REPORT OF THE
JOINT SUBCOMMITTEE STUDYING

Long-Term Care

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

House Document No. 30

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Final Report of the Joint Subcommittee
Monitoring Long-Term Care
To
The Governor and the General Assembly of Virginia
Richmond, Virginia
November, 1986

To: Honorable Gerald Baliles, Governor of Virginia,
and
The General Assembly of Virginia

BACKGROUND AND AUTHORITY FOR THE STUDY

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

The Joint Subcommittee Monitoring Long-Term Care was created in 1983 by House Joint Resolution No. 37. Its charge was to oversee the implementation of an integrated approach to long-term care by facilitating cooperation and exchange of information. It was 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. The Joint Subcommittee was continued in 1984 for two years by House Joint Resolution No. 52 and again in 1986 by House Joint Resolution No. 111. (Appendix A)

Activities of the Joint Subcommittee

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 development of 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 reported 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 amount 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 received the Department of Mental Health and Mental Retardation's report on census reduction at the state hospitals, prepared as requested in the 1984 Appropriations Act.

At the beginning of 1984, the Joint Subcommittee identified and initiated the study of several issues through the use of expert task forces organized by the Joint Subcommittee. These issues, discussed in detail in the Joint Subcommittee's interim report of January, 1985, (House Document No. 33) include regulation of life-care communities in Virginia, a revised method of Medicaid nursing home reimbursement, housing for persons with special needs, and post-education transition of the handicapped.

The Joint Subcommittee continued to monitor the Long-Term Care Council's study, undertaken 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 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 conference of the American Health Planning Association on "The Complex Cube of Long-Term Care."

During 1985, the Joint Subcommittee continued its study of regulation of life-care communities by focusing specifically on the need for maintenance of reserve funds. The Joint Subcommittee also completed its study of post-educational long-term care services required by the handicapped. These issues are discussed in detail in this report.

The Committee on Housing for the Disabled reported its findings to the Joint Subcommittee, which encouraged the passage of the Committee's legislative proposals by the 1986 Session of the General Assembly.

The Joint Subcommittee continued to monitor the study of the Medicaid nursing home reimbursement system. The study, completed late in 1985, was conducted by the Virginia Center on Aging by contract with the Virginia Department of Medical Assistance Services, pursuant to the 1984 recommendation of the Joint Subcommittee.

In October, 1985, the Long-Term Care Council reported to the Joint Subcommittee the results of its study, conducted as directed by SJR 30 (1984), on the public and private costs of institutional as compared to community-based long-term care. The study specified a need to provide financial assistance and other support to families and friends of those in need so that this informal support system can continue to meet the needs of impaired individuals.

Finally, the Joint Subcommittee held a symposium on the projected need for nursing home beds in Virginia through 1990. Representatives of public and private agencies and of advocacy groups concerned with long-term care planning participated to identify need and actions necessary to meet the need.

The 1986 General Assembly asked the Joint Subcommittee for recommendations regarding alternative methods of payment on behalf of residents of homes for adults which consider the amount of care provided to residents; feasibility, availability and affordability of private insurance coverage for long-term care services; and feasibility and efficacy of requiring continuing care retirement communities to maintain reserve funds.

Task forces studying the issues affecting homes for adults and continuing care retirement communities completed their work during 1986. Their findings and recommendations are reported in detail in this report.

The Joint Subcommittee monitored the progress of the study conducted in 1986 by the Bureau of Insurance and the Department of Medical Assistance Services, as authorized by House Joint Resolution No. 87 (1986), on action needed to encourage private insurance coverage of long-term care services. That study is in progress and due to be completed in time to report its recommendations to the 1987 Session of the General Assembly.

FINDINGS AND RECOMMENDATIONS

Long-Term Care Issues Examined by the Joint Subcommittee

The American Health Planning Association, in structuring its 1984 long-term care conference, described the nature of long-term care issues as a "complex

cube." 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, among national, state and local programs, 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.

To address some of these conflicts and deficiencies, the Joint Subcommittee conducted its study 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. Findings and recommendations endorsed by the Joint Subcommittee since its interim report issued in January, 1985, are summarized below.

Post-Educational Long-Term Services for the Handicapped

The Task Force on Post-Educational Long-Term Services for the Handicapped was charged with the development of a plan for providing services to handicapped persons who are no longer within the education system either because they have completed or quit the program or they have suffered a handicapping injury after the age of twenty-one.

The task force began its work in November, 1984. Senator Stanley Walker served as chairman of the task force, which included representatives of state and local public agencies responsible for social service, mental health and mental retardation and education programs, including the Departments of Social Services, Mental Health and Mental Retardation, Education and Rehabilitative Services, the Richmond Community Services Board and the Psychosocial Rehabilitation Center in Fairfax; representatives of transition and research programs, including the CHANCE PROJECT at old Dominion University, the Rehabilitation, Research and Training Center at Virginia Commonwealth University, and the Southeastern Cooperative Educational Program; and representatives of related professional and advocacy organizations, including the Virginia Association of Rehabilitation Facilities. The Joint Subcommittee is grateful to the task force members for their generous contribution of time and expertise to this effort.

The task force learned during its study that no mandatory post-educational services currently exist. Persons who could use vocational residential transportation and other services are not routinely identified and followed, which not only deprives those persons of needed services, but also inhibits planning for future needs by agencies responsible to provide services. In addition, the Commonwealth has adopted a policy of deinstitutionalization and is, therefore, responsible to serve additional persons with mental and physical handicaps who are returning to the community from institutions.

Many programs are available to the handicapped but may not be utilized effectively due to lack of knowledge of their existence, lack of communication between school personnel and adult service providers, and the lack of systematically planned transition programs. Programs, eligibility qualifications, and providers of

service vary, contributing to a system which has the potential to serve adequately but which is realized only by chance in many cases.

The problems identified by the task force are not peculiar to Virginia. According to the U.S. Commission on Civil Rights, in 1983, between 50% and 80% of working age adults who reported a general disability were without jobs. Approximately 8 % of the gross national product is spent each year in disability programs, with most of this amount funding programs that support dependence, according to the White House Working Group on Disability Policy.

The federal government has undertaken new initiatives in this field with Public Law 98-199, the 1983 amendments to the "Education of the Handicapped Act," which provides funds and support for education and transition services. The legislation was proposed because

> the subcommittee {on the Handicapped} recognizes the overwhelming paucity of effective programming for these handicapped youth, which eventually accounts for unnecessarily large numbers of handicapped adults who become unemployed and therefore dependent on society. These youth historically have not been adequately prepared for the changes and demands of life after high school. In addition, few, if any, are able to access or appropriately use traditional transitional services. Few services have been designed to assist handicapped young people in their efforts to enter the labor force or attain their goals of becoming self-sufficient adults and contributing members to our society." (Section 626, P.L. 98-199).

