A STUDY OF THE ADEQUACY OF ADULT RESIDENTIAL CARE HOME PAYMENTS AND PROBLEMS OF VACANCY, ADMISSION, AND DEMAND

Conducted by

Research Information Services

and

Office of the Legislative Auditor
State of Hawaii

A Report to the Governor and the Legislature of the State of Hawaii

Submitted by the

Legislative Auditor of the State of Hawaii
Honolulu, Hawaii

Report No. 89-13
January 1989

FOREWORD

The State provides for the care of elderly and other adults unable to care for themselves but who are not so impaired as to require placement in intermediate care facilities. The State provides this care by licensing adult residential care homes and by making cash disbursements to adults unable to purchase such care with only their own resources. The cash disbursements to these individuals may supplement other income sources, such as Social Security and pensions.

For a number of years, operators of these homes and various groups have maintained that the State's support is not adequate, and the program has problems in placement. The Legislature has been seeking answers to these issues, and in the 1988 session, it requested the Legislative Auditor to conduct a study.

We contracted with Research Information Services (RIS) to undertake the study, which involved extensive research and analysis. This published report is a condensed version of a lengthened report which fully documents the derivation of all expense estimates of adult residential care. The documentation is available for inspection at the offices of RIS and the Legislative Auditor.

With Research Information Services, we would like to express our appreciation to the many public officials and private individuals and organizations for their courtesy and assistance in this study.

Newton Sue
Acting Legislative Auditor
State of Hawaii

January 1989

TABLE OF CONTENTS

LIST OF TABLES

Chapter 1

INTRODUCTION

This study is prepared in response to Act 213, SLH 1988, which directs the Legislative Auditor to assess the adequacy of current adult residential care home (ARCH) payments and to determine the feasibility and need for annual cost of living adjustments. The act also requests a study of vacancy, admission, and demand problems experienced by residential care home operators.

Objectives

The objectives of this study are:

1. To compare current ARCH payments with the estimated monthly expense of providing ARCH residents with various minimum shelter and care services.
2. To evaluate the need for periodic inflation adjustments and to identify appropriate inflation index measures.
3. To analyze information relating to vacancy, admission, and demand problems in the ARCH program.

Organization of the Report

This report has four chapters. Chapter 1 consists of this Introduction. Chapter 2 describes the ARCH program and presents our cost estimates for adult residential care. Chapter 3 evaluates the adequacy of ARCH payments. Chapter 4 examines vacancy, admission, and demand issues. The responses of the agencies addressed by our recommendations and our comments on those responses conclude the report.

Chapter 2

COST ESTIMATES FOR ADULT RESIDENTIAL CARE

Adult residential care homes (ARCH) provide 24-hour living accommodations to elderly or disabled adults for a fee. These individuals are not related to licensee-operators of the facility. ARCH residents need at least minimal assistance with various activities of daily living but are not so impaired that they require intermediate care level services. Residents may pay privately or be supported by state and federal funds. Approximately 2475 adults currently reside in Hawaii's adult residential care homes.

The Scope of the Program

ARCH facilities. The facilities are regulated by two state agencies. Section 321-15.6, Hawaii Revised Statutes, authorizes the Department of Health (DOH) to license ARCH facilities and to adopt rules to regulate the homes. The Hospital and Medical Facilities Branch of DOH administers ARCH facility licensing under Title 11, Chapter 100 of the Hawaii Administrative Rules (hereafter referred to as HAR 11-100). Under Section 346.53(e), Hawaii Revised Statutes, the Department of Human Services (DHS) determines the rate of payment for domiciliary care for eligible recipients. It has primary administrative responsibility for client placement, case management, and payment under Title 17, Chapter 831 (hereafter referred to as HAR 17-831).

There are two ARCH facility licensing classifications. Type I ARCHs are limited to a maximum of five residents while Type II ARCHs can have six or more residents. According to DOH, the current inventory of ARCH facilities is as follows:

ARCH Classification	Number Licensed	Bed Capacity
Type I	602	2,725
Type II	15	485
Total	617	3,210

State supported ARCH residents. Approximately 1822 ARCH residents are currently supported by state supplemental funds. These individuals meet state income eligibility

requirements for income maintenance and social services and are also qualified to receive Federal Supplemental Security Income (SSI) payments.

ARCH residents are certified according to three levels of care (LOC) service categories for payment of state supplemental funds. These categories correspond generally with increasing degrees of impairment. Persons certified for Level I care require only minimal assistance. Level II care certification indicates a need for moderate assistance; Level III means the resident needs extensive assistance. Those awaiting final determination of level of care are labeled "unclassified." All state supported residents must be certified as to level of care by DOH or DHS even though they may have been initially placed by an agency other than DOH or DHS.

An individual's level of care is determined by evaluating the degree of assistance required in three functional areas: (1) activities of daily living, (2) supervision and behavioral management, and (3) health related services. Numerical points are assigned to identified services in each functional area. The total number of points given to an individual determines that person's level of care certification. The number of points for each of the three LOC payment categories is as follows:

LOC-I	--	0 - 6 points
LOC-II	--	7 - 11 points
LOC-III	--	12+ points

According to DHS, the number of State supported ARCH residents in each of the certified levels of care is:

LOC Certification	Number (%)
LOC-I	146 (8%)
LOC-II	237 (13%)
LOC-III	1,439 (79%)

Case management responsibilities for State supported ARCH residents, including certification of level of care, are shared now by DOH and DHS. DOH is responsible for 720 developmentally disabled or mentally ill residents while DHS manages the remaining 1102 residents. At one time DHS had authority over all ARCH residents.

ARCH payments. ARCH payments consist of a federal Supplementary Security Income (SSI) benefit and up to four State LOC supplements. These payments are made directly to residents who in turn pay ARCH licensee-operators for care services and support. This is an important point. The federal and state governments are not direct purchasers of care services. They simply provide qualified individuals with income to obtain these services on an individual basis.

Currently, the maximum federal SSI benefit is $354 per month for each resident depending on countable income. Countable income is any earned or unearned compensation received by a resident less applicable exclusions. Countable income may include trust fund income, pensions, social security payments, and others. SSI benefits for residents with countable income are reduced by the amount of that income. Persons having countable income are expected to use that income to pay for ARCH services.

The amount of the basic state-funded LOC supplement, available to all state-supported ARCH residents, depends on a resident's certified level of care need. As shown in Table 2.1, residents certified for Level I care receive a basic LOC supplemental payment of $79.90 per month; Level II care residents receive $129.90 per month and Level III residents, $191.90 per month. Both the basic LOC supplement and the SSI payments are administered by the Social Security Administration. Thus, every state-supported ARCH resident receives a check from the Social Security Administration which includes both federal and state funds. Funds from the DHS budget for the basic LOC supplement are transferred to the federal government to cover the State's share.

In addition, three other state-funded supplements as presented in Table 2.1 are available. Some supplements depend on whether the resident is in a Type I or Type II facility. All are administered by DHS and payments are made to the individual residents. Thus each resident receives at least two checks each month--one from DHS and one from the Social Security Administration. The one from DHS covers Supplement 1, 1 and 2, or 1, 2, and 3, as follows: Supplement 1 is a payment of $115 per month that is made to all ARCH residents. Supplement 2 is paid only to residents certified for Level II or Level III care who reside in Type II ARCH facilities. This supplement is $108 per month; 245 residents now receive this payment. Supplement 3 is meant as a temporary payment to LOC-III residents who are certified for and awaiting more specialized placement (e.g., in an intermediate care facility.) The supplement is $100 per month and approximately 200 residents now receive Supplement 3. However, only six of these are actually awaiting more specialized placement. The remainder are "grandfathered" in under previous criteria that provided the supplement for such problems as incontinence.

