Economic Impact Analysis
Virginia Department of Planning and Budget

12 VAC 5-381 –Virginia Department of Health
Regulations for the Licensure of Home Care Organizations
April 12, 2004

The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with Section 2.2-4007.G of the Administrative Process Act and Executive Order Number 21 (02). Section 2.2-4007.G requires that such economic impact analyses include, but need not be limited to, the projected number of businesses or other entities to whom the regulation would apply, the identity of any localities and types of businesses or other entities particularly affected, the projected number of persons and employment positions to be affected, the projected costs to affected businesses or entities to implement or comply with the regulation, and the impact on the use and value of private property. The analysis presented below represents DPB's best estimate of these economic impacts.

Summary of the Proposed Regulation

Due to the extensive nature of the changes, Virginia Department of Health proposes to replace the entire home care regulation with a new set of rules and regulations. The proposed substantive changes are (i) adding qualifications, supervision requirements, and continuing education requirements for personnel, (ii) adding one year of experience or training in direct health care delivery services to the administrator qualifications and requiring the back up administrator to have exactly the same qualifications, (iii) increasing license fees, (iv) switching from annual inspections to biennial inspections, (v) eliminating the restriction requiring home care agencies to provide services only in a defined geographical area, and (vi) incorporating several other changes such as adding statutorily required background check requirements for compensated employees, clarifying the type of insurance coverage required, adding that home visits are part of the inspection protocol, clarifying the quality improvement assessment indicators, removing contradictions with Medicaid and Medicare certification requirements,

detailing consumer complaint procedures, and clarifying financial control standards for initial licensure.

Estimated Economic Impact

These regulations contain rules for licensing and inspection of home care organizations as well as their operational standards. Approximately 85 home care organizations are currently regulated under these regulations. This action contains numerous substantive changes for the home care industry. Some of the proposed changes are likely to introduce unnecessary industry wide compliance costs as discussed below.

Personnel Qualifications, Supervision, and Continuing Education Requirements

The proposed regulatory language with respect to the qualifications of personnel providing different levels of service and the supervision of personnel performing different levels of service is unclear and problematic. The ambiguity in these areas has the potential to create significant economic costs for the providers as well as privately paying customers. However, it seems feasible and relatively easy to eliminate the ambiguities in the proposed version. Thus, it is in the best interest of the Commonwealth to devote additional administrative resources to refine the proposed rules.

Section 32.1-162.7 of the Code of Virginia describes three types of services in the definition of a home care organization: (1) home health services, (2) personal care services, and (3) pharmaceutical services. The proposed regulations define a uniform title, "home attendant," for personnel providing home health services and/or personal care services. The proposed language does not use or define the specific term "home health services" as used in the statue, but rather describes these services in terms of the services provided by a "home attendant." The proposed regulatory language in 12 VAC 5-381-310 and 350 delineating home health services and personal care services as follows:

Home attendant services:

1. *Assisting patients with: i) activities of daily living; ii) ambulation and prescribed exercise; and iii) other special duties with appropriate training and demonstrated competency;*
2. *Assisting with oral or topical medications that the patient can normally self-administer;*
3. *Measuring and recording fluid intake and output;*

4. Taking and recording blood pressure, pulse and respiration;
5. Recording and reporting to the appropriate health care professional changes in the patient's condition;
6. Documenting services and observations in the home care record; and
7. Performing any other duties that the aide is qualified to do by additional training and demonstrated competency, within state and federal guidelines.

Personal care services:

1. Assistance with the activities of daily living;
2. Taking and recording vital signs, if indicated in the personal care plan;
3. Recording, and reporting to the supervisor, any changes regarding the patient's condition, behavior or appearance; and
4. Documenting the services delivered in the patient's record.

Personal care services may also include instrumental activities of daily living related to the needs of the patient.

