REPORT OF THE
JOINT COMMISSION ON HEALTH CARE

STUDY ON CONTINUING CARE RETIREMENT COMMUNITIES PURSUANT TO SB 1139 OF 1997

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 36

COMMONWEALTH OF VIRGINIA
RICHMOND
1998

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PREFACE

Senate Bill (SB) 1139 of the 1997 Session of the General Assembly established that the Commissioner of Health shall only approve, authorize or accept applications for the issuance of certificates of public need (COPN)filed for continuing care retirement community (CCRC) nursing home bed projects by continuing care providers registered with the State Corporation Commission pursuant to Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2 for sixty or fewer beds. This legislation was implemented as a reaction to a certificate of public need application by a northern Virginia continuing care retirement community request for 240 bed nursing home beds.

The second enactment clause of SB 1139 directed the Joint Commission on Health Care, in cooperation with the Commissioner of Health and the Commissioner of Insurance, to study the management of applications for nursing facility projects in continuing care retirement communities under the Commonwealth's Medical Facilities Certificate of Public Need law and regulations including, but not limited to (i) whether to include or exempt CCRC projects from the Request for Application (RFA) process established pursuant to §32.1-102.3:2; (ii) the different forms of CCRC contracts being offered in Virginia and the effect of such contracts on the utilization of nursing facility beds in CCRCs; (iii) the impact of increase in nursing facility beds in CCRCs, if any, on the occupancy rates and charges of existing nursing homes and certified nursing facilities in the Commonwealth;(iv) the impact, if any, of nursing facility beds in CCRCs on Virginia Medicaid expenditures; and (v) the appropriateness of the present registration law, Chapter 49 (§38.2-4900 et seq.) of Title 38.2, for CCRC providers and the need for any modifications to such law, particularly in view of the changing configurations in the continuing care market.

Based upon our research and analysis, we concluded the following:

- The Bureau of Insurance and the Department of Health both provide regulatory oversight of CCRCs but the focuses of their regulation are not parallel. The emphasis of the Bureau's regulation is on financial solvency and consumer protection through disclosure while the Virginia Department of Health (VDH) administers the COPN program and Request for Proposal process for nursing home beds in the Commonwealth, licenses and regulates nursing home beds, and certifies Medicaid and Medicare beds in these facilities.
- Although the addition of any amount of nursing beds into a community will have some level of effect on the market share of any nursing homes in that area, regression analysis of occupancy rate data for nursing home beds in Virginia, during the years 1990-1995, shows no statistical significance of the effect of nursing home beds in continuing care retirement communities on occupancy rates of

free-standing nursing facilities. Nor was the growth of the CCRCs and their nursing bed market share in Virginia found to be statistically significant. With the availability of a growing list of alternative long-term care services, the decreasing occupancy rate in Virginia's nursing homes appears to be following the national trend.

- While there is concern that the configuration of CCRCs has changed in recent years, especially in respect to the addition of non-traditional contract types and fully or partially refundable entrance fees, there is no currently available data that would indicate that these market shifts require statutory change at this time. The majority of CCRCs continue to offer the traditional, insurance based contract and only 11 percent of CCRCs with affiliated nursing homes are not for-profit organizations.

- Nursing home beds in Virginia CCRCs have little impact on Medicaid expenditures. Data obtained from the Center for Health Statistics and the Department of Health support that Medicaid expenditures have not changed significantly from 1991 to 1996. Furthermore, nursing home beds in CCRCs have little impact on the Commonwealth's Medicaid expenditures.

- Based upon recent COPN decisions by the Commissioner of Health, no facility has been granted over 60 nursing beds in the past ten years, including the COPN application requesting 240 bed nursing home beds which resulted in SB 1139. The number of CCRC nursing home beds that will be open to the community under the three-year opens admissions restriction at the end of 1997 will represent approximately 4.4 percent of all CCRC nursing beds in Virginia.

Although current information does not substantiate any notable problems associated with the recent growth in CCRCs and their associated nursing home beds in the Commonwealth, the nursing home industry has raised concerns. It is their belief that their members are being treated unfairly because CCRCs are currently able to admit persons from the outside community without having to participate in the recently implemented, competitive Request for Application (RFA) process. The nursing home industry is concerned that, in conjunction with the trend towards alternative avenues in long-term care and the potential growth of large, fee-for-service CCRCs, occupancy rates and the percent of private pay residents will continue to decline in freestanding nursing homes.

The study brief for this study was originally presented at the October, 6, 1997 Commission meeting. Our review process on this topic included site visits to both nursing homes and CCRCs, an initial staff briefing which you will find in the body of this document, a public comment period following the presenta-

tion of the brief, a written mail survey to 178 nursing homes and 35 CCRCs, and analysis of those survey responses. A summary of the public comments received by this office and a summary of compiled survey results are provided at the end of this report. Both items may provide additional insight into the various issues addressed in this study.

Subsequent to this study, the Long-Term Care Subcommittee met and addressed the issues brought forth during the study process. The subcommittee then offered to the full Joint Commission on Health Care policy options for consideration. At the January 6, 1998 meeting of the Joint Commission on Health Care, the full Commission voted to introduce legislation that would codify restrictions on the growth of nursing home beds in CCRCs who choose to make application for a COPN outside of the RFA process. In addition, the bill requires CCRCs who seek COPNs under the RFA exemption to have a Qualified Resident Assistance Policy in place. The full Commission also voted to adopt a resolution which requests DMAS to study the issues regarding Medicaid reimbursement for nursing homes. During the 1998 General Assembly session, the major stakeholders met and developed a compromise approach which was introduced in the form of a substitute bill.

The final version of this bill, SB 466, provides criteria for the Commissioner of Health to follow when reviewing COPN applications by CCRCs who file outside of the Request for Application process. This new legislation includes language which addresses, but is not limited to, the following: a possible onetime, three-year open admissions period to CCRC nursing home beds; a limitation on the number of new nursing beds in any COPN not to exceed the lessor of twenty percent of the facility's licensed non-nursing beds or sixty beds; the inclusion of a Qualified Resident Assistance Policy in the resident contracts; and a provision which permits a family member to directly enter the CCRC's nursing facility when another family member enters a non-nursing home section of the CCRC.

On behalf of the Commission and its staff, I would like to thank the Bureau of Insurance, the Department of Medical Assistance Services, and the Virginia Department of Health for the assistance they provided during this study.

Jane N. Kusiak
Executive Director

March 24, 1998

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I. AUTHORITY FOR STUDY

Senate Bill 1139 was introduced to the 1997 General Assembly in reaction to the magnitude of a proposed continuing care retirement community (CCRC) in Northern Virginia, known as Greenspring Village. The filing requested a 240 nursing bed unit; in the previous ten years, the largest number of nursing beds under a single certificate of public need (COPN) for a CCRC had been 60. Thus, Senate Bill 1139 was introduced.

Senate Bill (SB) 1139, approved by the 1997 Session of the General Assembly, placed into statute the following action in order to prevent the potential approval of the Greenspring Village project as initially requested:

> "Not withstanding the provisions of § 32.1-102.3:2.1, the Commissioner shall only approve, authorize or accept applications for the issuance of certificate of public need filed for continuing care retirement community nursing home bed projects by continuing care providers registered with the State Corporation Commission pursuant to Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2 for sixty or fewer beds."

As a matter of compromise between the primary stakeholders, the bill further directed the Joint Commission on Health Care, in conjunction with the Commissioner of Health or his designee and the Commissioner of Insurance or his designee, to study the management of applications for nursing facility projects in CCRCs under the Commonwealth's Medical Facilities COPN law and regulations.

Specifically, the bill has directed the Joint Commission on Health Care to study the following five (5) issues as they relate to nursing home beds associated with continuing care retirement communities:

- whether to include or exempt CCRC projects from the Request for Application (RFA) process established pursuant to §32.1-102.3:2;
- the different forms of CCRC contracts being offered in Virginia and the effect of such contracts on the utilization of nursing facility beds in CCRCs;
- the impact of increase in nursing facility beds in CCRCs, if any, on the occupancy rates and charges of existing nursing homes and certified nursing facilities in the Commonwealth;
- the impact, if any, of nursing facility beds in CCRCs on Virginia Medicaid expenditures; and
- the appropriateness of the present registration law, Chapter 49 (§38.2-4900 et seq.) of Title 38.2, for CCRC providers and the need for any modifications to such law, particularly in view of the changing configurations in the continuing care market.

A copy of SB 1139 is provided at Appendix A.

As an effort to obtain additional data upon which to base the study's findings, a mail survey was administered subsequent to the original draft of the staff study report to 178 nursing facilities in all planning districts which contain at least one CCRC and to the Commonwealth's 35 CCRCs which have associated nursing facilities. A total of 47 nursing home surveys were returned in time to be included in the analysis, a response rate of 26%. Fourteen of the fifteen CCRC surveys that were returned and included in the anlysis were useable, providing a response rate of 40%. The overall findings from the survey analysis further support the study results. Results of the analysis is located in Appendix B.

II. BACKGROUND

DEFINITIONS

Continuing Care Retirement Communities (CCRC): CCRCs offer independent living, assisted living, and nursing home care, to residents who are financially able to contract with the CCRC for such life-time services. CCRCs are regulated by Virginia and are defined both in the *Code of Virginia* and in the standards of the State Medical Facilities Plan (SMFP). The SMFP contains the regulations by which the Division of Certificate of Public Need controls the growth of nursing home beds in the Commonwealth, including those in CCRCs. The definitions are as follows:

Code of Virginia (Chapter 49)

"*Continuing care* is defined as "providing or committing to provide board, lodging, and nursing services to an individual, (i) pursuant to an agreement effective for the life of an individual or for a period in excess of one year, and (ii) in consideration of the payment of an entrance fee." (1985)

"*Continuing care* also means providing or committing to provide lodging 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, (ii) in consideration for the payment of an entrance fee, and (iii) where board and nursing services are made available to the resident by the providers, either directly or indirectly through affiliated persons, or through contractual arrangements whether or not such services are specifically offered in the agreement for lodging. 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." (Added in 1993)

SMFP Standard

"*Continuing care retirement community* means those retirement communities for the elderly that provide residential, health care and support services through a continuing care contract. CCRCs can have nursing home services available either on-site, or at licensed facilities off-site."

Continuing Care and Life Care Contracts:

SMFP Standard

"*Continuing Care Contract* means the written agreement which provides for continuing care consistent with the requirements of Chapter 49 (§38.2-4900 et seq.) of Title 38.2 of the *Code*. It functions as an insurance policy, whereby the individual resident purchases from a Continuing Care Retirement Community (CCRC), through an entrance fee and periodic adjustable payments, a package of residential and health care services which the CCRC is obligated to provide at the time these residential and health care services are required. The health care services include adult care residence services (also know as domiciliary care, assisted living services or personal care) and nursing home services. Continuing care contracts are regulated by the Virginia Bureau of Insurance of the Virginia State Corporation Commission."

"*Life care contract* means a continuing care contract."