Table 2.1

Monthly ARCH Payment Schedule

LOC Category	Payment	ARCH Facility Classification Type I	Type II
LOC-I	SSI (maximum)	354.00	354.00
	State LOC Supplement	79.90	79.90
	Supplement 1	115.00	115.00
	Supplement 2	NA	NA
	Supplement 3	NA	NA
	Total	548.90	548.90
LOC-II	SSI (maximum)	354.00	354.00
	State LOC Supplement	129.90	129.90
	Supplement 1	115.00	115.00
	Supplement 2	NA	108.00
	Supplement 3	NA	NA
	Total	598.90	706.90
LOC-III	SSI (maximum)	354.00	354.00
	State LOC Supplement	191.90	191.90
	Supplement 1	115.00	115.00
	Supplement 2	NA	108.00
	Total	660.90	768.90
	Supplement 3	100.00	100.00
	Total	760.90	868.90

It is important to understand that ARCH fees (the amount licensee-operators actually charge residents) are not regulated, even though federal and state ARCH support payments to individuals are fixed. This means that licensee-operators can assess both government-supported and private paying individuals a fee that exceeds the current ARCH payment schedule. For government-supported individuals the additional payments can come from personal income, relatives, or other interested parties.

Estimates of ARCH Expenses

This section presents our estimates of the average long-term monthly financial expense of providing ARCH services to different LOC resident categories in both Type I and Type II facilities. The estimates were derived from a methodology that focuses upon *prospective* cost estimates and a set of assumptions and definitions for the ARCH program.

Estimation methodology. Prospective estimates forecast the expense of complying with minimum applicable licensing standards and requirements. The analysis relies on prospective cost estimates rather than retrospective actual operating cost data for several reasons. *First*, there is less risk that expense estimates will be biased by any operational quirks within the ARCH system. For example, operating cost data that reflects widespread inefficiency will cause estimates to be overstated. The same would be true if there is any significant substandard operation of a facility. It would be difficult to make statistical corrections for irregularities of this sort.

Second, detailed historical operating cost data are not available. A limited number of site visits found facilities keeping very broad and categorical expense records that rarely segregated expenditures for ARCH residents from general household or family expenses.

Third, there is a need to account for the compensable time licensee-operators expend in providing ARCH residents with care services. As might be expected, there are even fewer detailed records documenting the provision of such care.

Another point is that approximately three-fourths of all ARCH residents are now classified as requiring the highest and most costly level of care services--LOC-III. It is not clear whether this is due to attempts to maximize payments or a true reflection of resident needs. There have been suggestions that some individuals may be certified for Level III care simply to secure adequate funds for placement. This could undermine any estimation of ARCH expenses based on actual operating cost data.

Finally, prospective cost estimates are consistent with the lump-sum structure of ARCH payments. ARCH payments now depend on a resident's certified level of care need and whether he or she resides in a Type I or Type II ARCH facility. State reimbursement or billing the State for additional expenses is not allowed. The adequacy of flat-rate payment structures is best evaluated in terms of average program level expense estimates and not actual operating costs for specific facilities.

Assumption and definitions. The following assumptions and definitions provided the framework for this analysis.

ARCHs are a community asset. ARCHs are assumed to be a valuable and beneficial community asset regardless of ownership. This implies a common community interest in preserving the resource and fostering its growth, stability, and quality. The decision to recognize or disallow certain expenses can be affected by this stance.

Domiciliary care payments cover a resident's total needs. HAR 11-100 strongly implies that domiciliary care payments must provide for the total needs of a resident (except medical expenses). Moreover, DHS has restated this position on several occasions in its administration of State supplemental ARCH payments.

ARCHs are businesses. ARCHs are assumed to be businesses. As such they have certain financial requirements including: (1) operating expenses; (2) working capital requirements; (3) property, plant, and equipment acquisition; (4) debt service; and (5) reasonable profit.

Adequacy. ARCH payments are considered adequate only if they are sufficient on average to cover *all* recognized financial requirements of an ARCH.

Prudent, efficient, and cost-effective. All expense estimates assume prudent, efficient, and cost-effective management and operating practices.

Organization and accounting method. ARCHs are assumed to be for-profit entities organized either as sole proprietorships or Subchapter "S" corporations with 35 or fewer stockholders. This means that corporate income taxes do not apply to either form of business organization. ARCHs are also assumed to use a cash-basis accounting system. This means that revenues are only recognized when cash is actually received and expenses are recorded only when cash is disbursed.

Minimum standards. Expense estimates are based on minimum specified statutory requirements and standards.

Whenever an expense estimate is based on some type of cost index (e.g., Consumer Price Index budgets), "low" to "moderate" expenditure levels are generally used.

Prototype ARCH. All estimated expenses are apportioned on the basis of the prototype ARCH facilities developed for this study. The theoretical Type I and Type II ARCHs are composed of the following:

	Type I ARCH	Type II ARCH
Number of Persons	8.02	32
Make-up (case mix)	3 family members	
	1 LOC-I	3.2 LOC-I
	1 LOC-II	4.8 LOC-II
	3 LOC-III	24.0 LOC-III

The Type I prototype ARCH is based on census estimates that the average household size in Hawaii is 3.02 persons and licensing standards limit Type I ARCHs to a maximum of five residents. Resident make-up or case mix is based on DHS reports that recipients of domiciliary care payments are distributed according to certified level of care as follows: 10 percent in Level I, 15 percent in Level II, and 75 percent in Level III.

The Type II prototype ARCH is based on DOH data that the average capacity of Type II ARCHs is 32 beds.

Differences between Type I and Type II prototypes. Type I ARCHs are assumed to be single-family residences that also shelter homeowners and their family. Only a portion of the residence is dedicated to sheltering and caring for unrelated domiciliary care residents.

Type II ARCHs are assumed to be fully dedicated business facilities that have the primary purpose of providing shelter and care for domiciliary care residents.

Because of this assumption, certain expense estimates are developed and handled differently for the two types of facilities. For example, certain expenses recognized for Type II ARCHs may only be partially recognized or disallowed for Type I ARCHs because they are not regarded as fully dedicated businesses. These expenses include employment taxes, employee benefits, certain depreciation expenses, and administrative overhead.

This assumption also affects the use of pay rates in estimating labor expenses. The licensee-owner is assumed to be the primary service provider in Type I ARCHs. Consequently, labor expenses are generally estimated on the basis of one uniform hourly pay rate. In Type II ARCHs some services are assumed to be provided by paid employees. As a result, labor expenses are estimated on the basis of various appropriate pay rates. A staff mix of higher and lower compensated personnel to provide some services (e.g., resident care) can effectively lower some estimated labor expenses in Type II as compared with Type I ARCHs.

State level data for expense estimation. Expense estimates are based on state level data whenever possible. Expense estimates may occasionally be based on reliable data that is limited to Oahu or the Honolulu Standard Metropolitan Statistical Area (SMSA). This is justified because nearly three-fourths of the state population resides in the City and County of Honolulu. More importantly, approximately 74 percent of all ARCH facilities (accounting for 80 percent of the existing bed capacity) are currently located on Oahu.

Expense estimates adjusted to 1988. Expense estimates are all based on the latest available 1988 cost data. Indexed cost data are generally adjusted using specific price component values of the Consumer Price Index (CPI-U) for Honolulu. The CPI-U index for all urban consumers is used because it is more broadly representative of price changes than the CPI-W index for urban wage earners and clerical workers. The newer CPI-U index reflects the buying habits of 80 percent of the population while the CPI-W index reflects 40 percent of the population.

Other price adjustment indexes are used when appropriate. For example, construction cost data are adjusted using the monthly First Hawaiian Bank Construction Cost Index.

Chart of expense accounts. A chart of expense accounts was developed to organize and classify expense estimates. Expenses are recognized if they:

1. Cover direct or indirect resident services and care, or

2. Benefit the general well-being of residents, or
3. Are necessary to comply with licensing or placement requirements or standards, or
4. Help to offset recognized financial requirements of an ARCH, or
5. Meet part of the total needs (excluding medical) of residents.

The chart includes daily resident care; shelter; food service; recreation, rehabilitation and social services; transportation and escort services; laundry services; housekeeping and routine maintenance; miscellaneous personal expenses; in-service training fees; insurance; taxes; depreciation of capital assets; and administrative overhead. Each expense category is described further as follows:

Daily resident care. Daily care services are broadly specified by HAR 11-100-13 and implied in HAR 17-831. No comprehensive resident service model or detailed minimum standards of care have been developed for the ARCH program. A daily ARCH resident care model was developed for this study.

