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0075 Progress Report on Hospital and Medical Care and Related Health Services

Colorado Legislative Council

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HEALTH AND MEDICAL CARE AND RELATED HEALTH SERVICES

Legislative Council

Report To The

Colorado General Assembly

Research Publication No. 75
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COLORADO GENERAL ASSEMBLY

LEGISLATIVE COUNCIL

ROOM 341, STATE CAPITOL
DENVER 2, COLORADO
ACOMA 2-9911 - EXTENSION 2285

December 26, 1962

To Members of the Forty-fourth Colorado General Assembly:

As directed by the terms of Senate Joint Resolution No. 25 (1961) and Senate Joint Resolution No. 8 (1962), the Legislative Council is submitting herewith its report on the progress of the hospital and medical care study.

The Committee appointed by the Legislative Council to make this study submitted its progress report on November 30, 1962, at which time the report was accepted by the Legislative Council for transmittal to the General Assembly.

Respectfully submitted,

James E. Donnelly
Chairman

FOREWORD

This report covers the progress thus far in the study of hospital and medical care and costs authorized by Senate Joint Resolution No. 25 (1961). The scope of this study was expanded by Senate Joint Resolution No.8 (1962) to include all medical services, out-patient services, and convalescent services and facilities.

During the course of the study, the committee has given considerable attention to the many problems related to medical care for the aged, such as: 1) Cost of providing medical care for old age pensioners, with special emphasis on hospitalization and nursing home confinement; 2) determination of adequate benefits and level of care for old age pensioners: 3) medical needs of the aged not receiving the pension; and 4) public obligation in providing medical care for the aged non pensioners and the ways in which such care might be provided.

The first portion of this progress report summarizes the committee's work generally during the past two years. One section of the report covers a suggested approach to solving some of the problems related to the Old Age Pension Medical Care Program, while at the same time providing medical assistance for low income persons over the age of 65 who are not on the pension. The last part of this report presents a discussion of amounts and methods of payment to nursing homes participating in the Old Age Pension Medical Care Program.

December 26, 1962

Lyle C. Kyle
Director

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PROGRESS REPORT

November 28, 1962

TO: Colorado Legislative Council

FROM: Legislative Council Committee on Hospitals and Medical Care

SUBJECT: Hospital and Medical Care Study

Introduction

Senate Joint Resolution No. 25 (1961) directed the Legislative Council to appoint a committee "to make a full and complete study of legislation and other matters affecting hospitals and the needs and the requirements of the public in regard to hospitalization and hospital insurance. . ."

This study was continued by Senate Joint Resolution No. 8 (1962), which expanded the scope of the study to include medical services (needs and costs), out-patient services, and convalescent services and facilities.

The Legislative Council appointed the following committee to conduct the hospital and medical care study: Senator James E. Donnelly, Trinidad, chairman; Senator Edward J. Byrne, Denver, vice chairman; Senator William B. Chenoweth, Denver; Senator John J. Cleary, Denver; Senator Wilkie Ham, Lamar; Senator Floyd Oliver, Greeley; Senator L.T. Skiffington, Manitou Springs; Senator Hestia Wilson, Nucla; Representative Lowell B. Compton, La Junta; Representative John L. Kane, Northglenn; Representative C.P. Lamb, Brush; Representative Edwin S. Lamm, Grand Junction; Representative Carl Magnuson, Eaton; and Representative James T. O'Donnell, Denver,

Study Scope, Content, and Methodology

The Legislative Council Hospital and Medical Care Committee has included a large number of subjects within the scope of its study. The complexity and interrelationship of health needs, services, and costs has made the study much more extensive than had originally been contemplated. The committee found during its first year of work that a thorough study of the costs of hospital care also involves medical services, needs, and cost; health insurance; out-patient care; and convalescent services and facilities. Also involved are community and state-wide planning for health services and the impact of programs which are government sponsored or related. The subjects with which the committee has been concerned are outlined below.

Health Programs, Needs, and Services Directly Involving Government

Several state local agencies are directly involved in the provision of hospital and medical care and health services in a number of ways.

1) State Health Department.

   a) licensing of hospitals and nursing homes;

   b) preparation of annual plan for hospitals, nursing homes, and other medical facilities in connection with the administration and distribution on the state level of Hill-Burton funds; and

   c) supervision of state and local public health programs;

2) Local Health Departments -- local public health programs

3) State Welfare Department.

   a) administration of Old Age Pension Medical Care Program;

   b) administration of Aid to Needy Disabled Program;

   c) administration of Aid to the Blind Program; and

   d) administration of Aid to Dependent Children Program.

4) Local Welfare Departments.

   a) involvement in above programs; and

   b) provision of emergency medical care through general assistance funds.

5) Industrial Commission.

   a) hospital expenditures for workmen's compensation and occupational disease cases; and

   b) medical expenditures for worksmen's compensation and occupational disease cases.

6) Insurance Commission -- regulation of health insurance carriers

7) There are also several licensing and regulatory boards including: State Board of Medical Examiners, State Board of Pharmacy, State Board of Nursing, and State Board of Practical Nurse Examiners.

Licencing, Standards, and Accreditation. The committee has studied several aspects of the present hospital and nursing home licensing programs. These include: 1) statutory provisions; 2) content of rules, regulations, and standards promulgated by the

state health department; 3) relationship between licensing and accreditation and state responsibilities with respect to both; and 4) reactions, comments, and recommendations of hospital and nursing home administrators to the present state program and their observations on the relationship of licensing and accreditation.

