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CONGREGATE HOUSING

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Governor's Office of Policy and Planning
State House

Stephen Schoeman
Policy and Planning Specialist

September 1981

EXECUTIVE OFFICE



INTER-COMMUNICATION

SS.

From: Stephen Schoeman

To: Donald Linky, Director

Policy & Planning Specialist

Governor's Office of Policy

Date: September 2, 1981

and Planning (Institution or Department)

Re: Congregate Housing

You had asked me to review the attached packages of materials and suggest what we do next.

RECOMMENDATIONS

1. Determine the appropriate financing mechanisms for congregare housing programs.

The answer to this question depends upon the size of the program. A program which is concerned only with providing support services, as is the program of the Division of Aging, will require a lesser amount of financing than a program which additionally is concerned with providing new facilities, as is the program of the Housing Finance Agency. The Division of Aging provides for a modest program based upon financing from the Casino Revenue Account. The schedule of financing rises from \$500,000 the first year to \$750,000 the second year to \$1,000,000 the third year. Such financing would be used to provide support services to present residents of congregare housing. No new facilities can be contemplated under this approach given the cost of new construction. \$1,000,000, according to Bruce Coe, would support about 1,000 residents.

Whether the Casino Revenue Account could be used to finance the program the Division of Aging proposes is open to question given constitutional restrictions on the use of the Casino Account.

The Housing Finance Agency could theoretically provide for a larger congregare housing program, one able to provide new construction. The Agency can issue bonds. The key question is how these bonds would be backed.

The New Jersey Health Care Facilities Authority would not appear to be an alternative to the Housing Finance Agency. As a congregare housing facility is not a health care facility, the Health Care Facilities Financing Authority could not finance such a facility, according to former Attorney General John J. Degnan. According to Daniel J. O'Hern, former Counsel to the Governor, "The State agency which appears most appropriate for financing these projects is the Housing Finance Agency". (letter August 6, 1981, to Jerome M. St. John, Esq., Draft and Huges, Newark).

The size of the program in turn depends upon the perceived need for the program. A considerable population of people in New Jersey could benefit from congregate housing. According to Bruce Coe, there were 859,982 people in 1970 in New Jersey over the age of 65. In 1976, 38% of the people over 65 were over 75. It has been estimated by the Connecticut Division of Aging that 5% of the population over 75 could benefit from congregate housing. This would be about 16,340 people in New Jersey.

We should determine the kind of commitment which we would want to make to the potential congregate housing population. In general, the states with congregate housing have had modest programs. (Attachment A).

2. DETERMINE WHO SHOULD MANAGE THE PROGRAM

Management includes two sets of problems.

- a. THE CONGREGATE HOUSING FACILITY, including locating and using existing facilities and the siting, design, construction and maintenance of new facilities.

We should determine whether the Division of Aging or the Housing Finance Agency has the greater experience and expertise in management of this type. There are two separate concerns here, one having to do with existing facilities, the other with new construction.

As to existing facilities, the congregate housing program would be making use of a certain percentage of existing facilities. The Housing Finance Agency can properly claim jurisdiction over use of its housing projects for congregate housing. Furthermore, the Agency is a potentially greater source of existing facilities for the congregate housing program than is the Division of Aging.

As to new construction, the Housing Finance Agency has greater expertise in the siting, design, and building of new facilities than does the Division of Aging.

3. THE CONGREGATE HOUSING PROGRAM SUPPORT SERVICES, including assessment and referral, meals, house-keeping, personal services and security.

We should determine whether the Division of Aging or the Housing Finance Agency has greater experience and expertise in management of this type. The Division of Aging claims that it is better able to judge the needs of the elderly than is the Housing Finance Agency. The Housing Finance Agency claims that it too has such an ability.

A solution may be to give the Housing Finance Agency primary jurisdiction but with sufficient assistance from the Division of Aging.

COORDINATION. The agency having primary jurisdiction over the program might be either the Division of Aging or the Housing Finance Agency. Whichever agency has the primary jurisdiction must have the co-operation of all interested state agencies to insure the correct assessment and referral of the covered population.

Effective assessment and referral require that all institutions and situations in which the elderly are located be incorporated into a system of management to pinpoint needs and to match levels of need and levels of support services. Boarding homes, nursing homes, group arrangements for the de-institutionalized, mental health facilities, and hospitals would need to be monitored to determine who requires congregate care rather than institutionalization.

The Housing Finance Agency calls for an advisory committee of interested state agencies. The function of co-ordination, however, could be performed by the agency with primary jurisdiction over the program. Providing for a separate co-ordinating agency might in and of itself create co-ordinating problems with the agency with primary jurisdiction.

4. Arrange a meeting of the interested state agencies.

James Pennestri suggested a meeting with the Commissioner of Community Affairs and Bruce Coe. I suggest that we be represented at the meeting. It would appear, from conversations with both James Pennestri and Bruce Coe, that there is general agreement on the need for congregate housing. The difficulty rests in which agency should have primary jurisdiction over the program. The meeting should consider problems of management and financing as well as co-ordination. I would be happy to attend the meeting.

5. Determine whether we should support the Packwood-Bradley Long Term Care Bill (S. 861) (Attachment)..

The purpose of this bill is to demonstrate the feasibility of a comprehensive system of noninstitutional long-term care services for the aged and disabled. The emphasis is upon assisting these people to remain as functionally independent as possible in their own communities. It is not clear as to the date of this memorandum whether New Jersey will be one of the demonstration states.

I hope to have an answer from Senator Bradley's office when the person in charge of the bill returns from vacation after Labor Day.

Both the Division of Aging and the Housing Finance Agency support a demonstration project to establish the feasibility of congregate housing and to establish the savings to the state such a program should produce.

A condition of our support for the Packwood-Bradley Bill might be that New Jersey be designated one of the project demonstration states.

SOURCES OF INFORMATION

Senator Bradley's Office

James Pennestri, Division of Aging

Carlin, Division of Aging

Division of Aging, State of Connecticut

Bruce Coe, Housing Finance Agency

Philip Caton, Division of Housing of New Jersey

ATTACHMENT A



JOINT COMMITTEE ON LEGISLATIVE MANAGEMENT
OFFICE OF LEGISLATIVE RESEARCH

ED FRANTZ
DIRECTOR

December 15, 1980

TO: Honorable Anthony D. Truglia
FROM: Office of Legislative Research
Hugh A. McGuire, Senior Research Analyst
RE: Congregate Housing Programs

This is in response to your request for the following information regarding states that have congregate housing programs:

- 1) what states have congregate housing programs;
- 2) what is the cost to each of those states;
- 3) how are the programs administered;
- 4) how many people do they serve;
- 5) do all states have rent subsidies for such programs; and
- 6) are the operators of the congregate projects licensed.

