REPORT FROM THE COMMISSIONER OF THE

VIRGINIA STATE HEALTH DEPARTMENT

ON

EXPANSION OF THE NURSING HOME

PRE-ADMISSION SCREENING PROGRAM

TO

THE GOVERNOR

AND

THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 19

COMMONWEALTH OF VIRGINIA
RICHMOND
1982

Report of the
Department of Health to Prepare
To Expand the Nursing Home Pre-Admission
Screening Program
To
The Governor and the General Assembly of Virginia
Richmond, Virginia
October 1, 1981

To: The Honorable John N. Dalton, Governor of Virginia
and
The General Assembly of Virginia

INTRODUCTION

The Department of Health was authorized to prepare a plan and budget for the Nursing Home Pre-Admission Screening Program by House Joint Resolution No. 295 agreed to by the Senate and the House of Delegates of Virginia during the 1981 Session. The resolution is as follows:

House Joint Resolution 295

WHEREAS, the current Nursing Home Pre-Admission Screening Program in Virginia was begun in 1977 under the administration of the Department of Health; and

WHEREAS, the Program has improved significantly the capabilities of localities to assess the social and medical needs of impaired elderly persons who are eligible for public assistance and who apply for admission to a nursing home; and

WHEREAS, many elderly persons are being diverted from costly institutional care to community-based care which is less expensive and more appropriate; and

WHEREAS, many localities in Virginia are conducting very effective pre-admission screening programs which are coordinated with case management services designed to refer impaired elderly persons to services available in the community to help them to remain at home; and

WHEREAS, in its report to the 1981 Session of the General Assembly, the Joint Subcommittee to Study the Care of the Impaired Elderly recommends that the Nursing Home Pre-Admission Screening Program be expanded to provide increased screening services by localities; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Department of Health is requested to prepare to expand the current Nursing Home Pre-Admission Screening Program. The existing program which screens individuals in the community who apply for nursing home admission shall be expanded to include the screening of individuals who (i) at the time of application for admission to a nursing home would be likely to require financial assistance from the Medical Assistance Program within a 13 month period; and (ii) are

attempting to enter a nursing home from an acute care facility. The agencies whose representatives participate as members of the pre-admission screening teams shall be reimbursed for the time spent in conducting the individual assessments of nursing home applicants; and, be it

RESOLVED FURTHER, That the Department of Health is requested to prepare a plan and budget for this expansion of the Nursing Home Pre-Admission Screening Program for submission to the Governor and the 1982 Session of the General Assembly.

Executive Summary

House Joint Resolution 295 directed that the existing Nursing Home Pre-Admission Screening Program which screens individuals in the community who apply for nursing home admission shall be expanded to include the screening of individuals who (1) at time of application for admission to a nursing home would be likely to require financial assistance from the Medical Assistance Program within a thirteen (13) month period; and (2) are attempting to enter a nursing home from an acute care facility.

In carrying out this request, the Department of Health has been assisted by the Nursing Home Pre-Admission Planning Committee. Agencies and organizations with representation on this Committee include State and local Welfare Departments, State and local Health Departments, the Department of State Mental Health and Mental Retardation, the State Office on Aging, Health Systems Agencies, Professional Standards Review Organizations (P.S.R.O.), Virginia Hospital Association, Virginia Health Care Association, Virginia Center on Aging and the Virginia Society of Hospital Social Work Directors. This Committee is continuing to function as an advisory committee relating to Program expansion. Appendix C identifies the NHPAS Planning Committee members.

The attached report contains the following recommendations regarding the expansion of the Nursing Home Pre-Admission Screening Program:

1. The method for expanding the Program to include screening of individuals who are attempting to enter a nursing home from an acute care facility will be to contract with the acute care facility for the screening responsibility. The contractual arrangement will be between the Virginia Medical Assistance Program (VMAP) and the acute care facility with a payment for each screening.