The model covers three areas of functional capability: *daily living activities, supervision and behavioral management, and health care activities.*

1. Activities of daily living (ADL) include:
   - Eating/feeding
   - Bathing
   - Dressing/grooming
   - Mobility
   - Transfers
   - Toileting
   - Incontinence (urine, feces, or both)
2. Supervision and behavior management relate to:
   - Impaired ability to communicate
   - Impaired judgment
   - Agitated/hostile behavior
   - Hallucinations
   - Depression
   - Assaultive/destructive behavior
   - Verbally abusive behavior
   - Withdrawn/regressive behavior
   - Aimless wandering

3. Medically ordered health care services include:
   - Oral medications
   - Non-oral medication/dressings/other treatments
   - Special diets
   - Transportation to medical or psychiatric appointments/escort services

Every resident does not necessarily receive all of the care service components listed above. We first determined the average service and assistance mix for each LOC category. The total care time for each LOC category is then estimated using industrial engineering studies that have established average required times for performing specific care activities.[1]

Shelter. HAR 11-100-2 mandates the provision of shelter for ARCH residents. This expense account covers basic monthly shelter, energy, utility, and property tax expenses.

Basic monthly shelter expenses are estimated on the basis of: (1) the minimum square foot area required for each resident in various subsections of HAR 11-100, and (2) the current average equivalent monthly per square foot market rent for single-family dwellings.

All rent data are for *monthly contract rent.* This means that the dwelling unit and property taxes are covered but not utility charges. The data exclude notably expensive neighborhoods and multi-family, condominium/cooperative, and town house dwellings not suitable for ARCH operation.

Rent data are not weighted to reflect the current geographic clustering of ARCHs in Kalihi and Waipahu.[2]

Food service. HAR 11-100-10 mandates at least three meals during each 24-hour period. Daily meal service must satisfy nutritional requirements set forth by the Food and Nutrition Board (National Academy of Sciences) in its most current "Recommended Daily Allowance."[3]

There are three major expense components: (1) labor, (2) raw and packaged food, and (3) facility/equipment.

Food service labor expenses are generally estimated on the basis of standard *labor minutes per meal.* Standard food service labor minutes cover such direct and indirect work functions as: food processing, meal service, cleaning, receiving and storage of raw food, and dietary clerical record keeping.

Standard labor minutes are estimated using industrial engineering methods to determine the average time required for performing the sequential steps associated with each work function.[4, 5, 6] This results in an estimated requirement of 10.89 standard labor minutes per meal.

Raw/packaged food. ARCH food services must meet nutritional standards of the Recommended Daily Allowance. Dietary standards are generally converted to daily food allowances by using some form of the "Basic Four Food Group"[7, 8] which classify essential food items into meats, dairy products, vegetables and fruits, and grains and cereals.

Raw/packaged food expense estimates are based on an original retail price survey of selected food items from each food group conducted between October 8-15, 1988, by RIS staff.

Standard equivalent serving sizes or portions were determined for each food item using tables of equivalent weights and measures.9 Raw/packaged food expenses were then estimated by extending the average cost of each food group by the recommended number of daily servings.

Facility/equipment. Commercial kitchen facilities are assumed for Type II facilities. A prototype commercial kitchen equipment list was developed (including china and cutlery) using various institutional guides. Certain facility improvements were also included to comply with DOH regulations (e.g., vent ducting). Type II ARCH kitchen facility and equipment expenses are recognized as fully depreciable.

For Type I ARCHs, food service preparation is assumed to occur in the licensee/operator's own family kitchen. Accordingly, only selected kitchen equipment are recognized as depreciable expenses.

Recreational, rehabilitative, and social services. Recreational, rehabilitative, and social services are generally mandated by HAR 11-100-15. However, no specific details are provided concerning what those services should encompass. Interpretive guidelines for the administrative rule require that unspecified activities be provided regularly between three to five times a week depending on resident interests, needs, and capabilities. The required time for providing recreational, rehabilitative, and social services to each resident LOC category is estimated by using work sampling results reported by other studies.[10]

Transportation and escort services. Transportation services required for ARCH residents by HAR 11-100-15(h) include physician and other medical visits, facility transfers, and outside activities.

A standard maximum round trip travel distance is estimated based on one-half the maximum straight line point-to-point distance measured for each island (averaged across all islands). These distances provide for a radius of travel that would encompass most routine and normal journeys on any given island. Estimated distances are listed below.

Island	Maximum Round Trip Distance
Hawaii	48.75 miles
Maui	30.00 miles
Lanai	11.25 miles
Molokai	33.44 miles
Oahu	26.25 miles
Kauai	19.69 miles
Average	26.56 miles

Labor hour estimates for drive and escort time are based on a resident's LOC category. According to LOC certification procedures LOC-I residents are assumed to require one or fewer trips per month, LOC-II residents two trips per month, and LOC-III residents four or more trips per month. A family or facility owned automobile is assumed for providing resident transportation services. Operating expenses are estimated using a standard mileage allowance. Automobile purchase or debt service related expenses are not recognized.

Laundry services. HAR 11-100-13(f) specifies that residents must be appropriately dressed in *clean* suitable clothing. A key factor in estimating laundry service expenses is to determine the pounds of laundry expected per resident per day. Labor hour, supply, and inventory costs are all normally estimated on the basis of daily poundage figures. These figures depend on the number and type of laundry item cleaned and the wash frequency standards adopted.

We adopted guidelines that previously applied to "Family Boarding Homes" under Hawaii Administrative Rules, Title 17, Department of Social Services and Housing, Subtitle 6 Public Welfare Division, Chapter 883, Adult Family Boarding Home Licensing (hereafter HAR 17-883).

Labor hours are estimated on the basis of industry productivity standards for in-house health care laundries.[11, 12] Laundry services should produce 40 pounds of cleaned and pressed laundry per paid man-hour. That productivity standard covers all associated labor costs including: management-supervision, lead work, maintenance, soil sort, preparation, mending-marking, inspection, and pressing-folding.

Laundry services are not expected to vary significantly by LOC category. Residents who are less severely impaired may use more day clothing on average, but this tends to be offset by incontinence and other conditions that increase linen and underwear usage for more impaired residents.

Housekeeping and routine maintenance. Housekeeping and routine maintenance services are mandated by HAR 11-100-20(c). We again rely on HAR 17-883 which established standards for many housekeeping and maintenance duties.

Housekeeping and maintenance costs are usually estimated on the basis of floor area, frequency of cleaning standards, and industry productivity measures for specific duties.

The floor area used to estimate housekeeping expenses for Type I ARCHs is the minimum floor area per resident required under HAR 11-100 (141.92 square feet). A standard net floor area conversion factor of 1.5 is used to determine the floor area per resident for Type II ARCHs. This adjustment increases the minimum floor area to 212.88 square feet per resident and accounts for unused space, columns, walls, corridors, and the like.[13, 14] A net conversion allowance is permitted because Type II ARCHs are assumed to be fully dedicated businesses.

Labor hour estimates are based on industry housekeeping and maintenance productivity standards. Those standards specify the time in minutes per square foot required to perform different housekeeping and maintenance duties. In most cases the standards account for different degrees of obstruction (by furniture or equipment) and soiling.

Miscellaneous personal expenses. Miscellaneous personal expenses cover clothing, personal care items, and entertainment/spending money for ARCH residents. Currently, the DHS recommends a monthly allowance of $23.90 per resident.

Personal expense estimates are based on a 1984 Honolulu Standard Metropolitan Statistical Area consumer expenditure interview survey conducted for the consumer price index.[15] These data provide more detailed and generally accurate estimates of actual consumer expenditures than do the urban family and retired couple budget surveys published by the Bureau of Labor Statistics.[16, 17] The 1984 data are adjusted for inflation using the most current CPI-U index figures for apparel, entertainment, and personal care expenditure categories.

In-service training. HAR 11-100-6(a)(9) requires all licensee-operators to complete at least two training sessions each year. The rule is interpreted as simply requiring annual re-certification in cardiopulmonary resuscitation (CPR) and first aid recertification every three years. Licensee-operators must also complete at least one training course that is generally related to ARCH services. No additional course work is required during years when the licensee-operator is re-certified for both CPR and first aid.

