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
August 18, 2005

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 (VDH) proposes to replace the entire home care regulation with a new set of regulations. The proposed substantive changes are (i) adding supervision, continuing education, and qualification requirements for personnel, (ii) adding one year of experience or training in direct health care delivery services to administrator qualifications and requiring all back-up administrators to have the same qualifications as administrators, (iii) increasing license fees, (iv) switching from annual inspections to biennial inspections, and (v) eliminating the restriction requiring home care agencies to provide services only in a defined geographic area. Other changes include adding a statutorily-required background check requirement for compensated employees, clarifying the type of insurance coverage required, requiring home visits to be part of the inspection protocol, clarifying the quality improvement assessment indicators, removing any requirements that contradict 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 the operation, licensure, and inspection of home care organizations. Approximately 129 home care organizations are currently fall under these regulations. This action contains numerous substantive changes for the home care industry. As discussed below, a few of the proposed changes are likely to introduce unnecessary industry-wide compliance costs.

Supervision, Continuing Education, and Personnel Qualifications

The proposed regulatory language with respect to the *supervision and continuing education* requirements for personnel providing different levels of services seems to be excessive. Excessive supervision and continuing education requirements have the potential to create significant economic costs for both providers and private paying customers.

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 term "home health services" is not used or defined as it is in statue, but rather these services are described in terms of the services provided by a "home attendant." The proposed regulatory language in 12 VAC 5-381-320 and 12 VAC 5-381-360 delineating home health services and personal care services is as follows:

Home attendant services:

A. Services of the home attendant may include, but are not limited to:

1. *Assisting clients 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 client 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 client'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:

B. The personal care services shall include:
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.

These descriptions clearly indicate that home health services are more medically demanding and extensive than personal care services. However, the proposed regulations provide only one title and define all home care aides, home health aides, and personal care aides as "home attendants." The proposed regulations also require that home attendants providing home health services work under the supervision of an appropriate health care professional and be supervised on-site at least once every 30 days by a therapist, a registered nurse (RN), or a licensed practical nurse (LPN). Similarly, home attendants providing personal care services are required to work under the supervision of an RN and be supervised on-site at least once every 30 days by an RN, or an LPN.

The proposed requirement for supervision of home attendants providing only personal care services by an RN or LPN is problematic. First, the statutory language in §32.1-162.7 of the Code of Virginia appears to envision no supervision for personal care services. 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 for personal care services will force home care organizations 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 was $47,610 and $30,740, respectively.

The driving force behind the proposed supervision requirement for personal care services is concern about the protection of consumer health, safety, and welfare. In relation to this concern, it is imperative to note that these rules primarily regulate the provision of services to

private payers who do not receive any public assistance.[1] It is also imperative to note that some of these 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. Moreover, 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 best assess the effects of health-related services on customers, individuals and families are likely to best assess the effects of compensatory non-medical services.

VDH provided no evidence that unsupervised provision of non-medical personal care poses significant health, safety, or welfare risks, and that supervision will reduce these risks. Instead, VDH argued that provision of all personal care services falls under the protected scope of nursing practice and that nursing delegation rules prevent the provision of these services without the supervision of a nurse. Contrary to VDH's belief, the executive director of the board of nursing stated on September 2, 2004 that "**there is nothing in the scope of nursing practice regulations prohibiting provision of some personal care services by a home attendant without nursing supervision**." The director of nursing board is also of the opinion that "**it is reasonable for some personal care to be provided without nurse supervision**."

Medicare rules do not currently specify any supervisory requirements when only personal care services are provided. Moreover, 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 supervision of personal care personnel.[2]

DSS has been providing home care services, including assistance with bathing, dressing, toileting, and eating/feeding, to over 5,000 adults every year for more than ten years. DSS requires minimal qualifications from home-based providers who provide personal care services.

[1] Home care organizations providing services to Medicare recipients are routinely exempted from this regulation. Medicaid home care providers are not subject to these regulations. However, during this review, it was determined that the provision of personal care services by DSS is subject to these regulations.

[2] An online survey conducted by VDH at the request of DPB revealed that at the least Hawaii, Ohio, Massachusetts, Pennsylvania, Vermont, Iowa, West Virginia, and Alabama do not require licensure for home care providers. Moreover, there is reason to believe that Connecticut, Colorado, Michigan, Wisconsin, South Carolina, and Kentucky do not have licensure requirements for service organizations providing only personal care. The fact that

These qualifications are that all such providers (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 basic knowledge and skills required for the job (22 VAC 40-700-30). There are no specific medical supervision requirements in the DSS regulations. Despite the lack of supervision of personnel providing ADLs, DSS staff is 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 aides (1) be at least 18 years old, (2) be able to perform the personal care tasks required by the client, and (3) 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, the DMAS supervision requirement for consumer directed personal care is considerably less stringent than that proposed supervision requirements.