2. The expansion of the Program shall be restricted to individuals who are expected to become Medicaid eligible within six (6) months subsequent to nursing home placement.

3. A standard assessment instrument will be utilized to accomplish the pre-admission screening of both hospital-based and the community-based individuals.

4. An automated system will be developed for the purposes of data collection and monitoring of Program activities.

5. Regional Staff will be assigned for monitoring and technical assistance to acute care hospitals and community based screening activities.

6. Additional State funding is required to expand the Program.

7. The development of a uniform system of statewide community services is needed in Virginia. Components of such a system will include reorganization of the VMAP long-term care system which is allowed for in the Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35, Section 2176).

History

Current Nursing Home Pre-Admission Screening Program

The Nursing Home Pre-Admission Screening Program (NHPASP) was implemented on May 15, 1977, with the purpose of assuring that those individuals who are placed in nursing homes actually require nursing home care and that such care cannot be provided in the community. Nursing home pre-admission screening is accomplished through the use of an interdisciplinary team assessment of the individual's needs and the mobilization of community services.

Currently the only persons screened are those residing in the community or in a facility operated by the State Department of Mental Health or Mental Retardation at the time of nursing home application. Screening occurs if the individual is, or will become, Medicaid eligible within 90 days subsequent to nursing home admission. This screening is required as a part of the State's Medicaid nursing home admission certification and Medicaid payment is not made without the screening committee's approval.

Community based persons are assessed by the screening committee of the local health department where they live. The committee is composed of a public health physician, a public health nurse and a social worker. The social worker is employed by the local welfare department. In addition, the committees are encouraged to work with other community agencies offering services to the elderly and disabled. In some areas, the local area office on aging, the mental health clinic, and the ministerial association participate.

The local screening committees: (1) evaluate the medical, nursing and social needs of each individual referred for pre-admission screening; (2) analyze what specific services the individual needs; and (3) evaluate whether a service or a combination of existing community services is available to meet the individual's need. The committee's assessment of the availability of community services depends upon whether the needed service exists in the patient's community, the individual's financial eligibility for the service, and whether the service can be delivered at the time and in the amount necessary to meet the individual's need.

Upon receiving a screening referral, usually from the Welfare department or family, the committee's social worker and public health nurse visit the individual in his/her home. The social worker prepares a social evaluation of the individual; the nurse evaluates the person's nursing needs and obtains the medical history. The full committee meets and the evaluations are presented and discussed. If additional medical information is needed, the individual's private physician is contacted.

The committee carefully reviews each person's case to determine if nursing home admission is appropriate or if he or she can be cared for adequately at home or in the community through local services. When the committee has reached a decision, the referring agency or individual is informed by letter, with a copy to the local welfare department and a copy to the nursing home, if placement is approved.

The opportunity for referral for community services is an important aspect of the program. Human need is stressed from the initial personal contact with the individual by the nurse and social worker, through referral and follow up. Depending on the type of services needed, either the social worker or nurse will make the referral to the appropriate agency and assure that the individual and family understand how to receive services. In some instances, the nurse or social worker will make a phone call or visit the individual to determine if his or her needs are being adequately met. From time to time, the screening committee will discuss the individuals previously screened, evaluate their progress, and receive information on these individuals' status.

Pre-admission screening of prospective nursing home candidates from facilities of the State Department of Mental Health and Mental Retardation is conducted by the State Department of Health's central office Pre-Admission Screening Committee composed of a registered nurse and a social worker representing the State Department of Mental Health and Mental Retardation, and a social worker representing the State Medicaid Program. A Medicaid Program physician and a State Mental Health Department psychiatrist are consultant members of the Committee.

The referring facility prepares medical, nursing and social information on the potential nursing home candidate which is reviewed and discussed by the central office Pre-Admission Screening Committee. The basic considerations for determining the need for nursing home placement are the individual patient's medical needs, the specific services required to fill these needs, and the health personnel required to adequately provide these services. The referring facility is advised in writing of the Committee's decision.