Planning for Hospital and Medical Facilities -- Distribution of Hill-Burton Funds. The committee has reviewed state planning functions with the health department, as well as the basis for and the amount of Hill-Burton funds distributed in Colorado. The committee has examined Hill-Burton construction standards with respect to construction economy and realistic needs. Hospital administrators and representative have also been queried concerning the application of these standards.

Medical Care for the Aged. The OAP Medical Care Program and the related and larger problem of medical care for the aged has also been given careful consideration and study. The committee has been concerned with the cost of the OAP program and the benefits provided, as well as the regulations and methods and amount of payments by the welfare department to hospitals, nursing homes, and physicians. The possible application in Colorado of the provisions of the Kerr-Mills Act pertaining to medical care for aged non-pensioners has also been under consideration.[1]

Hospital and Medical Care for the Indigent. The committee has examined the provision of hospital and medical care for the indigent on the community level, primary through the use of general assistance welfare funds. Method and amount of payment, extent of services provided, and welfare department -- hospital relationships were all included in this examination.

Health Insurance. A problem worthy of special note is the apparent lack of state control and regulation over health insurance carriers. The absence of regulation and control over well-established and reputable carriers is not a matter of concern. There are, however, a number of small, little-known companies writing individual health insurance policies. These policies are often sold by direct mail or through newspaper and radio advertising. Examination of some of these policies by the committee (as well as testimony heard by the committee) indicates that people are being misled and believe they have coverage which is usually denied them by the small print in the policy.

The committee held a meeting with the insurance commissioner and representatives of the major health insurance carriers to discuss this problem and the committee's recommendation on this matter will be found in the last section of this report.

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1. The two memoranda attached to this progress report deal more extensively with medical care for the aged and the cost of such care. Proposed changes in the present program, and the possibility of adding medical care for aged non pensioners are also discussed.

Hospital Districts. Attention has also been given to the laws pertaining to the establishment and financing of hospital districts and three changes are recommended:

1) The ad valorum taxes collected for hospital districts should be excluded from the assessment of fees by the county treasurer as provided in 56-4-2, CRS, 1953.

2) The two mill levy limit imposed upon hospital districts should either be eliminated or raised.

3) The provision requiring that district hospital board members must be notified of meetings by registered or certified mail should be repealed.

Cost of Providing Hospital and Medical Care and Related Matters

The committee has given extensive attention to the cost of providing hospital and medical care and the reasons for increased costs. The committee has taken a look at the extent to which pre-paid health insurance is being utilized by Colorado residents and the impact that health insurance has upon hospital and medical costs. Attention has been given to hospital personnel problems (particularly on the professional level) and salary scales.

Hospital Questionnaire. To provide background material on these subjects, the committee sent an extensive questionnaire to all of the general hospitals in the state. Information requested included:

1) hospital auspices, capacity, and administration;

2) construction costs, method of financing, facilities, and equipment;

3) detailed hospital revenues;

4) detailed hospital expenditures;

5) staffing patterns and salary scales;

6) fees and charges;

7) patient days, occupancy , admissions, and discharges: and

8) hospital practices with respect to fees charged, admission of indigent patients, depreciation rates, and related matters.

This information was requested for a several-year period, so that trends could be ascertained.

Committee Meetings. Several meetings were held by the committee to obtain background information on the cost of Hospital and Medical care, the reasons for cost increases, and the ways in which these costs are being met. Those attending these meetings and the subjects covered included:

1) Industrial Commission and State Compensation Insurance Fund -- medical fees and hospital charges;

2) Colorado Hospital Association -- committee hospital questionnaires, general information on hospital operations;

3) Colorado Old Age Medical Care Program (State Department of Welfare Officials) -- operation, costs, problems, administration, and related matters;

4) Colorado State Department of Health -- administration of Hill-Burton program, licensing of hospitals, nursing homes, and related facilities;

5) Colorado Blue Cross Officials -- operation, costs, premium rates, and related matters;

6) Colorado Blue Shield Officials -- operations, costs, premium rates, and related matters; and

7) Commercial Health Insurance Carriers -- types of coverage, costs, premium rates, and related matters.

Regional Meetings. Following receipt of questionnaires from 85 per cent of the hospitals to which they were sent, the committee decided to hold a series of regional meetings. These meetings were considered necessary to obtain first hand information on hospital, medical, and other health services, and the cost of and planning for such services.

Two-day regional meetings were held in 1962 as follows:

Glenwood Springs (Western Slope) June 21 and 22

Colorado Springs (South Central Colorado) July 12 and 13

Alamosa (San Luis Valley and San Juan Basin) August 16 and 17

La Junta (Arkansas Valley) September 13 and 14

Invited to meet with the committee at these regional meetings were hospital administrators and board members, medical society officials and representatives, public health and welfare officials, nursing home operators and administrators, and health insurance carrier representatives. In connection with these regional meetings, the committee toured several hospitals and nursing homes.

Findings and Observations. The committee has no specific findings to make at this time, because the regional meeting schedule has not been completed. Further, the complexity of the wide range of subjects included within the committee's purview has made it difficult in such a short time to compile and interpret all of the statistical data and information collected by the committee.

The committee would like to call attention, however, to the high level of hospital and medical care provided at reasonable cost in rural areas of Colorado. The committee is concerned over the shortage of professional and semi-professional hospital and nursing home personnel and wished to commend those training programs which have been established in various parts of the state, usually in conjunction with a local college or junior college. It is the committee's opinion that more of these programs should be established, and further study is needed to determine the best way in which these programs may be encouraged on the state level.

A number of questions concerning the high cost of hospital and medical care are either entirely unanswered as yet or only partially answered. For this reason, the committee wishes to reserve comment at this time.