The need for nurse supervision of personal care providers apart, the proposed regulations require both home health service and personal care service personnel to receive exactly the same number of hours (12 hours per year) 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, the level of ongoing education should be commensurate with the type of service provided. By not doing so, the proposed regulations are not cost effective and are likely to lead to a waste of resources.

Contrary to the supervision and continuing education requirements, the proposed regulations distinguish between home health services and personal care services in establishing personnel qualifications. Home attendants providing personal care services will be able to qualify by passing the Medicare competency evaluation, which does not require the evaluation of personnel in tasks they will not be furnishing to clients. The other option available for personnel providing personal care services is the satisfactory completion of a Medicaid aide training course for personal/respite care services. These two options for qualification are the least cost

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these states do not require licensure indicates a lack of substantiated health and safety risks associated with the provision of non-health care services.

alternatives available to personnel providing personal care services. By requiring competency only in the areas in which services are to be provided, these proposed personnel qualifications are likely to be cost effective and economically efficient.

In summary, the proposed regulations establish the same supervisory and continuing education requirements for personnel providing personal care services and for personnel providing home health services. Moreover, the economic implications of failing to distinguish between the personal care and home health care when establishing supervisory requirements for the personnel could be quite significant.

The proposed supervision 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 hire a registered nurse or a licensed practical nurse to provide supervision, even if no home health care services are provided. Thus, these requirements can be expected to introduce unnecessary compliance costs and consequently create economic inefficiencies. One key unintended consequence of this regulatory provision will be to raise the price of personal care services, which is likely to result in a reduction in the number of hours purchased.

As mentioned previously, these rules primarily regulate the provision of services to private payers who do not receive any public assistance and DSS provision of personal care services. The likely effect of the proposed regulations on customers is very much analogous to them not being able to buy a beverage without having to buy the entire combo meal at a fast food 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 is likely to discourage some customers from getting the personal care services they would have otherwise purchased. Thus, the providers will be forced to give less and customers will be forced to receive less than the economically optimal amount of personal care. In other words, economic resources of a customer are likely to be channeled into different uses that are not as desirable as personal care. 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 the health, safety, and welfare of customers. For example, when these rules are adopted, DSS will no longer be able to provide the same amount of personal care services it currently provides due to increased costs associated with supervision of personal care services involving ADLs. Some low-income individuals are very much likely to stop receiving these services altogether, as they probably cannot afford to purchase these services privately. Similarly, there is little doubt that privately paying customers are likely to reduce consumption of personal care services in response to higher prices. Thus, it is impossible to conclude that the proposed regulations will achieve their goal of protecting health, safety, and welfare when it unambiguously reduces the consumption of needed personal care services.

In more personal terms, this regulation raises the cost to individuals of hiring personal care assistance. It does so by forcing consumers of this type of care to either 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 form of home care, when they would otherwise have chosen a lower-priced alternative, the proposed regulations reduce the amount of money these clients have to spend on other goods. An unintended consequence of these regulations for those home care customers who choose to go without or to go to unregulated sources of home care is likely to be a lower quality health care under these regulations than under the existing regulations. VDH 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 the proposed supervision requirement. With or without this proposed rule, those who wish to purchase the more expensive type of care may do so if they wish. So, there is no reason to force individuals wishing to purchase a lower-priced product to pay for a higher-priced product when they do wish to do so.

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 could have significant economic consequences. For example, assuming that there are 5,000 customers who need two hours of personal care services every day and that these services could be provided at an hourly rate that is $3 to $5 less than the hourly rate for the home health services, customers needing only personal services could save between $10.9 million to $18.2 million a year, or $2,190 to $3,650 per person per year if these regulations were to distinguish different levels of home care. These are significant adverse implications for both customers and providers and beg the

question: is it feasible to distinguish different levels of home care provided in Virginia and avoid a significant waste of resources?

To answer this question, one must ask whether it is practically possible to distinguish between 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 can 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 such that they distinguish between different types of services 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 are described as assisting clients and/or families with home management activities and personal care excluding duties that fall under a medically directed plan of care and excluding 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 supervision depending on the type of service provided.

Available information strongly indicates that these regulations could easily be tailored to minimize, if not eliminate, their adverse economic effects on customers and providers, without posing any additional health and safety risks for the consumers. Additionally, the Code of Virginia not only allows, but also seems to require that these regulations distinguish between different levels of home care. So, for instance, the home health services mentioned in section 32.1-162.7 could be defined as services that are similar to the Home Health Aide III services

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

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 statutorily exempt services.