Basic first aid and CPR certification courses are currently offered by the American Red Cross for $28 and $32 respectively. Various nursing and continuing education courses are offered by the UH Community College System for $25 per credit hour (the courses are generally for three credit hours). Based on these figures, an annual allowance of $70 per facility is recognized for in-service training expenses.

Fees. Although HAR 11-100-5 provides for the assessment of appropriate licensing fees, none are now collected.

Bookkeeping fees are only partially recognized for Type II ARCHs. There are no financial audit or accountability requirements for either class of ARCH facility. Type II ARCHs bear a significantly greater accounting and bookkeeping burden with resident accounts, employee payroll and tax records, large volume purchases, long range and annual budgets, and so on. These tasks usually require the services of an outside bookkeeper since they are often burdensome and complex.

Bookkeeping expenses for Type II ARCHs are only partially recognized because the facility administrator is assumed to have some general knowledge of simple business accounting practices (in compliance with HAR 11-100-6(b)). The administrator is expected to perform most of the daily bookkeeping and simple payroll functions. An outside accountant or bookkeeper will provide periodic consultation and comprehensive tax preparation services. Approximately 20 hours of consultant time at $75 per hour will be required based on this assumption and given annual revenues of between $250,000 to $300,000 with five to eight employees.

Legal fees are not recognized because legal services do not appear to be a routine and customary requirement for operating ARCH type facilities.

Insurance. Insurance premiums are recognized since coverage benefits the general well-being of ARCH residents by helping to assure some continuity of care in the event of unforeseen casualty losses. Moreover, insurance costs are almost universally accepted as a normal business operating expense.

Basic insurance requirements for an ARCH facility include: (1) fire and contents coverage, (2) comprehensive general liability, and (3) automobile insurance. Commercial coverage is required for both Type I and Type II ARCH facilities because they are both considered businesses.

Fire and liability insurance expense estimates are based on the prototype ARCH facilities described earlier. Automobile insurance costs are already covered by standard mileage charges.

Taxes. Five general categories of tax appear pertinent to ARCH type business operations. These include the state general excise tax, real property taxes, employment taxes (including mandatory employee health benefits), Federal self-employment taxes, and business profit taxes. Not all of these taxes are recognized in this study.

ARCHs are assumed to be organized as for-profit businesses. This means that the 4 percent State general excise tax is applicable to all gross income resulting from ARCH and other payments. Note that general excise taxes paid in connection with the purchase of goods and services are accounted under appropriate expense accounts.

Real property taxes for Type I ARCHs are covered by basic monthly shelter expense estimates. The prorated difference in expected property tax for Type I and Type II ARCHs is scheduled.

Employment taxes do not apply to Type I ARCHs because they are assumed to have no paid employees. The various employment taxes and mandatory employee health benefit costs applicable to Type II ARCHs are scheduled separately under appropriate expense accounts.

The net earnings of all ARCHs organized as sole proprietorships are subject to a Federal self-employment (SE) tax.[18] This tax is currently 13.02 percent on earnings in excess of $400 up to a maximum of $45,000. Self-employment taxes are not customarily recognized as a true business operating expense. This is because they represent a social security tax paid for the benefit of individual owner-operators. Consequently, this study does not recognize the SE tax.

Business profit taxes are not applicable because all ARCHs are assumed to be organized as sole proprietorships or Subchapter "S" corporations. This means that any net business proceeds or "profit" will be taxed as ordinary income for the individual owner or principal stock holders. Personal income taxes are not allowed as a business operating expense.

Depreciation of capital assets. The capital assets acquired by an ARCH are subject to depreciation. A depreciation allowance offsets those expenses over their useful life. Not every capital asset is considered a depreciable expense in this study. The only assets recognized as such are those directly or indirectly related to the provision of resident care. These include: (1) the floor area used to shelter and care for residents, (2) certain furnishings, (3) kitchen, laundry, housekeeping, and dining equipment; and (4) office equipment (Type II ARCHs only). Automobile depreciation expenses are covered by standard mileage rates. Linen costs are expensed annually.

Depreciation expenses are treated differently for Type I and Type II ARCHs. A more comprehensive list of depreciable assets is recognized for Type II ARCHs because they are considered fully dedicated businesses.

Depreciation expenses are estimated by the straight-line method. Whenever possible, life expectancies are based on actual experience case study guidelines. These tend to exceed class life guidelines specified by the Internal Revenue Service.[19]

Most capital assets in this study are depreciated on the basis of current replacement value. However, a different depreciation basis is used for ARCH building facilities. We used a weighted average replacement value for the year that each currently licensed facility was first dedicated to ARCH service. Separate calculations are made for Type I and Type II facilities. The procedure of using current replacement values as a basis for establishing depreciation expenses is equivalent to providing a capped program level allowance.

Depreciation expenses are estimated for Type I ARCHs assuming that there is no remaining salvage value for depreciated capital assets. A salvage value of approximately 10 percent is generally assumed for Type II ARCH capital assets because they typically have higher construction standards and/or commercial duty ratings.

Administrative overhead. Administrative overhead is not recognized for Type I ARCHs because there are few if any discrete administrative functions that can be identified in a Type I ARCH.

The administrative burden is greater in Type II ARCHs because more residents must be provided with care. This will create the need for employee/personnel management, large volume purchasing, and long-range budgeting. In addition, basic facility management tasks (e.g., equipment purchasing and maintenance, inventory management, and so on) will become more complex simply as a function of increased volume. Finally, HAR 11-100-6(b) requires that the facility administrator have specific management competencies.

Administrative overhead estimates for Type II ARCHs are based on the prototype facility described earlier. Licensee-operators (owners) are assumed to act as the facility administrator on a one-half time basis with the remainder of their time being distributed among various compensated service delivery activities (e.g., daily resident care).

Summary of cost estimates. Table 2.2 presents a summary of prospective cost estimates for each expense account considered in this study. Overall, we estimate that monthly expenses for each ARCH resident range from $680.88 for a LOC-I resident in a Type I ARCH to $1064.43 for a LOC-III resident in a Type II ARCH.

Details of the bases used, the calculations made, and the treatment of each subaccount are too voluminous to be included here but are available at the offices of Research Information Services and the Legislative Auditor.

Table 2.2

Estimated Monthly ARCH Expenses/Resident

EXPENSE	TYPE I ARCH LOC-I	LOC-II	LOC-III	TYPE II ARCH LOC-I	LOC-II	LOC-III
Daily Resident Care	114.13	221.80	344.59	111.12	215.92	335.45
Shelter	159.65	159.65	159.65	168.18	168.18	168.18
Food Service	229.48	229.48	229.48	258.12	258.12	258.12
Rec., Rehab., Soc.	18.10	23.64	17.64	17.69	23.05	17.21
Transportation	9.75	19.50	38.99	10.81	21.60	43.20
Laundry	14.53	14.53	14.53	17.78	17.78	17.78
Housekeeping	23.00	23.00	23.00	39.10	39.10	39.10
Personal Expenses	44.91	44.91	44.91	44.91	44.91	44.91
In-Service Training	1.17	1.17	1.17	.18	.18	.18
Fees	NA	NA	NA	2.93	2.93	2.93
Insurance	16.75	16.75	16.75	19.40	19.40	19.40
Taxes	27.19	32.31	37.98	31.35	36.88	42.51
Depreciation	22.22	22.22	22.22	30.16	30.16	30.16
Admin. Overhead	NA	NA	NA	45.30	45.30	45.30
Total Expense/ Resident	680.88	808.96	950.91	797.53	923.51	1064.43

Chapter 3

ADEQUACY OF PAYMENTS FOR ADULT RESIDENTIAL CARE

In this chapter we assess the adequacy of the current payments for adult residential care by comparing them with the expense estimates developed in chapter 2. We also address the issue of cost of living increases.

Summary of Findings

Four issues relating to payment adequacy are considered in this study. They include (a) the overall adequacy of ARCH payments for each LOC category and facility type; (b) the adequacy of payment differentials among LOC categories I, II and III; (c) the adequacy of differentials between Type I and Type II ARCH facilities; and (d) the adequacy of Special Supplement 3 for LOC-III residents awaiting more specialized placement.

In summary, we find that:

1. Current ARCH payments are deficient for all LOC categories and both facility types. The shortfall ranges from $131 per month to $295 per month. This is attributed primarily to the inadequate compensation of licensee-operators for direct daily resident care services.