To address the problems identified by the task force, the Joint Subcommittee proposes the recommendations described below. Legislation implementing these recommendations is included in Appendix B to this report.

1. Individual Transition Plans

All handicapped students aged fifteen years or older should receive a written Individual Transition Plan (ITP), which may or may not be a part of the Individual Educational Plan (IEP), in order to identify vocational, residential and educational needs. This should be accomplished in phases beginning with those already twenty-one years of age. The plan should include an evaluation of those barriers to meaningful transition from school to adult home and a strategy for implementation, including relevant program goals, educational programming and administrative action necessary, and describing the responsibilities of each ITP team member. Each member of the team preparing the ITP should participate in planning his agency's contribution. Each plan should be reviewed annually.

The Interagency Coordinating Council on Delivery of Services to Handicapped

Children should administer the development of the ITPs. This requires expansion of the Council to include the Department of Housing and Community Development and the Housing Development Authority. The Council should have a functional plan in place no later than June 30, 1986, and should report annually thereafter.The placement of this responsibility on the Council reflects concern for the lack of a designated lead agency and inadequate communication between involved agencies.

The Joint Subcommittee agreed that local coordinating councils composed of the local departmental participants should be in place no later than June 30, 1987. The local councils should prepare a plan for each individual, with the assistance of all affected service providers. The councils should request permission from parents and/or students for the exchange of information necessary to prepare the plan. A standardized format for the ITP should be developed for use on a statewide basis to facilitate the collection of data for evaluation.

The local education agency should be responsible for the coordination and completion of this plan unless the local governing body decides that some other agency would be more appropriate. The appointment of lead agencies should occur no later than January, 1988. Local councils should be composed of the local counterparts to the members of the State Council, with the community services boards representing the Department of Mental Health and Mental Retardation.

In order to plan and evaluate the effectiveness of the ITPs, the Council should be provided follow-up data as well as other aggregate data on handicapped students in order to effectively plan for handicapped students. Vocational education, supported employment, and other programs such as this are viewed as costly, but they actually can be cost-effective in comparison to the costs of dependent care, Social Security payments and other costs incurred for persons who lack training or support for relatively independent living.

2. Supported Employment Services

Supported employment is defined as on-going professional support provided at the job site for disabled persons who could not gain employment or maintain this employment without assistance. Employment counselors provide aid in every aspect of a person's employment, including such skills as catching the bus. Support can be intensive but is usually phased down as the individual becomes more adept. The General Assembly should provide funds to the Department of Rehabilitative Services (DRS) to provide supported employment services to transitional-age students who can be placed in a job with unsubsidized wages.

The Joint Subcommittee recognizes that not all persons needing supported employment services can be served immediately. At the present time, approximately 2,400 disabled persons need employment services. As a start, the Joint Subcommittee recommends that for the first year of this program $250,000 be appropriated to DRS for services. This amount would serve approximately 100 persons, based on an average cost of $2,500 per person for job placement. The annual sum of $250,000 plus $1,000 per person to maintain those already in supported

employment would be needed each year thereafter until the backlog has been absorbed. In a relatively short period of time, these costs could become fixed. This money should be allocated equally among the four regions of the State.

Supported employment services can eventually pay for themselves by savings in other areas. These students who have received years of publicly funded special education will have to be maintained at home, incurring costs for SSI/SSDI benefits and a loss of earning power. Students will go to adult activity centers and be unable to receive assistance in gaining and maintaining employment. Again, costs of SSI/SSDI benefits are incurred, in addition to $4,000 annually to state and local governments to maintain each person in a non-work center. Costs are also incurred in the loss of employment by a parent who must quit a job in order to stay at home and maintain a child who at the age of twenty-one has been through the educational system and now has nowhere to go. While no monetary figure can be set, improvements in quality of life for disabled persons helped to independence are significant.

The Joint Subcommittee considered but rejected task force recommendations to require guidance counselors in elementary schools and to provide a tax credit for employees who employ handicapped persons.

Maintenance of Reserve Funds by Continuing Care Retirement Communities.

Continuing care provider legislation was first introduced in Virginia during the 1984 Session of the General Assembly as Senate Bill 410. Its introduction was encouraged by a group of residents of The Virginian, a continuing care retirement community that was being reorganized under Chapter 11 of the federal bankruptcy laws. As the bill imposed substantial regulatory requirements on the continuing care provider industry, the Senate Committee on Commerce and Labor carried the bill over to the 1985 Session so that the issues could be studied prior to taking any action on the bill. The responsibility for this study was given to the Joint Subcommittee, which requested that Mr. James M. Thompson, Commissioner of Insurance, organize a task force to study the issues raised by Senate Bill 410.

The task force met between the 1984 and 1985 Sessions of the General Assembly. The task force concluded that some form of regulation of the continuing care industry was in order, but the majority of the task force agreed that Senate Bill 410 as it was introduced during the 1984 session went too far. The task force drafted new legislation which focused on disclosure of certain information relevant to existing and prospective residents of continuing care retirement communities. The bill was presented to the Joint Subcommittee, which endorsed its content. A more detailed discussion of the task force's work is contained in the Joint Subcommittee's interim report (House Document No. 33, 1985). The bill was passed during the 1985 session as an amendment in the nature of a substitute for Senate Bill 410.

Discussion within both Senate and House committees during the 1985 session indicated that some members believed that a reserve funding requirement should

have been included in Senate Bill 410. To further investigate this issue, Senate Joint Resolution 114 was adopted in 1985, directing the Joint Subcommittee to study the feasibility and efficacy of a requirement that continuing care facilities maintain reserve funds to ensure long-term financial ability of providers to meet the obligations of continuing care contracts. Senate Joint Resolution 114 also provides that the task force formed in 1984 assist the Joint Subcommittee in its study.

In addition to the State Corporation Commission's Bureau of Insurance, which has chaired the task force, members of the task force included several continuing care providers; a resident of The Virginian; the State Health Department; the State Department for the Aging; the Virginia Association of Non-Profit Homes for the Aging; the Health Systems Agency of Northern Virginia; the Virginia Health Care Association; the American Health Care Association; and several other interested parties. Several people were added to the task force during 1985, including two members of the Virginia Bar Association's Committee on Legal Problems of the Elderly.

After five meetings during 1985, the task force was unable to reach a consensus on its primary charge. Many of the task force members were not convinced that a reserve funding requirement would be feasible or effective. Some of the major problem areas identified by the task force include:

(1) Determination of whether or not reserves are in fact an effective way to protect residents' interests.

(2) Examination of the costs and benefits, both explicit and implicit, of imposing a reserve funding requirement. Clearly, the extra protection that a reserve fund may provide is not achieved without some cost.

(3) Determination of the appropriate level for reserve funds.

(4) Determination of when and under what circumstances reserve funds may be used.