The proposed descriptions clearly indicate that home health services are more demanding than the personal care services in terms of the qualifications of the personnel who will provide them and in terms of the supervision required. However, the proposed regulations provide only one title and define home care aides, home health aides, and personal care aides as "home attendant." Thus, personnel who may be providing only personal care services are required to meet the same qualifications of a "home attendant." The proposed qualifications in 12 VAC 5-381-250 are as follows:

Home attendants shall be able to speak, read and write English and shall meet one of the following qualifications:
1. Have satisfactorily completed a nursing education program preparing for registered nurse licensure or practical nurse licensure;
2. Have satisfactorily completed a nurse aide education program approved by the Virginia Board of Nursing;
3. Have certification as a nurse aide issued by the Virginia Board of Nursing;
4. Be successfully enrolled in a nursing education program preparing for registered nurse or practical nurse licensure and have currently completed at least one nursing course which includes clinical experience involving direct patient care; or
5. Have satisfactorily passed a competency evaluation program that meets the criteria of § 484.36 (b) of Title 42 of the Code of Federal Regulations.

For many, the Medicare competency evaluation mentioned in the fifth option is the simplest way to qualify for provision of regulated home care. Even this option requires 75 hours of classroom and supervised practical training under the oversight of a registered nurse. So, there are significant costs associated with the proposed personnel qualifications for those who will provide only non-medical personal care.

It is not clear whether this level of skills is necessary for those who will provide only personal care. In contrast to the proposed uniform qualifications, Medicare rules, 42 CFR 484.36 (e), states that a caregiver providing personal care exclusively "need not be determined to be competent in those services…that the individual is not required to furnish." Additionally, the Department of Social Services' (DSS) experience with providing home care services and the Department of Medical Assistance Services' (DMAS) experience with providing home care services through the consumer directed model do not support the proposed level of qualifications for personal care personnel.[1]

DSS has been providing home care services including assistance with bathing, dressing, toileting, and eating/feeding to over 5,000 adults every year going back more than 10 years. DSS requires minimal qualifications from home-based providers who provide personal care as well. These qualifications are (1) be at least 16 years old (homemaker providers must be 18 years old), (2) have a background check, and (3) demonstrate through interviews, references, and employment history the basic knowledge and skills required for the job (22 VAC 40-700-30). Despite allowing providers with substantially lower qualifications than those proposed for home care organizations to serve its clientele, DSS staff are not aware of any significant concerns with the quality of care provided and report that the rate of complaints has been relatively low. Similarly, under the consumer directed model, DMAS rules require that personal care aide be at least 18 years old, be able to perform the personal care tasks required by the client, and pass the background check. Training, where necessary, is provided by the client or by a facilitator hired by DMAS. The aide's work is overseen by the client or by the facilitator who is not required to be an RN or have a degree in a human services field. Thus, DMAS training and supervision

[1] Also, an online survey conducted by VDH at the request of DPB revealed that at least Hawaii, Ohio, Massachusetts, Pennsylvania, Vermont, Iowa, West Virginia, and Alabama do not require licensure for home care providers indicating lack of concern with respect to health and safety risks associated with provision of home care services in these states.

requirements for consumer directed personal care are considerably less stringent than those proposed.

The proposed supervision of personnel providing personal care services by a registered nurse (RN) or a licensed practical nurse (LPN) merits further consideration. First, the statutory language in §32.1-162.7 of the Code of Virginia appears to envision no supervision for personal care services. This is because the statute specifically requires home health services to be "provided by or under the direct supervision of any health care professional under a medical plan of care." By contrast, this specific supervision language is omitted in the description of personal care services. Second, the proposed supervision requirement will force a home care organization wishing to provide only personal care to hire an RN or an LPN and introduce significant compliance costs. According to the Bureau of Labor Statistics the most recent mean annual salary for registered nurses and licensed practical nurses in Virginia is $47,610 and $30,740, respectively.