Pre-Admission Screening Results

Statistical reports of the first four years of the Program reflect that an average of 2,115 local pre-admission screenings occur statewide per year; 20 percent of the individuals screened are not approved for nursing home placement.

During the same time period, an average of 180 patients per year in State Mental Health and Mental Retardation facilities were screened. An average of 18 percent of these individuals were not approved for nursing home placement.

Problem

Since 1978, the Department of Health has been studying the feasibility and the possible method of expanding the Program to include pre-admission screenings of acute care patients.

It is estimated that 47 percent of all nursing home admissions are from acute care facilities. The exclusion of the acute care population in the current pre-admission screening program has left a gap in the Program's ability to reduce nursing home admissions and to offer individuals a coordinated entry point into the community services delivery system.

This deficiency was reinforced by the Joint Subcommittee to Study the Care of the Impaired Elderly in its report to the General Assembly in House Document No. 20. This report recommended the expansion of the current screening program to include the screening of individuals who are attempting to enter a nursing home from an acute care facility.

Considerations in Planning for Program Expansion

In planning for expansion of the NHPASP, several major factors must be considered. The factors include the number of individuals to be screened, the screening method for patients in acute care and the cost. The following is a discussion of these factors.

During FY 1981, there were 10,088 admissions to community nursing homes. The local committees screened 2,192 people during the same period of time. HJR 295 requested study of an expansion to persons not previously served, acute care discharges and individuals who will be eligible for Medicaid within 13 months of admission. It is estimated that this expansion will result in the annual screening of approximately 10,500 individuals, 56 percent of whom will be discharged from acute care facilities.

Several methods of expansion were considered. One was the utilization of existing locally based Nursing Home Pre-Admission Screening Committees. However, these committees, do not have the capability of increasing the numbers of screenings to include patients in acute care facilities without a substantial increase in local health and welfare staff. It is noted that approximately 40% of the hospitals have sophisticated social work departments and the local Pre-Admission Screening Committee's direct involvement with these facilities would serve as a duplication.

A second method of expansion considered was State level (Health Department central office) authorization for nursing home payment based upon the written submission of information from the acute care facility. However, a critical issue in screening acute care patients is the necessity for a timely decision. This second approach would result in time delays and increased lengths of stay in hospitals. It would also substantially increase the staff requirements at the central office level.

A third method of expansion considered was that acute care hospitals be delegated the responsibility of nursing home pre-admission screening. This delegation would be through a contractual arrangement between the VMAP and the acute care facility providing for a negotiated payment for each pre-admission screening and adherence to pre-admission screening staff and/or consultation requirements set forth by the VMAP.

With this approach the acute care hospital may provide nursing home pre-admission screening by using existing staff or through a contractual

arrangement. The hospital-based medical/social worker has the capability of providing pre-admission screening for applicants for nursing home admission directly from the acute care hospital through consultation and coordination with the individual's physician and nursing staff.

Essential to the effectiveness of this approach is the utilization of an assessment instrument to assure consistency statewide, a more precise definition of when nursing home placement is required, the establishment of a mechanism by which hospital-based cases will receive referral for community services, and a monitoring system to assure that only those individuals who require nursing home care are approved for nursing home placement.

Method of Expanding The Nursing Home Pre-Admission Screening Program

With the recommendation and support of the Nursing Home Pre-Admission Screening Planning Committee, the Department of Health proposes to expand the program to include the acute care population by contract with the acute care hospitals for pre-admission screening. This pre-admission screening is to be accomplished through a social work hospital-based team responsible for the coordination and completion of the pre-admission screening.

The social worker involved will be knowledgeable about community services and will be able to coordinate with the physician, nurse, individual, family and community agencies regarding the individual's care needs and community service availability to meet these needs.