FIGURE 1

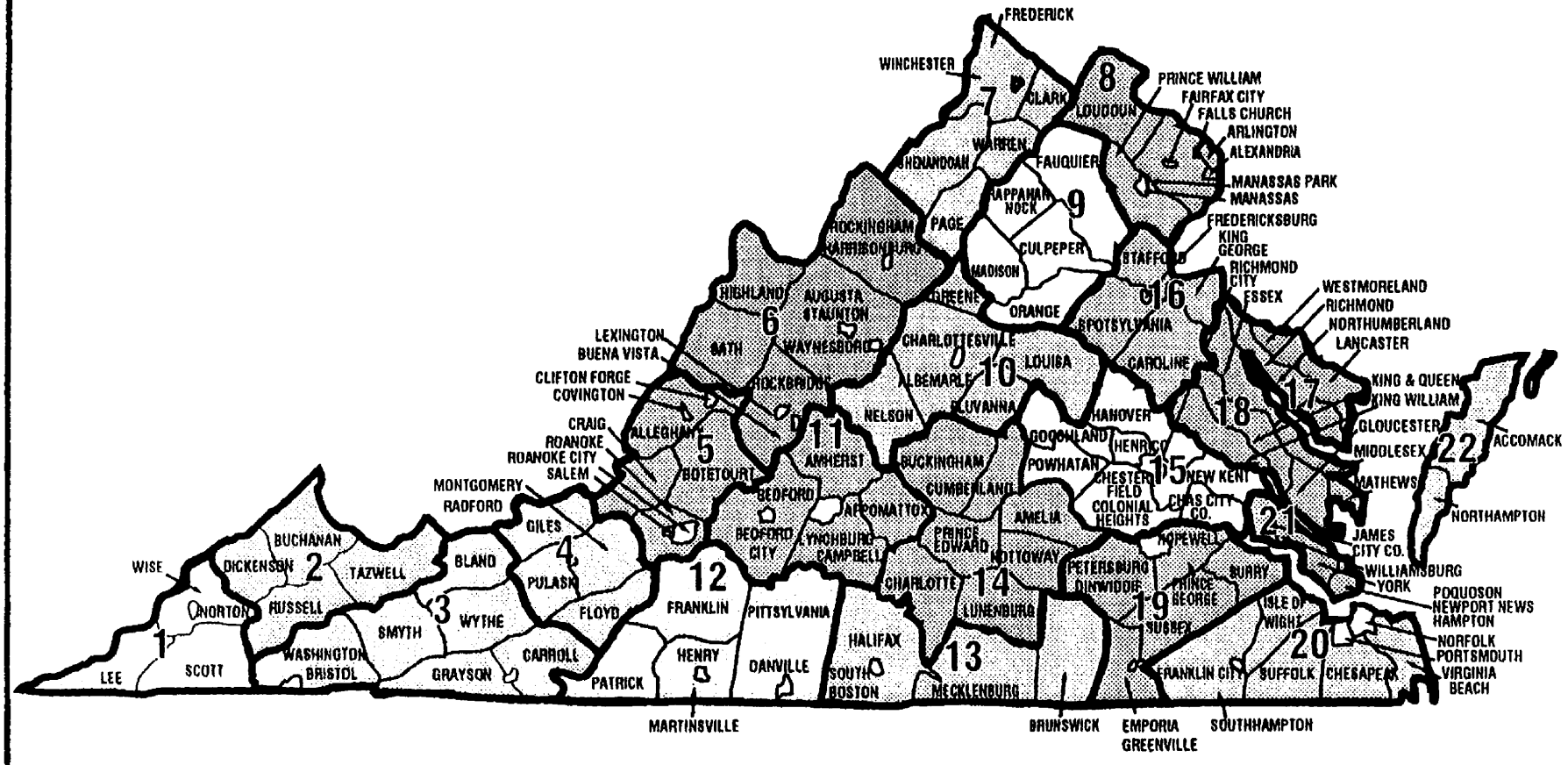
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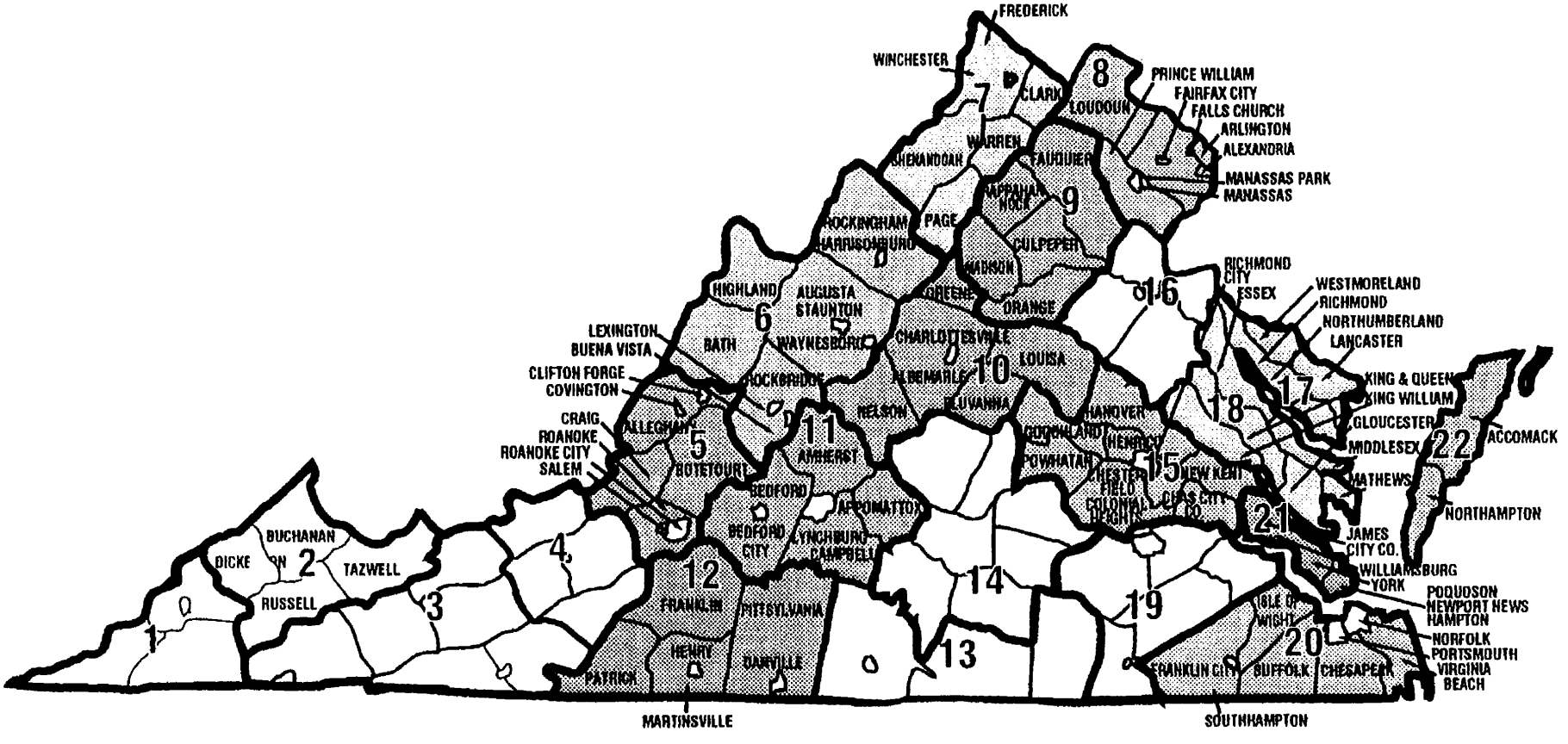
FIGURE 2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DEMOGRAPHICS OF NURSING HOMES AND NURSING BEDS IN CCRCS IN VIRGINIA

The Commonwealth of Virginia is home to approximately 261 nursing homes. Of these, 35 (excluding Greenspring Village) are associated with continuing care retirement communities (CCRC). There are just over 30,000 nursing beds, of which 2,654 (approximately 9%) are associated with CCRCs.

Of the twenty-two planning districts in the Commonwealth, fourteen contain at least one CCRC. Planning District 8 (Northern Virginia) has ten CCRCs, when Greenspring Village is included; Planning District 15 (Richmond) has six; and Planning Districts 5 (Roanoke) and 21 (Hampton Roads area) each have three. The other nine districts have less than three each. Figure 1 (See page 4) depicts the state's planning districts and Figure 2 (see page 5) high-lights those planning districts which contain at least one CCRC.

Of the 36 CCRCs with nursing facilities (including Greenspring Village), four are proprietary entities. Of the 2,654 total nursing beds in CCRCs:

- 2,272 beds were built with no restrictions placed on admissions (88.6%); many of these pre-date the COPN program
- 1,114 beds are Medicaid certified (42%)
- 250 beds are restricted and may not become Medicaid certified (9.4%)
- 268 beds are/have been open to outside admissions according to the three-year standard (10.1%); of these, 117 will remain open to outside admissions after December 31, 1997.

III. State Regulation of Continuing Care Retirement Communities

The State Corporation Commission's Bureau of Insurance (BOI) oversees the financial regulation and the Virginia Department of Health (VDH), provides health planning and regulation through the certificate of public need (COPN) program and the licensure of all nursing home beds. The regional Health Systems Agencies assist VDH with the health planning aspects. The Department of Social Services regulates the adult care residences in CCRCs, and the Department of Medical Assistance Services administers Medicaid reimbursement. Figure 3 contains an outline of the state agencies' responsibilities in the regulation of CCRCs and Figure 4 presents a summary time line of state regulation of CCRCs.

Figure 3

CCRC Oversight Functions Of State Agencies

State Agency	*Primary Oversight Function (s)*
State Corporation Commission	
Bureau of Insurance	Enforces Chapter 49 of Title 38.2 of the *Code of Virginia* with disclosure as the primary purpose and a main focus on financial condition
Department of Health	Regulates the Certificate of Public Need program, licenses and regulates nursing homes, and certifies Medicaid and Medicare beds in these facilities
Regional Health Planning Agencies	Participate in the COPN process; provide public notification of projects; conduct public hearings and make recommendations to the State Health Commissioner
Department of Social Services	Licenses and regulates adult care residence beds
Department of Medical Assistance Services	Enforces Medicaid program and Assistance Services reimburses nursing homes for Medicaid patient days

SOURCE: *Joint Commission on Health Care Staff Analysis*

FIGURE 4
LEGISLATIVE HISTORY OF CCRC REGULATIONS IN VIRGINIA
(1980 - 1996)

Chapter 49 requires CCRCs to register with the BOI	Life Care Standards developed in the SMFP	Beginning of Statewide Moratorium on Nursing Home Beds	Several CCRCs built under statutory exceptions to moratorium	End of moratorium; beginning of RFA process.	Senate Bill 1139
1985	1987	1988	1991 - 1993	1996	1997

SOURCE: *Joint Commission on Health Care Staff Analysis, 1997.*

The Financial Regulation Division of the State Corporation Commission Bureau of Insurance: The BOI has regulated Virginia CCRCs since July 1, 1985, under Chapter 49 of Title 38.2 of the *Code of Virginia*, with very little changes since its enactment. Currently, there are forty-nine (49) CCRCs registered as such in the Commonwealth of Virginia, thirty-six (36) of which have associated nursing facilities.

Regulatory oversight of CCRCs by the State Corporation Commission (SCC) Bureau of Insurance limited to enforcement of Chapter 49 of Title 38.2 of the *Code of Virginia*, the primary purpose of which is disclosure. The Bureau's main focus is monitoring the provider organization's financial condition. As a regulator, the Bureau of Insurance reviews the information that is presented to prospective CCRC residents through examination of required disclosure statements that are filed with the Bureau by the provider.