The driving force behind the proposed supervision requirement is the concern about the protection of consumer health, safety, and welfare. In relation to this concern, it is imperative to note that these rules regulate the provision of services to private payers who do not receive any public assistance.[2] It is also imperative to note that some of the services are non-medical, personal care services. It is not clear whether customers receiving only personal care services require the same level of protection as those receiving health related services. Also, it is not clear whether personal care customers need assistance from a nurse to assess the impact of non-medical support services on themselves. Bishop (1999, p. 283) suggests that while nurses are more likely to assess the effects of health related services on customers, individuals and families are likely to best assess the effects of compensatory non-medical services. Additionally, VDH provided no evidence that unsupervised provision of personal care poses significant health, safety, or welfare risks and supervision will reduce these risks. As mentioned before, DSS' and DMAS' experiences with no quality of care problems and a low complaint rate also do not support the proposed level of supervision for the personal care personnel.

[2] Home care organizations providing services to Medicare recipients are routinely exempted from this regulation. Medicaid home care providers are not subject to these regulations.

Moreover, the proposed regulations require both types of personnel to receive exactly the same hours of continuing education or training. While it is not clear whether continuing education should be required for personal care providers at all, at the least, it would be more cost effective to require level of ongoing education commensurate with the type of service provided and the level of experience possessed by the individual personnel providing care.

In short, the proposed regulations establish the same qualification, supervisory, and continuing education requirements for the personnel providing personal care services or home health services. This seems to be contrary to the section 32.1-162.12 of the Code of Virginia which mandates "Regulations shall be appropriate for the categories of service defined in §32.1-162.7." Additionally, the economic implications of failing to distinguish between the personal care and home health care when establishing qualifications and supervisory requirements for the personnel are quite significant.

The proposed uniform requirements eliminate economic incentives for providers wishing to provide and specialize in only personal care, but not in home health care. Under the proposed language, a personal care provider will be forced to maintain skilled personnel who are capable of providing home health care services and forced to hire a registered nurse or a licensed practical nurse to provide supervision, even if no home health care services are provided. Thus, these requirements are expected to introduce unnecessary compliance costs and consequently create economic inefficiencies. One key unintended consequence of this regulatory provision is to raise the price of the service, which will certainly result in a reduction in the number of hours purchased.

As mentioned already, these rules regulate an otherwise private market. And, the likely effects on customers are very much analogous to not being able to buy a beverage without having to buy the whole combo meal at a restaurant. In the home care market, unnecessary compliance costs will artificially raise the cost of personal care and equate it with the price of home health care. Distorted, or artificially high, personal care price will discourage some customers getting the personal care services they would have otherwise purchased. So, the providers will be forced to provide and customers will be forced to receive less than the economically optimal amount of personal care. In other words, economic resources of the customers will be channeled into different uses that are not as desired as the personal care by

them. This phenomenon is called as "allocative inefficiency," a technical term for the waste of society's scarce resources.

In addition, higher prices will encourage some customers to seek unregulated forms of personal care services such as the services offered by a family member, a neighbor, or an unlicensed organization. This may undermine the very intent of the proposed regulation, which is to protect health, safety, and welfare of customers. In more personal terms, this regulation raises the cost to individuals of hiring assistance. It does so by forcing many consumers of this care to purchase a more expensive type of home care than they want or need or to go without altogether. For those who do choose to buy the more expensive product, when they would otherwise choose a lower priced alternative, the regulation reduces the amount of money these clients have to spend on other goods. For those home care customers who choose to go without or to go to unregulated sources of home care, the unintended consequence of this regulation is that many people will actually have lower quality health care under this regulation than they would without it! The agency has not been able to provide any information that would lead one to conclude that there will be a net improvement in home care under this proposal. With or without this proposed rule, those who wish to purchase the more expensive type of care may do so if they wish.

Since these rules apply to many providers and affect thousands of private paying customers on a daily basis, even a small unnecessary increase in price has significant economic consequences. For example, assuming that there are 5,000 customers who need two hours of personal services every day and these services could be provided at an hourly rate of $5 less than the rate for the home health services, then the customers needing only personal services could save about $18.2 million in total, or $3,650 per person per year if this regulation distinguishes different levels of home care. These adverse implications for the customers and the providers are significant and beg the question: is it feasible to distinguish different levels of home care provided in Virginia and avoid waste of significant resources?