Acknowledgements. The committee wishes to thank all of the public officials, hospital and nursing home officials, physicians and surgeons, health insurance carrier representatives, and others who have taken time from their busy schedules to attend the regional meetings and to supply the committee with valuable information. In particular, the committee wishes to thank the administrators and staffs of those hospitals which provided the data requested on the committee questionnaires.

Recommendations

The committee wishes to make two specific recommendations at this time:

1) The hospital and medical care study should be continued under the auspices of the Legislative Council, and a joint resolution to this effect should be introduced for consideration by the Forty-fourth General Assembly.

2) One way in which more effective control could be exercised over the mail order sale of health insurance in Colorado by companies not licensed in this state would be for Colorado to join the same two dozen states who are parties to the reciprocal agreement covering non licensed carriers. The necessary amendatory legislation has been explained as follows on page 7 by the Commissioner of Insurance:[2]

2. Letter dated November 29, 1962, from Sam N. Beery, Commissioner of Insurance.

The present law states:

"72-1-40. Company unauthorized in other states. -- If, upon investigation, the commissioner finds that any insurance company incorporated under the laws of Colorado is doing business in another state or territory without having first procured a license or authority from such state or territory, if any is required, authorizing it to do business therein, he may revoke the authority of such company to do business in this state."

The technicality involved in this law is that the Attorney General has ruled that when a company mails an application to an individual in a state in which the company is not licensed and that individual completes the application and returns same with his premium to the Denver office, the transaction takes place in Colorado and does not take place in another state: i.e. "The company is not doing business in another state ***." A suggestion, made to the end that this State might be considered a reciprocal State, would be:

If, upon investigation, the Commissioner finds that any insurance company incorporated under the laws of Colorado is writing insurance or lives on property in another state or territory without first procuring a license or authority from such state or territory, if any is required, authorizing it to do business therein, he may revoke the authority of such company to do business in this state.

Thus...with a slight change in the present law, this state could be considered a reciprocal state and thus Colorado at least would be doing its best to combat mail order insurance.

MEMORANDUM

November 22, 1962

TO: Legislative Council Hospital and Medical Care Committee

FROM: Legislative Council Staff

SUBJECT: Medical Care for the Aged

Medical Care for the Aged in Colorado: Some Problems

Colorado's problems concerning medical care for the aged are two-fold. First, there is the problem of increasing expenditures in the Old Age Pension Medical Care Fund. Second, there is the problem of providing medical care assistance for persons over the age of 65 who may need such assistance but who are not receiving the old age pension. Both of these problems are explored in more detail below.

OAP Medical Care Program

The state welfare department estimates that more than $12 million will be expended for medical care for pensioners in the current fiscal year if the present rate of utilization continues. If this rate is projected to the 1963-1964 fiscal year, the anticipated total expenditure in the OAP medical care program is 14.5 million.

The state welfare board has already taken cognizance of these expenditure trends and has asked the department to develop suggestions for curtailing medical benefits, so that expenditures can be kept within the $10 million constitutional limit. The board has decided to take no action to curtail the program until after the General Assembly and the governor have the opportunity to review the problem.

While there has been an increase in hospital costs and utilization under the OAP medical care program, the most pronounced cost increase has been in nursing home care. One of the reasons for the increase in the cost of nursing home care has been much greater utilization, caused by several factors: 1) As the average age of OAP recipients increases, longer convalescent periods are needed to recover from illnesses. 2) Many of these older pensioners have chronic and possibly terminal ailments which require more medical attention and care than can be provided in their own homes. 3) Curtailment of program utilization in the past has usually been aimed at hospitalization; consequently, there has been a tendency to transfer patients to nursing homes as soon as their medical conditions permit.

Hospital spokesmen have complained at the committee's regional hearings that it is difficult, if not impossible, for them to provide sufficient care for pensioners under present cost and utilization restrictions. It is the opinion of some of these hospital representatives that the hospitals are being penalized while the nursing home program is allowed to expand without adequate control. Nursing home spokesmen, on the other hand, contend that they are being inadequately compensated for the care being provided pensioners.

There already has been considerable criticism by groups representing the pensioners over the restrictions already placed on the program. New restrictions will undoubtedly result in a further outcry.

All of the critics of the present program appear to be in agreement that either the $10 million constitutional limit should be removed, or the state should supplement the present maximum with general fund appropriations.

Medical Aid to the Aged (MAA)

Colorado at the present time has not taken advantage of the Kerr-Mills Act provisions which pertain to medical care for those over the age of 65 who are in low income groups but are not on the pension. The aggregate number of people in this category varies according to the income limits used and the assumptions made by spokesmen for MAA proposals. The number referred to is usually between 50,000 and 70,000.

There have been at least three proposals for an MAA program in Colorado, involving expenditures of from 3 million to more than $7 million in state funds.

Cost Problems Confronting the General Assembly and Possible Approaches

The General Assembly will be faced in the 1963 session with mounting expenses in the Old Age Pension Medical Care Fund, with the accompanying problem that the program can not be maintained at its present level of services and still be kept within the $10 million constitutional limit. In fact, unless the program is curtailed drastically during the last few months of fiscal 1963, a supplemental appropriation appears necessary. This supplemental appropriation might be as much as $1 million if the program is not changed and would be in addition to the $975,000 appropriated by the General Assembly in 1962 to supplement the $10 million in the OAP medical care fund.

In addition to the problems connected with the Old Age Pension medical care fund, the General Assembly will have demands made upon it to establish some kind of an MAA program for those older people with low incomes who are not receiving the pension.

