

HEALTH CARE

PROPOSAL	COST
MENTAL HEALTH	
-- Parity for private health plans	3.2% + premium increase
-- Medicare parity	\$5 billion over five years
-- Improving Medicaid coverage	\$5 billion over five years
LONG-TERM CARE	\$20 billion over five years
COVERAGE	
-- \$1,000 tax credit to buy individual coverage**	Easily \$100 billion over five years
CANCER	
-- <i>Medicare Cancer Clinical Trials*</i>	<i>\$2.5 billion over five years</i>
-- <i>Biomedical research</i>	<i>\$7 billion over five years</i>
-- New cancer proposal (tbd?)	\$1 billion over five years
<i>MEDICARE COVERAGE OF PRESCRIPTION DRUGS</i>	<i>\$75+ billion over five years</i>
PUBLIC HEALTH	\$5 billion
TOTAL	\$200+ billion over five years
CURRENT HEALTH CARE SPENDING	\$400 billion per year
-- Medicare	\$192 billion
-- Medicaid + Discretionary	\$131 billion
-- Tax expenditures	\$80 billion

*Italicized means currently being proposed by the Administration.

**There are more affordable options to expand coverage.

MENTAL HEALTH

Parity for private health plans. This is last year's CBO score of the proposal being offered by Senators Wellstone and Domenici that requires private plans to offer full mental health parity (3.2 percent was a previous CBO score on this bill although this legislation leaves out a few types of mental illnesses so full parity for all mental illnesses could, in fact, even be higher). This is an extremely high premium increase for a mandate. The patients' bill of rights only costs about 4.5 percent for the entire range of protections in the Kennedy bill, including the right to sue an HMO. In the past, CBO has estimated that for every percentage premium increase the number of uninsured increases by 100,000. There are ways to scale this proposal back – perhaps only passing ending arbitrary day and visit limits – that would lead to lower premium increases.

Parity for Medicare. This proposal would take steps to enhance mental health parity in the Medicare program by increasing the copayment for outpatient mental health services. Currently the copayment for most services is 20 percent while the copayment for services treating mental illness is 50 percent. This proposal is a high priority in the mental health community. (Cost: \$5 billion over five years – this estimate is off of an old baseline so could change. However, we could also lower the cost of this proposal by phasing in the increase). This policy does not bring Medicare to full parity. There is still a lifetime limit for hospital visits of 192 days for mental health services – and no lifetime limit for other services. However, fixing this is in no way the top priority of the community. (This too would cost in the range of \$5 billion over five years). The community would far prefer to fix the outpatient disparity or improve Medicaid rather than fix the inpatient day limit.

Improving Medicaid coverage for the severely mentally ill. Currently, there are a number of optional benefits through the Medicaid program that, taken together, could provide a person with a severe mental illness the comprehensive range of services they need. However, few states have chosen all of these options and even those that have rarely coordinate them for the mentally ill. This proposal would give states the option to have one Medicaid benefit that covers the Program of Assertive Community Treatment (PACT) Model – a well-validated multidisciplinary approach that ensures full integration between treatment, rehabilitation, housing, and other vitally important services for individuals with the most severe mental illnesses. It would cost Medicaid an estimated \$5 billion over five years.

NOTE: Parity in the Federal Employees Health Benefits Program. We are planning to bring FEHBP -- which covers 9 million Americans -- into full parity at the White House Conference on Mental Health. The Office of Personnel Management does not currently have estimates as to how much plans will adjust their premiums as a result.

LONG-TERM CARE

Policies TBD, a few options could include: (*extremely preliminary*) grants for states for home and community-based care; allowances for caregivers, credits for businesses to support eldercare programs, Eldercorps (as part of broader senior volunteer initiative, volunteers for people with long-term care needs); modification of Family and Medical Leave; initiative to assure quality home care workers (e.g. registry, background checks). This figure is clearly only a placeholder.

COVERAGE

We will have rough “back-of-the-envelope” estimates tomorrow. Assumptions are that this is a \$1,000 tax credit that is refundable. Eligible individuals would be those who choose to buy into the individual market to \$100,000 income. There are 7.6 million Americans who are currently buying into the individual market who would automatically be eligible. More than half of the 43 million uninsured pay taxes so even with a take up rate of 30%, this proposal could easily cost \$20 billion. (There would also be some currently insured in the group market who might choose to take this option – although a small number).

CANCER

The Medicare cancer clinical trials proposal is in the Administration’s budget. However, the scoring here reflects a more expansive approach that the cancer community is currently advocating and has been proposed by Senator’s Mack and Rockefeller rather than the Administration’s demo program. The research dollars assume a continued generous increase of the NIH budget overall, with specific allocation for cancer. (The research number too is generally consistent with the Administration’s current approach although more generous). This budget also holds dollars to be invested in a possible new cancer proposal tbd.

MEDICARE COVERAGE OF PRESCRIPTION DRUGS

This proposal will be in the Administration’s Medicare proposal that will be put forth in the coming weeks. The Administration is currently considering proposals in the range of \$75-100 billion over five years. The benefit structure is still being debated but main options include: (1) \$100 deductible, 20% copay, and \$1250 cap or (2) \$0 deductible; 50% copay, and \$4000 cap. (both are voluntary, both have premiums in the \$20 to \$30 range).

PUBLIC HEALTH

Optional placeholder for series of small health investments in the area of a prevention, such as healthy start newborn initiative, healthy aging or funding VP priorities such as HIV/AIDS etc.

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Funding their worker retraining initiative. Last summer, LA County requested additional Federal funds for a worker retraining initiative to assist in the restructuring and downsizing of the public health system, similar to the assistance provided in New York's 1115 waiver. Since LA County is already receiving Federal match for an extensive range of services, it will be difficult to provide LA County with the same type of assistance we provided in NY.

PERMANENT RELIEF FROM HOSPITAL SPECIFIC DSH LIMITS

To curb recycling, OBRA 93 limited DSH payments to 100% of hospitals' uncompensated care cost. The Balanced Budget Act set California's hospital-specific DSH limits are now at 175 percent of the cost of uncompensated care, providing LA County with an additional \$475 million in Federal funds for the next two years. The county seeks a permanent extension of this relief.

The BBA provision had no cost because CBO and OACT assumed that California would spend up to its BBA DSH allotment in absence of the provision. The cost of an extension would likely be minimal, and would depend on OACT and CBO's assumptions about California's continued ability to spend its allotment in absence of the waiver.

FLEXIBILITY IN THE CHILDREN'S HEALTH INSURANCE PROGRAM

Request for increased flexibility to cover children above 200 percent of FPL. States already have flexibility to extend CHIP benefits to children in families with incomes above 200% of the federal poverty level. While the statute limits eligibility for CHIP to children in families with incomes at or below 200% of FPL, states are free to use income disregards to expand CHIP eligibility to families with gross incomes beyond 200% of FPL.

California's original CHIP plan, which was in March 1998, included the use of income disregards in determining income eligibility for CHIP. In April 1998, the state submitted an amendment to its plan that eliminated the use of income disregards, effectively limiting eligibility for CHIP to children in families with gross incomes of 200% or less of FPL. This amendment was approved in June 1998.

Request for increased flexibility to cover low income families. CHIP funds are available for family coverage provided that states can meet a cost-effectiveness test which requires that the

cost of family coverage cannot be more expensive than the cost of covering just the child. The most likely way states could meet this test is through a subsidy for employer-sponsored insurance. We are not currently entertaining waivers of any Title XXI provisions to allow for increased flexibility in this area.

RESTORING BENEFITS TO LEGAL IMMIGRANTS

Restoring Health Benefits to Legal Immigrant Children and Pregnant Women. States currently can provide health coverage to immigrant children and pregnant women who entered the U.S. before August 22, 1996. The President's FY 2000 Budget would give states the option to provide health coverage to these individuals. The proposal for children would cost about \$220 million and serve approximately 55,000 children in FY 2004. The proposal for pregnant women would cost \$105 million and serve approximately 23,000 pregnant women in FY 2004. Under these restorations, the current law five-year ban, sponsor deeming, and affidavit of support sponsor reimbursement requirements would be waived.

Issuing guidance on public charge. We are concerned about reports that legal immigrants -- including the citizen children of legal immigrants -- are not accessing benefits for which they are eligible, including health coverage, because of concerns about being determined a "public charge." We are in the process of finalizing INS guidance on this issue and anticipate it will be released shortly. While we cannot comment on details, we believe the guidance will address many of the concerns raised by immigrants, advocacy groups, States, and others.

acute care policies, where most employers pay a large proportion of the cost of insurance, most employer-sponsored long-term care policies are offered on an employee-pay-all basis.

The Advantages of the Employer-Sponsored Market

Theoretically, employer-sponsored plans offered to the nonelderly provide several advantages over those purchased individually. First, premiums for younger policyholders can be substantially lower than those for older policyholders because younger policyholders pay premiums over a longer period of time and because earnings on premium reserves have more time to build. For example, the premiums for a 42-year-old will be approximately one-quarter to one-third of the premium for a 67-year-old (Wiener, Harris and Hanley, 1990). Computer simulations suggest that purchase of long-term care insurance by the younger population could largely solve the affordability problem of private long-term care insurance, even without employer contributions (Table 1). Because of the improved affordability, significant Medicaid savings could be achieved if persons purchased long-term care insurance when they were younger.

Although lower premiums are tied to the age of the purchaser and not necessarily to the fact that the policy is employer-sponsored, the nonelderly are easiest to reach through their place of employment. The workplace is where most health, life, and disability insurance is purchased and most retirement savings through pensions are established.

Lower administrative and marketing costs offer another potential source of savings over individual policies. Administrative and marketing costs are high in individual policies because sales have to be made one at a time. Group markets are able to achieve lower costs through economies of scale. Moreover, in group policies, employers bear many of the costs of administering the policy, such as collecting premium payments through payroll deductions. Employers may also elect to assume part of the costs of marketing the plan to their employees. However, informal discussions with insurance actuaries suggest that most assume only a ten percentage point difference in the anticipated loss ratio between individual and group plans.³ Thus, although the administrative savings of group policies are desirable and not trivial, they will not dramatically lower premiums.

Enrolling people at younger ages through the workplace also reduces the risk of adverse selection and therefore the need for medical underwriting. Disability is relatively rare at younger ages. The less frequent underwriting typical of employer-based policies is an improvement over the universally strict practices used for purchase of individual insurance policies. However, most younger persons with significant disabilities are not in the work force and would not, therefore, be eligible for these policies.

Finally, advocates of employer-sponsored insurance argue that the quality of policies should improve through the involvement of company benefit managers. Large groups have more market power than individuals to negotiate with insurance carriers for less restrictive policies with richer benefits and lower prices. In general, the quality of policies in the employer market is quite good, especially in providing home care benefits. On the other hand, most employer-sponsored policies have grossly inadequate inflation protection. Under most policies, the insured must purchase additional coverage from time-to-time to compensate for inflation, but at the new older age and therefore at a substantially higher premium.⁴

Impediments to an Employer-Sponsored Strategy

Despite the potential advantages of selling to the nonelderly population through employer groups, the employer-sponsored market may not expand enough to play a significant role in financing long-term care. Employers are reluctant to offer the policies, and employees are not rushing to purchase them. In particular, employers have been unwilling to contribute to the cost of policies.

Tax Treatment of Private Long-Term Care Insurance

Employer contributions could make long-term care insurance more affordable by reducing the amount that employees have to pay out-of-pocket and might give employees confidence in the product. Until

passage of the Kassebaum-Kennedy bill in 1996, private long-term care insurance was not specifically recognized in the federal tax code. Because of its unique characteristics, long-term care insurance did not fit neatly into the existing tax models of health and accident, life, or disability insurance, pensions or private annuities. As a result, the tax status of employer contributions and of insurance benefits were unclear and this lack of clarity no doubt slowed the growth of long-term care insurance, at least to some extent. The Kassebaum-Kennedy bill clarified that contributions towards the cost of group long-term care insurance policies was a tax-deductible expense for employers (like health insurance) and that benefits (within limits) were not considered income.

A persistent problem with tax incentives is the probability that most of the tax expenditures will be for people who would have purchased policies anyway. As a result, tax subsidies can be very costly ways of promoting private insurance. For example, Wiener, Illston, and Hanley (1994) estimate that the lost revenue to the federal government of allowing employers to deduct the cost of their contribution to private long-term care insurance would be \$7,900 to \$11,300 per year per additional policy sold.

These tax benefits are also not free to the federal government, producing potentially substantial tax losses. Some advocates argue that reductions in government expenditures for Medicaid nursing home and home care will offset the tax loss because some people who will buy private insurance would otherwise be eligible for Medicaid. At least for a long time period, these offsets are unlikely to occur because the tax loss will happen immediately, because the revenue loss is linked to premium payments, but the savings, if any will not occur until the benefits are used, typically many years into the future. This imbalance in timing guarantees short-term tax losses. Using a computer simulation model, Wiener, Illston, and Hanley (1994) estimate that it could take twenty-five years before the annual tax loss approximately equals the Medicaid savings.

While the uncertain tax status of long-term care insurance has no doubt prevented some employers from offering long-term care insurance policies to their employees, these factors are likely to be overwhelmed by the financial problems facing employer-sponsored acute health insurance benefits for retired employees which supplement the Medicare program. Unlike pensions, virtually all corporations offering post-retirement health benefits have financed them on a pay-as-you-go basis rather than prefunding them. Prodded by accounting rules established by the Financial Accounting Standards Board that require companies to disclose their future financial liability for these benefits, corporations are now aware that, collectively, they have an estimated \$187 billion to \$400 billion in mostly unfunded liabilities (U.S. General Accounting Office, 1993; Warshawsky, 1992; U.S. General Accounting Office, 1989).

As a result, large numbers of employers, concerned about health care costs for both their active employees and retirees, are cutting back on retiree benefits, making retirees pay a greater part of the cost or dropping that coverage altogether. For example, data from Foster Higgins' annual survey of mostly large employers found a drop in retiree health benefits between 1988 and 1992 (Foster Higgins, 1993). In 1988, 55 percent of responding firms offered retiree health benefits to Medicare eligible retirees; by 1992, only 46 percent of responding firms did so. The percentage of full-time workers in state and local governments with retiree health benefits declined between 1990 and 1992 from 58 percent to 50 percent (U.S. Department of Labor, 1994, 1991). A recent study of 50 of the largest companies showed that 31 companies reported increases in retiree cost sharing for medical benefits in 1994 (Watson Wyatt Worldwide, 1995). In this environment, it seems unlikely that many additional employers will want to contribute to a new, potentially expensive insurance plan that will primarily benefit retirees twenty to thirty years after they have left the company. Indeed, employers are trying to distance themselves as much as possible from such benefits.

Limited Employee Demand

To date, employee demand has not played a large role in the decision of companies to add long-term care insurance to their benefit package. The desire to maintain a company's image as a leader in employee benefits or a personal sensitivity to the problem by a senior officer or employee benefit manager have been larger factors. Nonetheless, surveys of large employers suggest the possibility of a large increase in the number of companies offering policies, if not paying for them. Employees also have been reluctant to purchase insurance. The Health Insurance Association of America estimates that,

depending on how the universe of eligibles is defined, only 5.3 percent to 8.8 percent of those offered employer-sponsored long-term care insurance have purchased policies (Coronel, 1991).

Several factors limit employee demand. First, although premiums for policies without inflation adjustment are lower at younger ages, they cost more than many people are willing to pay voluntarily. Moreover, a high quality long-term care insurance policy with a level premium, inflation protection, and nonforfeiture benefits purchased at age 50 can cost more than \$1,000 a year (Coronel and Kitchman, 1997). In a survey of nonpurchasers of employer-sponsored policies offered by two major insurers, LifePlans, Inc., reported that 82 percent of respondents felt that the fact that "the policy costs too much" was either "very important" or "important" in their decision not to purchase a policy (LifePlans, 1992). Even though economists contend that increased employer contributions for fringe benefits are mostly offset by reduced wages, 90 percent of respondents in this survey said that they would be more willing to purchase a policy if their employer contributed to the cost.

In addition, middle-age workers usually must contend with other, more immediate expenses, such as child care, mortgage payments, and college education for their children. In the LifePlans, Inc. (1992), survey, 80 percent of nonpurchasers stated that "more important things to spend money on at this time" was either "very important" or "important" in their decision not to purchase a policy. The risk of needing long-term care is too distant to galvanize many people into buying insurance.

Finally, selling to the nonelderly population raises difficult considerations of pricing and product design. An actuary pricing a private long-term care insurance product for a 45-year-old must predict what is going to happen forty years into the future, when the insured is age 85. To say the least, this is difficult. Ironically, although one of the advantages commonly claimed for private insurance is its flexibility to respond to the needs and wants of consumers, policyholders who buy insurance at younger ages could be locked into the existing model of service delivery decades before they use services. Who knows what the optimal delivery system will be a half century from now?

TAX INCENTIVES FOR INDIVIDUAL PURCHASE OF PRIVATE INSURANCE

Another set of options would improve the affordability of private long-term care insurance by offering direct tax incentives to individuals who purchase policies. For example, the Kassebaum-Kennedy legislation allow individuals to count private long-term care insurance premiums as a health expense.⁵ Health care expenses in excess of 7.5 percent of adjusted gross income are tax deductible. As a result of the ability to deduct part of the cost of private long-term care insurance, the net price of insurance policies will be reduced. Some insurance advocates argue that providing a tax benefit will have a "sentinel" effect, promoting insurance beyond merely reducing the price. A tax incentive, they contend, will signal potential purchasers that the government thinks private long-term care insurance is a worthwhile product.

The type of tax chosen to provide the tax subsidy defines the scope of who can benefit. Allowing taxpayers to deduct all or part of the cost of a private long-term care insurance policy would provide a premium subsidy valued at the marginal tax rate of the household. Since upper-income taxpayers have higher marginal tax rates than lower-income taxpayers, deductions are regressive in nature. That is, they are worth more to upper-income people than to lower-income people. However, for the 72 percent of taxpayers in the 15 percent tax bracket in 1993, this type of tax subsidy would reduce the cost of obtaining long-term care insurance by only about one-seventh, probably not enough to motivate very many additional people to purchase policies (Cruciano and Strudler, 1996). The other major drawback is that relatively few taxpayers itemize their deductions. In 1993, only 29 percent of all tax returns included itemized deductions; only 4 percent claimed a deduction for medical expenses (Internal Revenue Service, 1996).

The other broad approach is to provide a tax credit, which is a direct reduction in the amount of tax owed, for purchase of policies. In theory, tax credits need not be as regressive as deductions. However, as a practical matter, moderate and low-income taxpayers may not have the cash on hand to pay premiums during the year so as to be able to claim a tax credit in the following year. The other problem is that, unless the credit is refundable, it is an ineffective policy for people who do not have a tax

liability. This is especially a problem for the elderly; only about half of whom have any federal income tax liability (Committee on Ways and Means, 1996).

As with tax subsidies for employer contributions to private long-term care insurance, the key issue is whether tax incentives are an effective and efficient way to promote the purchase of private long-term care insurance, and thereby, the reform of nursing home and home care financing. For example, estimating the effect of an income-related tax credit for the purchase of private long-term care insurance, Wiener, Illston and Hanley (1994) estimated the cost per additional policy induced by the tax benefit at between \$1,700 and \$1,900 per year. Similarly, they estimate that the tax loss through 2018 will be at least four times the Medicaid savings.

EASIER ACCESS TO MEDICAID: A PUBLIC-PRIVATE PARTNERSHIP

While changing the tax code is the most commonly proposed way of publicly subsidizing private long-term care insurance, the initiatives by Connecticut, Indiana, California, Iowa and New York take a substantially different approach. Commonly referred to as the "Robert Wood Johnson Public-Private Partnerships" (named for the foundation that promoted this strategy), these states provide easier access to Medicaid for persons who purchase a state-approved private long-term care insurance policy. In essence, these states allow nursing home patients with private long-term care insurance to be Medicaid eligible with substantially higher levels of assets than is normally allowed.⁶ At present, Medicaid only allows unmarried nursing home patients to retain \$2,000 in assets (excluding the home). While employer-paid plans and tax incentives seek to reduce the net cost of insurance, this public-private partnership does the reverse by trying to increase the amount of benefits received per dollar spent.

There are two models of how to link Medicaid and private insurance.⁷ In both cases, Medicaid acts as a kind of reinsurance for persons with limited private long-term care insurance. In one model used by Connecticut, California, Indiana, and Iowa, the level of Medicaid-protected assets is tied to the amount that the private insurance policy pays out. For example, if a person buys a policy that pays \$100,000 in long-term care benefits, then that individual can keep \$100,000 in assets and still be eligible for Medicaid. Consumers are able to purchase insurance equivalent to the amount of assets they wish to preserve, potentially reducing the amount of insurance individuals need to buy.

The other model, used by New York, provides protection of an unlimited amount of assets if an individual purchases a policy that meets state standards, including coverage of at least three years of a combination of nursing home and home care, with a minimum \$100 per day indemnity payment. The rationale for not requiring an asset test for Medicaid coverage is that nursing home costs are so high in New York that few individuals can avoid Medicaid over an extended period of time.⁸ Thus, New York is targeting a higher income population, with potentially more assets, than are the other states.

The key observation supporting the public-private approaches is that long-term care insurance that covers shorter periods of nursing home and home care are cheaper and more affordable than policies that cover longer periods of care.⁹ The problem with the current system is that if an individual buys a policy that covers, for example, two years of nursing home care and ends up staying in a nursing home for five years, then the insured's assets can still be lost. Thus, under these Medicaid initiatives, it is possible to obtain lifetime asset protection without having to buy an insurance policy that pays lifetime benefits. Proponents of this approach contend that the goal is not asset protection, per se., but rather to preserve financial autonomy toward the end of life.

Supporters assert that by encouraging purchase of insurance, Medicaid long-term care expenditures will possibly be reduced or, at least, will not increase. This argument is probably stronger for the approach used by Connecticut, Indiana, Iowa, and California, where there is a "dollar-for-dollar" correspondence between the amount the insurance pays and the level of Medicaid protected assets. In New York, the ability to protect potentially very large amounts of assets makes this argument weaker, although still possible. To the extent that these systems are budget-neutral, these strategies will be a move toward what economists call "Pareto Optimality," that is, making some people better off without making anybody worse off. Insurance dollars are simply substituted for private asset dollars.

There are two other potential advantages to this approach. First, since only "approved" policies are eligible for the enhanced asset protection, state regulators can use the initiative as a "carrot" to induce insurance companies to upgrade the quality of their policies.¹⁰ Second, by giving the elderly the alternative of protecting their assets by purchasing insurance, legal and illegal transfers of assets for the purpose of obtaining Medicaid eligibility may be reduced.

Despite these arguments, there are several concerns about the equity and efficiency of this option. The first concern is whether it is appropriate to use a means-tested welfare program--Medicaid-- as a mechanism to protect the assets of upper-middle and upper-income elderly. Indeed, under this approach, it remains an open question how far down the income distribution insurance purchase will go. Computer simulations by Wiener, Illston and Hanley (1994) suggest that the vast bulk of private insurance expenditures will be for the relatively well-to-do elderly.

The second concern is whether providing improved asset protection will actually induce substantial numbers of people to purchase long-term care insurance who would not otherwise have bought it. As of December 1996, participation in partnership plans has been disappointing, with only 22,000 policies in force, over half of which are in New York State (University of Maryland Center on Aging, 1997). While it is difficult to sift through people's motivations for buying insurance, one recent study of purchasers found that only 23 percent of respondents listed protection of assets as the "most important" reason for buying insurance (LifePlans, 1995). Asset protection may have a narrow appeal because most elderly have relatively modest levels of financial wealth (Radner, 1993).

Even more fundamentally, many elderly do not want easier access to Medicaid. Indeed, one of the major reasons people buy long-term care insurance is to avoid having to apply for welfare. One survey of insurance purchasers found that 91 percent of respondents reported that avoiding Medicaid was an "important" or "very important" reason for buying a policy (LifePlans, 1995). Medicaid's relatively low reimbursement rates have led to inadequate access and quality of care problems in nursing homes heavily dependent on Medicaid (Nyman, 1988; Institute of Medicine, 1986; and, Scanlon, 1980). In addition, upper-middle and upper-income elderly will probably find the \$30 a month personal needs allowance of the Medicaid program to be inadequate. Therefore, they would use up at least some of their newly-protected assets for daily living expenses. Avoiding Medicaid is also the principal argument that insurance agents use to market policies; the partnership plans require a radical revision in the agent's "sales pitch." In sum, it is not clear that easier access to Medicaid will be enough of an inducement to get large numbers of additional elderly to purchase private long-term care insurance.

The third concern is whether the public-private partnership will truly be budget-neutral. After all, Medicaid benefits are being offered to people who would otherwise not be eligible. Because most policies probably will be sold to healthy young elderly who are at least 10 to 20 years away from needing nursing home care, even fragmentary evidence as to the effect of the partnership on the public purse will not be available for a decade or two. If additional public expenditures should prove to be required, then one may well ask whether providing asset protection to relatively well-to-do elderly is the best place to put our next long-term care dollar.

It is also important to realize that an indispensable component for assessing the effect on the Medicaid budget is establishing a comparison level of expenditures. In a world with no private long-term care insurance at all, it is likely, although not certain, that the partnership would be budget-neutral. However, there is likely to be continuing modest growth in the number of private long-term care insurance policies sold. Compared to this scenario, if the partnership does not induce substantial numbers of additional insurance purchasers, then the partnership will require larger Medicaid expenditures than would otherwise be needed. This is because under current Medicaid rules purchasers of insurance who would have bought policies without the public-private partnership would have to spend-down their assets after their insurance benefits have been exhausted before qualifying for Medicaid, something that they are not required to do under the partnership.

In addition, while supporters argue that the partnership offers persons a more appealing alternative to transferring assets as a way to avoid Medicaid's claim on these resources, it is conceivable that it will

actually increase the level of premature asset transfer. Current rules prohibit the transfer of assets to other persons at less than fair market value for 36 months prior to application for Medicaid eligibility (Burwell and Crown, 1996). Once the partnership has encouraged the elderly to look to Medicaid as a way to protect their assets, some insurance purchasers may only buy the 36 months worth of coverage required to comply with Medicaid rules and then legally transfer the remainder of their financial wealth upon entry to a nursing home. Others may calculate that they can transfer or shelter their assets and obtain Medicaid benefits without purchase of any long-term care insurance policy.

CONCLUSIONS AND RECOMMENDATIONS

The United States faces major challenges in the way it organizes and finances long-term care for the elderly. The aging of the baby boom generation absolutely guarantees that expenditures for nursing home and home care will grow substantially in the future. Based on the available evidence, the following observations should form the framework for reform:

- Although the role of private long-term care insurance will inevitably grow over time, it is doubtful that it will ever play a major role in the financing of long-term care. Especially for the elderly population, good-quality policies are simply too expensive. Medicaid savings are particularly unlikely because the people who can afford policies are not the people who spend down to Medicaid.
- Selling private long-term care insurance to younger people through employers can make policies significantly more affordable. However, policies are still costly and employees have so far been unwilling to buy policies in large numbers. Substantial employer subsidies could make private long-term care insurance more attractive, but even with tax subsidies employers are unlikely to make contributions because of their large unfunded liability for retiree acute care benefits. Employee demand among people in their 40s is low because of competing demands for their spending. As a result, market penetration is likely to be far below the levels projected by simulations (including my own) based solely on upper-bound determined affordability.
- While some of the tax clarifications for private long-term care insurance enacted in the Health Insurance Portability and Accountability Act of 1996 were desirable, the tax deduction for individual purchase of private long-term care insurance is regressive, primarily benefits the well-to-do, and is a highly inefficient way to encourage the purchase of private long-term care insurance. Most of the subsidy will go to people who would have bought insurance without the tax benefit. Even clarifying the tax treatment of employer contributions will result in federal tax losses that are "spending" are surely as any direct appropriation. Congress should refrain from providing any more tax incentives for the purchase of private long-term care insurance.
- While the quality of policies has improved dramatically over the last ten years, the lack of inflation protection and nonforfeiture benefits in most policies are significant deficiencies. Congress lost a major opportunity to upgrade policies when they provided tax breaks to insurance companies without requiring any substantial upgrading in consumer protection.
- While a favorite of some policy analysts, the public-private partnerships for long-term care have failed the market test--very few policies have been sold, even in states that have promoted them for several years. Although the reasons are unclear, probably the primary reason is that insurance agents prefer to sell policies by emphasizing the negative aspects of the Medicaid program, a strategy that is inconsistent with a product whose primary benefit is easier access to the program.
- Given the limitations of private long-term care insurance, serious long-term care reform that seeks to make life better for the great majority of elderly will require expansions of public programs--Medicare, Medicaid, and others--that currently are the major source of third-party funding. To ignore the public programs in the hope that private insurance will replace them someday is a luxury that the disabled elderly and their families can ill afford.