2. Level of care payment differentials among LOC I, II and III are deficient by an average of $80 for each step-up in care level. This appears to stem from the fact that current LOC payment differentials do not accurately reflect expected differences in the amount of care time required by individuals at different overall levels of impairment.

3. The payment differential between Type I and Type II facilities is adequate. This payment differential is not available to LOC-I residents in Type II ARCHs.

4. Special Supplement 3 is adequate provided no additional requirements are imposed on ARCHs that continue to shelter LOC-III residents certified for and awaiting more specialized placement.

Overall Payment Adequacy

Table 3.1 compares current ARCH payments against the estimated monthly expense for each LOC category.

Table 3.1

Comparison of Current ARCH Payments With
Estimated Monthly Expense Per Resident

	TYPE I ARCH			TYPE II ARCH		
	LOC-I	LOC-II	LOC-III	LOC-I	LOC-II	LOC-III
Estimate	680.88	808.96	950.91	797.53	923.51	1064.43
Actual	548.90	598.90	660.90	548.90	706.90	768.90
Shortfall	131.98	210.06	290.01	248.63	216.61	295.53

These findings are very consistent. ARCH payments fall short of estimated expenses for both Type I and Type II facilities and for all level of care categories. The explanation for this deficiency is also fairly clear.

The shortfall for each ARCH facility type and LOC category is very close to the corresponding estimated expense of daily resident care services summarized in Table 2.2. The only exception is for LOC-I residents in Type II ARCHs. This shortfall is $248.63 while the estimated expense is $111.12. The difference can be explained by the fact that Type II ARCH residents needing Level I care do not receive Supplement 2 of $108.00. The indicated shortfall would correspond more closely with estimated daily care expenses for LOC-I residents in Type I ARCHs if $108 were added.

ARCH payments appear to be inadequate largely because licensee-operators are not sufficiently compensated for the time they expend in providing direct daily resident care services. This conclusion is supported by the following.

The expense estimates developed in this study are fairly consistent with previous cost breakdowns developed by DHS for food, shelter, transportation, clothing, personal care items, and recreation expenses. This tends to indicate that there are no gross inconsistencies of estimation in those areas. The critical difference is that DHS has not developed any explicit estimates of the cost of direct care services provided to residents by licensee-operators.

In the absence of official estimates of required care time, we developed some estimates for this study. On the basis of several studies of care time requirements in long term care settings, we estimated that the time needed for preparation of materials and supplies, provision of assistance or service, and cleanup for each resident were as follows: .53 hours per day for

an LOC-I resident; 1.03 hours per day for an LOC-II resident; and 1.60 hours per day for an LOC-III resident. The increasing requirements for care time correspond with the increasing levels of impairment, from minimum to moderate to maximum impairment.

A focus upon care time requirements for residents will also reveal problems with the workload for a given ARCH's case mix. The concern here is that a Type I ARCH operator will expend about eight hours for direct care each day if there are five LOC-III residents who each require 1.60 hours of care per day. This does not include the additional time required for food preparation, housekeeping, and so on. A continuous workload in excess of this appears unrealistic for one individual and ultimately detrimental to the well-being of residents.

Type II ARCHs, of course, might well be able to accept a number of LOC-III residents who require the maximum number of care hours per day. However, this may be economically unfeasible for the operator. Moreover, for individuals requiring more than a reasonable maximum of care time, an ARCH placement may not be an appropriate placement at all. Some maximum expected care time might be considered as a requirement for placing a resident in some other setting than an ARCH.

The inadequate compensation of daily care time also explains how ARCHs can continue to operate in the face of such apparently serious shortfalls. For Type I ARCHs, the licensee-operator's time does not constitute a tangible out-of-pocket expense. However, inadequate compensation does represent a hidden deficit that may eventually affect the financial viability of those facilities.

Type II ARCHs with paid employees do experience the inadequate compensation of care time as a tangible out-of-pocket expense. These facilities may continue to operate because the deficit is partially offset by a larger base of higher paying privately placed residents.

Adequacy of LOC payment differential. Basic ARCH payments increase as a resident's certified level of care becomes more acute. As shown by the payment schedule in Table 2.1, there is a $50 per month differential between LOC-I and LOC-II and a $62 per month differential between LOC-II and LOC-III regardless of facility classification. This section assesses the adequacy of those payment differentials.

From the estimated expenses shown in Table 2.2 it is possible to estimate the expected difference in cost between the level of care categories. We compared the total estimated expense per resident between Levels I and II and between Levels II and III in Table 3.2 below:

Table 3.2

Cost Differentials Between Level of Care Categories

ARCH Classifications	Expected Cost Difference LOC-I - LOC-II	LOC-II - LOC-III
Type I	128.08	141.95
Type II	125.98	140.92

In light of the current differentials of $50 and $62, respectively, the basic LOC differential schedule is short by approximately $80 for each step-up in certified level of care in both facility types. One possible explanation is that these payment differentials are not based on the expected differences in care time required by residents but instead on broader assessments of impairment.

Adequacy of ARCH facility classification differential. LOC-II and LOC-III residents who reside in Type II ARCHs receive a supplemental payment of $108 per month. According to Table 2.2 the differences in estimated expense between Type I and Type II facilities are as follows:

LOC Category	Type I ARCH	Type II ARCH	Expense Difference
LOC-I	680.88	797.53	116.65
LOC-II	808.96	923.51	114.55
LOC-III	950.91	1064.43	113.52

These findings indicate that the current facility classification allowance of $108 per month is adequate.

It is important to note that facility classification payments currently apply only to those residents certified for Level II or III care. There is no classification differential for LOC-I residents. The foregoing results clearly demonstrate that there is a facility related difference in expected costs for LOC-I residents as well. Facility classification payments should be extended to cover LOC-I residents in Type II ARCHs.

Adequacy of Special Supplement 3. A special temporary supplemental payment of $100 per month is provided to LOC-III residents certified for and awaiting more specialized placement. This payment is assumed to cover only the additional expected care required by such persons.

Facility, program, and service up-grades normally associated with intermediate or skilled nursing care settings should not be expected in ARCHs because they are not licensed to provide that level of care.

Based on various nurse staffing studies, a resident certified for an intermediate care facility is estimated to require at a minimum 2.19 hours of direct nurse aide care time per day. This creates an additional care time burden of .59 hours over the 1.60 hours per day expected for LOC-III residents.

Assuming that direct care time is compensated at $6.98 per hour in Type I ARCHs and $5.64 per hour in Type II ARCHs, there is an additional monthly expense per resident of $125.28 for Type I ARCHs and $121.91 for Type II ARCHs.

Special Supplement 3 appears to be adequate overall. This conclusion applies *only* if the supplement is limited to covering care time expenses. The supplement must be judged inadequate if additional requirements (such as registered nurse services) are imposed on ARCHs that continue to care temporarily for LOC-III residents awaiting more specialized placement.

Adjustments for Cost of Living Increases

Act 213, SLH 1988, requested that this study include an examination of the need for annual cost of living adjustments in the ARCH payment schedule. However, such adjustments should be undertaken only if the payment schedule itself is deemed valid and adequate. It should be recalled that the methodology adopted for assessing the adequacy of the current schedule was a prospective, not a retrospective, one--that is, the expected expenses were estimated on the basis of minimum standards and requirements and not on actual operating cost data from operators.

Any changes made to the ARCH program need to be applied for some period of time to test their validity and reliability. A new payment schedule and certification criteria should be established and evaluated before any adjustments are proposed. Whether the payment deficiencies shown in this study are corrected, whether the payment levels offered in this study or any other are selected, the State needs some analysis as to whether the expense elements are being adequately compensated. Only then should the State attempt an examination of adjustments for cost of living increases.

Some basis already exists for considering such increases. The State's public assistance statutes require DHS to submit a report to the Legislature in odd-numbered years on the amount of additional moneys required to implement a cost of living increase in the basic needs allowance of public assistance grants. The computation of the annual percentage increase can be based either on (a) the average weekly wage in specified employment categories, as computed by the

Director of Labor and Industrial Relations, or (b) the Consumer Price Index for Hawaii as computed by the U.S. Department of Labor, whichever is lower. DHS should be able to submit similar figures for the ARCH program.

