INTERIM REPORT OF THE
JOINT SUBCOMMITTEE

Monitoring Long-Term Care

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

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Interim Report of the Joint Subcommittee
Monitoring Long-Term Care
To
The Governor and the General Assembly of Virginia
Richmond, Virginia
January, 1985

To: Honorable Charles S. Robb, Governor of Virginia,
and
The General Assembly of Virginia

BACKGROUND OF THE STUDY

The Joint Subcommittee Monitoring Long-Term Care was created in 1983 by House Joint Resolution No. 37 (Appendix A). Its charge is to oversee the implementation of an integrated approach to long-term care by facilitating cooperation and exchange of information. It is to accomplish this by receiving regular reports of cooperative action and proposals for joint effort from agencies involved in the provision of long-term care.

During 1983, the Joint Subcommittee heard reports on activities from agencies and groups active in long-term care service provision. The Department of Mental Health and Mental Retardation reported on the rationale for and community responses to deinstitutionalization of geriatric patients from the state hospitals in 1983 and 1984. The Department also discussed the needs of mentally ill children and the growing problem of serving chronically mentally ill young adults.

The Long-Term Care Council presented its state plan to the Joint Subcommittee. The Council also discussed its efforts in developing alternative services to prevent unnecessary institutionalization of the elderly; these efforts include a study of costs of public and private community services for this population and a discussion of problems in cost-sharing between federal, state and local governments in service provision.

The Department of Health presented progress reports on the status of relevant Medicaid waivers, including those related to case management and home and community-based services and on the accomplishments of the Nursing Home Preadmission Screening Program.

The Department of Social Services discussed fire safety standards in homes for adults. The Joint Legislative Audit and Review Commission discussed its recommendations regarding level of auxiliary grants from its report on Local Mandates and Financial Resources. These grants are the major resource used by residents of homes for adults to pay their room and board.

Finally, the American Health Care Association and its Virginia counterpart presented an overview of the system of life-care communities.

The Joint Subcommittee received a report on the deinstitutionalization pilot project in the City of Richmond and the Department of Mental Health and Mental Retardation's report on census reduction at the state hospitals as requested in the 1984 Appropriations Act.

The Joint Subcommittee was continued in 1984 for two years by House Joint Resolution No. 52 (Appendix B). The Joint Subcommittee at the beginning of 1984 identified several issues for intensive review by expert task forces organized by the Joint Subcommittee. These issues, discussed in detail in the findings of this report, are:

1. Need for state regulation of life-care communities in Virginia.

2. Need for and feasibility of a revised method of Medicaid nursing home reimbursement.

3. Housing for persons with special needs.

4. Post-education transition of the handicapped.

In addition, the Joint Subcommittee has continued to monitor the Long-Term Care Council's study, pursuant to Senate Joint Resolution No. 30, of the cost-effectiveness of maintaining the frail and impaired elderly in community settings, to be determined through documentation of public and private costs associated with community placement.

The Joint Subcommittee also held two public hearings to provide an opportunity for public comment on available effective services and services which are needed to serve all populations in need of long-term care.

Finally, the Joint Subcommittee attended the working conference of the American Health Planning Association on "The Complex Cube of Long-Term Care."

FINDINGS AND RECOMMENDATIONS

Long-Term Care Defined

Long-Term Care can be defined as a system of health and social services required by the frail and handicapped of all ages to assist them in activities of daily living. These services may be required either continuously or intermittently but are required over an extended period of time. The services may be provided by a formal organization or by informal resources such as family.

The Population in Need

The population in need of long-term care services includes the frail elderly, the developmentally disabled, the physically handicapped and the chronically mentally ill.

Long-Term Care Issues Examined by the Joint Subcommittee

The nature of long-term care issues generally was aptly described as a "complex cube" by the American Health Planning Association in structuring its 1984 conference, attended by the the Joint Subcommittee. The system consists of complex mixtures of service components, funding sources, affected population groups and eligibility requirements which are interrelated yet often uncoordinated in their provisions, requirements and effects. Conflicts in services and responsibility exist between jurisdictions, between the national, state and local levels and between the public and private sectors. Long-term care is fragmented, costs are increasing rapidly, public funding is threatened and inconsistent, and institutional care is often encouraged.

In its effort to address some of these conflicts and deficiencies, the Joint Subcommittee conducted its study this year by identifying several specific issues on which it could facilitate coordination and collaboration to solve existing problems. The Joint Subcommittee investigated these issues by creating and monitoring task forces composed of experts in each area. Some of these task forces worked throughout 1984 and reported to the Joint Subcommittee in December. Others were organized and will conduct their studies during 1985. The findings and recommendations or proposed study plans of these task forces are summarized below.

Need for Regulation of Life-Care Communities

Life-care communities are multi-service living arrangements developed for the elderly. They provide facilities for a range of needs from independent living through skilled nursing care. Residents enter into a contract with the provider for at least one year but usually for life and pay a substantial entrance fee and usually a periodic charge while in residence. In return, the residents' changing levels of need are accommodated within the facility, often at no additional cost. Dining and recreational facilities are usually provided. Residents can pay entry fees with proceeds from the sale of their home and monthly fees can usually be paid from social security, pension or other retirement income.

The Joint Subcommittee agrees that life-care communities help to prevent Medicaid-dependence among the elderly and that their development should be encouraged. However, because of the significant investment required for residence in life-care communities and the recent losses suffered by residents in other states, consumers of these services should be protected.

To develop recommendations to address the dual needs of encouraging facility development and consumer protection, the Bureau of Insurance agreed to conduct a task force study on this issue for the Joint Subcommittee. The membership of the Task Force consisted of providers of services, residents in life-care communities, and representatives of the Virginia and American Health Care Associations and the Virginia Association of Nonprofit Homes for the Aging. Staff assistance was provided by the Bureau of Insurance and the Joint Subcommittee staff.

The Task Force determined at the outset that its study should address minimum financial standards for life-care communities, monitoring mechanisms to ensure viability of facilities, contract provisions, entrance fees and periodic charges, and alternatives to legislation and regulation if these were determined inadvisable.

Task Force members also agreed on several general considerations that should guide their deliberations. First, a regulatory scheme must consider quality of care and condition of physical plants. Therefore, an integrated regulatory approach must be developed which includes the Departments of Health and Social Services, which currently monitor these areas. Second, a major consideration in any life-care regulatory scheme developed is the nature of facilities to which the law applies. It was determined that a working definition of life-care should be developed for the study but not considered final until the Task Force had looked at the facilities which will fall into or out of a given definition. In this way, the Task Force hoped to avoid problems other states have had with certain facilities evading the statute. This effort should include a catalogue of laws and regulations that already exist and to whom they apply, such as hospitals, nursing homes, and homes for adults. It was suggested that the Departments of Health and Social Services testify as to their experience in capturing facilities which they license.

The Task Force based much of its discussion of potential legislation on Senate Bill No. 410, introduced by Senator Joseph V. Gartlan, Jr., and carried over by the 1984 Session of the General Assembly. The Task Force also studied provisions of legislation enacted in other states. In this context, the following issues found in detailed regulatory schemes were discussed:

Definition of continuing care
Certification/licensing
Escrow requirements
Reserve requirements
Investment limitations
Bonding requirements
Fee regulation
Financial disclosure
Contract regulation
Right to self-organization
Advertising regulation
Lien provisions and preferred claims
Responsible agency
Investigative, enforcement and rehabilitative power

At the conclusion of these discussions, the Task Force agreed that legislation was appropriate, but that it should be of a limited nature, emphasizing disclosure over active supervision of operations and detailed regulation. The legislation should include the following items:

1. Registration rather than certification.

2. Disclosure of financial situation, background of provider, and provisions for facility operation and management.

3. Minimum contract components.

4. Provisions regarding sale or transfer of ownership or change in management.

5. Consumer protection in cases of financial instability of facilities.

6. Prohibitions against provision of false information.

7. Right of residents to organize.

8. Civil liability of provider for violations.

9. Special provisions for providers existing at time of enactment of legislation.

10. Authority for issuance of cease and desist orders and injunctions and for collection of fines.

The Task Force also agreed that the recommendations should include a statutory provision for the special considerations needed in issuing certificates of need for the nursing home components of life-care facilities.

The legislation developed by the Task Force may be found in Appendix C of this report.

Revision of Medicaid Nursing Home Reimbursement Formula

The Task Force on Nursing Home Reimbursement was created by the Joint Subcommittee to Monitor Long-Term Care pursuant to a charge in House Joint Resolution No. 52 (1984) to

> consider, with the cooperation of the State Health Department and providers of nursing home care in the Commonwealth, alternative reimbursement plans for nursing home patients which pay the provider of services according to the amount of care required.

The Task Force, chaired by Delegate George H. Heilig, is composed of representatives of the nursing home industry, including proprietary, nonprofit and government-operated nursing homes. State Medicaid administrators also served on the Task Force and the Attorney General's Office monitored its deliberations.

The nursing home industry representatives on the Task Force specified several problems with the current reimbursement system which they believed necessitated the consideration of a change in reimbursement policy. The use of "diagnostic-related groupings" by hospitals is causing hospital discharges appropriately but earlier than previously. Therefore, sicker patients are entering nursing homes and requiring services once only provided by hospitals. Hospital-based nursing homes claim to be especially burdened by this policy. Also, the formula does not account for quality-of-care factors, especially in relation to patients requiring heavy care. The statewide median reimbursement level provides incentive to reject heavy-care indigent patients or to cut costs by lowering quality of care. This may work a serious hardship on government-operated and nonprofit homes, which accept a higher percentage of indigent, heavy-care patients than do proprietary nursing homes. A long-range concern is patient access to care, especially for heavy-care Medicaid patients.

Other problems mentioned with the current system included the fact that it does not provide adequately for return on equity, and that it may not be assessing the impact of inflation accurately. There is also reportedly disparity among nursing homes in staffing levels and services provided.

The Task force addressed the issues mentioned through the creation of a separate "Formula Committee" charged with preparing a proposal for a new formula. Representatives in both financial and program areas from all three types of nursing homes served on the Formula Committee, moderated by Dr. Robert Deane of the American Health Care Association.

Dr. Deane developed and the Formula Committee reviewed a suggested new approach to nursing home reimbursement for Virginia. The proposal attempts to provide incentives and benefits to patients, providers and the State. Payment is based on level of care required by each patient. Reimbursement ceilings are set by cost center, including three operating cost centers and a property cost center. The proposal may be found in Appendix D of this report. After

review and discussion, however, the Formula Committee determined that while the proposal has some degree of merit and addresses many of the problems specified, additional information is needed before the proposal can be assessed adequately, both in cost and substance.

The Formula Committee therefore agreed that before any new formula is recommended, the following patient and service data be collected and assessed for a cross-section of nursing homes:

1. Patient intensity needs, based on care required in time increments.

2. Operating costs, including plant costs.

3. Wage ranges by category of staff.

4. Fringe benefits provided to staff.

5. Affiliation with other facilities and impact of such affiliation on costs.

Only when this data has been analyzed will it be feasible to recommend a formula change which will fully address current problems and the cost of which can be assessed. The Formula Committee recommends, however, that any new reimbursement formula or modification to the existing formula be based on the framework provided by the proposal considered by the Formula Committee in its deliberations this year.

While this data is being collected, it was suggested that a pilot study of the reimbursement formula developed with Dr. Deane might be undertaken. The study would include a cost analysis of simulated implementation of the formula in three nursing homes from each of the three provider groups. It should be conducted in close coordination with the State Office of Medical Assistance.

The Formula Committee further recommended that while the feasibility of a new formula is assessed, certain measures can and should immediately be taken within the current reimbursement system to correct existing deficiencies.

The first major area requiring immediate action involves the CPI inflator. First, the original first year ceiling calculations set by the Virginia Medical Assistance Program (VMAP) for providers with fiscal years beginning in the second, third and fourth quarters did not reflect inflation between June 30, 1982, and the beginning of the providers' fiscal year. Accordingly, up to nine months of inflation was lost if the provider's fiscal year did not coincide with the State's fiscal year. For example, a provider with a cost reporting period beginning April, 1983, and ending March, 1984, was allowed inflation for twelve months, when in fact twenty-one months of inflation took place between June 30, 1982, and March 31, 1984. Also, by using the fourth quarter ceiling as the new median for each succeeding quarter in the second year beginning July 1, 1983, VMAP is incorrectly using the CPI to simply track inflation as it goes up or down and to accordingly lower ceilings when the CPI annual increase as measured at the end of the fourth quarter has a lower value than during the first quarter. As long as inflation is at a positive value, the previous year's ceiling should be advanced by the amount of inflation that has taken place over the previous year. Finally, the CPI selected may be inappropriate. Nursing homes are suppliers and providers of health care. The CPI used by VMAP measures the entire breadth of the economy using the CPI. A more sophisticated and sensitive measurement would be a CPI based on the health care market basket.