Before taking any deposits from or offering to provide services to prospective residents, all CCRCs must submit to the BOI a registration statement which includes a disclosure statement and all resident contracts that will be used at the facility. The initial disclosure statements must contain detailed information such as, but not limited to, general business information (name, address, names of officers, etc.); certified financial statements; pro forma income statements; descriptions of real property, financial arrangements and mortgages; construction information and costs; descriptions of the admissions process; services to be offered and fees to be charged; copies of resident continuing care contracts; and procedures by which a resident may file a complaint or disclose a concern. The providers must update the disclosure statement at least annually, or when any material changes have occurred.

The information required to be included in the continuing care contracts is also specified in the *Code*. This information is mainly for disclosure purposes and includes: criteria for residing at the CCRC

and moving between levels of care; services to be provided to the resident; and explanation of the termination policy and refund provisions.

The *Code* empowers the Bureau of Insurance to investigate a provider whenever a possible violation of Chapter 49 becomes apparent. When violations occur, the Bureau may make a recommendation that the SCC fine the provider, issue cease and desist orders, or issue temporary or permanent injunctions against the continuing care provider.

The Virginia Department of Health: The VDH Division of Certificate of Public Need regulates the establishment of nursing homes; the addition of beds by an existing nursing home; and the introduction of nursing services by an existing medical care facility. In addition, VDH is responsible for the licensure of nursing facilities in the Commonwealth, as well as the certification of these facilities for Medicaid and Medicare.

The 1996 General Assembly established the Request for Application (RFA) process when the latest moratorium on the construction of nursing beds was permitted to sunset on June 30, 1996. Under this procedure, the State Health Commissioner must:

- issue a Request for Application (RFA) jointly developed with the Department of Medical Assistance Services;
- base the RFA on an analysis on the need for increases in the bed supply of each planning district;
- accept for review only those proposals that conform with the geographic and bed need specifications of the RFA; and
- issue an RFA at least annually.

The first RFA, which was issued on August 20, 1997, targeted eight planning districts for a total of 1,080 nursing beds. All targeted planning districts must have met the following three criteria:

1. have a projected bed need which is determined through population projections and 1994 use rates;
2. have experienced an estimated average annual occupancy rate of Medicaid-certified nursing home beds of 95% or higher for the years 1994-1996; and
3. have no authorized Medicaid-certified nursing home bed projects that have not yet been completed.

If CCRCs wish to apply for Medicaid certified nursing beds, they must participate in the RFA process. For those who desire to contract only with private pay residents, they may apply for a COPN outside of the RFA process. Their COPN filing is then reviewed under the SMFP standards for CCRCs.

For those CCRCs who choose not to participate in the RFA process, the State Board of Health, in its SMFP, has adopted into regulation a standard for consideration of CCRC projects which essentially mirrors the generic CCRC moratorium exception of the COPN law prior to July 1, 1996. The following five (5) conditions under which a nursing facility can be built as a part of a CCRC are included in this amended SMFP which went into effect in January, 1997:

- the total number of new or additional nursing home beds plus any existing nursing home beds operated by the continuing care provider are not to exceed twenty percent (20%) of the continuing care provider's total existing or planned independent living and adult care residence population when the beds are added by new construction, or twenty-five (25) beds when the beds are added by conversion on site of existing beds in an adult care residence;
- such beds are necessary to meet existing or reasonably anticipated obligations to provide care to present or prospective residents of the continuing care facility pursuant to the facility's continuing care contracts;
- the provider agrees, in writing, not to seek certification of the use of such new or additional beds by persons eligible to receive medical assistance services (Medicaid);
- the provider agrees, in writing, to obtain, prior to admission of every resident of the continuing care facility, the resident's written acknowledgment that the provider does not serve recipients of medical assistance services and that, in the event such resident becomes a medical assistance recipient eligible for nursing placement, such resident will not be eligible for placement in the provider's nursing facility unit; and
- the provider agrees, in writing, that only continuing care contract holders will be admitted to the nursing home beds after the first three years of operation.

The Virginia Health Systems Agencies: The Commonwealth is divided into five health planning regions, each having its own planning agency. Over the past twenty (20) years, these regional health planning agencies have been involved in the planning for nursing home facilities and services in conjunction with VDH's certificate of public need program. Their responsibilities include:

- gathering data and undertaking the community level planning;
- analyzing COPN proposals filed in the region;
- notifying interested parties of proposed program changes and capital outlays; and
- conducting public hearings and developing a public record for consideration by the Commissioner of Health.

State regulation of nursing facilities in CCRCs is cited both in the *Code of Virginia* and VDH regulations in the SMFP as outlined in Figure 5.

FIGURE 5

REGULATION OF CCRCS

Code Section	*Regulatory Function*
§32.1-102.1 through §32.1-102.11	Requires owners or sponsors of medical facilities to secure a certificate of public need (COPN)
§32.1-102.32 and §32.1-12	Directs the Board of Health to promugate and prescribe rules and regulations deemed necessary to effectuate the purposes of the above COPN statute
Chapter 49 §38.2-4900 et seq	Directs the registration of CCRCs with the State Corporation Commission
State Medical Facilities Plan	***Regulation***
12 VAC 5-360-10	Defines continuing care contracts, life care contracts and continuing care communities
12 VAC 5-360-40 C	Establishes bed need forecasting method
12 VAC 5-360-40 E	Describes continuing care retirement communities nursing bed restrictions

SOURCE: *Joint Commission on Health Care Staff Analysis of the Code of Virginia*

IV. MAJOR ISSUES TO BE ADDRESSED IN THIS STUDY

ISSUES RELATED TO SENATE BILL 1139

Should CCRCs Continue to be Exempt From the RFA Process in View of the Changing Configurations in the Continuing Care Market?

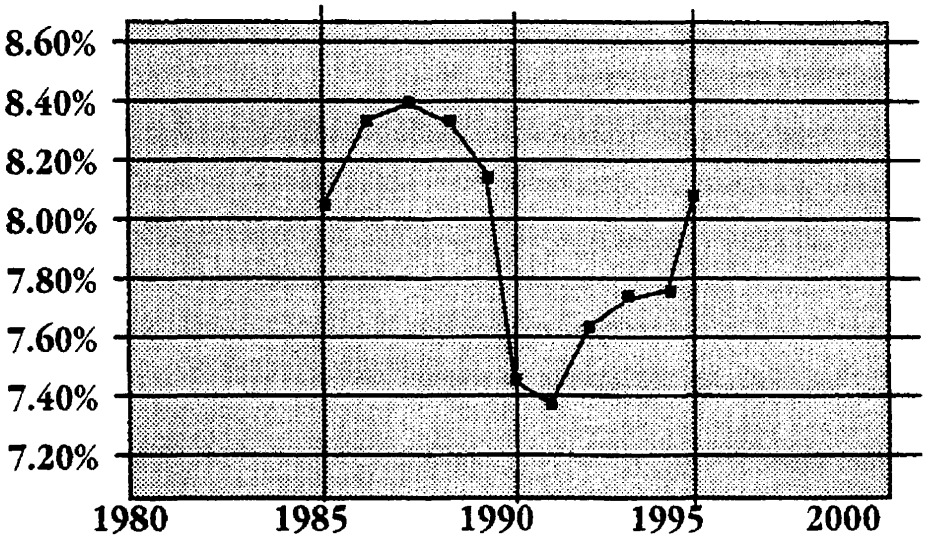
In reaction to the 1996 filing by Senior Campus Living to build Greenspring Village in Northern Virginia, which included a request for a two hundred and forty (240) nursing bed unit, concerns arose over the adequacy of current statute and regulations of nursing beds in CCRCs. Although it is agreed that the current regulations were adopted after discussion between the interested parties (state and private) and all parties acknowledge that there is no history of significant problems under these previously acceptable regulations, the nursing home industry is expressing serious concern for the future.

Size and Market Share: For ten years prior to this filing for 240 nursing beds under a single COPN, there has never been a request for over 60 such beds by a CCRC. Although the regulations permit a ratio of 1:5 (20%) nursing home beds to the total number of non-nursing bed units per COPN to be built in a CCRC, no previous filing has exceeded 60 beds. The Northern Virginia project is far larger than any other in the state; the first phase of this project is to include approximately 1200 units. Based purely on the 1:5 ratio, the project could have been granted the entire 240 nursing home beds. The final phase, which is scheduled to be completed in approximately six (6) years, will have a full capacity of just under 1800 units. (The next largest Virginia CCRC with an associated nursing facility contains less than 900 units.) The freestanding nursing homes in proximity to this new CCRC have expressed concern that they would have suffered a serious negative impact on their occupancy levels, especially for private pay residents, if such a large number of nursing beds had been granted with a three-year open admissions period.

The nursing home industry argues that the CCRCs have an unfair advantage in the market place under the current procedure which requires a CCRC to obtain COPN but exempts them from the competitive RFA process, to which freestanding nursing facilities must abide. Figure 6, developed from the latest available data, illustrates the growth in market share of nursing beds in CCRCs for the period of 1985 to 1995. Very little increase is found. The CCRCs have maintained a market share of nursing beds between 7.4 % and 8.4%, over this ten year period.

FIGURE 6

TIMES SERIES OF CCRC NURSING BED MARKET SHARE IN VIRGINIA, 1985-1995



SOURCE: *Joint Commission on Health Care Staff Analysis 1997.*

CON/COPN: Other States- In a recent survey of eleven neighboring and mid- and south- east coast states, staff did not find any other states that address CCRC regulation in the same manner as Virginia. All states surveyed incorporate a CON/COPN process in their regulation of nursing home beds. Most other states, in some way, take into account CCRC nursing beds in their state plan for nursing bed need projections. The standard appears to be that if CCRC nursing beds are regulated under a CON/COPN program, then their nursing beds are included in the state bed need projection formulas. And, the two of the three states that exempt CCRC nursing beds from their CON/COPN process, do not permit CCRC nursing beds to be open to direct admissions from the outside community. Conversely, when CCRCs do participate in an optional CON/COPN process, they are more likely to have equal opportunity to admit non-contract holders directly into their nursing facility. Where CON/COPN participation is mandatory, it is customary to utilize two different levels of review based upon whether or not the nursing facility is applying for opened or closed beds.

Virginia's overall regulation of CCRCs appears to be generally in concert with the majority of the eleven (11) states who were polled. The least restrictive approach exempts CCRCs from CON/COPN as well as permits the continuing care provider to admit from the outside community for a period of at least five (5) years. The most restrictive prohibits the construction of any new nursing beds, including those in CCRCs. The *Code of Virginia* and the standards provided by the SMFP, together, appear to provide a level of regulation that would be considered moderately conservative.

OPTIONS FOR CONSIDERATION

Option I. ..... Take No Action

Option II. ..... Request the Commissioner of Health to Amend the SMFP Standards to Require all CCRCs to Participate in the RFA Process

Option III. ..... Request the Commissioner of Health to Amend the SMFP Standards to Require all CCRCs Defined as Commercial Models to Participate in the RFA Process

Under this option, there is the presumption that new definitions of CCRCs would be developed that distinguish between the traditional, insurance-based facility and the commercial, fee-for-service type facility.

Should regulations be altered in response to the new types of continuing care contracts? Specifically, should the definitions presented in statute and in regulation be amended?