SUMMARY

Eight states have been identified as having congregate housing programs (Connecticut, Maine, Maryland, Massachusetts, New Jersey, New York, Ohio and Vermont). Connecticut and Massachusetts are the only two states of those identified that directly subsidize the construction of the congregate units. The other states provide subsidies for support services such as housekeeping, common meals, etc. In most states, the

congregate program is administered through the state department of aging or human services. Only Connecticut, Massachusetts, New Jersey and Vermont do not certify the operators of congregate projects; the other states do.

STATES WITH CONGREGATE HOUSING PROJECTS

Congregate housing is generally defined as a form of residential environment consisting of independent living assisted by congregate meals, housekeeping and personal services for the elderly who have temporary or periodic difficulties with one or more essential activities of daily living such as feeding, bathing, grooming, dressing or transferring. Congregate housing is a middle ground between a person's private home and a nursing home. A congregate housing unit generally consists of a living area, a bedroom and a small kitchen area. A congregate unit can also consist of a single room with or without kitchen facilities. According to Dr. Kevin Mahoney of the Connecticut Department of Aging, it appears that congregate housing units cost approximately one-third to two-thirds less to build than conventional elderly housing.

According to Mr. Tom Beall of the International Center for Social Gerontology in Washington, D.C., there are eight states that have established congregate housing programs (or as they are sometimes called, Enriched Living Programs). The following outline provides a description of each state's program.

STATE	WHEN ESTABLISHED	SOURCE OF FINANCING	ADMINISTERING AGENCY	# UNITS	SUBSIDIZED BY STATE	OPERATORS LICENSED	COMMENTS
Connecticut	1977	\$5 million (construction and services)	Dept. Housing Dept. Aging (in advisory capacity)	100	yes	no	The State Department of Housing constructs and provides service. The State Department on Aging advises the Department of Housing. The state issues bonds for construction and uses federal subsidies when available. If federal subsidies are not available, construction financing is provided as a grant-in-aid. Rents are based on cost of maintenance and operation.
Maine	1980	\$87,000 was provided by the General Assembly during the 1980 session to provide social services in congregate housing. No direct construction subsidies are provided by the state. Congregate housing is developed using federal Section 8 funds.	Dept. Human Services	50-60	no	certification	

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Connecticut	1977	\$5 million (construction and services)	Dept. Housing Dept. Aging (in advisory capacity)	100	yes	no	The State Department of Housing constructs and provides services. The State Department on Aging advises the Department of Housing. The state issues bonds for construction and uses federal subsidies when available. If federal subsidies are available, construction financing is provided as grant-in-aid. Rents are on cost of maintenance and operation.
Maine	1980	\$87,000 was provided by the General Assembly during the 1980 session to provide social services in congregate housing. No direct construction subsidies are provided by the state. Congregate housing is developed using federal Section 8 funds.	Dept. Human Services	50-60	no	certification	

STATE	WHEN ESTABLISHED	OF FINANCING	ADMINISTERING AGENCY	# UNITS	SUBSIDIZED BY STATE	OPERATORS LICENSED	COMMENTS
Maryland	1976	\$1,538,114	Dept. on Aging	550	no	certified	Maryland's congregate housing projects are subsidized under various federal programs. The state provides no direct construction subsidies. The state finances the provision of services such as household health care, etc.
Massachusetts	1979	\$5,460,000 (approximately)	Executive Off. of Communities & Development	195	yes (similar to Connecticut)	no	Massachusetts's congregate program operates in a way that is similar to Connecticut. If federal funds are not available, the state directly subsidizes the cost of construction. Rent is scaled so as to not exceed 30% of an occupant's income. Support services are provided through federal subsidies such as Title XX, Medicare, etc. The state provides staff assistance for the coordination of support services.
New Jersey	1979	FY 1980 - \$90,000 FY 1981 - \$200,000 (support services)	Dept. of Community Aff. Division on Aging	220	no	no	New Jersey directly finances only support services. The congregate projects are built by the state housing finance agency using federal subsidies.

STATE	WHEN ESTABLISHED	AMOUNT OF FINANCING	ADMINISTERING AGENCY	# UNITS	ARE RENTS SUBSIDIZED BY STATE	OPERATORS LICENSED	COMMENTS
New York	1978 (enriched living)	\$3 million (approximately)	Dept. of Social Services	300 (approx.)	no	Operators are certified.	New York State does not directly finance the construction of congregate housing units. It supplements the income of low income social security recipients living in privately developed congregate housing for such services as housekeeping, congregate meals, etc.
Ohio (Sheltered housing)	1979	No funding to date	Commission on Aging	48 (approx.)	no	yes (certified)	Federal funds used to develop projects. Support services paid to residents.
Vermont	1978 Demonstration program using Title III, Older Americans Act funds.	Privately developed using Sec. 8 funds. No direct rent subsidies are provided by the state.	Dept. of Human Services	52	no	no	The State of Vermont finances a services package that provides life support services to people living in congregate housing. The services package was originally financed as a demonstration program between 1978 and 1980. During the 1981 session of the General Assembly, \$100,000 in funding will be sought to finance services for 55 new units and to continue services to the 52 already occupied.

ATTACHMENT B

P. S3353

Senate

NONINSTITUTIONAL ACUTE AND LONG-TERM CARE SERVICES FOR THE ELDERLY AND DISABLED

Mr. BRADLEY. Mr. President, I am pleased to join Senator PACKWOOD as well as Senators HEINE, MATSUNAGA, MOYNIHAN, PRYOR, COCHRAN, and RIZGLE in introducing today a bill to create a new title—title XXI—of the Social Security Act. The purpose of this legislation is to demonstrate the feasibility of a comprehensive system of noninstitutional long-term-care services for the aged and disabled. Our emphasis here is on noninstitutional, for our intent is to insure that those Americans who are aged 65 and over and those who are disabled are assisted in remaining as functionally independent as possible in their own communities.

It has become increasingly obvious, Mr. President, that we must revise our policies governing the provision of services to those who require long-term care. Placing people in nursing homes may be appropriate in certain cases; but just as frequently such placements can have adverse social and economic effects on our elderly and disabled citizens, on our health care system, and on the public budget. This is especially true when the only reason people are in nursing homes is because adequate services are not available in their own community.