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Figure 1

Private Long-Term Care Insurance Options: Simulation Assumptions

All persons purchase insurance policies that cover two or four years of nursing home and home care and pay an initial indemnity value of \$60 per day for nursing home care and \$30 per visit for home care in 1986. Indemnity values increase by 5.5% per year on a compound basis. Premiums for nonelderly persons increase by 5.5% per year until age 65 and are then level. All nondisabled person who meet affordability criteria buy as much as insurance as they can afford.

- **5% Income:** All elderly purchase policies if they can afford them for 5% of the income or less and if they have \$10,000 or more in nonhousing assets.
- **Medicaid Insurance:** Elderly who purchase private long-term care insurance may receive Medicaid nursing home benefits while retaining liquid assets beyond what is normally allowed. The additional assets that they keep equal the amount that the private insurance policy pays out in benefits. All elderly persons purchase policies when they can afford them for 7% of their income or less and if they have \$10,000 or more in nonhousing assets.
- **Tax-Favored Insurance:** Provides an income-related tax credit of up to 20% of the premium cost for elderly purchasing insurance. All elderly purchase policies when they can afford them for 5% of their income or less and if they have \$10,000 or more in nonhousing assets.
- **Employer-Sponsored Insurance:** Persons as young as age 40 purchase group or individual long-term care insurance policies. Nonelderly purchase policies if premiums are between 2% and 4% of income (depending on age). Elderly persons purchase policies if they can afford them for 5% or less of income and if they have \$10,000 or more in nonhousing assets.

Source: Wiener et al., 1994.

Table 1

How Much Can Private Insurance Do? Simulation Results for Four Major Options, 2018

Option	Elderly with Private Insurance ^a	Total Long-Term Care Spending Paid by Private Insurance ^b	Private Insurance Spending on Nursing Home Patients with Incomes >\$40,000 ^c	Reductions in Medicaid Nursing Home Spending ^d	Reductions in Catastrophic Out-of-Pocket Spending for Nursing Home Patients ^e
5% Income	20%	9%	70%	-2%	-6%
Medicaid Insurance	32%	14%	61%	-4%	-11%
Tax-Favored Insurance	28%	12%	64%	-3%	-8%
Employer-Sponsored	80%	35%	26%	-32%	-28%

Source: Wiener et al. 1994.

Notes:

- a. Age at initial participation is 67 for all options. Consequently, all are expressed as the percent of elderly aged 67 and older.
- b. Total long-term care expenditures vary by option.
- c. Income is presented in 1993 dollars.
- d. Medicaid nursing home expenditures for the base case are \$49 billion.
- e. Defined as >40% of income and nonhousing assets.

Notes

1. "The number of policies ever sold" is a highly misleading figure because it does not take into account that many people have let their policies lapse or that some policyholders have died. The Health Insurance Association of America does not collect information on the number of policies in force.
2. While policies without inflation protection (i.e., at least 5 percent annual compound increase in the indemnity level) and nonforfeiture benefits are cheaper, they are essential elements of good policies.
3. The loss ratio is the percentage of the premium that is for benefits rather than administrative and other overhead. Many companies assume a loss ratio of 60 percent for individual policies and 70 percent for group policies.
4. For example, if a person buys a policy at age 42 that pays \$60 a day in nursing home benefits and if inflation is 33 percent during the next five years, then the insured can buy additional coverage of \$20 a day to compensate for the inflation but at the price charged 47-year-olds, not 42-year-olds. We estimate that to retain purchasing power, the inflation-adjusted premium at age 82 would be approximately ten times what they were at age 42. This is because nursing home use is exponential by age.
5. The level of private long-term care insurance that can be included varies by age. For 1997, it is limited to \$200 for persons age 40 and younger; for persons aged 70 and older, it is limited to \$2,500.
6. Medicaid law allows states great flexibility in determining countable income and assets of medically-needy patients--patients with high medical bills in relation to their income. In essence, states using this strategy exclude insurance-related assets from their definition of resources that must be counted in determining Medicaid eligibility. However, the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) severely restricts the ability of additional states to pursue this option by including the insurance-related protected assets in an individual's estate. OBRA 1993 requires states to attempt to recover the cost of institutional care from the estates of Medicaid patients. Thus, patients may not be able to pass on these additional funds to their heirs, substantially lessening the appeal of this approach.
7. In both models, nursing home patients must still contribute all of their income towards the cost of care except for a small

(usually \$30 per month) personal needs allowance.

8. In 1993, the average Medicaid rate was \$185 per day, compared with \$88 for the United States as a whole (American Health Care Association, 1996).

9. At age 67, prototype individual private insurance policy costs \$2,337 a year for a policy that covers four years of nursing home and home care, but \$1,617 a year for a policy that covers only two years of nursing home and home care (Wiener, Harris and Hanley, 1990).

10. For example, Connecticut mandates compound inflation adjustment of indemnity benefits. In addition, the State is requiring a type of nonforfeiture benefit that requires companies to offer a policy with less extensive coverage to individuals who discontinue their premiums payments and let their policy lapse. Connecticut has also mandated training for insurance agents selling certified policies and is requiring the distribution of a consumer booklet that compares insurance policies.



Home



How to contact the Urban Institute.

How to order Urban Institute Publications.

The DLC Update, Friday, March 27, 1998

Highlights Include:

- Idea of the Week: Smart Cards, Smart Government
- A Bad Proposition in California
- Sauce for the Gander
- Slow Learners

Idea of the Week: Smart Cards, Smart Government

If "modernizing the public sector" is a central goal for New Democrats, then pushing government to take full advantage of new information technologies is one obvious and useful means for achieving that goal. This is much more than a matter of whiz-bang innovation, or even efficiency. Empowering citizens to directly access government information and services electronically is essential to breaking down the old bureaucratic model of "programs" that "clients" enter through a maze of regulatory barriers, led by paternalistic agency intermediaries.

Electronic empowerment is fast approaching the line that separates isolated experimentation from a systematic agenda. One real pioneer has been Texas Comptroller (and long-time DLC member) John Sharp. Back in 1991, Sharp unveiled the Lone Star Card--an ATM-type "smart card" that food stamp recipients could use at the checkout counter instead of the paper food stamp, which had become the currency of a corrupt, underground economy linking food markets with drug markets. Now 36 states have initiated pilot "electronic benefit" projects, though Texas and Maryland are the only two where the paper food stamp has vanished statewide.

Remember President Ronald Reagan's constant talk about reducing "waste, fraud, and abuse" in federal programs? It took a New Democrat to show how to virtually abolish it in the food stamp program.

Former Michigan Governor (and DLC stalwart) Jim Blanchard proposed a similar "smart card" to help workers negotiate the complex welter of skills training programs--an idea that is central to the G.I. Bill for Workers proposal developed by his former advisor Doug Ross during his stint as Assistant Secretary of Labor in the Clinton Administration.

Information-Age innovations in governing are now popping up constantly. U.S. Rep. Anna Eshoo (D-CA) has introduced a bill that would require all federal agencies to make their forms available on the Internet, and just as importantly, to accept "digital signatures." A more direct blow at the "send this form back in triplicate" culture of federal bureaucracies is hard to imagine. A more welcome marriage of information technology and citizen empowerment is also hard to imagine--but we hope someone does.

A Bad Proposition in California

In the June primary elections, California voters will consider Proposition 226, modeled on the so-called Payroll Protection Act that Senate Republicans have used as a "poison pill" to block campaign finance reform. Its basic thrust is to impose on labor unions a unique obligation to affirmatively secure written permission individually from members before using their dues for political activities. Its more practical effect would be to widen the advantage Republicans already enjoy in "soft money" contributions to political



Page 3 of 7 -- November 1996

Message from
the Mayor

A Success
Story

Indy's "Job or
Jail" Program

Faith & Families
Update

"A Promise to
Keep" for IPS

The IPS Honor
Card Program

What's Next
for RF ?

Contacts

The Indianapolis "Job or Jail" Program

While in office as Marion County Prosecutor, one of Mayor Goldsmith's highest priorities was the enforcement of child support payments. While he substantially increased the annual collection of child support through a process still in place, many people still manage to sneak through the system and deny the responsibility they assumed when they created a child. With continued pursuit, enforcement, and if necessary, prosecution of such people in mind, the Job or Jail Program acts as an enabler to make such progress. This novel initiative gives those parents that have neglected their child support obligations a simple choice: make the child support payments or go to jail.

The Job or Jail program provides a means for non-custodial parents to gain self-sufficiency through employment. More specifically, this program will assist parents that do not have custody of their children in finding a solid, permanent job.

The program is founded on the belief that non-custodial parents have the potential to succeed if adequate support systems are afforded to them. By providing participants with the skills and training that are essential to secure long-term employment, the Job or Jail program ensures that non-custodial parents can support themselves and their children. This way, the cycle of dependency and poverty will be broken.

The Marion County Child Support Division is directing the Job or Jail program, and this innovative demonstration program will target participants who are able-bodied but frequently unmotivated, unemployed parents, who fail to meet court ordered child support payments.

The long-term, primary objective of this program is to increase the level of reliable support available to the children. The Job or Jail program was officially implemented on July 1, 1996, and since August 1, 1996, over 60 parents have been referred to the program. Half are being placed into jobs (one-third are already working full-time and meeting their support orders), 30 percent have been referred to community work and 20 percent have been referred to the job-readiness training and placement program. The Job or Jail program creates incentives so that parents are motivated to do the right thing for their children, in terms of economic investment and emotional involvement.



Return to Newsletter home page.

Move on to ... Faith & Families.



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When Curtis Andrews was employed during the last five years he never missed a child support payment. Unemployed for seven months, he accumulated over \$2,600 in unpaid support. A child support branch office suggested that Andrews contact "Job or Jail" Coordinator KerryAnn May for assistance finding employment. May referred him to Goodwill Industries for help with his resume and job-search training. Andrews had an initial meeting with a Goodwill counselor, and the following week they worked together on his resume. After just four days Andrews found a job at Promex Inc. A portion of his income is now being withheld to pay his current and back child support. Andrews is happy to have a steady job and his son is once again receiving support.

rebuilding
families newsletter

June 1997

page 4

License suspensions encourage fathers to pay support

The objective of the license suspension initiative is not to take away professional licenses, but to encourage non-custodial parents to take responsibility and pay child support. The threat of suspension of their professional license has caused hundreds of delinquent support payers to pay owed support and agree to have money withheld from their paychecks for current support payments. The Prosecutor's Office has filed petitions to suspend 21 occupational licenses including physicians, attorneys,

and teachers. Since the program began last year, five licenses have been suspended, but were later restored when all five fathers made their child support payments and agreed to continue making payments.



Currently, four other professionals have license suspension actions under

advisement pending their agreements with the Prosecutor's Office to pay support. Payments of more than \$30,000 have been received on these cases since the suspension petitions were filed. Delinquent payers who hold professional or driver's licenses are notified by mail that their licenses may be suspended. Each month the Prosecutor's Office targets a different profession; they have, for example, focused on commercial driver's licenses in June. More than \$100,000 has been collected from delinquent payers who have received letters warning them about the suspension of their license.

the church will become a donor and the family a recipient. This is

Success Story

In November 1996 the Faith & Families Resource Center paired the Beth-El Zedeck synagogue with a single mom named April. Here are a few of the things Beth-El Zedeck Faith & Families liaisons Barbara Bohard and Helaine Herman had to say about their congregation's relationship with April and her son:

"Our first impression of April was that of a bright, personable young woman who had the ambition and drive to succeed, but not the education or support system that so many of us are lucky enough to have in place. From our first meeting until now, we have dealt with financial, educational, employment, health and transportation issues. We have a wonderful group of congregates who volunteer their time, professional expertise and connections to help April meet nearly all her goals. She is employed full time with medical coverage and now has some computer training. Her son is benefiting from a Big Brother and has a Boys Club close to home. She still wants to continue her education and wants to be able to have her own home -- but these are long-term goals and she is working toward them. April has an incredibly positive attitude about her future, as do we."

**rebuilding
families** newsletter

June 1997

page 3

Job or Jail: Breaking a cycle of irresponsibility

"Job or Jail" is encouraging responsible fatherhood by making non-custodial parents accountable for their child support payments. The program helps out-of-work parents find a job so they can make support payments, or

contempt of court for not paying child support, the commissioner can place them in "Job or Jail." Participants must pay the court-ordered portion of owed child support or they are assigned to one of three program components:

Prosecutor Judith Kernel, direct and indirect-job placement gives people who have not had the best opportunities a chance to really be responsible. "I can see the people who are going to Goodwill, perhaps they've

requires parents who won't pay child support to complete community service work rather than sit in jail. The program has proven beneficial for parents, their children, and the city. If parents don't pay owed support and they are not assigned to the "Job or Jail" program, they are sentenced to jail. However, "Job or Jail" has actually decreased the number of delinquent support payers going to jail because of the assistance it gives unemployed parents who want to pay support, its community service component, and its success in collecting support payments. In less than a year, "Job or Jail" has recovered \$170,699 from parents who have been referred to the program. Mayor Stephen Goldsmith and Prosecutor Scott Newman envisioned "Job or Jail" as a part of the Rebuilding Families initiative that would encourage responsible fatherhood by increasing the level of reliable support available to children in the custody of a single parent. A deputy prosecutor recommends participants for the program. If parents are found in

direct job placement, indirect-job placement, or community service. Since August, over 500 referrals have been made to "Job or Jail."

Individuals with job skills and a history of paying support when they have been employed are referred to direct job placement. "Job or Jail" coordinator Kerry Ann May solicits businesses to participate in this part of the program. With help from the Indianapolis Private Industry Council (IPIC), she matches program clients with positions at the 10 companies currently involved. Since August 1996, 113 people have been referred, and more than 20 have found work. Individuals with few job skills, and who haven't been employed for some time, are referred to indirect-job placement. Goodwill Industries and other special-help agencies assist with this part of the program. Since August, 195 referrals have been made to indirect-job placement, about 80 have taken advantage of Goodwill's job training services, and several of those individuals have found full-time employment. According to Deputy

never gone to a job before or they don't have the basic skills we take for granted, and they are successful after they've been through the training. If we can help one person with this program, that is one more child who is getting support," said Kernel.

Many people referred to "Job or Jail" have a history of not paying support even if they are employed. These individuals are placed in the community service component of the program. The court typically assigns individuals 64 hours of community service for not paying support. The service time is arranged so that participants must arrive at the jail at 7 a.m., once a week, for greenway maintenance, trash clean-up or park beautification. According to Kernel, the community service component of the program not only helps with jail overcrowding, but it has participants giving something back to the community. Since "Job or Jail" began, the court has ordered 13,000 hours of community service. "I think those people who have been sent to community service now understand that there will be consequences if they don't pay their child support," said Kernel.

Success Story

"Job or Jail" not only helps individuals that the court assigns to the program, but has increasingly been able to assist those struggling to pay their child support before they must appear in court.

The DLC Update, Friday, October 16, 1998

Highlights Include:

- Idea of the Week: Real Patients' Rights
- The GOP's K Street Strategy: A Cynical Abuse of Power

Idea of the Week: Real Patients' Rights

The formal burial of the "patients' bill of rights" legislation in the U.S. Senate last week ended one of this Congressional session's few substantive debates. Frankly, that is all many members of both parties intended from the very beginning, with Democrats seeking a campaign issue by forcing the GOP to kill their bill, and Republicans laboring to neutralize the issue by offering their own legislation.

But the issue is bound to come up again in the next Congress. When it does, it is crucially important that both parties junk their flawed, partisan, election-year vehicles and take a fresh look at how health care consumers can be empowered in their dealings, not only with managed care plans, but with the entire health care system.

As Progressive Policy Institute (PPI) senior analyst for Health Policy **David B. Kendall** shows in his new Backgrounder: Better Luck Next Time: Moving Beyond Partisan Posturing Over Patients' Rights you can put together a truly effective contribution to health consumer empowerment with key elements from both Democratic and Republican bills.

Here's how:

- Promote **Health Plan Report Cards** (see the February 20, 1998 Idea of the Week: Health Care Report Cards), as provided for in the Democratic **Daschle-Dingell** patients' rights bill (H.R. 3065 and S. 1890), and the bipartisan bill offered by Sens. **Chafee, Graham, and Lieberman** (S. 2416). Today, health plans compete for business primarily on the basis of cost and coverage. Quality factors--such as competency of staff, dispute resolution, customer service, and most of all health care outcomes--are less important because consumers, including employers, do not have access to information necessary to make comparisons and choices. Legislation should require that health plans make such information available to all consumers, using comparable data. Ultimately, a public-private partnership should be created (as recommended by the White House Quality Forum under the leadership of Vice President **Al Gore** to develop institutions and processes (perhaps similar to the Securities and Exchange Commission (SEC)) for fair and full assessment of health plan quality indicators.
- Create **Health Marts** (see the May 15, 1998, Idea of the Week: Health Martss provided for in the House Republican patients' rights bill (H.R. 4250). One of the most important impediments to consumer power in the health care marketplace is simply a lack of choice in health plans, especially for consumers whose health plans are chosen by employers. Health Marts (basically cooperative supermarkets for buying health insurance) would enable employers to offer a much wider range of plans, while also making it easier for smaller businesses, or individuals, to afford quality health insurance in the first place. Health Marts could also provide a vehicle for expanding health insurance for the uninsured if future Congresses move to create health care tax credits (see "Idea of the Week" in the September 25, 1998 *DLC Update*) as an alternative to employer tax deductions for health insurance purchases.

- Develop an **Arbitration System for Health Plan Grievances** before resorting to litigation, as provided for in the Democratic, Republican, and bipartisan patients' rights bills. An arbitration system, similar to the one already provided for Medicare patients in managed care plans, would guarantee speedy resolution of adverse decisions by health plans through an independent arbitrator, without the cost and inconvenience of lawsuits. Litigation could still be available if patients are unhappy with the arbitrator's decision, or suffer damages the health plan cannot cover through the reversal of decisions by the arbitrator.
- Create **Limited Rules to Protect Consumers** from common problems as provided for to some degree by all the current legislation. Some complaints against managed care plans are so common, and involve benefits or treatments that are so reasonable, that legislating a solution is not a bad idea. The classic example is access to emergency care. Some health plans, out of a reasonable desire to discourage patients from running to the high-cost emergency room with routine medical conditions, have unreasonably created bureaucratic hurdles that sometimes prevent patients who need emergency care from getting it promptly. All the current bills solve this problem by legislating a "prudent layperson" standard that guarantees coverage for emergency room visits if the patient has reason to believe he or she truly faces a medical emergency.

There is a fifth key element of real patients' rights legislation: **Do No Harm**. Along with the four good ideas outlined above, there are a wide array of bad ideas nestled in every Congressional patients' rights proposal--from regulatory micro-management of health plans to special protection for the market share of favored medical professionals.

Congress could have "better luck next time" on patients' rights legislation if it cools down the partisan rhetoric and sticks to provisions that empower consumers, instead of bureaucrats, providers, or lawyers.

The GOP's K Street Strategy: A Cynical Abuse of Power

Even as they pontificate about the President's morals, and even as their public relations firms churn out campaign ads about the GOP's unshakeable commitment to "ethics," "values," and "integrity," House Republicans are engaging in a blatant and cynical abuse of power: the "K Street Strategy."

Named after the legendary Washington address of many trade associations and lobbying firms, the "K Street Strategy" is an effort that was launched the moment the GOP took over the Congress in 1995. Under the stewardship of House Majority Leader **Tom DeLay** (R-TX), its thrust is to deny access to the legislative process to those business groups who do not agree to tilt campaign contributions heavily to Republicans and hire only Republicans as staff members.

As befits an access-peddling and shakedown effort that would have embarrassed Boss Tweed, Republicans have pursued the "K Street Strategy" off the record--until this week, at least. The initiative suddenly broke into the open thanks to an internecine struggle among House GOP barons about exactly how abrasively and arrogantly they should pressure one trade association--the high-tech Electronic Industries Alliance (EIA)--to do their bidding. Already suspect because some high-tech CEOs endorsed the President's re-election in 1996, the EIA offended the House leadership by naming former U.S. Rep. (and DLC Chairman) **Dave McCurdy** (D-OK) as its new president, apparently frustrating the career aspirations of retiring Rep. **Bill Paxon** (R-NY). Rep. **John Boehner** (R-OH), the leadership's liaison to business groups, began quietly pressuring EIA to fire McCurdy and hire Paxon, only to discover that DeLay had poached on his turf by letting EIA officials know he had put a hold on pending copyright legislation out of anger at the McCurdy hiring.

After Boehner's and DeLay's staff hurled insults at each other for a couple of days, the House GOP let the

The DLC Update, Friday, September 25, 1998

Highlights Include:

- Idea of the Week: Health Care Tax Credits
- Ideas For a New Century: Get Your *Blueprint*
- Miracle on Capitol Hill?

Idea of the Week: Health Care Tax Credits

This year's preoccupation in Congress with addressing abuses by managed care health plans has sidetracked a broader debate about the future shape of our health care system. Now that it's reasonably clear neither party's version of "patient's rights" legislation is going to be enacted in this Congress, it's time to get back to that broader debate.

In fact, there is a major new reform that is beginning to draw support from both political parties: moving away from the current employer-based system of health insurance to one that empowers individuals with the choice and the resources to buy their own policies.

The mechanism for achieving this shift is obvious: creating an alternative to the current federal tax break for employer-paid health insurance.

The central flaws in the employer-based system are well known. It subsidizes health insurance for those lucky enough to work for an employer that decides to take advantage of the tax break, while leaving other employees--not to mention the unemployed and the self-employed--on their own. It equally rewards employers who provide a choice of high-quality health plans, and those who don't. And it undermines personal responsibility for health care because so many of the costs appear "free" to employees.

Its advantage, of course, is to give real purchasing power to many workers who would otherwise have no way to buy insurance through a large group.

Republicans tend to like health care tax credits because they increase individual choice over health insurance. Democrats tend to like them because they provide a way to expand coverage to the uninsured. We share both concerns: enlivening the health care market place with real, system-wide competition that helps improve quality while holding down costs, and finally moving towards universal access to health insurance.

Last June, another influential voice **Nancy Dickey**, President of the American Medical Association--weighed in with a call for completely replacing the employer-based system with individual ownership of health insurance. She noted that such a step would resolve "many of the issue-by-issue, regulation-by-regulation battles that we currently fight and that consume so much of our time and energy." At a very different point on the political spectrum, Rep. **Jim McDermott** (D-WA), a long-time supporter of the "single payer" approach to health care reform, has actually introduced a bill (H.R. 539) that would create a refundable (i.e., payable in cash to those without income tax liability) tax credit for workers who lack employer-based insurance.

The key differences between the AMA and McDermott approaches are that the former would eliminate the tax break for employer-based insurance, while the latter would preserve it but supplement it with a tax credit for those not covered. Combining Republican and Democrat approaches, the "third way" is clear: a universal,

refundable tax credit for purchase of health insurance as an alternative to the employer-based tax break. The uninsured would get covered, while those already covered by an employer-paid plan could "opt out" if unsatisfied and buy their own insurance with the new credit.

This single step would simultaneously promote individual responsibility for health care, more choice and competition among health plans, competitive pressure to increase quality while reducing costs, and financing universal coverage.

Let's hope that's where the continuing health care debate moves in the next Congress.

Ideas For a New Century: Get Your *Blueprint*

This week the DLC formally inaugurated a new policy journal designed to identify the central ideas that will carry American politics into the 21st century. Called ***Blueprint: Ideas for a New Century***, this new quarterly aims at framing the national political debate going into the election in 2000, which is shaping up as the most pivotal "year of decision" in a generation.

Each issue of ***Blueprint*** will focus on one important policy issue, and will supply both a complete briefing and cutting-edge policy proposals from a national network of progressive thinkers.

The inaugural issue sets the political context for the policy debates of the 21st century. Entitled "The Next Politics," it features:

- Former White House advisors **Bill Galston** and **Elaine Kamarck** with the "Five New Realities" of demographic and economic trends that will shape the politics of the next several decades.
- Presidential pollster **Mark Penn** with an exclusive new public opinion survey on the "Active Center" of the electorate and its implications for both political parties.
- Former Vice Presidential speechwriter **Daniel Pink** on the politics of "free-agent workers"--the ever-increasing percentage of Americans who do not work in traditional workplaces.
- ***Blueprint*** editor **Andrei Cherny** on generational change in the Democratic Party.
- **Al From** and **Will Marshall** with "Ten Commandments" for Democrats hoping to succeed in the new political environment.

Future issues of ***Blueprint*** will focus on such topics as "expanding the winner's circle" for success in the new global economy; modernizing the Social Security and Medicare entitlement programs; bringing public schools into the Information Age; and reweaving the strands of our civic life.

For more information on *Blueprint*, call (202)546-0007, or visit the *Blueprint* web page at www.dlc.org/blueprint.

It is required reading for New Democrats or anyone interested in new ideas.

Miracle on Capitol Hill?

Believe it or not, a couple of pieces of serious New Economy legislation may get enacted by Congress and signed by the President before this scandal-plagued session ends.

The DLC Update, Friday, June 12, 1998

Highlights Include:

- Idea of the Week: Physicians Profile
- Modernizing Social Security: Another Voice Joins the Chorus
- Gunning for Respectability

Idea of the Week: Physicians Profile

"You ought to be able to choose your own doctor" has become the battle cry of many politicians who hope to ride the current backlash against managed care plans to electoral victory this November. As we have noted previously, this sound-bite approach overshoots legitimate concerns about cost-driven decisions by health plans concerning treatments and access to specialists. It also threatens to unravel managed care's one major accomplishment: breaking the back of health care inflation (and the associated rise in the ranks of the uninsured) by eliminating the money-is-no-object ethic of the old fee-for-service system of health insurance.

Many health care plans, of course (especially the preferred provider organization, or the PPO model), allow some consumer choice of both primary care and speciality physicians. But whether you are talking about choosing physicians under managed care or under the old fee-for-service system, how, exactly, do consumers choose wisely? After all, Marcus Welby, MD, has retired. Do you rely on word of mouth? Advertising (strongly discouraged and limited by the profession)? Convenience? Referrals from other physicians? Trial and error?

The truth is that it is much harder to knowledgeably choose a doctor than a car, a school, a house, or even a health plan. "Freedom of choice" is pretty meaningless without the ability to make an informed choice.

In Massachusetts, you can make a phone call or go onto the Internet and immediately get basic information about any of the 27,000 doctors licensed to practice medicine in the state. Thanks to legislation sponsored by State Sen. Mark Pacheco (D- Taunton), a member of the DLC's State Legislative Advisory Board, the State Medical Board prepares and updates "physicians profiles" that provide:

- Physician addresses, speciality areas, education and training, and insurance plan (including Medicaid) participation;
- Honors, awards, and professional publications;
- Any disciplinary actions by hospitals or licensing boards, or criminal convictions;
- Any malpractice payments over the last 10 years, rated by relative amount in the physician's specialty.

Are Massachusetts consumers using this information? Since "physician profiles" went up on the Internet in May 1997, the web site (available at www.docboard.org) has averaged 1400 "hits" per day, along with 125 phone calls a day to the state medical board. An estimated 50,000 requests for profiles were received by the state medical board's hotline (800/377-0550 or 617/727-0773) before the web site information became available. Clearly, these profiles have become an important and routine part of the process of choosing a doctor in Massachusetts.

Most interesting of all, Massachusetts physicians have actively cooperated in the profile initiative. Pacheco's legislation required that physicians have the opportunity to review profiles to check their accuracy before they were posted. Physicians and their representatives have worked with the state medical board in improving the information it provides. A "virtuous cycle" of more sophisticated information, and more intelligent consumer choice, appears to be in play.

Other states are working on similar initiatives, including Florida (see www.fdhc.state.fl.us/license.html). It's time for even more states to follow suit with their own physician profiles. No matter how the current debate over managed care and consumer choice plays out, empowerment of consumers with better information on both providers and health plans is essential to ensure that the values of choice and quality pull the health care system in the same positive direction. For more info, contact Mike Sroczynski at Sen. Pacheco's office at 617/722-1551.

Modernizing Social Security: Another Voice Joins the Chorus

The momentum continues to build for a new center in the debate over Social Security's future. Just two months ago, we noted with delight that Sen. Daniel Patrick Moynihan has weighed in with a plan that broke ranks with the orthodox left. Now comes another high-powered proposal, from an equally reputable source, that breaks with the stand-pat left and privatizing right.