(5) Resolution of questions as to the financial ability of existing providers to comply with reserve funding requirements.

(6) Coordination of statutory reserve funds with other reserve funds that may be required under certain financing arrangements.

(7) Determination of appropriate investment vehicles and corresponding levels of risk and liquidity assets.

(8) Consideration of alternative techniques for meeting reserve fund requirements such as surety bonds, letters of credit, and guarantees from upstream affiliates.

Further, many of the task force members also expressed the opinion that no

reserve fund requirement should be proposed until the effects of the disclosure requirements of Senate Bill 410 relating to reserve funds are assessed.

The task force agreed, however, that the reserve funding question is a complex issue that deserves further study and, therefore, recommended that the task force be continued for one year to continue its study of reserve funding requirements.

The task force reached a consensus, however, on a related issue. It was agreed that prepaid entrance fees should be held in escrow until the resident's living facility is available for occupancy. This requirement is particularly important for new facilities that are under construction and those that have not started construction. It appears that this is an area where prospective residents face significant risk of financial loss due to fraud or mismanagement. Proposed legislation implementing this recommendation is contained in Appendix C of this report.

The task force resumed its work on the reserve issue in 1986. It surveyed other states which regulate continuing care retirement communities. Eleven states do not have a reserve requirement, some because of concern that such a requirement would impede development of the facilities. Of those states requiring reserves, investment restrictions in some states make the reserve an accounting rather than a funding requirement. The task force learned that some communities in Virginia voluntarily maintain reserves, the most restrictive provisions of which are tied to debt obligations. The task force identified both a funding approach and an accounting approach to maintenance of reserves. Agreement among members on a funding approach appeared very unlikely. The task force did agree, however, that development of minimum accounting standards could provide significant safeguards. This method requires that financial statements reflect future liability inherent in residents' contracts. The accounting standards can be set by regulation rather than by statute.

The Joint Subcommittee recommends that the task force discontinue its formal investigation but continue on an informal basis to assist the Bureau of Insurance in the development of minimum accounting standards as described above.

Payment of Homes for Adults According to Levels of Care

The Task Force to Study Levels of Care in Homes for Adults met during 1986 to study the feasibility of paying homes for adults an amount based on the level of care provided to each resident. The Task Force was chaired by Delegate Marshall and consisted of representatives of the Virginia Center on Aging, the Department of Medical Assistance Services, the Department of Social Services, the Department of Health, the Virginia Association of Homes for Adults, the Department of Mental Health and Mental Retardation, the Virginia Association of Non-Profit Homes for the Aging, the Department for the Aging, the Virginia Health Care Association, and the Veterans Administration.

Homes for adults are residential facilities which provide domiciliary care to

adults who cannot lead independent lives due to physical or mental infirmities. Domiciliary care includes room, board, supervision, and assistance with activities of daily living. Homes which provide this service to four or more adults must be licensed by the Department of Social Services (DSS).

In recent years, the number of these homes has increased dramatically due to a steadily increasing percentage of elderly persons in our society, development of medical technology which provides for increased longevity, and the process of deinstitutionalization, responsible for the release of many institutionalized persons who still need supervisory care. Inflation, the need for services, new safety requirements and rising insurance costs are reported to have greatly increased the cost of these placements and many of those in need are not able to pay.

The Supplemental Security Income Program (SSI) was created in 1974 to replace the federally financed adult assistance programs which had been administered by the states or their political subdivisions. Because the program, administered by the Social Security Administration, provided assistance at a flat rate rather than based on need, a state auxiliary grant program was created to close the gap between SSI and actual need of those in homes for adults. The grant is based on the maximum rate for each home as set by DSS. The rate is less than or equal to the maximum allowable figure set by the state Appropriations Act. To qualify for an auxiliary grant, an individual must receive SSI or qualify for SSI but have excess income and must live in a home for adults or adult family care. The State pays 80% of the auxiliary grants, and localities provide 20%. Some localitites may not be able to afford their portion any longer as costs of care increase.

Providers claim that the rates of payment to home-for-adults residents are insufficient. They have proposed a system which provides payment to clients in homes for adults based on the level of care provided to a client. Such a system requires subjective decisions regarding services needed and an enforcement process to verify service needs and the provision of services. The proponents hope to find a method of caring for individuals in homes for adults in a manner which guarantees an acceptable quality of life and paying on that basis, without creating a system so complex that it forces smaller homes out of business.

In the course of its study, the Task Force determined that there is considerable variation in the service requirements of residents in homes for adults that is not recognized by current regulations or payment processes. There seems to be no consistent manner of evaluating residents to determine what their needs are, how best to fill those needs, what future needs may be, and how to pay for the provision of services. Presently DSS requires homes for adults to do a basic, simple assessment of each client when admitted. The Joint Subcommittee urges the Long Term Care Council to develop a uniform assessment tool.

A perception emerged that some publicly supported residents receive a higher level of care than they require, while others are receiving inadequate levels of care. It appears that some residents would be more appropriately placed in nursing facilities, while others who do not qualify for nursing home care still require more

intensive services than homes for adults can provide given current reimbursement levels. There is no data on the extent of this problem.

There is evidence from recent studies by the Virginia Center on Aging and the Joint Legislative Audit and Review Commission that aged, chronically physically impaired public program residents and both aged and younger chronically mentally impaired residents may be receiving inadequately coordinated and managed services in homes for adults. This problem has resulted in individuals who are lost to follow-up by DSS, receive little or no casework services, receive no special planning for activities or rehabilitative services, or experience avoidable nursing home admissions and/or state mental hospital readmissions. Efforts to ensure appropriate quality of care are soon fragmented by the lack of consistent oversight, and authority to regulate is often divided between several state agencies. A lack of consistent case management follow-up hinders accurate and timely needs assessment. Currently, DSS is not notified of a person's presence in a home unless there is a request for services. This is being addressed by the Department of Mental Health and Mental Retardation (DMHMR) for their clients.

The task force recommended to the Joint Subcommittee that the following goals and objectives be addressed in the future by the appropriate agencies:

1. A client-based system basing payment on individual needs assessment and service provision, although more time-consuming to monitor, is more accurate and desirable than facility-based assessment based on licensing according to levels of care. Rates could be prospectively determined and consistent across localities with some variation to account for regional inflators. The rate could be negotiated along with the service package at admission and reassesed no less than annually or at the request of the home administrator. Such a reimbursement approach would probably not be budget neutral. The degree to which reimbursement rates should be increased, however, is an empirical issue and thus a detailed cost study of production costs of care for different groups of patients is required in order to establish an exact rate structure that is both acceptable to providers and designed to encourage efficiency in service delivery. The Veterans' Administration model might provide some guidance in the development of this as could the model provided by the Medicaid Review Plan.