Contracts: Over the past decade, there has been a significant change in the types of contracts which CCRCs offer to potential residents. The traditional CCRC contract has been based upon insurance principals and been presented as a life-care contract in which the monthly fees remain relatively stable regardless of the level of care at which the resident resides. These are identified as Type A contracts. Although they continue to be offered, two new types of contracts have gained popularity in Virginia. Type B contracts offer stable monthly fees for independent and assisted living levels, but specify a limited number of nursing bed days per year that will be fully covered by the normal monthly charge, after which a per diem is added. The third contract option, Type C, is basically a fee-for-service contract in which the monthly fee increases (through a per diem add-on) when more intense levels of care are required.

Other States- From the information obtained through the survey of other states, the trend appears to be that the number of more non-traditional contracts is increasing. Type C contracts, which are fee-for-service structured contracts, are a response to the consumer market and provide CCRCs as an option for long-term care to more middle income families.

Definitions: Concerns have been raised that the newer, non-traditional, fee-for-service oriented contracts are changing the playing field by removing one of the primary reasons for differential treatment in the regulation of nursing beds in CCRCs (i.e., treatment as an insurance-based structure and exemption from the RFA process). Therefore, it is argued that the current exemption for CCRCs from the competitive RFA process should be granted only to those true life-care model CCRCs.

A common issue is whether the Commonwealth should modify its definition of CCRCs in the *Code of Virginia* and/or in its regulatory standards? It has been suggested that there at least be language in the definition that differentiates between the true life-care, traditional CCRC model and the newer "commercial" CCRCs.

Other States- Virginia's definition of a CCRC, as stated in Chapter 49 of Title 38.2 of the *Code of Virginia*, is as inclusive as any definition cited by the eleven (11) other surveyed states. Nearly 50% of these states had fewer requirements, but none had any significant additional requirements. The critical issues which consistently appear in these definitions include: entrance and periodic fees, terms in excess of one year; and mutually terminable contracts.

It has been suggested that the definition stated in the SMFP standards be placed in the *Code of Virginia* because it actually defines "life-care community" and "life-care contract." While it can be inferred that an insurance factor is intrinsic to CCRCs by the mere fact that BOI registration is required, the definition of CCRC in Chapter 49 of the *Code of Virginia* does not include the term "insurance policy." The definition in the SMFP does contain the term "insurance policy."

All contracts must spell out in understandable terms (which is monitored by the BOI) the specific terms under which services are received and the arrangement for payment of such services. However, the difficulty in trying to define the difference between a true life-care community and one that is not must be addressed. As noted, contract options have become the norm, even among CCRCs that have previously offered only the traditional, life-care type contracts.

Changing financial structure: The large majority of CCRCs in Virginia continue to be not-for-profit. Only four (4) of the 36 CCRCs with nursing facilities are proprietary. Three of these for-profit facilities were built prior to 1995. There is no evidence, at present, that a large increase in for-profit continuing care providers is occurring in this area of the country.

What has not been adequately demonstrated is that the current CCRCs, including the newest project in Northern Virginia, do not adhere to the definitions in the *Code* and in the SMFP. In fact, they are required to meet the definitions in order to obtain both BOI registration and their COPNs. Thus, is the question really about the definition of a life-care community or contract or about *how* one pays for contracted services along the continuum of care that must be made available in a life-care contract?

It is true that time has changed the format of CCRC contracts and that there has been a slight addition of for-profit facilities in Virginia. Contract changes have been primarily market driven and financial status has remained predominantly not-for-profit. However, there appears to be no strong evidence at this time

that a need exists to change the definition of CCRCs in the law. JCHC staff are developing surveys to be sent to both CCRCs and freestanding nursing facilities in the Commonwealth. Staff are also conferring with representatives of both supporting organizations in an attempt to construct the surveys in such a way that at least some of the currently unavailable information pertinent to this study can be obtained. These proposed surveys include questions which attempt to provide information on the number of contracts currently in effect and how they are distributed in the three categories of contracts previously outlined. These results should provide evidence of how many current residents have chosen to enter CCRCs under the non-traditional contracts.

OPTIONS FOR CONSIDERATION

Option I. ..... No Action

Option II. ..... The Joint Commission of Health Care Would Introduce Legislation in the 1998 General Assembly to Amend Chapter 49 of the *Code of Virginia* to Include the Definitions Regarding CCRCs that are Currently Listed in the State Board of Health's' SMFP

Option III. ..... The Joint Commission of Health Care May Wish to Introduce Legislation in the 1998 General Assembly to Amend the Definition in the *Code of Virginia* to Include Elements Which Distinguish the Types of CCRCs Based Upon Their Predominant Contract Type

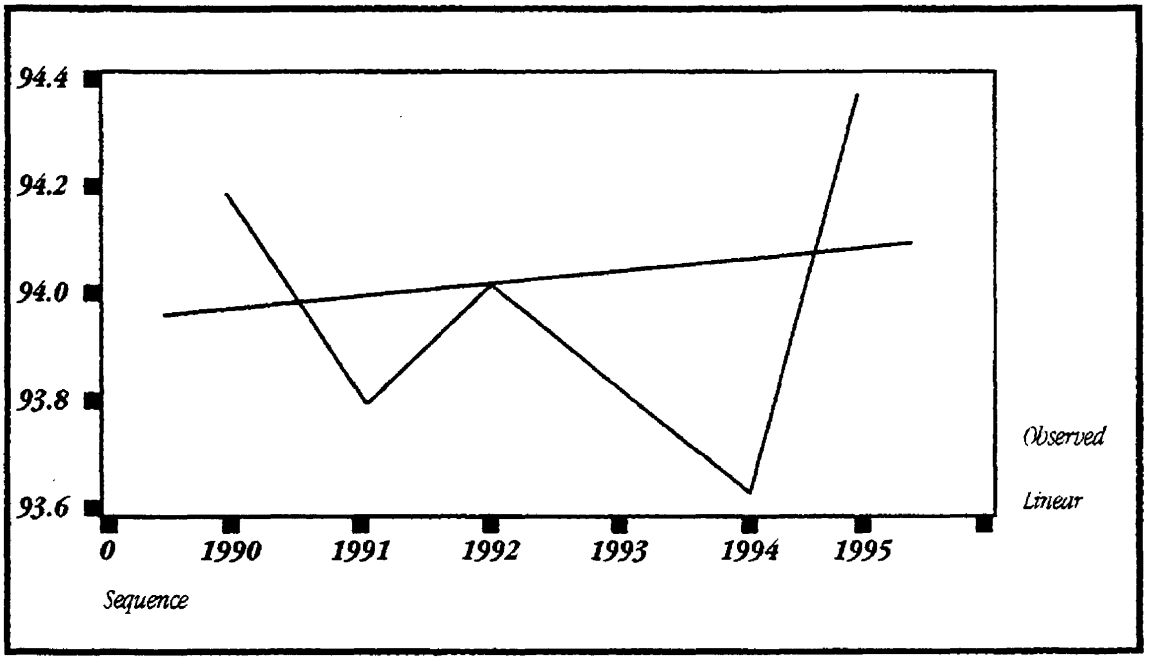
Has the increase in CCRC nursing beds impacted occupancy rates and charges of existing nursing homes and certified nursing facilities in the Commonwealth?

Concerns have been raised that if CCRCs are permitted to market to the outside community and offer temporary nursing bed services to non-contract holders, that occupancy rates and charges of freestanding nursing facilities will be negatively impacted. Maximum Medicaid reimbursement is dependent upon an occupancy rate of 95%. The nursing home industry states that even the maximum reimbursement amount falls short of their per diem expenses and that revenues from private pay residents help cover the shortages. Since CCRCs traditionally serve more private pay residents (some are restricted from serving Medicaid residents), the freestanding facilities could potentially see a greater decrease in their share of private pay residents if CCRC nursing beds remain open to non-contract holders. Consequently, a need to increase charges to private pay residents to cover overall revenue losses could result.

Occupancy Rates: Based upon the latest available data, a regression analysis has indicated that there is no significant change in occupancy rates across the state for the period 1990-1995. Figure 7 illustrates the time series graph of this analysis. Occupancy rates for 1996 were not available for analysis.

FIGURE 7

REGRESSION ANALYSIS GRAPH OF OCCUPANCY RATES IN NURSING HOMES 1990-1995



Source: *Joint Commission on Health Care Staff Analysis 1997.*

Occupancy rates in freestanding nursing facilities in Northern Virginia and Tidewater planning districts, on average, run below the 95% threshold for minimum Medicaid reimbursement and occupancy rate requirements for REA participation. Conversely, it is known and accepted that occupancy rates for the more rural areas of the state tend to run higher than 95%. These areas do not have the concentration of CCRCs that the major metropolitan regions have. In 1995, approximately 62.5% of the planning districts without CCRCs had occupancy rates of 95% or higher. Conversely, approximately 37% of planning districts with CCRCs had an average occupancy rate of 95% or above. Therefore, in a comparison of the average occupancy rates in planning districts with CCRCs and those without, there is a slight increase in such rates in the planning districts which do not have CCRCs. Figure 8 displays these rates.

FIGURE 8

1995 Nursing Bed Occupancy Rates in Virginia Planning Districts With and Without CCRCs

Planning Districts without CCRCs	*1995 Occupancy Rates*	*Planning Districts with CCRCs*	*1995 Occupancy Rates*
1	97.4	5	94.8
2	97.6	6	94.0
3	93.9	7*	94.3
4	94.3	8	90.3
13*	97.1	9	92.7
14	94.3	10	92.0
16*	97.5	11*	95.3
19*	98.4	12*	97.6
		15	93.2
		17*	96.2
		18*	95.7
		20	93.7
		21	94.7
		22	96.5
Average	96.31		94.36

Planning Districts Targeted in August, 1997 REA

Source: *Joint Commission on Health Care Staff Analysis 1997.*

Five (5) of the eight (8) planning districts that have been selected to participate in the first RFA process, contain at least one CCRC. This indicates that positive bed need projections are not limited to planning districts without CCRCs and that other factors are contributing to the lower occupancy rates of certain planning districts. The average occupancy rates across the state in 1995 were at their highest point during the period between 1990 and 1995.

Charges: Data recently obtained from Virginia Health Information indicate that charges in freestanding nursing homes across the state have been decreasing at a slower rate over the past four years. Thus, there is no supporting data that indicate that CCRC nursing beds are driving up charges in the freestanding facilities. Figure 9 lists the average median charges, from 1993 to 1996, by Health Services Areas and across the state as a whole.

FIGURE 9

MEDIANS FOR GROSS INPATIENT REVENUE MINUS ANCILLARY CHARGES DIVIDED BY PATIENT DAYS

HSA	1996	1995	1994	1993
I	$98.34	$98.67	$94.41	$90.93
Annual % Increase	-0.34%	4.51%	3.83%	
II	$129.42	$127.53	$123.70	$117.01
Annual %Increase	1.48%	3.10%	5.72%	
III	$92.47	$89.77	$85.32	$81.83
Annual % Increase	3.01%	5.22%	4.26%	
IV	$$92.75	$91.79	$90.34	$89.03
Annual % Increase	1.04%	1.60%	1.42%	
V	$100.27	$98.41	$94.68	$94.20
Annual % Increase	1.89%	3.94%	0.51%	
State	$98.29	96.69	$91.97	$88.92
Annual % Increase	1.65%	5.13%	3.43%	

SOURCE: *Virginia Health Information Analysis.*

OPTIONS FOR CONSIDERATION

The growth in nursing beds in CCRCs in Virginia appears to have had no significant impact on either charges or occupancy rates in the Commonwealth. In fact, the nursing home industry has indicated that historically they have had no major concerns in these areas. They are, however, very apprehensive about negative impact on both occupancy rates and charges if large numbers of CCRC nursing beds are made available to outside community persons.