The potential pay-off that can be expected from additional efforts to distinguish among the different levels of home care service appears to be significant. Supervision of personnel providing personal care services may not be required, or experienced personal care personnel could provide any supervision that may be required without having personal care providers hire a registered nurse or a licensed practical nurse. Also, continuing education requirements for personnel may be revised to recognize the different levels of skill required for personal care personnel and home health personnel.

Administrator Qualifications

The proposed regulations add one-year training and experience in direct health care delivery to the existing qualifications for administrators. Also, the new language specifies that currently required supervisory experience be acquired within the last five years. In the past, the department received applications from people who were not qualified for the position, such as from a person with restaurant management experience or with experience in a position distantly related to health care. In one case, a home health care provider with tenure many years ago in home care who had abandoned all of his patients and was a defendant in an investment scam litigation applied for an administrator position. The purpose of these requirements is to make sure that 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 on smaller organizations. In its submission

package, VDH did not address the reasons for the identical requirements for the back up administrator. 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 home care organizations will lead to an 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 by definition temporary. 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 license fees. The fee changes are summarized in the following table.

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

According to VDH, fees have not been updated since 1990.[4] In fiscal year 2003, the annual budget for the home care program was $176,430, which covered surveyors' salaries, benefits, travel expenses, and all other miscellaneous expenses. The average cost of a survey was about $1,680. However, VDH only collected a total $17,220 from all providers, or about

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

$202 per provider. Thus, approximately 90% of total survey costs was financed through general fund revenues and only 10% through license fees. With the proposed fee structure, the department will collect approximately $64,500 from providers biennially. In short, proposed changes will shift a higher proportion of costs to operate the licensing program from the general fund to providers.

On average, a provider will pay an additional $298 every biennium. 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, and 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 when periodic inspections are scheduled. 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 geographic area. Under 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 providers as well as customers without introducing any additional public health and safety risks.

No change in health and safety risks is expected because there is no evidence indicating 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 are likely to provide services where the demand is highest and consequently improve access to services where they are needed the most. This change is also likely to contribute to competition in the home care market. Without geographic boundaries, a home care organization does not just compete with other (if any) providers within the same boundary, but all providers within reach of a customer. 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 geographic area. The expected outcome is a market structure with characteristics much closer to that of a competitive market. Providers are likely to save because of the additional flexibility regarding where to locate or whom to serve. Customers are likely to benefit as they can now freely choose to receive services from any provider that suits them best. The overall expected result of the proposed change is an improved allocation of society's scarce resources and a net positive economic impact.

Other Miscellaneous Changes

The remaining changes are not likely to produce significant economic effects. They are mainly clarifications of 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, requiring home visits to be part of the inspection protocol, clarifying the quality

improvement assessment indicators, removing any requirements that contradict 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, at no significant additional cost.

Businesses and Entities Affected

The proposed regulations apply to approximately 129 home care providers licensed by the state as of July 2005.

Localities Particularly Affected

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

Projected Impact on Employment

The likely effects of the supervision requirement on employment are differential on providers according to the types of services provided and the market characteristics in the geographic area they are currently operating in. The supervision requirement may have caused hiring new personnel for personal care only providers but may have also increased compliance costs, which would have reduce the number of employment positions. On the other hand, 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 supervision requirement may have contributed to their profitability and created new employment at the consumers' expense. In general, the proposed supervision requirement have been probably causing some providers to hire personnel beyond the economically optimal level while causing some other providers to reduce personnel below the optimal level. Since the supervision requirement distorts the prices in home care market, the overall effect on net employment is to drive it away from the optimal level, causing significant waste of resources.

The removal of geographic service area limitations could result in employment effects as well. Some home care firms will have reduced compliance costs, as they will now be able to make their location decisions based on economic factors alone. This may encourage firms to enter into the home care market in certain geographic areas, which would contribute to

employment. On the other hand, some incumbent home care providers will face new competition and may lose 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 because of no longer having to serve an entire geographic area. Contrary to the supervision requirements, removal of service area limitations is likely to improve allocative efficiency. This will be achieved through encouraging competition in the home care market and removing restrictions that distort current prices. While some providers will reduce their employment, others will increase their employment relative to current levels. Whether the net effect of removing geographic restrictions is an increase or decrease in employment, it 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 supervision requirement could have been hurting or improving 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.

Small Businesses: Costs and Other Effects

According to VDH, all of the home care providers licensed appear to be small businesses. Thus, the economic effects discussed above describe the costs and other economic effects on small businesses.

Small Businesses: Alternative Method that Minimizes Adverse Impact

Similarly, the discussion on alternative methods to minimize compliance costs in the estimated economic impact section applies to small businesses.

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