The National Commission on Retirement Policy (NCRP) last month issued a new report, "The 21st Century Retirement Security Plan," containing a comprehensive set of proposals for remaking the retirement system in advance of the upcoming retirement of the Baby Boomers. Without requiring tax increases or burdening future generations, its authors say the plan would increase retirement security for every American by modernizing the Social Security system while increasing the availability of pensions and other kinds of personal savings.

The commission, a private, bi-partisan group of lawmakers, economists, business executives, and other experts, was convened last year by the Center for Strategic and International Studies. Its members include New Democrat stalwarts Sen. John Breaux (D-LA) and Rep. Charles Stenholm (D-TX), two of six NCRP co-chairs, and Dr. William Galston of the University of Maryland.

Like Moynihan's plan, and one proposed by Robert Shapiro in PPI's 1997 book, Building the Bridge, the NCRP's "21st Century" plan would gradually raise the eligibility age for Social Security and divert 2 percentage points of the payroll tax for individuals under age 55 into individual savings accounts, along with numerous other adjustments. It would use general revenues made available by the budget surplus to maintain benefits for those under the old system during the transition period. Finally, it would establish a new guaranteed minimum: if you worked 20 years, you would be guaranteed a payout equal to 60 percent of the poverty line; if you worked 40 years, you would get 100 percent.

The package is a huge leap forward in the debate on Social Security reform and, also like Moynihan, scores high on the New Democratic checklist of reforms: fiscal responsibility, progressivity, careful experimentation with private supplemental savings, and most of all, immediate action to reduce the horribly regressive burden of payroll taxes for working Americans.

And because it's bi-partisan, this plan can and should attract a lot of attention and support from both parties on both ends of Pennsylvania Avenue.

Gunning for Respectability

Early this week the National Rifle Association, hemorrhaging members and money over the last few years,

The DLC Update, Friday, May 15, 1998

Highlights Include:

- Idea of the Week: Health Marts
- Slaughter That Road Hog
- You Can't Have Regional Skills Alliances Without Alliances
- A Race to the Wire With a Bad Idea

Idea of the Week: Health Marts

Under the name "health insurance purchasing cooperatives" (HIPC's), purchasing groups for health care consumers were a key feature of the Cooper-Breaux legislation that New Democrats supported during the 1994 health care debate--legislation that Republicans shot down along with the Clinton Health Plan. Indeed, purchasing groups are central to all reform plans based on the "managed competition" model that so many Republicans demonized as socialized medicine during that toxic debate.

It's ironic, and important, that Republicans now seem to be discovering the virtues of health purchasing groups. House Commerce Committee Chairman Thomas Bliley (R-VA) is working on a proposal to create private sector "health marts"--purchasing groups through which employers could buy their employees into a system that provides a broad range of choices of health insurance plans, modeled on the popular and cost-effective Federal Employee Health Benefit plan. The proposal would allow employers to apply the current tax break for employee health benefits for participation in "health marts," and would presumably help make health plans affordable for many small businesses that do not provide employee health insurance at all.

The impetus for this proposal is to make managed care plans more accountable to patients without increasing costs, thereby blunting the drive for government regulations to protect patients. This is a political imperative for many Congressional Republicans, who are caught between the rock of Democratic demands for a "Patients Bill of Rights" aimed at health plan abuses, and the hard place of Republican Rep. Charles Norwood's more draconian Patient Access to Responsible Care Act (PARCA).

Perhaps if they think about it long enough, Rep. Bliley and his GOP associates may realize that "health marts" are a good idea in themselves, worth pursuing whether or not they are politically useful. Who knows, they may even discover that if it makes sense to model a private "health mart" for employers on FEHBP, it also makes sense to provide access to FEHBP itself for Americans who do not have access to employer-sponsored plans, as has been recommended by Senator John Breaux (D-LA) and by the Progressive Policy Institute as a variation on the President's Medicare "buy-in" proposal. Finally, since only employers currently receive a tax break for buying health insurance, it's a small logical leap to envision a system where individuals would receive a tax credit for purchasing their own insurance through "health marts," public or private. Take the Bliley proposals and think it through logically and you arrive at the longstanding Progressive Policy Institute vision of an Information Age system--a health "network"--in which purchasing groups, health plans, and providers all compete to give people better health.

The bottom line is that purchasing groups, public or private, can create a true "buyer's market" for health insurance--lowering costs, increasing choice, and immeasurably improving health care quality without over-regulation. If both Republicans and Democrats would move in that direction, the sterile health care debate of the last few years can finally come alive.

The DLC Update, Friday, February 20, 1998

Highlights Include:

- Idea of the Week: Health Plan Report Cards
- Paying Attention to What Works
- Something To Crow About
- Upcoming Events: California and Florida Conferences

Idea of the Week: Health Plan Report Cards

Every year public and private-sector employers, and a majority of American citizens, make decisions on participation in health care plans. For the most part, they decide on the basis of just two factors: cost and scope of services. But health plans, like health providers, actually vary on the basis of quality: how well they deliver care; how well they help people stay healthy; how well they help people recover from illnesses; how well they support people with chronic illnesses; and how well they adjust to the changing needs of patients. Without reliable and widely disseminated information on the quality of care provided by health plans, it is no wonder so many purchasers focus excessively on cost, while so many plans seem to focus excessively on holding down costs at the expense of quality.

Fortunately, help is on the way. Spurred on by many health plan sponsors, with an extra push from federal and state elected officials alarmed by anecdotes about low-quality care, there is now a national movement to create Health Plan Report Cards that let consumers know how well specific plans have performed in producing key health outcomes for their participants. The National Committee for Quality Assurance, a private agency, has already developed and implemented one report card, though its utility has been limited by its focus on preventive health measures and the relatively small group of health plans that have agreed to supply the relevant information. Meanwhile, the Foundation for Accountability (FACCT), another private entity, has just released a "template" for Health Plan Report Cards that covers all five of the health outcomes consumers most need to know about--satisfaction with care, prevention, recovery from illness, support in chronic illness, and adaptability to changing needs. If every purchaser--employer or individual--had access to this kind of information, then health plans would compete for business on the basis of quality as well as cost and scope of services.

Government--federal and state--can best promote Health Care Report Cards not by issuing them, but by demanding them. By using their leverage as major purchasers of health care for their employees, government can push health plans to make public the necessary information so that private entities can use them to produce report cards and purchasers can use them to encourage quality-based competition. Legislation (S.795) sponsored by Sens. Joe Lieberman (D-CT), John Breaux (D-LA), John Chafee (R-RI), and James Jeffords (R-VT) would do exactly that on behalf of the federal government. State lawmakers should follow suit. In addition, government should require health plans to supply health outcome information so that purchasers can create their own report cards. Ultimately, we believe quality measurement should extend to health providers--hospitals and doctors--as well as to insurers, creating a true "buyer's market" in health care.

Paying Attention to What Works

When President Clinton signed the 1996 welfare reform legislation, we made it clear we believed the task of replacing welfare with work had just begun. As many conservatives declared victory and assumed that

PAUL D. WELLSTONE
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WASHINGTON, DC 20510-2303

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106TH CONGRESS
1ST SESSION**S.** 465

IN THE SENATE OF THE UNITED STATES

Mr. WELLSTONE introduced the following bill; which was read twice and referred to the Committee on

A BILL

To meet the mental health and substance abuse treatment needs of incarcerated children and youth.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the "Mental Health Juve-
5 nile Justice Act".

6 **SEC. 2. TRAINING OF JUSTICE SYSTEM PERSONNEL.**

7 Title II of the Juvenile Justice and Delinquency Pre-
8 vention Act of 1974 (42 U.S.C. 5611 et seq.) is amended
9 by adding at the end the following:

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S.L.C.

2

1 **"PART K—ACCESS TO MENTAL HEALTH AND**
2 **SUBSTANCE ABUSE TREATMENT**
3 **"SEC. 299AA. GRANTS FOR TRAINING OF JUSTICE SYSTEM**
4 **PERSONNEL.**

5 “(a) IN GENERAL.—The Administrator shall make
6 grants to State and local juvenile justice agencies in col-
7 laboration with State and local mental health agencies, for
8 purposes of training the officers and employees of the
9 State juvenile justice system (including employees of facili-
10 ties that are contracted for operation by State and local
11 juvenile authorities) regarding appropriate access to men-
12 tal health and substance abuse treatment programs and
13 services in the State for juveniles who come into contact
14 with the State juvenile justice system who have mental
15 health or substance abuse problems.

16 “(b) USE OF FUNDS.—A State or local juvenile jus-
17 tice agency that receives a grant under this section may
18 use the grant for purposes of—

19 “(1) providing cross-training, jointly with the
20 public mental health system, for State juvenile court
21 judges, public defenders, and mental health and sub-
22 stance abuse agency representatives with respect to
23 the appropriate use of effective, community-based al-
24 ternatives to juvenile justice or mental health system
25 institutional placements; or

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S.L.C.

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1 “(2) providing training for State juvenile proba-
2 tion officers and community mental health and sub-
3 stance abuse program representatives on appropriate
4 linkages between probation programs and mental
5 health community programs, specifically focusing on
6 the identification of mental disorders and substance
7 abuse addiction in juveniles on probation, effective
8 treatment interventions for those disorders, and
9 making appropriate contact with mental health and
10 substance abuse case managers and programs in the
11 community, in order to ensure that juveniles on pro-
12 bation receive appropriate access to mental health
13 and substance abuse treatment programs and serv-
14 ices.

15 “(c) AUTHORIZATION OF APPROPRIATIONS.—There
16 are authorized to be appropriated from the Violent Crime
17 Reduction Trust Fund, \$50,000,000 for fiscal years 1999,
18 2000, 2001, 2002, and 2003 to carry out this section.”.

19 **SEC. 3. BLOCK GRANT FUNDING FOR TREATMENT AND DI-**
20 **VERSION PROGRAMS.**

21 Part K of title II of the Juvenile Justice and Delin-
22 quency Prevention Act of 1974 (42 U.S.C. 5611 et seq.)
23 is amended by adding at the end the following:

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S.L.C.

4

1 **"SEC. 299BB. GRANTS FOR STATE PARTNERSHIPS.**

2 “(a) **IN GENERAL.**—The Attorney General and the
3 Secretary of Health and Human Services shall make
4 grants to partnerships between State and local/county ju-
5 venile justice agencies and State and local mental health
6 authorities (or appropriate children service agencies) in
7 accordance with this section.

8 “(b) **USE OF FUNDS.**—A partnership described in
9 subsection (a) that receives a grant under this section
10 shall use such amounts for the establishment and imple-
11 mentation of programs that address the service needs of
12 juveniles who come into contact with the justice system
13 (including facilities contracted for operation by State or
14 local juvenile authorities) who have mental health or sub-
15 stance abuse problems, by requiring the following:

16 “(1) **DIVERSION.**—Appropriate diversion of
17 those juveniles from incarceration—

18 “(A) at imminent risk of being taken into
19 custody;

20 “(B) at the time they are initially taken
21 into custody;

22 “(C) after they are charged with an of-
23 fense or act of juvenile delinquency;

24 “(D) after they are adjudicated delinquent
25 but prior to case disposition; and

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S.L.C.

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1 “(E) after they are released from a juve-
2 nile facility, for the purposes of attending after-
3 care programs.

4 “(2) TREATMENT.—

5 “(A) SCREENING AND ASSESSMENT OF JU-
6 VENILES.—

7 “(i) IN GENERAL.—Initial mental
8 health screening shall be completed for all
9 juveniles immediately upon entering the ju-
10 venile justice system or a juvenile facility.
11 Screening shall be conducted by qualified
12 health and mental health professionals or
13 by staff who have been trained by qualified
14 health, mental health, and substance abuse
15 professionals. In the case of a screening by
16 staff, the screening results should be re-
17 viewed by qualified health, mental health
18 professionals not later than 24 hours after
19 the screening.

20 “(ii) ACUTE MENTAL ILLNESS.—Juve-
21 niles who suffer from acute mental dis-
22 orders, who are suicidal, or in need of de-
23 toxification shall be placed in or imme-
24 diately transferred to an appropriate medi-
25 cal or mental health facility. They shall be

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S.L.C.

6

1 admitted to a secure correctional facility
2 only with written medical clearance.

3 “(iii) COMPREHENSIVE ASSESS-
4 MENT.—All juveniles entering the juvenile
5 justice system shall have a comprehensive
6 assessment conducted and an individual-
7 ized treatment plan written and imple-
8 mented within 2 weeks. This assessment
9 shall be conducted within 1 week for juve-
10 niles incarcerated in secure facilities. As-
11 sessments shall be completed by qualified
12 health, mental health, and substance abuse
13 professionals.

14 “(B) TREATMENT.—

15 “(i) IN GENERAL.—If the need for
16 treatment is indicated by the assessment of
17 a juvenile, the juvenile shall be referred to
18 or treated by a qualified professional. A ju-
19 venile who is currently receiving treatment
20 for a mental or emotional disorder shall
21 have treatment continued.

22 “(ii) PERIOD.—Treatment shall con-
23 tinue until additional mental health assess-
24 ment determines that the juvenile is no
25 longer in need of treatment. Treatment

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S.L.C.

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1 plans shall be reevaluated at least every 30
2 days.

3 “(iii) DISCHARGE PLAN.—An incar-
4 cerated juvenile shall have a discharge plan
5 prepared when the juvenile enters the cor-
6 rectional facility in order to integrate the
7 juvenile back into the family or the com-
8 munity. This plan shall be updated in con-
9 sultation with the juvenile’s family or
10 guardian before the juvenile leaves the fa-
11 cility. Discharge plans shall address the
12 provision of aftercare services.

13 “(iv) MEDICATION.—Any juvenile re-
14 ceiving psychotropic medications shall be
15 under the care of a licensed psychiatrist.
16 Psychotropic medications shall be mon-
17 itored regularly by trained staff for their
18 efficacy and side effects.

19 “(v) SPECIALIZED TREATMENT.—Spe-
20 cialized treatment and services shall be
21 continually available to a juvenile who—

22 “(I) has a history of mental
23 health problems or treatment;

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S.L.C.

8

1 “(II) has a documented history
2 of sexual abuse or offenses, as victim
3 or as perpetrator;

4 “(III) has substance abuse prob-
5 lems, health problems, learning dis-
6 abilities, or histories of family abuse
7 or violence; or

8 “(IV) has developmental disabil-
9 ities.

10 “(C) MEDICAL AND MENTAL HEALTH
11 EMERGENCIES.—All correctional facilities shall
12 have written policies and procedures on suicide
13 prevention. All staff working in correctional fa-
14 cilities shall be trained and certified annually in
15 suicide prevention. Facilities shall have written
16 arrangements with a hospital or other facility
17 for providing emergency medical and mental
18 health care. Physical and mental health services
19 shall be available to an incarcerated juvenile 24
20 hours per day, 7 days per week.

21 “(D) CLASSIFICATION OF JUVENILES.—

22 “(i) IN GENERAL.—Juvenile facilities
23 shall classify and house juveniles in living
24 units according to a plan that includes age,
25 gender, offense, special medical or mental

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S.L.C.

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1 health condition, size, and vulnerability to
2 victimization. Younger, smaller, weaker,
3 and more vulnerable juveniles shall not be
4 placed in housing units with older, more
5 aggressive juveniles.

6 “(ii) BOOT CAMPS.—juveniles who are
7 under 13 years old or who have serious
8 medical conditions or mental illness shall
9 not be placed in paramilitary boot camps.

10 “(E) CONFIDENTIALITY OF RECORDS.—
11 Mental health and substance abuse treatment
12 records of juveniles shall be treated as confiden-
13 tial and shall be excluded from the records that
14 States require to be routinely released to other
15 correctional authorities and school officials.

16 “(F) MANDATORY REPORTING.—States
17 shall keep records of the incidence and types of
18 mental health and substance abuse disorders in
19 their juvenile justice populations, the range and
20 scope of services provided, and barriers to serv-
21 ice. The State shall submit an analysis of this
22 information yearly to the Department of Jus-
23 tice.

24 “(G) STAFF RATIOS FOR CORRECTIONAL
25 FACILITIES.—Each secure correctional facility

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S.L.C.

10

1 shall have a minimum ratio of no fewer than 1
2 mental health counselor to every 50 juveniles.
3 Mental health counselors shall be professionally
4 trained and certified or licensed. Each secure
5 correctional facility shall have a minimum ratio
6 of 1 clinical psychologist for every 100 juve-
7 niles. Each secure correctional facility shall
8 have a minimum ratio of 1 licensed psychiatrist
9 for every 100 juveniles receiving psychiatric
10 care.

11 “(H) USE OF FORCE.—

12 “(i) WRITTEN GUIDELINES.—All juve-
13 nile facilities shall have a written behav-
14 ioral management system based on incen-
15 tives and rewards to reduce misconduct
16 and to decrease the use of restraints and
17 seclusion by staff.

18 “(ii) LIMITATIONS ON RESTRAINT.—

19 Control techniques such as restraint, seclu-
20 sion, chemical sprays, and room confine-
21 ment shall be used only in response to ex-
22 treme threats to life or safety. Use of these
23 techniques shall be approved by the facility
24 superintendent or chief medical officer and
25 documented in the juvenile’s file along with

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S.L.C.

11

1 the justification for use and the failure of
2 less restrictive alternatives.

3 “(iii) LIMITATION ON ISOLATION.—

4 Isolation and seclusion shall be used only
5 for immediate and short-term security or
6 safety reasons. No juvenile shall be placed
7 in isolation without approval of the facility
8 superintendent or chief medical officer or
9 their official staff designee. All cases shall
10 be documented in the juvenile's file along
11 with the justification. A juvenile shall be in
12 isolation only the amount of time necessary
13 to achieve security and safety of the juve-
14 nile and staff. Staff shall monitor each ju-
15 venile in isolation once every 15 minutes
16 and conduct a professional review of the
17 need for isolation at least every 4 hours.
18 Any juvenile held in seclusion for 24 hours
19 shall be examined by a physician or li-
20 censed psychologist.

21 “(I) IDEA AND REHABILITATION ACT.—

22 All juvenile facilities shall abide by all manda-
23 tory requirements and time lines set forth
24 under the Individuals with Disabilities Edu-

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S.L.C.

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1 cation Act and section 504 of the Rehabilitation
2 Act of 1973.

3 “(J) ADVOCACY ASSISTANCE.—

4 “(i) IN GENERAL.—The Secretary of
5 Health and Human Services shall make
6 grants to the systems established under
7 part C of the Developmental Disabilities
8 Assistance and Bill of Rights Act (42
9 U.S.C. 6041 et seq.) to monitor the mental
10 health and special education services pro-
11 vided by grantees to juveniles under para-
12 graph (2) (A), (B), (C), (H), and (I) of
13 this section, and to advocate on behalf of
14 juveniles to assure that such services are
15 properly provided.

16 “(ii) APPROPRIATION.—The Secretary
17 of Health and Human Services will reserve
18 no less than 3 percent of the funds appro-
19 priated under this section for the purposes
20 set forth in paragraph (2)(J)(i).

21 “(c) AUTHORIZATION OF APPROPRIATIONS.—

22 “(1) IN GENERAL.—There are authorized to be
23 appropriated from the Violent Crime Reduction
24 Trust Fund, \$500,000,000 for fiscal years 1999,

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S.L.C.

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1 2000, 2001, 2002, and 2003 to carry out this sec-
2 tion.

3 “(2) ALLOCATION.—Of amounts appropriated
4 under paragraph (1)—

5 “(A) 35 percent shall be used for diversion
6 programs under subsection (b)(1); and

7 “(B) 65 percent shall be used for treat-
8 ment programs under subsection (b)(2).

9 “(3) INCENTIVES.—The Attorney General and
10 the Secretary of Health and Human Services shall
11 give preference under subsection (b)(2) to partner-
12 ships that integrate treatment programs to serve ju-
13 veniles with co-occurring mental health and sub-
14 stance abuse disorders.

15 “(4) WAIVERS.—The Attorney General and the
16 Secretary of Health and Human Services may grant
17 a waiver of requirements under subsection (b)(2) for
18 good cause.

19 **“SEC. 299CC. GRANTS FOR PARTNERSHIPS.**

20 “(a) IN GENERAL.—Any partnership desiring to re-
21 ceive a grant under this part shall submit an application
22 at such time, in such manner, and containing such infor-
23 mation as the Attorney General and the Secretary of
24 Health and Human Services may prescribe.

O:\JEN\JEN99.162

S.L.C.

14

1 “(b) CONTENTS.—In accordance with guidelines es-
2 tablished by the Attorney General and the Secretary of
3 Health and Human Services, each application submitted
4 under subsection (a) shall—

5 “(1) set forth a program or activity for carrying
6 out one or more of the purposes specified in section
7 299BB(b) and specifically identify each such pur-
8 pose such program or activity is designed to carry
9 out;

10 “(2) provide that such program or activity shall
11 be administered by or under the supervision of the
12 applicant;

13 “(3) provide for the proper and efficient admin-
14 istration of such program or activity;

15 “(4) provide for regular evaluation of such pro-
16 gram or activity;

17 “(5) provide an assurance that the proposed
18 program or activity will supplement, not supplant,
19 similar programs and activities already available in
20 the community; and

21 “(6) provide for such fiscal control and fund ac-
22 counting procedures as may be necessary to ensure
23 prudent use, proper disbursement, and accurate ac-
24 counting of funds receiving under this part.”.

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S.L.C.

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1 **SEC. 4. INITIATIVE FOR COMPREHENSIVE, INTERSYSTEM**
2 **PROGRAMS.**

3 Subpart 3 of part B of title V of the Public Health
4 Service Act (42 U.S.C. 290bb-31 et seq.) is amended by
5 adding at the end the following:

6 **"SEC. 520C. INITIATIVE FOR COMPREHENSIVE, INTERSYS-**
7 **TEM PROGRAMS.**

8 "(a) IN GENERAL.—The Attorney General and the
9 Secretary, acting through the Director of the Center for
10 Mental Health Services, shall award competitive grants to
11 eligible entities for programs that address the service
12 needs of juveniles and juveniles with serious mental ill-
13 nesses by requiring the State or local juvenile justice sys-
14 tem, the mental health system, and the substance abuse
15 treatment system to work collaboratively to ensure—

16 "(1) the appropriate diversion of such juveniles
17 and juveniles from incarceration;

18 "(2) the provision of appropriate mental health
19 and substance abuse services as an alternative to in-
20 carceration and for those juveniles on probation or
21 parole; and

22 "(3) the provision of followup services for juve-
23 niles who are discharged from the juvenile justice
24 system.

25 "(b) ELIGIBILITY.—To be eligible to receive a grant
26 under this section an entity shall—

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S.L.C.

16

1 “(1) be a State or local juvenile justice agency,
2 mental health agency, or substance abuse agency
3 (including community diversion programs);

4 “(2) prepare and submit to the Secretary an
5 application at such time, in such manner, and con-
6 taining such information as the Secretary may re-
7 quire, including—

8 “(A) an assurance that the applicant has
9 the consent of all entities described in para-
10 graph (1) in carrying out and coordinating ac-
11 tivities under the grant; and

12 “(B) with respect to services for juveniles,
13 an assurance that the applicant has collabo-
14 rated with the State or local educational agency
15 and the State or local welfare agency in carry-
16 ing out and coordinating activities under the
17 grant;

18 “(3) be given priority if it is a joint application
19 between juvenile justice and substance abuse or
20 mental health agencies; and

21 “(4) ensure that funds from non-Federal
22 sources are available to match amounts provided
23 under the grant in an amount that is not less
24 than—

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S.L.C.

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1 “(A) with respect to the first 3 years
2 under the grant, 25 percent of the amount pro-
3 vided under the grant; and

4 “(B) with respect to the fourth and fifth
5 years under the grant, 50 percent of the
6 amount provided under the grant.

7 “(c) USE OF FUNDS.—

8 “(1) INITIAL YEAR.—An entity that receives a
9 grant under this section shall, in the first fiscal year
10 in which amounts are provided under the grant, use
11 such amounts to develop a collaborative plan—

12 “(A) for how the guarantee will institute a
13 system to provide intensive community serv-
14 ices—

15 “(i) to prevent high-risk juveniles
16 from coming in contact with the justice
17 system; and

18 “(ii) to meet the mental health and
19 substance abuse treatment needs of juve-
20 niles on probation or recently discharged
21 from the justice system; and

22 “(B) providing for the exchange by agen-
23 cies of information to enhance the provision of
24 mental health or substance abuse services to ju-
25 veniles.

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S.L.C.

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1 “(2) 2-5TH YEARS.—With respect to the sec-
2 ond through fifth fiscal years in which amounts are
3 provided under the grant, the grantee shall use
4 amounts provided under the grant—

5 “(A) to furnish services, such as assertive
6 community treatment, wrap-around services for
7 juveniles, multisystemic therapy, outreach, inte-
8 grated mental health and substance abuse
9 treatment, case management, health care, edu-
10 cation and job training, assistance in securing
11 stable housing, finding a job or obtaining in-
12 come support, other benefits, access to appro-
13 priate school-based services, transitional and
14 independent living services, mentoring pro-
15 grams, home-based services, and provision of
16 appropriate after school and summer program-
17 ing;

18 “(B) to establish a network of boundary
19 spanners to conduct regular meetings with
20 judges, provide liaison with mental health and
21 substance abuse workers, share and distribute
22 information, and coordinate with mental health
23 and substance abuse treatment providers, and
24 probation or parole officers concerning provision
25 of appropriate mental health and drug and alco-

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S.L.C.

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1 hol addiction services for individuals on proba-
2 tion or parole;

3 "(C) to provide cross-system training
4 among police, corrections, and mental health
5 and substance abuse providers with the purpose
6 of enhancing collaboration and the effectiveness
7 of all systems;

8 "(D) to provide coordinated and effective
9 aftercare programs for juveniles with emotional
10 or mental disorders who are discharged from
11 jail, prison, or juvenile facilities;

12 "(E) to purchase technical assistance to
13 achieve the grant project's goals; and

14 "(F) to furnish services, to train personnel
15 in collaborative approaches, and to enhance
16 intersystem collaboration.

17 "(3) DEFINITION.—In paragraph (2)(B), the
18 term 'boundary spanners' means professionals who
19 act as case managers for juveniles with mental dis-
20 orders and substance abuse addictions, within both
21 justice agency facilities and community mental
22 health programs and who have full authority from
23 both systems to act as problem-solvers and advocates
24 on behalf of individuals targeted for service under
25 this program.

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S.L.C.

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1 “(d) AREA SERVED BY THE PROJECT.—An entity re-
2 ceiving a grant under this section shall conduct activities
3 under the grant to serve at least a single political jurisdic-
4 tion.

5 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
6 shall be made available to carry out the section, not less
7 than 10 percent of the amount appropriated under section
8 1935(a) for each of the fiscal years 1999 through 2003.”.

9 **SEC. 5. INTERAGENCY RESEARCH, TRAINING, AND TECH-**
10 **NICAL ASSISTANCE CENTERS.**

11 (a) GRANTS OR CONTRACTS.—The Secretary of
12 Health and Human Services, acting through the Sub-
13 stance Abuse and Mental Health Services Administration
14 and in consultation with the Juvenile Justice and Delin-
15 quency Prevention Office and the Justice Assistance Bu-
16 reau, shall award grants and contracts for the establish-
17 ment of 4 research, training, and technical assistance cen-
18 ters to carry out the activities described in subsection (c).

19 (b) ELIGIBILITY.—To be eligible to receive a grant
20 or contract under subsection (a), an entity shall—

- 21 (1) be a public or nonprofit private entity; and
22 (2) prepare and submit to the Secretary of
23 Health and Human Services an application, at such
24 time, in such manner, and containing such informa-
25 tion as the Secretary may require.

21

1 (c) ACTIVITIES.—A center established under a grant
2 or contract under subsection (a) shall—

3 (1) provide training with respect to state-of-the-
4 art mental health and justice-related services and
5 successful mental health and substance abuse-justice
6 collaborations, to public policymakers, law enforce-
7 ment administrators, public defenders, police, proba-
8 tion officers, judges, parole officials, jail administra-
9 tors and mental health and substance abuse provid-
10 ers and administrators;

11 (2) engage in research and evaluations concern-
12 ing State and local justice and mental health sys-
13 tems, including system redesign initiatives, and dis-
14 seminate information concerning the results of such
15 evaluations;

16 (3) provide direct technical assistance, including
17 assistance provided through toll-free telephone num-
18 bers, concerning issues such as how to accommodate
19 individuals who are being processed through the
20 courts under the Americans with Disabilities Act of
21 1990 (42 U.S.C. 12101 et seq.), what types of men-
22 tal health or substance abuse service approaches are
23 effective within the judicial system, and how commu-
24 nity-based mental health or substance abuse services

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1 can be more effective, including relevant regional,
2 ethnic, and gender-related considerations; and

3 (4) provide information, training, and technical
4 assistance to State and local governmental officials
5 to enhance the capacity of such officials to provide
6 appropriate services relating to mental health or
7 substance abuse.