To answer this question, one must ask whether it is practically possible to distinguish among different categories of home care services. The term "home care" is arbitrarily used to describe a wide spectrum of services ranging from skilled nursing and physical therapy to assistance with activities of daily living and even sometimes assistance with homemaker

services. However, home care services could be relatively easily categorized with respect to their intended effect on the person receiving the service. For example, Bishop (1999) describes two categories of home care services: ones that focus on restoration, improvement, and maintenance of health and ones that focus on ongoing support for daily functioning. So, it seems possible to classify home care services as (1) medical services and (2) non-medical services.

Furthermore, a 2002 position paper by Home Care Aide Association of America (HCAAA) may be used as a starting point to tailor these regulations to distinguish among different types of services, personnel qualifications, and supervision requirements. HCAAA suggests three levels of home care aides with associated duties, training, and supervision.[3] Duties of Home Care Aide I are outlined as assisting with environmental services such as housekeeping and homemaking services excluding personal care. Duties of Home Care Aide II described as assisting client and/or family with home management activities and personal care excluding duties under a medically directed plan of care and assistance with medication, or wound care. Duties of Home Care Aide III include working under a medically supervised plan of care to assist the client and/or family with household management and personal care. This position paper shows that it is feasible to define different levels of home care and to establish different levels of personnel qualifications according to the type of service provided.

Available information strongly indicates that these regulations could be easily tailored by health care professionals to minimize, if not eliminate, their adverse economic effects on customers and providers, without posing health and safety risks for the consumers. Additionally, the Code of Virginia not only allows, but also seems to require that these regulations distinguish among the different levels of home care. So, for instance, the home heath services mentioned in section 32.1-162.7 could be defined as services that are similar to the Home Health Aide III services mentioned in the HCAAA position paper. Similarly, personal care services mentioned in the Code of Virginia could be defined as services that are similar to the Home Health Aide II services. The services described for Home Health Aide I appear to closely resemble the statutorily exempt services.

In short, the potential pay off that can be expected from additional efforts to distinguish among the different levels of home care service by refining and tailoring readily available

[3] This paper does not provide detailed information with respect to the type of supervision.

categories of home care services appear to be substantial. Furthermore, supervision of personal care personnel may not need to be required, or experienced personal care personnel could provide such supervision without forcing personal care providers to hire a registered nurse, or a licensed practical nurse. Finally, continuing education requirements for personnel may be removed completely, or revised to recognize the different levels of skill sets between personal care personnel and home health personnel and the level of experience possessed by an individual care provider.

In addition to those already mentioned, other problematic areas in the proposed language that needs further consideration include (1) failure to delineate exempt services (with the exemption of homemaker services) any further than referencing the statute, (2) failure to clarify whether environmental services can be performed by home attendants as they are included in the definition of the home attendant, but not listed under service description, (3) failure to clarify whether environmental services should be considered as exempt, (4) inconsistent listing of some services under personal care services, but not under home attendant services, (5) failure to clarify the meaning of "appropriate health care professional" who will supervise the home attendant, (6) unclear rationale for requiring state licensure prior to applying for national accreditation or federal certification as these organizations will be exempt from these regulations, and (7) inappropriate use of the term "patient" for individuals receiving personal care exclusively. Some of these problems, particularly the ambiguity with respect to the types of services that will be exempt from licensure, may introduce significant compliance costs for the providers.

Administrator Qualifications

The proposed changes add a one-year training and experience requirement in direct health care delivery to the qualifications for the administrator. Also, the new language specifies that currently required supervisory experience be within the last five years. In the past, the department received applications from people who were not qualified for the position, for example, a person with restaurant management experience and experience in a position distantly related to health care. Also, in one of the cases a home health care provider with tenure in home care a long time ago, who later abandoned all of his patients, was a defendant in investment scam litigation. The purpose of these requirements is to make sure that the administrators possess appropriate training and experience to manage a home care business.