The evidence of the past 15 years of increasing nursing home usage at increasing public cost suggests the need for reevaluating our current long-term-care policies and programs. A look forward to the next two decades would seem to compel such a reevaluation. First, the United States is undergoing significant demographic change in the age composition of its population. Both the absolute numbers and the proportion of the population over 65 are on the rise. This year there are more than 25 million men and women over 65 years of age; by the year 2000, this number will rise to more than 32 million. In percentage terms, 9.8 percent of the population in 1970 was over 65; this figure rose to 11.2 percent in 1980 and is projected to be 12.2 percent by 2000. About 15 percent of these elderly are either bedridden or require assistance in the basic functions of daily living. As the post-World War II

baby boom ages, the need for a comprehensive and efficacious long-term-care system will become more acute.

The pressures on our long-term care system created by an aging population will be compounded by the shifting composition of the labor force. As more women and young people enter the work force, the component of long-term care formerly supplied by the family will decrease. Public and private initiatives will be required to facilitate the working family's efforts to care for its aged and disabled members without having to resort to institutionalization.

The growth in the population in need of some long-term care services, combined with the absence of an effective system of noninstitutional long-term care, has already led to seriously inadequate living situations for many elderly and disabled individuals. First, a significant number of needy aged and disabled do not receive publicly provided services of any kind; they are unknown by our official systems of health and social services, coping as best they can. Some are doing well, with the help of friends and family; some are not. Many others are insufficiently or inappropriately served in hospitals and nursing homes. Finally, substantial numbers of individuals are overserved in their present locations. Nearly 1 million Americans are now residents of nursing homes, even though leading health experts estimate that thousands of them—anywhere from 10 to 25 percent—do not need this level of care. Moreover, because nursing homes are crowded with individuals who could more appropriately be served in noninstitutional settings, these same nursing homes do not have room for thousands of chronically impaired patients who are forced to remain in even more expensive acute care hospital beds. In both instances, the Government, through Medicare and Medicaid, pays a substantial portion of an unnecessarily costly bill.

The costs of this inefficient use of our institutional services are extremely high, from both a social and financial standpoint. Individuals placed in institutions suffer a variety of costs: They are uprooted from their homes, they are severed from normal contact with their family, friends, and community. They

cases there is even a loss of life-long possessions. I believe strongly that whenever possible such institutionalization and its disruptive effects should be avoided.

From a monetary standpoint, unnecessary nursing home placement also has a negative impact. The alarming escalation in the costs of nursing home care is an increasingly onerous burden on both the individual and the Government. In 1978, \$8.8 billion in public money was spent on nursing home care; this figure will become \$11 billion in 1981. In far too many cases individuals enter institutions as nonmedical private patients and then, shortly after, their resources depleted, they become medicaid eligible. The current portion of the Federal medicaid budget that goes to financing nursing home care is over 40 percent. Long-term care is the fastest growing part of medicaid. In 1970, only 25 percent of medicaid funds went to nursing home payments.

The search for alternatives to inappropriate institutionalization is not made easy by the current confusion of programs and lack of a clear strategy which encourages and facilitates noninstitutional care. Both medicare and medicaid, for instance, have a strong institutional bias in the services they fund and the situations in which these services will be covered. Some services are paid for only if provided in a hospital or nursing home, but not in the individual's own home. Existing long-term care services are supported by differing funding streams and have widely ranging administrative arrangements, eligibility requirements and benefits. This fragmentation means that services for older and disabled people in need of long-term care will vary from community to community and State to State; they may be multiple, parallel, overlapping, noncontinuous or even not provided at all. The common denominator is confusion.

In seeking a clearer strategy for noninstitutional long-term care, we have focused on two questions:

How can we keep individuals out of hospitals and nursing homes when an institution is not needed?

How can we, at the same time, provide care to individuals in their homes or their communities and help them lead as independent lives as possible through support and self-care?

In title XXI, we are proposing an approach which we think may offer answers to these questions.

Under title XXI, noninstitutional long-term care services currently provided under medicare, medicaid, or social services—titles XVIII, XIX, and XX of the Social Security Act—would be combined and would be supplemented with certain

homemaker-home health aides, adult day care, and respite care services would be covered. Any person who is aged 65 or over or who is disabled would be eligible for title XXI services.

The needs of each individual for services will be evaluated by a preadmission screening and assessment team (the PAT), composed of health and social service professionals. The purpose of the PAT is to devise a plan of care specifically tailored for each individual. The PATs will also assist the individual in obtaining needed services and conduct periodic reassessments to update care. The PATs will especially seek to divert persons away from skilled and intermediate nursing facilities and hospitals to community-based care whenever a less restrictive and less institutional level of care is more appropriate.

While the Federal Government will assume most of the costs of title XXI services, a copayment system will be tested for individuals participating in the program, in recognition of the very real need to control the long-term care budget. Those individuals whose incomes qualify them for medicaid will be exempt from copayments; those with incomes at \$12,000 or less will be eligible for a specified number of free services before they begin to make copayments; and those with incomes above \$12,000 will make copayments beginning with the first service. Thus the individual's share will be based entirely on his or her ability to pay.

As you can see, title XXI is a very ambitious program. Even as I have great hopes for the title XXI approach, our bill has been fashioned with the awareness that its concepts must be fully tested and that changes will likely be made as we proceed with its implementation. With this in mind, the bill we are introducing today calls for a 6-year, 10-State demonstration of the title XXI program.

The experience of these 10 States will provide Congress with the information upon which subsequent decisions can be based. By designing title XXI as a demonstration, we expect to be able to learn which program features, which provisions and conditions, best meet the needs of older and disabled Americans before embarking on the program nationwide. We know too little about the level of demand that may exist for these services, too little about the costs and financing arrangements and too little about the organizational aspects of screening and assessment teams and service delivery mechanisms. For these reasons, we have opted for a 6-year demonstration project on a sufficiently large scale so we will be able to recommend to our colleagues at the end of that time the adoption of a well-tested and well-proved concept as national policy.

or unproved concept, however. We have found encouragement in the diverse projects now underway in various parts of the country which share numerous features with our title XXI legislation. They have demonstrated, each in different ways, that we can do a much better job in providing comfortable, safe and normal environments for the aged and disabled, and that we can do so in a cost-effective way. For many, a greater independence can be achieved through accessibility to a rather simple set of services and supports. If we can provide in the community a range of services which can help the elderly and disabled meet their needs for limited or temporary assistance, we will enrich their lives and our own as well.

In closing, I must again stress that institutional care is expensive, and that unnecessary institutional care is wasteful of both dollars and lives. Society's overreliance on and overuse of nursing homes has serious adverse economic, psychological and social effects on the elderly and disabled, their families and those third party payers, including the Federal Government, and ultimately the taxpayer, who share these burdens.