Due to variations in staff of acute care hospitals, the following models to accomplish nursing home pre-admission screening in acute care hospitals will be acceptable:

1. Acute care hospitals having a department or section with medical social workers (master's degree social workers or social workers supervised directly by a master's degree social worker) may contract with the Virginia Medical Assistance Program (VMAP) to provide nursing home pre-admission screening for applicants seeking admission to nursing homes directly from the acute care hospital.

2. Acute care hospitals that do not have medical social workers may contract with the VMAP to provide for nursing home pre-admission screening through the utilization of the services of a medical social work consultant. This consultant must be currently working in a health care setting or have had previous experience in a health care setting. The contract for medical social work consultation must be on a regular schedule for the purpose of reviewing pre-admission screening requests.

In viewing the cost of expanding the NHPASP the following additional areas were addressed: (a) the assessment, (b) reimbursement for assessment, (c) the feasibility of expanding the program to include pre-admission screening of individuals who are potentially eligible within 13 months subsequent to nursing home placement, and (d) monitoring and technical assistance cost. (The budget reflecting expansion of the NHPASP is given in Appendix B.)

Assessment

One of the key elements of nursing home pre-admission screening is the assessment of the individual's needs and the community services available to meet his needs. It is essential to utilize a standard assessment instrument with expansion of the Program for the following reasons:

1. To assure that only those persons who actually require nursing home care are placed in a nursing home and then only when such care cannot be provided in the community.

2. To enhance the quality of the individual assessment process.

3. To assure uniform assessments statewide.

4. To record critical data necessary to measure and evaluate the effectiveness and quality of the Program.

The assessment instrument includes evaluation of the factors that are critical in determining individual needs for care, the type of care required and whether the care can be received in the community. The components of the assessment instrument address medical condition, nursing care needs, social and emotional factors, the individual's functioning ability in the areas of bathing, dressing, feeding and ambulation, information regarding the individual's informal or family support system and information regarding the availability of formal or agency provided community services.

Reimbursement for the Pre-Admission Screening Assessment

Currently, the Virginia Medical Assistance Program reimburses local health departments $44 per screening. This fee does not include the local Welfare Department's involvement with pre-admission screening. HJR 295 specifically requests that the agencies whose representatives participate as members of the pre-admission screening team be reimbursed for the time spent in conducting the individual assessments.

After careful study, the State Health Department believes that $65 is a reasonable payment per nursing home pre-admission screening. Both the acute care hospital-based teams and the community-based teams would be reimbursed $65 per screening. The reimbursement fee for community screenings would be shared by a direct reimbursement to the local Health Departments and through a state to state contract with State Welfare. The pre-admission screening reimbursement fee is discussed in Appendix A and is included as a cost item in Appendix B.

Program Policy

HJR 295 requests that a plan and budget for Program expansion include those individuals who will become Medicaid eligible within 13 months subsequent to nursing home placement.

However, based upon study of this request the Health Department recommends that Program expansion be limited to those individuals who will become Medicaid eligible within six (6) months subsequent to nursing home placement. The 13-month period was predicated on the Medicaid 12-month property transfer policy which indicated a 12-month ineligibility period when property was transferred for less than fair market value. This period of ineligibility was changed to at least 24 months effective July 1, 1981. Therefore, the basis for the proposed 13-month pre-admission screening policy would no longer seem valid.

Statistics indicate that most individuals who become Medicaid eligible do so within six months subsequent to nursing home placement. Expansion of the Program to individuals potentially Medicaid eligible within 12 months subsequent to nursing home placement would result in a projected 10,700 screenings per year. With expansion of the Program to individuals potentially Medicaid eligible within six (6) months subsequent to nursing home placement, it is projected that 10,500 screenings would occur annually.

Monitoring and Technical Assistance

In addition to the utilization of a standard assessment instrument, the VMAP must have the capability of program monitoring and offering technical assistance to both the acute care hospital and the local screening committees.

The expansion of the Program will generate approximately 8,500 screenings yearly in addition to the 2,115 yearly screenings of the current program. This volume cannot be managed manually.