2. The DSS should, in conjunction with DMHMR, be responsible for preadmission assessment and ongoing case management for appropriate home-for-adult residents supported by public funds. DMHMR should participate in assessment and case planning for deinstitutionalized patients. Public payment for homes should be contingent on preadmission assessment and assignment of a case manager. This will represent increased workload for both DSS and DMHMR. The relationship between the two agencies needs to be clarified regarding placement, monitoring, funding and services of home-for-adult residents. Many of these problems are currently being addressed by these Departments.

3. The development of prospectively determined reimbursement for homes for adults should not occur without needed quality assurance mechanisms. In order

to serve clients at a given level, the facility must demonstrate that it has appropriate staffing and support systems. New quality-of-care criteria must be developed with sensitivity to client needs and the recognition of diversity among providers. Criteria must also recognize the desire to avoid inflating the costs in the homes beyond justified levels. More information is needed about which clients are currently receiving what level of care and with what outcomes in order to develop and justify new quality standards.

4. A determination of the effectiveness of the present system must be made in order to determine where the problems are and how they might be solved. Factual data must be collected on residents, facilities and services available and the best way of providing linkages. A draft survey is contained in Appendix D.

5. There is a need to provide consumer protection for residents in private-pay facilities, but proposed public fund accountability criteria should not apply to those homes which receive no public funds.

6. A definition of "homes for adults" is needed which explains the differences in care levels provided by these homes and which is meaningful and useful. Data collected by the survey may provide guidance.

7. The concept of after-care grants for the mentally disabled needs to be examined further.

8. The rate application form collected from homes to determine what services are being provided and what payment is justified should be evaluated and possibly changed to more adequately reflect the differences between the homes, including variations in methods of meeting certain requirements and the differences in staff capability, particularly between the large and small homes, but to still provide some standardization of information for comparative use. This will be examined by the Department of Social Services.

9. The current rates for homes for adults should reflect actual costs plus a reasonable profit.

The Joint Subcommittee accepts the task force's report and recommends that the executive branch conduct the survey recommended by the task force. Appendix D contains a proposed survey instrument.

Private Long-Term Care Insurance

The Joint Subcommittee has monitored the progress of the study of issues related to private insurance coverage for long-term care, undertaken by the Bureau of Insurance and the Department of Medical Assistance Services, as requested in 1986 by House Joint Resolution No. 87 (Appendix E). The study group will report its findings to the 1987 Session of the General Assembly. Both government and industry representatives have assisted in the study.

The study group's findings to date indicate that private long-term care insurance currently pays only 5% to 10% of the cost of a nursing home stay throughout the nation. The other 90% to 95% is paid either by government funds or by consumers. A year's stay in a nursing home costs an average of $15,000 to $26,000 in Virginia. At this cost, even the middle income family's savings are quickly exhausted. The need for increased coverage from the private sector is critical. As the "baby boom" generation matures, the need for this coverage will increase. Ninety-five thousand Virginians are over the age of 80; by the year 2000 the number will be 179,000.

The study group has conducted surveys of the public and of insurance companies licensed to do business in Virginia. Data has also been collected regarding the demographics of the Virginia population and its nursing home patients. The results reveal two major areas of concern. First, there appears to be low demand by the public to pursue long-term care coverage, possibly because of a lack of knowledge of what Medicare and Medicare Supplement policies provide and a general readiness to rely on Medicaid to provide long-term care services. The study group is surveying the general population to identify the need for education and to gauge willingness to purchase long-term care insurance. Secondly, the data that is currently available indicates to many members of the insurance industry that the pricing and underwriting of long-term care policies is not actually sound because of the small pool of insured persons and their significant health needs. A larger pool of younger, healthier persons must be sought to enter the market.

Currently, there are at least thirteen companies approved to sell nursing home coverage in Virginia. The policies vary as to the type of coverage they offer, the length of time they provide coverage, and the cost of coverage. The insurance industry has begun to recognize the need for this coverage and the potential in the market, particularly as the U.S. population grows older. The market is now in an experimental introductory stage as companies begin to test approaches to coverage. The study group recognizes the need for regulation which will protect consumers but encourage new offerings of coverage.

The National Association of Insurance Commissioners (NAIC) has been studying issues related to long-term care insurance. The Advisory Committee conducting the study has presented a draft of its report to the NAIC, which the study group is reviewing carefully.

The nursing home providers want minimum standards to ensure that every individual with a nursing home policy will have a certain level of coverage. The study group agrees that minimizing any existing barriers and monitoring the results for any problems may be the proper approach. Consumers would have the protection of the general insurance laws, including the Unfair Trade Practices Act, the minimum standards for accident and sickness policies generally, and readability provisions.

Private insurance coverage appears to be a feasible solution to the increasing

cost of long-term care services. The Joint Subcommittee encourages the study group in its efforts to expand the availability of such coverage and lends its support to actions needed to overcome existing barriers.

Respectfully submitted,

MEMBERS:
Delegate Mary A. Marshall
Delegate George H. Heilig, Jr.
* Senator Dudley J. Emick, Jr.
Senator Thomas J. Michie, Jr.
Delegate Franklin M. Slayton
Delegate C. Jefferson Stafford
Senator Stanley C. Walker

* Senator Emick was appointed to the Joint Subcommittee after it had agreed to the recommendations contained in this report.

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.

HOUSE JOINT RESOLUTION NO. 111

Continuing the Joint Subcommittee Monitoring Long-Term Care.

Agreed to by the House of Delegates, February 10, 1986
Agreed to by the Senate, March 6, 1986

WHEREAS, House Joint Resolution No. 37, agreed to by the 1983 Session of the General Assembly, created the Joint Subcommittee Monitoring Long-Term Care to discuss and facilitate the exchange of information regarding the problems of providing long-term care services to the physically and mentally handicapped and the frail elderly; the Subcommittee was continued for two years in 1984 by House Joint Resolution No. 52; and

WHEREAS, the joint subcommittee has determined that further discussion and attention is needed in this area in light of the complexity of the subject and recent events affecting such; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Joint Subcommittee Monitoring Long-Term Care be continued. The membership of the committee shall continue to serve, and any vacancies which occur shall be filled in the manner of the original appointments.

In addition to other matters, the joint subcommittee shall (i) consider, with the cooperation of other state agencies and providers of care in homes for adults, alternative reimbursement methods for clients in homes for adults which pay the providers of services according to the amount of care required; (ii) consider the feasibility, availability and affordability of insurance coverage for long-term care services given the increasing numbers of the elderly requiring such services and decreasing Medicaid and other fund sources to cover these services; and, (iii) consider the feasibility and efficacy of a requirement that continuing care retirement communities maintain reserve funds to protect the consumer's investment by ensuring the financial ability of providers to meet their obligations.

The joint subcommittee shall complete its work prior to November 15, 1986.

All costs associated with this study, direct and indirect, are $12,035.