Alternatives

There are several ways in which the General Assembly may try to meet these medical care problems: 1) The General Assembly could refuse to provide either a supplemental appropriation for the OAP medical care program during the current fiscal year or an appropriation in addition to the $10 million in the up coming fiscal year. Such action would cause the State Welfare Board to curtail the medical care program and might lead to an effort being made in 1964 to raise or eliminate the $10 million limit by constitutional amendment. Adherence to the $10 million limit would be the least costly in the short run as no further appropriations would be required. In the long run, it might be the most expensive alternative, because elimination of the ceiling on the fund would make it very difficult for the state welfare board to control extent of benefits and amount of utilization. It appears unlikely if this approach is followed that any MAA program proposal would receive favorable consideration, because there is little justification for greatly increasing the number of people who may receive benefits at the same time that the benefits being received by those already eligible are being sharply curtailed.

2) The General Assembly could take steps to assure that the OAP medical program would be maintained at the present level by providing necessary additional funds. Such action would require a supplemental appropriation for the current fiscal year of perhaps as much as $1 million and an appropriation of $4.5 million for fiscal 1964. This approach would hold the line as far as present medical care benefits for the aged are concerned, but would not extend benefits nor increase the number of people who might be eligible for medical assistance. Should one of the MAA proposals be adopted, the cost during the next fiscal year might be from $3 to $7 million. The total amount which would have to be appropriated for fiscal 1964 to assure keeping the OAP medical care program at its present level and to provide some medical benefits also for non pensioners would be between $7.5 and $11.5 million.

3) The General Assembly might consider the method adopted in at least five other states to relieve pressure on their old age pension medical care programs, while at the same time providing medical assistance for aged non pensioners.[1] To make this proposal possible, the State Welfare Board would have to agree to eliminate nursing home care in excess of 30 days from the OAP medical care program. Long-term nursing home care would be part of an MAA program, so that pensioners who remained in nursing homes after 30 days would have a choice of going off the pension in order to have their nursing home care paid for or remaining on the pension and paying for nursing home care themselves. Based on experience in other states, it is assumed that the pensioners in nursing homes would voluntarily leave the pension rolls for the remainder of their nursing home confinement.

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1. Massachusetts, New York, Idaho, North Dakota, Utah.

Those pensioners who transferred to MAA for nursing home care would lose the $10 a month they now receive for personal needs.[2] This amount could be returned to them by placing them under the Aid to the Needy Disabled Program (AND). A few perhaps would not qualify for AND, but they could receive the personal needs allowance from the state funds.

It is proposed that the MAA program benefits be the same as those in the OAP medical care program, with the exception of nursing home care. Further, it has been proposed that at least during the first year of the MAA program, eligibility be limited to those over the age of 65 not on the pension, but who meet the same eligibility requirements established for pensioners.

Advantages. There are several advantages which might result from the adoption of this proposal: a) The pressure on the $10 million dollar limit in the OAP medical care fund would be relieved through the removal of the nursing home program. This would make it possible to maintain the OAP medical program at its present level (with the exception of nursing home care) without any appropriation required at least during fiscal 1964.[3] Federal funds would finance 50 per cent of the nursing home program as compared with approximately 30 per cent at present. Additional federal funds and the increased spill over resulting from the reduction of some 3,700 nursing home patients from the pension rolls appear to make it possible to finance an MAA program for little more than the state is now spending. Consequently, the state would be able to maintain the present OAP medical care program and add an MAA program for several million dollars less than under the second alternative discussed above. (A detailed explanation of the costs and method of financing this proposal will be found in a following section).

Disadvantages. The major disadvantage is that the door is opened as far as providing medical care for aged non-pensioners is concerned. Ultimately this program could become extremely expensive. (Initially, however, it is the least expensive of all MAA proposals and would probably remain so in the future unless eligibility is widened and benefits improved.) While the pressure would be removed in the short run from the $10 million ceiling on the OAP medical care fund, at best it will be only two years before the limit will again be inadequate to keep benefits at the present level -- even though nursing home care in excess of 30 days is no longer part of the program. There is also some question as to whether pensioners and/or their spokesmen will find this program acceptable, even though those who left the pension rolls while in nursing homes more than 30 days would suffer no loss of benefits and would be returned to the pension rolls upon termination of nursing home care.

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2. This amount is the amount the pensioner in a nursing home is allowed to retain of his monthly check, the remainder is given to the nursing home as partial payment for care.
3. A supplemental appropriation for fiscal 1963 might still be necessary.

MAA Program -- In Connection With the Transfer of Nursing Home Care from OAP

People over age 65 whose annual incomes are the same or less than those on the pension ($1,356) should be eligible for the same medical benefits as those received by pensioners, because it seems unfair to penalize a person who chooses to remain off the pension, thereby saving public funds, but who may have occasional need of medical care beyond his resources.

Underlying Assumptions. The cost estimates discussed in a later section of this memorandum are based on the following underlying assumptions relating to the proposed MAA program:

1) The rate of increase in the aged population (65 and over) experienced during the decade of the 1950's has continued so that as of October, 1962, Colorado has a population of 170,000 persons age '65 and over.

2) Resources of non OAP recipients with annual incomes of $1,356 or less do not differ significantly from resources of pensioners who receive a maximum of $1,356 annually. As a corollary to this assumption, persons with incomes of $1,356 or less annually tend to live within the limits of their incomes and other resources until such time as medical needs and resultant expenditures cannot be met by such available resources. At such time, they may look to public welfare for assistance, which comes primarily through the old age pension program.

3) Attitudes of aged persons towards the receipt of public assistance will not be altered, either immediately or radically, should an MAA program be enacted; those who now tend to exist on available resources, exclusive of public assistance, would continue to do so as long as possible. Some persons who perhaps would otherwise apply for OAP might look to MAA for medical needs and not apply for OAP.