In order to avoid inappropriate screenings, to assure that the Program purpose is accomplished, and to record, measure and evaluate the effectiveness of the Program, it is essential to have an automated management information monitoring and retrieval system.

This system will provide data on individuals and services which can be used by planning and services agencies to assure that services are provided to the citizens of the Commonwealth. By comparing information on individuals within one locality or within the State, it will be possible to measure the needs of specific patient populations. Also by comparing the performance of agencies and facilities with statewide norms, it will be possible to measure the effectiveness of their pre-admission screening performance.

Such a system can also alert the VMAP to individuals who are admitted to a nursing home and are expected to have a short length of stay. The VMAP staff can work closely with the nursing home regarding discharge of such individuals for return to the community.

In addition to the automated monitoring system, a regional level staff to work closely with acute care hospitals and local pre-admission screening committees is considered essential for coordination within and between regions. Regional staff will use the automated monitoring system to identify and monitor acute care hospitals and local screening committees that are not performing satisfactorily. Regional staff would also be responsible for initial orientation and training, ongoing training and technical assistance in Program policy and procedure, consultation regarding individual cases in acute care hospitals and local committees final approval for nursing home placement.

Each Health Region's staff would at a minimum consist of a Public Health Nurse Consultant, a Clinical Social Worker and a Clerk-Typist C.

Projected Results of Expanding the Nursing Home Pre-Admission Screening Program

It is anticipated that 10,500 acute care patients and community based individuals will be screened by the NHPASP annually. Of these, 1,470 (14%) individuals will not be approved for nursing home admission. This is a potential savings to the State of $4,899,350 annually. However, to the extent that other individuals with greater needs may enter a nursing home, for each individual denied admission, these savings may not be truly realized. In a larger sense, however, the reserving of nursing home care for those most in need will be cost effective.

In addition to potential cost savings, the Program will continue to emphasize the human factor and will continue to assist disabled and elderly persons in securing the most appropriate services to meet their needs. Wherever possible, disabled and elderly persons will not be uprooted from their homes and communities and placed in institutional settings.

The NHPASP is, however, only a part of an effort toward community-based care. The Program cannot stand alone. The development of a uniform system of statewide community services available in all localities is essential. This system cannot succeed without the support of the General Assembly. The State must provide the impetus for the community service system in partnership with each county and independent city.

Changes in the Virginia Medical Assistance Program (Now Under Study) Which Support Statewide Refocus on Community-Based Services

Additional options for reducing the Medicaid expenditures for nursing home care are being carefully studied. The preliminary result of this effort is the conclusion that the most effective long-range reduction of Medicaid expenditures can be achieved by reorganizing coverage of long-term care services under

Medicaid to permit allocation of funds for institutional and non-institutional programs. Under the current system, the Virginia Medical Assistance Program provides little funding for in-home services while providing coverage for a full range of institutional services. Also, many individuals who are ineligible while living at home become eligible immediately upon admission to a nursing home. Thus, almost irresistible pressure is created toward institutionalization.

The following is a proposal for changes in the Medical Assistance Program's services and management to shift the focus of Medicaid long-term care coverage to a more evenly balanced coverage of both community-based services rendered in a recipient's home and institutional care. This proposal is compatible with the Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35, Section 2176).

1. REVISION OF THE CRITERIA FOR INTERMEDIATE CARE

Since 1972, the criteria used to determine a patient's appropriate placement in intermediate care has been extremely broad and somewhat vague. Much difficulty has been experienced in applying these criteria and confusion has resulted in determining when a patient qualifies for intermediate care. For these reasons, new criteria for intermediate care have been developed which can be easily and consistently applied by private physicians, nursing home preadmission screening committees, Medical Review Teams, and hospital and nursing home discharge planning personnel.

The proposed revised criteria are focused on the care and services required by an individual. Thus, the criteria may be applied to an individual in any setting and may serve to determine his eligibility for institutional and non-institutional services such as nursing home care, home health services, or personal care services. Any individual whose care needs do not meet these criteria would not qualify for Medicaid long-term care services.