1986 SESSION

LD0436508

HOUSE BILL NO. 798

Offered January 21, 1986

A BILL to amend and reenact § 2.1-700 of the Code of Virginia, to amend the Code of Virginia by adding a section numbered 2.1-700.1, and to repeal the Second Enactment of Chapter 377 of the 1983 Acts of Assembly, relating to services to handicapped persons.

Patrons—Marshall; Senator: Walker

Referred to Committee on Health, Welfare and Institutions

Be it enacted by the General Assembly of Virginia:

1. That § 2.1-700 of the Code of Virginia is amended and reenacted and that the Code of Virginia is amended by adding a section numbered 2.1-700.1 as follows:

§ 2.1-700. Interagency Coordinating Committee on Delivery of Related Services to Handicapped Children continued as Council.—The Interagency Coordinating Committee on Delivery of Related Services to Handicapped Children is continued and shall hereafter be known as the Interagency Coordinating Council on Delivery of Related Services to Handicapped Children. The Interagency Coordinating Council shall consist of one representative to be appointed by the agency executives from each of the following: Department of Education, Department of Social Services, Department of Corrections, Department of Health, Department of Correctional Education, Department of Rehabilitative Services, Department for the Visually Handicapped, Department for Children, Department of Mental Health and Mental Retardation , *Department of Housing and Community Development, Virginia Housing Development Authority* and the State Advocacy Department for the Developmentally Disabled. The Coordinating Council shall annually elect a chairman. Each agency shall contribute a pro rata share of the required support services. Additional members may be appointed by the agency executives as required.

The Interagency Coordinating Council shall be responsible for (i) coordination of service delivery to handicapped children, birth through twenty-one years of age; (ii) developing and implementing an interagency state plan for the provision of such services; (iii) initiating cooperative arrangements at the local level; (iv) receiving comments and recommendations from the local public service agencies, private providers and citizens concerning problems in service delivery to handicapped children; (v) designing strategies to mediate such problems; ~~and~~ (vi) monitoring the changes in programs and delivery of services in order to provide services that are needed and to prevent duplicative or unnecessary services *; and (vii) plan and coordinate the implementation of § 2.1-700.1 and report on such implementation by July 1, 1987, and annually thereafter* . The Coordinating Council shall make and submit to the various agency executives a report and recommendations annually, and at such other times as it deems necessary and expedient.

§ 2.1-700.1. Local coordinating council on delivery of services to handicapped persons; individual transition plans.—A. There shall be created no later than January 1, 1987, a local coordinating council on delivery of services to handicapped persons in each county or city of the Commonwealth. The local coordinating councils shall consist of a representative of the following agencies serving the city or county: local school division, local department of social services, local department of health, regional department of rehabilitative services, community services board, and a representative of the Department of Correctional Education, Department for the Visually Handicapped or Department for the Deaf and Hard-of-Hearing when appropriate. The representative of the local school division shall serve as chairman of the council unless the local governing body determines that another council member should serve.

B. The local coordinating council shall be responsible to develop an individual transition plan for each handicapped child as defined in § 22.1-213 who has reached the ages of twenty-one by September 30, 1986; twenty by September 30, 1987; nineteen by

September 30, 1988; eighteen by September 30, 1989; seventeen by Septemeber 30, 1990; sixteen by September 30, 1991; and fifteen by September 30, 1992.

The plan shall identify the child's anticipated educational and vocational needs at the age of twenty-one, contain a strategy for meeting those needs, identify existing barriers to successful transition from special education to adult life, describe the responsibilities of each member of the local coordinating council in implementing the plan and include a schedule for completion of the plan. The council shall request that the child's parent, and the child when feasible, consent to the release and exchange of information needed for development of the plan. The plan may be part of the child's individualized education program. The local coordinating council shall review each plan at least annually, amending the plan as necessary.

C. The local coordinating council shall collect and provide to the Interagency Coordinating Council on Delivery of Related Services to Handicapped Children aggregate data from the plans to assist the Council in planning services for handicapped children.

2. That the Second Enactment of Chapter 377 of the 1983 Acts of Assembly is repealed.

Official Use By Clerks	
Passed By The House of Delegates	**Passed By The Senate**
without amendment ☐	without amendment ☐
with amendment ☐	with amendment ☐
substitute ☐	substitute ☐
substitute w/amdt ☐	substitute w/amdt ☐
Date: _____	Date: _____
_____	_____
Clerk of the House of Delegates	Clerk of the Senate

1986 SESSION

LD0764118

SENATE BILL NO. 65

Offered January 13, 1986

A BILL to amend and reenact §§ 38.1-955 and 38.1-957 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 38.1-959.1, relating to escrow of entrance fees by continuing care providers.

Patrons–Holland, E. M. and Gartlan; Delegate: Marshall

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.1-955 and 38.1-957 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding a section numbered 38.1-959.1 as follows:

§ 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 *in the aggregate* 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.

§ 38.1-957. 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 10% 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 criminal charge, or been held liable or enjoined in a civil action by final judgment, if the crime or civil action involved fraud, embezzlement, fraudulent conversion, misappropriation of property or moral turpitude; 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~~ *a description of* provisions ~~exist~~ for the escrowing and return of any such funds, ~~property~~ *assets* or entrance fee ~~and~~ the manner and any conditions of return *and to whom earnings on escrowed funds are payable* ; 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. The disclosure statement shall clearly state whether or not reserve funds are maintained.

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 of 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 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.

§ 38.1-959.1. Escrow of entrance fee.—A. A provider shall maintain in escrow with a bank or trust company, or other escrow agent approved by the Commission, all entrance fees or portions thereof in excess of $1000 per person received by the provider prior to the date the resident is permitted to occupy a living unit in the facility. Funds or assets deposited therein shall be kept and maintained in an account separate and apart from the provider's business accounts.

B. All funds or assets deposited in the escrow account shall remain the property of the prospective resident until released to the provider in accordance with this section. The funds or assets shall not be subject to any liens, judgments, garnishments or creditor's claims against the provider or facility. The escrow agreement may provide that charges by the escrow agent may be deducted from the funds or assets if such provision is disclosed in the disclosure statement.

C. All funds or assets deposited in escrow pursuant to this section shall be released to the provider when the provider presents to the escrow agent evidence that (i) a unit has been occupied by the resident or a unit of the type reserved is available for immediate occupancy by the resident or prospective resident on whose behalf the fee was received and (ii) the facility has at least forty percent of its residential units occupied pursuant to a continuing care contract or reserved for occupancy pursuant to a bona fide reservation agreement for continuing care. For purposes of this section, a "bona fide reservation agreement" shall include but not be limited to the following:

1. Any agreement pursuant to which the provider has collected (i) a nonrefundable application or reservation fee in excess of $1000, (ii) ten percent of the current entrance fee for that unit, twenty percent of which shall be forfeited in the event of termination of the contract for reasons other than those specified in § 38.1-960 B or C, or (iii) ten percent of the current entrance fee, to be held by the provider until the unit reserved is resold in the event of termination of the contract for reasons other than those specified in § 38.1-960 B or C.