The second area needing immediate attention is the use of the Baa Municipal Index to limit interest. Currently, VMAP is using the Baa Municipal Bond Limit as the limit on interest reimbursed Virginia nursing homes. This is inequitable since nursing homes in Virginia do not enjoy the credit-worthiness of most municipalities. A fairer and more appropriate index is the Baa Corporate Interest Limit.

Finally, the Attorney General's Office has indicated that, as of June 30, 1982, the incentive payment limitation of 9% would be terminated. For those providers whose fiscal year overlaps June 30, 1982, the State has indicated orally that the provider can submit an interim cost report or adjust for the incentive limit based on billable days. The State has reportedly taken no steps to implement this procedure and, moreover, has indicated that if an interim cost report has

been filed, the part of the year after June 30, 1982, will be used to establish the new prospective ceiling. An interim cost report should be filed only to calculate the incentive payment limit for the period before June 30, 1982.

The Appropriations Act as amended by the 1985 Session of the General Assembly for the second year of the 1984-86 biennium includes an appropriation of $100,000 for the Department of Medical Assistance to have an independent study conducted on the current nursing home reimbursement formula under the Medicaid plan. The proposed budget amendment directs that the findings of the Joint Subcommittee's Task Force on Nursing Home Reimbursement be considered and that results of the study be presented to the 1986 Session of the General Assembly.

Post-educational Transition of the Handicapped

The Joint Subcommittee Monitoring Long-Term Care created this Task Force to assist the Joint Subcommittee in its study of the varied needs of all groups requiring long-term care services in order to enhance coordination of services available to those groups.

The Task Force is specifically studying the problems associated with the transition from education programs for the handicapped provided pursuant to P.L. 94-142 to employment or other appropriate activities of adult life.

Chaired by Senator Stanley C. Walker, the Task Force is composed of representatives of the State Departments of Education, Mental Health and Mental Retardation, Social Services, and Rehabilitative Services, in addition to representatives of the CHANCE Project transitional program at Old Dominion University, Psychosocial Rehabilitation Center in Fairfax, Richmond Community Services Board, Virginia Association of Rehabilitation Facilities, Southeastern Cooperative Educational Programs, and the Rehabilitation Research and Training Center at Virginia Commonwealth University.

The Task Force held an organizational meeting on November 21, 1984, to prepare for its work in 1985. The group began its study with a presentation by Judith Schapiro, Director, and Mrs. Susan Meslang, Coordinator of the CHANCE Project. Dr. Schapiro and Mrs. Meslang described their program, designed to provide support for the mildly mentally retarded adult and his family in his transition from special education classes to the adult community experience. The program was developed because there were few programs for developmentally disabled adults, who are often too immature emotionally while in school programs to benefit from social training. In addition, many parents of such adults are not prepared for the level of independence their children are experiencing outside of institutions.

The CHANCE Project offers a series of six courses for retarded adults between the ages of twenty-two and fifty-five and one section for family and caregivers. The retarded adults are taught social and independent living skills such as communication and self-concept, with plans for more emphasis on transportation, household management and interpersonal relationships. Instruction is offered to the support group of parents and staff on helping in this transition towards self-sufficiency.

The students attend the program while living at the Southeastern Virginia Training Center, local group homes, independent apartments, or at home with their families.

It is anticipated that the program will enable the retarded clients to increase their level of self-sufficiency as measured by teacher evaluations and standardized testing. It is also expected that the project will increase community awareness of the need in this area. A model is being developed for providing appropriate postsecondary services to the mentally retarded adult and his family and caregivers and will be disseminated to human resource agencies.

It is estimated that there is a large pool of potential participants waiting for a program such as CHANCE. The Task Force noted that it would be useful to project the number of such potential participants, perhaps by tracking the current special education population in public schools.

In setting its agenda for the study in 1985, the Task Force determined that it should first

identify the existing transition programs for this population. With this information, the group can consider coordination of existing services, avoidance of duplication and filling of service gaps in developing its recommendations. The Task Force should then be ready to identify the issues it will address in its work.

In the preliminary discussion at this meeting, the Task Force members, however, did agree on several major areas needing attention if the transition process is to be improved. The group agreed that the area needing the most attention is the procedure for the shift in case management from the Department of Education to other agencies providing services. The case management problem is compounded when the agencies which provide services to these clients separate their programs by disability, resulting in duplication and lack of coordination. Public and private sector programs are also duplicative when the public sector does not have access to private sector services. The Department of Rehabilitative Services is working on this issue now and will report its activities in this area to the Task Force.

Possible solutions to this problem begin prior to graduation. The case management problems could be addressed through pre-graduation use of community prescription teams established by Chapter 10 of Title 37.1 of the Code of Virginia. The teams can go into public schools now, but only for certain categories of clients; these categories should be broadened.

Another current effort in this area which should be monitored is the Interagency Coordinating Committee on Delivery of Related Services to Handicapped Children, established by the legislature in 1983 in § 2.1-700 of the Code. This legislation facilitates interagency coordination for school-aged handicapped children. The Task Force could serve as a monitoring agent for the Committee.

In summary, the Task Force's approach to transition problems should define a target group and look at educational programs provided for the handicapped prior to their reaching the age of twenty-two, including assessments by schools and provision of a realistic, functional curriculum. It should investigate transition from schools to agencies and between agencies, ensure consistency in approach and follow-through, and address areas of policy, financing and monitoring.

Housing for Persons with Special Needs

A place to live is essential before services can be provided. The need for housing is common to all populations requiring long-term care, especially to older retarded citizens, the elderly who are too frail for their own homes, the chronically mentally ill, and many but not all "street people". The Joint Subcommittee will work with this Task Force to explore public and private programs to solve problems of financing and operating a variety of housing options, including but not limited to life-care communities. homes for adults. group homes, and supervised apartments.

The initial formation of the Task Force was coordinated by Dr. Joseph Fisher, Secretary of Human Resources, and Dr. Betty Diener, Secretary of Commerce and Resources. The participation of these two secretariats enables the Task Force to coordinate housing financing and marketing issues with the needs of the handicapped. The Task Force is chaired by Dr. Joseph J. Bevilacqua, Commissioner of the Department of Mental Health and Mental Retardation. The membership currently includes the heads of the Department of Rehabilitative Services, Department of Social Services, Department for the Visually Handicapped, Department of the Deaf and Hard-of-Hearing, Advocacy Department for the Developmentally Disabled, Department for the Aging, Virginia Housing and Development Authority, and the Department for Housing and Community Development. Representatives from advocacy organizations and the housing industry will be involved as appropriate. Because of the range of agencies and interests involved, the Task Force will take a generic approach to its study of low-income housing needs by disability groups, not concentrating on any one type of housing or disability group. Instead, housing types and disability groups will be specified as is appropriate within four themes. These include (i) data on existing housing stock and disability group needs, (ii) financing of construction and renovation, (iii) financing and coordination of services needed when housing resources are in place, and (iv) marketing to promote housing for the disabled among producers of low-income housing units.

The Task Force will conduct its work in 1985, using the Joint Subcommittee for legislative access on an ongoing basis. A report is anticipated by July, 1985. A detailed study plan developed by the Task Force is included in Appendix E to this report.

Respectfully submitted,

Mary A. Marshall, Chairman
Edward E. Willey, Vice-Chairman
George H. Heilig., Jr.
Thomas J. Michie, Jr.
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APPENDIX A

HOUSE JOINT RESOLUTION NO. 37

Establishing the Joint Subcommittee to Monitor Long-Term Care.

Agreed to by the House of Delegates, February 8, 1983
Agreed to by the Senate, February 14, 1983

WHEREAS, the long-term care of the physically and mentally handicapped and of the frail elderly is an obligation and responsibility of government as well as family, friends and voluntary agencies; and

WHEREAS, the cost of long-term care is a substantial portion of state and local budgets; and

WHEREAS, long-term care should provide institutional care for those in need of such care and alternatives such as home services for those who need a more independent program; and

WHEREAS, the Commonwealth has demonstrated its desire to offer expanded community alternatives for long-term care through the Medicaid personal care waiver, companion services, group homes and auxiliary grants; and

WHEREAS, the services needed in long-term care programs are provided by the Departments of Health, Social Services, Rehabilitative Services, Mental Health and Mental Retardation, and Aging; by the Virginia Housing Development Authority and by other state and local government agencies; and

WHEREAS, the Commonwealth has demonstrated its desire to coordinate long-term care services on the state and local levels through the establishment of the Long-Term Care Council and local long-term care coordinating committees; and

WHEREAS, the Secretary of Human Resources has the responsibility for coordinating activities of agencies involved in long-term care; and

WHEREAS, the investigation of possibilities for pooling of long-term care resources or joint funding of cooperative programs is in the best interest of the Commonwealth and of the clients served; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That a joint legislative subcommittee to monitor long-term care is hereby established. The joint subcommittee shall oversee the implementation of an integrated approach to long-term care by facilitating cooperation and exchange of information. The subcommittee shall receive regular reports of cooperative action and proposals for joint effort from agencies engaged in providing long-term care. The joint subcommittee shall be composed of seven members appointed by the Speaker of the House of Delegates and the Senate Privileges and Elections Committee. Two members shall be appointed from the House Committee on Appropriations, two members from the House Committee on Health, Welfare and Institutions, two members from the Senate Committee on Finance and one member from the Senate Committee on Education and Health.

The joint subcommittee shall submit any recommendations it deems appropriate to the 1984 Session of the General Assembly.

The cost of this study shall not exceed $4,500.

HOUSE JOINT RESOLUTION NO. 52

Continuing the Joint Subcommittee Monitoring Long-Term Care.

Agreed to by the House of Delegates, March 8, 1984
Agreed to by the Senate, March 6, 1984

WHEREAS, House Joint Resolution No. 37, agreed to by the 1983 Session of the General Assembly of Virginia, established the Joint Subcommittee to Monitor Long-Term Care; and

WHEREAS, the joint subcommittee met during 1983 with representatives of the Department of Health, the Department of Social Services, the Department for the Aging, the Department of Mental Health and Mental Retardation and other agencies and associations involved in providing long-term care services; and

WHEREAS, these meetings have helped to provide a forum for discussion and to facilitate the exchange of information regarding problems and concerns of providing long-term care services to the physically and mentally handicapped and the frail elderly; and

WHEREAS, the joint subcommittee has determined that further discussion and attention is needed in the area of long-term care services, especially life-care services for the elderly; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the joint subcommittee, consisting of members from the House Committee on Appropriations, the House Committee on Health, Welfare and Institutions, the Senate Committee on Finance and the Senate Committee on Education and Health, established to monitor long-term care is hereby continued for two years. The membership of the joint subcommittee shall continue to serve. Any vacancies in the membership shall be filled in the manner of the original appointments.

In addition to other matters, the joint subcommittee shall (i) review and evaluate with the Department of Mental Health and Mental Retardation the policy of releasing geriatric, mental and mentally retarded patients into communities and assess the abilities of communities to provide, pay for, and maintain those patients; (ii) consider, with the cooperation of the State Health Department and providers of nursing home care in the Commonwealth, alternative reimbursement plans for nursing homes patients which pay the provider of services according to the amount of care required; and (iii) determine, with the assistance of the Department on Aging, the cost effectiveness of maintaining the frail and impaired elderly in community settings, documenting both public costs for support of these individuals as well as all private costs associated with maintaining them in their home communities.

The joint subcommittee shall submit any recommendations it deems appropriate to the 1985 and 1986 Sessions of the General Assembly.

All direct and indirect costs of this study for the two-year period are estimated to be $36,940.

APPENDIX C

SENATE BILL NO. .... HOUSE BILL NO. ....

A BILL to amend and reenact § 32.1-102.3 of the Code of Virginia and to amend the Code of Virginia by adding in Title 38.1 a chapter numbered 31, consisting of sections numbered 38.1-955 through 38.1-971, relating to continuing care provider registration and disclosure; penalty.