Option I. ..... Take No Action but Request that the Joint Commission on Health Care Continue to Monitor these rates.

Option II. ..... Request the Department of Medical Assistance Services to Consider Whether or not the Current Occupancy Rate Factors Used in Setting Medicaid Reimbursement to Nursing Homes and Per Diem Rates are Appropriate

Have Nursing Facility Beds in CCRCs Impacted Virginia Medicaid Expenditures?

In a comparison of Medicaid patient days to total patient days for 1991 and 1996, as illustrated in Figure 10, the total percent of Medicaid days of all nursing home patients days has not increased. In fact, the percent of Medicaid days is lower in 1996 than in 1991. Data, as listed in the Center for Health Statistics *Beds and Utilization* publications, indicate that 1991 was a typical year and that figures from 1991 to 1996 show a gradual increase in total patient days and a gradual increase in Medicaid patient days until 1996, when a significant decrease occurred. These data support the fact that Medicaid expenditures have not changed significantly from 1991 to 1996 in either the total nursing home beds population or in the CCRC nursing bed population. It may be of interest to note that of the 1,344 Medicaid certified beds available in CCRCs in 1996, only 412 were occupied by Medicaid residents on the last day of 1996.

FIGURE 10

COMPARISON OF MEDICAID PATIENTS DAYS IN NURSING FACILITIES IN 1991 AND 1996

	1991	*1996*
Patient days in VA NH	9,415,927	10,372,434
Medicaid Patient Days in VA NH	6,198,479	6,364,337
% of Medicaid Patient Days	65.83%	61.36%

	1991	*1996*
Patient Days in CCRC NH	655,122	695,394
Medicaid Patient Days in CCRC NH	155,388	149,728
% of Medicaid Patient Days	23.72%	21.53%

SOURCE: *Joint Commission on Health Care Staff Analysis and Virginia Department of Health data.*

OPTIONS TO CONSIDER

There appears to be no significant increase in Medicaid expenditures for all nursing beds in Virginia nor any increase that can be specifically associated with nursing beds in CCRCs. The recent decline in the actual number and percent of Medicaid days cannot, at this time, be attributed to any one cause without further investigation.

Option I. ..... Take No Action

Option II. ..... Request the Department of Medical Assistance Services to Conduct a Study to Determine What Factors are Contributing to Changes in Medicaid Reimbursement Levels in Nursing Homes

Should Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2 be modified, particularly in view of the changing configurations in the continuing care market?

The review of information received from the other states who were polled indicates that Virginia's Chapter 49 of Title 38.2 substantially mirrors such statutes in other states. Similar to the comparison of definitions of CCRCs, Virginia appears to have included in its laws those requirements on CCRC registration found in most of these other states' codes. Whether or not it is appropriate at this time to amend the *Code*, depends on whether or not the changing market configurations are considered to be in conflict with the intentions of the current *Code*.

OPTIONS TO CONSIDER

Option I. ..... Take No Action

Option II. ..... The Joint Commission of Health Care may Wish to Introduce Legislation in the 1998 General Assembly to Amend Chapter 49 of Title 38.2 of the *Code of Virginia* to Include the Definitions Regarding CCRCs that are Currently Listed in the State Board of Health's' SMFP

V. Additional Issues Raised During the Process of the Study

Should the following standards in the SMFP be modified in view of the changing configurations in the continuing care market?

Standard 1 - **Three-year window for CCRCs to admit nursing home residents directly from the outside community:** This regulation, established in the standards on CCRCs in the SMFP, has been identified as a major point of concern. The nursing home industry, among others, feels that this window of opportunity to admit residents directly into nursing beds, without a life-care contract, establishes preferential treatment for CCRCs. With the recent Greenspring Village's filing for a 240 bed nursing home unit, freestanding facilities have realized that the potential for significant loss of market share is likely to result from the opening of such a large scale project. They are afraid that, if this is the beginning of a new trend in the industry, the problem could potentially cause significant market share and revenue losses in the nursing home industry in the future.

Secondly, the nursing home industry has concern with the fact that CCRCs may apply for additional COPNs beyond the initial one and obtain additional three-year windows of opportunity. They further attest that a need for CCRCs to admit from the community, at any point in time, has not been established.

The CCRC industry's response is that nursing beds are required for CCRCs to meet their contractual obligation to provide the full continuum of care. This three-year period of open admissions makes it more financially acceptable to both their financial backers and to the CCRC residents themselves. The residents who live in the non-nursing bed units of the CCRC must partially support the costs incurred by the construction of a nursing home unit if the facility cannot admit non-contract holders directly into the CCRC's nursing home beds. They feel that the three year window was openly negotiated during the time the RFA process was being constructed and that this recently reestablished regulation should remain in effect as currently written. The CCRC industry suggests that their industry has caused no appreciable problems in the past and that current regulatory policies are appropriate and work well.

This position is supported by the resolution of the Greenspring Village COPN filing. After lengthy negotiations with VDH and the Northern Virginia Health Systems Agency, Greenspring Village was awarded a COPN for a 60-bed nursing unit (instead of the original 240 beds) and agreed to directly admit to these beds only persons from the community who sign a life-care contract with the CCRC.

Other States- Policies for direct admissions from the outside community (non-contract holders) into nursing beds in CCRCs varies among the other states who provided information during the survey process. Approximately one third of those who responded stated that their state has no restrictions on admissions to CCRC nursing beds. Those who do restrict usually tie such restrictions to whether or not the CCRC has

undergone the CON process for those particular beds. It is a common policy that CCRCs who undergo the CON/COPN process do not have restrictions on admissions, and the CCRCs who do not participate in an optional CON/COPN program may only obtain closed beds. Two states simply report that their CON/COPN review process differs depending on whether or not the CCRC's nursing beds are open or closed. Florida and New Jersey both have a limited period of years (generally 5 years for both states) during which the CCRC can admit directly from the outside community. This is comparable to Virginia's three-year open admissions period. Once again, Virginia's policy (including options under the SMFP standards) appears to be neither more restrictive nor much less restrictive than the other states who provided information to this study.

The Division of Certificate of Public Need has identified seven (7) CCRCs who have been granted the three-year window to admit persons from the outside community, for a grand total of 268 beds. Of these beds, after December 31, 1997, 117 beds will remain open for direct admissions from the outside community.

OPTIONS TO CONSIDER

Option I. ..... Take No Action

Option II. ..... Request that the Commissioner of Health Amend the COPN Regulation to Decrease the Window of Time for the Open Admission Period

Option III. ..... Request that the Commissioner of Health Amend the COPN Regulation to Allow a One-time-only Open Admissions Window, Either at the Current Number of Years or at a Longer or Shorter Period of Time

Option IV. ..... Request that the Commissioner of Health Amend the COPN Regulation to Remove the Time Limitations on Direct Admissions from the Outside Community but Require a Life-care Contract for Any Direct Admissions, with the Inclusion of a Definition of a Life-care Contract

Option V. ..... Request that the Commissioner of Health Amend the COPN Regulation by adding to the Regulations a Caveat for "Couples, Where One Person Requires Nursing Home Care While the Other Requires a Lower Level of Care

Option VI. ..... **Request that the Commissioner of Health Amend the COPN Regulation to (i) Redefine CCRCs to enable one to Distinguish the Type of CCRC According to its Predominant Contract Type and (ii) Create New Regulations for the Commercial Type CCRC and Either Retain the Current Standards for the Life-care Type Model or Modify the Period of Time that an Open Window for Admissions is in Effect**

Option VII. ..... **Request that the Commissioner of Health Amend the COPN Regulation to Remove All Restrictions From the Standards**

Standard 2 **-The ratio of total number of nursing home beds to non-nursing home units in the CCRC:** Senate Bill 1139 has restricted growth in nursing beds in CCRCs to 60 or fewer beds. The current SMFP standards that originated in 1987 and were reaffirmed in 1996, stipulate that the total number of new or additional nursing home beds plus any existing nursing home beds operated by the continuing care provider do not exceed 20% of the continuing care provider's total existing or planned independent living and adult care residence population.

Other States - Of the states who responded to this question, only Maryland incorporates a ratio in its regulatory policy. Like Virginia, Maryland has a 5 : 1 ratio (twenty percent (20%). Pennsylvania has no statute but generally follows a customary ratio of approximately ten percent (10%). Figures were not provided by other states.

The nursing home industry has asked that a cap be placed at "the lessor of twenty percent (20%) of their total number of independent beds or sixty (60) beds." In other words, no matter what the size of the CCRC, the nursing home unit should be restricted to a maximum of sixty beds.

Representatives of the CCRC industry are of the opinion that the present regulation which bases the number of nursing beds on the population of the CCRC is most appropriate. Again, they note that current regulations effectively dealt with Greenspring Village's request for an unusually high number of beds.

OPTIONS TO CONSIDER

Option I. ..... **Take No Action**

Option II. ..... **The Joint Commission on Health Care Would Introduce Legislation in the 1998 General Assembly to Reenact Section 1 of Senate Bill 1139**

Option III. ..... **Request That the Commissioner of Health Amend the COPN Regulation to Limit the *Total* Number of Nursing Beds in CCRCs to the Lessor of Twenty Percent (20%) of Their Total Number of Independent Beds or Sixty (60) Beds**

Option IV. ..... **Request That the Commissioner of Health Amend the COPN Regulation to Limit the Number of Nursing Beds *Per COPN* to the Lessor of Twenty Percent (20%) of Their Total Number of Independent Beds or Sixty (60) Beds**

Option V. ..... **Request That the Commissioner of Health Amend the COPN Regulation to Decrease the Ratio of Nursing Beds to Non-nursing Bed Units, Granted Per COPN, to 15% or 10%**

<u>Standard 3</u>- **The restriction on CCRCs' obtaining Medicaid Certification and providing services to Medicaid eligible persons:** This issue has arisen out of discussion surrounding a directive in Senate Bill 1139. The Department of Medical Assistance Services administers the Commonwealth's Medicaid program, of which an important part is long-term care services. Nursing facility reimbursement represents the greatest expense in long-term care services. As noted earlier, the current reimbursement model is very dependent upon occupancy rates. The differential treatment of CCRC nursing facilities in the COPN process, including the application of standards specific to CCRCs, is well-ingrained in this health care delivery model.

Traditionally, the nursing home industry has relied on Medicaid residents to enhance their occupancy rates and CCRCs have marketed to private pay individuals. As previously stated, only 42% of CCRC nursing beds are Medicaid certified and of those, less that one third are actually occupied by Medicaid eligibles.

On one hand, the nursing home industry is unhappy that private pay persons in the outside community may choose CCRC nursing facilities when given the opportunity, thus shrinking their portion of private pay residents. On the other hand, an increase in Medicaid admissions to CCRC nursing home beds is likely to decrease overall occupancy rates in the freestanding nursing homes.