In the use of the Consumer Price Index, serious consideration should be given to the use of the CPI-U index rather than the CPI-W index if the Consumer Price Index is used at all. As discussed earlier in this chapter, the CPI-U index is more broadly representative of price changes. It includes a wider range of employment, including professional and management workers, the self employed, retirees, short-term workers, and the unemployed.

Further, even after annual cost of living adjustments might be implemented on the basis of a valid payment schedule, some consideration might be given to periodic assessments of the payment schedule similar to the current study. This will assure greater accuracy and help avoid any irrational price spiral. The studies might be conducted every five to ten years.

Recommendations

We recommend that State ARCH payments be increased for residents in all levels of care categories and for both ARCH facility types. The Department of Human Services and the Department of Health should present a joint proposal for legislative consideration which encompasses the following interrelated elements.

1. Retain the three existing level of care payments categories, LOC I, II and III, but modify category definitions to reflect estimated care time requirements at various impairment levels. Adopt new level of care certification procedures that more accurately reflect how many hours per day are required to assist individuals with various daily living activities, supervision and behavioral management, and health care activities. Consider setting a maximum on the expected care time requirements for resident case mix in each ARCH. We suggest the following care time requirements to help define each level of care:

LOC-I	0	to	.50 hours per day
LOC-II	.50	to	1.00 hours per day
LOC-III	1.00	to	1.60 hours per day

2. Re-certify all current ARCH residents using revised level of care definitions. This can be accomplished gradually as part of continuing case management activities.

3. Retain the $108 per month ARCH facility classification payment differential for Type II ARCHs (Supplement 2) and extend this to cover LOC-I residents.

4. Retain the $100 per month Special Supplement 3 for LOC-III residents who have been certified for and are awaiting more specialized placement (e.g., in an ICF).

5. Explore the possibility of consolidating all state-funded supplemental payments as indicated below and having them administered by the Social Security Administration.

If all of these interrelated elements are presented by DHS and DOH to the Legislature, the payment structure will be as follows:

LOC Certification	Payment	ARCH Facility Type I	Classification Type II
LOC-I	SSI	354.00	354.00
	State Supp.	334.90 (+140)*	442.90 (+248)
		688.90	796.90
LOC-II	SSI	354.00	354.00
	State Supp.	454.90 (+210)	562.90 (+210)
		808.90	916.90
LOC-III	SSI	354.00	354.00
	State Supp.	596.90 (+290)	704.90 (+290)
		950.90	1,058.90

* Figures in parentheses represent the amounts in addition to current payments.

We estimate that the additional cost of implementing this payment schedule for the current residents, if they remained in the same LOC classes and in the same facility types, will range from $2.1 million to $2.8 million in state funds. This would be in addition to the $3.1 million currently expended. So the ARCH program would cost the State $5.2 to $5.9 million each year. However, should revised LOC certification criteria and procedures be put into effect to reflect more accurately the care time requirements of each resident, the distribution of the current residents among the LOC categories may change. Some may be more accurately placed in lower LOC classes.

We also recommend that two years after any new payment schedule and certification procedure is implemented, DHS and DOH review the need for cost of living adjustments and present their recommendations to the Legislature. The two departments should also be prepared to assess the need for periodic studies of the payment schedule for purposes of realignment.

Chapter 4

VACANCY, ADMISSION, AND DEMAND PROBLEMS

This chapter examines the problems of vacancy, admission and demand--collectively called placement problems. We find difficulties in the attempts to match clients with available spaces. We examine the issues in the context of the fact that ARCHs are not legally required to accept every person referred for placement although they cannot discriminate on the basis of race, color, religion, ancestry, or national origin. Correspondingly, potential clients have a right to reject placement in any particular facility.

Summary

A number of vacancy, admission, and demand problems were identified during numerous interviews with agencies involved in placement and with operators. Difficulty in placing individuals who have specific impairment profiles was the most consistently reported problem. These are persons who require extensive amounts of direct care time or who pose or are perceived as posing unusual risks for operators or other residents. Three factors were identified as primary sources of the problem: (1) fear and lack of knowledge, (2) non-standard admission policies, and (3) payment inequities.

Several other important placement issues also came to light. These concern: (1) the need for more geographically dispersed ARCH locations, (2) the lack of consistent backup provisions for sheltering difficult and impossible to place individuals, (3) inadequate current ARCH vacancy reports, and (4) a possibility that pre-conditions for liability insurance coverage may create new placement problems.

Placement Problems

Scope of the problem. Certain segments of the potential ARCH resident population experience significant difficulties in obtaining appropriate satisfactory placement. Sometimes 20 to 40 contacts or more are made with facilities before any placement is secured; occasionally the effort proves futile.

Individuals reportedly experiencing the greatest placement difficulties are those who:

1. Require significant amounts of behavioral supervision (e.g., Alzheimer's Disease patients);
2. Have extensive special diet requirements;
3. Are non-ambulatory or wheelchair-bound;
4. Are severely mentally ill or have past histories of violent behavior;
5. Are incontinent;
6. Have very advanced levels of impairment;
7. Are very aged; and
8. Are epileptic.

As a group, these individuals clearly require extensive amounts of direct care time. They also pose or are perceived as posing unusual risks for licensee-operators and other residents. They tend to experience blanket rejection once their impairments are known by licensee-operators.

The problem of selective admissions for certain individuals is not due to any general shortage of ARCH bed space. According to the DOH inventory report of July 6, 1988, there were more than 250 vacancies. It is also unlikely that this problem stems from any widespread limitation in the capability of licensee-operators. As a condition of licensure ARCH licensee-operators are expected to be generally capable of providing minimum levels of assistance and care.

A number of factors cause this placement problem, including: (1) fear and lack of knowledge on the part of licensee-operators, (2) non-standard admission policies, and (3) payment inequities.

Fear and lack of knowledge. There is a general concern that many licensee-operators do not have much detailed knowledge about the diverse range of resident impairments for which they are expected to provide care. Consequently, admission decisions are often based on unwarranted fears or misinformation.

To be fair, it must be acknowledged that the ARCH program does encompass a very diverse and expansive range of unrelated impairments. Yet the facilities are intentionally meant to be informal and non-institutional in character. This raises a question about the appropriateness of placing certain individuals in an ARCH setting, especially those who require inordinate amounts of direct care and supervision or who have significant medical or psychological conditions.

This problem will not be easily resolved by simply educating licensee-operators. At its core the problem manifests a conflict between the normal prerogatives of choice accorded any domestic homeowner and fairness requirements imposed on regulated businesses.

Type I operators feel they have a right to decide who will be allowed to reside in their homes. Placement agencies tend to adopt the stance that ARCH licensure is a voluntary act conveying

certain responsibilities and limitations that can erode that prerogative somewhat. Any attempt to reconcile these conflicting views must carefully balance the need for fair access against possible in-placement neglect (of mandatorily placed residents) or loss of many ARCH facilities. The problem requires further policy exploration.

Non-standard admission policies. Many placing agencies believe that arbitrary admission criteria are sometimes applied to exclude potentially difficult individuals.

This conclusion is hard to challenge because ARCHs are not currently regulated by any detailed standard admission policy. ARCH licensing rules (HAR 11-100-8) are not sufficiently comprehensive to assure much uniformity or consistency in admission practices. As a result, placement agencies must deal with a host of sometimes conflicting and unknown admission criteria. There are many opportunities for arbitrary applications in situations of that sort.

Payment inequities. Payment inequities are a major source of the placement selectivity problem.

We know that ARCH payments are inadequate in several respects. It is also apparent that current LOC certification and payment procedures do not accurately compensate for variations in the expected amount of care time required by residents with different impairment profiles. This deficiency creates a placement problem.

The amount of care time required by an individual will vary according to that person's specific impairments and overall functional capability. Some types and combinations of impairment require more service time than others.

To illustrate, compare the need for assistance with eating/feeding versus dressing/grooming. More time on average is required to assist a person with eating as compared with dressing. And more time will be required to assist with feeding as a person's overall level of impairment deteriorates. The same is not necessarily true for dressing. That is, highly impaired and sedentary persons may actually require less assistance with dressing as compared with more capable but still dependent individuals who engage in many outside activities.