Mr. President, for these compelling reasons, I urge my colleagues to join us in support of this worthy and much overdue piece of legislation.

97TH CONGRESS
1ST SESSION

S. 861

To amend the Social Security Act to provide for a six-year demonstration program of comprehensive community-based noninstitutional acute and long-term care services for the elderly and disabled.

IN THE SENATE OF THE UNITED STATES

APRIL 2 (legislative day, FEBRUARY 16), 1981

Mr. PACKWOOD (for himself, Mr. BRADLEY, Mr. HEINZ, Mr. MATSUNAGA, Mr. MOYNIHAN, Mr. PRYOR, Mr. COCHRAN, and Mr. RIEGLE) introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

To amend the Social Security Act to provide for a six-year demonstration program of comprehensive community-based noninstitutional acute and long-term care services for the elderly and disabled.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*
3 That this Act may be cited as the "Noninstitutional Acute
4 and Long-Term Care Services for the Elderly and Disabled
5 Act".

1 NONINSTITUTIONAL ACUTE AND LONG-TERM CARE

2 SERVICES FOR THE ELDERLY AND DISABLED

3 SEC. 2. The Social Security Act is amended by adding
4 at the end thereof the following new title:

5 "TITLE XXI—NONINSTITUTIONAL ACUTE AND
6 LONG-TERM CARE SERVICES FOR THE EL-
7 DERLY AND DISABLED

8 "PURPOSE OF TITLE

9 "SEC. 2101. (a) It is the purpose of this title—

10 "(1) to provide a comprehensive system of nonin-
11 stitutional health, developmental, and social services
12 for individuals with chronic disabilities, to ensure that
13 such individuals are assisted in remaining in their own
14 homes or communities, and therefore avoid unneces-
15 sary placement of such individuals in institutional facil-
16 ities, and, where possible, to allow individuals in such
17 facilities to return to their communities;

18 "(2) to test three different methods of reimburse-
19 ment in order to determine the most cost-effective and
20 efficient way of providing the services available under
21 this title;

22 "(3) to assess the impact of the services provided
23 under this title in aiding families in caring for individ-
24 uals eligible for benefits under this title, and, to the
25 extent possible, to determine if the provision of such

1 services has encouraged such families to forestall
2 placement of such individuals in nursing homes or
3 other institutional facilities; and

4 “(4) to assess how systems serving both the elder-
5 ly and the disabled can be combined in a coordinated
6 and consolidated generic approach, thus eliminating the
7 fragmented categorical design of the current long-term
8 care system.

9 “(b) It is not the purpose of this title to replace assess-
10 ment systems, particularly those in place and being utilized
11 by various disability programs.

12 “SCOPE OF BENEFITS

13 “SEC. 2102. (a) Each eligible individual (as determined
14 under section 2103) shall be entitled to the following benefits:

15 “(1) Home health services.

16 “(2) Homemaker-home health aide services.

17 “(3) Adult day services.

18 “(4) Respite care services for up to 14 days, or
19 336 hours, in any calendar year.

20 “(5) Service coordination.

21 “(6) Home help services.

22 “(7) Other services which the Secretary deter-
23 mines may be of value to aged or disabled individuals,
24 which shall be provided on a demonstration basis in
25 one or more States to eligible individuals.

1 “(b) For purposes of this title—

2 “(1)(A) The term ‘home health services’ means
3 the following items and services furnished to an indi-
4 vidual which are furnished by a home health agency,
5 by a center or agency for the handicapped, or by
6 others under arrangements with them made by such
7 entity, under a plan developed, approved, and periodi-
8 cally reviewed by a preadmission screening and assess-
9 ment team (PAT) (as defined in section 2104) which
10 items and services are, except as provided in clause
11 (vi), provided on a visiting basis in a place of residence
12 used as such individual’s home—

13 “(i) part-time or intermittent nursing care
14 provided by or under the supervision of a regis-
15 tered professional nurse;

16 “(ii) physical, occupational, or speech ther-
17 apy;

18 “(iii) medical supplies (other than drugs and
19 biologicals), and the use of medical appliances,
20 while under such a plan;

21 “(iv) drugs and biologicals necessary for the
22 control of a disability (as determined under sub-
23 paragraph (E));

24 “(v) in the case of a home health agency
25 which is affiliated or under common control with

1 a hospital, medical services provided by an intern
2 or resident-in-training of such hospital under a
3 teaching program of such hospital approved as
4 provided in section 1861(b)(6) of this Act; and

5 “(vi) any of the foregoing items and services
6 which are provided on an outpatient basis, under
7 arrangements made by the home health agency,
8 at a hospital, skilled nursing facility, or intermedi-
9 ate care facility, or at a rehabilitation center
10 (within the meaning of section 1861(p)) which
11 meets such standards as may be prescribed in reg-
12 ulations, and—

13 “(I) the furnishing of which involves the
14 use of equipment of such a nature that the
15 items and services cannot readily be made
16 available to the individual in such place of
17 residence, or

18 “(II) which are furnished at such facil-
19 ity while he is there to receive any such item
20 or service described in division (I), but not
21 including transportation of the individual in
22 connection with any such item or service
23 unless such transportation is included on a
24 demonstration basis as authorized under sub-
25 section (a)(7);

1 excluding, however, any other item or service if it --
2 would not be included under section 1861(b) if fur-
3 nished to an inpatient of a hospital.

4 “(B) The term ‘home health agency’ means a
5 public agency or private organization, or a subdivision
6 of such an agency or organization, which—

7 “(i) is primarily engaged in providing skilled
8 nursing services and other therapeutic services;

9 “(ii) has policies, established by a group of
10 professional personnel (associated with the agency
11 or organization), including one or more physicians
12 and one or more registered professional nurses, to
13 govern the services (referred to in clause (i))
14 which it provides, and provides for supervision of
15 such services by a physician or registered profes-
16 sional nurse;

17 “(iii) maintains clinical records of all pa-
18 tients;

19 “(iv) in the case of an agency or organization
20 in any State in which State or applicable local
21 law provides for the licensing of agencies or orga-
22 nizations of this nature, (I) is licensed pursuant to
23 such law, or (II) is approved, by the agency of
24 such State or locality responsible for licensing

1 which is to provide residential care on a 24-hours-
2 per-day basis); or

3 “(ii) any agency certified or licensed by the
4 State as being an agency designed to assist indi-
5 viduals eligible for services under this title to
6 reach their maximum level of independence.

7 “(E) The term ‘disability’ means (i) inability to
8 engage in any substantial gainful activity by reason of
9 any medically determinable physical or mental impair-
10 ment which can be expected to result in death or has
11 lasted or can be expected to last for a continuous
12 period of not less than 12 months (or, in the case of a
13 child under the age of 18, a medically determinable
14 physical or mental impairment of comparable severity),
15 or (ii) blindness (as defined in section 216(i)(1)).