4) The Kerr-Mills Act prohibits placement of restrictions of residence and citizenship upon eligibility requirements for MAA. These two factors would not provide an MAA program with a large number of recipients not now eligible for OAP but might possibly result in some reduction in the Aid to the Needy Disabled program through transfer to MAA. (Review by the welfare department of the Aid to the Needy Disabled program (AND), which carries a one-year residence requirement and no citizenship requirement, indicates that a substantial number of aged persons actually in need are now covered by this program; data on citizenship and residence is now being collected in a special study of characteristics of AND recipients. Almost half of the 400 AND nursing home patients are over 65 years of age.)

5) Utilization rates found in the OAP program are considered as maximums for MAA, since it may be assumed that persons having substantial medical care needs are presently receiving such care through some form of public assistance; cost data for the OAP program is applicable to MAA, since no significant difference appears to exist in the types and extent of care required.

6) Due to the relatively large proportion of the aged population now receiving OAP, the experience of other states which have gone into MAA programs provide a valuable bench mark in estimating utilization. Other states, including those with comprehensive programs, have rarely had usage of the MAA program by more than three per cent of the total aged population; therefore, initially, a three per cent rate of utilization would seem to be a reasonable maximum estimate. Utilization in succeeding years would depend on what medical care, other than nursing home care, is needed and whether the person in need will look to MAA for medical care only or to OAP for both medical and financial assistance.

Cost Factors. Proceeding from these underlying assumptions, the following factors appear to relate to the cost of a Colorado MAA program:

1) Approximately 55,000 persons in Colorado would be eligible for MAA benefits. These 55,000 persons are age 65 and over, non-pensioners, and have cash incomes of $1,356 or less annually.

2) An estimated 5,100 cases (three per cent of 170,000) would be expected to use one or more types of medical care in a comprehensive MAA program within a given month; this includes an estimated 3,900 nursing home cases now on OAP and AND, plus additional cases which would be added as need arises.

3) Nursing home care under MAA is expected to cover some 3,700 persons transferred from the OAP program or who would become MAA rather than OAP recipients plus some 200 AND recipients aged 65 and over who are presently in nursing homes. (The majority of these persons are receiving nursing home care from AND rather than OAP due to one of two reasons: a) the recipient does not have the five years' residence needed to qualify for the pension; or b) the recipient is not a citizen of the United States, which is a requirement for determination of OAP eligibility.

4) Costs experienced in the OAP program during the 1961-62 fiscal year and adjusted for an expected annual increase would be applicable to MAA.

5) Estimated costs of medical care for MAA recipients are based on an assumption that hospitalization, in-hospital physicians' services, care in nursing homes, and drugs and physicians' services for nursing home patients will be provided under the same conditions and regulations which apply to OAP. No estimate has been made for home and office calls, which are provided under OAP, for two reasons: a) utilization rates for a population with a large number of unknown characteristics is virtually impossible to predict; and b) the extremely difficult administrative procedures required to police such a program adequately. (It appears likely that inclusion of drugs and physicians' services for nursing home patients will qualify as "some non-institutional care" which is required by the Kerr-Mills Act as an essential segment of any MAA program.)

Estimated Cost of MAA-OAP Proposal

Cost estimates for the 1963-1964 fiscal year of the proposed MAA-OAP program (including the transfer between programs of nursing home care in excess of 30 days) have been based on the following:

1) 3,700 pensioners presently in nursing homes in excess of 30 days will voluntarily remove themselves from the pension rolls. Resultant state savings because pension payments would no longer be made to these people is estimated at $3,007,000 annually, this amount would spill over into the general fund.

2) Virtually all of these 3,700 nursing home patients would be eligible for AND, so that their monthly allowance for personal needs would be met by this program. Because of the matching formula for determining the amount of federal aid under this program, Colorado would receive an estimated $697,000 more annually than the cost of adding these 3,700 people to the AND program.

3) The state appropriation for the MAA program would be matched by the federal government under the provisions of the Kerr-Mills Act. Those receiving nursing home care under this program would be required to contribute any monthly income they might receive toward the cost of this care. The average monthly per capita income for these 3,700 nursing home patients now on the pension is $19.31.

Cost Estimate

Total Estimated Cost of Proposed MAA Program		$10,686,000
Nursing Home Payments by Patients ($19.31 x 12 x 3,700)		858,000
	Net Cost	$ 9,828,000
	State Share (50%)	$ 4,914,000
Additional Annual Spillover (3,700 no longer receiving pension)		$ 3,007,000
additional savings AND Program		697,000
	Total	$ 3,704,000

Net Cost to State

$4,914,000	appropriation for MAA
- 3,704,000	savings
$1,210,000	

This amount is $235,000 more than the state appropriated in 1962 to supplement the OAP medical care program.

If the State Welfare Board should decide that the recent three dollar per month pension increase is to be retained for personal needs by pensioners in nursing homes, this would require a $13 monthly payment to be made under AND rather than $10. This would increase state costs under the proposed program an estimated $180,000 to $1.39 million or $415,000 more than the 1962 appropriation. It should be noted that Congress might exclude MAA recipients from AND payments by amendatory legislation in the next session. If this happened, Colorado would be saddled with the entire cost of providing the monthly allowance for personal needs and would also lose the AND funds received over and above providing payments for the 3,700 nursing home patients. This would increase Colorado's annual cost of funding the MAA-OAP proposal in future years by approximately $1.14 million.

Administrative Costs. Administrative costs would be borne largely on the county level, but both county and state additional administrative expense could be financed 75-25 by the federal government. The counties might also realize a slight saving in county AND funds and a possible reduction in general assistance funds for medical care for those over the age of 65.