Current LOC certification-payment procedures do not recognize this. ARCH payments are now based on a resident's certified level of care need. This is determined by evaluating the degree of assistance required in three broad functional areas as described in Chapter 2. Unfortunately, the numerical points in the evaluation process do not account for variations in the amount of time required to provide different care services (e.g., feeding vs. dressing) or the influence of a resident's overall functional capability. Higher numbers are always assigned to more advanced levels of functional debility and they always have the same value for every care service at any given functional level.

As a consequence, there is no systematic relationship between the level of care need categories and the expected amount of care time actually required by residents classified in any category. Under current procedures it is quite possible for an individual certified as needing Level I care to actually require *more* care time than someone certified for Level II care.

To demonstrate this point we show in Table 4.1 the *minutes per resident day* required to assist individuals at different levels of overall impairment with various activities of daily living.

Table 4.1

Assistance Time Required by ARCH Residents

Type of Assistance with Activities of Daily Living	Minutes of Care Time/Day by Overall Level of Impairment		
	LOC-I	LOC-II	LOC-III
Eating/Feeding	1.27	1.78	5.30
Bathing	15.32	16.79	15.61
Dressing/Grooming	33.00	27.35	22.89
Mobility	12.74	17.01	26.73
Transfers	3.96	5.29	8.32
Toileting	3.49	3.44	5.38
Incontinence	0.00	35.50	32.30

Consider two individuals seeking placement in a Type I facility. One requires only verbal reminders for toileting (LOC I impairment) but extensive assistance with eating/feeding and bathing (LOC III impairment)--a total of 20.40 minutes per day. The second requires minimal LOC I assistance with all activities--eating/feeding, bathing, dressing/grooming, mobility, transfers, and toileting--for a total of 69.78 minutes per day. According to current procedures the first person would be certified for Level II care and a basic payment of $598.90 per month; the second for Level I care and basic payment of $548.90 per month. So the more time consuming LOC I resident has a *rate* of compensation for ARCH licensee-operators that is significantly lower than the LOC II resident.

Overall, current LOC certification-payment procedures create artificial placement barriers for certain combinations of degree and type of impairment by not accounting properly for expected difference in care time requirements.

Need for better ARCH vacancy reports. Placing agencies assert that the problem of difficult to place individuals is compounded by inadequate ARCH vacancy reports. Specifically, these DOH reports do not accurately report vacancies (indicating a vacancy when none is available) and do not contain information that could expedite pre-placement files. Placing agencies maintain their work would be assisted greatly by the following:

1. Current resident case mix (i.e., the number, type, and degree of impairment for current residents).

2. Summary of incident reports that document unusual events related to residents in the facility.

3. Indications about the licensee-operator's actual capabilities and any special skills or training beyond minimum licensing requirements.

4. Concise statement of admission policies.

Other placement issues. The remaining important placement issues--geographic clustering of ARCH facilities, the lack of backup provisions for difficult to place individuals, and the possibility that pre-conditions for liability insurance may create new placement problems--require more extensive study and discussion on a policy level. While we found that these are significant problems, they are either already being addressed by other agencies or should be more fully probed as part of another analysis.

Recommendations

To improve placement we recommend the following:

1. The Department of Health develop uniform admission standards and make these immediately applicable to all ARCHs.

2. The Department of Health and the Department of Human Services apply the new level of care certification and payment procedures recommended in Chapter 3 to correct payment inequities for care time required to assist individuals at different overall levels of impairment.

3. The Department of Health and the Department of Human Services re-evaluate the types of impairment eligible for ARCH placement and consider whether the current range of eligible impairments and any inordinate care time requirements are consistent with the intended character and role of an ARCH. Any change in eligibility criteria may require a review by the Department of the Attorney General to assure compliance with non-discrimination requirements.

4. The Department of Health revise the ARCH vacancy reports to include more information that would be useful in expediting pre-placement screening activities. Input from State and private placement agencies and groups should be solicited to obtain maximum benefit from any revision. Consideration should also be given to implementing a more effective data base management system with computerized access. This may help to improve the timeliness of ARCH vacancy reports.

NOTES

Chapter 2

1. L. N. Murphy, M. S. Dunlap, M. A. Williams, and M. McAthie, *Methods for Studying Nurse Staffing in a Patient Unit: A Manual to Aid Hospitals in Making Use of Personnel*, DHEW Publication No. HRA 78-3, Bethesda, U.S. Department of Health, Education, and Welfare, May 1978.

2. Hawaii, Governor's Community Task Force on Group Living Facilities, *The Dispersal of Group Living Facilities in Hawaii*, Honolulu, Department of Health, State Health Planning and Development Agency, January 1988.

3. National Academy of Sciences, National Research Council, Food and Nutrition Board, *Recommended Dietary Allowances, Revised, 1980*, Washington, 1980.

4. American Society for Hospital Food Service Administration, American Hospital Association, *Hospital Food Service Management Review*, Chicago, 1980.

5. K. G. Bartscht, F. H. Bayha, D. C. Molhoek, and G. J. Kausler, *Hospital Staffing Methodology Manual, MM-3 Dietary*, (Revised 1968), Ann Arbor, Community Systems Foundation, March 1968.

6. R. E. Bresnahan and K. L. Goldenberg, *Dietetic Staffing Study, Nutrition Care: Phase II, Report of Results*, Arlington, VA, ANSER Analytic Services, Inc., August 1980.

7. U.S., Department of Agriculture, *Food*, Science and Education Administration Home and Garden Bulletin No. 228, Washington, 1980.

8. U.S., Department of Agriculture, *The Hassle-Free Guide to a Better Diet*, Science and Education Leaflet No. 567, Washington, U.S. Government Printing Office, 1980.

9. American Home Economics Association, *Handbook of Food Preparation*, Washington, 1975.

10. E. M. McKnight, *Nursing Home Research Study: Quantitative Measurement of Nursing Services*, Department of Health, Education and Welfare (National Institute of Health), Publication No. 72-223, Bethesda, October 1970.

11. P. N. Groner, "Productivity and Incentives," in *A Review and Evaluation of Nursing Productivity*, by R. C. Jelinek and L. C. Dennis, II, DHEW (HRA) Publication No. 77-15, Bethesda, U.S. Department of Health, Education, and Welfare, Health Resources Administration, November 1976.

12. W. L. Scheyer, *Handbook of Health Care Material Management*, Rockville, MD, Aspen Systems Corporation, 1985.

13. *Ibid.*

14. U.S., Department of Labor, Bureau of Labor Statistics, *Labor and Material Requirements for Nursing Home Construction*, Bulletin No. 2154, Washington, January 1983.

15. U.S., Department of Labor, Bureau of Labor Statistics, *Consumer Expenditure Survey: Interview Survey, 1984*, Bulletin No. 2267, Washington, August 1986.

16. U.S., Department of Labor, Bureau of Labor Statistics, *Autumn 1981 Urban Family Budgets and Comparative Indexes for Selected Urban Areas*, Release No. USDL 82-139, Washington, 1982.

17. U.S., Department of Labor, Bureau of Labor Statistics, *Three Budgets for a Retired Couple, Autumn 1981*, Release No. USDL 82-266, Washington, 1982.

18. U.S., Department of the Treasury, Internal Revenue Service, *Self-employment Tax*, Publication No. 533 (Revised Nov. 1987), Washington, 1987.

19. U.S., Department of the Treasury, Internal Revenue Service, *Depreciation*, Publication No. 534 (Revised Dec. 1987), Washington, 1987.

RESPONSES OF THE AFFECTED AGENCIES

AGENCY RESPONSES

On January 17, 1989, we transmitted a preliminary draft of this report to the Department of Human Services and the Department of Health. A copy of the transmittal letter to the Director of Human Services is included as Attachment 1. A similar letter was also sent to the Director of Health. The response from the Director of Human Services is included as Attachment 2. The response from the Director of Health is included as Attachment 3.

Department of Human Services Response

The Director of Human Services responded with five points of information for our consideration but has not responded to our central recommendation that ARCH payments be increased for residents in all level of care categories and for both ARCH facility types.

Department of Health Response

The Director of Health responds that the report is accurate overall and that the Department agrees with it for the most part with the exception of three areas of concern.