Another pertinent issue related to Medicaid and occupancy rates is the formulas for determining projected bed need in state planning districts. The nursing home industry and the CCRC industry are not in concert with the state's methodology. The RFA process includes CCRC populations in the determination of bed need projection and Medicaid certified CCRC nursing beds in the formula to estimate occupancy rates. Freestanding nursing homes and the CCRCs feel that the counting of "sheltered" beds (those utilized by

CCRC contract-holders only) overstates the supply of nursing beds in a community and that occupancy rates of planning districts may be understated when CCRC Medicaid beds are included.

Other States - Once again, other states vary in their inclusion of CCRC nursing beds in their formulas to determine bed need projection across their states. The majority of states which include CCRC nursing beds in the state plan formulas only do so for CCRCs who have participated in the CON/COPN process. North Carolina counts nursing beds in CCRCs that are closed to direct admissions from the community at a rate of fifty percent.

OPTIONS TO CONSIDER

Option I. ..... Take No action

Option II. ..... Request That the Commissioner of Health Amend the COPN Regulation to Remove the Medicaid Restriction from CCRCs, with the Option of Including a Threshold Percent of Medicaid Beds to the Total Number of Nursing Beds

Option III. ..... Request That the Commissioner of Health Amend the COPN Regulation to Require that CCRCs Certify and Fill a Given Percent of Their Nursing Beds Not Required for CCRC Contract Holders with Medicaid Residents

Option IV. ..... Request the Department of Medical Assistance Services to Study the Appropriateness of Remodeling the Formulas for Predicting Bed Need Levels and Occupancy Rates to Take into Account only Those CCRC Nursing Beds That are Not "Sheltered"

Should a mechanism to monitor the adherence of admissions restrictions, including enforcement options for violations, be established?

As presented by the director of the Division of Certificate of Public Need, in his presentation to the Long-Term Care Subcommittee, steps have been taken by VDH to prevent a CCRC from extending its three-year restriction on open admissions by developing a "quasi" contract for potential residents admitted from the community. However, the VDH does not have the resources or authority to monitor and enforce restrictions on CCRC nursing beds, as written in the SMFP standard.

OPTIONS TO CONSIDER

Option I. ..... **Take No action**

Option II. ..... **Request the Joint Commission on Health Care to Introduce Legislation in the 1998 General Assembly that Empowers the VDH to Monitor and Enforce Admission Restrictions Which are Established in the SMFP**

VI. CONCLUSION

While considerable concern for the future impact of the changing configurations in the CCRC industry on nursing home occupancy rates and charges is based upon a recent proposed COPN request, no substantial evidence has been presented, thus far, that supports the need to amend regulations and state law, at this time.

A number of alternative options have been presented that may warrant consideration to enhance or clarify the current regulation of nursing beds in CCRCs. It is not clear, however, that changes to existing state law are needed. The JCHC staff will continue to gather data to test assertions regarding the impact of CCRCs on the nursing home industry. Remaining data collection includes mail surveys of CCRCs and nursing homes.

VII. APPENDICES

APPENDIX A

CHAPTER 568

An Act to amend the Code of Virginia by adding a section numbered 32.1-102.3:2.2, relating to certificates of public need; study.

[S 1139]
Approved March 20, 1997

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding a section numbered 32.1-102.3:2.2 as follows:

§ 32.1-102.3:2.2 . Conditions on issuance of certificates of public need for continuing care retirement communities; expiration of section.

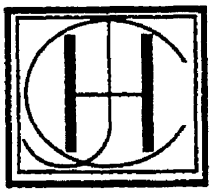
Notwithstanding the provisions of § 32.1-102.3:2.1 , the Commissioner shall only approve, authorize or accept applications for the issuance of certificates of public need filed for continuing care retirement community nursing home bed projects by continuing care providers registered with the State Corporation Commission pursuant to Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2 for sixty or fewer beds.

2. That the Joint Commission on Health Care, in conjunction with the Commissioner of Health or his designee and the Commissioner of Insurance or his designee, shall study the management of applications for nursing facility projects in continuing care retirement communities under the Commonwealth's Medical Facilities Certificate of Public Need law and regulations, including, but not limited to (i) whether such projects should be included or exempted from the Request for Applications (RFA) process established pursuant to § 32.1-102.3:2; (ii) the different forms of continuing care contracts being offered by continuing care providers in Virginia and the effect of such contracts on the utilization of nursing facility beds in continuing care retirement communities; (iii) the impact of increases in nursing facility beds in continuing care retirement communities, if any, on the occupancy rates and charges of existing nursing homes and certified nursing facilities in the Commonwealth; (iv) the impact, if any, of nursing facility beds in continuing care retirement communities on Virginia Medicaid expenditures; and (v) the appropriateness of the present registration law, Chapter 49 (§38.2-4900 et seq.) of Title 38.2, for continuing care providers and the need for any modifications to such law, particularly in view of the changing configurations in the continuing care market. The Joint Commission shall report its preliminary findings by December 1, 1997, and shall complete its work in time to submit its findings and recommendations to the Governor and the 1998 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

3. That the provisions of this act shall expire on July 1, 1998.

4. That an emergency exists and this act is in force from its passage.

APPENDIX B



JOINT COMMISSION ON HEALTH CARE

SUMMARY OF PUBLIC COMMENTS: STUDY ON CONTINUING CARE RETIREMENT COMMUNITIES SB 1139

INDIVIDUALS/ORGANIZATIONS SUBMITTING COMMENTS

A total of twelve (12) individuals and organizations submitted comments in response to the Study on Continuing Care Retirement Communities (Senate Bill 1139).

Counsel for Greenspring Village

Fairfax Nursing Center, Inc.

Health Systems Agency of Northern (HSANV)

Medical Facilities of America

Northern Virginia Aging Network (NVAN)

State Corporation Commission, Bureau of Insurance (BOI)

Virginia Association of Nonprofit Homes for the Aging (VANHA)

Virginia Association of Regional Health Planning Agencies

Virginia Department of Health (VDH)

Virginia Health Care Association (VHCA)

Virginia Hospital & Healthcare Association (VHHA)

Woodbine Rehabilitation & Healthcare Center

POLICY OPTIONS INCLUDED IN THE ISSUE BRIEF

Should CCRCs continue to be exempt from the RFA process in view of the changing configurations in the continuing care market?

Option I. ..... Take no action.

Option II. ..... Request the Commissioner of Health to amend the SMFP standards to require all Continuing Care Retirement Communities (CCRCs) to participate in the RFA process.

Option III. ..... Request the Commissioner of Health to amend the SMFP standards to require all CCRCs defined as commercial models to participate in the RFA process.

Should regulations be altered in response to the new types of continuing care contracts? Specifically, should the definitions presented in statute and in regulation be amended?

Option I. ..... **Take no action.**

Option II. ..... **The Joint Commission on Health Care (JCHC) would introduce legislation in the 1998 General Assembly to amend Chapter 49 of the *Code of Virginia* to include the definitions regarding CCRCs that are currently listed in the State Board of Health's SMFP.**

Option III. ..... **The JCHC would introduce legislation in the 1998 General Assembly to amend the *Code of Virginia* to include elements which distinguish the types of CCRC based upon their predominant contract type.**

Has the increase in CCRC nursing beds impacted occupancy rates and charges of existing nursing home and certified nursing facilities in the Commonwealth?

Option I. ..... **Take no action but request the JCHC to monitor these rates.**

Option II. ..... **Request the Department of Medical Assistance Services to consider whether or not the current occupancy rate factors used in setting Medicaid reimbursement to nursing homes and per diem rates are appropriate.**

Have nursing facility beds in CCRCs impacted Virginia Medicaid expenditures?

Option I. ..... **Take no action.**

Option II. ..... **Request the Department of Medical Assistance Services to conduct a study to determine what factors are contributing to changes in Medicaid reimbursement levels in nursing homes.**

Should Chapter 49 (§ 38.2-4900 et seq.) be modified, particularly in view of the changing configurations in the continuing care market?

Option I. ..... **Take no action.**

Option II. ..... **The JCHC may wish to introduce legislation in the 1998 General Assembly to amend Chapter 49 of the *Code of Virginia* to include the definitions regarding CCRCs that are currently listed in the State Board of Health's SMFP.**

Should the following standards in the SMFP be modified in view of the changing configurations in the continuing care market?

Standard I- The three-year window for CCRCs to admit nursing home residents directly from the outside community.

Option I. ..... **Take no action.**

Option II. ..... **Request that the Commissioner of Health amend the COPN regulation to decrease the window of time for the open admission period.**

Option III. ..... **Request that the Commissioner of Health amend the COPN regulation to allow a one-time only open admissions window, either at the current number of years or for a longer or shorter period of time.**

Option IV. ..... **Request that the Commissioner of Health amend the COPN regulation to remove the time limitations on direct admissions from the outside community but require a life-care contract for any direct admission, with the inclusion of a definition of a life-care contract.**

Option V. ..... **Request that the Commissioner of Health amend the COPN regulation by adding to the regulations a caveat for "couples," where one person requires nursing home care services while the other requires a lower level of care.**

Option VI. ..... **Request that the Commissioner of Health amend the COPN regulation to (i) redefine CCRCs to enable one to distinguish the type of CCRC according to its predominant contract type and (ii) create new regulations for the commercial type CCRC and either retain the current standards for the life-care type model or modify the period of time that an open window for admissions is in effect.**

Option VII. ..... **Request that the Commissioner of Health amend the COPN regulation to remove all restrictions from the standards.**

Should the following standards in the SMFP be modified in view of the changing configurations in the continuing care market?

Standard II- The ratio of total number of nursing home beds to non-nursing home units in the CCRC.

Option I. ..... Take no action.

Option II. ..... The JCHC would introduce legislation in the 1998 General Assembly to reenact Section 1 of SB 1139.

Option III. ..... Request that the Commissioner of Health amend the COPN regulation to limit the *total* number of nursing beds in CCRCs to the lessor of twenty percent (20%) of their total number of independent beds or sixty (60) beds.

Option IV. ..... Request that the Commissioner of Health amend the COPN regulations to limit the number of nursing beds *per COPN* to the lessor of twenty percent (20%) of their total number of independent beds or sixty (60) beds.

Option V. ..... Request that the Commissioner of Health amend the COPN regulations to decrease the ratio of nursing beds to non-nursing bed units, granted per COPN, to 15% or 10%.

Standard III- The restriction on CCRCs' obtaining Medicaid certification and providing services to Medicaid eligible persons.

Option I. ..... Take no action.

Option II. ..... Request that the Commissioner of Health amend the COPN regulation to remove the Medicaid restriction from CCRCs, with the option of including a threshold percent of Medicaid beds to the total number of nursing beds.

Option III. ..... Request that the Commissioner of Health amend the COPN regulations to require that CCRCs certify and fill a given percent of their nursing beds not required for CCRC contract holders with Medicaid residents.

Option IV. ..... Request the Department of Medical Assistance Services to study the appropriateness of remodeling the formulas for predicting bed need levels and occupancy rates to take into account only those nursing beds that are not "sheltered."

Should a mechanism to monitor the adherence of admission restrictions, including enforcement options for violations, be established?

Option I. ..... Take no action.

Option II. ..... Request the JCHC to introduce legislation in the 1998 General Assembly that empowers the VDH to monitor and enforce admission restrictions which are established in the SMFP.