2. Any agreement satisfactory to the Commission.

D. Notwithstanding any other provision of this section, all funds or assets deposited in escrow pursuant to this section shall be released according to the terms of the escrow agreement to the prospective resident from whom it was received (i) if such funds or assets have not been released within three years after placement in escrow or within three years after construction has started, whichever is later, or within such other period as determined appropriate by the Commission in writing or (ii) upon rescission of the contract pursuant to provisions in the contract or in this chapter. However, funds or assets subject to release under item (i) above may be held in escrow for an additional period at the mutual consent of the provider and the prospective resident. Item (i) above shall not apply if fees are refundable within thirty days of request for refund.

E. Unless otherwise specified in the escrow agreement, funds or assets in an escrow account pursuant to this section may be held in the form received or if invested shall be invested in instruments authorized for the investment of public funds as set forth in Chapter 18 (§ 2.1-327 et seq.) of Title 2.1 and not in default as to principal or interest.

F. This section shall not apply to entrance fees for initial occupancy of units under construction on June 30, 1986.

G. This section shall not apply to application or reservation fees whether or not such fees are considered to be a portion of the entrance fee, provided such application or reservation fees are not in excess of $1,000 per person.

Official Use By Clerks	
Passed By The Senate	**Passed By The House of Delegates**
without amendment ☐	without amendment ☐
with amendment ☐	with amendment ☐
substitute ☐	substitute ☐
substitute w/amdt ☐	substitute w/amdt ☐
Date: _____	Date: _____
_____	_____
Clerk of the Senate	Clerk of the House of Delegates

Medical College of Virginia
Virginia Commonwealth University

MEMORANDUM

TO: Members of the Task Force on
Levels of Care in Homes for Adults

FROM: John A. Capitman, Ph.D.
Health Policy Analyst
Virginia Center on Aging

DATE: June 3, 1986

RE: Discussion Draft Proposal for Study
of Homes for Adult Clients, Services, and Costs

Background

Delegate Mary Marshall has been leading a Task Force on Levels of Care in Homes for Adults. The task force including representatives of the industry and the major public actors in financing and coordination of Home for Adults (HFA) service delivery reached consensus that there is a need for policies, regulations, administrative procedures, and reimbursement approaches that recognize the following:

1. The approximately 16,145 HFA residents in the Commonwealth are an extremely heterogeneous group. They differ with regard to source of payment, reason for HFA placement, level of functional and mental/ cognitive dependence, and needs for social, employment, medical/ nursing, and mental health services;

2. The approximately 370 licensed HFA providers in Virginia are also an extremely heterogeneous group. They differ with regard to ownership class, size, services available, staffing levels, linkages with other provider types, average characteristics of residents with regard to the factors above, daily operating costs and margins, and management sophistication; and,

3. The availability of consumer information and care coordination services varies from community to community within the Commonwealth. There is the perception that for certain classes of users (e.g. those discharged from mental health institutions, those approaching nursing home eligibility with respect to functioning, those privately paying individuals lacking assistance in placement etc.) the care coordination and consumer information services are currently inadequate.

Virginia Center on Aging • 1008 East Clay Street • Box 229 MCV Station
Richmond, Virginia 23298 • (804) 786-1525

The Task Force noted, however, that there is a basic lack of descriptive information on the current HFA delivery system and public financing approaches. This lack of information precludes development of realistic recommendations for policy and program changes. At the same time, the 1986 Virginia General Assembly in SJR-70 has called for a comprehensive examination of the need for improved care coordination and levels of care in HFAs.

In order to respond to these information deficits, the Task Force created a sub-committee to develop a proposal for a preliminary study of the HFA providers and residents that might serve as the basis for recommended policy and program changes. The subcommittee was charged with developing a low cost research approach, that would build on the current efforts of the Department of Social Services (DSS) in studying the Adult Service population, and would be based in a model of public/private partnership for implementation. The remainder of this memorandum describes the study that the subcommittee would propose, and an outline of the tasks and resources required for its implementation.

Study Goals

The proposed study has the following four goals.

1. To describe the characteristics of publicly-supported and privately paying HFA residents with regard to demographics, sources of payment, reasons for placement, functioning in basic and instrumental activities of daily living, psychological, cognitive, emotional and social functioning, use of externally provided services, needs for additional services, and financial and administrative barriers to adequate service delivery.

2. To describe the characteristics of HFA providers with regard to daily operating costs and margins per resident, staffing levels, services provided, barriers to effective service provision, linkages with external providers of health, mental health, social/recreational, and employment/educational services, and relationships with public agencies responsible for care coordination and consumer information.

3. To describe the relationships between resident characteristics and needs, and operating costs, taking both clinical judgements of service adequacy and use of externally provided services, margins, and other factors into account, so that preliminary recommendations for levels of care for regulatory and reimbursement purposes can be made.

4. To describe HFA provider perceptions of the kinds of consumer information and care coordination services required from public agencies that are needed for more adequate service delivery. To use these findings and perceptions by public agency officials in developing preliminary recommendations for policy and program changes.

Study Procedures

The proposed study would examine a sample of HFA residents in a sample of facilities. Both samples would be drawn so as to be representative of the Commonwealth as a whole. Data would be collected by HFA providers through the cooperation of the three main provider organization: Virginia Association of Homes for Adults (VAHA), Virginia Association of Non-Profit Homes for Adults (VANHA), and the Virginia Health Care Association (VHCA). These provider groups would be assisted in instrument design, training of data collectors, data collection management, and data analysis and interpretation by State agencies including the Departments of Social Services and Mental Health and Mental Retardation, and the Virginia Center on Aging. The study is expected to take 9 months, beginning in the Summer of 1986. Because of the major contribution of volunteer labor by the provider associations, and the in-kind contributions of participating public organizations, direct costs for the project are estimated at $14,000. The provider associations have offered to participate in financing these direct costs. Each of the main elements of the study design are described below.

HFA Facility Sample: A 20% sample of the 370 licensed HFA facilities or approximately 80 facilities would be selected for the study. The facility sample would be stratified by (1) ownership class, (2) region within the Commonwealth, and (3) number of beds, so that the sample is representative of the provider group as a whole. Only HFAs that are members of one or more of the provider associations would be included. Given the relative size of the provider association memberships, approximately 64 VAHA, 10 VANHA, and 10 VHCA members would be selected for participation.