First, the department of health believes that compensation for Type I operators while they are away from the home is not covered in our calculations. This is not so. Our estimates are based on residents' active care time requirements; time spent in such operator activities as shopping and taking courses is accounted for, and to be compensated, in the appropriate expense account.

Second, the department disagrees with the recommendation that it develop uniform admission standards and apply them to all ARCHs. The department maintains that it has standardized admission policies. In support of its position, the department attributes difficulties in finding places to the LOC evaluation process and inequitable reimbursement for the additional care some individuals require. This is precisely our point. Current policies permit operators to reject applicants without explanation. Conversely, there are no standards that recognize that some types of residents may be inappropriate to place in certain kinds of family situations. More defined standards and criteria would begin to address these placement problems.

Third, with respect to our recommendation on improving ARCH vacancy reports, the department suggests the substitution of the term "usefulness" for "timeliness." However, we believe that in its entire context, the original language is appropriate.

THE OFFICE OF THE AUDITOR
STATE OF HAWAII
465 S. KING STREET, RM. 500
HONOLULU, HAWAII 96813

ATTACHMENT 1

January 17, 1989

COPY

Mrs. Winona Rubin
Director of Human Services
Department of Human Services
Liliuokalani Building
1390 Miller Street
Honolulu, HI 96813

Dear Mrs. Rubin:

Enclosed are two copies, numbered 4 and 5, of the preliminary report on **A Study of the Adequacy of Adult Residential Care Home Payments and Problems of Vacancy, Admission, and Demand.** If you would like to comment on our recommendations, we ask that you indicate by telephone by January 19, 1989 your intention to do so. If you decide to submit a response, please submit that response by January 26,1989. We will append the response to the report submitted to the Legislature.

The Governor and the presiding officers of the two houses of the Legislature have also been provided copies of this preliminary report. Copies have also been transmitted to Dr. John Lewin, Director of Health.

Since the report is not in final form and changes may be made, access to this report should be restricted to those individuals whom you might wish to call upon to assist you in reviewing the report. Public release of the report will be made solely by our office and only after the report is published in its final form.

We appreciate the continuing assistance and cooperation extended to us by the staff of the Department of Human Services.

Sincerely,

Newton Sue
Acting Legislative Auditor

Enclosures

ATTACHMENT 2

JOHN WAIHEE
GOVERNOR

WINONA E. RUBIN
DIRECTOR

ALFRED K. SUGA
DEPUTY DIRECTOR

MERWYN S. JONES
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
P. O. Box 339
Honolulu, Hawaii 96809

January 26, 1989

MEMORANDUM

TO: Mr. Newton Sue
Acting Legislative Auditor

FROM: Winona E. Rubin, Director

SUBJECT: PRELIMINARY REPORT: STUDY OF THE ADEQUACY OF ADULT RESIDENTIAL CARE HOME PAYMENTS AND PROBLEMS OF VACANCY, ADMISSION, AND DEMAND

We have reviewed the preliminary report, A Study of the Adequacy of Adult Residential Care Home Payments and Problems of Vacancy, Admission, and Demand. We would like to submit the following information for your consideration:

1. The fixed SSI federal payment amount for each of the levels of care used for ARCH payment computations in Chapters 2 and 3 is $354 per month. Effective 1/1/89, this amount was increased to $368 per month because of a 4% federal cost-of-living allowance (COLA). The federal SSI payment amounts have been incorporating COLA increases annually. As examples, the COLA rates of increase over the past five years have been: 4.0% in 1989; 4.2% in 1988; 1.3% in 1987; 3.1% in 1986; and 3.5% in 1985.

2. Also effective 1/1/89, we increased our recommended personal essential allowance from the current amount of $23.90 (cf:page 14) to $30.00 per month to coincide with the $30.00 amount SSI individuals in medical institutions currently receive. The Social Security Administration noted inequity in the amounts of personal expenditures permitted SSI individuals in care homes ($22.90 at time of review in 1987) and individuals in medical institutions ($25 at time of review in 1987) and advised us that the amounts should be equitable. We are making arrangements to inform all recipients residing in care homes and their home operators of this recommended increase.

3. On page 6, the study notes that licensee-operators can assess both government-supported and private paying individuals a fee that exceeds the amount in the ARCH

payment schedule (since ARCH fees are not regulated) and that "for government-supported individuals the additional payments can come from personal income, relatives, or other interested parties". We wish to note that the recipient's eligibility for DHS social services and income maintenance assistance is jeopardized if he/she receives additional funds. All personal income and contributions received from relatives or interested parties of a government-supported individual are countable income for eligibility/payment purposes.

4. On page 24, the study recommends the retention of the $100 per month State supplement for LOC III residents who have been certified for and are awaiting more specialized placement, primarily because the payment is in an amount close to what the additional care is worth. Although the $100 payment is also advantageous for the Medicaid program because of the cost effectiveness of delaying institutionalization and the higher costs it will incur, the recommendation to retain this payment could be interpreted as an endorsement of care in inappropriate settings - adult residential care homes which are not licensed to provide higher than LOC III care. This will then increase the State's vulnerability in liability issues.

5. There was a citation on page 5 that DHS administers all three State supplemental payments. A recommendation was subsequently made on page 25 for a possible consolidation of all State-funded supplemental payments to be administered by the Social Security Administration (SSA). The SSA was able to administer, effective 7/1/88, only the $115 State supplemental payment which all SSI-eligible recipients residing in ARCHs receive. SSA administration of the $108 and/or $100 payments, which not all SSI individuals receive, will require additional payment levels beyond the maximum 5 levels which SSA is authorized to administer. The maximum 5 levels currently being administered are the three LOC payments, the payment to SSI individuals living in independent arrangements, and the payment to SSI individuals living in households of another.

Director

cc: Honorable John Waihee

ATTACHMENT 3

JOHN WAIHEE
GOVERNOR OF HAWAII

JOHN C. LEWIN, M.D.
DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH
P. O. BOX 3378
HONOLULU, HAWAII 96801

In reply, please refer to:
File: MedH-HMF

January 26, 1989

RECEIVED
JAN 27 4 32 PM '89
OFC. OF THE AUDITOR
STATE OF HAWAII

Mr. Newton Sue
Acting Legislative Auditor
The Office of the Auditor
465 South King Street, Room 500
Honolulu, Hawaii 96813

Dear Mr. Sue:

The report done by your office "A Study of the Adequacy of Adult Residential Care Home Payments and Problems of Vacancy, Admission and Demand" is overall accurate and one with which we can agree for the most part. There are only three areas of concern or disagreement:

(1) Page 2. An important cost item for Type I appears not to be included. Type I operators have 24-hour/day responsibility. When they go shopping, take courses, or are away, they must have coverage. This represents a person (employee?) who should be paid, representing a "tangible out-of-pocket expense." The Report seems not to have considered this expense although it contributes directly to the overall cost of care. Type II facilities have 8-hour shifts and the cost of employees to cover 24 hours is considered. We suggest the cost of "employees" to cover the operator's absence in Type I should also be recognized, and delineated.

(2) We disagree with the statement on page 29 that admission policies are not standardized. They are currently standardized as requiring patient severity and care needs to correspond with operator skills and capability, with an upper limit (not requiring care in an intermediate care facility, i.e., 24-hour nursing). We feel this is the most reasonable way of matching operator skills with client's care needs. Hence, we must disagree with Recommendation #1 on page 31, as it is written.

It is difficult for case managers to place some clients because these clients represent problems which demand many hours of care and special skills, and the L.O.C. evaluation process currently does not account for or reimburse

variations in the amount of time required to provide assistance within the same L.O.C. Hence, the operators reject clients requiring greater hours if the payment level is the same or less than someone requiring fewer hours, or skills.

Adequate reimbursement for amounts of care needed is the key factor to encourage admissions.

One must remember also that these are private homes with families and some types of care are inappropriate to bring into family situations.

(3) Page 31, Recommendation #4. Last sentence. We suggest the word "timeliness" be changed to "usefulness". We believe that the reports are currently sent out on time.

We agree with the remaining recommendations and with the report as a whole. Many thanks for the opportunity to comment.

Yours very truly,

JOHN C. LEWIN, M.D.
Director of Health