Be it enacted by the General Assembly of Virginia:

1. That § 32.1-102.3 of the Code of Virginia is amended and reenacted and that the Code of Virginia is amended by adding in Title 38.1 a chapter numbered 31, consisting of sections numbered 38.1-955 through 38.1-971, as follows:

§ 32.1-102.3. Certificate required; criteria for determining need.–A. No person shall commence any project without first obtaining a certificate issued by the Commissioner. No certificate may be issued unless the Commissioner has determined that a public need for the project has been demonstrated. If it is determined that a public need exists for only a portion of a project, a certificate may be issued for that portion and any appeal may be limited to the part of the decision with which the appellant disagrees without affecting the remainder of the decision. Any decision to issue or approve the issuance of a certificate shall be consistent with the most recent applicable provisions of the State Health Plan and the State Medical Facilities Plan; provided, however, if the Commissioner finds, upon presentation of appropriate evidence, that the provisions of either such plan are inaccurate, outdated, inadequate or otherwise inapplicable, the Commissioner, consistent with such finding, may issue or approve the issuance of a certificate and shall initiate procedures to make appropriate amendments to such plan.

B. In determining whether a public need for a project has been demonstrated, the Commissioner shall consider:

1. The recommendation and the reasons therefor of the appropriate health systems agency.

2. The relationship of the project to the applicable health plans of the Board, the health system agency, and the Statewide Health Coordinating Council.

3. The relationship of the project to the long-range development plan, if any, of the person applying for a certificate.

4. The need that the population served or to be served by the project has for the project.

5. The extent to which the project will be accessible to all residents of the area proposed to be served.

6. The area, population, topography, highway facilities and availability of the services to be provided by the project in the particular part of the health service area in which the project is proposed.

7. Less costly or more effective alternate methods of reasonably meeting identified health service needs.

8. The immediate and long-term financial feasibility of the project.

9. The relationship of the project to the existing health care system of the area in which the project is proposed.

10. The availability of resources for the project.

11. The organizational relationship of the project to necessary ancillary and support services.

12. The relationship of the project to the clinical needs of health professional training

programs in the area in which the project is proposed.

13. The special needs and circumstances of an applicant for a certificate, such as a medical school, hospital, multidisciplinary clinic, specialty center or regional health service provider, if a substantial portion of the applicant's services or resources or both is provided to individuals not residing in the health service area in which the project is to be located.

14. The special needs and circumstances of health maintenance organizations. When considering the special needs and circumstances of health maintenance organizations, the Commissioner may grant a certificate for a project if the Commissioner finds that the project is needed by the enrolled or reasonably anticipated new members of the health maintenance organization or the beds or services to be provided are not available from providers which are not health maintenance organizations or from other health maintenance organizations in a reasonable and cost effective manner.

15. The special needs and circumstances for biomedical and behavioral research projects which are designed to meet a national need and for which local conditions offer special advantages.

16. In the case of a construction project, the costs and benefits of the proposed construction.

17. The probable impact of the project on the costs of and charges for providing health services by the applicant for a certificate and on the costs and charges to the public for providing health services by other persons in the area.

18. Improvements or innovations in the financing and delivery of health services which foster competition and serve to promote quality assurance and cost effectiveness.

19. In the case of health services or facilities proposed to be provided, the efficiency and appropriateness of the use of existing services and facilities in the area similar to those proposed.

20. The need and the availability in the health service area for osteopathic and allopathic services and facilities and the impact on existing and proposed institutional training programs for doctors of osteopathy and medicine at the student, internship, and residency training levels.

21. The special needs and circumstances of any continuing care facility as defined in § 38.1-955 of this Code proposing to provide nursing services under the terms of its contract with its residents in a nursing facility to be located on the same site as the continuing care facility. When considering the special needs and circumstances of a continuing care facility proposing to provide nursing services, the Commissioner may grant a certificate of public need for the project if the Commissioner finds, upon presentation of appropriate evidence, that:

a. The continuing care facility has been registered with the State Corporation Commission pursuant to Title 38.1, Chapter 31, of this Code;

b. The number of nursing beds proposed to be licensed will not exceed a ratio of one nursing bed for every five occupied residential units in the continuing care facility; and

c. Within five years of first operation of the continuing care facility, at least seventy percent of the beds in the nursing unit will be occupied by residents of the continuing care facility, as defined by § 38.1-955 of this Code.

Any application by a continuing care facility for nursing home beds in excess of those allowed by subparagraph b above shall meet the same criteria as an application for beds in a free-standing nursing home.

CHAPTER 31.

CONTINUING CARE PROVIDER REGISTRATION AND DISCLOSURE.

§ 38.1-955. Definitions.–As used in this chapter:

"Continuing care" means providing or committing to provide board, lodging and nursing services to an individual, other than an individual related by blood or marriage, (i) pursuant to an agreement effective for the life of the individual or for a period in excess of one year, including mutually terminable contracts, and (ii) in consideration of the payment of an entrance fee or periodic charges. A contract shall be deemed to be one offering nursing services, irrespective of whether such services are provided under such contract, if nursing services are offered to the resident entering such contract either at the facility in question or pursuant to arrangements specifically offered to residents of the facility.

"Entrance fee" means an initial or deferred transfer to a provider of a sum of money or other property made or promised to be made in advance or at some future time as full or partial consideration for acceptance of a specified individual as a resident in a facility. A fee which is less than the sum of the regular periodic charges for one year of residency shall not be considered to be an entrance fee.

"Facility" means the place or places in which a person undertakes to provide continuing care to an individual.

"Provider" means any person, corporation, partnership or other entity that provides or offers to provide continuing care to any individual in an existing or proposed facility in this Commonwealth. Two or more related individuals, corporations, partnerships or other entities may be treated as a single provider if they cooperate in offering services to the residents of a facility.

"Resident" means an individual entitled to receive continuing care in a facility.

"Solicit" means all actions of a provider or his agent in seeking to have individuals enter into a continuing care agreement by any means such as, but not limited to, personal, telephone or mail communication or any other communication directed to and received by any individual, and any advertisements in any media distributed or communicated by any means to individuals.

§ 38.1-956. Registration.–A. Except as provided in § 38.1-967, no provider shall engage in the business of providing or offering to provide continuing care at a facility in this Commonwealth unless the provider has registered with the Commission with respect to such facility.

B. A registration statement shall be filed with the Commission by the provider on forms prescribed by the Commission and shall include:

1. All information required by the Commission pursuant to its enforcement of this chapter; and

2. The initial disclosure statement required by § 38.1-957.

C. Registration shall be deemed complete if the Commission has not notified the provider of incompleteness within ninety days of the filing.

§ 38.1-957. Disclosure statement.–A. The disclosure statement of each facility shall contain all of the following information unless such information is contained in the continuing care contract and a copy of that contract is attached to and made a part of the initial disclosure statement:

1. The name and business address of the provider and a statement of whether the provider is a partnership, foundation, association, corporation or other type of business or legal entity.

2. Full information regarding ownership of the property on which the facility is or will be operated and of the buildings in which it is or will be operated.

3. The names and business addresses of the officers, directors, trustees, managing or general partners, and any person having a ten percent or greater equity or beneficial interest in the

provider, and a description of such person's interest in or occupation with the provider.

4. For (i) the provider, (ii) any person named in response to paragraph 3 of this subsection or (iii) the proposed management, if the facility will be managed on a day-to-day basis by a person other than an individual directly employed by the provider:

a. A description of any business experience in the operation or management of similar facilities.

b. The name and address of any professional service, firm, association, foundation, trust, partnership or corporation or any other business or legal entity in which such person has, or which has in such person, a ten percent or greater interest and which it is presently intended will or may provide goods, leases or services to the provider of a value of $500 or more, within any year, including:

(1) A description of the goods, leases or services and the probable or anticipated cost thereof to the provider;

(2) The process by which the contract was awarded;

(3) Any additional offers that were received; and

(4) Any additional information requested by the Commission detailing how and why a contract was awarded.

c. A description of any matter in which such person:

(1) Has been convicted of a felony or pleaded nolo contendere to a felony charge, or been held liable or enjoined in a civil action by final judgment if the felony or civil action involved fraud, embezzlement, fraudulent conversion or misappropriation of property; or

(2) Is subject to an injunctive or restrictive order of a court of record, or within the past five years had any state or federal license or permit suspended or revoked as a result of an action brought by a governmental agency or department, arising out of or relating to business activity or health care, including without limitation actions affecting a license to operate a foster care facility, nursing home, retirement home, home for the aged or facility registered under this chapter or similar laws in another state; or

(3) Is currently the subject of any state or federal prosecution, or administrative investigation involving allegations of fraud, embezzlement, fraudulent conversion, or misappropriation of property.

5. A statement as to:

a. Whether the provider is or ever has been affiliated with a religious, charitable or other nonprofit organization, the nature of any such affiliation, and the extent to which the affiliate organization is or will be responsible for the financial and contractual obligations of the provider.

b. Any provision of the Federal Internal Revenue Code under which the provider is exempt from the payment of income tax.

6. The location and description of the real property of the facility, existing or proposed, and to the extent proposed, the estimated completion date or dates of improvements, whether or not construction has begun and the contingencies under which construction may be deferred.

7. The services provided or proposed to be provided under continuing care contracts, including the extent to which medical care is furnished or is available pursuant to any arrangement. The disclosure statement shall clearly state which services are included in basic continuing care contracts and which services are made available by the provider at extra charge.

8. A description of all fees required of residents, including any entrance fee and periodic charges. The description shall include (i) a description of all proposed uses of any funds or property required to be transferred to the provider or any other person prior to the resident's occupancy of the facility and of any entrance fee, (ii) whether provisions exist for the escrowing and return of any such funds, property or entrance fee and the manner and any conditions of return, and (iii) the manner by which the provider may adjust periodic charges or other recurring fees and any limitations on such adjustments. If the facility is already in operation, or if the provider operates one or more similar facilities within this Commonwealth, there shall be included tables showing the frequency and average dollar amount of each increase in periodic rates at each facility for the previous five years or such shorter period that the facility has been operated by the provider.

9. Any provisions that have been made or will be made to provide reserve funding or security to enable the provider to fully perform its obligations under continuing care contracts, including the establishment of escrow accounts, trusts or reserve funds, together with the manner in which such funds will be invested and the names and experience of persons who will make the investment decisions.

10. Certified financial statements of the provider, including (i) a balance sheet as of the end of the two most recent fiscal years and (ii) income statements of the provider for the two most recent fiscal years or such shorter period that the provider has been in existence.

11. A pro forma income statement for the current fiscal year.

12. If operation of the facility has not yet commenced, a statement of the anticipated source and application of the funds used or to be used in the purchase or construction of the facility, including:

a. An estimate of the cost of purchasing or constructing and equipping the facility including such related costs as financing expense, legal expense, land costs, occupancy development costs, and all other similar costs that the provider expects to incur or become obligated for prior to the commencement of operations.

b. A description of any mortgage loan or other long-term financing intended to be used for any purpose in the financing of the facility and of the anticipated terms and costs of such financing, including without limitation, all payments of the proceeds of such financing to the provider, management or any related person.

c. An estimate of the percentage of entrance fees that will be used or pledged for the construction or purchase of the facility, as security for long-term financing or for any other use in connection with the commencement of operation at the facility.

d. An estimate of the total entrance fees to be received from or on behalf of residents at or prior to commencement of operation of the facility.

e. An estimate of the funds, if any, which are anticipated to be necessary to fund start-up losses and provide reserve funds to assure full performance of the obligations of the provider under continuing care contracts.

f. A projection of estimated income from fees and charges other than entrance fees, showing individual rates presently anticipated to be charged and including a description of the assumptions used for calculating the estimated occupancy rate of the facility and the effect on the income of the facility of any government subsidies for health care services to be provided pursuant to the continuing care contracts.

g. A projection of estimated operating expenses of the facility, including (i) a description of the assumptions used in calculating any expenses and separate allowances for the replacement of equipment and furnishings and anticipated major structural repairs or additions and (ii) an estimate of the percentage of occupancy required for continued operation of the facility.

h. Identification of any assets pledged as collateral for any purpose.

i. An estimate of annual payments of principal and interest required by any mortgage loan or other long-term financing.

13. A description of the provider's criteria for admission of new residents.

14. A description of the provider's policies regarding access to the facility and its services for nonresidents.

15. Any other material information concerning the facility or the provider that may be required by the Commission or included by the provider.

B. The disclosure statement shall state on its cover that the filing of the disclosure statement with the Commission does not constitute approval, recommendation or endorsement of the facility by the Commission.

C. A copy of the standard form or forms for continuing care contracts used by the provider shall be attached as an exhibit to each disclosure statement.

D. If the Commission determines that the disclosure statement does not comply with the provisions of this chapter, it shall have the right to take action pursuant to § 38.1-970.