The use of these criteria will assure that no individual enters a nursing home unless he has medical and nursing needs. The new criteria represent a stricter definition of intermediate care since an individual with mental but no physical impairments would not be eligible for intermediate care; nor would an individual with minimal impairments be eligible for intermediate care unless he had clearly defined nursing needs.

A pilot test of these criteria was carried out by the Medical Review Teams between July 1, and August 30, 1981. The Medical Review Reports of 1,365 patients were reviewed to determine what effect these criteria would have had on patient continued stay. The test demonstrated that the new criteria will ensure that only patients that have demonstrable nursing care needs and severe functional impairment will qualify for Intermediate Care, ensuring the best use of long-term care services. It is estimated after using these criteria that approximately 14% of patients who seek admission to nursing homes will not be eligible for Medicaid payment. In addition, some patients now receiving Medicaid payment in Intermediate Care Facilities (ICF) may become ineligible for Medicaid payment.

2. COVERAGE OF PERSONAL CARE UNDER MEDICAID

Most individuals enter nursing homes because their personal care needs cannot be met in the home. These individuals require assistance with activities of daily living such as bathing, dressing, eating, elimination, and ambulation. Many individuals remain at home as long as there are interested family members who provide assistance with these necessary personal activities. However, the individual who has no family or no family available or able to assist him enters the nursing home.

Several states have adopted coverage under Medicaid the optional service of Personal Care. Personal Care services are medically oriented tasks having to do with an individual's physical requirements (as opposed to housekeeping) which enable an individual to be treated by his physician on an outpatient rather than inpatient basis. These are long-term maintenance or supportive services. The tasks included require less skill than some of the duties included in Home Health care performed by a home health aide.

Experience in other states demonstrates that this service is a cost effective alternative to nursing home care. Based upon statistics from the Nursing Home Pre-Admission Screening Program and the present Medicaid long-term care population, it is estimated that approximately 2,056 individuals (per year) can be served by Personal Care services enabling these individuals to be cared for in their own homes rather than in a nursing home. The average monthly cost of personal care is estimated to be $300.00; rather than $970.00 for nursing home care.

In order to guarantee that adoption of coverage of a new service under Medicaid does not result in greater expenditure of Medicaid funds than is currently being spent for nursing home care, certain administrative controls will be placed on this service. First, no individual may receive Personal Care services without assessment of need by the Nursing Home Pre-Admission Screening Committee, and his needs meet criteria for intermediate care and other alternative community services, both formal and informal (including family) cannot meet his needs. Second, his plan of care must be certified by a physician, supervised at specific intervals by a nurse, and monitored for medical necessity and quality of care. In addition, this monitoring will also include the cost effectiveness of the services. At the point that the cost of in-home services surpasses the cost of institutional care, the individual will no longer be eligible for personal care services in his home.

3. REDEFINITION OF HOME HEALTH SERVICES

Home Health services will be evaluated and, where appropriate, redefined to enhance its effectiveness in preventing institutionalization. Recent changes in the Medicare limits on Home Health Services make it possible to receive a greater amount of Home Health Services from Medicare. Medicaid coverage of these services can be redefined to take full advantage of this change in Medicare regulations. Staff of the Department of Health have been designated to carry out this study.

4. A WAIVER FOR CHANGES IN ELIGIBILITY RULES FOR PERSONS AT RISK FOR INSTITUTIONALIZATION.

Many individuals are forced into institutional services because they are financially ineligible for assistance to pay for the cost of in-home services. However, they become financially eligible for Medicaid when they are admitted to a nursing home. Ineligibility for Medicaid outside a nursing home also often prevents discharge from a nursing home when the individual cannot pay for in-home services. Institutionally biased eligibility criteria in Medicaid has been a potent force in creating the demand for nursing home beds for those individuals whose income exceeds the eligibility standards while living at home but who cannot afford to purchase in-home services and do not qualify for services under other programs.