8 (d) AUTHORIZATION OF APPROPRIATIONS.—There is
9 authorized to be appropriated, \$4,000,000 for each fiscal
10 year to carry out this section.

11 **SEC. 6. FEDERAL COORDINATING COUNCIL ON THE CRIM-**
12 **INALIZATION OF JUVENILES WITH MENTAL**
13 **DISORDERS.**

14 (a) ESTABLISHMENT.—There is established a Fed-
15 eral Coordinating Council on Criminalization of Juveniles
16 With Mental Disorders as an interdepartmental council to
17 study and coordinate the criminal and juvenile justice and
18 mental health and substance abuse activities of the Fed-
19 eral Government and to report to Congress on proposed
20 new legislation to improve the treatment of mentally ill
21 juveniles who come in contact with the juvenile justice sys-
22 tem.

23 (b) MEMBERSHIP.—The Council shall include rep-
24 resentatives from—

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1 (1) the appropriate Federal agencies, as deter-
2 mined by the President, including, at a minimum—

3 (A) the Office of the Secretary of Health
4 and Human Services;

5 (B) the Office for Juvenile Justice and De-
6 linquency Prevention;

7 (C) the National Institute of Mental
8 Health;

9 (D) the Social Security Administration;

10 (E) the Department of Education; and

11 (F) the Substance Abuse and Mental
12 Health Services Administration; and

13 (2) children's mental health advocacy groups.

14 (c) DUTIES.—The Council shall—

15 (1) review Federal policies that hinder or facili-
16 tate coordination at the State and local level between
17 the mental health and substance abuse systems on
18 the one hand and the juvenile justice and corrections
19 system on the other;

20 (2) study the possibilities for improving collabo-
21 ration at the Federal, State, and local level among
22 these systems; and

23 (3) recommend to Congress any appropriate
24 new initiatives which require legislative action.

25 (d) FINAL REPORT.—The Council shall submit—

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1 (1) an interim report on current coordination
2 and collaboration, or lack thereof, 18 months after
3 the Council is established; and

4 (2) recommendations for new initiatives in im-
5 proving coordination and collaboration in a final re-
6 port to Congress 2 years after the Council is estab-
7 lished.

8 (e) EXPIRATION.—The Council shall expire 2 years
9 after the Council is established.

10 **SEC. 7. MENTAL HEALTH SCREENING AND TREATMENT**
11 **FOR PRISONERS.**

12 (a) ADDITIONAL REQUIREMENTS FOR THE USE OF
13 FUNDS UNDER THE VIOLENT OFFENDER INCARCER-
14 ATION AND TRUTH-IN-SENTENCING GRANTS PROGRAM.—
15 Section 20105(b) of the Violent Crime Control and Law
16 Enforcement Act of 1994 is amended to read as follows:

17 “(b) ADDITIONAL REQUIREMENTS.—

18 “(1) ELIGIBILITY FOR GRANT.—To be eligible
19 to receive a grant under section 20103 or 20104, a
20 State shall, not later than January 1, 2001, have a
21 program of mental health screening and treatment
22 for appropriate categories of juvenile and other of-
23 fenders during periods of incarceration and juvenile
24 and criminal justice supervision, that is consistent
25 with guidelines issued by the Attorney General.

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1 “(2) USE OF FUNDS.—

2 “(A) IN GENERAL.—Notwithstanding any
3 other provision of this subtitle, amounts made
4 available to a State under section 20103 or
5 20104, may be applied to the costs of programs
6 described in paragraph (1), consistent with
7 guidelines issued by the Attorney General.

8 “(B) ADDITIONAL USE.—In addition to
9 being used as specified in subparagraph (A),
10 the funds referred to in that subparagraph may
11 be used by a State to pay the costs of providing
12 to the Attorney General a baseline study on the
13 mental health problems of juvenile offenders
14 and prisoners in the State, which study shall be
15 consistent with guidelines issued by the Attor-
16 ney General.”.

17 **SEC. 8. INAPPLICABILITY OF AMENDMENTS.**

18 Section 3626 of title 18 is amended by adding at the
19 end the following:

20 “(h) INAPPLICABILITY OF AMENDMENTS.—A civil
21 action that seeks to remedy conditions which pose a threat
22 to the health of individuals who are—

23 “(1) under the age of 16; or

24 “(2) mentally ill;

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1 shall be governed by the terms of this section, as in effect
2 on the day before the date of enactment of the Prison Liti-
3 gation Reform Act of 1995 and the amendments made by
4 that Act (18 U.S.C. 3601 note).".

February 22, 1999

THE WHITE HOUSE

Office of the Vice President

EMBARGOED:

**For Release to print and broadcast media
dated Thursday, April 29, 1999**

Contact:

(202) 456-7035

VICE PRESIDENT AL GORE ANNOUNCES TEEN BIRTH RATES DECLINING NATIONWIDE

Also Highlights New Incentives for States to Reduce Out-of-Wedlock Birth Rates

Washington, DC -- Vice President Al Gore announced a new report showing that teen birth rates have declined nationwide by 16 percent from 1991 to 1997, and by four percent since 1996 and will highlight these successes at a round table at the White House on Thursday.

The Vice President praised this decrease which has occurred in every state in the country and among African-Americans, Hispanics, and whites as evidence that efforts to encourage young people to make responsible choices are having an effect. The report also showed that out-of-wedlock births continue to decline across the nation.

"We have made real progress -- and must do more -- to encourage more young people to delay parenthood until they are truly ready to live up to its important responsibilities," said Vice President Gore. "This good news shows that when Americans come together in support of our basic values we can send a clear message that our children should not be having children."

In specific, the report, a Department of Health and Human Services study, found that:

Birth rates have fallen among teens. The birth rate for teenagers has fallen 16 percent -- from 62.1 births per 1,000 women aged 15-19 years in 1991 to 52.3 in 1997.

Teen birth rates are down in all fifty states. The report shows that teen birth rates are down in all fifty states. In 10 states and the District of Columbia, the rate is down by more than 20 percent.

Teen birth rates are down across ethnic and racial groups. Teen birth rates declined for white, black, American Indian, Asian or Pacific Islander and Hispanic women.

Out-of-wedlock birth rates are also declining at record numbers. The report also found that out-of wedlock births continue to decline-- from six percent from the peak in 1994 and two percent since 1996. The birth rate for unmarried teens fell nine percent from its peak in 1994.

The Vice President will highlight a recent final rule that rewards states that have the greatest success in reducing out-of-wedlock births. Beginning in FY 1999, up to five states can qualify for up to \$25 million each if they successfully reduce the percentage of children born out-of-wedlock without increasing abortions. Children who are born into homes without two parents are more likely to drop out of school, get involved in crime and drugs, and end up in poverty. These bonus funds, which were part of the 1996 welfare reform law, are designed to encourage state efforts to develop effective solutions for addressing this critical social issue.

The Vice President praised the National Campaign to Prevent Teen Pregnancy for their continuing efforts to support values and encourage actions across all parts of the nation to promote a pregnancy-free adolescence. This year, the Campaign is focusing on the important positive role that teens have in influencing other teens to prevent teen pregnancy. The Campaign was created in response to President Clinton's 1995 State of the Union challenge to "parents and leaders all across this country to join together in a national campaign against teen pregnancy."

"By mobilizing our communities, churches, the media, parents, and young people themselves to promote responsible choices, we can help make sure that every child has responsible parents and can fulfill their potential," said Vice President Gore.

###

STATE-BY-STATE BIRTH RATES FOR TEENS AGED 15-19 YEARS

STATE	1991	1997	% CHANGE FROM 1991 TO 1997
Alabama	73.9	66.6	-10%
Alaska	65.4	44.6	-32%
Arizona	80.7	69.7	-14%
Arkansas	79.8	72.9	-9%
California	74.7	57.3	-23%
Colorado	58.2	48.2	-17%
Connecticut	40.4	36.1	-11%
Delaware	61.1	55.8	-9%
DC	114.4	91	-20%
Florida	68.8	57.7	-16%
Georgia	76.3	67.2	-12%
Hawaii	58.7	43.8	-25%
Idaho	53.9	43.3	-20%
Illinois	64.8	54.7	-16%
Indiana	60.5	54.2	-10%
Iowa	42.6	35.7	-16%
Kansas	55.4	48.5	-12%
Kentucky	68.9	59.6	-13%
Louisiana	76.1	66.3	-13%
Maine	43.5	32	-26%
Maryland	54.3	43.9	-19%
Massachusetts	37.8	31.7	-16%
Michigan	59	43.9	-26%
Minnesota	37.3	32	-14%
Mississippi	85.6	73.7	-14%
Missouri	64.5	51.5	-20%
Montana	46.7	37.6	-19%
Nebraska	42.4	37.2	-12%
Nevada	75.3	67.7	-10%
New Hampshire	33.3	28.6	-14%
New Jersey	41.6	35	-16%
New Mexico	79.8	68.4	-14%
New York	46	38.8	-16%
North Carolina	70.5	61.3	-13%
North Dakota	35.6	30.1	-15%
Ohio	60.5	49.8	-18%
Oklahoma	72.1	64.3	-11%
Oregon	54.9	46.9	-15%
Pennsylvania	46.9	37.3	-20%
Rhode Island	45.4	42.7	-6%
South Carolina	72.9	61.4	-16%
South Dakota	47.5	39.7	-16%
Tennessee	75.2	64.5	-14%
Texas	78.9	71.7	-9%
Utah	48.2	42.6	-12%
Vermont	39.2	26.9	-31%
Virginia	53.5	44.2	-17%
Washington	53.7	42.5	-21%
West Virginia	57.8	49.1	-15%
Wisconsin	43.7	35.9	-18%
Wyoming	54.2	43.3	-20%
United States	62.1	52.3	-16%

Source: NCHS, National Vital Statistics Report, April 29, 1999. Data on territories also available.
Birth rates per 1,000 estimated female population 15-19 years in each area.

About Assisted Living

THE NATIONAL CENTER FOR ASSISTED LIVING

Key Concepts Of Assisted Living

NCAL's General Philosophy

Definition

While assisted living is the most common term used in the nation, assisted living settings may be known by as many as 26 different names, including residential care, personal care, adult congregate care, boarding home and domiciliary care. Common to all these terms, however, is the understanding that an assisted living setting is:

- a congregate residential setting that provides or coordinates personal services, 24-hour supervision and assistance (scheduled and unscheduled), activities, and health-related services;
- designed to minimize the need to move;
- designed to accommodate individual residents' changing needs and preferences;
- designed to maximize residents' dignity, autonomy, privacy, independence, choice and safety; and
- designed to encourage family and community involvement.

Size

An assisted living residence is not defined by its capacity for residents, but by the scope of the services it provides. The size and configuration of each assisted living residence should be determined by consumer demand and the types of services provided. Services to individuals with mental illnesses, developmental disabilities, Alzheimer's disease, other forms of dementia or disabilities requiring specialized services, must be delivered in an appropriate and safe setting in compliance with state and federal regulations.

Physical Plant

An assisted living residence should be designed, operated, and maintained in a manner appropriate to the special needs of the population served. The residence should be located, constructed, and equipped in compliance with all applicable local codes and state and federal regulations. An assisted living setting should be designed in a way that maximizes the quality of life, independence, autonomy, safety, dignity, choice and privacy of residents. Settings should also be designed in a manner that encourages family and community involvement.

Move-In and Occupancy Agreements

New residents and/or their family members should receive an orientation about the services the assisted living residence offers.

Individuals should not be allowed to move into an assisted living residence that is unable to meet the full scope of their needs.

Occupancy agreements should clearly specify what services can and will be provided, the facility's rates for all services and payment structure, the facility's occupancy criteria, and relocation criteria.

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Service Agreements

When moving into an assisted living setting, each resident should be evaluated or assessed to determine how his or her need for services can best be met. A service agreement should be developed indicating what services will be delivered to meet particular needs based on the individual's physical, psychosocial and cognitive capabilities. The individual, family, or a responsible party should assist in the development of the service agreement, which should be reviewed and updated regularly or as needed.

An assisted living service coordinator should be designated to be responsible for developing, implementing, and evaluating the progress of the service agreement.

A copy of the agreement should be given to the resident or his or her legal guardian.

Health Needs

The assisted living residence should provide daily supervision or assistance with, activities of daily living and instrumental activities of daily living, coordinate services by outside agencies, and monitor the activities of the resident to ensure his or her health, safety, and well being. Daily assistance with activities may include the administration, supervision and/or assistance with self administration of medication by qualified staff person, and other health care services as permitted by state laws, rules and regulations.

An emphasis on wellness should be part of each setting's approach toward health care delivery. In addition, staff should assure that prompt and appropriate medical, health, and dental care services are obtained when required. The health care of each resident will be under the supervision of a physician of his/her choice.

Residents with temporary periods of incapacity due to major illness, injury, or recuperation from surgery should be allowed to remain in the facility or be readmitted from a hospital if appropriate services can be provided. If possible, the facility should help residents remain in the facility when death is imminent if appropriate palliative services can be provided in the setting.

Staff Qualifications and Training

The assisted living residence administrator should be responsible for the overall operation of the facility. The administrator should ensure that all staff members are qualified to care for residents and are competent in performing their duties consistent with applicable state and federal regulations. The administrator should assure that residents receive all services indicated in their service plan.

An assisted living residence administrator should have:

- An adequate education, demonstrated experience, and/or on-going training to meet the health and psychosocial needs of the resident; and
- Demonstrated management or administrative ability to maintain the overall operations of the setting.

A competent acting administrator should be designated to act on the administrator's behalf when the administrator is not readily available.

The personal care staff should:

- Be sufficient in numbers and qualifications to meet the 24-hour scheduled and unscheduled needs of residents and to deliver provided services; and
- Have adequate skills, education, experience and on-going training to serve residents and their families in a manner consistent with the philosophy of assisted living.

Personal care staff or medication assistants whose responsibilities include administration, assistance with self-administration or supervision of medications should be qualified by certification and/or training.

Staffing Patterns

Assisted living facilities should offer 24-hour protective supervision and oversight of residents. Assisted living residences should embrace the philosophy of "aging in place" which allows individuals to remain the residence as long as staff can properly provide for residents' health, safety and well being.

The number and type of staff employed by an assisted living facility should depend on a number of factors, including state regulations, the number of people living in the facility, each resident's service requirements, and the range of services offered.

The assisted living residence should employ adequate staff to maintain the facility in a manner that promotes the safety, health, and well-being of residents and staff.

Resident Rights

The philosophy of assisted living emphasizes the right of the individual to choose the setting for care and services. Resident rights should include the right to:

- Privacy
- Be treated at all times with dignity and respect
- Control personal finances
- Retain and have use of personal possessions
- Interact freely with others both within the assisted living residence and in the community
- Practice religion or abstain from religious practice
- Control receipt of health-related services
- Be free from abuse and neglect
- Organize resident councils

Upon move-in, all residents should be given a copy of their rights and responsibilities and should be encouraged to ask questions or discuss their rights with staff or the administrator at any time. A copy of those rights and responsibilities should be posted in a conspicuous place at all times.

Assisted living administrators should also:

- Permit access to the facility and to residents (with the individual resident's permission) by approved advocates and community organizations at reasonable times;
- Ensure that an informal or formal communications process is in place between the residence administration, residents and families;
- Establish residence rules governing visitors, usage of tobacco and alcohol and the use of personal property; and
- Ensure each resident is free from discrimination as provided by local, state and federal law.

Licensure and Certification

In most states assisted living residences are licensed or certified by an appropriate department or agency of the state that should have a process for issuance of initial licenses and for renewing existing licenses. A variance or waiver should be available to allow an individual facility to seek an exception to a requirement of the licensure or certification rules.

The state should maintain an aggressive program to seek out unlicensed or uncertified facilities and bring them into compliance with applicable licensure or certification standards. The health, safety, and well being of the residents should be the primary consideration when a state determines if a facility can be brought into compliance in a reasonable period of time or if closure is necessary. In addition, poor performing facilities that refuse to correct incidences of abuse and neglect should not be allowed to continue to operate.

Each state should also establish a program to reward -- through public recognition, incentive payments,

both -- assisted living residences that provide the highest quality care to residents.

Measuring and Improving Quality

The National Center for Assisted Living (NCAL) strongly believes that placing assisted living on a parallel regulatory track with nursing homes would be a mistake. Such a regulatory model would stifle the very spirit that led to the creation of assisted living. Instead of following the nursing home regulatory model, a quality assurance system for assisted living that focuses on customer satisfaction and actual outcomes should be designed and built. Such a system could be utilized by providers, consumers, managed care entities, and governments to ensure that quality services and care are being maintained. More important, such a system would better serve the interests of assisted living customers by providing them with powerful input into the quality evaluation process and the delivery of services.

Customer satisfaction measurement must be at the root of any system designed to measure quality in the assisted living setting. NCAL already has accomplished much in the area of customer satisfaction measurement in the assisted living setting. In 1996, NCAL, working with the Gallup Organization and the University of Wisconsin, conducted research and developed and tested a customer satisfaction assessment questionnaire based on those factors that residents deem important to their sense of satisfaction and well being.

Beyond customer satisfaction, any quality measurement system must also include measurement of actual facility performance. To be able to measure performance, certain data about each resident must be obtained, tracked and updated. From this data, quality indicators can be identified and utilized to track the outcomes of the care and services being provided by a facility. The quality indicators will produce tangible data and feedback that can be used to continuously improve assisted living quality. NCAL currently is conducting research and gathering data to develop quality indicators for the assisted living setting.

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About Assisted Living

The National Center for Assisted Living

Assisted Living Facility Profile

Number of Facilities-The absence of a common definition for assisted living makes it difficult to pinpoint the number of residences in the United States. However, recent analyses by NCAL indicate that there are approximately 28,000 assisted living residences housing 1.15 million people. NCAL's analyses of residences closely mirrors findings in a 1998 U.S. Department of Health and Human Services report on the assisted living industry.

Size-The average assisted living facility has 43 units and 40 residents. However, assisted living facility size varies greatly and facilities may be much smaller or larger.

Age of Structures-The average assisted living facility has been in operation for seven years and the physical structure that houses the assisted living residence has existed for 11 years.

Fees-Costs for assisted living residences vary greatly and depend on the size of units, services provided and location. Forty-nine percent of all assisted living facilities charge between \$1,001 and \$2,000 in average monthly rent and fees. Another 26 percent charge between \$2,001 and \$3,000 and 7 percent charge more than \$3,000 each month. A full 18 percent charge less than \$1,000.

Rules-A majority of residences (65 percent) allowed the use of tobacco and (52 percent) the consumption of alcohol. Consistent with the varying policies found in apartment living, 49 percent of residences allowed residents to keep small pets. Another 40 percent provided facility-owned pets for all residents to enjoy. A full 89 percent of assisted living residents need or accept help with housework, while 80 percent needed or accepted help with their daily medication.

Visitors-Most residences place no restrictions on visitors during the day, while 54 percent of facilities allow residents to have overnight guests.

Services-Assisted living residences typically provide or coordinate:

- 24-hour supervision;
- Three meals a day plus snacks in a group dining room; and
- A range of services that promote resident quality of life and independence, including:
 - Personal care services (help with eating, bathing, dressing, toileting, etc.);
 - Various health care services;
 - Social services;
 - Supervise persons with cognitive disabilities; Social and religious activities;
 - Exercise and educational activities;
 - Arrangements for transportation;
 - Laundry and linen service;

What's NCAL?

About Assisted Living

Consumer Information

Assisted Living News

Educational Resources

Links of Interest

Members Only

Site Search

Home

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1000 - 2000

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2000 - 3000

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3000 +

- and Housekeeping and maintenance.

All information comes from the National Center for Assisted Living's (NCAL) 1998 nationwide survey of the assisted living industry or reflects NCAL's philosophy. To order a copy of the findings from the complete survey, call 1-800-321-0343 and request the 1998 edition of Facts and Trends: The Assisted Living Sourcebook.

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About Assisted Living

The National Center for Assisted Living

Assisted Living Resident Profile

Age-The "average" age of residents, women and men combined, is 83 years. The average age of the oldest residents is 97; the youngest is 64.

Sex-Nearly 3/4 of assisted living residents are female; 26 percent are male.

Typical Resident-The "typical" assisted living resident is an 83-year-old woman who is mobile, but needs assistance with one or two activities of daily living.

Number of Residents-Approximately 1.15 million people nationwide live in assisted living settings.

Activities of Daily Living-A full 26 percent of all residents need no help taking care of their activities of daily living (ADLs), others did in varying degrees. On average, assisted living residents needed help with 1.7 ADLs. The chart below details the various activities of daily living and the levels of assistance that assisted living residents need.

Personal Activities	Independent	Some Help	Dependent
Bathing	33%	47%	21%
Dressing	53%	32%	15%
Transferring	78%	13%	9%
Toileting	73%	17%	10%
Eating	87%	9%	4%

Other Common Services-A full 89 percent of assisted living residents need or accept help with housework, while 80 percent needed or accepted help with their daily medication.

Moving In-Residents come to assisted living facilities from a variety of settings, including:

- 58 percent moved from their homes
- 13 percent came from a nursing facility
- 12 percent came from another assisted living residence
- 12 percent came from hospitals
- 5 percent came from other settings

Moving Out-Conversely, as needs change, elderly people may relocate from assisted living residences. The NCAL survey found that a majority of residents left the assisted living facility because they needed a higher level of medical care.

- 43 percent went to a nursing facility
- 22 percent died
- 13 percent returned to their homes

What's NCAL?

About Assisted Living

Consumer Information

Assisted Living News

Educational Resources

Links of Interest

Members Only

Site Search

Home

- 11 percent went to a hospital
- 9 percent went to another assisted living residence
- 3 percent went to other settings

Average Stay-Residents stay in assisted living residences an average of nearly 3 years.

Resident Rights-The National Center for Assisted Living advocates that residents' rights should include the right to:

- Privacy
- Be treated at all times with dignity and respect
- Control personal finances
- Retain and have use of personal possessions
- Interact freely with others both within the assisted living residence and in the community
- Freedom of religion
- Control receipt of health-related services
- Organize resident councils

All statistics come from the National Center for Assisted Living's 1998 nationwide survey of the assisted living industry. To order a copy of the findings from the complete survey, call 1-800-321-0343 and request the 1998 edition of Facts and Trends: The Assisted Living Sourcebook.

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About Assisted Living

The National Center for Assisted Living

State Regulatory Review, 1998

Assisted living has emerged on the long term care spectrum as a rapidly growing and innovative phenomenon. Unlike most senior housing that has been around for decades, assisted living residences provide specialized oversight and assistance with daily tasks such as bathing, dressing, and personal services to promote independence.

Assisted living, a Scandinavian model of service for the elderly that began to develop in the United States in the mid-1980's, is still struggling to define itself. As many as 29 different terms may be used interchangeably to describe assisted living, including assisted living, residential care, personal care, sheltered care, and boarding homes.

Despite these many terms, the National Center for Assisted Living (NCAL), the assisted living voice of the American Health Care Association, believes it is important to develop guidance to help give assisted living a more precise identity. NCAL believes assisted living is part of a comprehensive long term care continuum that provides the necessary level of services to a dependent elderly or disabled population in an appropriate environment. Assisted living services are typically rendered in state-licensed settings and may include 24-hour protective oversight, food, shelter, and the provision and/or coordination of a range of services that promote the quality of life and independence of the individual.

Oversight of the assisted living industry occurs at the state level. The varying laws and regulations affecting these settings have created a diverse and fluid operating environment for providers and a mix of terminology, settings, and available services for consumers.

Many states are currently developing and refining their assisted living rules and guidelines. Readers are encouraged to contact the identified state agencies for additional or updated information. The following review is based on the applicable statutes and regulations in each state and specifically summarizes the following information:

- **Agency/Phone Number:** name and general phone number of the state assisted living regulatory agency.
- **Contact Name/Phone Number:** name and direct phone number of the state agency representative who is knowledgeable about state regulatory classifications and whether new initiatives regarding assisted living are planned.
- **Licensure Term:** lists the term used by states that most closely fits the general definition of "assisted living."
- **Opening Statement:** includes comments about new assisted living legislation or regulation that is being discussed, drafted, or proposed by the state.
- **Definition:** summarizes the state's definition of the licensure term.
- **Facility Scope of Care:** summarizes the nursing and personal care services that may be provided.
- **Third Party Scope of Care:** indicates whether services may be provided by home health agencies, hospice providers, etc.
- **Admission/Discharge Requirements:** summarizes limitations on the types of residents who may be admitted and resident conditions or other criteria that mandate discharge.
- **Medication Management:** indicates whether administration of medication is permitted and the extent to which assistance with self-administration is permissible.

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[About Assisted Living](#)

[Consumer Information](#)

[Assisted Living News](#)

[Educational Resources](#)

[Links of Interest](#)

[Members Only](#)

[Site Search](#)

[Home](#)

- **Physical Plant Requirements:** summarizes the square footage requirements for resident apartments and any other special physical plant requirements.
- **Residents Allowed Per Room:** summarizes the maximum number of residents allowed per resident unit.
- **Bathroom Requirements:** indicates whether bathrooms may be shared and how many toilets, lavatories, and/or bathing facilities are required per resident.
- **Alzheimer's Unit Requirements:** may either indicate whether facilities are permitted to care for residents with Alzheimer's or may summarize special requirements for facilities that care for such residents.
- **Staffing Requirements:** lists required staff and may list staff-to-resident ratios.
- **Administrator Education/Training:** summarizes qualifications for administrators.
- **Staff Education/Training:** summarizes qualifications for various staff positions.
- **Continuing Education (CE) Requirements:** summarizes the number of hours of continuing education that may be required annually of administrators and staff.
- **Entity Approving CE Program:** if applicable, lists the state entity or body that gives prior approval for continuing education courses.

Alabama
Alaska
Arizona
Arkansas
California
Colorado
Connecticut
Delaware
Florida
Georgia
Hawaii
Idaho
Illinois

Indiana
Iowa
Kansas
Kentucky
Louisiana
Maine
Maryland
Massachusetts
Michigan
Minnesota
Mississippi
Missouri
Montana

Indiana
Nevada
New Hampshire
New Jersey
New Mexico
New York
North Carolina
North Dakota
Ohio
Oklahoma
Oregon
Pennsylvania

Rhode Island
South Dakota
South Carolina
Tennessee
Texas
Utah
Vermont
Virginia
Washington
West Virginia
Wisconsin
Wyoming

Alabama

Agency: Department of Public Health, Division of Licensure and Certification

Phone Number: 334/206-5190

Contact Name: Mia Sadler

Contact Phone Number: 334/206-5216

Licensure Term: Assisted Living Facilities

Opening Statement: Revisions were made to these rules in March 1997. A state Health Coordinating Committee has been convened to study assisted living, but has yet to issue a report or make any recommendations.

Definition: An Assisted Living Facility provides room, board, meals, laundry, assistance with personal care and other services for not less than 24 hours per week. Assisted living is subclassified according to number of residents.

Facility Scope of Care: Assistance with activities of daily living such as bathing, oral hygiene, and grooming may be provided. An RN must provide or supervise care during periods of temporary illness.

Medication Management: A resident not fully aware of the medications he or she is taking is not permitted to administer his or her own medications. Medication must be administered by a licensed nurse to residents for whom self-administration is not feasible, and to those who do not require acute, continuous, or extensive medical or nursing care.

Physical Plant Requirements: Private resident units must be a minimum of 80 square feet and double occupancy resident units must be a minimum of 130 square feet.

Residents Allowed Per Room: A maximum of two residents is allowed per resident unit.

Bathroom Requirements: Bathrooms may be shared and resident rooms may have common toilets, lavatories, and bathing facilities.

Alzheimer's Unit Requirements: Alabama is conducting a pilot study of dementia care in assisted living facilities. Currently, Alabama's Assisted Living Facility regulations do not allow facilities to have secured/locked dementia or Alzheimer's units. Under the pilot study, a licensed nurse must be available and must administer medication; facilities must submit quarterly reports; and, site visits must be made by the state when complaints are made against the facility or when the facility requests consultation.

Staffing Requirements: There must be an administrator, RN consultants, and personal care staff as needed to provide adequate care and promote an orderly operation of the facility. Specifically, there must be at least one staff person for every six residents in the facility at all times.