§ 38.1-958. Availability of disclosure statement to prospective residents.–At least three days prior to the execution of a continuing care contract or the transfer of any money or other property to a provider by or on behalf of a prospective resident, whichever first occurs, the provider shall deliver to the person with whom the contract is to be entered into a copy of a disclosure statement with respect to the facility in question meeting all requirements of this chapter as of the date of its delivery.

§ 38.1-959. Annual disclosure statements.–A. Within four months following the end of the provider's fiscal year, each provider shall file with the Commission and make available by written notice to each resident at no cost an annual disclosure statement which shall contain the information required for the initial disclosure statement set forth in § 38.1-957.

B. The annual disclosure statement shall also be accompanied by a narrative describing any material differences between:

1. The prior fiscal year's pro forma income statement, and

2. The actual results of operations during that fiscal year.

C. The annual disclosure statement shall describe the disposition of any real property acquired by the provider from residents of the facility.

D. In addition to filing the annual disclosure statement, the provider shall amend its currently filed disclosure statement at any other time if, in the opinion of the provider, an amendment is necessary to prevent the disclosure statement from containing any material misstatement of fact or failing to state any material fact required to be stated therein. Any such amendment or amended disclosure statement shall be filed with the Commission before it is delivered to any resident or prospective resident and is subject to all the requirements of this chapter and the provider shall notify each resident of the existence of such amendment or amended disclosure statement.

E. If the Commission determines that the disclosure statement does not comply with the provisions of this chapter, it shall have the right to take action pursuant to § 38.1-970.

§ 38.1-960. Resident's contract.–A. In addition to other provisions considered proper to effect the purpose of any continuing care contract, each contract executed on or after the effective date of this chapter shall:

1. Provide for the continuing care of only one resident, or for two or more persons occupying space designed for multiple occupancy, under appropriate regulations established by the provider.

2. Show the value of all property transferred, including donations, subscriptions, fees and any other amounts paid or payable by, or on behalf of, the resident or residents.

3. Specify all services which are to be provided by the provider to each resident including, in detail, all items that each resident will receive and whether the items will be provided for a designated time period or for life and the estimated current monthly cost to the provider for providing the care. Such items may include, but are not limited to, food, shelter, nursing care, drugs, burial and incidentals.

4. Describe the physical and mental health and financial conditions upon which the provider may require the resident to relinquish his space in the designated facility.

5. Describe the physical and mental health and financial conditions required for a person to continue as a resident.

6. Describe the circumstances under which the resident will be permitted to remain in the facility in the event of financial difficulties of the resident.

7. State (i) the current fees that would be charged if the resident marries while at the designated facility, (ii) the terms concerning the entry of a spouse to the facility and (iii) the consequences if the spouse does not meet the requirements for entry.

8. Provide that the provider shall not cancel any continuing care contract with any resident without good cause. Good cause shall be limited to: (i) proof that the resident is a danger to himself or others; (ii) nonpayment by the resident of a monthly or periodic fee; (iii) repeated conduct by the resident that interferes with other residents' quiet enjoyment of the facility; or (iv) persistent refusal to comply with reasonable written rules and regulations of the facility. If a provider seeks to cancel a contract and terminate a resident's occupancy, the provider shall give the resident written notice of, and a reasonable opportunity to cure within a reasonable period, whatever conduct is alleged to warrant the cancellation of the agreement. Nothing herein shall operate to relieve the provider from duties under § 55-248.1 when seeking to terminate a resident's occupancy.

9. Provide in clear and understandable language, in print no smaller than the largest type used in the body of the contract, the terms governing the refund of any portion of the entrance fee and the terms under which such fees can be used by the provider.

10. State the terms under which a contract is cancelled by the death of the resident. The contract may contain a provision to the effect that, upon the death of the resident, the money paid for the continuing care of such resident shall be considered earned and become the property of the provider.

11. Provide for at least thirty days' advance notice to the resident, before any change in fees, charges or the scope of care or services may be effective, except for changes required by state or federal assistance programs.

12. Provide that charges for care paid in one lump sum shall not be increased or changed during the duration of the agreed upon care, except for changes required by state or federal assistance programs.

B. A resident shall have the right to rescind a continuing care contract, without penalty or forfeiture, within seven days after making an initial deposit or executing the contract. A resident shall not be required to move into the facility designated in the contract before the expiration of the seven-day period.

C. If a resident dies before occupying the facility, or is precluded through illness, injury or incapacity from becoming a resident under the terms of the continuing care contract, the contract is automatically rescinded and the resident or his legal representative shall receive a full refund of all money paid to the provider, except those costs specifically incurred by the provider at the request of the resident and set forth in writing in a separate addendum, signed by both parties to the contract.

D. No standard continuing care contract form shall be used in this Commonwealth until it has been submitted to the Commission. If the Commission determines that the contract does not comply with the provisions of this chapter, it shall have the right to take action pursuant to § 38.1-970 to prevent its use. The failure of the Commission to object to or disapprove of any contract shall not be evidence that the contract does or does not comply with the provisions of this chapter. However, individualized amendments to any standard form need not be filed with the Commission.

§ 38.1-961. Sale or transfer of ownership or change in management.–A. No provider and no person or entity owning a provider shall sell or transfer, directly or indirectly, more than fifty percent of the ownership of the provider or of a continuing care facility without giving the Commission written notice of the intended sale or transfer at least thirty days prior to the consummation of the sale or transfer. A series of sales or transfers to one person or entity, or one or more entities controlled by one person or entity, consummated within six-month period that constitute, in the aggregate, a sale or transfer of more than fifty percent of the ownership of a provider or of a continuing care facility shall be subject to the foregoing notice provisions.

B. A provider or continuing care facility that shall change its chief executive officer, or its management firm if managed under a contract with a third party, shall promptly notify the Commission and the residents of each such change.

§ 38.1-962. Financial instability.–A. The Commission may act as authorized by § 38.1-970 to protect residents or prospective residents when the Commission determines that:

1. A provider has been or will be unable, in such a manner as may endanger the ability of the provider to fully perform its obligations pursuant to its continuing care contracts, to meet the pro forma income or cash flow projections previously filed by the provider; or

2. A provider is bankrupt, insolvent, under reorganization pursuant to federal bankruptcy laws or in imminent danger of becoming bankrupt or insolvent.

§ 38.1-963. Waivers.–No act, agreement or statement of any resident or by an individual purchasing care for a resident under any agreement to furnish care to the resident shall constitute a valid waiver of any provision of this chapter intended for the benefit or protection of the resident or the individual purchasing care for the resident.

§ 38.1-964. Untrue, deceptive or misleading advertising.–The provisions of § 18.2-261 shall apply to all providers.

§ 38.1-965. Right of organization.–A. Residents shall have the right of self-organization. No retaliatory conduct shall be permitted against any resident for membership or participation in a residents' organization. The provider shall be required to provide to the organization a copy of all submissions to the Commission.

B. The board of directors, its designated representative or other such governing body of a continuing care facility shall hold meetings at least quarterly with the residents or representatives elected by the residents of the continuing care facility for the purpose of free discussion of issues relating to the facility. These issues may include income, expenditures and financial matters as they apply to the facility and proposed changes in policies, programs, facilities and services. Residents shall be entitled to seven days' notice of each meeting.

§ 38.1-966. Civil liability.–A. A person contracting with a provider for continuing care may terminate the continuing care contract and such provider shall be liable to the person contracting for continuing care for repayment of all fees paid to the provider, facility or person violating this chapter, together with interest thereon at the legal rate for judgments, court costs and reasonable attorney's fees, less the reasonable value of care and lodging provided to the resident prior to the termination of the contract and for damages if after the effective date of this chapter such provider or a person acting on his behalf, with or without actual knowledge of the violation, entered into a contract with such person:

1. For continuing care at a facility which has not registered under this chapter;

2. Without having first provided to such person a disclosure statement meeting the requirements of this chapter and not omitting a material fact required to be stated therein or necessary in order to make the statements made therein not misleading, in light of the circumstances under which they are made; or

3. If such contract does not meet the requirements of § 38.1-960.

B. A person who wilfully or recklessly aids or abets a provider in the commission of any act prohibited by this section shall be liable as set out in subsection A of this section.

C. The Commission shall have no jurisdiction to adjudicate controversies concerning continuing care contracts. A breach of contract shall not be deemed a violation of this chapter. Termination of a contract pursuant to subsection A of this section shall not preclude the resident's seeking any other remedies available under any law.

§ 38.1-967. Special provisions for existing providers; rights of residents with certain existing providers.–A. Providers existing prior to the effective date of this chapter shall comply with its provisions within six months of its effective date. However, the Commission may extend the period within which an existing facility shall comply with this chapter for an additional six months with good cause shown.

B. Continuing care contracts entered into prior to the effective date of this chapter or prior to registration of the provider shall be valid and binding upon both parties in accordance with their terms.

§ 38.1-968. Regulations.–A. The Commission shall have the authority to adopt, amend or repeal rules and regulations that are reasonably necessary for the enforcement of the provisions of this chapter. Any initial rules and regulations necessary to the implementation of this chapter may be promulgated prior to the effective date of this chapter. The Commission may issue regulations setting forth those transactions which shall require the payment of fees by a provider and the fees which shall be charged.

B. Any provider may be given a reasonable time, not to exceed 120 days from the date of publication of any applicable rules and regulations or amendments thereto adopted pursuant to this chapter, within which to comply with the rules and standards.

§ 38.1-969. Investigations and subpoenas.–A. The Commission may make public or private investigations within or outside of this Commonwealth it deems necessary to determine whether any person has violated any provision of this chapter or any rule, regulation or order promulgated by the Commission.

B. For the purpose of any investigation or proceeding under this chapter, the Commission or any officer designated by it may administer oaths and affirmations, subpoena witnesses, compel their attendance, take evidence and require the production of any books, papers, correspondence, memoranda, agreements or other documents or records which the Commission deems relevant or material to the inquiry.

§ 38.1-970. Cease and desist orders; injunctions.–Whenever it appears to the Commission that any person has engaged in, or is about to engage in, any act or practice constituting a violation of this chapter or any rule, regulation or order issued under this chapter, the Commission may:

1. Issue an order directed at any such person requiring him to cease and desist from engaging in such act or practice.

2. Upon a proper showing, issue a permanent or temporary injunction, or a restraining order to enforce compliance with this chapter or any rule, regulation or order issued under this chapter.

§ 38.1-971. Penalties.–A. Any person who willfully and knowingly violates any provision of this chapter, or any rule, regulation or order issued under this chapter, shall be subject to payment of a fine as provided in § 38.1-40.

B. Nothing in this chapter limits the power of the Commonwealth to punish any person for any conduct which constitutes a crime under any other statute.

VIRGINIA:
A SUGGESTED APPROACH TO
LONG-TERM CARE
MEDICAID REIMBURSEMENT

by

The Formula Committee

of the

Task Force on Nursing Home Reimbursement

Deane 12/84

**VIRGINIA: A SUGGESTED APPROACH TO
LONG-TERM CARE MEDICAID REIMBURSEMENT**

The Formula Committee of the Task Force on Nursing Home Reimbursement believes that the State of Virginia must implement a reimbursement system which adequately address a number of concerns:

- Nursing homes are only one part of a continuum of care so that the proper placement of patients in nursing homes is critical. Light care patients that don't need nursing home care should not be in nursing homes and heavy care patients that can be cared for in nursing homes should not be placed in hospitals. Proper placement will require adequate pre-admission screening and a reimbursement system that properly discriminate between heavy care and light care patients.

- If the continuum of care is to be a reality, nursing homes must be prepared to deal with the increasing debility level of hospital discharges anticipated as a result of the new DRG hospital reimbursement system.

- To ensure that resources are available to provide quality care for all patients, the reimbursement system should recognize the added needs of heavy care patients.

- In order to properly differentiate among patients by level of resource needs, patients must be assessed properly (i.e., their needs must be measured accurately) and the patient assessment tool must be simple and not administratively burdensome.

- The reimbursement system must be able to improve the access to nursing homes of Medicaid patients in general, and heavy care Medicaid patients in particular, with adequate recognition of those patients with special needs (e.g., tube feeding, IV care, decubitus ulcers, suctioning).

- Facilities should be required to meet minimum staffing levels that are explicit, sensitive to the patient mix being served, and reasonable relative to current nursing practices so that quality care can be assured.

- Reimbursement levels should recognize patient-mix changes as quickly as possible so as to encourage the admission of a reasonable mix of heavy care patients.

- Property costs should be adequately reimbursed according to economic concepts of cost rather than accounting concepts of cost in order to ensure that facilities are well-maintained and that adequate capital formation is available to meet future needs.

- The level of property cost reimbursement should be neutral with respect to changes in property ownership.