While the main purpose of more advanced administrator qualifications is increasing the health and safety protection afforded to patients, the actual costs and benefits of this requirement will depend on the current compliance level with the proposed standards. Therefore, it is not clear whether the proposed administrator qualifications will introduce significant costs.

In addition, the proposed regulations will require the person acting on behalf of the agency administrator to meet the same requirements as the administrator. According to comments received from members of the industry, this new requirement may place additional costs and burdens on home care organizations, especially smaller agencies. VDH did not address the reasons for the identical requirements for the back up administrator in its submission package. Since the agency has been unable to provide any examples of problems with unqualified personnel acting on behalf of administrators, it cannot be considered likely that the additional costs to agencies will lead to any increase in patient safety or quality of care. It is unclear whether the same level of qualifications is necessary for the back up administrators as their responsibility is temporary by definition. It seems more likely that allowing a person with lower level qualifications to be a back up administrator would actually add to the net economic benefits.

Licensure Fees

The proposed changes will significantly increase the license fees. The fee changes are summarized in the following table.

According to the department, the fees have not been updated since 1990.[4] In fiscal year 2003, the annual budget for the home care program was $176,430, which covers surveyors' salaries, benefits, travel expenses, and all other miscellaneous expenses. The average cost of a survey was about $1,680. However, the department collected only $17,220 from all providers, or about $202 per provider. Thus, approximately 90% of the total cost was financed through general fund revenues and only 10% through license fees. With the proposed fee structure, the department will collect approximately $42,500 from providers every year. In short, proposed changes will shift a higher proportion of costs to operate the licensing program from the general fund to providers.

[4] Consumer prices have increased by 45% on average since 1990.

Annual Budget	Type	Current Fee	Proposed Fee
Over $200,000	Initial License	$200	$500
	Renewal License	$100	$500
$100,000 to $199,999	Initial License	$150	$500
	Renewal License	$75	$500
Less than $100,000	Initial License	$100	$500
	Renewal License	$50	$500
All	License Reissue	$25	$250
All	License Extension/Late fee	$25	$50
All	Exemption Determination	NA	$75

On average, a provider will pay an additional $298 per year. Most home care recipients are private payers. Thus, the ability of providers to pass on some of the costs to their patients seems to be significant. However, the potential effects on prices and the quantity of services purchased do not seem to be significant due to large number of customers who will share the increase in fees. In exchange for very small costs on individual customers and providers, the main benefit of this change is the reduction in the general fund monies needed to finance this program.

Inspection Frequency

Another significant change is the proposal to conduct state inspections every two years rather than every year. The scope of the inspections covers the qualifications of the personnel, provision and coordination of services, management, operations, staffing, equipment, clinical records, and quality of care. The department notes that the complaint rate for the home care program is nominal and indicates that complaints would be investigated when they are received regardless of the periodic inspections. Thus, there does not seem to be a good reason to expect significant adverse health and safety effects from less frequently conducted state inspections.

On the other hand, biennial inspections will provide significant savings in staff time. The department notes that the number of licenses has been increasing in the last four years. The biennial inspections are expected to relieve some of the increase in the workload, allow the current staff to meet the current periodic survey needs, and improve complaint investigations.

Service Areas

The proposed changes will eliminate the restriction requiring home care agencies to provide services only in a defined geographical area. Under the current regulations, home care organizations are limited to serve patients in service areas "geographically limited to the county or independent city in which that agency's office is located and the counties or independent cities immediately contiguous to that location or both." The removal of this restriction will provide significant benefits to the providers as well as customers without introducing public health and safety risks.

No change in health and safety risks is expected because there is no evidence showing that service area boundaries contribute to improved quality of care or that home care organizations provide emergency services. Also, other health care professionals who provide care in home settings (such as physicians and therapists) are not restricted as to where they may accept patients.