16 “(2)(A) The term ‘homemaker-home health aide
17 services’ means services provided by a homemaker-
18 home health aide who meets training guidelines speci-
19 fied by the State, or by a center or agency for the
20 handicapped, to an individual, which are designed to
21 maintain or increase the personal care of such individ-
22 ual and his home (not including the structure of the
23 home) in a manner which promotes the functional
24 independence of the individual and to avoid the need
25 for institutionalization. Such services shall include—

1 “(i) personal care services designed to assist
2 such individual in the activities of daily living
3 such as bathing, exercising, personal grooming,
4 and getting in and out of bed; and

5 “(ii) household care services such as main-
6 taining a safe living environment, light housekeep-
7 ing, and ensuring good nutrition (including the
8 purchase and preparation of food).

9 “(B) The term ‘homemaker-home health aide
10 agency’ means a separate agency, or a program which
11 is part of a multipurpose agency (including a county or
12 local health department, a family or child welfare serv-
13 ice agency, a multipurpose senior center, a center or
14 agency for the handicapped, or any similar agency),
15 which meets guidelines specified by, and is approved
16 by, the State as being capable of providing home-
17 maker-home health aide services as defined in subpara-
18 graph (A).

19 “(3) the term ‘adult day services’ means services
20 provided (other than care provided for the primary ob-
21 jective of providing medical services) on a regular
22 basis, but less than 24 hours per day, in a multipur-
23 pose senior center, rehabilitation center, center or
24 agency for the handicapped, or any other facility which
25 meets guidelines specified by, and is approved by, the

1 State, which are provided to an individual who is-in
2 need of social, training, or developmental activities
3 during the daytime hours because of a functional im-
4 pairment but does not require institutionalization, and
5 which are provided for the purpose of assisting such in-
6 dividual to maintain a maximum level of independence.
7 Such services may include (but are not limited to) pro-
8 vision of health care, recreation and educational activi-
9 ties, physical and vocational rehabilitation, and social,
10 developmental, or independent living services.

11 “(4) The term ‘respite care services’ means serv-
12 ices for an individual who is unable to care for himself
13 on a full-time basis, which are provided on a tempo-
14 rary basis to such individual to provide relief for the
15 person who normally cares for such individual. Such
16 services shall be provided by persons who have met
17 specific training guidelines specified by the State, and
18 who are employed by a local public health department,
19 a local agency participating in a State program estab-
20 lished under title XX of this Act, a certified home
21 health agency, a homemaker-home health aide agency,
22 a center or agency for the handicapped, or any agency
23 or organization which meets guidelines specified by the
24 State for agencies which provide services described in
25 the preceding sentence. Such services shall, when nec-

1 essary and appropriate, be provided in addition to other
2 services under this title to ensure that such individual
3 receives a coordinated system of services designed to
4 help that individual reach a maximum level of
5 independence and to lessen such individual's depend-
6 ence upon the individual who normally cares for him.

7 “(5) The term ‘service coordination’ means serv-
8 ices, provided to an individual who has a developmen-
9 tal or other disability, which will assist such individual
10 in gaining access to necessary social, medical, health,
11 educational, and other services, including—

12 “(A) follow-along services which insure,
13 through a continuing relationship between an
14 agency or provider and such individual and the in-
15 dividual's family or guardian, that the changing
16 needs of such individual and family relating to
17 such disability are recognized and appropriately
18 met; and

19 “(B) services which provide support to such
20 individual, access to and coordination with appro-
21 priate service providers, information relating to
22 available programs and services, and monitoring
23 of such individual's progress.

24 “(6) The term ‘home help services’ means house-
25 hold care services (not including care of the structure

1 of the home) such as maintaining a safe living environ-
2 ment, light housekeeping, and ensuring good nutrition
3 (including the purchase and preparation of food), pro-
4 vided by an individual who meets such training re-
5 quirements as may be developed by the State and ap-
6 proved by the Secretary.

7 “(7) The term ‘institutional facility’ means a hos-
8 pital, a skilled nursing facility, or an intermediate care
9 facility as those terms are defined for purposes of titles
10 XVIII and XIX of this Act.

11 “ELIGIBILITY FOR BENEFITS

12 “SEC. 2103. (a) Every individual who resides in a State
13 in which this title is in effect and who—

14 “(1) has attained age 65, is a resident of the
15 United States, and is either a citizen or an alien law-
16 fully admitted for permanent residence;

17 “(2) is disabled and is eligible for benefits under
18 title II, XVI, or XVIII of this Act;

19 “(3) is disabled and is eligible for medical assist-
20 ance under a State plan approved under title XIX of
21 this Act; or

22 “(4) was an eligible individual under this title by
23 reason of paragraph (2) or (3) but ceased to meet the
24 requirements of such paragraph, but only if it is deter-
25 mined by a PAT designated under section 2104 that—

1 “(A) loss of benefits under this title would
2 seriously jeopardize such individual’s ability to
3 continue to live in a noninstitutional community
4 residence, and

5 “(B) such individual’s income is not sufficient
6 to allow him to provide for himself a reasonable
7 equivalent of the services available to him as an
8 eligible individual under this title;
9 is an eligible individual for purposes of this title.

10 “(b) Certification of eligibility under this section shall be
11 made by the Secretary.

12 “PREAMISSION SCREENING AND ASSESSMENT

13 “SEC. 2104. (a)(1) No eligible individual as defined
14 under section 2103 shall be eligible to receive any benefits
15 under this title, or any long-term care benefits under title
16 XVIII of this Act, or any long-term care under a State plan
17 approved under title XIX or XX of this Act, unless such
18 individual has been screened and assessed in accordance with
19 the provisions of this title, and has a plan of care (as defined
20 in this section) under which the provision of such care or
21 benefits is determined to be appropriate.

22 “(2) The purpose of such assessment and screening is to
23 provide, through the use of a preadmission assessment and
24 screening team (PAT), a thorough evaluation of each individ-
25 ual’s health status, functional capabilities, and, where appro-

1 priate, home and family environment, to determine the types.
2 and frequency of services required by such individual in order
3 to assure the achievement of the maximum level of independ-
4 ence by such individual, consistent with the availability and
5 accessibility of such services in the community, and to in-
6 clude a plan for patient education to assure that such individ-
7 ual and his family understands what services are being pro-
8 vided to him, and why they are being provided.