- Property cost reimbursement should recognize the tax status of the facility only to the extent of equalizing after-tax returns to investment.

- Property cost reimbursement should reward commitments of owners to

the industry by having the property cost reimbursement recognize equity investments.

- Costs should be indexed from the mid-point of the cost report to the mid-point of the rate year, and each cost component (i.e., each cost report line item) should have the index most applicable to those costs applied to it rather than applying an overall CPI to the aggregate of all costs.

- The reimbursement system should not pay more than required of an efficient and economically operated facility and should stimulate efficiencies and achieve budgetary cost containment through the use of meaningful incentives.

With these goals in mind, the Formula Committee has produced a general framework for a Medicaid reimbursement system for the State of Virginia that it hopes will be subjected to indepth analysis and study using detailed data from Virginia providers, and then modified as necessary. The system is prospective and contains a total of four (4) cost centers: three (3) operating cost centers and a property cost center. Multiple cost centers are proposed so that different objectives can be emphasized in each. Consequently, this framework is presented as a total package, each of the component parts of which are complimentary and mutually supporting. Therefore, the component parts should not be evaluated separate from the whole, and modification of any of the component parts should be considered with caution.

ADMINISTRATIVE AND ROUTINE COSTS

This first cost center is designed to achieve cost containment through the payment of meaningful incentive payments. Accordingly, the costs in this cost center should represent resources that are the least directly connected with the provision of patient care. Such costs would include: administrative, medical records, training, dietary (exclusive of raw food), laundry, housekeeping, operation and maintenance, and capitalized organization and start-up costs. These costs typically represent 40 percent of all costs and about 45 percent of all operating costs. Therefore, this cost center forms a considerable base for cost containment.

It is suggested that the present Virginia reimbursement approach be utilized in this cost center, but with some small, but important, modifications. Prospective rates should be set facility-by-facility, based on the indexed historical costs (indexed from the midpoint of the cost reporting year to the midpoint of the rate year) of each facility. The individual items comprising the components of the cost center should be separately indexed with their own indices, rather than indexing the cost center totals with a general CPI. Such a procedure will more nearly approximate the expected cost experience in the Virginia nursing home industry and, because the reported costs would serve as the weights for the indexes, this procedure would more accurately anticipate the future cost experience of each individual facility.

These facility-specific prospective rates should be limited or capped by the experience of the industry as a whole. Therefore, facility-specific prospective

rates should be limited by, say, 105 to 115 percent of the median of the expected per diem costs (as indexed) for the entire state or geographic region. Such a ceiling(s) would remain fairly stable and provide a continuing and meaningful incentive for high cost facilities to lower costs. The final percent of the median to be used in setting the ceiling can be (and should be) established by calibrating against historical ceilings or acceptable percentiles; but it is important to have future ceilings set using a percentage of the median so that all cost containment incentives will remain intact overtime.

In order for a long-run incentive to accrue to the most efficient facilities, each facility should be paid at least 40 percent, but probably not more than 50 percent, of the difference between its class ceiling and its individual prospective rate (if below the class ceiling). Without this long-run incentive payment, the benefits to the facility from generating efficiencies accrue only in the year the efficiencies are achieved. In these circumstance, the incentive for a facility to initiate efficiencies is seriously weakened, and the system ends up rewarding high cost facilities and penalizing efficient facilities, with no consequent benefit to the state. These payments, of course, should be limited to, say, 10 or 15 percent of the value of the ceiling so as to prevent draconian cost reductions that may impact on quality care.

The ceilings should recognize geographic differences if statistically warranted, but they should not recognize differences in facility size, facility ownership, or hospital affiliation. Further, there is little reason to impose an occupancy adjustment on the data prior to the calculation of facility rates and ceilings, because only a small proportion of the costs in this cost center can be considered

invariant (fixed) with respect to the percent of occupancy. (In other words, the per diem costs of this cost center will vary little as the occupancy increases.)

OTHER PATIENT CARE

This second cost center involves cost which are more directly related to patient care than those of the Administrative and Routine cost center. These costs substantially contribute to the quality of the care given and often vary from patient to patient. These costs include: medical director, physical therapy, pharmacy, oxygen, recreational activities, patient care consultant, occupational therapy, raw food, social services, and religious services.

These costs are listed separately from those of the previous cost center because cost containment is not to be stressed, trade-offs between these cost items and those in the previous cost centers are not to be encouraged, and, in the interest of stimulating and maintaining quality care, no pressure should be exerted to restrict the utilization of these services when needed. A further argument against lumping these costs together with other costs is that the utilization of these services varies substantially according to the patient mix of the facility and a fixed annual reimbursement rate cannot accommodate such service variation. Accordingly, the reimbursement mechanism should encourage service utilization when required by the patient without excessive incentives to cost contain, and should provide for short-term variations in utilization of these services due to variations in patient mix. In short, this cost center should encourage the prudent buying of necessary services as required by each patient, and yet be responsive to short-run patient mix changes.

The best prospective approach to reimbursement for this cost center is to use an approach similar to that suggested for the Administrative and Routine cost center. That is, prospective rates should be facility-specific and based on indexed reported costs, with the facility-specific prospective rates subject to a ceiling set at 115 percent to 120 percent of the median per diem costs for the state (or geographic region). Such a high ceiling is necessary to ensure that there are no barriers to providing these services which are necessary to quality care, but some meaningful ceiling is necessary to stimulate prudent buying.

Incentive payments are also necessary in this cost center to stimulate prudent buying and to provide long-run returns to those who undertake administrative expenditures, such as group purchasing, automated record keeping, etc., in order to reduce costs in this cost center. These long-run returns should be small, on the order of 25 percent of the difference between the prospective rate of the facility and the state (or geographic) ceiling if the prospective rate is beneath the ceiling. The total incentive payment should also be limited to not more than 10 percent of the ceiling.

Finally, some consideration should also be given to providing at least quarterly adjustments to the facility-specific rates (and to the incentives) for facilities that experience measurable changes in their patient mixes (as measured by the change in utilization of ancillaries). The mechanics of such an adjustment process will need to be worked out, but some adjustment based upon some threshold of change in patient-mix will be necessary to provide an

incentive for facilities to accept the heavier care patients. This adjustment should work in both directions so that no perverse incentive to admit a reduced debility level of patients is present.

As with Administrative and Routine Costs, geographic difference should be recognized, but facility-based characteristics such as size, ownership, or hospital affiliation should not. Also there is little rationale for the imposition of an occupancy adjustment in this cost center.

NURSING SERVICE COSTS

This cost center covers all nursing service costs plus nursing supplies, and accounts for more than 40 percent of all costs in a typical facility. In order to meet the quality and access goals described above, it is proposed that the Maryland system of nursing service reimbursement be adapted to the State of Virginia. While some interesting prototypes are available in other states, the Maryland patient assessment process and payment mechanism are simpler. In addition, the incentive structure is stronger in Maryland because it sets patient-specific rates and service utilization rates prospectively. Thus, facilities get immediate payment adjustments as they change their patient mixes, rather than having to wait up to 18 months for final cost settlement. As evidence that the inducement to take heavy care patients works, the substantial backup of heavy care Medicaid patients in Maryland hospitals was eliminated within three months of the system's implementation.

In the proposed approach, the patient-specific prospective rates are based

on the prevailing-wages and fringe benefits in each geographic region, knowledge of the amount of nursing staff time required to care for each need level of patient and service type, and cost data on nursing supplies. The system uses three classes of patients based on the number of Activities of Daily Living (ADL) dependencies (Light Care = 0 to 2 dependencies, Moderate Care = 3 or 4 dependencies, and Heavy Care = dependencies in all 5 ADLs) and 10 additional services. The payments for each of the services are additive to the three base rates as they are utilized.

The provider needs only to invoice for each patient each month by recording the prevailing patient condition (class) for the month and the number of days each of the services that were utilized. These invoices are later verified through periodic, retrospective paper assessments conducted by a Utilization Control Agent. Such verification assessments need be conducted only 2 to 4 times a year and need target only a sample of patients in a sample of facilities (Maryland verifies all patients in all facilities by choice). The threat of verification, backed by strong sanctions for systematic erroneous patient assessment, is all that is needed to prevent patient assessment "creep".

If the present care being provided in Virginia is considered adequate, then it is quite easy, and appropriate, to maintain budget neutrality in this cost center in a static sense. This is accomplished by calibrating the criterion for the selection of the "prevailing" wage on the current nursing services budget. The object is to take the current nursing service budget and reallocate it among facilities according to the needs of their patients. If all facilities maintained static patient mixes, there would likely be a considerable reallocation of existing

reimbursements. But, as facilities begin to compete for the admission of heavy care patients, and the variation in patient mixes among facilities should narrow considerably. This behavioral response will significantly reduce the actual reallocation of existing reimbursements among facilities.

Finally, since reimbursements in this cost center will be based on patient needs, there is little rationale for retaining ICF and SNF facility certifications. All facilities could be certified as Medicaid SNF/ICF (Maryland calls them "Comprehensive Care"). The certification level of the patient would still be retained because it is necessary for federal reporting purposes, but not for reimbursement.

Clearly, the above description provides only the barest outline of the rationale for, and mechanics of, the types of prospective, patient-based nursing service reimbursement system proposed by the Formula Committee for Virginia. Therefore, as an attachment to this proposal, a more complete description of the Maryland plan (with emphasis on the Nursing Service cost center) is provided. A word of caution is in order, however. Virginia needs a system that is tailored to Virginia's needs and this may not be identical with a system tailored to the needs of Maryland. Obviously, Virginia wage, fringe benefit, and nursing supply cost data should be used to set the Virginia rates, existing Virginia budgeting levels must be taken into consideration in calibrating the "prevailing" wage criterion, the unique characteristics and needs of Virginia patients (e.g., behavior problems, mental health problems, respirator dependent patients) must be incorporated into the system, the nursing practices of Virginia should be used to establish the nursing staff times, Virginia will probably need its own invoicing procedures and forms, and Virginia will most likely want to use a

different approach to provide the threat of verification. Nevertheless, a more complete description of the Maryland system will help focus on what system elements are transferable and which elements must be tailored to the Virginia experience.

PROPERTY COSTS

The key to paying for property costs is to provide a return to both for-profit and non-profit organizations sufficient to compete in the capital markets. It is only in this way that a sufficient supply of well-maintained beds can be assured. Therefore, a system should be selected which avoids the potentially onerous implications of the capital asset freeze imposed by the Deficit Reduction Act of 1984.

It is possible that a flat rate property cost reimbursement system (e.g., North Carolina) would allow the state to provide assurances of compliance with the law, but, frankly, such a flat rate system is likely to overly discourage new construction in times of acute need. Therefore, it is suggested that a Fair Value Rental system be considered. Such a rental system will likely create some upward pressure on the budget in the short-run, but it is anticipated that this will largely be offset by the cost containment in the Administrative and Routine cost center. This is a further reason for considering the entire proposed system as a package and for not adopting only selected parts.

There are two basic components to a Fair Value Rental system: (1) the establishment of the value of the assets of the facility, and (2) a mechanism to generate a rental from the value of the asset previously established.

Asset Value Options

Acceptable options for establishing the value of patient-related building and fixed assets are:

- o indexing the historical book value or initial acquisition cost forward according to some index like the Dodge Construction Index;

- o using the automated computer appraisal service such as that offered by E.H. Boeckh Company (Wisconsin is currently considering this option); or

- o using a "segregated cost" approach to determining reconstruction cost minus any physical deterioration and functional obsolescence as estimated through the "breakdown" method (used as the basic asset valuation approach by Maryland).

It is important to stress that each of these options are designed to minimize the degree of latitude that those administering the program have to influence or "adjust" the capital valuations. The indexing option is to be explicitly specified so that the capital value is locked in to the movement of the index. Further, the appraisal options listed above are based on methodologies that minimize appraiser subjectivity by applying specific indicies to the physical measurements of the facility. None of these methodologies for determining the value of building and fixed assets are subject to the criticisms of appraisals

based on market values and income capitalizations which involve a great deal of appraiser subjectivity.

The above option descriptions, of course, leave out a considerable amount of necessary detail. For example, the options described above refer only to building and fixed equipment, and not to land or moveable equipment. Land must either be valued at initial acquisition cost with appropriate indexing, or "highest and best use" market value with indexing between appraisals. Since moveable equipment as specific asset items are difficult and time consuming to either index or appraise, it is best to provide a per bed equipment allowance (as in Maryland) with annual indexing of the allowance. Such an equipment allowance should be established at (at least initially) about 10 percent of an overall per bed limit to be set for the total of land, building, and equipment. Such an overall limit is necessary and proper, providing it is sufficiently high to permit new construction as needed. This limit will have to be unique to Virginia and must be indexed forward annually. Another important detail is that, if the non-automated appraisal methodology is selected, the appraisals need not be conducted annually -- evèry three to four years is sufficient as long as capital indexing is undertaken in the intervening years.