Administrator Education Training: Administrators are required to be "well-trained."

Staff Education/Training: Staff are required to take a 16-hour course within their first year.

Continuuig Education (CE) Requirements: Administrators must complete six hours of continuing education per year.

Entity Approving CE Program: N/A



Alaska

Agency: Department of Administration, Division of Senior Services

Phone Number: 907/465-4416

Contact Name: Kathy DiMaria

Contact Phone Number: 907/269-3666

Licensure Term: Assisted Living Homes

Opening Statement: Alaska is unique due to its size and sparse population. Providers determine the level of care and services they will provide, but must provide the state with a list of these services.

Definition: Assisted Living Homes provide a system of care in a home-like environment for elderly persons and persons with mental or physical disabilities who need assistance with activities of daily living.

Facility Scope of Care: Facilities may provide nursing care, assistance with activities of daily living, intermittent nursing services and skilled nursing care by arrangement. A licensed nurse may delegate certain tasks, including non-invasive routine tasks, to staff.

Medication Management: If self-administration of medications is included in a resident's assisted living plan, the facility may supervise the resident's self-administration of medications.

Physical Plant Requirements: If a room is shared, the regulations require "reasonable privacy."

Residents Allowed Per Room: Not specified.

Bathroom Requirements: Not specified.

Alzheimer's Unit Requirements: The facility must provide a safe environment for residents with Alzheimer's.

Staffing Requirements: Not specified.

Administrator Education Training: An administrator must be at least 21 years of age and have sufficient education and experience in an out-of-home care facility and is subject to a criminal background investigation.

Staff Education/Training: Care providers in non-supervisory roles must be at least 16 years of age.

Continuuing Education (CE) Requirements: N/A

Entity Approving CE Program: N/A



Arizona

Agency: Department of Health Services, Home and Community Based Licensure

Phone Number: 602/674-9775

Contact Name: Laura Hartgroves

Contact Phone Number: 602/674-9779

Licensure Term: Assisted Living Facilities

Opening Statement: Arizona passed legislation which will put new regulations for Assisted Living Facilities into effect November 1, 1998. The new licensure category consolidates the previous six licensure categories for residential care institutions (adult care homes, adult foster care homes, supportive residential living centers, supervisory care homes, and unclassified residential care institutions) into a universal assisted living license. This license will be subclassified based on size and level of services provided. All facilities will be required to comply with resident rights, food service, administration requirements, abuse reporting, and resident agreements. Training and physical plant requirements will vary depending upon size and level of care.

Definition: An Assisted Living Facility is a residential care institution that provides or contracts to provide supervisory care services, personal care services or directed care services on a continuing basis.

Facility Scope of Care: Facilities may provide personal care services, including assistance with activities of daily living, that can be performed by persons without professional skills or professional training. Facilities may also provide or coordinate intermittent nursing services and the administration of medications and treatment by a licensed nurse.

Medication Management: Medication administration is permitted by licensed nurses.

Physical Plant Requirements: Facilities must comply with all local building codes, ordinances, fire codes, and zoning requirements. Private resident units must be a minimum of 80 square feet and shared resident units must provide a minimum of 60 square feet per resident.

Residents Allowed Per Room: A maximum of two residents is allowed per resident unit.

Bathroom Requirements: Shared bathrooms are permitted and there shall be at least one full bathroom for every eight residents.

Alzheimer's Unit Requirements: Not specified.

Staffing Requirements: The regulations require that supervisory care services, personal care services, or directed care services consistent with the level of service for which the facility is licensed are to be provided.

Administrator Education Training: Managers must be at least 21 years of age and be certified as assisted living facility managers.

Staff Education/Training: All staff must be trained in first aid specific to adults. Caregivers must be at least 18 years of age, trained at the level of service the facility is licensed to provide, and have a minimum of three months of health-related experience. Assistant caregivers must be at least 16 years of age.

Continuing Education (CE) Requirements: All staff must complete a minimum of 12 hours of continuing education per year in areas related to: promotion of resident dignity, independence, self-determination, privacy, choice, and resident rights; fire, safety, and emergency procedures; infection control; and abuse, neglect, and exploitation prevention and reporting requirements.

Entity Approving CE Program: N/A



Arkansas

Agency: Department of Human Services, Office of Long Term Care

Phone Number: 501/682-8468

Contact Name: Jerry Rayburn/Sue Hill

Contact Phone Number: 501/682-8468

Licensure Term: Residential Long Term Care Facilities

Opening Statement: There have been no changes to these rules since January 1, 1997.

Definition: Residential Long Term Care Facilities serve individuals with impaired functioning who do not require hospital or nursing home care and who self-administer medication.

Facility Scope of Care: The facility may supervise activities of daily living, but not assist.

Medication Management: Medication administration may not be performed by the facility staff. The supervision of self-administered medication is limited to cuing.

Physical Plant Requirements: Private resident units must be a minimum of 100 square feet and shared resident units must provide a minimum of 80 square feet per resident.

Residents Allowed Per Room: A maximum of two residents is allowed per resident unit.

Bathroom Requirements: Shared bathrooms are permitted and there must be at least one toilet and lavatory for every six residents and one tub or shower for every 10 residents. Dormitory or communal type bathroom facilities are not permitted.

Alzheimer's Unit Requirements: Not specified.

Staffing Requirements: A full-time administrator must be on the premises during normal business hours. The regulations list specific staffing ratios (e.g., one staff person for one to 16 residents during the day, evening, and night).

Administrator Education Training: Administrators must be at least 21 years of age and are required to be certified as a residential care facility administrator through a department-approved certification program and hold a high school diploma or GED.

Staff Education/Training: Staff must be at least 18 years of age and are required to complete an orientation program on resident rights.

Continuuuing Education (CE) Requirements: N/A

Entity Approving CE Program: N/A



California

Agency: Department of Social Services, Community Care Licensing Division

Phone Number: 916/327-2459

Contact Name: Dennyse Provolt

Contact Phone Number: 916/327-2459

Licensure Term: Residential Care Facilities for the Elderly

Opening Statement: The regulations were recently revised to allow a single license to be issued to certain integral facilities conducting multiple, related programs which would otherwise require separate licenses.

Definition: A Residential Care Facility for the Elderly is a housing arrangement chosen voluntarily where 75 percent of the residents are 60 years of age or older and where varying levels of care and supervision are provided. Younger residents must have needs compatible with other residents.

Facility Scope of Care: The facility may provide assistance with activities of daily living, observation and reassessment, postural support that can be released by the resident, other specific types of care or "incidental medical services" (e.g., intermittent administration of oxygen, colostomy/ileostomy care, irrigation of indwelling catheters, and injections). Several incidental medical services require specific approval by the licensing authority.

Medication Management: Facility staff may assist residents with the self-administration of medication.

Physical Plant Requirements: The regulations allow for private or semi-private resident rooms. Resident rooms must be furnished and of sufficient size to allow for easy passage of wheelchairs and walkers.

Residents Allowed Per Room: A maximum of two residents is allowed per resident unit.

Bathroom Requirements: Common toilets, bathing, and lavatory facilities are permitted.

Alzheimer's Unit Requirements: The regulations were revised recently to permit secured perimeters for Alzheimer's residents. Facilities may opt to install delayed egress doors or lock perimeters. A special permit is required for these special units.

Staffing Requirements: Facility personnel must be sufficient to provide the services necessary to meet resident needs.

Administrator Education Training: An administrator must complete a 40+ hour approved certification program (nursing home administrators are exempt from this requirement), 15 college or continuing education units, and have at least one year of experience or equivalent (in facilities with 16-49 residents) or two years of college and at least three years of experience (in facilities with 50 or more residents). Nursing home administrators are exempt from the certification requirement, but are required to have taken 12 continuing education courses in Residential Care Facilities for the Elderly administrator core curriculum subjects.

Staff Education/Training: Services requiring specialized skills are to be provided by qualified personnel in accordance with recognized professional standards.

Continuing Education (CE) Requirements: Administrators must complete 20 hours of continuing education per year in areas related to aging and/or administration.

Entity Approving CE Program: Program Support Bureau



Colorado

Agency: Department of Public Health

Phone Number: 303/692-2846

Contact Name: Joanne Lingk

Contact Phone Number: 303/692-2846

Licensure Term: Personal Care Boarding Homes

Opening Statement: The regulations have been in effect since 1993.

Definition: Personal Care Boarding Homes provide assistance with activities of daily living, homemaker, and other supportive services. Alternative Care Facilities, a subset of Personal Care Boarding Homes, differ in that they have Medicaid certification.

Facility Scope of Care: The facility may provide oversight and assistance with activities of daily living. Intermittent skilled services may be provided by qualified providers.

Medication Management: Residents shall maintain and self-administer without documentation by the facility only non-prescription medications or those medications prescribed by a physician or other authorized practitioner for the sole use by the resident. Unless self-administered, prescription and non-prescription medications must be administered by qualified medication administration staff and only upon written order of a licensed physician or authorized practitioner.

Physical Plant Requirements: Private resident units must be a minimum of 100 square feet and double occupancy resident units must provide a minimum of 60 square feet per resident.

Residents Allowed Per Room: A maximum of two residents is allowed per resident unit. Prior to July 1, 1986, up to four residents were allowed per room.

Bathroom Requirements: Shared bathrooms are permitted and there shall be at least one full bathroom for every six residents.

Alzheimer's Unit Requirements: Secured units for the purposes of serving residents with early stage Alzheimer's disease are allowed.

Staffing Requirements: Not specified.

Administrator Education Training: Operators must complete an approved program of certification at college, through a program or seminar, or through in-service training. The curriculum must include at least 30 hours of which at least 15 teach resident rights, environment and fire safety procedures, how to deal with difficult situations and behavior and nutrition. The remaining 15 hours must provide emphasis on meeting specific resident population needs, e.g., the elderly and those with Alzheimer's.

Staff Education/Training: Staff shall be given on-the-job training or have related experience in the job assigned to them.

Continuuuing Education (CE) Requirements: N/A

Entity Approving CE Program: N/A



Connecticut

Agency: Department of Health, Health Facilities Division

Phone Number: 860/509-7400

Contact Name: Victoria Carlson

Contact Phone Number: 860/509-7400

Licensure Term: Assisted Living Services Agencies

Opening Statement: The regulations have been in effect since November 29, 1994 and only cover the core services provided in a managed residential community. Physical plant/setting requirements, etc. are regulated by the state and local building and fire codes.

Definition: Assisted Living Services Agencies provide nursing services and assistance with activities of daily living to clients living within a managed residential community having supportive services that encourage clients primarily age 55 or older to maintain a maximum level of independence.

Facility Scope of Care: Nursing services and assistance with activities of daily living may be provided to residents with chronic and stable conditions as determined by a physician or health care practitioner.

Medication Management: Not specified.

Physical Plant Requirements: The managed residential community where services are offered must have private residential units that include a full bath, access to facilities, and equipment for the preparation and storage of food. A resident may choose to share a room. Common space in the facility must be sufficient enough to accommodate 50 percent of the residents at any given time.

Residents Allowed Per Room: Not specified.

Bathroom Requirements: Not specified.

Alzheimer's Unit Requirements: Not specified.

Staffing Requirements: Staffing must be adequate to meet residents' needs.

Administrator Education Training: The supervisor must be a registered nurse with at least two years' experience in nursing, including one year in a home health agency; or a high school diploma with four years' experience, including two in a home health agency. Assisted living aides must have a CNA or CHHA certification.

Staff Education/Training: Assisted living aides must complete 12 hours of continuing education per year.

Continuuuing Education (CE) Requirements: Assisted living aides must complete 12 hours of continuing education per year.

Entity Approving CE Program: N/A



Delaware

Agency: Department of Health & Social Services, Division of Public Health

Phone Number: 302/577-6666

Contact Name: Kevin Charles

Contact Phone Number: 302/739-6603

Licensure Term: Assisted Living Agencies

Opening Statement: Regulations went into effect on December 15, 1997 and are to be interpreted in a manner consistent with a social philosophy of care, which is the promotion of the consumer's independence, privacy, dignity, and the provision of services in a home-like environment. Assisted Living Agency regulations are expected to be reviewed in early 1999.

Definition: Assisted Living is a fee-based residential arrangement for dependent and elderly adults with disabilities that provides assistance with activities of daily living and other services that promote the consumer's quality of life.

Facility Scope of Care: The facility may provide residents with assistance with activities of daily living and other services that promote quality of life. Facilities are not intended for persons who require nursing home services that are beyond their capability.

Medication Management: Facilities must comply with the Nurse Practice Act. Residents may receive assistance with self-medication by designated care providers, while administration of medication may only be performed by RNs and LPNs

Physical Plant Requirements: Individual living units without kitchens shall have an appropriately designed central kitchen that is readily accessible to the resident. The central kitchen in the facility must meet "Public Eating Place Regulations."

Residents Allowed Per Room: A maximum of two residents is allowed per resident unit.

Bathroom Requirements: Bathing facilities shall be available either in an individual living unit or in an area readily accessible to each resident.

Alzheimer's Unit Requirements: Not specified.

Staffing Requirements: Each facility shall have a director who is responsible for operation of the program. 24-hour on-site or on-call supervision must be provided. Overall staffing must be sufficient in number to meet the needs of the residents.

Administrator Education Training: There are no specified training requirements for administrators at this time.

Staff Education/Training: Staff must be adequately trained to meet the needs of the resident and the facility must provide and document staff training.

Continuing Education (CE) Requirements: N/A

Entity Approving CE Program: N/A



Florida

Agency: Agency for Health Care Administration

Phone Number: 850/487-2515

Contact Name: Mary Loepp

Contact Phone Number: 850/487-2515

Licensure Term: Assisted Living Facilities

Opening Statement: Regulations were last revised in early 1998, and additional revisions are in the process of being made.

Definition: Assisted Living Facilities provide housing, food service, and one or more "personal services" (e.g., assistance with activities of daily living and supervision of self-administered medication).

Facility Scope of Care: Facilities may provide assistance with personal services, including medications. Nursing services are permitted for facilities that hold a special license.

Medication Management: Unlicensed staff may provide hands-on assistance with self-administered medications. Staff must have four hours of medication training by a RN or registered pharmacist.

Physical Plant Requirements: Private resident units must provide a minimum of 80 square feet of usable floor space and multiple-occupancy resident rooms must provide a minimum of 60 square feet per resident. An additional minimum of 35 square feet of living and dining space per resident is required.

Residents Allowed Per Room: A maximum of four residents is allowed per resident unit.

Bathroom Requirements: Shared bathrooms are permitted and a facility must provide one toilet and sink per six residents and one bathing facility per eight residents.

Alzheimer's Unit Requirements: Facilities that advertise special care for persons with Alzheimer's disease or related disorders must: have a physical environment that provides for the safety and welfare of residents; offer activities specifically designed for these residents; have 24-hour staffing availability; and employ staff who have completed an eight-hour approved training course and must complete four hours of continuing education per year.

Staffing Requirements: Staffing requirements vary depending upon the numbers of residents (e.g., nine full-time staff per 76-85 residents at all times would be required). At least one employee certified in first aid must be present at all times. Staffing must be sufficient to meet residents' needs.

Administrator Education Training: Administrators must have a high school diploma or GED and complete a core training program and competency test.

Staff Education/Training: Direct-care staff must have six hours of initial training.

Continuing Education (CE) Requirements: Administrators must complete twelve hours of continuing education every two years.

Entity Approving CE Program: N/A



Georgia

Agency: Department of Human Resources, Personal Care Home Program

Phone Number: 404/657-4076

Contact Name: Hazel Crawford

Contact Phone Number: 404/657-5636

Licensure Term: Personal Care Homes

Opening Statement: June 15, 1994 regulations for Personal Care Homes are still in effect in Georgia.

Definition: Personal Care Homes provide housing, food services, and one or more personal services, including supervision of self-administered medication, assistance with ambulation and transfers, and essential activities of daily living such as eating, bathing, grooming, dressing, and toileting.

Facility Scope of Care: The personal services provided by the homes shall include 24-hour responsibility for the well-being of the residents and protective care and watchful oversight.

Medication Management: All medications shall be self-administered by the resident except when the resident requires administration of oral or topical medication by or under supervision of a functionally literate staff person.

Physical Plant Requirements: Private and shared resident units must provide a minimum of 80 square feet per resident.

Residents Allowed Per Room: A maximum of four residents is allowed per resident unit.

Bathroom Requirements: Common toilets, lavatories, and bathing facilities are permitted.

Alzheimer's Unit Requirements: Not specified.

Staffing Requirements: At least one administrator, on-site manager, or responsible staff person shall be on the premises 24 hours per day. There should be a minimum of one on-site staff person per 15 residents during waking hours and one staff person per 25 residents during non-waking hours.

Administrator Education Training: N/A

Staff Education/Training: The administrator, on-site manager and all other responsible staff must be at least 21 years of age. All persons working in the facility shall receive work-related training acceptable to the Department within the first 60 days of employment.

Continuing Education (CE) Requirements: All staff, including the administrator/on-site manager, who offer direct care to the residents, must satisfactorily complete at least sixteen hours of continuing education per year.

Entity Approving CE Program: N/A



Hawaii

Agency: Department of Health, Hospital and Medical Facilities Branch

Phone Number: 808/586-4080

Contact Name: Helen Yoshimi

Contact Phone Number: 808/586-4080

Licensure Term: Assisted Living Facilities

Opening Statement: New Assisted Living Facility regulations are expected to be finalized in October 1998.

Definition: An Assisted Living Facility is a combination of housing, health care services, and assistance with activities of daily living and instrumental activities of daily living as required by the individual resident in an environment that promotes independence.

Facility Scope of Care: The facility must provide services to assist residents in performing all activities of daily living as well as nursing assessment, health monitoring, and routine nursing tasks.

Medication Management: The facility must have medication management policies related to self-medication and the administration of medication.

Physical Plant Requirements: Facilities shall provide residents with private apartment units with a minimum of 220 square feet, not including the bathroom. Units must have a full bathroom, refrigerator, and cooking capacity with a sink.

Residents Allowed Per Room: Not specified.

Bathroom Requirements: Each resident unit must have a private full bath.

Alzheimer's Unit Requirements: Not specified.

Staffing Requirements: An awake, on-site direct-care staff person must be on the premises 24 hours per day.

Administrator Education Training: The administrator or director must have at least two years of experience in management and in the housing, health care services, or personal care industries. The completion of an assisted living facility administrator's course or equivalent is required.

Staff Education/Training: All facility staff must complete in-service training.

Continuuing Education (CE) Requirements: All staff must complete at least six hours of continuing education per year.

Entity Approving CE Program: N/A



Idaho

Agency: Department of Health and Welfare

Phone Number: 208/334-6626

Contact Name: Eric Mundell

Contact Phone Number: 208/334-6626

Licensure Term: Residential Care Facilities

Opening Statement: The regulations have been in effect since July 1996.

Definition: Residential Care Facilities provide a human, safe, and home-like living arrangement for individuals with a mental illness, developmental/physical disability, or who are elderly and in need of some assistance with activities of daily living and personal care.

Facility Scope of Care: The facility must supervise residents and provide assistance with activities of daily living and instrumental activities of daily living.

Medication Management: Staff who attend an assistance with medications course are permitted to assist residents with the self-administration of medication. A nurse is required to check the medication regimen for residents monthly.

Physical Plant Requirements: Private resident units must be a minimum of 100 square feet and shared resident units must provide a minimum of 80 square feet of floor space per resident.

Residents Allowed Per Room: A maximum of two residents is allowed per resident unit.

Bathroom Requirements: Common toilet, bathing, and lavatory facilities are permitted.

Alzheimer's Unit Requirements: Idaho has fairly extensive requirements for the care of Alzheimer's residents. Separate Alzheimer's units are permitted in facilities.

Staffing Requirements: A full-time licensed administrator must devote a minimum of 20 hours per week to the day-to-day administration of the facility. If the facility houses 30 or more high-acuity residents, one awake staff person must be on-site during resident sleeping hours. There must be sufficient staff during all hours to provide care and at least one staff person immediately available at all times.

Administrator Education Training: Administrators must be licensed.

Staff Education/Training: Staff must complete an updated training course every six months.

Continuing Education (CE) Requirements: Administrators must complete 12 hours of continuing education per year.

Entity Approving CE Program: The Board of Examiners of Residential Care Facility Administrators approves courses that are relevant to residential care administration. There is no application process.



Illinois

Agency: Department of Public Health

Phone Number: 217/782-5180

Contact Name: Susan Meister

Contact Phone Number: 217/782-2913

Licensure Term: Sheltered Care Facilities

Opening Statement: Senate Bill 743, the "Assisted Living Establishment Act," is pending as a study bill until 1999. The bill, referencing assisted living establishments, would require a written contract for each resident and would establish an assisted living advisory commission to assist with licensure and disciplinary actions.

Definition: Sheltered Care Facilities provide food, shelter, laundry services, and personal care to residents who do not need nursing care.

Facility Scope of Care: Facilities may provide general watchfulness and appropriate action to meet the total needs of residents, exclusive of nursing care.

Medication Management: All medications must be self-administered or administered by a licensed personnel. Facility staff may give medication reminders and monitor residents to make sure they follow the directions on the container.

Physical Plant Requirements: Private resident units must be a minimum of 100 square feet and shared resident units must provide a minimum of 80 square feet of floor space per resident. Square footage requirements do not include closets, wardrobes, bathrooms, or entryways. Beds must be at least three feet apart.

Residents Allowed Per Room: A maximum of four residents is allowed per resident unit.

Bathroom Requirements: The regulations have very specific ratios for numbers of toilets and bathing facilities per number of residents. One toilet must be provided for every 15 residents per floor and one lavatory and water closet for every 10 residents per floor.

Alzheimer's Unit Requirements: A facility must fill out an Alzheimer's Special Care Disclosure Form if they offer care to Alzheimer's residents in a special unit.

Staffing Requirements: A full-time administrator must be employed along with sufficient staff in numbers and qualifications. Staff shall be on duty all hours of each day to provide services that meet the total needs of the residents. There must be a minimum of one staff member awake, dressed, and on duty at all times.

Administrator Education Training: The administrator must be a high school graduate or equivalent and at least 18 years of age.

Staff Education/Training: All personnel must have training and/or experience in the job assigned to them. An ongoing in-service training program is required to ensure staff have the necessary skills to perform job duties.

Continuuing Education (CE) Requirements: N/A

Entity Approving CE Program: N/A



Indiana

Agency: Department of Health, Division of Regulations and Information Services

Phone Number: 317/233-1325

Contact Name: Sue Hornstein

Contact Phone Number: 317/233-7289

Licensure Term: Residential Care Facilities

Opening Statement: Senate Enrolled Act 436 (Housing with Services Establishments) will become effective in September 1998 and will require any residential care facility providing assisted living services to register with the Family and Social Services Administration (FSSA) and disclose its name, address and phone. This will not be a certification process, but instead will help the FSSA to learn about the amount and types of facilities in Indiana. Housing with Services Establishments provide sleeping accommodations to at least five residents and offer or provide for a fee: at least one regularly scheduled health related service or at least two regularly scheduled supportive services whether offered or provided directly by the establishment or by another person arranged for by the establishment.

Definition: A Residential Care Facility provides room, food, laundry, and occasional assistance in activities of daily living for residents who need less service than the degree of service provided by a Comprehensive Care Facility (a health facility that provides nursing care, room, food, laundry, administration of medications, special diets and treatments, and that may provide rehabilitative and restorative therapies under the order of an attending physician). There is an overall general supervision of health care, medications, and diets as defined in the written policies of the facility.

Facility Scope of Care: Personal care and supervision shall be provided as needed by residents.

Medication Management: Medication shall be administered by licensed nursing personnel or qualified medication aides. Facilities that administer medication shall provide a medicine station for 24-hour distribution. Bedside medications and treatments for self-administration shall be permitted with the approval of a physician, unless the facility does not permit self-administration of medication.

Physical Plant Requirements: Private resident units must be a minimum of 100 square feet and multiple-occupancy resident units must provide a minimum of 80 square feet per resident.

Residents Allowed Per Room: A maximum of five residents is allowed per resident unit.

Bathroom Requirements: The regulations have very specific ratios for numbers of toilets and bathing facilities per number of residents (e.g., one toilet must be provided for every eight residents).

Alzheimer's Unit Requirements: Recommended/voluntary guidelines ask that if a facility advertises to the public that it is offering a special care unit it must file a disclosure statement that includes information on ownership, management, number of beds in the unit, special staffing requirements, special education/training requirements for staff, and cost of care (e.g., base rate).

Staffing Requirements: Each facility shall have at least one employee on duty at all times. The facility shall provide the number of staff as required to carry out all the functions of the facility. An administrator must be on staff to organize and implement the day-to-day operations of the facility.

Administrator Education Training: Administrators must either have a baccalaureate or higher degree in any subject and complete a six-month training program; possess an associate degree in long term care, health care administration, or equivalent and complete a six-month training program; or complete a specialized course of study in long term health care administration and a six-month administrator training program.

Staff Education/Training: The facility must provide for organized, ongoing in-service education and training for administrators and staff that includes prevention and control of infection, fire prevention, safety and accident prevention, and the needs of specialized populations served.

Continuuug Education (CE) Requirements: Administrators must complete 20 hours of continuing education per year.

Entity Approving CE Program: N/A



Iowa

Agency: Department of Elder Affairs

Phone Number: 515/281-5187

Contact Name: Beth Bahnson

Contact Phone Number: 515/281-8640

Licensure Term: Assisted Living Programs

Opening Statement: New regulations went into effect July 1, 1997.

Definition: Assisted Living Programs provide housing with services which may include but are not limited to health-related care, personal care, and assistance with instrumental activities of daily living to six or more tenants in a physical structure which provides a homelike environment. Assisted living also includes encouragement of family involvement, tenant self-direction, and tenant participation in decisions that emphasize choice, dignity, privacy, individuality, shared risk, and independence.

Facility Scope of Care: Facilities may provide assistance with acitivities of daily living and instrumental activities of daily living, but may not provide personal care or health-related care.

Medication Management: Residents are permitted to self-administer medications. The regulations defer to the Iowa Nurse Practice Act which allows nurses to delegate medication administration to unlicensed staff (intravenous or intramuscular injections are exempted). Medication reminder boxes are permitted in resident rooms.

Physical Plant Requirements: Private resident units must be a minimum of 120 square feet and double occupancy resident units must be a minimum of 290 square feet.

Residents Allowed Per Room: A maximum of two residents is allowed per resident unit.

Bathroom Requirements: Not specified.

- Alzheimer's Unit Requirements:** A facility must be designed to meet the needs of residents with Alzheimer's disease.
- Staffing Requirements:** A qualified manager must be employed by the facility and sufficient trained staff must be available at all times to fully meet residents' identified needs.
- Administrator Education Training:** The manager must be at least 21 years of age.
- Staff Education/Training:** All personnel must be able to implement the programs' accident, fire safety, and emergency procedures.
- Continuuuing Education (CE) Requirements:** N/A
- Entity Approving CE Program:** N/A



Kansas

- Agency:** Department of Health and Environment
- Phone Number:** 913/296-1240
- Contact Name:** Pat Maben
- Contact Phone Number:** 913/296-1246
- Licensure Term:** Assisted Living Facilities/Residential Health Care Facilities
- Opening Statement:** Regulations for Adult Care Homes, in which Assisted Living Facilities are a subset, went into effect in February 1997. Revisions addressing medication management are expected to go into effect in 1999.
- Definition:** An Assisted Living Facility is a place caring for six or more individuals who may need personal care and/or supervised nursing care to compensate for activities of daily living limitations.
- Facility Scope of Care:** Direct care staff may provide assistance with activities of daily living. Skilled nursing services are not prohibited but must be limited, intermittent, or routine but limited in scope. Wellness and health monitoring is required.
- Medication Management:** Until revisions to the medication management section of the regulations go into effect sometime in 1999, facilities must choose either to manage their residents' medication or to allow all residents to engage in the self-administration of medication.
- Physical Plant Requirements:** Facilities consist of apartments which meet minimum dimensions as specified in the Uniform Building Code, section 1204. The apartments must contain a living area, storage area, full bath, kitchen, and lockable door. If the facility is a designated residential health care facility, the living area is not required to have a kitchen.
- Residents Allowed Per Room:** Not specified.
- Bathroom Requirements:** Not specified.

Alzheimer's Unit Requirements: In facilities that admit residents with dementia, inservice education on treatment of behavioral symptoms must be provided.

Staffing Requirements: A full-time operator (not required to be a licensed administrator) must be employed by the facility and sufficient numbers of qualified personnel are required to ensure that residents receive services and care in accordance with negotiated service agreements.