Federal regulations for eligibility for Medicaid require that an alternate budgeting scale be used to determine eligibility for Medicaid when a person enters a nursing home. Because of this provision, individuals who are ineligible for Medicaid while living at home become eligible as soon as they are admitted to a nursing home.

A waiver of the eligibility rules for individuals who would be eligible for Medicaid if they enter an institution would allow eligibility for these individuals to be evaluated the same as it is evaluated for nursing home patients, deducting from their income the non-institutional income scale and the cost of in-home services necessary to keep the individual at home. If they have insufficient income to pay for the care, they would become Medicaid eligible so Medicaid payment could be made for personal care or covered medical and home health services.

This change in policy would require a waiver from the Department of Health and Human Services. However, it would assure that individuals would not be forced into institutional placement or kept there because of their inability to purchase income services when it is cost-beneficial to the Program to maintain them at home.

In order to assure that this care was not more expensive than nursing home care, an upper maximum would be applied to limit Medicaid payment to an amount equal to or below the payment that Medicaid would make for that person in a nursing home.

Program regulations could be so written to assure that the only individuals eligible for this alternate eligibility status are those who have been screened and would have to be approved for admission to a nursing home because the unavailability of alternative services was due to their inability to purchase in-home services and their ineligibility for Title XX and Title XIX.

5. DEVELOPMENT OF A LONG-TERM CARE INFORMATION AND MONITORING SYSTEM

In order to record, measure, and assess the quality and necessity of long-term care services, it is essential to develop a management tool which will permit Medicaid staff to evaluate the quality, necessity, and effectiveness of Medicaid's long-term care services. Such a system should provide data on

individuals, services, and providers which will have wide utilization by planning and regulatory agencies to assure that adequate services of high quality are provided to the citizens of the Commonwealth and to project future needs.

The Virginia Medical Assistance Program currently collects patient information at four patient assessments: pre-admission screening, admission to a nursing home, utilization review (a desk review), and Medical Review (an on-site visit), all of which occur during the first year of nursing home placement. After the first year, each Medicaid patient is assessed twice annually; once through a desk review of an assessment form submitted by the nursing home, and once through an on-site review carried out by a Medicaid Medical Review Team. Because of unanticipated Program expansion, the criteria for these assessments are not uniform and the data cannot be compared to either an individual over time or facility-wide basis without laborious manual cross-matching of information. Although the information collected is similar, the data must be exactly matched in order to be compared by an automated system.

This proposed monitoring system will record the condition of patients from pre-admission assessment, admission assessment, and periodic inpatient assessment to assure prompt discharge of patients from institutions when institutional services are no longer needed and controlled access to in-home Medicaid services. The system will provide prompt data on all long-term care services and measure the outcomes of patient care to assure that patients receive only the services they actually require, and permit the Medicaid Program to assess the actual degree to which facilities render rehabilitative services which result in improved health and functioning of nursing home patients.

The regular analysis of such data will lead to shorter lengths of stay by focusing review attention on those patients most likely to be candidates for discharge from long-term care facilities and assure that discharge planning begins promptly after admission. Shorter lengths of stay will result in savings to the Virginia Medical Assistance Program since presently constructed long-term care facilities operate at full capacity prompting the continuous construction of new facilities. By better monitoring the use of institutional and non-institutional care, the Program can reduce the demand for new nursing home beds.

An additional purpose of development of the long-term care information and monitoring system is the opportunity it represents to control administrative expenditures by limiting the necessity for additional Medicaid staff to carry out Federally mandated utilization review activity.

It is possible to receive a waiver of the Federal requirements for long-term care review provided Virginia can demonstrate that it has a method to assure it can identify those patients and facilities most in need of review. The long-term care information and monitoring system will assure that Virginia can meet these criteria. A waiver of the utilization control requirements will also protect Virginia from the imposition of severe fiscal penalties if the 100% review requirement is not met.