Rental Mechanisms

Acceptable options for generating prospective payments from the value of the assets previously established are:

- to pay all facilities a rental on the gross allowable value of their

patient-related assets using a rental rate that is set at the beginning of the rate year based on the six month moving average of an index of long-term mortgage rates or long-term money yields, plus a small risk premium of 1 to 2 percentage points (this option will be referred to as the "floating rate" option because the uniform rental rate is reestablished for all facilities annually regardless of ownership changes); or

- to pay each facility a rental rate on the gross allowable value of its patient-related asset using a rental rate that is set at the time of a change of ownership based on the six to twelve month moving average of an index of long-term mortgage rates or long-term money yields, plus a small risk premium of 1 to 2 percentage points (this option will be referred to as the "fixed rate" option because the rental rate for each facility is established at the time of an ownership change and remains fixed until a subsequent ownership change).

Both of these options substitute a rental payment for all other property cost reimbursements: mortgage interest, property insurance, depreciation, return on equity, and property taxes. Since property taxes are completely outside of the control of existing facilities, it is possible that this cost could be reimbursed as a passthrough separate from the rental payment. The annual rental also needs to be converted to a per diem. It is best to undertake this calculation by incorporating an occupancy adjustment: divide the gross annual rental by, say, 95 percent of licensed annual bed capacity days so that a positive incentive is provided for high occupancy. New facilities of less than one year of age

should have capital payments during the first year of operation adjusted for the average occupancy actually experienced during the first year of operation.

Leases can be handled in a variety of ways. The easiest way is to treat a leased facility as if it were wholely-owned, so that a full rental is paid on the total value of the assets. This total rental then provides an upper limit to the reimbursement for lease costs and it behooves leasers to negotiate future lease within this constraint. Since only gross rentals are being proposed as capital reimbursement options, difficulties in transitioning from the current system to one of these options is minimized. Some consideration should be given to the difficulties that may be faced by those presently with long-term lease arrangements and new facilities with heavy debt financing. Such facilities should be examined on a case-by-case basis to see if some form of relief may be necessary. After all, these facilities entered into long-term financial arrangements in good faith under the old reimbursement rules. On the other hand, the facility-specific "fixed rate" option should not adversely impact enough providers sufficiently to warrant special treatment, and whatever adverse impacts are realized through the selection of the "floating rate" option should dissipate overtime as leases come up for renewal and as loans are amortized.

Both options incorporate very strong incentives to increased equity ownership because it is mainly through the establishment of equity ownership that the facility is able to generate revenues that are retained by the facility. The use of the moving average of an index also encourages equity investment because the lack of leverage is the best way the facility can hedge against future unanticipated fluctuations in interest rates under the "floating rate" system.

Equity investment also keeps open the option to refinance in the future under the "fixed rate" option when such refinancing will not qualify for a rental rate change (i.e., when the refinancing is at a higher interest rate).

Suitable indices for the establishment of the rental rate could be either the Federal Home Loan Mortgage rate plus a risk premium, the yield on a 20-year Treasury Bond plus a risk premium, or a number of other widely available bond yields plus a risk premium. The only other adjustment to these indices would be to accommodate non-profit entities. Since these facilities do not incur a tax liability on profits and since it is equitable to try to equalize after-tax returns between for-profit and non-profit entities, the rental for non-profit facilities should be approximately one percentage point below that established for for-profit facilities. One way of handling this is to allow the addition of the risk premium for for-profit facilities only.

The calculation for deterring the per diem rental for a for-profit, 100 bed facility assuming a moving average index of 12 percent, a risk premium of 1.5 percent, an occupancy adjustment of 95 percent, and a movable equipment allowance of $2,500 per bed is as follows:

GROSS RENTAL SYSTEM EXAMPLE FOR 100 BED FACILITY

Land	$ 200,000
Building	1,050,000
Equipment ($2,500 x 100)	250,000
Total Allowable Asset Value	$1,500,000

Annual rental @ 13.5% = $202,500
Per diem rental @ 36500 x .95 days = $5.84

Either of these system options can be modified, or otherwise altered (improved) to fit the needs of Virginia. Care must be taken, however, to ensure that the final capital system produces capital reimbursements that permit the nursing home industry to compete with other industries for capital, maintain patient access to care, and moderate trends toward industry concentration. Both of the proposed options avoid the capital freeze provision of the Deficit Reduction Act of 1984, since no change in asset valuation is ever the sole result of a change of ownership. However, the "fixed rate" option involves a change in the rental rate as a result of a change in ownership and may become subject to the restrictions of the Deficit Reduction Act of 1984 (DRA84) under future interpretations of the statute by the Health Care Financing Administration (HCFA). This would have to be a very strict interpretation of the statute and would be applicable only under conditions of rising interest rates. On the other hand, the test of compliance with Section 2314 of DRA84 is supposed to be an aggregate test and not an individual facility test. Therefore, in the long run, interest rates will both rise and fall so that the "fixed rate" approach should involve just as many rental rate decreases as rental rate increases. Under these circumstances, the state could give reasonable assurances to HCFA that the "fixed rate" approach is no more likely to increase rental rates as it is to lower rental rates so that, in the long run, this option on balance would neither raise nor lower reimbursement rates as a result of ownership changes.

FISCAL IMPACT

Inherent in the design of the system is budget neutrality in the Nursing Service cost center. Further, the budget impact in the Other Patient Care cost

center is negligible because of the small size of this cost center. Therefore, the budget impact of the entire system will depend on the relative magnitudes of the cost containment in the Administrative and Routine cost center and the increased reimbursements in the Property cost center. Data are not yet available to provide a firm estimate of this net impact, but present conditions in Virginia combined with past experiences in other states will permit some tentative conclusions.

Cost containment can be expected from the Administrative and Routine cost center in Virginia. This cost center provides a very large base of costs upon which to operate, and the incentive structure as proposed will provide extremely strong incentives to eliminate operating inefficiencies and reduce costs to a minimum consistent with quality care. The elimination of inefficiencies will require up to four years to fully accomplish, but the savings (net of inflation) can be expected to be on the order of $1.50 per patient day by that time.

In most states the imposition of a fair value rental system will increase reimbursements in the short-run. The size of the increase depends upon the average age of the facilities currently in the industry, the typical debt position of those facilities, and the relative characteristics of the existing system and the rental system. The older the existing facilities and the less debt they have, the lower will be current property costs and the larger the expected increase in reimbursement due to the implementation of a fair value rental system. The Virginia long-term care industry has few older facilities (or at least few facilities that have been under the same ownership for prolonged periods) and most facilities are highly levered in terms of their debt/equity ratios. This

is evident from the average property costs in Virginia being in the area of $7.50 per patient day. Under these circumstances, one can expect that the reimbursement increase due to the implementation of a fair value rental system will be very small. (For example, the currently used rental system in Maryland produces reimbursements on average of <u>under</u> $7.00 per patient day.) Using the average property cost figure of $7.50 per patient and assuming a gross rental rate of 13.5 percent one can calculate that the average state-wide asset valuation could be as high as $20,278 per bed before reimbursements would exceed current levels in property costs. On balance, then, one can anticipate that the cost containment of the Administrative and Routine cost center will easily compensate for any reimbursement increase in the Property cost center.

Should this not be the case, or should this not be the case until the full cost containment impact is realized, it is possible to attenuate the reimbursement increase by phasing-in or staging the introduction of the reimbursement system. One approach would be to stage the introduction of the rental system to match the gradual phase-in of the cost containment. This can be done by (1) allowing asset values to incrementally reach their full values over a period of 2 to 4 years, (2) having the rental rate approach its true index value over a period of 2 to 4 years, or (3) some combination of the first two options. In other words, the first year could use, say, 85 percent of asset value, for reimbursement calculations, the second year 90 percent, etc., so that by year 4 (and thereafter), 100 percent of asset value is used. By the same token, the rental rate could be increased by .5 or .25 percentage points each year over a period of 4 years until the full index value is attained.

Another alternative would be to introduce the Administrative and Routine part of the system prior to the introduction of the rental system so that the cost containment aspects of the former would coincide with the budget impact of the latter. The Other Patient Care cost center should be introduced at the same time as the Nursing Service cost center. They could be introduced without regard to the staging of the other cost centers but only after appropriate set-up work has been completed. The decision as to whether such a phase-in approach is needed and, if so, which approach is to be used must await the release of more precise budget impact data once the parameters of the system have been set.

As a final note, it should be made very clear that this general framework is not yet operational. That is, the framework is as yet only a statement of reimbursement philosophy. It's description may appear to be detailed and specific, but this is not the case. Only the methodology has been specified. For example, it is recommended that ceilings be set at the median plus a percentage, but the precise percentage must yet be determined. The same can be said for the saving sharing rates, the prevailing wage percentile, the choice of cost indices, the need for separate regions, the base rental rate index, the rental rate risk premium, the non-profit rental rate discount, the property cost occupancy adjustment, etc. Until such specificity is provided in alternative combinations, budgetary impacts cannot be estimated and questions concerning the need for staging cannot be adequately addressed.

This specificity should be provided as part of a general research effort, using Virginia data, into each of the cost centers, but, most particularly,

the Nursing Service cost center where the measurement of patient needs and the assignment of reimbursement rates is critical. This research is highly advisable for generating the necessary parameter specificity if the goals and concerns of the system are to be met and if the system is to provide the stability that everyone seeks. Much of this research is quite straightforward and need take only a few months, other aspects of the research may take up to two years to complete if simulations are to be included to assess the distributional impacts among facilities by size, type, location, etc., and adjuncts to the system parameters are to be effected to eliminate systematic biases. Additional time will then be required to complete the legislative, regulatory, and administrative aspects of full system implementation. In the meantime, various stop gap measures should be undertaken to address some of the more important of the concerns until full system implementation can become a reality.

RTD:cjw
November 15, 1984
84431.04

MARYLAND:

A CASE STUDY OF

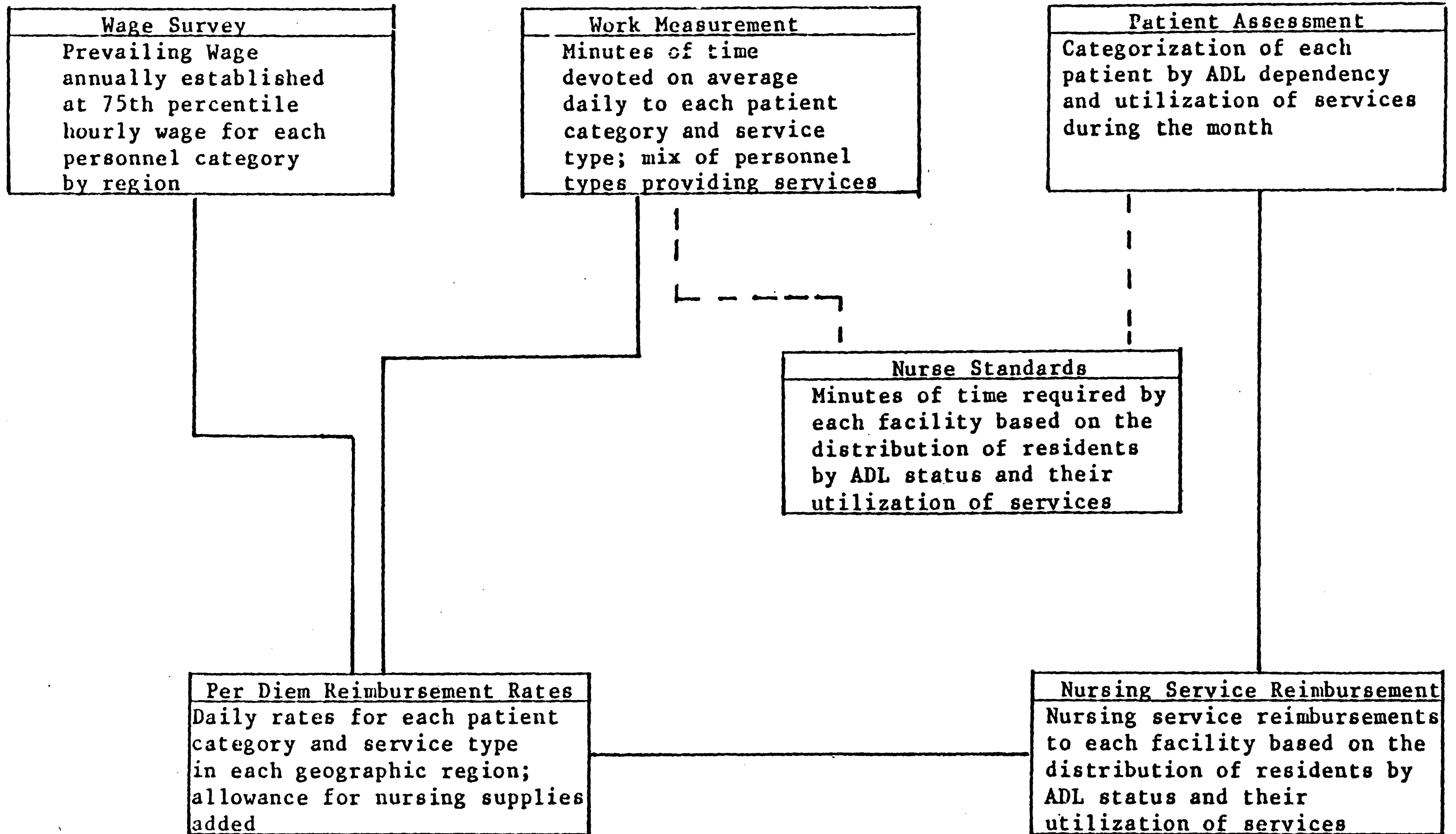
PATIENT-BASED REIMBURSEMENT

On January 1, 1983, the State of Maryland implemented a new Medicaid reimbursement system for long term care. In order to simultaneously achieve the potentially conflicting objectives of cost containment, patient access to care, quality care, and a fair return to investments; the system was built around four separate cost centers, each with its own method of reimbursement. Both the Administrative and Routine cost center and the Other Patient Care cost center have prospective ceilings with final reimbursement and incentive payments based on retrospective determination of reported costs. On the other hand, the Capital cost center replaces depreciation with a rental and uses retrospective reimbursement for the other capital costs. Lastly, the Nursing service cost center is entirely prospective by providing fixed patient day rates by category of patient and type of service received. All of these cost centers except the capital cost center consider geographic location in the determination of the reimbursement, and the Administrative and Routine cost center considers facility size as well.

Clearly, one of the most innovative aspects of this system is the patient-based prospective reimbursement in the Nursing Service cost center. Since this cost center usually accounts for over 40 percent of all allowable costs and comprises all nursing expenses related to the direct provision of patient care, including nursing supplies; it provides an opportunity to address the problems of quality care and adequate access to care by medical assistance patients with varying levels of need. It does this by establishing standard prospective daily rates (for each level of need and quantity of services used) which are sufficient to provide quality care without being excessive.

As shown in Figure 1, the per diem rates are established by combining knowledge

FIGURE 1: NURSING SERVICE COST CENTER REIMBURSEMENT



of the nursing time required to serve the needs of varying types of patients with data on the wages and fringe benefits of the nursing personnel used to satisfy those needs. Once the per diem rates are established for the year, they are applied monthly to each patient as classified through a simplified patient assessment process. In essence, the provider is given a list of prices which the state will pay the provider depending on the acuity of the patient and the services he/she requires.

This system is extremely easy to operate under, and ensures that sufficient resources are available as the patient needs them. Nevertheless, it is necessary, at the risk of confusing the reader, to describe in more detail how the prospective daily rates are generated and how the patient assessment system was developed. This can be shown by referring to Figure 1.

The top middle box of Figure 1 represents the need to conduct a work measurement (i.e., time and motion) study of nursing personnel (every five years or so) in order to measure how the average daily time is spent by each type of nursing staff. Literally all of the time of the nursing staff is accounted for through this industrial engineering technique. All nursing time is identified as belonging to 56 different types of activities, which can then be grouped into direct patient care, indirect patient care, and non-patient care. After observing the frequencies with which services/procedures were performed, the non-patient care time is proportionally allocated to the direct and indirect patient care times. This results in daily nursing hours necessary for each patient category and service. These daily hours are shown on Table 1 along with the proportion of these hours accounted for by each nursing personnel type.

TABLE 1: DAILY HOURS REQUIRED AND WEIGHTS FOR PERSONNEL CATEGORIES BY RESIDENT ADL CLASSIFICATION AND PROCEDURE TYPE

ADL Classification and Procedure Types	Daily Hours Required	Personnel Categories	Weights
Light Care	1.4398	Director of Nursing	0.0486
		Registered Nurse	0.1236
		Licensed Practical Nurse	0.1344
		Nurse Aide	0.6610
		Certified Medication Aide	0.0324
Moderate Care	1.9273	Director of Nursing	0.0363
		Registered Nurse	0.1077
		Licensed Practical Nurse	0.1171
		Nurse Aide	0.7147
		Certified Medication Aide	0.0242
Heavy Care	2.8545	Director of Nursing	0.0245
		Registered Nurse	0.1136
		Licensed Practical Nurse	0.1235
		Nurse Aide	0.7220
		Certified Medication Aide	0.0164
Decubitus Ulcer Care	0.8642	Registered Nurse	0.4790
		Licensed Practical Nurse	0.5210
Tube Feeding	0.9660	Registered Nurse	0.4790
		Licensed Practical Nurse	0.5210
Turning and Positioning	0.4372	Nurse Aide	1.0000
Ostomy Care	0.1173	Registered Nurse	0.4790
		Licensed Practical Nurse	0.5210
Oxygen/Aerosol Therapy	0.1042	Registered Nurse	0.4790
		Licensed Practical Nurse	0.5210
Suction/Tracheotomy	0.2470	Registered Nurse	0.4790
		Licensed Practical Nurse	0.5210
IV/Subcutaneous	0.3330	Registered Nurse	1.0000
Physical Restraints	0.3600	Registered Nurse	0.1359
		Licensed Practical Nurse	0.1479
		Nurse Aide	0.7162
Injections--single	0.0800	Registered Nurse	0.4790
		Licensed Practical Nurse	0.5210
Injections--multiple	0.1600	Registered Nurse	0.4790
		Licensed Practical Nurse	0.5210

The top left hand box of Figure 1 represents the need to generate a "prevailing wage" for each personnel category. To do this a wage and staff survey is undertaken in all nursing homes in the state for a two week period in January. Hourly wages in each of three geographic regions are computed and ordered within each personnel grouping so that the hourly wage associated with the 75th percentile hour (low to high) can be identified, indexed forward, and adjusted to include fringe benefits. This rather involved procedure is used in order to establish "prevailing wages" that (at least theoretically) are sufficiently high to cover the wages actually paid on average by facilities operating under the system. If an average wage were used as the "prevailing wage," it is certain that approximately half of the providers would not have their wages covered. The application of percentile "prevailing wages" to their respective daily hours for each patient category and procedure on Table 1 produces the basis for a per diem prospective nursing service rate for each resident category and service type. The final prospective rates are then generated by applying an adjustment factor (described below) and by including an allowance for daily nursing supplies.

The top right hand box of Figure 1 represents the need to assess each patient in order to: (1) categorize the patient with respect to dependencies in Activities of Daily Living (ADL), and (2) measure the frequency of utilization of the procedures listed in Table 1. When the patient assessment is completed, the monthly reimbursement for each resident is determined by multiplying the number of days of residency during the month by the basic ADL category rate, and adding this product to the sum of the products of the number of days each procedure has been provided and its respective daily reimbursement rate. In other words, each facility

submits on behalf of each resident a monthly invoice for days of residency and days of receiving each of the selected services, and is then paid for each day of residency and service invoiced. Figure 2 is the invoice presently being utilized in Maryland. The SNF/ICF distinction on this invoice is for federal reporting purposes only. Such a distinction has no influence on the reimbursement for the patient beyond the ADL classification and the service utilization invoiced.

The patient classification is based on the dependency of the resident in each of five ADLs:

- Bathing,
- Dressing,
- Mobility,
- Continence, and
- Feeding.

And, the number of dependencies among these five ADLs establishes the ADL classification of each resident:

ADL Classification	Number of Dependencies
Light Care	0 to 2
Moderate Care	3 to 4
Heavy Care	5

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ELIGIBILITY DATES FROM THRU | RESUBMITTAL | (4) PAYEE PROVIDER NO

(1) PATIENT'S LAST NAME | FIRST NAME OR INITIALS | TYPE | (5) NAME

(2) ADDRESS | (6) ADDRESS

(3) IDENTIFICATION NUMBER

PATIENT IDENTIFICATION | PROVIDER IDENTIFICATION

STATE OF MARYLAND - DEPARTMENT OF HEALTH AND MENTAL HYGIENE - MEDICAL ASSISTANCE PROGRAM

LONG-TERM CARE REPORT AND INVOICE

(7) DHMH-1321 ATTACHED (BED RESERVATION) ☐ | (8) DHMH-1295 ATTACHED (THERAPEUTIC LEAVE) ☐ | (9) DHMH-3787 ATTACHED (PATIENT ALLOWANCE-COMMUNITY) ☐ | (10) BED RESERVATION DAYS THIS MONTH | (11) THERAPEUTIC LEAVE DAYS THIS MONTH | (12) ADMINISTRATIVE DAYS THIS MONTH

(13) FACILITY ADMISSION DATE / / | (14) MEDICAL ASSISTANCE ELIGIBILITY DATE / / | (15) DEATH/DISCHARGE DATE / / | (16) INVOICE COVERS MONTH FROM / / THRU / / | (17) ADMITTING DIAGNOSIS

(18) WAS TREATMENT DUE TO ACCIDENTAL INJURY? YES ☐ NO ☐ | (19) PATIENT RESOURCES $. | (20) PROVIDER'S PATIENT ID NO. (OPTIONAL) | DHMH ONLY

(21) THIRD-PARTY POTENTIAL? YES ☐ NO ☐ | (22) THIRD-PARTY ID NO. IF ANY | (23) NAME OF POTENTIAL THIRD-PARTY PAYER | (24) AMOUNT PAID BY THIRD-PARTY PAYER $.

(25) ORIGIN OF PATIENT (NEW ADMISSION ONLY)
☐ 1 - HOME 3 - OTHER NH
2 - ACUTE HOSPITAL 4 - OTHER ____

(26) PATIENT STATUS - ENTER ONE
☐ 0 - STILL PATIENT 3 - DISC. / TRANS. ICF 6 - DISC. UNDER CARE HH AGENCY
1 - DISC. HOSPITAL 4 - DISC. / TRANS. OTHER INST. 7 - LEFT AGAINST ADVICE
2 - DISC. / TRANS. SNF 5 - DISC. HOME / SELF CARE 8 - DIED

(27) DATE OF CHANGE IN LEVEL OF CARE / /

LINE NO.	(28) PROCEDURE CODE	(29) DAYS OF SERVICE	(30) DESCRIPTION OF SERVICE
1.	N0010		Days of Care - Light - ICF
2.	N0011		Days of Care - Light - SNF
3.	N0020		Days of Care - Moderate - ICF
4.	N0021		Days of Care - Moderate - SNF
5.	N0030		Days of Care - Heavy - ICF
6.	N0031		Days of Care - Heavy - SNF
7.	N0040		Days of Care - Heavy Special - ICF
8.	N0041		Days of Care - Heavy Special - SNF
9.	N0042		Decubitus Ulcer Care
10.	N0043		Turning and Positioning
11.	N0044		Tubefeeding
12.	N0050		Restraints
13.	N0060		Single Injections
14.	N0070		Multiple Injections
15.	N0080		Ostomy Care
16.	N0090		Oxygen / Aerosol Care
17.	N0100		IV / Subcutaneous Care
18.	N0110		Suctioning / Tracheostomy
19.	N0120		Medicare Coinsurance
20.			
21.			

MAIL TO:
MEDICAL ASSISTANCE OPERATIONS ADMINISTRATION
STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE
P.O. BOX 1935
BALTIMORE, MARYLAND 21203

IF PATIENT HAS MEDICARE, SUBMIT HCFA-1453 to MEDICARE

TO BE PAYABLE THIS INVOICE MUST BE RECEIVED WITHIN TWELVE (12) MONTHS OF THE DATE ON WHICH SERVICES WERE RENDERED.

This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact may be prosecuted under applicable Federal and State laws. I certify that the services shown on this report were rendered and that no charge has been or will be made for payment from the patient, the patient's family or other source except as authorized by the Program. I certify further that all reasonable measures to identify and recover third party liabilities to the patient have been taken and all such collections therefrom have been or will be reported to the State. I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to Title XIX recipients and to furnish information regarding any payments claimed for providing such services as the State may request for five years from the service date. Payment is hereby requested.