Administrator Education Training: Operators must be 21 years of age, possess a high school diploma or equivalent, and hold a Kansas license as an adult care home administrator or engage in an operator training program.

Staff Education/Training: Orientation is required for all new employees and regular in-service education regarding the principles of assisted living is required for all employees. Disaster and emergency preparedness training is required for all staff.

Continuuing Education (CE) Requirements: N/A

Entity Approving CE Program: N/A



Kentucky

Agency: Cabinet for Health Services, Division of Licensing and Regulation

Phone Number: 502/564-2888

Contact Name: Tim Veno

Contact Phone Number: 502/564-2888

Licensure Term: Assisted Living Residences

Opening Statement: Kentucky does not mandate licensure or certification of Assisted Living Residences at this time, however facilities may apply for voluntary certification through the Office of the Inspector General.

Definition: Assisted Living Residences are apartments or home-style housing unit residences which provide assisted living to two or more adults.

Facility Scope of Care: A supportive service package is required and may include assistance with: eating; dressing; bathing; transferring; toileting; a congregate meal site; barber and beauty services; sundries for personal consumption; and supervision of self-administration of medications.

Medication Management: Medication administration is not permitted.

Physical Plant Requirements: Single-occupancy apartment units must be provided unless the unit is shared with a spouse or other individual by mutual agreement. Resident units must include a private bath with lavatory, toilet, bathtub or shower and kitchenette. Units must also have lockable doors.

Residents Allowed Per Room: Not specified.

- Bathroom Requirements:** A maximum of two resident units may share one bathroom.
- Alzheimer's Unit Requirements:** Not specified.
- Staffing Requirements:** Not specified at this time.
- Administrator Education Training:** Not specified at this time.
- Staff Education/Training:** Not specified at this time.
- Continuuing Education (CE) Requirements:** Not specified at this time.
- Entity Approving CE Program:** N/A



Louisiana

- Agency:** Department of Social Services Licensing Bureau
- Phone Number:** 504/922-0015
- Contact Name:** Thalia Millican
- Contact Phone Number:** 504/922-0015
- Licensure Term:** Adult Residential Care Facilities
- Opening Statement:** New regulations for adult residential care homes have been proposed and are expected to be effective by early 1999.
- Definition:** Adult Residential Care Facilities are publicly or privately operated residences that provide personal assistance, lodging, and meals for compensation to two or more adults who are unrelated to the residence licensee, owner, or director.
- Facility Scope of Care:** Facilities may provide personal assistance with activities of daily living and supervision of self-administered medication.
- Medication Management:** Staff may supervise the self-administration of prescription and non-prescription medication. This assistance shall be limited to reminders, cuing, opening containers, and pouring medication. Residents may contract with an outside source for medication administration; however, facilities may not contract for this service.
- Physical Plant Requirements:** Private resident units must be a minimum of 80 square feet and multiple-occupancy resident units must provide a minimum of 60 square feet per resident.
- Residents Allowed Per Room:** A maximum of two residents is allowed per resident unit.
- Bathroom Requirements:** Common toilets, lavatories, and bathing facilities are permitted. Facilities must provide public restrooms of sufficient number and location to serve residents and visitors.
- Alzheimer's Unit Requirements:** If a facility accepts residents with dementia or other residents at risk of wandering, an enclosed area shall be provided adjacent to the facility so that the residents may go outside safely.

Staffing Requirements: Facilities must be staffed to properly safeguard the health, safety, and welfare of the residents. At a minimum, a director, designated recreational/activity staff person, and a direct care staff person are required, however, one person may occupy more than one position.

Administrator Education Training: Administrators must be at least 21 years of age.

Staff Education/Training: Direct-care workers must participate in in-service training each year in areas relating to: the facility's policies and procedures; emergency and evacuation procedures; residents' rights; procedures and legal requirements concerning the reporting of abuse and critical incidents; resident care services; infection control; and any specialized training to meet residents' needs.

Continuuuing Education (CE) Requirements: Administrators must complete 12 hours of continuing education per year in areas related to the field of geriatrics, assisted living concepts, specialized training in the population served and/or supervisory/management techniques.

Entity Approving CE Program: N/A



Maine

Agency: Department of Human Services, Bureau of Medical Services, Division of Residential Care

Phone Number: 207/624-5250

Contact Name: Bob Steinberg

Contact Phone Number: 207/624-5250

Licensure Term: Assisted Living Facilities/Residential Care Facilities

Opening Statement: Legislation was passed in 1996 to create a new licensure category for "assisted living." New regulations for assisted living facilities, replacing both Boarding and Adult Foster Homes, became effective May 29, 1998.

Definition: A Residential Care Facility I (6 or fewer residents) or Residential Care Facility II (7 or more residents) may provide Assisted Living Services, including housing and assistance with activities of daily living and instrumental activities of daily living.

Facility Scope of Care: Assisted living services may include, but are not limited to, personal supervision; protection from environmental hazards; assistance with activities of daily living and instrumental activities of daily living; administration of medications; and nursing services.

Medication Management: Administration of medication is permitted and includes reading labels for residents; observing residents taking their medications; checking dosage; removing the prescribed dosage; and the maintenance of a medication record for each resident. Injections may only be administered by licensed staff.

Physical Plant Requirements: Facilities must be designed to meet the special needs of the population served. Private resident units must be a minimum of 100 square feet and shared resident units must provide a minimum of 80 square feet per resident.

Residents Allowed Per Room: A maximum of two residents is allowed per resident unit.

Bathroom Requirements: Shared bathrooms are permitted at a ratio of at least one toilet per six users. Shared bathing facilities are also permitted at a ratio of one bathing facility per every 15 users.

Alzheimer's Unit Requirements: All facilities with Alzheimer's/Dementia Care Units must offer special weekly activities such as gross motor, self-care, social, outdoor, spiritual, and sensory enhancement activities. The regulations require specific physical plant design for Alzheimer's units. If the facility has an Alzheimer's unit it is required to disclose certain information.

Staffing Requirements: An on-site administrator must be employed by the facility. Facilities with 10 or fewer beds are required to have, at a minimum, one responsible adult present at all times to perform resident care and provide supervision. Facilities with more than 10 beds are required to have at least two responsible adults at all times. The regulations also have specific staff-to-resident ratios, depending upon time of day.

Administrator Education Training: Administrators must be at least 21 years of age. While providers in level I facilities need only to have sufficient education, experience and training to meet residents' needs; level II administrators must either complete an approved training program or have a nursing home or residential facility administrator license.

Staff Education/Training: For Level II facilities, Maine requires that staff complete a six-day training course. If staff administer medications, they must complete a 24-hour medications course. Pre-service training is required for staff that work in Alzheimer's or dementia units.

Continuuuing Education (CE) Requirements: Administrators must complete 10 hours of continuing education per year in areas related to the care of the population served by the facility.

Entity Approving CE Program: N/A



Maryland

Agency: Department of Health and Mental Hygiene, Licensing and Certification Department

Phone Number: 410/764-2770

Contact Name: Yvette Dixon

Contact Phone Number: 410/764-2770

Licensure Term: Assisted Living Programs

Opening Statement: New regulations for Assisted Living Programs were drafted in July 1998 are expected to go into effect November 1998. These regulations will repeal all licensing requirements for domiciliary care homes and residential care homes.

Definition: An Assisted Living Program is a residential or facility-based program that provides housing and supportive services, supervision, personalized assistance, health-related services, or a combination thereof to meet the needs of residents who are unable to perform, or who need assistance in performing, the activities of daily living, or instrumental activities of daily living, in a way that promotes optimum dignity and independence for the residents.

Facility Scope of Care: Facilities may provide one of three levels of care: low, moderate, or high. The levels of care are defined by varying service requirements pertaining to health and wellness, assistance with functioning, assistance with medication and treatment, management of behavioral issues, management of psychological or psychiatric conditions, and social and recreational concerns. A level of care waiver, though subject to several limitations, may be granted. If a facility continues to serve a resident requiring a higher level of care than that for which the facility is licensed or requiring care above level three, a waiver may be granted.

Medication Management: Medication may be administered by staff who complete a medication administration course. Staff who cue, coach, and monitor residents who self-administer medications with or without assistance must complete training courses offered by the Department.

Physical Plant Requirements: Private rooms must provide a minimum of 80 square feet of functional space and double occupancy rooms must provide a minimum of 120 square feet per resident.

Residents Allowed Per Room: A maximum of two residents is allowed per resident unit.

Bathroom Requirements: Toilets with locks must be provided to residents. Facilities with one to eight residents shall have a minimum ratio of one toilet to every four residents. Buildings with nine or more residents shall have a minimum ratio of one toilet to every four residents. There must be a minimum of one bathtub or shower to every eight residents.

Alzheimer's Unit Requirements: Not specified.

Staffing Requirements: An assisted living manager must be on site or available on call. On-site staff must be sufficient in number and qualifications to meet the 24-hour scheduled and unscheduled needs of the residents.

Administrator Education Training: The assisted living manager must be at least 21 years of age and possess a high school diploma or equivalent.

Staff Education/Training: Staff must be at least 21 years of age (unless supervised on site at all times by another staff person who is at least 21 years of age) and must have the ability to provide the services listed for each level of care.

Continuuuing Education (CE) Requirements: N/A

Entity Approving CE Program: N/A



Massachusetts

Agency: Executive Office of Elder Affairs

Phone Number: 617/727-7750

Contact Name: Naren Dhamodharan

Contact Phone Number: 617/222-7465

Licensure Term: Assisted Living Residences

Opening Statement: Regulations went into effect in January 1996.

Definition: An Assisted Living Residence is any entity that provides room and board and provides or arranges for personal care services and activities of daily living for three or more adults.

Facility Scope of Care: The facility shall provide for the supervision of and assistance with activities of daily living and instrumental activities of daily living.

Medication Management: Self-administration of medication is permitted.

Physical Plant Requirements: Facilities must provide either single- or double-occupancy resident units with lockable doors and either a kitchenette or access to cooking facilities. Units constructed after 1995 must also provide a private bathroom equipped with one lavatory, one toilet, and one bathtub or shower stall.

Residents Allowed Per Room: A maximum of two residents is allowed per resident unit.

Bathroom Requirements: For facilities constructed after 1995, each living unit must provide a private bathroom equipped with one lavatory, one toilet, and one bathtub/shower. All other residences must provide a private half-bathroom for each living unit equipped with one lavatory and one toilet, and at least one bathing facility for every three residents.

Alzheimer's Unit Requirements: Not specified.

Staffing Requirements: The facility must have a manager and service plan coordinator on staff. A staff person must be on the premises 24 hours a day.

Administrator Education Training: The manager of a facility must be at least 21 years of age, hold a bachelors degree or have equivalent experience in human services, housing, or nursing home management, and have administrative experience and supervisory and management skills.

Staff Education/Training: Personal care staff must be licensed nurses, CNAs, certified home health aides, or qualified personal care homemakers or complete a 54-hour training course. The service coordinator must have at least two years' experience working with the elderly or disabled and must hold a bachelors degree or have equivalent experience and knowledge of aging and disability issues. All staff who have direct contact with residents must receive a six-hour orientation.

Continuuing Education (CE) Requirements: All staff must complete at least six hours of continuing education per year.

Entity Approving CE Program: N/A



Michigan

Agency: Department of Consumer and Industry Services

Phone Number: 517/373-8562

Contact Name: Walt Wheeler

Contact Phone Number: 517/241-2632

Licensure Term: Homes for the Aged

Opening Statement: There have been no changes to the regulations since 1994. Assisted living task force meetings were held from September 1997 to June 1998, during which the Department planned to formulate recommendations on unlicensed and unregulated assisted living facilities. A final report of recommendations is due Fall 1998.

Definition: A Home for the Aged is a supervised personal care facility, other than a hotel, adult foster care facility, hospital, nursing home, or county medical care facility, that provides room, board, and supervised personal care to 21 or more unrelated, nontransient individuals who are 60 years of age or older.

Facility Scope of Care: Facilities may provide assistance with activities of daily living.

Medication Management: If the facility decides to administer medication, it must have a safe and sound medication administration system to protect residents from accidents or injuries from improper, inappropriate, or unsafe medication administration. Only licensed personnel can accept verbal medication orders from physicians. Licensed nurses may administer injectible medication and registered nurses may delegate nursing function (e.g., insulin injections) to unlicensed personnel. Trained, unlicensed personnel may also assist residents who self-administer medication.

Physical Plant Requirements: Private resident units must be a minimum of 80 square feet for existing buildings and 100 square feet for new construction. Multiple-occupancy resident units must provide a minimum of 70 square feet per resident for existing buildings and 80 square feet per resident for new construction.

Residents Allowed Per Room: A maximum of two residents is allowed per resident unit.

Bathroom Requirements: There must be one toilet for every eight residents per floor, and one bathing facility for every 15 residents.

Alzheimer's Unit Requirements: Specialized programs of care, such as Alzheimer's units require a special program, environment, and staffing to meet the needs of these residents.

Staffing Requirements: Facilities must have an administrator and one awake supervisor of resident care on duty at all times, and a sufficient number of attendant personnel to meet the personal care needs of the residents.

Administrator Education Training: Administrators must be competent and at least 21 years of age.

Staff Education/Training: All staff in supervisory positions must be at least 21 years of age. All staff must go through training to learn how to work with the population for which they are caring.

Continuing Education (CE) Requirements: N/A

Entity Approving CE Program: N/A



Minnesota

Agency: Department of Health

Phone Number: 651/643-2156

Contact Name: Maggie Friend

Contact Phone Number: 651/643-3615

Licensure Term: Housing with Services Establishments

Opening Statement: In 1995 the legislature separated housing from services, requiring a facility to obtain a home care license in order to provide health-related services (e.g. medication administration). Minnesota then created a registration category called Housing with Services Establishments that applies to facilities that provide sleeping accommodations to residents ages 55 or older and one or more health-related services or two or more supportive services. Minnesota has a number of home health licensure categories, two of which are appropriate for the Housing with Services Establishments setting. A third category, "Assisted Living Home Care Provider," is most appropriate for this setting.

Definition: Housing with Services Establishments provide sleeping accommodations to one or more adult residents, at least 80 percent of whom are 55 years of age or older. These facilities offer or provide, for a fee, one or more regularly scheduled health-related services or two or more regularly scheduled supportive services.

Facility Scope of Care: The facility may only provide housing, food, activities and transportation to non-medical appointments.

Medication Management: Home care licensure laws must be referenced.

Physical Plant Requirements: Facilities must comply with local building codes. There are no specific square footage requirements specified in the regulations.

Residents Allowed Per Room: Not specified.

Bathroom Requirements: Not specified

Alzheimer's Unit Requirements: Not specified.

Staffing Requirements: Not specified.

Administrator Education Training: Not specified.

Staff Education/Training: Not specified.

Continuuuing Education (CE) Requirements:

N/A

Entity Approving CE Program: N/A



Mississippi

Agency: Department of Health, Health Facilities Licensure and Certification Division

Phone Number: 601/354-7300

Contact Name: Dale Carr

Contact Phone Number: 601/354-7300

Licensure Term: Personal Care Homes

Opening Statement: A committee will begin to draft revisions to these regulations in 1999.

Definition: Personal Care Homes are homes or institutions that give personal care to aged or infirm, ambulant residents who are not in need of nursing care.

Facility Scope of Care: Facilities may provide assistance with activities of daily living that may extend beyond providing shelter, food, and laundry. Assistance may include, but is not limited to: bathing, walking, toileting, feeding, personal grooming, dressing, and financial management.

Medication Management: Facilities may provide assistance with the self-administration of medication.

Physical Plant Requirements: Private and shared resident units must provide a minimum of 80 square feet per resident.

Residents Allowed Per Room: A maximum of four residents is allowed per resident unit.

Bathroom Requirements: Separate toilet and bathing facilities shall be provided on each floor for each sex in the following ratios as a minimum: one bathtub/shower for every 12 or fewer residents; and one lavatory and one toilet for every 6 or fewer residents.

Alzheimer's Unit Requirements: Facilities are only permitted to house persons with up to stage II Alzheimer's disease.

Staffing Requirements: A full-time operator must be designated to manage the facility. Another staff person with the same qualifications as the operator must be present to represent the operator in his/her absence. There must be one attendant per 10 residents from 7:00 a.m. to 6:00 p.m. and sufficient staff on hand to meet the personal care needs of residents at all other times.

Administrator Education Training: Operators must be at least 21 years of age and must be able to read and write.

Staff Education/Training: Not specified.

Continuuing Education (CE) Requirements: N/A

Entity Approving CE Program: N/A



Missouri

Agency: Department of Social Services

Phone Number: 573/751-3082

Contact Name: Gary Thompson

Contact Phone Number: 573/526-8554

Licensure Term: Residential Care Facilities

Opening Statement: The regulations have not been revised since 1996.

Definition: Residential Care Facilities I and II provide three or more residents with shelter, board, protective oversight. In addition to these, level II facilities provide supervision and assistance with personal care.

Facility Scope of Care: Residential Care Facilities I and II may provide shelter, board, protective oversight, and care during short-term illness or recuperation. Residential Care Facilities II may provide additional services such as dietary supervision, personal care assistance, and supervision of health care under the direction of a licensed physician.

Medication Management: Administration of medication by licensed or certified personnel is permitted.

Physical Plant Requirements: Private and shared resident units must provide a minimum of 70 square feet per resident.

Residents Allowed Per Room: A maximum of four residents is allowed per resident unit.

Bathroom Requirements: Shared bathrooms are permitted. One tub or shower shall be provided for every 20 residents and one toilet and lavatory shall be provided for every six residents.

Alzheimer's Unit Requirements: Not specified.

Staffing Requirements: An administrator must be employed by the facility and one staff member must be on duty at all times. At a minimum, one employee shall be on duty for every 40 residents.

Administrator Education Training: The administrator of a level II facility must be a licensed nursing home administrator. In a level I facility, the administrator must either be a licensed nursing home administrator or attend at least one continuing education workshop per year. All administrators must complete a course in medication administration.

Staff Education/Training: Staff who administer medication must be certified as a level I Medication Aide, which requires the completion of a 16-hour approved course.

Continuuuing Education (CE) Requirements: N/A

Entity Approving CE Program: N/A



Montana

Agency: Department of Public Health and Human Services, Quality Assurance Division

Phone Number: 406/444-2868

Contact Name: Bonnie Brown

Contact Phone Number: 406/444-2676

Licensure Term: Personal Care Facilities

Opening Statement: The regulations were last updated in June 1995.

Definition: A Personal Care Facility is a home or institution that is licensed to provide personal care to either six or more residents (category A) or fewer than six residents (category B). A limited provision of skilled nursing services is allowed in category A facilities while full services are allowed in category B facilities.

Facility Scope of Care: Category A facilities must provide assistance with activities of daily living and skilled nursing care by contract with a third-party provider. Category B facilities may provide skilled nursing care and assistance with activities of daily living.

Medication Management: Residents who self-medicate must be supervised by facility staff.

Physical Plant Requirements: Private resident units must be a minimum of 100 square feet and shared units must provide a minimum of 80 square feet per resident.

Residents Allowed Per Room: A maximum of four residents is allowed per resident unit.

Bathroom Requirements: Common toilet, bathing and lavatory facilities are permitted. In addition, each resident must have access to a toilet room without entering another resident's room or the kitchen, dining or living areas.

Alzheimer's Unit Requirements: Not specified.

Staffing Requirements: An administrator must be employed by the facility and at least one staff member must be present on a 24-hour basis. Adequate staff must be present to meet the needs of the residents.

Administrator Education Training: Administrators must have a high school diploma or GED.

Staff Education/Training: Owners of facilities must make sure that uncertified aides receive proper on-the-job orientation and training.

Continuing Education (CE) Requirements: Administrators must complete at least six hours of continuing education per year. If aides are certified, they must receive 15 hours of continuing education per year.

Entity Approving CE Program: N/A



Nebraska

Agency: Department of Health and Human Services, Division of Regulations and Licensure

Phone Number: 402/471-2946

Contact Name: Claire Titus

Contact Phone Number: 402/471-4963

Licensure Term: Assisted Living Facilities

Opening Statement: Regulations were revised in June 1998.

Definition: Assisted Living Facilities provide to four or more unrelated individuals, 24-hour consecutive accommodation, board, and an array of services for assistance with or provision of personal care, activities of daily living, health maintenance activities, or other supportive services.

Facility Scope of Care: The facility may provide personal care, health maintenance activities (i.e., non-complex nursing interventions which can safely be performed according to exact directions), transportation, laundry, housekeeping, financial assistance/management, behavioral management, case management, shopping, beauty/barber and spiritual services.

Medication Management: Residents may self-administer medications. When medication administration is provided by the facility, it must be administered by licensed staff or medication assistants approved by the department.

Physical Plant Requirements: In existing facilities, private resident units must be a minimum of 80 square feet and double-occupancy units must provide a minimum of 60 square feet per resident. In new facilities, private resident units must be a minimum of 80 square feet and double-occupancy units must be a minimum of 160 square feet.

Residents Allowed Per Room: In existing facilities, a maximum of four residents is allowed per resident unit. In new facilities, a maximum of two residents is allowed per resident unit.

Bathroom Requirements: Facilities must provide a bathing facility adjacent to each room or central bathing facilities. In existing facilities, at least one bathing facility must be provided for every 16 residents. In new facilities, one bathing facility must be provided for every eight residents.

Alzheimer's Unit Requirements: Facilities serving special populations must assess each resident to identify his/her abilities and needs, provide specially trained staff, prepare service agreements and provide a physical environment that conforms to and accommodates the special needs.

Staffing Requirements: The facility shall have an administrator who is responsible for the overall management of the facility and who shall ensure staffing appropriate to meet the needs of the residents.

Administrator Education Training: Not specified.

Staff Education/Training: Direct-care staff must complete an initial orientation and ongoing training.

Continuuing Education (CE) Requirements: All staff must complete at least 12 hours of continuing education per year on topics appropriate to the employee's job duties, including meeting the physical and mental special care needs of residents in the facility.

Entity Approving CE Program: N/A



Nevada

Agency: Division of Health, Bureau of Licensure and Certification

Phone Number: 702/687-4475

Contact Name: Sharon Devers

Contact Phone Number: 702/486-6515

Licensure Term: Residential Facilities for Groups

Opening Statement: New regulations for residential facilities for groups became effective January 1998. The regulations establish care categories I and II. Care category I residents are ambulatory and can evacuate with minimal assistance in the event of a fire. Only one wheelchair-bound resident is permitted in unsprinklered facilities in this category. Care category II residents are physically or mentally incapable of evacuation and require the assistance of another person.

Definition: A Residential Facility for Groups is operated 24 hours per day and houses on a 24-hour basis one or more persons who receive care, treatment, and/or services.

Facility Scope of Care: Facilities must provide residents with assistance with activities of daily living and protective supervision. Facilities must also provide medical or personal care, including preparation of food, laundry, and housekeeping.

Medication Management: Direct care staff may administer medication (however, no injections are allowed) upon the completion of an approved training program and passing of an exam.

Physical Plant Requirements: Private resident units must be a minimum of 80 square feet and shared resident units must provide a minimum of 60 square feet of floor space per resident.

Residents Allowed Per Room: A maximum of three residents is allowed per resident unit.

Bathroom Requirements: A toilet and lavatory must be provided for every four residents and a tub or shower must be provided for every six residents.

Alzheimer's Unit Requirements: Eight hours of training is required for staff supervising residents with Alzheimer's. Locked quarters are allowed in Alzheimer's units.

Staffing Requirements: An administrator and a sufficient number of caregivers must be employed by the facility. Facilities with more than 20 residents shall ensure that at least one employee is awake and on duty at all times.

Administrator Education Training: Administrators must be licensed by the Nevada state board of examiners for administrators of facilities for long term care.

Staff Education/Training: Caregivers must be at least 18 years of age; have personal qualities enabling them to understand the problems of the aged and disabled; be able to read, write, speak, and understand English; and possess knowledge, skills, and abilities to meet residents' needs.

Continuing Education (CE) Requirements: All staff must complete eight hours of continuing education per year. Training must be related to the care of the elderly and, depending upon the facility's population, related to specific populations (e.g., dementia-related training for those who supervise persons with Alzheimer's disease).

Entity Approving CE Program: Bureau of Licensure and Certification



New Hampshire

Agency: Division of Public Health, Bureau of Health Facilities Administration

Phone Number: 603/271-4592

Contact Name: Terry Jarvis

Contact Phone Number: 603/271-4607

Licensure Term: Residential Care Home Facilities

Opening Statement: Revisions to these regulations are being proposed for 1999.

Definition: Residential Care Home Facilities are non-medical and non-institutional, public or privately owned and operated, community-based living arrangements providing shelter, food, and protective oversight to a population of adult, elderly, disabled, special needs, and/or special care residents.

Facility Scope of Care: Facilities may provide protective services including supervision of activities of daily living, nutrition, and medication.

Medication Management: Residents must be able to self-administer medications; however, staff may supervise.

Physical Plant Requirements: Private resident units must be a minimum of 80 square feet and shared resident units must be a minimum of 140 square feet.

Residents Allowed Per Room: A maximum of two residents is allowed per resident unit.

Bathroom Requirements: The number of sinks, toilets, tubs/showers shall be in ratio of one to every six residents

Alzheimer's Unit Requirements: Not specified.

Staffing Requirements: All facilities must employ a full-time administrator who shall be responsible for its day-to-day operation. Personnel levels are determined by the administrator based on the services required by residents and the size of the facility (e.g., at least one staff member must be on duty at all times when there are more than four residents in the facility).

Administrator Education Training: Administrators must be at least 21 years of age and have three letters of reference attesting to their knowledge, skills, and ability to run a facility. Administrators of facilities with four to 16 residents must additionally have a high school diploma or equivalent plus one year of work experience in a health or human services field, or an associates degree in a health field. Administrators of facilities with 17 or more residents must additionally have a high school diploma plus five years of direct care experience, an associates degree plus three years experience in a health or human services field, or a bachelor's degree in a health field.

Staff Education/Training: Direct-care staff must be at least 18 years of age. All personnel must have orientation and training in the performance of their duties and responsibilities.

Continuuuing Education (CE) Requirements: Administrators must complete a minimum of 12 hours of continuing education per year relating to resident plan of care; characteristics of client disabilities; nutrition, basic hygiene, and dental care; first aid; medication managment; dementia; resident assessment; aging; and resident rights.

Entity Approving CE Program: N/A



New Jersey

Agency: Department of Health, Division of Long Term Care Systems, Development and Quality

Phone Number: 609/633-9060

Contact Name: Chris Temple/Pat Carter

Contact Phone Number: 609/984-8171

Licensure Term: Assisted Living Residences/Comprehensive Personal Care Homes

Opening Statement: New regulations are expected to be published in October 1998. No major revisions are anticipated.

Definition: An Assisted Living Residence provides apartment-style housing and congregate dining and assures that assisted living services are available when needed, for four or more adult persons. There are three categories of assisted living: Assisted Living Residences (new construction), comprehensive personal care homes (converted/residential boarding home which may not meet all building code requirements), and assisted living programs (services provided).

Facility Scope of Care: Facilities provide a coordinated array of supportive personal and health services 24 hours per day, including assistance with personal care, nursing, pharmacy, dining, activities, recreational, and social work services to meet the individual needs of each resident.

Medication Management: Staff who have completed a medication aid course and passed a certifying exam are permitted to administer medication to residents under the delegation of an RN. The only injections allowed in this case are predrawn insulin injections.

Physical Plant Requirements: Private resident units must provide a minimum of 150 square feet of clear and useable floor area and semi-private resident units must provide a minimum of 80 square feet of clear floor area per resident.

Residents Allowed Per Room: A maximum of two residents is allowed per resident unit.

Bathroom Requirements: Bathrooms may be shared but a bathroom with a toilet, bathtub/shower, and sink must be located in each resident unit. Additional toilet facilities shall be provided to meet the needs of residents, staff, and visitors to the facility.

Alzheimer's Unit Requirements: Not specified.

Staffing Requirements: Staffing must be sufficient to meet residents' needs. At least one awake personal care assistant and one additional employee must be on site 24 hours per day. An RN must be available 24 hours per day.

Administrator Education Training: Administrators must be at least 18 years of age and possess a high school diploma or equivalent. Administrators must also either hold a current New Jersey license as a nursing home administrator, be eligible to take the exam to become a licensed nursing home administrator, or complete an approved training course.

Staff Education/Training: Personal care assistants must either successfully complete an approved nurse aide training course, an approved homemaker/home health aide training program, or other equivalent approved training program.

Continuing Education (CE) Requirements: Administrators must complete a minimum of 10 hours of continuing education per year relating to assisted living concepts and related topics.