9 “(b)(1) The PAT services shall be provided to every eli-
10 gible individual. Such individual’s physician shall be a
11 member of the PAT whenever possible, and shall, in any
12 event, be consulted with and kept informed by the PAT with
13 respect to the plan of care developed by such team for such
14 individual and shall be consulted as appropriate while the
15 plan of care is implemented to ensure successful implementa-
16 tion. Other professionals involved in providing care to such
17 individual shall be consulted with and kept informed by the
18 PAT with respect to the plan of care. Such screenings and
19 assessments shall include the following:

20 “(A) An initial screening to determine the need
21 for and appropriateness of any acute or long-term care
22 provided for or reimbursed under this title, or any
23 long-term care provided for or reimbursed under title
24 XVIII, XIX, or XX of this Act, that may be required
25 by the individual at the time of initial referral.

1 “(B) The preparation of a plan of care for the in-
2 dividual based upon a thorough assessment of the indi-
3 vidual’s health status and functional capabilities. Such
4 plan of care shall determine those acute and long-term
5 care services (if any) which are most appropriate for
6 the individual. Payment under this title shall not be
7 made for any services unless such services are ap-
8 proved in the plan. Payment under title XVIII, and
9 under State plans approved under title XIX or XX of
10 this Act, shall not be made for any long-term care
11 services unless such services are approved in the plan.
12 Such plan shall also indicate the types of services re-
13 quired by such individual, the frequency of such serv-
14 ices, and the frequency of reassessments by the PAT.
15 Any change in the type or frequency of the services
16 provided under the plan of care shall be preceded by a
17 reassessment of such individual by the PAT. The PAT
18 shall cooperate with any other person providing medi-
19 cal, health, social, or other services relevant to such
20 individual’s plan of care to ensure that other services
21 appropriate to meeting the long-term care needs of
22 such individual shall be incorporated into such plan of
23 care so as to ensure maximum functional independence
24 for the individual, and any change in such plan of care
25 shall require agreement as to such change between the

1 PAT and such other persons. If no such agreement can
2 be reached, final authority for the plan of care shall
3 rest with the PAT.

4 "(C) An ongoing assessment of the individual's
5 status and appropriate update of the plan of care. An
6 initial review of the plan of care shall be made within
7 30 days after the initiation of the plan of care and on-
8 going assessments shall be made at such times as the
9 PAT determines to be necessary, but not less often
10 than every six months for any individual aged 65 or
11 over. Assessments shall be made in cooperation with
12 any agency providing services to such individual under
13 this title.

14 "(D) Supplying the individual or his representa-
15 tive with a list of all providers of services in the area
16 who are qualified to provide services under this title
17 which such individual may require, and, if such individ-
18 ual is unable to contact such a provider, contacting
19 such a provider on behalf of such individual. In devel-
20 oping the plan of care, the PAT shall utilize, when
21 possible and appropriate, services provided by volun-
22 teers, to ensure that such volunteer services are con-
23 tinued whenever possible.

24 "(F) Referral to any other appropriate services
25 specifically designated for the elderly or disabled and

1 available to such individual in his community, and co-
2 ordination with community mental health centers with
3 respect to services provided under the Mental Health
4 Systems Act.

5 “(F) The collection, at the time the PAT per-
6 forms the assessments and screenings, of relevant infor-
7 mation with respect to such individuals for the purpose
8 of developing a national data base. Such information
9 shall include functional ability at the start of care,
10 functional ability after care, and, to the extent possible,
11 the extent and type of involvement by family and
12 friends in the care of such individual. Such data shall
13 remain confidential and be used to make comparisons
14 with respect to the average number of visits required,
15 the average length of a visit, the average cost per
16 visit, the average cost per individual and per case, and
17 any other information deemed necessary. Such data
18 shall be broken down by demographic factors, health
19 status, services provided, and other procedural factors
20 as the Secretary determines to be appropriate.

21 “(G) In the case of an individual who is being dis-
22 charged from an institutional facility, an assessment of
23 such individual's place of residence in the community
24 when appropriate and necessary; and such assessment

1 shall be made in coordination with the discharge unit
2 of such facility.

3 “(2) Such screenings and assessments shall be provided
4 by a preadmission screening and assessment team (PAT) des-
5 ignated under subsection (c) without charge to the individual.

6 “(3) Except in the case of an individual who is a resi-
7 dent in an institutional facility, such screenings and assess-
8 ments may be provided in the individual’s place of residence,
9 or, if the individual is capable of traveling to the location of
10 the PAT, at such location.

11 “(c)(1) The Governor of each State shall designate the
12 State agency or agencies which shall administer or supervise
13 the administration of the PAT program in such State, and if
14 more than one agency is so designated, the Governor shall
15 determine the parts of such program which each shall admin-
16 ister and shall ensure cooperation among such agencies.
17 Agencies so designated may include the State’s department
18 of health (or equivalent agency), the State agency designated
19 under the State plan under title XIX of this Act, the State’s
20 department on aging (or equivalent agency), the State’s de-
21 partment on mental retardation or developmental disabilities,
22 the State’s department for social services, or the State’s de-
23 partment for the blind or visually handicapped. Such agency
24 or agencies designated by the Governor shall coordinate the
25 designation of preadmission screening and assessment teams

1 (PAT) in as many areas of the State as such agency or agen-
2 cies, and the Secretary, determine to be necessary. Such
3 agency or agencies shall designate entities, in those areas,
4 which shall be responsible for establishing the PAT. Such
5 entities may include the State agency designated under the
6 State plan approved under title XIX or XX, an area agency
7 on aging, the discharge planning unit of a hospital, a local
8 government's department of health, a rural health clinic, a
9 health maintenance organization (HMO), a center or agency
10 for the handicapped, a home health agency, or any similar
11 entity, if such entity meets the requirements of this title for a
12 PAT.

13 “(2)(A) The members of a preadmission screening and
14 assessment team (PAT) may be full- or part-time employees
15 of the entity establishing the PAT or may operate under con-
16 tractual arrangements with the entity which will ensure the
17 availability of appropriate personnel to conduct the required
18 screenings and assessments.

19 “(B) The Secretary shall determine the composition of
20 the PAT, and such composition shall initially vary in differ-
21 ent States in order to assess the effectiveness of each such
22 composition. In some States each PAT shall consist of at
23 least—

24 “(i) a physician, who shall be the individual's per-
25 sonal physician or, if the individual has no personal

1 physician or if such personal physician is unable or un-
2 willing to participate in the PAT, shall be a physician
3 designated by the entity establishing the PAT,

4 “(ii) a registered nurse or nurse practitioner, and

5 “(iii) a social services worker.