SUMMARY

This five-part proposal to reorganize Medicaid long-term care services and management will allocate the Program's limited resources for long-term care to a continuum of services tailored to meet individual needs in a cost effective and efficient manner. Better services, better adapted to the needs of individuals will be the result. Moreover, only the amount and kind of services actually required by an individual will be delivered.

Respectfully submitted,

James B. Kenley, M.D.
State Health Commissioner

APPENDIX A

The proposed $65 reimbursement for each Pre-Admission Screening is based upon the following information:

- Local Health Departments are currently reimbursed at $44 per screening. This includes Public Health Nurse and Physician time. When the program started there were no cost figures available. An estimate of costs was based on the involvement of local Health Department physicians and nurses.

- August 1, 1982, median salary of local welfare department Service Worker will be $9.16 per hour. This includes salary and administrative costs.

- Reporting of the current NHPASP indicates the average time per screening is four (4) hours.

- It is estimated that the local welfare departments average time involvement in screening is two (2) hours per screening or $18.32 per screening ($9.16 x 2).

- The acute care hospital based pre-admission screening will require that the social worker carry the responsibility of coordinating and completing the screening, including completing of the assessment instrument. However, the screening process will of necessity require physician and nurse involvement.

Therefore, $65 for each nursing home pre-admission screening seems to be an appropriate and reasonable reimbursement fee. The fee per screening will be allocated in the following manor: $45 to the local Health Department and $20 to the Welfare Department. Acute care hospitals will receive the full $65 per screening.

APPENDIX B

COSTS FOR PRE-ADMISSION SCREENING-EXPANSION

ASSESSMENT COST

Total number of screenings per year (Community based/acute care)	10,500
Cost per screening-(assessment/referral for services)	x $65
Costs per year for screening	$682,500
Less current costs for screening	-93,500
Projected assessment cost for expansion	$589,000

ADMINISTRATIVE COSTS (Central Office)

Public Health Nurse Consultant Salary	$22,000
Clerk Typist C Salary	10,715
Social Work Consultant	3,500
Fringe Benefits for Additional Positions	4,500
Office Equipment	3,500
Travel	12,000
Publications	2,000
Mailing Fees	1,000
Training Materials	2,000
	$61,215

ADMINISTRATIVE COSTS (Regional Offices)

Public Health Nurse C (5)	$91,400
Clinical Social Worker B (5)	76,465
Clerk-Typist C(5)	53,575
Fringe Benefits	19,000
Travel	24,000
Office Equipment	15,000
	$279,440

COMPUTER COSTS

Development costs	$232,000
Ongoing costs (yearly)	127,800
Data Entry Operator	11,195
DEO fringe benefits	1,350
	$372,345

PRE-ADMISSION SCREENING EXPANSION - START UP AND FIRST YEAR OF OPERATION

Assessment costs		$589,000
Administrative costs (Central Office & Regional Office)		340,655
Computer costs		372,345
Total Costs		$1,302,000
	State (25%)	$ 325,500
	Federal (75%)	$ 976,500

APPENDIX C

Nursing Home Pre-Admission Screening Planning Committee

Baker, Billy
Supervisor
Medical Care Section
Division of Financial Services
Department of Welfare

Bear, Ruth, RN
Assistant Director of Nursing
Arlington Department of Human Resources

Caley, George B.
Assistant Administrator
Winchester Memorial Hospital

Carnes, Charlotte C., MSW
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Nursing Home Pre-Admission Screening Program

Cook, Ann E., ACSW
Director
Medical Social Services
Medical Assistance Program

Felder, Muriel, ACSW
Director of Social Work
Medical College of Virginia

Gray, M. P.
Eastern Virginia Health Systems Agency, Inc.

Green, Miriam
Administrator
The Towers Nursing Home

Itzkovitz, Jackie, MSW
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McAuley, James, Phd.
Virginia Center on Aging

Rollins, Saundra, MSSW
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