Entity Approving CE Program: The New Jersey Nursing Home Administrators Licensing Board approves courses.



New Mexico

Agency: Department of Health, Health Facilities Licensing and Certification Bureau

Phone Number: 505/827-4200

Contact Name: Roy Weidner

Contact Phone Number: 505/827-4200

Licensure Term: Adult Residential Care Facilities

Opening Statement: Regulations were updated in April 1997.

Definition: An Adult Residential Care Facility provides programmatic services, room, board, assistance with one or more activities of daily living, and/or general supervision to two or more adults who have difficulty living independently or managing their own affairs.

Facility Scope of Care: The facility may provide assistance with activities of daily living and periodic professional nursing care for adults with physical or mental disabilities.

Medication Management: Licensed health care professionals are responsible for the administration of medications. If a resident gives written consent, trained facility staff may assist a resident with medications.

Physical Plant Requirements: Private resident units must be a minimum of 100 square feet and semi-private resident units must provide a minimum of 80 square feet of floor space per resident.

Residents Allowed Per Room: A maximum of two residents is allowed per resident unit.

Bathroom Requirements: A minimum of one toilet, sink, and bathing unit must be provided for every eight residents.

Alzheimer's Unit Requirements: Not specified. However, in the facility's program description and outline of services, it must be specified that it provides care that meets the needs of the residents.

Staffing Requirements: The minimum staff-to-resident ratio is one staff person to 15 or fewer awake residents. When residents are sleeping, there shall be one staff person to every 16-60 residents; two staff persons to every 61-120 residents; and three staff persons to every 120 or more residents.

Administrator Education Training: Administrators must be at least 21 years of age, possess management and administrative skills, and have a high school diploma or equivalent.

Staff Education/Training: Direct-care staff must be at least 18 years of age and have adequate education, training, or experience to provide for the needs of the residents. Staff are required to complete on-going training programs relating to fire safety; first aid; safe food handling practices; confidentiality of records and resident information; infection control; resident rights; reporting requirements for abuse and neglect exploitation; and providing quality resident care based on current resident needs.

Continuuing Education (CE) Requirements: N/A

Entity Approving CE Program: N/A



New York

Agency: Department of Health

Phone Number: 518/432-2968

Contact Name: Robert Kellenher

Contact Phone Number: 518/432-2968

Licensure Term: Assisted Living Programs

Opening Statement: A complete review of the multiple regulations and categories is underway in New York.

Definition: Assisted Living Programs use existing licensure categories. In order to receive state payment under the assisted living program, a provider must be licensed as an adult home or enriched housing program and be licensed as or contract with a certified home health care agency or a long term home health care program. For the purposes of this summary, the definitions of these categories are as follows: 1) Assisted Living Programs combine residential and home care services. They are designed as an alternative to nursing home placement for individuals who have historically been admitted to nursing homes for social rather than medical reasons. Programs must provide or arrange for resident services, including room, board, housekeeping, supervision, personal care, case management and home health services. 2) Enriched Housing Programs provide long term residential care to five or more adults (mostly age 65 years of age or older), in community integrated settings resembling independent housing units and must provide or arrange for room, board, housekeeping, personal care, and supervision. 3) Adult Care Homes provide long term residential care, room, board, housekeeping, personal care, and supervision to five or more adults.

Facility Scope of Care: Adult Care Homes and Enriched Housing Programs can provide supervision, personal care, housekeeping, case management, activities, food service, and assistance with medication.

Medication Management: Assistance with self-administration of medication is permitted in facilities. This includes prompting, identifying the medication for the resident, bringing the medication to the resident, opening containers, positioning the resident, and disposing of used supplies.

Physical Plant Requirements: Assisted Living Programs must comply with the relevant requirements under which the contracting facility is licensed. Enriched Housing Programs must provide single occupancy units, unless residents want to share. Adult Care Homes may provide either single- or double-occupancy resident units.

Residents Allowed Per Room: A maximum of two residents is allowed per resident unit.

Bathroom Requirements: Enriched Housing Programs must provide a toilet, lavatory, shower, or tub for every three residents. Adult Care Homes must provide one toilet and lavatory for every six residents and one tub/shower for every 10 residents.

Alzheimer's Unit Requirements: Not specified.

Staffing Requirements: Adult Care Homes must have a case manager and have staffing that is sufficient to provide the care needed by residents. The regulations list specific staffing ratios (e.g., one staff person for one to 40 residents during the day, evening, and night).

Administrator Education Training: Administrators generally must be at least 21 years of age, have a master's degree in social work and one year experience, or a bachelor's degree and three years of acceptable experience. Requirements for administrators varies further based on the number of residents in the facility.

Staff Education/Training: Personal care staff of a home health agency must complete a personal care aide or home health aide training course or other approved examination. Enriched housing programs and Adult Care Homes must provide an orientation and in-service training in the characteristics and needs of the population served, resident rights, program rules and regulations, duties and responsibilities of all staff, general and specific responsibilities of the individual being trained, and emergency procedures.

Continuing Education (CE) Requirements: Administrators not holding a current New York license as a nursing home administrator must complete a minimum of 60 hours of continuing education every two years.

Entity Approving CE Program: N/A



North Carolina

Agency: Department of Human Resources, Facilities Services

Phone Number: 919/733-6650

Contact Name: Doug Barrick/Betty Callahan

Contact Phone Number: 919/733-6650

Licensure Term: Assisted Living Residences

Opening Statement: Legislation passed in July 1995 that established an umbrella term of "assisted living" which includes "adult care homes" and "Multi-Unit Assisted Housing with Services" (MAHS).

Definition: Assisted Living Residences provide group housing with at least one meal per day and housekeeping. Personal care services are provided by agreement with a licensed home care or hospice agency. There are two types of assisted living residences: MAHS and Adult Care Homes. Adult Care Homes are further categorized as Family Care (housing two to six residents), Group Homes for Developmentally Disabled Adults (housing two to nine developmentally disabled adult residents, or Homes for the Aged (housing seven or more residents). This summary briefly discusses the differences between the two types of Assisted Living Residences.

Facility Scope of Care: In a MAHS, housing and assistance with coordination of personal and health care services through licensed home care agencies is permitted. In Adult Care Homes, housing, personal care, and health care services may be provided by staff or through licensed home care agencies. Adult Care Homes also have a provision for 24-hour staff monitoring and supervision of residents.

Medication Management: In a MAHS, assistance with self-administration of medications may be provided by appropriately trained staff when delegated by a licensed nurse. Adult Care Homes require that medications be administered by designated, trained staff.

Physical Plant Requirements: In Adult Care Homes, private resident units must be a minimum of 100 square feet and shared resident units must provide a minimum of 80 square feet per resident.

Residents Allowed Per Room: In Adult Care Homes, a maximum of four residents is allowed per resident unit.

Bathroom Requirements: Shared bathroom and toilet facilities are permitted in Adult Care Homes as long as one toilet and hand lavatory is provided for every five residents and a tub or shower is provided for every 10 residents.

Alzheimer's Unit Requirements: Not specified.

Staffing Requirements: Staffing requirements in Adult Care Homes vary depending upon the numbers of residents (e.g., facilities with 12 or fewer residents must ensure that an administrator or supervisor-in-charge is in the facility or within 500 feet of the facility and immediately available).

Administrator Education Training: Administrators must complete an approved on the job training program or have appropriate education, training, and experience.

Staff Education/Training: Staff in Adult Care Homes who perform or directly supervise staff who perform personal care tasks must complete either a 40-hour or 75-hour training program, depending upon the level of care tasks for which they are responsible.

Continuuig Education (CE) Requirements: All administrators must complete 15 hours of continuing education per year and supervisors in charge must complete 12 hours of continuing education per year.

Entity Approving CE Program: There is an internal approval system for adult care facilities with an application process.



North Dakota

Agency: Department of Health, Division of Health Facilities

Phone Number: 701/328-2352

Contact Name: Darlene Bartz

Contact Phone Number: 701/328-2352

Licensure Term: Basic Care Facilities

Opening Statement: North Dakota is conducting pilot projects with the intent of reforming current policy. Because the legislature meets bianually, changes to the regulations are not expected to become effective until 2001.

Definition: A Basic Care Facility provides room and board to five or more individuals who, because of impaired capacity for independent living, require health, social, or personal care services, but do not require regular 24-hour medical or nursing services.

Facility Scope of Care: The facility may provide assistance with activities of daily living, defined as prompting, encouragement, or minimal hands-on assistance. It shall provide personal care services to assist residents to attain and maintain their highest level of functioning consistent with the resident assessments and care plans.

Medication Management: Unlicensed staff may administer medication except for "as needed" controlled prescription drugs. In Spring 1997, a medication administration bill was passed allowing for the administration of limited medications by unlicensed personnel. This provision requires training and monitoring for those personnel where care is provided by the supervision of a RN.

Physical Plant Requirements: Private resident units must be a minimum of 100 square feet; semi-private resident units must provide a minimum of 80 square feet per resident; and multiple-occupancy resident units must provide a minimum of 70 square feet per resident.

- Residents Allowed Per Room:** A maximum of four residents is allowed per resident unit.
- Bathroom Requirements:** Common toilets, lavatories, and bathing facilities are permitted.
- Alzheimer's Unit Requirements:** Not specified.
- Staffing Requirements:** A full-time administrator, personal care aides, activities director, and social services employee must be on staff.
- Administrator Education Training:** Administrators must have a bachelor's degree and a nursing home administrator license or high school diploma and three years of experience in the health or human services field.
- Staff Education/Training:** Personal care aides must have in-service training.
- Continuing Education (CE) Requirements:** Administrators must complete at least 12 hours of continuing education per year relating to care and services for residents.
- Entity Approving CE Program:** N/A



Ohio

- Agency:** Department of Health, Special Projects Section
- Phone Number:** 614/752-2761
- Contact Name:** Sandra Williams
- Contact Phone Number:** 614/466-7713
- Licensure Term:** Residential Care Facilities
- Opening Statement:** Residential Care Facilities (formerly known as Rest Homes) regulations were amended in June 1997.
- Definition:** Residential Care Facilities provide accommodations for 17 or more unrelated individuals, supervision and personal care services for three or more of those individuals who are dependent on the services of others by reason of age or physical or mental impairment, or accommodations for three or more individuals and skilled nursing care services for at least one individual.
- Facility Scope of Care:** Facilities provide supervision, personal care services, administer medication, supervise special diets, and perform dressing changes. Facilities may also provide up to 120 days of nursing services on a part-time, intermittent basis.
- Medication Management:** Residents must either be capable of self-administering medications or the facility must provide for medication administration by a home health agency, hospice, or qualified staff person (e.g., registered nurse, licensed practical nurse, and physician). Trained, unlicensed staff may assist with self-administration only if the resident is mentally alert and able to participate in the medication process. Assistance includes reminders, observing, handing medications to the resident, verifying the resident's name on the label, etc. An RN, LPN, or physician must be on duty when medications are being administered.

Physical Plant Requirements: Private resident units must be a minimum of 100 square feet and multiple-occupancy resident units must provide a minimum of 80 square feet per resident.

Residents Allowed Per Room: A maximum of four residents is allowed per resident unit.

Bathroom Requirements: One toilet, sink, tub/shower is required for every eight residents. Additionally, if there are more than four persons of one sex to be accommodated in one bathroom on a floor, a bathroom must be provided for each sex residing on that floor.

Alzheimer's Unit Requirements: Not specified.

Staffing Requirements: A facility must have an administrator who is responsible for its daily operation. At least one staff member must be on duty at all times and sufficient additional staff members must be present to meet the residents' total care needs. Sufficient nursing staff is required to provide needed skilled nursing care. At night, a staff member may be on call if the facility meets certain call signal requirements.

Administrator Education Training: Administrators must be 21 years of age, be licensed as a nursing home administrator, have 2000 hours of direct operational responsibility, complete 100 credit hours of post high school education in the field of gerontology or health care, be a licensed health care professional, or hold a college degree in health.

Staff Education/Training: Staff members providing personal care services must be at least 16 years of age, have first-aid training and complete a specified training program. All staff must be able to understand and communicate job-related information in English and must be appropriately trained to implement residents' rights.

Continuing Education (CE) Requirements: Administrators must complete nine hours of continuing education in gerontology, health care, business administration, or residential care administration per year.

Entity Approving CE Program: N/A



Oklahoma

Agency: Department of Health, Residential Care Division

Phone Number: 405/271-6868

Contact Name: Leslie Elliot

Contact Phone Number: 405/271-6868

Licensure Term: Assisted Living Centers

Opening Statement: Regulations for assisted living went into effect July 1, 1998 to accommodate those residential care homes that want to provide more nursing services.

Definition: An Assisted Living Center is a home or establishment offering, coordinating, or providing services to two or more persons who by choice or functional impairment, need or may need assistance with personal care or nursing supervision; intermittent or unscheduled nursing care; medication assistance; and assistance with transfer and/or ambulation.

Facility Scope of Care: Providers may define their scope of services, admission criteria and the nature of the residents they serve. Facilities may provide assistance with personal care; nursing supervision; intermittent or unscheduled nursing care; medication administration; assistance with cognitive orientation and care or service for Alzheimer's disease and related dementias; and assistance with transfer or ambulation.

Medication Management: Medication administration is permitted.

Physical Plant Requirements: Design shall be appropriate to the mental or physical disabilities of the residents served.

Residents Allowed Per Room: A maximum of two residents is allowed per resident unit.

Bathroom Requirements: Shower and bathing facilities shall not be occupied by more than one resident at a time and no more than four residents may share bath and toilet facilities.

Alzheimer's Unit Requirements: The facility must disclose whether it has special care units. If it does, it must outline the scope of services provided within the unit and specific staffing to address the needs of the population.

Staffing Requirements: Each facility shall designate an administrator responsible for its operation. Facilities shall provide adequate staffing as necessary to meet the services described in the facility's contract with each resident. Dietary and nurse staffing shall be provided or arranged.

Administrator Education Training: An administrator must either hold a nursing home administrator's license, a residential care home administrator's certificate of training, or a nationally recognized assisted living certificate of training and competency.

Staff Education/Training: All staff shall be trained to meet the specialized needs of residents. Direct care staff shall be trained in first aid and CPR.

Continuuuing Education (CE) Requirements: Administrators must complete 16 hours of continuing education per year.

Entity Approving CE Program: N/A



Oregon

Agency: Department of Human Resources, Senior and Disabled Services

Phone Number: 503/945-6411

Contact Name: Dennett Taber

Contact Phone Number: 503/945-5793

Licensure Term: Assisted Living

Opening Statement: Oregon is drafting revised Assisted Living regulations that are expected to be effective in early 1999.

Definition: Assisted Living is a program approach that provides or coordinates a range of services for the support of resident independence in a residential setting.

Facility Scope of Care: To encourage aging in place, needed services are added, increased, or adjusted to compensate for a decline in a resident's condition.

Medication Management: Medication may be administered by specially trained unlicensed personnel. In addition, Oregon applies nurse delegation rules to these regulations.

Physical Plant Requirements: Newly constructed private resident units must be a minimum of 220 square feet (not including the bathroom) and must include a kitchen. Resident units may only be shared through waivers considered on a case-by-case basis. Other extensive physical plant requirements apply.

Residents Allowed Per Room: Not specified.

Bathroom Requirements: Private bathrooms are required.

Alzheimer's Unit Requirements: A facility that advertises that it provides care to residents with Alzheimer's must apply to the state for an Alzheimer's Special Care Unit Endorsement.

Staffing Requirements: An administrator must be employed by the facility.

Administrator Education Training: The administrator is required to complete a 40-hour assisted living internship in an approved program.

Staff Education/Training: Direct-care staff must complete a training course and must demonstrate competency in provision of services and principles of assisted living.

Continuuig Education (CE) Requirements: Administrators must complete 20 hours of continuing education per year.

Entity Approving CE Program: N/A



Pennsylvania

Agency: Department of Public Welfare, Division of Personal Care Homes

Phone Number: 717/783-8391

Contact Name: Pat Post

Contact Phone Number: 717/783-8391

Licensure Term: Personal Care Homes

Opening Statement: While there is no Medicaid funding available for Personal Care Homes, Pennsylvania does provide a state supplement to Supplemental Security Income (SSI) for residents in these types of facilities. There is a movement within Pennsylvania to regulate "assisted living," and recommendations have been made to introduce some form of Medicaid funding (not a separate entitlement program) for "assisted living."

Definition: A Personal Care Home provides food, shelter, and personal assistance or supervision for four or more adults who do not need nursing home care. Residents may require assistance or supervision in matters such as dressing, bathing, diet, financial management, evacuation, and medication prescribed for self-medication.

Facility Scope of Care: The facility may provide assistance with activities of daily living and self-administered medications.

Medication Management: Personnel can offer assistance with self-administered medications.

Physical Plant Requirements: Private resident units must be a minimum of 80 square feet and multiple-occupancy resident units must provide a minimum of 60 square feet per resident.

Residents Allowed Per Room: A maximum of four residents is allowed per resident unit.

Bathroom Requirements: Shared bathing and lavatory facilities are permitted.

Alzheimer's Unit Requirements: Not specified.

Staffing Requirements: An administrator or designee must be on the premises 24 hours per day. Sufficient staff must be present to provide one hour of personal care per day, 75 percent of which should be given during waking hours, for each resident requiring personal care. At least one CPR-certified staff member must be on the premises at all times.

Administrator Education Training: An administrator must have a high school diploma or GED and have completed a 40-hour approved training course.

Staff Education/Training: Direct-care staff must complete facility training in specified areas.

Continuuuing Education (CE) Requirements: Administrators must complete six hours of continuing education through a recognized training source annually.

Entity Approving CE Program: N/A



Rhode Island

Agency: Department of Health Facilities, Regulation Division

Phone Number: 401/222-4531

Contact Name: Arthur Pullano

Contact Phone Number: 401/222-4535

Licensure Term: Residential Care and Assisted Living Facilities

Opening Statement: The regulations have not been amended since March 1996.

Definition: A Residential Care and Assisted Living Facility is a residence that provides directly or indirectly personal assistance, lodging, and meals to two or more adults who do not require medical or nursing care.

Facility Scope of Care: Facilities may provide assistance with activities of daily living, arrange for support services, and monitor residents' recreational, social, and personal activities. Residents requiring more intensive services must move to a nursing facility.

Medication Management: Facilities are further classified by the degree to which they manage medications. Level M1 licensed facilities may serve residents who require that the facility centrally store and have licensed personnel administer medications. Residents may receive assistance with the self-administration of medications in a level M2 facility.

Physical Plant Requirements: Private resident units must be a minimum of 100 square feet in area and eight feet wide and semi-private resident units must be a minimum of 160 square feet in area and 10 feet wide.

Residents Allowed Per Room: A maximum of two residents is allowed per resident unit.

Bathroom Requirements: The facility shall provide a minimum of one bath per 10 residents and one toilet per eight residents.

Alzheimer's Unit Requirements: If facilities offer to provide or provide care for residents with Alzheimer's disease or other dementia, by means of a special care unit, they must disclose the form of care or treatment provided. The information disclosed must explain the additional care that is provided in philosophy; pre-admission, admission and discharge; assessment, care planning and implementation; staffing patterns and training ratios; physical environment; and resident activities.

Staffing Requirements: Each facility shall have a certified administrator. A responsible adult must be on the premises at all times. All facilities must provide staffing which is sufficient to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well being of the residents.

Administrator Education Training: To be certified, administrators must complete a 40-hour approved training course.

Staff Education/Training: For each job specification, staff must have the appropriate orientation and training.

Continuuig Education (CE) Requirements: Administrators must complete 16 hours of continuing education per year.

Entity Approving CE Program: N/A



South Carolina

Agency: Department of Health and Environmental Control, Division of Health Licensing

Phone Number: 803/737-7236

Contact Name: Sandra Jones

Contact Phone Number: 803/737-7236

Licensure Term: Community Residential Care Facilities

Opening Statement: Regulations have been in effect since 1991. In 1996, South Carolina began to study assisted living and continues to do so.

Definition: A Community Residential Care Facility offers room and board and a degree of personal assistance for a period of time in excess of 24 consecutive hours for two or more persons. Facilities offer a beneficial or protected environment specifically for the mentally ill or drug addicted or alcoholic, and provide specific procedure or process for the cure or improvement of that disease or condition.

Facility Scope of Care: Facilities may assist residents with activities of daily living, including making appointments and arranging transportation that is necessary in order for the resident to receive the supportive services required in the care plan. Facilities must also be aware of residents' general whereabouts and monitor activities of residents to ensure health, safety and well-being.

Medication Management: Medication administration by unlicensed staff is permitted.

Physical Plant Requirements: Private resident units must be a minimum of 80 square feet and multiple-occupancy resident units must provide a minimum of 60 square feet per resident.

Residents Allowed Per Room: A maximum of four residents is allowed per resident unit.

Bathroom Requirements: One toilet is required for every eight residents and one tub/shower is required for every 10 residents.

Alzheimer's Unit Requirements: The rules have recently been amended to require certain facilities offering special care units or programs for residents with Alzheimer's disease to disclose the form of care or treatment provided that distinguishes it as being especially suitable for the resident requiring special care.

Staffing Requirements: An administrator must be in charge of all functions and activities of the facility and must be available and responsible within a reasonable time and distance. There must be at least one staff person for every 10 residents during all periods of peak resident activity. During nighttime hours, at least one staff member must be on duty for every 44 residents.

Administrator Education Training: Administrators must have a high school education or equivalent.

Staff Education/Training: Staff must complete in-service training programs that include training in basic first aid; fire protection; medication administration and management; care of persons who may have contagious, communicable, or sexually transmitted diseases; and, licensing regulations. In-service training must be provided on a continuing basis and not less than annually.

Continuing Education (CE) Requirements: Administrators must complete 12 hours of continuing education per year. Courses must meet domains of practice.

Entity Approving CE Program: The South Carolina Board of Long Term Care Administrators (803/896-4544) approves continuing education courses, however, courses are automatically approved if they are NAB-approved.



South Dakota

Agency: Department of Health, Office of Health Care Facilities Licensure and Certification

Phone Number: 605/773-3364

Contact Name: Alan Baldwin

Contact Phone Number: 605/773-5726

Licensure Term: Assisted Living Centers

Opening Statement: Regulations were most recently revised July 1998.

Definition: Assisted Living Centers are defined as any institution, rest home, boarding home, place, building, or agency which is maintained and operated to provide personal care and services which meet some need beyond basic provision of food, shelter, and laundry to five or more persons in a free-standing, physically separated facility.

Facility Scope of Care: Facilities must provide supportive services, activities, and services to meet the spiritual needs of residents. Facilities must also provide for the availability of physician services.

Medication Management: Facilities that admit or retain residents who require administration of medications must employ or contract with a licensed nurse. Unlicensed staff must receive annual training for medication administration.

Physical Plant Requirements: Private resident units must be a minimum of 95 square feet and shared resident units must provide a minimum of 75 square feet per resident.

Residents Allowed Per Room: A maximum of two residents is allowed per resident unit.

Bathroom Requirements: Not specified.

Alzheimer's Unit Requirements: Not specified.

Staffing Requirements: An administrator must be responsible for the daily overall management of the facility. There must be a sufficient number of qualified, awake personnel to provide effective care.

Administrator Education Training: Administrators must hold a high school diploma or equivalent and complete a training program and competency evaluation.

Staff Education/Training: All staff must complete a formal orientation and ongoing education program covering such issues as emergency procedure, accident prevention, proper use of restraints, etc.

Continuuing Education (CE) Requirements: N/A

Entity Approving CE Program: N/A



Tennessee

Agency: Department of Health, Division of Health and Environment

Phone Number: 615/741-7221

Contact Name: Bobbie Wood or Marta Forte

Contact Phone Number: 615/741-7188 or 615/741-7484

Licensure Term: Assisted-Care Living Facilities

Opening Statement: The regulations became effective on April 25, 1998.

Definition: An Assisted-Care Living Facility is a building, establishment, complex, or distinct part which accepts residents for domiciliary care and non-medical assistance, and medical assistance as prescribed by the resident's treating physician, limited to the extent such orders can be provided by a home care organization.

Facility Scope of Care: The facility may provide protective care and supervision to residents, assistance with medications, and assistance with all activities of daily living.

Medication Management: Medication shall be self-administered, or administered by a licensed professional. The facility may assist residents with medication, including reading labels, reminders, and observation.

Physical Plant Requirements: A minimum of 80 square feet of bedroom space must be provided to each resident.

Residents Allowed Per Room: A maximum of two residents is allowed per resident unit.

Bathroom Requirements: Each toilet, lavatory, bath, or shower shall serve no more than six residents.

Alzheimer's Unit Requirements: Facilities are permitted to have secured Alzheimer's units and can retain residents up to the last stages of Alzheimer's disease.

Staffing Requirements: Facilities must employ an administrator, an identified responsible attendant, and a sufficient number of staff to meet the needs, including medical services as prescribed, of the residents. A licensed nurse must be available as needed.

Administrator Education Training: Administrators must hold a high school diploma or equivalent.

Staff Education/Training: The responsible attendant and direct care staff must be at least 18 years of age.

Continuuig Education (CE) Requirements: Administrators must complete 12 hours of continuing education per year in courses related to Tennessee rules and regulations, health care management, nutrition and food service, financial management, and healthy lifestyles.

Entity Approving CE Program: N/A



Texas

Agency: Department of Human Services

Phone Number: 512/438-3011

Contact Name: Bevo Morris

Contact Phone Number: 512/438-2363

Licensure Term: Personal Care Facilities

Opening Statement: Revised Personal Care Standards went into effect August 1998 and new Alzheimer's Personal Care standards are expected to be effective in Fall 1998.

Definition: Personal Care Facilities (PCFs) may provide assistance with activities of daily living. There are two types of PCFs that are closest to the universal definition of assisted living. In a type A PCF, a resident must be mentally capable of evacuating the facility unassisted in the event of an emergency; may not require routine attendance during sleeping hours; and must be capable of following directions. In a type B PCF, a resident may require staff assistance to evacuate; be incapable of following directions under emergency conditions; require attendance during sleeping hours; or, not be permanently bedfast, but may require assistance in transferring to and from a wheelchair.

Facility Scope of Care: Facilities may provide assistance with activities of daily living, assist with the administration and management of medication, but may not provide nursing care.

Medication Management: Residents who choose not to or cannot self-administer medication must have medication administered by a person who: holds a current license to administer medication; holds a current medication aide permit (this person must function under the direct supervision of a licensed nurse on duty or on call); or is an employee of the facility to whom the administration of medication has been delegated by a RN.

Physical Plant Requirements: In type A PCFs, private resident units must be a minimum of 80 square feet and multiple-occupancy resident units must provide a minimum of 60 square feet per resident. In type B PCFs, private resident units must be a minimum of 100 square feet and multiple-occupancy resident units must provide a minimum of 80 square feet per resident. The regulations list extensive fire safety requirements under Chapter 21 of the NFPA Life Safety Code, "Residential Board and Care Occupancies." Type A PCFs are classified as "slow" evacuation and type B PCFs are classified as "impractical" evacuation capability.

Residents Allowed Per Room: A maximum of four residents is allowed per resident unit.

Bathroom Requirements: All bedrooms must be served by separate private, connecting, or general toilet rooms for each sex. A minimum of one water closet, lavatory, and bathing unit must be provided on each sleeping floor. One water closet and one lavatory for every six residents and one tub or shower for every ten residents is required.

Alzheimer's Unit Requirements: Any facility which advertises that it provides specialized care for persons with Alzheimer's disease must provide a disclosure statement that describes the nature of its care or treatment of residents with Alzheimer's disease.

Staffing Requirements: Each facility must designate a manager to have authority over its operation. A facility must have sufficient staff to maintain order, safety, and cleanliness; assist with medication regimens; prepare and service meals; assist with laundry; provide supervision and care to meet basic needs; and ensure evacuation in case of an emergency. The new regulations do not create specific staff-to-resident ratios, however, facilities must post staffing patterns monthly.

Administrator Education Training: Managers must have a high school diploma or certification of equivalency of graduation.

Staff Education/Training: Full-time facility attendants must be at least 18 years of age or hold a high school diploma. The regulations list specific training requirements for licensed nurses, nurse aides, and medication aides.

Continuuuing Education (CE) Requirements: Managers must complete 12 hours of continuing education per year in courses related to at least two of the following areas: resident and provider rights and responsibilities, abuse/neglect, and confidentiality; basic principles of supervision; skills for working with residents, families, and other professional service providers; resident characteristics and needs; community resources; accounting and budgeting; first aid; and federal laws, such as the Americans With Disabilities Act and Fair Housing Act.