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(31) SIGNED

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The Heavy Special Care category on Table 1 is defined as a 5 ADL resident who also requires tube feeding, decubitus ulcer care (when the condition is stage III or IV and was not a result of the care given at the facility), and/or turning and positioning (for a full 24 hour period). While a resident at any level of ADL dependency can logically receive (and get reimbursed for) these services, the Heavy Special Care residents are differentiated in order to ensure that an increasingly positive incentive is provided to admit the heaviest care patients. Accordingly, the following factors are applied to the per diem reimbursement rates after the addition of fringe benefits but prior to the addition of the daily allowance for nursing supplies:

ADL Classification and Procedure Types	Adjustment Factor
Light Care	1.00
Moderate Care	1.02
Heavy Care	1.03
Heavy Special Care	1.04
Decubitus Ulcer Care	1.04
Turning Positioning	1.04
Tube Feeding	1.04

The provider, of course, does not need to be concerned with this rather involved, three-step procedure, except to participate in the annual wage and staff survey and to invoice for each Medical Assistance patient served during the month. As mentioned earlier, this process produces a very brief list of

prices which determines the per-patient reimbursement and influences the admission pattern of the facility. These prices are generated by combining the nursing service rates resulting from this three-step process with the interim rates from the other three cost centers. Figure 3 presents a set of fiscal year 1984 prices or composite rates for one facility in Maryland. These composite rates clearly illustrate the differences in rates among the ADL categories and demonstrate how patient-based daily reimbursement could vary for this facility from a low of $36.92 to a high of over $90, depending on the needs of the patient in question.

Clearly, this system provides an incentive to equalize access to care on behalf of residents at all levels of need, promotes quality care, and allows a wide range of management decisions with regard to staffing levels and wage policies. However, it also adds somewhat to the administrative tasks required of the facilities and the program administrators: a wage and staff survey should be undertaken and processed annually, facilities must carefully document resident ADL dependencies and service utilizations if they expect to receive full payment, and the state should contract with a Utilization Control Agent to periodically conduct "paper" assessments of at least a sample of resident on a retrospective basis in order to verify the monthly invoices submitted by the provider. Figure 4 is the Patient Assessment Form currently being used by the Utilization Control Agent in Maryland. On the other hand, these additional tasks are more than a fair price to pay to maintain access to quality care for those in need.

This approach should have other payoffs as well. Nursing homes have traditionally been somewhat uncertain as to what the appropriate level of staffing should be as the mix of residents by ADL dependency status and service utilization

COMPOSITE INTERIM RATES

Provider No. 160520 Date: 99/99/99

DESCRIPTION	DAILY RATE	PROCEDURE CODE
Light Care (0-2 ADL)	$36.92	N0010,N0011
Moderate Care (3-4 ADL)	$40.45	N0020,N0021
Heavy Care (5 ADL)	$47.68	N0030,N0031
Heavy Special Care (5 ADL plus)	$47.90	N0040,N0041
Decubitus Ulcer Care	$11.67	N0042
Tube Feeding	$16.62	N0044
Turning and Positioning	$ 2.58	N0043
Ostomy care	$ 1.37	N0080
Aerosol/Oxygen Care	$ 1.22	N0090
Suctioning	$ 2.89	N00110
IV Care	$ 4.31	N0100
Restraints	$ 2.72	N0050
Injections - single	$ 0.94	N0060
Injections - multiple	$ 1.87	N0070

PATIENT ASSESSMENT FORM

PATIENT NAME: ______________ LAST ______________ FIRST ______________ MIDDLE

ASSESSMENT DATE: ______ MONTH ______ DAY ______ YEAR

FACILITY ID: ___ ___ ___ ___ ___

MEDICAID ID: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

ASSESSOR ID: ___ ___ ___

PERIOD COVERING: Month 1 ___/___ MO/YR Month 2 ___/___ MO/YR Month 3 ___/___ MO/YR Month 4 ___/___ MO/YR Month 5 ___/___ MO/YR Month 6 ___/___ MO/YR Month 7 ___/___ MO/YR

I. ADMINISTRATIVE DATA

1. Initial Assessment: 0 = No 1 = Yes ____
2. Date of Admission or Conversion to Medicaid: ___ ___ MONTH ___ ___ DAY ___ ___ YEAR
3. Date of Discharge, Transfer, Death or Medicaid Lost or Denied: ___ ___ MONTH ___ ___ DAY ___ ___ YEAR
4. Days of Home Leave Taken: ___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6 ___ 7

II. ACTIVITIES OF DAILY LIVING

(Enter one code for each month)

5. Bathing:
   - 0 = Independent
   - 1 = Dependent

   ___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6 ___ 7
6. Dressing:
   - 0 = Independent
   - 1 = Dependent

   ___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6 ___ 7
7. Mobility: 0 = Independent
   - 1 = Dependent
   - 2 = Bed/Chair Confined

   ___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6 ___ 7
8. Continence:
   - 0 = Independent
   - 1 = Dependent

   ___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6 ___ 7
9. Eating:
   - 0 = Independent
   - 1 = Receives Help
   - 2 = Spoonfed
   - 3 = Tubefeeding

   ___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6 ___ 7

III. SPECIAL SERVICES

(Enter number of days services were received for each month.)

10. Decubitus Care: ___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6 ___ 7
11. Turning and Positioning for a 24 Hour Period: ___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6 ___ 7
12. Tubefeeding: ___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6 ___ 7

IV. ADDITIONAL SERVICES

(Enter number of days services were received for each month.)

13. Restraints: ___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6 ___ 7
14. a. Single Injections: ___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6 ___ 7

    b. Multiple Injections: ___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6 ___ 7
15. Ostomy Care: ___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6 ___ 7
16. Oxygen/Aerosol: ___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6 ___ 7
17. IV/Subcutaneous: ___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6 ___ 7
18. Suctioning/Tracheostomy: ___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6 ___ 7

DHMH 4143 (Rev. 11/82)

changes. Further, under other reimbursement systems, nursing homes may be forced into tradeoffs between applying resources to nursing services and applying them to non-patient care activities. This system identifies nursing service as a selfcontained management activity with its own budget -- one that is adequate, and one which automatically fluctuates with the patient mix of the facility -- so that the possibility for such tradeoffs is eliminated. Further, the daily nursing hours behind the prospective rates serve as standards by which nursing homes can periodically assess the adequacy of their staffing levels. The dashed lines on Figure 1 show how the daily times can be applied to the patient mix to generate nurse staffing standards for the facility. Should a consistent pattern of understaffing be observed by the state, Licensure and Certification will take a close look at the facility to see if the situation is due to high staff turnover, extremely high nurse productivity, or an overt effort to convert the Nursing Service cost center into a profit center at the expense of patient care.

Finally, as an incentive to continue to provide quality care that is directed toward improving the condition of the resident, a bonus is to be available whenever the ADL dependency of the resident is reduced. This bonus is in the form of continued, higher payments at the old ADL classification rate for two months past the point of the ADL improvement.

In summary, this approach to nursing service reimbursement should remove a great deal of uncertainty, reduce the frequency of situations in which the quality of care might be compromised by management decisions, improve access to care, and generate valuable data for Licensure and Certification. As a test

of these assertions, the reader is encouraged to assess the residents of his/her facility (using definitions of ADL dependencies available for distribution from AHCA) and apply the times included in Table 1 in order to independently establish the simplicity, accuracy, and usefulness of the work measurement approach in determining patient needs and staffing to meet those needs.

RTD:cjw

November 5, 1984

84422a.04

COMMONWEALTH of VIRGINIA

Department of

Mental Health and Mental Retardation

MAILING ADDRESS
P O BOX 1797
RICHMOND, VA 23214

January 22, 1985

Susan Ward
P. O. Box 406
Richmond, Virginia 23203

Dear Susan:

As Chairman of the Committee on Housing for the Disabled, I want to apprise you about the status of this interagency, cross-Secretariat task force which is attempting to examine and address the multidimensional issues around the provision of low income housing units and residential and support programs needed in Virginia by persons with mental and/or physical disabilities.

The Committee on Housing for the Disabled has met twice (December 11, 1984 and January 14, 1985) and we have determined a scope and work plan for the first phase of our work through approximately July 1985. Subsequent work of the Committee, if appropriate, will be determined later in the year.

Attached for your information is a Roster for our Committee (which designates liaison staff persons) and a copy of our Proposed Work Plan 2/85 -7/85. The Committee has determined that during at least this initial phase of our work, we will not formally expand Committee membership. However, as you can see in the Work Plan, we will involve appropriate constituencies and interest groups among persons with disabilities, human service providers and the housing industry to develop and conduct the topical presentations.

The Committee on Housing for the Disabled certainly extends an invitation to you to attend our future meetings. Our next scheduled meeting is Thursday, February 21, 1985, 2:00 - 4:00 P.M. at the Department of Rehabilitative Services, 4901 Fitzhugh Avenue, Richmond, Virginia, and you will be notified of subsequent meetings. As you know, Delegate Mary Marshall, Chairman of the Joint Subcommittee Monitoring Long Term Care has expressed interest in the work of our Committee. Our activities may also be relevant to the Joint Commission on Deinstitutionalization.

Please contact me if you have questions or concerns.

Sincerely,

Joseph J. Bevilacqua, Ph.D.
Commissioner

JJB/LCV:skt
Attachments

cc: Joseph L. Fisher, Ph.D., Secretary of Human Resources
Betty J. Diener, Ph.D., Secretary of Commerce

COMMITTEE ON HOUSING FOR THE DISABLED

Proposed Work Plan
2/85 - 7/85

February

Topic: Financing of Low Income Housing Stock
Lead Agency: VHDA

Presentation on the financing of construction and/or renovation of properties for low income housing units. What are current economic realities (bond market, federal aid, costs of construction, availability and cost of real estate, etc.)? What is the current lowest feasible per unit cost for construction and/or renovation? What are the other dynamics involved in increasing the supply and availability of low income housing? What are prospects for increasing the supply and availability of low income housing stock. What state level activity could stimulate this? What are other states doing which might be replicated in Virginia?

March

Topic: Financing of Residential and Other Community Support Programs for the Disabled.
Lead Agency: DMHMR

Presentation on federal, state, and local funding streams and mechanisms to fund client support services required to maintain persons with disabilities in low income housing in the community. What are the available sources, levels, and restrictions for existing service funds? What are the dynamics which affect the current availability of support services and coordination of these services with low income housing resources. What are the prospects for increasing the availability of support services and coordination of these services with low income housing resources? What are other states doing which might be replicated in Virginia?

NOTE: Lead Agency designation connotes responsibility to plan, arrange, and conduct the topical presentation (including involving appropriate agencies and organizations, constituencies, presenting descriptive information and identifying both opportunities and barriers), and preparing a written synopsis of the presentation. Each topical presentation should generate entries for a glossary and a series of recommendations for possible consideration by the Committee.

April

Topic: Current Data on Existing Low Income Housing Stock and Need for Low Income Units by Persons with Disabilities.
Lead Agency: DHCD

Presentation on data and estimates currently available from all sources on:

- available units of low income housing
- number of existing units built under Section 202, including a breakout of the number of those which are barrier free.
- number of Section 8 housing certificates available and being utilized in Virginia, including the number utilized by persons with disabilities.
- need for low income housing units needed in Virginia by disabled constituencies, including a breakout of need for barrier free unit.

Data will be presented on both current and projected availability of low-income housing and need for such housing by disabled constituencies. Issues must be articulated regarding data gaps and barriers to developing, accessing, and utilizing necessary data.

May

Topic: Marketing to Promote Housing for the Disabled.
Lead Agency: To be Determined

Presentation on how producers of low-incoming housing units and providers of human services can coordinate and collaborate to increase the utilization and availability of low income housing (including barrier free units) needed by disabled persons in our communities. What are some innovative approaches to this issue which have been or are being demonstrated in Virginia and in other states. How can the Commonwealth promote establishment of public-private partnerships to collaborate on such issues as:

- Assisting human service agencies at the community level to identify and access existing low income housing.
- Technical assistance by public agencies to mobilize local efforts to increase low income housing options for the disabled.
- Provision of a clearing house function to connect persons who require barrier free housing with existing accessible units (including both subsidized and non-subsidized units)
- Creative approaches to capital formation, public-private partnerships, and funding of support services.

June

Committee discusses draft report of findings and recommendations. Staff incorporates Committee's input and finalizes report.

July

Report of Committee's findings and recommendations circulated.