HFA Resident Sample: HFA residents would be sampled from the facilities included in the HFA Facility Sample. For facilities with less than 50 residents, all residents would be included in the sample. For facilities with more than 50 resident, a random sample of 50 would be drawn within the facility. Random sampling within facilities will be supervised by public agency staff to assure no bias in selection. Note that for life-care and other multi-level residential facilities, only residents at the Personal Care Unit level would be eligible for study inclusion. Based on the distribution of facilities with regard to number of beds, it is estimated that about 2,000 residents would be selected for the study or about 13% of the more than 16,000 residents statewide.

HFA Facility Sample Data Collection: While data is collected by DSS on operating costs and other characteristics of facilities, there is general agreement that many facilities do not provide adequate cost data. In order to provide more reliable data on operating costs per resident day, a revised cost data collection form will be developed. Data on patient revenues for both private and public patients will be collected as well to permit estimation of operating margins per patient day as a function of payment type. Supplementing this data will be detailed information on facility characteristics, staffing patterns, services available, and linkages with external service providers. Attitudinal data from facilities will explore operator perceptions on barriers to effective delivery, consumer information,

and care coordination.

All facility level data will be collected by association members who are themselves owners or managers of HFAs. The operator of the facility will not complete the form without assistance, and it is expected that this procedure will yield both more reliable and objective data than is currently available on financial aspects of HFA provision. For a subset of facilities, staff from public agencies will collect the financial data along with the association members, in order to permit an additional check of the reliability of data collection. The forms and procedures for this portion of the study have not been fully developed, since this will require considerable effort and consultation with both industry and public agency representatives.

HFA Resident Sample Data Collection: The assessment of resident characteristics, service use, and service needs for sampled HFA residents will be implemented using a modification of the tool developed by DSS for their current Adult Services caseload study. The tool incorporates all elements of the National Long Term Care Minimum Data Set and is also consistent in overlapping areas with the data collected as part of the Nursing Home Pre-admission Screening Program using the Long Term Care Information System. This comparability of data collection will permit comparisons of HFA residents with nursing home and personal care users in Virginia, and with similar long term care populations nationwide. The proposed tool also collects data on service needs and service use, and on patient specific barriers to effective care delivery and coordination. A working draft of the proposed instrument is attached.

The assessments of HFA residents will be conducted by facility staff under the guidance of the association members responsible for facility level data. These individuals will participate in not less than 6 hours of training in data collection procedures and the use of the instruments. All assessments will be conducted in a facility during a 3-5 day period and will focus on current functioning, service use and service needs. As for the facility level sampling, concurrent reliability and validity of the data collection process will be checked by having public agency staff conduct concurrent assessments for a sub-sample of residents.

Data Management and Analysis: Data management during the data collection phase, data editing and entry, and data analysis will be conducted by the participating public agencies. Data analysis will be conducted in three stages. In Stage I, the reliability of both facility-level and resident data will be assessed using the sub-samples for whom concurrent interviewing was implemented. In Stage II, descriptive analyses of the resident sample will be conducted, along with descriptive analysis of facility data. The goal at this point will be to identify factors at both client and facility level that need to be considered in defining level of care groupings. In the final Stage, multiple regression analysis and other multivariate techniques will be used to explore the relationships between facility characteristics, resident characteristics and operating costs per day. These analyses will permit preliminary recommendations regarding the desirability and potential definitions of levels of care and

associated regulatory and reimbursement procedures.

Study Timetable: The following preliminary timetable for the proposed study is based on the assumption that approval and funding for direct costs can be obtained by July 1, 1986. Of course, the timetable will need to be modified if a latter start date is required.

July 1 - September 1, 1986

1. HFA resident sample instrument finalized.
2. HFA facility sample instrument designed and finalized.
3. HFA facility sample drawn and approvals obtained.
4. Association members responsible for data collection identified.

September 1 - October 1, 1986

1. Training of association and public agency data collectors in regional meetings.
2. Data collection management procedures finalized.
3. Research assistant hired and trained.

October 1 - December 15, 1986

1. HFA facility data collected.
2. HFA resident data collected.
3. Data editing and entry initiated.

December 15, 1986 - January 30, 1987

1. Data editing and entry completed.
2. Reliability assessment completed.

February 1 - March 15, 1987

1. Data analysis completed.
2. Preliminary recommendations developed for discussion with Task Force, provider associations, and public agencies.
3. Preliminary presentation to General Assembly.

March 15 - April 15, 1987

1. Preparation of final report.

Study Direct Costs: The major costs for most studies such as the one here proposed relate to data collection personnel. In this case, all such costs will be met in in-kind contributions from the provider association memberships. Nonetheless, there will be the following direct costs.

Item	Costs
Travel related to training and data collection monitoring	$2,000
Instrument and report printing	$1,500
Research assistant for data collection monitoring and data analysis (7 months)	$6,000
Data editing and entry technician (3 months)	$1,500
Computer costs	$2,000
Telephone, miscellaneous	$1,000
TOTAL	$14,000

HOME FOR ADULTS SERVICES STUDY - QUESTIONNAIRE

Date: _____

Interviewer Telephone Number: _____

Client's Name: _____

Name of Facility: _____

Facility City/County: _____

* * * * * * * *

Instructions: Enter the code on the blank line in the left margin that represents the appropriate response to each question or enter response.

___ 1. a) CASE TYPE: 1) Auxiliary Grant
2) DMH/MR hospital discharge
3) Auxiliary Grant/DMH-MR hospital discharge
4) Veteran Community Care
5) Private funds and own health care providers
6) Other public funds _____ (specify)

b) Monthly payment received for this client. $ _____

___ 2. AGE: (years) _____

___ 3. SEX: 1) Male 2) Female

___ 4. CURRENT MARITAL STATUS: 1) Single 4) Separated
2) Married 5) Widowed
3) Divorced 6) Unknown

___ 5. RACE: 1) American Indian 4) Black
2) White 5) Asian
3) Hispanic 6) Other _____ (specify)

___ 6. State the amount of monthly income received from any of the following sources rounded off the nearest dollar.

$ _____ a. Social security

$ _____ b. Railroad retirement

$ _____ c. Veterans retirement or pension

$ _____ d. Other _____ (specify)

___ 7. State the amount of monthly benefits received from any of the following sources rounded off to the nearest dollar.

$ _____ a. Supplementary security income

$ _____ b. General relief

$ _____ c. Auxiliary grant

$ _____ d. Veterans benefits for facility compensation

___ 8. Is this client currently enrolled in Medicaid?

1) yes 2) no

___ 9. State the number of children the client has the live within approximately a 30-mile radius or one half hour driving distance.

___ 10. If this client is a resident of a home for adults, which of the following arranged the placement?

1) self
2) relative
3) physician
4) acute care hospital
5) private psychiatric hospital
6) MHMR state hospital
7) Community service board
8) Department of health
9) Area agency on aging
10) Department of social services
11) Other _____ (specify)

___ 11. If this client is a resident of a home for adults, is there a social services, mental health or other caseworker actively involved in the ongoing monitoring of this case?