6 “(C) In other States the Secretary shall test other com-
7 binations of professionals as the members of a PAT in order
8 to determine the most efficient and cost-effective mode of
9 conducting preadmission screening and assessment. Such
10 professionals may include, where necessary and appropriate,
11 any of the following:

12 “(i) Any of the professionals listed in subpara-
13 graph (B).

14 “(ii) A physical, occupational, or speech therapist.

15 “(iii) A qualified professional in the field of mental
16 retardation or developmental disabilities.

17 “(iv) A qualified professional in the field of blind-
18 ness or visual impairment.

19 “(v) A volunteer senior citizen advocate.

20 “(vi) A volunteer advocate for the disabled.

21 “(vii) A qualified professional in the field of social
22 work.

23 “(viii) Such other professionals as the PAT may
24 determine to be necessary.

1 “(D) Any individual who is a member of, or consultant
2 to, a PAT, shall meet such training requirements as may be
3 developed by the State and approved by the Secretary.

4 “(E) In any case where a rural health clinic has been
5 designated as a PAT, a physician assistant or nurse practi-
6 tioner (as defined in section 1861(aa)(2)) may be a member of
7 such PAT instead of a physician.

8 “(3) The plan of care for each individual shall be devel-
9 oped and agreed upon by the PAT and such individual (or
10 such individual’s representative where appropriate).

11 “(4) Each PAT within a State shall collect data with
12 respect to individuals receiving services under this title or
13 referred for other services by the PAT, utilizing a statewide
14 uniform assessment instrument. Each State shall determine
15 the type of uniform instrument it will use, but such instru-
16 ment must contain at least the information required under
17 subsection (b)(1)(F) and must be approved by the Secretary.

18 “(d) The Secretary shall reimburse any designated
19 preadmission screening and assessment team (on a per visit
20 basis), and any State, for the reasonable costs incurred by
21 such PAT or State in carrying out its duties under this title.
22 The per visit reasonable cost for providing services under this
23 title shall be determined on a State-by-State negotiated rate
24 basis between the Secretary and the appropriate State agen-

1 cies, but the Secretary shall make the final determination of
2 such rates.

3 “(e) Each PAT shall submit two copies of the plan of
4 care developed by such PAT for an eligible individual to the
5 Secretary, or the carrier (if any) having an agreement with
6 the Secretary with respect to services provided to such indi-
7 vidual, for the purpose of assisting the Secretary or the car-
8 rier to verify, prior to payment, that all bills submitted for
9 services provided to such individual are for services consist-
10 ent with the plan of care and authorized by the PAT.

11 “(f) If a State fails to carry out its duties under this title,
12 the Secretary shall assume such duties and shall designate
13 preadmission screening and assessment teams in such State.

14 “COPAYMENTS BY ELIGIBLE INDIVIDUALS

15 “SEC. 2105. (a) Subject to the provisions of subsection
16 (b), copayments for any eligible individual shall be determined
17 as follows:

18 “(1) Any eligible individual whose income is at or
19 below the income level which would qualify such indi-
20 vidual for benefits under the State plan approved under
21 title XIX for the State in which he resides for a calen-
22 dar year, if such individual were otherwise qualified for
23 such benefits, shall not be required to make any copay-
24 ment under this title for such calendar year.

1 “(2) Any eligible individual who does not meet
 2 the requirements of paragraph (1) who has an income
 3 for any calendar year which is less than \$12,000, shall
 4 be required to make copayments with respect to bene-
 5 fits received under this title for services in an amount
 6 equal to 20 percent of the reimbursable amount (as de-
 7 termined under section 2106(a)) for any such services
 8 received in such calendar year in excess of 25 visits.

9 “(3) Any eligible individual who does not meet
 10 the requirements of paragraph (1) who has an income
 11 for any calendar year which is \$12,000 or greater,
 12 shall be required to make copayments with respect to
 13 benefits received under this title for services other than
 14 respite care services in an amount equal to 20 percent
 15 of the reimbursable amount (as determined under sec-
 16 tion 2106(a)).

17 “(b)(1) No eligible individual shall be required to make
 18 copayments under subsection (a) in any calendar year which
 19 are in excess of the applicable percent of his income for such
 20 calendar year as determined under the following table:

“Income:	Applicable percent
\$0 to \$3,500.....	0
\$3,501 to \$5,000.....	1
\$5,001 to \$8,500.....	2
\$8,501 to \$10,000.....	3
\$10,001 to \$15,000.....	4
\$15,001 to \$20,000.....	5
\$20,001 to \$30,000.....	6
\$30,001 to \$40,000.....	7
\$40,001 or over.....	8

1 “(2) For purposes of this subsection the term ‘income’
2 means income as determined under section 1612(a) of this
3 Act.

4 “(3) All income determinations under this title shall be
5 made by the Secretary.

6 “(4) The Secretary shall collect such copayments as
7 may be appropriate and shall deposit the amounts collected
8 into the Federal Long-Term Care Trust Fund established
9 under this title.

10 “PAYMENT OF BENEFITS

11 “SEC. 2106. (a)(1) The Secretary shall pay, on behalf of
12 each eligible individual who incurs expenses for services with
13 respect to which benefits are payable under this title,
14 amounts as determined under paragraph (2), as the Secretary
15 may determine to be appropriate.

16 “(2) For the purpose of demonstrating the feasibility and
17 effectiveness of alternative methods of reimbursement under
18 this title, the Secretary shall provide that such reimburse-
19 ment be made on the basis of a fee schedule, a capitation
20 basis, or on a prospective basis. Such methods of reimburse-
21 ment shall be developed jointly by the Secretary and the ap-
22 propriate State agencies as determined by the Governor.
23 Such reimbursement shall reflect urban and rural differentials
24 and shall be adjusted periodically to reflect changes in costs.
25 Proposed methods of reimbursement shall be submitted to

1 each unit of general purpose local government to allow pro-
2 viders in such area 30 days for comment. Such proposals
3 shall be accompanied by an explanation of how the method
4 was determined. The State shall issue final reimbursement
5 methods within 60 days after reviewing and evaluating public
6 comment received with respect to such methods after they
7 have been approved by the Secretary.

8 “(3) The amount which may be paid under this title for
9 adult day services in any State under paragraph (2) may not
10 exceed 75 percent of the amount paid for intermediate care
11 facility services under the State plan of such State approved
12 under title XIX, as determined on a daily, monthly, or
13 annual basis as the Secretary determines to be appropriate.

14 “(b) No payment shall be made to any person under this
15 title unless there has been furnished such information as may
16 be necessary in order to determine the amounts due such
17 person under this title for the period with respect to which
18 the amounts are being paid, or for any prior period.

