania l	Yes	Yes	Yes	No	Every year
Rhode Island m	Yes	No	No	No	Every year
South Carolina n	Yes	No	Yes	Yes	No requirement for periodic inspections
South Dakota o	No	No	Yes	No	Every year
Tennessee p	Yes	No	Yes	No	Every 15 months
Texas q	Yes	Yes	Yes	No	Every two years
Utah r	Yes	No	Yes	No	No requirement for periodic inspections
Vermont t	Yes	Yes	No	No	No requirement for periodic inspections
Virginia s	Yes	Yes	Yes	No	Every year
Washington u	Yes	Yes	Yes	No	Every two years
Washington, D.C. y	Yes	Yes	No	No	Every year
West Virginia w	Yes	No	Yes	Yes	Every year
Wisconsin v	Yes	Yes	Yes	No	Every two years
Wyoming x	No	Yes	No	No	Every three years

About the data

The rules and regulations proved not easy to decipher. There is, for instance, no single, standard definition of assisted living. As well, each state defines and licenses assisted living differently. Many states set different staffing and training requirements depending on a facility's size, the levels of care offered, and other types of services. In addition, many states have also recently revised or are in the process of refining their rules and regulations. According to the National Center for Assisted Living, 18 states reported regulatory, statutory, or policy changes affecting assisted living and other residential care facilities in 2012.

States also vary in how much information about assisted living they post online. While some states post the entire inspection reports for individual facilities online, others post only a portion of the reports, a simple listing of violations, or the enforcement letters the state sent to individual facilities. Here, if a state is listed as "No" in this category, it means that the state does not post any information from either complaint or inspection reports on the Internet.

Most states require a high school diploma, a GED or some post-high school education as part of their qualifications to become an administrator of an assisted living facility. However, some states require high school diplomas for certain types of assisted living facilities, but not all. Similarly, some states, Alabama, Arkansas and Maine among them, set specific staffing ratios for certain types of assisted living facilities, such as those that offer specialty Alzheimer's and dementia care, but not all.

When it comes to the frequency of inspections, our graphic reflects the maximum time each state allows between routine inspections conducted by the state regulatory agency. In some of these states, certain facilities may be inspected more frequently. Our data does not include state investigations prompted by complaints, reports of abuse, or other incidents.

We intend this information to be of assistance to families, legislators, and to all involved in caring for, or advocating on behalf of, the elderly. We invite informed readers to offer clarifications to existing regulations or updates as rules and regulations are modified in the months ahead.

Donate

Long Term Care Cost and Services Comparison

1) **All Long Term Care Options are Private Pay.** Only after you have spent down all of your savings do you qualify for Medicaid and then the State pays. Medicare only pays for up to 100 dyas of rehab after a 3 day hospital stay. Medicare does not pay for long term care.

2) **Skilled Nursing Facilities (SNF's) & Residential Care Homes (RCH's) are the *only* options that practically provide 24hr care** and supervison, of which RCH's are the most cost effective. Other choices are more short term options for people with minimal to moderate care needs, who have family to supplement care and are very expensive. Reducing/ Reallocating SNF and RCH beds will further limit discharge optoins and force more Nevadans into out of state SNF's. These changes target Alzheimers and Mental illness residents who need 24hr care.

Nursing Home (SNF- 5000 Beds)

Resident Type	Payer	Daily rate	Monthly rate
Long term care	Medicaid	$200/day	$6000/mo
	Private Pay	$250 - $400	$7,500 -$12,000
Mental/Behavior health	Medicaid	$300 - $500	$9,000- $15,000
Short Term Rehab	Medicare	$600	$18,000

- Nursing homes provide the heavy care that no one else can. They are a vital resource to society. They cost consumers more than RCH.
- Expensive for both private pay families and for the state / Medicaid.
- The new Medicaid plan to increase funding for Behavioral/Mental health beds in SNF's is likely to reduce the number of chronic long term care beds in SNF's by 2/3 by reallocating use of the fixed 5000 beds to mental health and short term rehab.
- Increased use of SNF's for short term rehab will reallocate beds away from long term care use.
- Where will the chronic long term care cases go if nursing home beds are filled/reallocated by short term & behavioral /mental health cases?

Residential Care Home (RCH- 3000 beds)

Resident Type	Payer	Daily rate	Monthly rate
Long term Care	Medicaid	$30- $50/day	$900-$1500/mo
	Private pay	$50-$150/day	$1,500 -$4,500/mo

- Offers a ranges in rates from $30/day to $150/day. Allows seniors and disabeld to remain in the community. Allows low and middle income seniors and disabled to remain private pay and stay off the state medicaid dole
- Provides seniors and their families with choice to choose what type of assited living setting works for them based on individual preferences and financial cirmustatnces.
- RCH's are fully licensenced and monitored by the state. Nevadas RCH's are the most regulated and monitored homes in the nation!
- RCH's are required to carry liability insurance, have annual state inspections, are supervised by a BELTCA certified administrator and have a R3 residnetial sprinkler sytem with moniotred alarm with a record of no fire deaths in Residential Care Homes over

Other care options that offer less than 24 hr care

Assitsted Living

- **Private** Pay =- $2000 base rate for room & meals only add ons for assitance with care & meds from $2-4000 more, total $6000 for minimal assistance and supervision.
- Waiver -a rare few ALF accept the WEARC waiver, $2000- 3000/ month (Highest pay waiver byfar)
- Only 2 to 3 caregivers for 100 residents day shift- 1 caregiver -overnight

In-Home Care

- **Private Pay =** $6,000/month for only 8hrs /day @ $25per hr for 30 days
- Medicaid only pays up to 3- hrs/day $17/hr
- Does not provide Medication assistance
- Aide's change frequently
- family needs to provide back up & assitance

Adult Day Care

- **Private Pay=** $3000/month or $100/day for 8hrs/day for 30 days,
- no medication assitance
- no personal care assitance
- family has to provide all supplemental care
- does not provide 24 hr supervision. Family needs to provide back up and assistance