The benefits of removing this restriction are significant. Without this restriction, home care providers will make their "location" decisions based on economic factors rather than regulatory requirements. Since firms strive to maximize profits, they will likely to provide services where the demand is highest and consequently improving access to services where they are needed the most. This change is also likely to contribute to competition in the home care market. Without the geographic boundaries, a home care organization does not just compete with other (if any) providers in the same boundary, but all of the providers within the reach of the customers. The customers will also have a broader selection of providers to choose from. If they are not satisfied with a provider, they can go to another provider that may not be in the same geographical area. The expected outcome is a market structure with characteristics much more close to a competitive market. The providers will likely save because of their flexibility as to where to locate, or their flexibility as to whom to serve and customers are likely to save as they

can freely choose to receive services from any provider that is best for them. The overall expected result is an improved allocation of society's scarce resources.

Other Miscellaneous Changes

The remaining changes are not likely to produce significant economic effects. They are mainly clarifications of the current practice and updating of language to incorporate statutory changes that have occurred since 1990. These changes include adding a statutorily required background check for compensated employees, clarifying the type of insurance coverage required, adding that home visits are part of the inspection protocol, clarifying the quality improvement assessment indicators, removing contradictions with Medicaid and Medicare certification requirements, detailing consumer complaint procedures, and clarifying financial control standards for initial licensure. These changes can be expected to increase the clarity of the regulation and provide some benefit to regulated community.

Businesses and Entities Affected

The proposed regulations apply to approximately 85 home care providers licensed by the state.

Localities Particularly Affected

No localities are expected to be affected any more than others.

Projected Impact on Employment

The proposed changes will likely have differential employment effects on providers according to the types of services provided and the market characteristics in the geographic area they are currently operating in. The proposed personnel qualifications and supervision requirements may necessitate hiring new personnel for personal care only providers but are also expected to increase compliance costs which may reduce the number of employment positions. The providers offering home health services in conjunction with the personal care services probably already have nursing personnel who can provide supervision eliminating the need to create additional positions for supervision, but the enhanced ability to charge higher prices for personal care under the proposed regulations may contribute to their profitability and create new employment at the consumers' expense. In general, the proposed personnel requirements will cause some providers to hire personnel beyond the economically optimal level while causing

some other providers to reduce personnel below the optimal level. Since the proposed regulatory design will distort the prices in home care market, the overall effect on net employment will be to drive it away from the optimal level, causing significant waste of resources.

The removal of geographic service area limitation could result in differential employment effects as well. Some home care firms will have reduced compliance costs because they can make their location decisions based on economic factors. This may encourage entry into home care market in certain geographical areas, which would contribute to employment. Some incumbent home care providers will face new competition and may loose some of their customers leading to a reduction in the number of personnel needed to run their business. Additionally, some incumbents may be able to reduce their compliance costs as a result of no longer being forced to serve the whole geographic area. Contrary to the personnel requirements, removal of service area limitation will likely improve allocative efficiency. This will be achieved through improving competition in the home care market and removing a limitation that is distorting the current prices. While some providers will reduce their employment some others will increase their employment relative to current levels. Whether it is an increase or decrease, this expected movement at the individual firm level that will result from this portion of the proposed changes will improve allocative efficiency and prevent waste of society's valuable resources.

In short, not only the net employment effects of each of these changes are ambiguous, but also the magnitudes of their opposing effects on "allocative efficiency" are not known. Thus, it is impossible to make a conclusive statement about the net effect of the proposed regulations as a package on employment.

Effects on the Use and Value of Private Property

Similarly, no uniform effect on the value of businesses providing home care should be expected. Each provider will experience differential effects depending on whether the proposed changes improve their profitability or not. Some providers may experience improved profitability as result of improved regulatory design such as the removal of service area limitation while others may be hurt by it. The proposed personnel qualifications could also hurt or improve the profitability of an individual provider. Thus, it is impossible to make a

conclusive statement about the net effect of the proposed regulations as a package on the use and value of businesses in Virginia's home care market.

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