MEMORANDUM

November 23, 1962

TO: Legislative Council Hospital and Medical Care Committee

FROM: Legislative Council Staff

SUBJECT: Method of Payment for Nursing Home Care Under the OAP Medical Care Program and Other Welfare Programs (Aid to the Blind and Aid to the Needy Disabled)

Present Method of Payment

The State Department of Welfare is very much concerned with nursing home operations because of the large amount of public funds spent by this agency to purchase care in these homes. Three welfare programs are involved: 1) OAP Medical Care Program; 2) Aid to the Blind; and 3) Aid to the Needy Disabled.

Of these three, the one most important and causing the most concern is the OAP Medical Care Program. There are 3,700 OAP patients in nursing homes, and these patients fill approximately 60 per cent of all nursing home beds in the state. Welfare department vendor payments to nursing homes have increased from $1,805,000 in 1958 to $2,680,000 in 1961, and the cost in 1963 is estimated at $3.6 million. In addition to these vendor payments, the nursing homes receive $100 per month from each pensioner so confined. This leaves the pensioner with $10 a month to spend as he chooses.

For the past several years, public payments to nursing homes have been determined by two variables: 1) the quality rating of the nursing home; and 2) the degree of care provided. Nursing homes are ranked from I to IV, with those in the first group considered the worst and those in Group IV considered the best. There are three classes of patient care, ranging from ambulatory to completely bedridden.[1] The range of payments by category of nursing home and type of care provided is shown in Table I.

Problems With Present Program

This basis for determining payment has proven to be unsatisfactory according to welfare department officials. First, too few items have been used to determine the category in which a nursing home should be placed. Investigation has shown that there is a vast variation in the quality of care being provided within each of the nursing home categories. Secondly, these ratings are based on quarterly reports made by the nursing homes. In the past, these reports were not field audited. Investigations during the past year have shown that a number of these reports were unreliable.

1. Welfare vendor payments are no longer made for patients in Class I (ambulatory).

TABLE I

Welfare Payments for Nursing Home Care

Group		Patient Classification	Total Vendor Payment		Pensioner	Total To Nursing Home
I	0	1[a]	$00.00	0	$100.00	$100.00
		2	25.00	(25.00)	"	125.00
		3	50.00	(50.00)	"	150.00
II	1.5 (20.00)	1[a]	20.00	0	"	120.00
		2	45.00	(25.00)	"	145.00
		3	70.00	(50.00)	"	170.00
III	2.0 (35.00)	1	35.00	0	"	135.00
		2	60.00	(25.00)	"	160.00
		3	85.00	(50.00)	"	185.00
IV	2.5 (45.00)	1[a]	45.00	0	"	145.00
		2	70.00	(25.00)	"	170.00
		3	95.00	(50.00)	"	195.00

a. No longer in effect.

Payment on the basis of the type of care provided the patient has also been unsatisfactory. Investigation and complaints made to the department have shown that the provision of the highest payments for bedfast patients has, in a number of instances, discouraged patient improvement or recovery; once the patient's condition improves so he is no longer bedfast, the amount received by the nursing home decreases.

Investigation has also shown that the initial classification of patients has also been abused. Some physicians have complained to the department that pressure has been placed on them by relatives to classify nursing home patients in the highest care category. The homes, under welfare regulations, may charge a maximum of $250 per month, with the relatives or guardians responsible for the difference between $250 and the amount paid by the welfare department. Consequently, the more paid from welfare funds, the less which would have to be paid by relatives and/or guardians. This has been enough of a problem that some county and the state medical societies have requested that doctors no longer be required to classify patients.

Proposed New Program

Because of the problems and difficulties with the present method of paying nursing homes, the welfare department has been working more than a year to develop a new program to determine the quality of care and the amount of payment which should be made.

In developing this program, the welfare department has held many meetings with the health department and the state and local medical societies. The new rules and regulations were drawn up only after a long series of meetings with nursing home operators. (A committee of nine nursing home representatives participated, three each from the Western Geriatrics Association, Colorado Nursing Home Association, and the independents.) The standards adopted by the welfare department also incorporate all the features desired by the health department.

Following is a comparison of the present and proposed programs:

NURSING HOME CARE

Present Program	Proposed Program
1. License:	1. License:
Current Public Health license based on physical plant standards.	Current Public Health license based on physical plant and nursing service standards (minimum basic requirements).
2. Group Rating:	2. Group Rating:
Based upon a Quarterly Report on licensed nurse supervision and hours of nursing care given.	Based upon periodic home visitation and evaluation by a team from Public Health and Public Welfare covering six (6) major areas of nursing home functions, supplemented by Quarterly Reports as received presently. Field auditor will verify records.
3. Admission of Patient:	3. Admission of Patient:
Based upon a MED-9 from the attending physician certifying need for the care and the condition of the patient used as a basis for classification. Form sent to county department for classification under state regulations and notification to nursing home.	Based upon a new medical report including nursing care orders, medication, therapy, and activity tolerance. Report is sent to county department for authorization for admission and forwarded to Medical Services Division together with a brief case history for review. No classification of patients. Nursing home is notified via the county department. Utilization control established at state level.