Entity Approving CE Program: N/A



Utah

Agency: Department of Health, Bureau of Health Facilities Licensure

Phone Number: 801/538-6152

Contact Name: Debra Wynkoop-Green

Contact Phone Number: 801/538-6152

Licensure Term: Assisted Living Facilities

Opening Statement: The regulations summarized below have been in effect since July 1995. Revised regulations are expected to be published Fall 1998.

Definition: Assisted Living Facilities are home-like and provide an array of 24-hour coordinated supportive personal and health care services.

Facility Scope of Care: Facilities must provide personal care, food service, housekeeping, laundry, maintenance, activity programs, administration, and assistance with self-administration of medication, and arrange for necessary medical and dental care. Facilities may provide intermittent nursing care.

Medication Management: Licensed staff may administer medication and unlicensed staff may assist with self-medication.

Physical Plant Requirements: Private resident units (without living rooms, dining areas, or kitchens) must be a minimum of 120 square feet and double-occupancy resident units must be a minimum of 200 square feet.

Residents Allowed Per Room: A maximum of two residents is allowed per resident unit.

Bathroom Requirements: Common toilet, lavatory, and bathing facilities are permitted.

Alzheimer's Unit Requirements: Not specified.

Staffing Requirements: Facilities must employ an administrator and direct care staff are required on-site 24 hours per day to meet resident needs as determined by assessments and service plans.

Administrator Education Training: Administrators must complete a national certification program and must have either experience, an administrator's license, or a college degree.

Staff Education/Training: All staff must complete orientation to include job descriptions; ethics, confidentiality, and resident rights; fire and disaster plan; policies and procedures; and report responsibility for abuse, neglect, and exploitation. Staff must also complete extensive inservice training. Personal care staff must be CNAs or complete a CNA training program within four months of employment.

Continuuing Education (CE) Requirements: N/A

Entity Approving CE Program: N/A



Vermont

Agency: Department of Aging and Disabilities, Division of Planning and Analysis

Phone Number: 802/241-2425

Contact Name: Heather Johnson-Lamarche

Contact Phone Number: 802/241-2425

Licensure Term: Assisted Living Residences

Opening Statement: Regulations for Assisted Living will be filed with the rules committee in August and are expected to be finalized for implementation in January 1999.

Definition: An Assisted Living Residence is a program which combines housing, health, and supportive services for the support of resident independence and aging in place. Within a home-like setting, a minimum of a private bedroom, private bath, living space, kitchen capacity, and a lockable door are provided.

Facility Scope of Care: The facility must provide services such as, but not limited to, 24-hour staff supervision to meet emergency, scheduled and unscheduled needs; assistance with all personal care activities and instrumental activities of daily living; nursing assessment, health monitoring, routine nursing tasks and intermittent skilled nursing services; appropriate supervision and services for residents with dementia or related issues requiring ongoing staff support and supervision; and medication management, administration and assistance. A resident needing skilled nursing care may arrange for that care to be provided in the facility by a licensed nurse as long as it does not interfere with other residents.

Medication Management: If residents are unable to self-administer medications, they may receive assistance with administration of medications from trained facility staff. If staff are deemed competent by the registered nurse, they may administer "as needed" medications.

Physical Plant Requirements: Private resident units must be a minimum of 225 (160 in pre-existing structures) square feet, excluding bathrooms and closet. Each resident unit shall include a private bedroom, private bathroom, living space, kitchen capacity, adequate space for storage, and a lockable door. Units may be shared by resident choice only.

Residents Allowed Per Room: Not specified.

Bathroom Requirements: Not specified.

Alzheimer's Unit Requirements: Not specified.

Staffing Requirements: Staff must have access to the director and/or designee at all times. At least one personal care assistant shall be on site and available 24 hours per day to meet residents' scheduled and unscheduled needs. On-site trained staff must be available in sufficient number to meet the needs of each resident. A registered or licensed practical nurse must be on site as necessary to oversee service plans.

Administrator Education Training: The director must be at least 21 years of age and have demonstrated experience in a gerontological field.

Staff Education/Training: All staff providing personal care must be at least 18 years of age. All staff must be oriented to the principles of assisted living and receive training on an annual basis regarding the provision of services in accordance with the resident-driven values of assisted living. All staff providing personal care must receive training in the provision of personal care activities (e.g., transferring, toileting, infection control, Alzheimer's, and medication assistance and administration).

Continuuig Education (CE) Requirements: Directors/administrators must complete 20 hours of continuing education per year in courses related to assisted living principles and the philosophy and care of the elderly and disabled individuals. All personal care services staff must receive 24 hours of continuing education in courses related to Alzheimer's disease, medication management and administration, behavioral management, documentation, transfers, infection control, toileting, bathing, etc. A program for approving courses will be set up in early 1999.

Entity Approving CE Program: To be determined in 1999.



Virginia

Agency: Department of Social Services, Division of Licensing Programs

Phone Number: 804/692-1786

Contact Name: Judy McGreal

Contact Phone Number: 804/692-1792

Licensure Term: Adult Care Residences

Opening Statement: The regulations were last updated in February 1996.

Definition: An Adult Care Residence is a place, establishment, or institution, public or private, providing care to four or more adults who are aged, infirm, or disabled and who are cared for in a primarily residential setting. "Assisted Living" is a level of service provided in an Adult Care Residence for adults who may have physical or mental impairments and require assistance with two or more activities of daily living.

Facility Scope of Care: The facility may provide assistance with activities of daily living and may restrain residents if necessary.

Medication Management: Medication may be administered by staff who have successfully completed a Board of Nursing approved medication training program or who are licensed to administer medications.

Physical Plant Requirements: Private resident units must be a minimum of 100 square feet and shared resident units must provide a minimum of 80 square feet per resident.

Residents Allowed Per Room: A maximum of four residents is allowed per resident unit.

Bathroom Requirements: Common toilets, lavatory, and bathing facilities are permitted.

Alzheimer's Unit Requirements: The regulations cover facilities caring for adults with serious cognitive deficits. At least two direct care staff members must be in the building at all times and doors leading to the outside shall have a system of security monitoring. Free access to an indoor walking corridor or other areas used for walking must be provided.

Staffing Requirements: The facility must employ an administrator and staff sufficient to provide services to maintain the physical, mental, and psychosocial well-being of each resident. If assisted living services are provided, a licensed health care professional must be on site at least quarterly to provide health care oversight and nursing staff must be present to meet residents' skilled nursing needs.

Administrator Education Training: Administrators in facilities with assisted living must be at least 21 years of age and have a high school education or GED and two years post secondary education and one year administrative experience in caring for adults with mental or physical impairments in a group care facility.

Staff Education/Training: Direct-care staff in facilities with assisted living must complete a CNA or other specified training program.

Continuing Education (CE) Requirements: Administrators must complete 20 hours of continuing education annually. Direct care staff must complete eight hours (for residential living settings) or 12 hours (for assisted living settings) of continuing education per year, depending upon the level of care at the facility. Courses should be related to the management or operation of a residential care facility and should be related to the population residing in the facility (e.g., courses related to mental impairments if population is mentally impaired).

Entity Approving CE Program: N/A



Washington

Agency: Aging and Adult Services Administration

Phone Number: 360/493-2556

Contact Name: Harry Sedies

Contact Phone Number: 360/493-2556

Licensure Term: Boarding Homes/Assisted Living

Opening Statement: Washington has experienced a shift in Boarding Home licensure from the Department of Health to the Department of Social and Health Services. Boarding homes receiving Medicaid reimbursement must also comply with WAC 388-110 (not summarized).

Definition: A Boarding Home/Assisted Living Facility is any home or institution, however named, which is advertised, announced or maintained for the express or implied purpose of providing board and domiciliary care to three or more aged persons not related by blood or marriage to the operator.

Facility Scope of Care: Facilities may provide basic domiciliary care, general health supervision, and assistance with: self-administration of medications; following prescribed diets and activity regimes; making and keeping appointments for health care services; maintaining personal hygiene; obtaining and maintaining functional aids; arranging for social, recreational and religious activities; resident mobility; and incontinence care. Facilities may provide or supervise limited nursing services, such as insertion of catheters; routine ostomy care; enemas; uncomplicated routine colostomy and urethral care; care of superficial wounds; and assistance with glucometer testing.

Medication Management: Residents are categorized based on the level of assistance needed with medication. Category A residents can self-administer medication or are capable of directing others to administer medication. Category B residents need reminding, guiding, or coaching. Category C residents can not safely self-administer medication and medication may be administered by a nurse or other individual authorized to administer medications in Washington state.

Physical Plant Requirements: Private resident units must be a minimum of 80 square feet and shared resident units must provide a minimum of 70 square feet per resident.

Residents Allowed Per Room: A maximum of four residents is allowed per resident unit.

Bathroom Requirements: One toilet and sink is required for every eight residents and one bath/shower is required for every 12 residents.

Alzheimer's Unit Requirements: If the facility accepts residents with dementia care needs, it must provide qualified staff who are present at all times. Staff must prevent residents from wandering from the facility and the regulations also specify special physical plant requirements, such as slip-resistant floors free of abrupt changes.

Staffing Requirements: The facility must employ an administrator and designate an alternate administrator to be responsible for the overall 24-hour operation of the facility. Sufficient and trained staff must be hired to furnish care to residents, maintain the facility free of safety hazards, and implement fire and disaster plans.

Administrator Education Training: The administrator and designated alternate must be at least 21 years of age and must hold an associate or advanced degree in health, personal care, or business administration; be certified by a department-recognized national accreditation health or personal care organization; have a high school diploma or equivalent and two years experience as a resident-care staff person, including one year of caring for residents representative of the population in the facility; or have held the position of an administrator in a Washington state licensed boarding home or nursing home prior to August 1, 1994.

Staff Education/Training: Resident-care staff must be at least 18 years of age and have current CPR and first aid cards. Facilities must provide staff orientation and appropriate training for expected duties, including: organization of the facility; physical boarding home layout; specific duties and responsibilities; policies, procedures, and equipment necessary to perform duties; and HIV/AIDS education and training.

Continuuuing Education (CE) Requirements: N/A

Entity Approving CE Program: N/A



West Virginia

Agency: Department of Health and Human Resources, Office of Health Facilities Licensure and Certification

Phone Number: 304/558-0050

Contact Name: Sandra Daubman

Contact Phone Number: 304/558-0050

Licensure Term: Personal Care Homes

Opening Statement: The regulations were last updated in August 1996.

Definition: A Personal Care Home provides accommodations and personal assistance and supervision for a period of more than 24 hours to four or more persons who may require limited and intermittent nursing care and hospice care.

Facility Scope of Care: The facility may provide assistance with activities of daily living and has the option of providing intermittent nursing services and making arrangements for hospice care.

Medication Management: Licensed staff may administer medication and staff may supervise the self-administration of medication by residents. The use of as needed controlled or prescription drugs that require judgment capabilities beyond the expertise of unlicensed staff is prohibited.

Physical Plant Requirements: Newly constructed double-occupancy resident units must provide a minimum of 80 square feet per resident.

Residents Allowed Per Room: A maximum of two residents is allowed per resident unit.

Bathroom Requirements: Common toilet, lavatory, and bathing facilities are permitted.

Alzheimer's Unit Requirements: Not specified.

Staffing Requirements: An administrator must be on staff and at least one personal care staff member must be present on a 24-hour basis. If nursing services are provided, a registered nurse supervisor and adequate nurse staff must be present. If nursing services are not provided, a registered nurse supervisor must be provided on a weekly basis. Personal care staff-to-resident ratios are dependent on the needs of the residents.

Administrator Education Training: The administrator must be at least 21 years of age and have an associate degree or its equivalent in a related field. If nursing services are provided at the facility, the administrator must also have one year of experience.

Staff Education/Training: Personal care staff must complete an orientation and annual in-service training sessions.

Continuuig Education (CE) Requirements: Administrators must complete at least 10 hours per year of continuing education related to the operation and administration of a personal care home.

Entity Approving CE Program: N/A



Wisconsin

Agency: Department of Health and Social Services, Division of Community Services, Bureau on Aging

Phone Number: 608/266-3878

Contact Name: David Robertson

Contact Phone Number: 608/264-9888

Licensure Term: Residential Care Apartment Complexes

Opening Statement: The Wisconsin statutes were revised in July 1996 to authorize the operation of "assisted living facilities." In September 1997, the name was changed to "residential care apartment complexes" in order to clear up public confusion over certified assisted living facilities and other care facilities using that term in their advertising.

Definition: Residential Care Apartment Complexes provide supportive services (e.g., meals, housekeeping, laundry and access to medical services), personal services/assistance with activities of daily living, and nursing services (e.g., health monitoring, medication administration/management). Facilities may not provide all of these services to five or more adults for more than 28 hours per week.

Facility Scope of Care: Facilities shall provide services that are sufficient and qualified to meet the care needs identified in the tenant service agreements, to meet unscheduled care needs of its tenants and to make emergency assistance available 24 hours a day. At a minimum, facilities must provide: supportive services, including meals, housekeeping, access to medical services; personal services, including daily assistance with all activities of daily living; and nursing services, including health monitoring, medication administration and management.

Medication Management: Medication administration and management shall be performed by or, as a delegated task to unlicensed staff, under the supervision of, a nurse or pharmacist.

Physical Plant Requirements: All resident units must be independent and must provide a minimum of 250 square feet of interior floor space, excluding closets. Multiple occupancy of an independent apartment shall be limited to a spouse or a roommate chosen at the initiative of the resident. Each unit shall have at a minimum a lockable door, a kitchen, an individual bathroom, a sleeping area, and a living area.

Residents Allowed Per Room: A maximum of two residents is allowed per resident unit.

Bathroom Requirements: Not specified.

Alzheimer's Unit Requirements: Not specified.

Staffing Requirements: Staffing must be adequate to provide all services identified in the residents' service agreements. A designated service manager must be awake and on duty and be able to be present on short notice.

Administrator Education Training: Service managers must be capable of managing a multi-disciplinary staff.

Staff Education/Training: Tenant care staff must have documented training or experience in the needs and techniques for assistance with activities of daily living. All staff shall have training in fire safety, first aid, universal precautions and the facility's emergency plan, and in the facility's policies and procedures relating to tenant rights. Staff providing services to tenants shall have documented training or experience in the physical, functional and psychological characteristics associated with aging and the purpose and philosophy of assisted living.

Continuuuing Education (CE) Requirements: N/A

Entity Approving CE Program: N/A



Wyoming

Agency: Department of Health, Office of Health Quality

Phone Number: 307/777-7121

Contact Name: Jane Taylor

Contact Phone Number: 309/777-7121

Licensure Term: Assisted Living Facilities

Opening Statement: Regulations went into effect in October 1994 that rename and modify the board and care licensure category. If a board and care facility wishes to provide limited skilled nursing services and medication administration, it may be licensed as an assisted living facility.

Definition: Assisted Living Facilities provide limited nursing care, personal care, and boarding home care; but may not provide rehabilitative care.

Facility Scope of Care: The facility shall provide assistance with transportation; assistance with obtaining medical, dental, and optometric care; assistance in adjusting to group activities; partial assistance with personal care; limited assistance with dressing; minor non-sterile dressing changes; stage I skin care; infrequent assistance with mobility; cuing; limited care to residents with incontinence and catheters (if the resident can care for his/her condition independently); and 24-hour supervision of each resident.

Medication Management: Residents are permitted to self-medicate or receive medication assistance including but not limited to reminders, assistance with removal of cap or medication, and observation.

Physical Plant Requirements: Private resident units must be a minimum of 120 square feet and shared resident units must provide a minimum of 80 square feet per resident.

Residents Allowed Per Room: A maximum of two residents is allowed per resident unit.

Bathroom Requirements: At least one flush toilet and lavatory shall be provided for every two residents and at least one tub or shower shall be provided for every 10 residents.

Alzheimer's Unit Requirements: Not specified.

Staffing Requirements: Staffing shall be sufficient to meet the needs of all residents. For facilities with 10 or more residents, there shall be at least one staff person on duty and awake at all times. The facility must designate a manager who is responsible for the facility and the 24-hour supervision of residents. There shall be personnel on duty to maintain order, safety, and cleanliness of the premises; prepare and serve meals; assist the residents in personal needs and recreational activities; and meet the other operational needs of the facility. If need dictates, there must be a RN, LPN or CNA on every shift.

Administrator Education Training: The manager must be at least 21 years of age; be familiar with and follow these regulations; be a certified nursing assistant or the equivalent, or otherwise be capable of making informed decisions regarding quality of care.

Staff Education/Training: Not specified.

Continuuing Education (CE) Requirements: N/A

Entity Approving CE Program: N/A



Financing:

2.5 2.5 2.75 2.75 3.0 = 13.5

S. To Discuss.
Sorry for the scribbles.

RE: Covering the Parents of Children

This proposal would ^{extend} expand the Children's Health Insurance Program to the parents of children who are insured by Medicaid or CHIP up to 200 percent of poverty. As this is a capped entitlement, the costs of this proposal are flexible, but we would recommend proposing approximately \$20 billion over five years. (how much does it cost?) How much is each subsidy for a parent? *To This would probably cost about \$30 billion over 5 years and cover an estimated 3.2 million uninsured parents.*

Background

Since 1994, the Administration has taken an incremental approach to expanding health care coverage, with the most important victory being the Children's Health Insurance Program. There are eleven million uninsured children. We also know that ^{8%} most of the parents of uninsured children are themselves uninsured, as parents rarely cover themselves and not their kids. In fact, there are currently eleven million uninsured parents of children.

over 7

whose children are eligible for or enrolled in Medicaid or CHIP.

Policy Proposal

This proposal would allocate Federal funds to states at the CHIP matching rate (which states like because it is higher than the Medicaid matching rate) to expand health care coverage to parents of children under 200 percent of poverty. Just like with CHIP, states would be required to offer a benefits package comparable to a commercial plan or some other benchmark plan. (States also prefer this to Medicaid because it provides more flexibility). Also similar to CHIP, parents with health care coverage would not be eligible for these programs.

① Provide enhanced CHIP matching rate to states that expand through

This program would be a capped entitlement so states could cover as many parents as possible with their allotted funds. However, states would have the flexibility to cover parents up to 200 percent of the poverty level (XX for a family of four). *② Expand CHIP - Add \$ to Allotment*

Pros

** Helps most + need of those w/ least access*
** Well targeted*

well targeted - already have the kids.

This proposal would be a meaningful coverage expansion for millions of uninsured adults. It would also have the indirect impact of having many children enroll in the CHIP or Medicaid programs because it holds families together allowing them to apply together for coverage. It would end the current irrational policy that allows pregnant women coverage until their baby is born and would also be extremely helpful for fathers who are generally not in jobs that receive health care coverage.

CHIP has been popular among the states and in only a little over a year ^{every} state has applied for funding coverage. Some states have clearly indicated an interest in expanding their proposals beyond this level. This program builds on the strengths of the CHIP model in that gives states flexibility to design programs that meet their needs, while assuring Federal accountability. Moreover,

we can't cover parents of Medicaid-eligible (or CHIP) kids but can give enhanced program

funding

validators would definitely far prefer this incremental approach to health care coverage than a tax credit approach.

Cons

This program, like all incremental coverage policies, certainly will not lead to universal coverage. In fact, it would even leave millions of adults without children without access to affordable health care coverage. This policy builds on the CHIP model approach that leaves many of the design issues up to the states and gets further away from minimum Federal standards for coverage. There are, in fact, large variations in states in the area of coverage and this proposal would only further expand that trend. Moreover, the CHIP program has been, by some accounts, slow to get off the ground, and there could be some criticisms that we are proposing to throw funding into more state subsidies that do not prove to work.

Financing

States would also be able to use their CHIP dollars for this purpose provided they have already covered children up to 200 percent of poverty and that they do not provide coverage for adults at a higher level of poverty

Policy options

One option is to offer this program only to the states that provide coverage to parents up to 100 percent of poverty. States already have the authority to cover these adult -- and those at higher rates of poverty -- under Medicaid -- although most have not. However, given the budget surplus and the money states have received through the tobacco settlement, most have the funds to cover these populations if they want. This is probably better policy than providing a higher matching rate for adults that states already could and should be coverage. It would also cost less money to cover more people since states would cover these kids at a lower Federal matching rate.

The disadvantage of this approach is that fewer states would take up this proposal. States currently have the authority to expand Medicaid to these populations and have chosen not to do so. It is not entirely clear that the option to cover their higher income populations (which they can also already do under Medicaid) at a better matching rate would be enough of an incentive to expand in this area.

Another option is to extend the enhanced match for states that choose any expansions. Even with this proposal though it is important to assure that states do not cover parents that are a higher poverty rates than other parents they have not chosen to cover. States would have the authority to cover parents up to 200 percent of poverty.

ELIGIBLES

1.5m Uninsured

2.7m Reduc.

1.6m

→

4.3

4.4m/year med.

2.6 b./year CHIP,

7.0 b./year.

2001

2.5	2.5	2.75	2.75	3	3.2 b. 13.5
3.0	3.1	3.3	3.5	3.6	2.0 b. 16.5
					2.5
5.5	5.6	6.05	6.25	6.6	-30

April 29, 1999

Note to: Elaine Kamarck and Morley Winograd

From: Pamela Johnson

Subject: PATIENT-CENTERED HEALTHCARE

Here is an outline of some of the themes that might be highlighted as part of "patient-centered healthcare." As we discussed last month, I think that there is a real opportunity to link the Vice President's reinvention initiatives in federal healthcare with a larger healthcare agenda. I'd like to get your reaction to this direction and then complete a more comprehensive paper.

Patient-centered healthcare

- Patients' Bill of Rights
- Patient-controlled information
- Patient choice
- Consumer-driven competition for quality, service and price
- Plain language labels, bills and medical information
- Family centered health
- Healthy workplaces
- Personal health and well-being

Current Themes	Emerging Themes
Access	Consumer information, <i>SEC idea</i>
Managed competition/Cost Containment	Competition for quality, service and price
Rights	Personal health and well-being

CURRENT THEMES

ACCESS:

Administration goals and accomplishments

- Universal health insurance for children
- Immunization coverage for children and older Americans
- Mammography, diabetes screening and other preventive benefits
- Long term care
- VHA – access to prostate cancer screening
- Telemedicine

Issues and new opportunities

- Pharmaceuticals
- Out-of-pocket expenses for poor, older Americans
- Mental health services
- Workplace health – stress, eye strain, etc

Vision

*People in control of their
own health records
& have to give
permission*

*current state
of the law...*

MANAGED COMPETITION/COST CONTAINMENT

Administration goals and accomplishments

- Medicare Choice
- Fraud prosecution

Issues and new opportunities

- Fraud prevention

RIGHTS

Administration goals and accomplishments

- Patient Bill of Rights

Issues and new opportunities

EMERGING THEMES

CONSUMER INFORMATION:

Administration goals and accomplishments

- Plain language drug labels
- Web-based health information
 - Medicare.gov
 - Healthfinder
 - National Library of Medicine
- VHA and DOD innovations – telemedicine, reengineering, etc.
- Report cards posted in DOD hospitals

Issues and opportunities

- Plain language medical bills
- Plain language medical information
- Report cards *on facilities DOD has things posted in hospitals*
- Patient-owned/patient-controlled access to integrated medical records (*smart card...*)

COMPETITION

Administration goals and accomplishments

- Medicare Choice
- Quality Information
- Federal Employee Health Benefits
- CAHPS

Issues and opportunities

- Consumer-driven competition
- SEC for health (PPI)
- Tax subsidies for individual coverage (AMA, PPI)
- Medical Savings Accounts (AMA)
- Increase access to information on performance, customer satisfaction
- Expand Federal Employee Health Benefits as model

*\$ universal
no barrier
no state plans*

Breaux

QUALITY AND SERVICE

Administration goals and accomplishments

- Quality Council
- VHA, DOD reinvention, customer service, quality initiatives
- FR7 initiatives
- Agency for Health Care Policy Research

Issues and opportunities

- Customer service
- Increase quality
- Reduce medical errors
- Improve treatment for asthma, diabetes, etc.
- Reengineering of health sector for quality and service - - better late than never!

HEALTH & WELL-BEING

Administration goals and accomplishments

- Children and tobacco
- Putting Prevention into Practice (DOD)

Issues and opportunities

- Personal responsibility
- Alternative medicine
- Nutrition
- Personal well-being and fitness
- Strategic health research (PPI)

OTHER ISSUES AND OPPORTUNITIES

- Human Genome Project results



Safe and Effective Schools for All Students and All Communities:

What Works

September 15-17, 1999 Washington, DC

Presented & Sponsored by:

U.S. Department of Education: Office of Special Education and Rehabilitative Services, Office of Correctional Education, Office of Adult and Vocational Education, & the Safe and Drug-Free Schools Program, Office of Elementary and Secondary Education **U.S. Department of Health and Human Services:** Center for Mental Health Services, National Institute of Mental Health, & the Centers for Disease Control and Prevention **U.S. Department of Justice:** Office of Juvenile Justice and Delinquency Prevention & the National Institute for Justice **National Organizations:** Center for Effective Collaboration and Practice and the National Governors = Association
April 8, 1999

Dear Colleague:

The Center for Effective Collaboration and Practice, in partnership with the U.S. Departments of Education, Health and Human Services, Justice, and the National Governors = Association, invites you or a senior member of your staff to join with other key state officials in a three-day working meeting which will help you improve your state's capacity to support safe schools and healthy students.

The *Safe and Effective Schools* meeting will be an invitational working meeting focusing on the exchange of knowledge and strategies for establishing safe and effective schools. The design and content of the meeting will incorporate feedback from focus group discussions with state-level agency representatives from several states. Six-person teams from every state will, with the assistance of facilitators, engage in analysis of state data, strategic planning, collaboration, and networking that emphasizes improving student behavior and discipline and preventing violence in our schools. In addition to the focus on state level collaboration, we are anticipating the participation (in a Town Hall meeting) of senior Federal officials, including Secretary of Education Richard Riley, Secretary of Health and Human Services Donna Shalala, and Attorney General Janet Reno.

Key Features of the Conference:

An outcome-driven design and focus.

Supporting materials will be available to participants before the meeting. These materials include the following documents: *Safe and Effective Schools for All Students: What Works!*; *Early Warning, Timely Response: A Guide to Safe Schools* and an accompanying implementation guide and toolkit; *Promising Practices in Children's Mental Health. The Role of Education in a System of Care: Effectively Serving Children with Emotional or Behavioral Disorders*; and the *1998 Annual Report on School Safety*.

Linked to a satellite teleconference with over 1000 sites nationwide in which school and community members learn about effective practices and discuss ways to support safe schools and healthy students.

Web site to facilitate links to local communities during the meeting and the exchange of information among meeting participants after the meeting.

Workshops on effective approaches, practices, and programs, and an opportunity to meet with presenters during follow-up poster sessions. Each workshop will be presented by a developer, practitioner, and consumer who will provide information on outcomes, the types of settings in which the interventions have been applied, and what was done to enable the intervention to be successful.

Panel discussion on creative funding strategies to support collaboration.

A youth presentation.

Facilitated state meetings to assess needs, examine effective approaches, and develop cross-agency action plans as well as one cross-state meeting where participants from the same departments areas will meet to discuss effective approaches.

Networking receptions.
Town Hall meeting with senior Federal officials (Secretaries Riley and Shalala and Attorney General Reno have been invited).
Post-meeting panel with Federal officials from all sponsoring agencies.

Outcomes: Attendees will leave the conference more prepared to:

- Extend or develop state level collaborations to support safe and effective schools;
- Overcome barriers to communication and collaboration at the state and local levels;
- Support the implementation of effective practices and successful model programs; and
- Leverage Federal and national funding, programs, technical assistance, materials, and research findings.

Participants: Strategically chosen six-person teams will meet on each day of the conference and engage in data analysis, knowledge exchange, and strategic planning. These teams will include state-level representatives from the following groups:

- Special Education
- Mental Health
- Juvenile Justice
- Safe and Drug-Free Schools
- Child Welfare, Health, and Youth Development
- Family Members

Registration: There is no registration fee to attend this meeting, and some funding may be available to state team members to help defray transportation expenses. Registration for the meeting is being handled by Professional and Scientific Associates. They have set up an online registration form on their website that you can access as follows: <website address will go here>. Additional information, registration information, and answers to questions you may have can be found on our web site at <<http://www.air.org/cecp/meeting>>.

A tentative agenda for the meeting is enclosed for your review. We are looking forward to a very important and productive meeting, which will be strengthened by your attendance and participation. Should you have additional questions, please do not hesitate to contact us via E-mail at <center@air-dc.org> or call us toll-free at 1-888-457-1551.

Sincerely,

Enclosure