(A CCRC is considered to be a "commercial" model CCRC when it operates primarily under fee-for service type contracts. Residents pay additional monthly fees depending upon which level of care they require. On the other hand, true life-care contracts retain the social insurance model where monthly fees are not affected by the level of care required.)

Should CCRCs continue to be exempt from the RFA process?

The Virginia Association for Nonprofit Homes for the Aging (VANHA) and legal counsel for Greenspring Village, recommend Option I. They support the conclusion of the draft study that no substantial evidence thus far supports the need tc amend regulations and state law. They feel that current regulation through the Certificate of Public Need (COPN) process allows for appropriate oversight, protections, and public review of the development of nursing facility beds.

The Virginia Association of Regional Health Planning Agencies urges the adoption of Option I if other recommendations, as listed later in this document, are also adopted.

The Virginia Hospital and Healthcare Association (VHHA), one nursing home corporation, two nursing homes, the Virginia Health Care Association (VHCA), the Northern Virginia Aging Network (NVAN), and the Health Systems Agency of Northern Virginia all recommend that CCRCs who are true-life care providers (and not commercial model CCRCs) should remain exempt from the Request for Application process (Option III). Commercial ventures which operate on the fee-for-service model should be required by regulation to participate in the competitive RFA process just as any freestanding nursing facility.

Should regulations be altered in response to the new types of continuing care contracts? Specifically, should the definitions presented in statute and in regulation be amended?

BOI supports Option I and believes that Chapter 49 of Title 38.2 is adequate. The following points are raised in the comments. The Bureau:

- does not categorize CCRCs according to contract types.
- does not require CCRCs to report the number of each type of contract in use in their disclosure statements.

- indicates that perhaps all elements of a CCRC contract as defined in the SMFP are not elements in an insurance policy and it is not clear that the "health care services" included in the SMFP are equivalent to the nursing services included in Chapter 49 of Title 38.2.

VDH supports Option I and believes that regulation of CCRCs by the BOI is separate and distinct in its purpose and operation from regulation of CCRC nursing facilities by VDH. VDH states that "Any changes deemed appropriate in VDH regulation of CCRC nursing facilities can be readily accomplished without interfering with regulation of CCRCs by the SCC (BOI), which relates to issues of financial solvency and consumer protection preliminary to consideration of public need and impact related to nursing home beds operated by CCRCs." VDH's also comments:

- It is not necessary to create, through legislation, new definitions of CCRCs to distinguish between types of CCRCs for differential treatment purposes within the COPN program.
- The current standards provide a reasonable basis for consideration of the types of CCRCs and the various contractual arrangements.
- While changes in the retirement community industry and experience with the current standards may warrant consideration in the future, such amendments would be premature at this time.

VANHA and Counsel for Greenspring Village support Option I.

The Virginia Association of Regional Health Planning Agencies recommends that Chapter 49 be amended to include definitions regarding CCRCs that are currently in the SMFP, Option II:

- with additional language clarifying what a CCRC is and is not, and
- with additional language in the SMFP definition to clarify what a CCRC is and is not for purposes of qualifying for the CCRC exemption.

The VHCA states that the Commonwealth has always had an expectation that CCRCs provide life care and have an insurance aspect to their contracts. VHCA supports Option III with these additional comments:

- Life care provisions in the SMFP are a clear & distinct feature that is integral to a CCRC.
- The need for any exemption is predicated on the "life care" obligation.
- CCRCs should report the various types and number of contracts in force at their facilities on an annual basis.

APPENDIX C

RESULTS OF ANALYSIS OF SURVEY RESPONSES FROM NURSING HOME AND CONTINUING CARE RETIREMENT COMMUNITY SURVEYS

The following survey results were reported to the Long-Term Care Subcommittee on December 2, 1997. Nursing facilities were requested to return their surveys by October 27, 1997, and the CCRCs were asked to respond by October 30, 1997. Only those survey responses that were received by November 12, 1997, were compiled.

These survey instruments were an attempt to obtain additional information upon which to base a study conclusion. However, evaluation of the data provided by the responding facilities did not support any significant changes in the staff's original study conclusion. Current and historical data do not suggest that CCRCs, across the state, are a significant threat to the free-standing nursing home industry as they are currently structured and regulated. As noted previously, the primary concerns of the nursing home industry is for the future.

JOINT COMMISSION ON HEALTH CARE

SURVEY RESULTS ON NURSING FACILITIES AND CONTINUING CARE RETIREMENT COMMUNITIES SB 1139

SURVEY DESCRIPTION

A survey was mailed to 178 freestanding nursing homes. Of these, 47 responses were received and useable, resulting in a 26% response rate.

Another survey was mailed to 35 Continuing Care Retirement Communities (CCRCs). Of these, 15 CCRCs responded, of which 14 responses were useable. The response rate was a 40%.

Data was reported by fiscal year unless otherwise stated.

NURSING HOME SURVEY

The following Virginia Planning Districts were represented in the survey responses:

PLANNING DISTRICTS OF SURVEY RESPONDENTS

*PD**	*#of NHs*	*PD*	*#of NHs*
5	*4*	*11*	*5*
6	*3*	*12*	*5*
7	*3*	*15*	*3*
8	*4*	*17*	*1*
9	*1*	*20*	*7*
10	*2*	*21*	*7*
Unindentified	*2*		

**A map of Virginia indicating the planning districts can be found on page 6.*

The average occupancy rate for 1996, of the responding Nursing homes, was 95%.

The average rates of the various primary payer types during 1996 were:

- 66% of all residents had Medicaid as their primary payer;
- 6% of all residents had Medicare as their primary payer; and
- 33% of all residents were private payers.

(Figures do not add to 100% due to reporting methods.)

The average payment/reimbursement rates for 1996 were reported as follows:

Average net revenue/diem	$96.61/day
Average Medicaid Reimbursement	$74.05/day
Average Private Payment	$107.48/day
Average Medicare Reimbursement	$221.82/day

Figures representing the percent of residents of the responding nursing facilities discharged to various settings were reported as indicated in the following table:

AVERAGE RATES FOR DISCHARGES TO VARIOUS ALTERNATIVE SETTINGS

Year	Acute	Other NH	CCRC NH	Lower Level	Death	Other
1996	*29%*	*7%*	*<1%*	*18%*	*40%*	*5%*
1995	*30%*	*5%*	*<1%*	*16%*	*43%*	*5%*

In 1996, approximately 2% of responding nursing homes' residents entered these facilities from out-of-state locations.

CCRC SURVEY RESULTS

COPN restrictions on the 14 facilities whose survey data were analyzed were reported as follows:

- Ten facilities have no restrictions associated with their Certificate of Public Need.
- Three facilities have a 3-year open admissions policy on at least a portion of their beds.
- One facility has a unique set of restrictions.

The following Virginia Planning Districts were represented by the responding CCRCs:

PLANNING DISTRICTS OF SURVEY RESPONDENTS

*PD**	*#of NHs*	*PD*	*#of NHs*
7	*1*	*12*	*2*
8	*3*	*15*	*2*
9	*1*	*20*	*1*
10	*1*	*21*	*2*
11	*1*		

**A map of Virginia indicating the planning districts can be found on page 6.*

The average daily census rates for 1996 were reported by the responding CCRCs as follows. Of the 11 facilities that did not have a three-year open admissions policy:

- 66% -of CCRCs' nursing home residents (based upon average daily census) were under life-care contracts
- 34% - of CCRCs' nursing home residents (based upon average daily census) were admitted from the community

The three CCRCs who have (have had) a three-year open admissions policy reported the following rates for direct admissions from the community for 1996:

- Facility A- 69% (opened for one year);
- Facility B- 15% (only 3 beds have this restriction); and
- Facility C- Data not available, a recently opened facility.

The following table indicates data reported by all responding CCRCs regarding sources of admissions for 1995 and 1996 where at least one admission occurred in each category.

SOURCES OF ADMISSIONS		
Year	*Admits from within the CCRC*	*Admits from the Community*
1996	*75%*	*25%*
1995	*86%*	*14%*

The 1996 average daily charges for the nursing home residents admitted from the community, as reported by the responding CCRCs, was $132/day.

Currently accepted definitions of the basic CCRC contract types are:

Type A: Stable monthly fees are charged across all levels of care.

Type B: A limited number of nursing home days per year are permitted before monthly fees are increased as the level of care increases.

Type C: Under this pay-as-you-go / fee-for-service model monthly fees increase as the level of care increases.

The responding CCRCs reported the following information regarding their active resident contracts as of June 30, 1997:

- 71% of all responding facilities had greater than 75% Type A contracts;
- Three responding facilities had Type B contracts ranging from 1.8 to 13.4 % of their effective contracts; and
- Three responding facilities had greater that 75% Type C contracts.

When asked to describe their policy on refundable entrance fees, if such a policy exists, the facilities with refundable entrance fees reported the following information:

- One CCRC had a fully refundable fee except for expenses incurred for apartment repairs;

- Seven CCRCs had partially refundable fees;
- Two CCRCs offered a variety of options for partially refundable fees;
- Three CCRCs had a variety of options for refundable fees (ranging from 0-100% refundable).

Twelve of the fourteen responding facilities reported that they currently had benevolent funds in effect. Of the two who do not, one facility reported that residents are covered under a benevolent care fund housed in a separate foundation and the other is in the process of drafting such a policy.

Discharge disposition information submitted by the responding CCRCs is outlined in the following table:

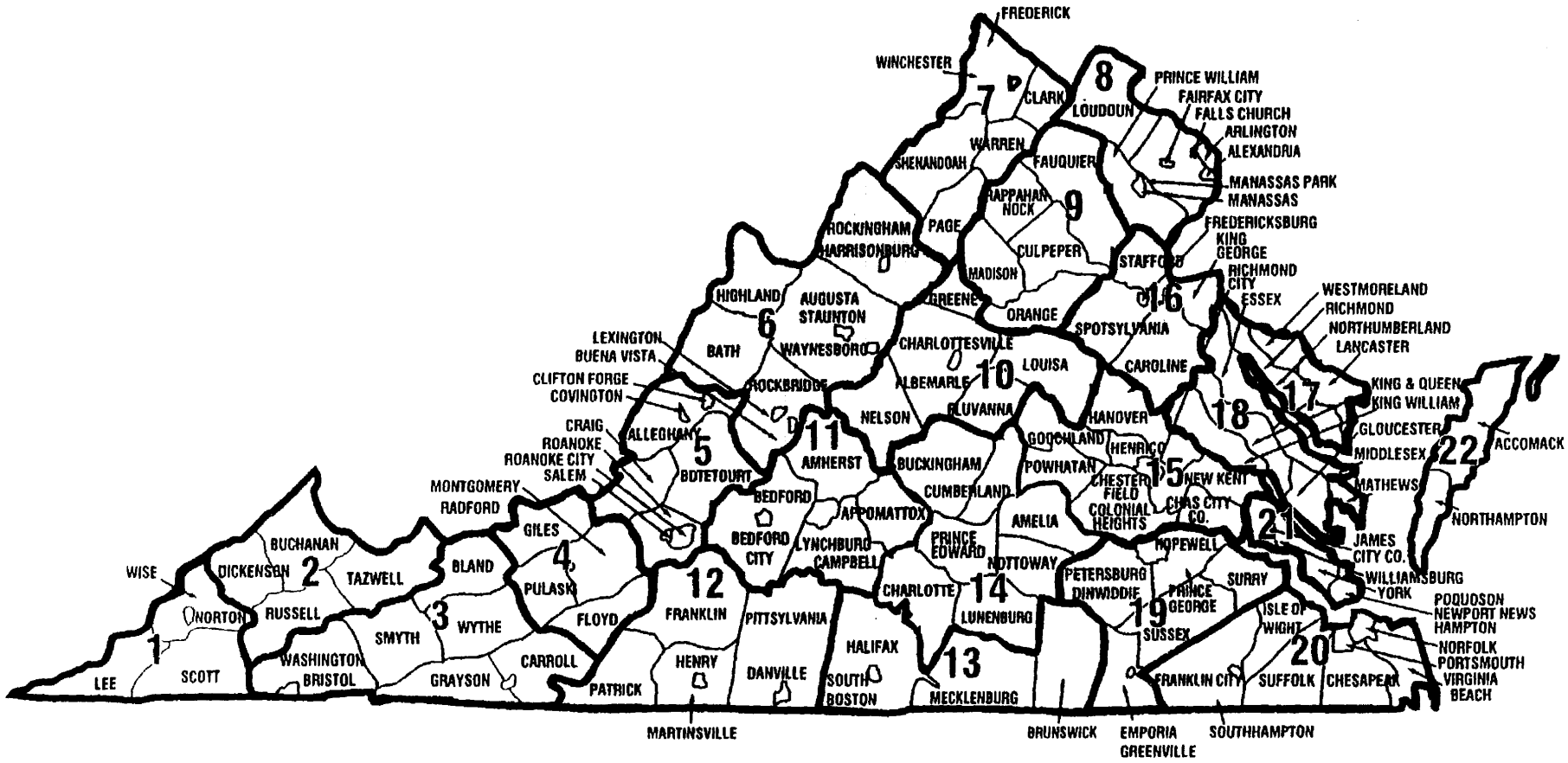
CCRC DISCHARGES IN 1996 & 1995

Year	*Independ Living*	*Assisted Living*	*CCRC NH*	*NH*	*Deatb*	*Other*
1996	*37%*	*16%*	*	**	*30%*	*15%*
1995	*38%*	*22%*	*	*0%*	*29%*	*11%*

** A total of 3 residents discbarged to a CCRC NH in 1996 and a total of 1 resident discbarged to a CCRC NH in 1995*
*** One facility with an unusual structure reported 20 residents discbarged to a freestanding NH in 1996*

In 1996, approximately 16% of the responding CCRCs' residents entered these facilities from out-of-state locations.

Virginia Planning Districts



VHHA supports Option III. VHHA refers to the definitions in the SMFP as being an appropriate description of insurance-based CCRCs, but suggests possible clarification in COPN law and regulations to ensure that an exemption from the RFA process does not apply to CCRCs offering contracts that move away from the insurance model and toward the fee-for-service model.

The Northern Virginia Aging Network recommends that both Options II and III be combined.

Has the increase in CCRC nursing beds impacted occupancy rates and charges of existing nursing home and certified nursing facilities in the Commonwealth?

VDH supports Option I and notes that:

- the addition of nursing home beds in an area will naturally affect the occupancy rates of other nursing facilities to some degree;
- the standards for COPN regulation of nursing facilities are aimed at maintaining high average occupancy rates in order to minimize unit costs and the cost burden on the Medicaid program; and
- current restrictions on the CCRC nursing home beds limit the negative impact on other nursing facilities.

VANHA supports Option I.

VHCA and Medical Facilities of America, Inc. believe that CCRCs have negatively affected nursing bed occupancy rates but the VHCA feels it is unclear if there has been an effect on charges. VHCA recommends, if their other suggested changes to Virginia's CCRC law are not adopted, that the General Assembly direct the Department of Medical Assistance Services (DMAS) to lower the 95% occupancy standard for full Medicaid reimbursement of nursing facilities. Medical Facilities of America, Inc. agrees with this. VHCA did not choose either option.

Legal counsel for Greenspring recommends Option II.

Have nursing facility beds in CCRCs impacted Virginia Medicaid expenditures?

VDH does not believe any action is necessary at this time (Option I). Current restrictions on the expansion of Medicaid certified beds in CCRCs, if they remain in effect, should further decrease the proportion of CCRC nursing beds that are Medicaid certified.

VANHA and Counsel for Greenspring Village also support Option I.

VHCA expresses concern for the future. It believes that unrestricted building of CCRC nursing beds that are open to the community will impact Medicaid expenditures when traditional nursing facilities experience difficulty because of low occupancy rates (and, consequently lower levels of reimbursement) and lack of private pay patients to subsidize the cost of Medicaid residents.

Should Chapter 49 (§ 38.2-4900 et seq.) be modified, particularly in view of the changing configurations in the continuing care market?

VDH reiterates that it does not see any basis for amending Virginia insurance law, irregardless of any concern with COPN regulation of CCRC nursing facilities (Option I).

BOI, VANHA and Counsel for Greenspring Village support Option I.

VHCA and the Virginia Association of Regional Health Planning Agencies expressed the same comment as they did on the second issue (previously presented).

Should the following standards in the SMFP be modified in view of the changing configurations in the continuing care market?

Standard I- The three-year window for CCRCs to admit nursing home residents directly from the outside community.

VDH comments on the study include:

- Closing admissions from day one of operations of the CCRCs most recently developed in Virginia would not have presented a difficulty for the developers to the extent of jeopardizing the project.
- However, VDH believes the current three-year standard is appropriate when CCRCs are initially establishing their retirement community and will have no substantial impact in areas where occupancy rates are in the 90%-95% range.
- VDH plans to propose a new standard which addresses subsequent construction of additional beds.

VANHA and Counsel for Greenspring Village express that this policy has worked well and was a part of an agreement reached between advocates of the nursing home industry and CCRCs and thus support Option I.

The nursing home industry representatives who have submitted comments and VHCA support Option II proposing the total elimination of the open admissions period.

HSANV supports Option IV for those CCRCs who are established under RFA exemption, namely only bona fide (contract-holding) residents of the CCRC should be admitted to the CCRC's nursing facility.

VANHA also recommends Option V, a caveat for "couples."

VHHA's comment suggests Option VI with CCRCs building only the number of nursing beds required for their contract-holders.

Standard II- The ratio of total number of nursing home beds to non-nursing home units in the CCRC.

VANHA and Counsel for Greenspring Village support Option I.

HSANV supports Option I for CCRCs registered with the BOI and that are life-care communities.

VDH intends to propose changes in the SMFP that will limit the initial award of nursing home beds to a new CCRC to 60 beds (essential Option II/SB 1139). VDH, therefore, recommends that JCHC support a one year extension of SB 1139, through June 30, 1999, in order to provide the time necessary to promulgate such a change

Two of the three nursing home providers who commented support Option II, with a limitation of 60 nursing home beds per COPN.

VHCA recommends Option III if the current open admissions regulation remains in effect. If the open admissions period is removed, VHCA would have no concerns about the number of CCRC nursing beds built.

VHHA and the Virginia Association of Regional Health Planning Agencies support Option IV (maximum of 60 beds with a 20% cap).

Standard III- The restriction on CCRCs' obtaining Medicaid certification and providing services to Medicaid eligible persons.

VDH and the Virginia Association of Regional Health Planning Agencies recommend that no action be taken on this policy (Option I). If CCRCs wish to obtain Medicaid certified nursing beds, they may proceed to do so through the RFA process. VDH believes that it is appropriate to insulate the non-competitive track from the larger public need arena of the RFA process, which will allow for an uncomplicated comparative evaluation of a competing pool of applicants of who serve the general public.

HSANV recommends that CCRC nursing beds be available to Medicaid eligibles if the CCRC has obtained approval through the RFA process. If, however, the open enrollment period is eliminated for beds outside the RFA process, the agency feels it fair to permit the CCRCs to serve Medicaid residents.

VANHA and Greenspring Village support Option II which permits CCRCs to serve Medicaid residents. VANHA agrees to a threshold which would provide Medicaid with a cost control mechanism.

Should a mechanism to monitor the adherence of admission restrictions, including enforcement options for violations, be established?

VDH, VANHA, Counsel for Greenspring Village feel that current regulation provides adequate control mechanisms and support Option I.

Both VHCA and the Virginia Association of Regional Health Planning Agencies support Option II.

The Bureau of Insurance would like to review a detailed legislative proposal before taking a position on this issue. The BOI is concerned with both legal and financial consequences to CCRCs if the enforcement options are so severe as to prevent the CCRC from meeting commitments required by Chapter 49.

The following summarizing comments and comments on related issues are included in the responses from commenters:

VDH believes that the controversy that gave rise to SB 1139 can be effectively addressed by the following two amendments to the CCRC standard which exists in the SMFP:

- The standard should limit the initial award of nursing facility beds for new CCRCs to 60 beds (SB 1139).
- The standard should limit "open" admissions to CCRC nursing facility beds to the first three years of operation of the CCRC. Any beds authorized as additions to the CCRC nursing facility should be limited to closed beds required to meet the needs of the CCRC contractual residents.

VDH also recommends that the JCHC support repeal of § 32.1-102.3:21 and §32.1-102.4D of the *Code of Virginia*. VDH contends that these sections should have been repealed in 1996 when the general moratorium was amended to include the competitive RFA process. The former section is a "moratorium exception" and the latter is a "potpourri" of project completion schedule extensions granted for various projects that delayed implementation during the early years of the moratorium. All of these provisions are now moot.

VANHA and the Counsel of Greenspring Village support the general conclusions of the report that there is no substantial evidence thus far that supports the need to amend state law and regulation. Current statutory requirements for CCRCs offer adequate protection for consumers, residents, and the nursing facility industry.

The Virginia Association of Regional Health Planning Agencies members believe that an exemption for nursing facility projects in CCRCs from the RFA process should be retained, but law and regulations should be amended to include the following:

- A revised definition of CCRC to clarify what is and what is not a CCRC;
- A limitation of 60 nursing home beds on the initial application for COPN, with subsequent application reviewed on the specifics of that application with no change in the 5:1 ratio of nursing beds to non-nursing beds;
- A restriction of admissions to nursing beds authorized under the exemption to CCRC contract holders;
- Maintaining of the Medicaid restriction on CCRC nursing beds not obtained through the RFA process; and
- The establishment of a mechanism to monitor adherence and enforce violations for CCRC admission restrictions.

VHCA has stated that the final result in the Greenspring application is in effect the statutory and regulatory changes VHCA is recommending. VHCA has also recommended that the JCHC should evaluate whether CCRC residents need state law protection in the event they run out of money.

The Northern Virginia Aging Network stated that the "commercial" CCRC (i.e. Greenspring Village) "should not be associated with the traditional lifecare communities."

The HSANV notes two flaws in the current RFA process that it feels require serious attention:

- the favorable treatment accorded CCRCs in adding nursing home beds; and
- the interpretation now being used as to the applicability of the RFA process to the movement of licenses for nursing home beds from one planning district to another, outside the RFA process.

JOINT COMMISSION ON HEALTH CARE

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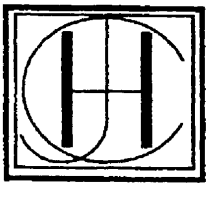

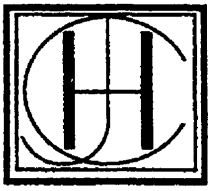

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