1) Yes. If is, state worker's name: _____

Agency: _____

2) No

___ 12. Has this client been screened by a nursing home pre-admissions screening committee within the last 6 months?

1) Yes 2) No 3) Unknown

___ 13. a) Enter the code that best describes this client's orientation to person, place and time.

1) Oriented
2) Disoriented - some spheres, sometime
3) Disoriented - some spheres, all the time
4) Disoriented - all spheres, sometime
5) Disoriented - all spheres, all the time
6) Comatose

b) Does this client exhibit any of the following behaviors: wandering, assaultive, abusive?

1) Yes 2) No

___ 14. Has this client been recommended for supervision because of a cognitive impairment? (e.g., confusion, disorientation, or mental health problems)

1) Yes 2) No

If yes, describe: _____

___ 15. Does this client have any chronic health conditions that require supervision, special treatments, or nursing procedures?

1) Yes _____
(Specify diagnosis/condition (e.g., diabetes)

_____
(Specify treatment/procedure (e.g., help with insulin injections)

2) No

___ 16. Has committee or guardian been appointed for this client?

1) Yes 2) No 3) Unknown

17. Was this client a patient during the last six months in:

___ a) an acute care hospital (1 Yes - 2 No)
___ b) a DMH/MR psychiatric hospital (1 Yes - 2 No)
___ c) a private psychiatric hospital (1 Yes - 2 No)
___ d) a skilled nursing facility (1 Yes - 2 No)
___ e) an intermediate care facility (1 Yes - 2 No)

18. Activities of Daily Living: In the first column, enter the code from Group1 which indicates how the client usually performs each of the following activities. In the second column, enter the code from Group 2 which indicates who usually performs each of the activities.

Group 1
1) Independent (performs without human or mechanical help)
2) Partial-dependent (perform with some human and/or mechanical help)
3) Dependent (activity is completely performed for client with or without mechanical help)

Group 2
1) Self
2) Family
3) Neighbor/friend/volunteer
4) Private paid family member, friend, or agency
5) Community agency other than facility (public or private)
6) Facility staff
7) Not performed

COLUMN I	COLUMN II	ACTIVITIES
_____	_____	a. bathing
_____	_____	b. dressing
_____	_____	c. toileting
_____	_____	d. transferring
_____	_____	e. eating/feeding
_____	_____	f. medication administration
_____	_____	g. transportation
_____	_____	h. shopping
_____	_____	i. meal preparation
_____	_____	j. managing finances
_____	_____	k. housekeeping
_____	_____	l. walking

19. Column I

If the client currently receives any of the services listed below that are administered by a public agency, enter the code for the agency providing the service.

1) Dept. of Welfare/Social Serv.
2) Dept. of Health
3) Community Services Board
4) Area Agency on Aging
5) Dept. of Medical Assistance Services
6) Dept. for the Visually Handicapped
7) Dept. of Rehabilitative Serv.
8) Medicare
9) Other _____ (specify)

Column II

Does the client need any of the services listed below, in addition to the services currently received. Enter the code in Column II.

0 - not needed; 1 - needed but not provided in the community; 2 - needed but client not eligible; 3 - needed but not available to client

COLUMN I	COLUMN I	
_____	_____	a. Case management/advocacy/counseling
_____	_____	b. Clinic services
_____	_____	c. Counseling and treatment
_____	_____	d. Day care for adults
_____	_____	e. Development day care for adults
_____	_____	f. Education
_____	_____	g. Employment services/sheltered workshop
_____	_____	h. Eligibility determination
_____	_____	i. Friendly visiting
_____	_____	j. Nursing, OT, PT
_____	_____	k. Legal services
_____	_____	l. Nutrition education
_____	_____	m. Other outpatient medical services
_____	_____	n. Personal care/health aide
_____	_____	o. Protective services
_____	_____	p. Recreation/socialization
_____	_____	q. Transportation
_____	_____	r. Other

20. a) Does this client require any special supplies or equipment (e.g., diapers, ostomy, walker, etc.)

1) Yes _____
(specify)

2) No

b) Are these special supplies or equipment?

1) purchased by client out-of-pocket
2) purchased by public agency (specify) _____
3) not purchased
4) Other (specify) _____

21. The following questions must be asked of the client during a face-to-face interview. Record verbatim responses. Enter appropriate code in left margin to indicate if the response was correct or incorrect. Before the questions are asked, read or explain the following paragraph to the client.

If have a few basic questions I would like to ask you. You may find them very easy, so please bear with me. Some people forget these things from time to time.

1) Correct response 2) Incorrect response

___ a. What is the date today? _____
(mm - dd - yy)

___ b. What day of the week it is? _____

___ c. What is the name of this place? _____

___ d. What is your telephone number. (If no telephone, what is your street address?

_____

___ e. How old are you? _____

___ f. When were you born? _____
(mm - dd - yy)

___ g. Who is the President of the U.S. now? _____

___ h. Who was the President's first before him? _____

___ i. Who was your mother's maiden name? _____

___ j. Subtract 3 from 20 and keep subtracting 3 from each number you get, all the way down

_____
(Correct: 17, 14, 11, 8, 5, 2)

HOUSE JOINT RESOLUTION NO. 87

Requesting the Bureau of Insurance, with the Department of Medical Assistance Services, to conduct a study concerning changes needed in order to implement private insurance coverage for patients residing in nursing homes.

Agreed to by the House of Delegates, February 10, 1986
Agreed to by the Senate, March 6, 1986

WHEREAS, in the United States, an estimated one-half of all nursing home patients who enter as private paying patients become indigent within a two-year period; and

WHEREAS, nursing home reimbursement is the largest line item in the Commonwealth's Medicaid budget; and

WHEREAS, most elderly people are unaware that Medicare will only reimburse a maximum of 100 days of skilled nursing care; and

WHEREAS, the growth of the elderly population in Virginia is increasing at a rate higher than the national average; and

WHEREAS, the high cost of nursing home services can be traumatic and devastating to not only the patient but also the family, who are usually in the position of caring for the patient, and, in some cases, causes the deterioration of familial relationships; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Bureau of Insurance, with the Department of Medical Assistance Services, with the assistance of other individuals, groups and agencies as it deems appropriate, conduct a study to review the need for and feasibility of enacting legislation which would specifically encourage private insurance coverage for long-term care coverage. The study should include, but not be limited to, the identification of barriers in the current state statute to the provision for such insurance, as well as potential tax incentives, educational requirements, public awareness programs and consumer guides that would be needed in order to make this type of insurance feasible.

The Bureau of Insurance and the Department of Medical Assistance Services shall report their findings and recommendations to the General Assembly prior to the 1987 Session; and, be it

RESOLVED FURTHER, That the Clerk of the House of Delegates transmit copies of this resolution to the Directors of the Bureau of Insurance and the Department of Medical Assistance Services.