	Present Program	Proposed Program
4.	Nursing Care:	Nursing Care:
	Variable as to quantity and quality. No actual field evaluation or basis for licensure. Passive palliative care. Only complaints are investigated. Subject to question.	Field visitation and evaluation by qualified R.N. Supervision and in-service training for rehabilitative nursing for self-care, preventive nursing, in some cases--convalescent care. Involve some physical therapy. Encourage occupational therapy. Consultants supplied by Public Health and Public Welfare.
5.	Payment: (Monthly)	Payment: (Monthly)
	Based on Quarterly Report and Classification of Patient plus flat $100 payment by OAP. Maximums range from $150 total to $195 total from welfare funds. Relatives may supplement up to total maximum ceiling of $250. State and local medical associations and individual physicians ask for a change in this system for many practical reasons.	Based on basic care paid by OAP at rate of $100, plus vendor payment for health care at $30, quality points (classification ranging from $50 to $80, plus (in some cases) special care up to additional $20 if the home is deemed qualified to give needed care). Total maximums range from $130 total to $210 total plus special care in some cases. Relatives may supplement up to a total maximum ceiling of $270. Special care payment is not included in the ceiling. Also based upon written application and terms as to basis for payment involving facilities and services provided by the nursing home. State and local medical associations and individual physicians are in sympathy with the new payment plan. They find this is a great improvement over the present system.

Status of Proposed Program

Originally, department officials expected that the proposal program would go into effect on July 1, 1962. The effective date has been delayed for several reasons:

1) Many nursing home operators have strong objections to the proposal.

2) It would be unfair to pay some nursing homes under the present formula and others under the new formula; therefore, it is desirable to complete all necessary preliminary investigations before the program is adopted.

3) Completion of all preliminary investigations are necessary not only to set the rates for all nursing homes prior to the effective date of the program, but also to have sufficient information to evaluate the program and determine charges, if any, before its adoption.

Nursing Home Operators' Objections to Present and Proposed Programs

There are three general groups of nursing homes in Colorado, two of which are organized. The Western Geriatrics Association is the organization to which most of the non-profit and hospital-affiliated nursing homes belong. The Colorado Nursing Home Association's membership is composed of proprietary nursing homes. In addition, there are a number of nursing homes which will have nothing to do with either organized group. These independents are primarily older proprietary nursing homes. (The newer proprietary homes are usually members of the Colorado Nursing Home Association.)

Committee Regional Meetings. Several objections to both the present basis and the proposed basis for welfare department vendor payments for nursing home care were voiced at the regional meetings of the Hospital and Medical Care Committee (especially the Glenwood Springs and Colorado Springs meetings). These objections may be summarized as follows:

1) The standards used by the welfare department are too high in relation to what the department is willing to pay. Consequently, most nursing homes are losing money by caring for OAP patients and would continue to lose money under the proposed program. Either the standards should be reduced or the amount of vendor payments increased.

2) The proposed program places the welfare department in the position of being judge, jury, and prosecutor, because the department would become much more extensively concerned with standards of care and internal nursing home operations than at present and would also dictate the amount the homes are to receive.

3) The welfare department has not given sufficient consideration to nursing home problems and the suggestions of operators in administering the present program and in developing the new one.

The nursing home operators' major complaint is that it costs more to meet welfare department standards than the department is willing to pay. Other criticisms appear to be incidental. (To a certain extent, the same complaint is made by some hospitals, but there is less cause, as hospitals are paid on an actual per patient day cost basis.)

Welfare Department Responsibilities. Perhaps it is only concern for their own facilities and programs, but it has often seemed that a number of nursing home operators have forgotten that the welfare department has responsibilities in the administration of the OAP medical care program which extend beyond paying the nursing homes what the operators consider to be a proper reimbursement. The department has an obligation to keep the total expenditures for medical care within the $10 million limit approved by Colorado voters. Further, the department has a responsibility both to the people of the state generally and to the recipients of medical care specifically to see that the care provided is adequate and necessary, so that money is not being misspent. These responsibilities have a direct bearing on the nursing home care requirements and the reimbursement levels established by the department.

Another Approach to Nursing Home Reimbursement

Perhaps the simplest way to assure that nursing homes are being compensated adequately, within the limits of the OAP medical care fund, would be to make payments on an actual cost basis, with an upper limit.

There are several questions which must be answered in considering nursing home reimbursement on an actual cost basis. These include:

1) What should actual costs include and how should they be determined?

2) What rate of depreciation should be allowed on buildings and equipment?

3) Should proprietary nursing homes be reimbursed on a cost plus basis?

4) Will payment on a cost basis result in the department making reimbursements in higher cost nursing homes for patients who need a minimum of care?

5) Would a maximum limit on cost reimbursement still penalize a number of nursing homes?

6) What effect would reimbursement on a cost basis have on total expenditures for nursing home care?

These questions are discussed and possible alternatives presented in the following section.

Nursing Home Cost Survey.

In connection with the proposed program for nursing home payment, the welfare department asked the nursing homes to provide data on their operating costs and number of patient days for the first nine months of 1962. This information was supplied by 48 nursing homes (40 of which were used for the analysis discussed on the following pages).

The 40 nursing homes for which data was compiled at the time of this memorandum appear to constitute a representative sample of all homes in the state. These 40 homes are distributed in size as follows:

0-24 beds	8
25-49 beds	21
50-74 beds	4
75-99 beds	4
100 beds or more	3
Total	100

All areas of the state are represented by these 40 nursing homes as follows:

Denver Metropolitan Area	8
Boulder-Larimer-Weld	8
Northeastern Colorado	5
Colorado Springs-Pueblo Area	10
Western Slope	4
Arkansas Valley	3
Southwestern Colorado	2
Total	40

Thirty of these nursing homes are proprietary and the other 10 are non-profit; five of these 10 are hospital-affiliated. The operating costs per patient day during the first nine months of 1962 as computed from data supplied by the homes are shown in the following table:

Daily Per Capita Operating Cost	No. of Homes
$5 and less	1
$5.01-$5.50	4
$5.51-$6.00	6
$6.01-$6.50	11
$6.51-$7.00	4
$7.01-$7.50	6
$7.51-$8.00	1
$8.01-$8.50	4
$8.51-$9.00	1
$9.01 and up	2
Total	40

The median per patient day operating cost was $6.46, and the mean was $6.80. The nursing homes were also asked to indicate the rate of depreciation used for buildings and equipment. The variance in depreciation rates among these nursing homes is indicated by the following:

Rate of Building Depreciation	No. of Homes	Rate of Equipment Depreciation	No. of Homes
0%	4	3%	1
1	1	5	1
2	4	6	2
2.5	3	7	2
3	6	8	1
3.3	2	10	17
4	2	12.5	2
5	9	14.3	1
6.7	1	15	1
10	1	16	1
12	1	20	6

Cost Comparisons. Several comparisons were made between the costs reported by the 40 homes, the amounts they have received from the welfare department during the first nine months of the year, and also the amounts they might have received had the proposed plan formula been in effect.

The maximum daily payment per patient which is made under the present method of reimbursement is $6.50 ($100 pension payment plus $95 vendor payment, divided by 30). Under the proposed plan formula it would be $7.00. As can be seen from the table showing the per capita daily operating costs reported by the 40 nursing homes, 18 of the 40 homes had per capita daily costs in excess of the present welfare maximum of $6.50.

A home-by-home comparison on costs, payment received, and possible payment under the proposed plan shows that 18 homes received payment in excess of their costs during the first nine months of 1962, and 22 received less. Under the proposed plan formula, 12 homes would have received payments in excess of reported costs, 25 would have received less, and three would have received payments about equal to reported costs.

Thirty-one of the 40 homes reporting costs are presently classified as Group IV homes; this means they are eligible to receive the highest welfare vendor payments. Seven of the other nine are in Group III, one in Group II, and one in Group I. Seven of the nine homes rated below Group IV received welfare payments in excess of their reported costs during the first nine months of this year. Had the proposed plan formula been in effect, six of these nine homes would have received payment in excess of reported costs.

Average per capita daily cost and payment comparisons show the following:

Average Per Capita Daily Cost Reported	$6.80
Average Per Capita Daily Payment Made (Present Program)	$6.29
Average Per Capita Daily Payment (Proposed Plan)	$6.24

The average per capita daily cost reported by the 40 homes is approximately eight per cent higher than the average per capita daily payment now made. This average was computed from all daily cost figures reported with no maximum limit, such as the $6.50 per capita daily payment under the present program. Were a $7.00 per capita daily limit imposed on daily costs, the average would only be two per cent higher than present payments to the 40 homes, even though the maximum limit would be eight per cent higher.

Considerations In Establishing A Cost Reimbursement Program

Two major conclusions may be drawn from the data discussed above: 1) There appears to be a low correlation between amount of payment received and actual cost of providing nursing home care, with some homes receiving more and others less than per capita daily operating costs. 2) There will probably be an increase in expenditures for the nursing home program if a cost reimbursement program is established. The extent of this increase will be governed in part by the following:

a) establishment of a cost reimbursement ceiling;

b) use of strict rather than lenient depreciation allowances;

c) determination of whether reimbursement to proprietary homes should include a profit margin; and

d) expansion rate of staff, equipment, and facilities by homes whose costs are less than the maximum limit.

It appears obvious that some ceiling would have to be established if a cost-reimbursement program were adopted. If not, nursing home expenditures would increase astronomically. The limit established should be high enough to cover as many nursing homes as possible consistent with available funds and good administration. If the maximum limit were set at $7.00, 65 per cent of the 40 homes returning questionnaires would be covered. Some of the homes reporting daily per capita costs between $7.00 and $7.50 used very high depreciation allowances. Had more reasonable allowances been used, they might also be within a $7.00 ceiling.

While 30 to 35 per cent of the nursing homes would still not be reimbursed for costs (according to their reports) with a $7.00 limit, at least there would be no homes with costs less than $7.00 who would receive reimbursement in excess of costs. The present arrangement which permits nursing homes to collect additional funds from relatives, guardians, or other persons legally responsible for patients could be adapted to a cost-reimbursement program.

Such additional charges might be applied in one of two ways -- or both:

1) If the home's per capita daily costs were in excess of the state limit, the difference not to exceed a specified amount (such as $1.50 per day or $45 per month), could be collected from relatives or legal guardians.

2) The agreed upon rate of profit to accrue to proprietary homes if such practice is found desirable could be paid through a charge to legal guardians or relatives, rather than from state payments.

The latter proposal is included, because the biggest problem reported by nursing homes is that costs are not being met by welfare payments. It would appear, therefore, that any initial remedial action taken by the state should be directed at this problem, with profit a matter of later concern. A compromise could be achieved by permitting nursing homes to make an additional charge to persons responsible for the patient.

If a cost-reimbursement program were adopted, perhaps it should be handled in the same way as the hospital program. If this were done, nursing home books would be audited every six months, and payments would be based on the audit results. Certain limits could be set on depreciation rates and the amount of cost increase from one audit period to the next which would be reimbursable. This latter limit would help to control cost increases resulting from possible unnecessary staff and equipment expansion.

The cost of nursing home service under the OAP medical care program has been increasing annually. This increase has resulted from greater utilization as well as higher classification of patients and nursing homes. Neither the homes nor the welfare department are satisfied with the present arrangement. Adoption of a cost-reimbursement program will not reduce the program's expense, in fact, the opposite is much more likely to be the result, but it might make payments more equitable and provide proper justification for payment increases.