19 “(c) No payment may be made under this title with re-
20 spect to any service provided to an individual unless such
21 service is approved by a preadmission screening and assess-
22 ment team in accordance with section 2104.

23 “(d) No payment shall be made to any person under this
24 title unless such person agrees that the amount paid under
25 this title shall be the full charge for such service, and that the

1 eligible individual shall not be required to make any payment
2 to such person for such service.

3 "USE OF CARRIERS AND STATE AGENCIES

4 "SEC. 2107. (a)(1) The Secretary may enter into agree-
5 ments with carriers for the purpose of administering the
6 benefits available under this title in the same manner in
7 which such agreements are entered into under section 1842
8 for purposes of administering part B of title XVIII, to the
9 extent consistent with the provisions of this title.

10 "(2)(A) Any agreement entered into under paragraph (1)
11 shall provide that the carrier will transmit copies of all bills
12 submitted for payment for services under this title to the
13 PAT having responsibility over the plan of care for the indi-
14 vidual with respect to whom such services were rendered.

15 "(3) Any person submitting a bill directly to the Secre-
16 tary for payment for services under this title shall submit a
17 copy of such bill to the PAT having responsibility over the
18 plan of care for the individual with respect to whom such
19 services were rendered.

20 "(b) The Secretary shall make an agreement with any
21 State which is able and willing to do so, in the same manner
22 as under section 1864, under which an appropriate State
23 agency shall make determinations as to whether an agency
24 or organization meets the requirements of this title as a pro-
25 vider of services.

1 "FEDERAL LONG-TERM CARE TRUST FUND

2 "SEC. 2108. (a) There is hereby created on the books of
3 the Treasury of the United States a trust fund to be known
4 as the 'Federal Long-Term Care Trust Fund' (hereinafter in
5 this section referred to as the 'Trust Fund'). The Trust Fund
6 shall consist of such gifts and bequests as may be made as
7 provided in section 201(i)(1), and such amounts as may be
8 deposited in, or appropriated to, such fund as provided in this
9 title.

10 "(b) With respect to the Trust Fund, there is hereby
11 created a body to be known as the Board of Trustees of the
12 Trust Fund (hereinafter in this section referred to as the
13 'Board of Trustees') composed of the Secretary of the Treas-
14 ury, the Secretary of Labor, and the Secretary of Health and
15 Human Services, all ex officio. The Secretary of the Treas-
16 ury shall be the Managing Trustee of the Board of Trustees
17 (hereinafter in this section referred to as the 'Managing
18 Trustee'). The Administrator of the Health Care Financing
19 Administration shall serve as the Secretary of the Board of
20 Trustees. The Board of Trustees shall meet not less frequent-
21 ly than once each calendar year. It shall be the duty of the
22 Board of Trustees to—

23 "(1) hold the Trust Fund;

24 "(2) report to the Congress not later than the first
25 day of April of each year on the operation and status

1 of the Trust Fund during the preceding fiscal year and
2 on its expected operation and status during the current
3 fiscal year and the next 2 fiscal years;

4 "(3) report immediately to the Congress whenever
5 the Board is of the opinion that the amount of the
6 Trust Fund is unduly small; and

7 "(4) review the general policies followed in man-
8 aging the Trust Fund, and recommend changes in such
9 policies, including necessary changes in the provisions
10 of law which govern the way in which the Trust Fund
11 is to be managed.

12 The report provided for in paragraph (2) shall include a state-
13 ment of the assets of, and the disbursements made from, the
14 Trust Fund during the preceding fiscal year, an estimate of
15 the expected income to, and disbursements to be made from,
16 the Trust Fund during the current fiscal year and each of the
17 next 2 fiscal years, and a statement of the actuarial status of
18 the Trust Fund. Such report shall be printed as a House
19 document of the session of the Congress to which the report
20 is made.

21 "(c) It shall be the duty of the Managing Trustee to
22 invest such portion of the Trust Fund as is not, in his judg-
23 ment, required to meet current withdrawals. Such invest-
24 ments may be made only in interest-bearing obligations of the
25 United States or in obligations guaranteed as to both princi-

1 pal and interest by the United States. For such purpose such
2 obligations may be acquired on original issue at the issue
3 price, or by purchase of outstanding obligations at the market
4 price. The purposes for which obligations of the United
5 States may be issued under the Second Liberty Bond Act, as
6 amended, are hereby extended to authorize the issuance at
7 par of public-debt obligations for purchase by the Trust Fund.
8 Such obligations issued for purchase by the Trust Fund shall
9 have maturities fixed with due regard for the needs of the
10 Trust Fund and shall bear interest at a rate equal to the
11 average market yield (computed by the Managing Trustee on
12 the basis of market quotations as of the end of the calendar
13 month next preceding the date of such issue) on all marketa-
14 ble interest-bearing obligations of the United States then
15 forming a part of the public debt which are not due or call-
16 able until after the expiration of 4 years from the end of such
17 calendar month; except that where such average yield is not
18 a multiple of one-eighth of 1 per centum, the rate of interest
19 on such obligations shall be the multiple of one-eighth of 1
20 per centum nearest such market yield. The Managing
21 Trustee may purchase other interest-bearing obligations of
22 the United States or obligations guaranteed as to both princi-
23 pal and interest by the United States, on original issue or at
24 the market price, only where he determines that the purchase
25 of such other obligations is in the public interest.

1 “(d) Any obligations acquired by the Trust Fund (except
2 public debt obligations issue exclusively to the Trust Fund)
3 may be sold by the Managing Trustee at the market price,
4 and such public-debt obligations may be redeemed at par plus
5 accrued interest.

6 “(e) The interest on, and the proceeds from the sale or
7 redemption of, any obligations held in the Trust Fund shall
8 be credited to and form a part of the Trust Fund.

9 “(f) The Managing Trustee shall transfer to the Trust
10 Fund on a periodic basis amounts from the Federal Hospital
11 Insurance Trust Fund and the Federal Supplementary Medi-
12 cal Insurance Trust Fund in accordance with the provisions
13 of section 2109.

14 “(g) There shall be transferred on a quarterly basis to
15 the Trust Fund from the general fund of the Treasury the
16 amounts withheld from payments to States under title XIX
17 of this Act as required under section 2110.

18 “(h) The Secretary of Health and Human Services shall
19 deposit into the Trust Fund all copayment amounts collected
20 under section 2105.

21 “(i) There are authorized to be appropriated for each
22 fiscal year to the Trust Fund such additional sums as may be
23 necessary to ensure that sufficient funds are available in the
24 Trust Fund to make all payments provided for by this title.

1 they received such services, individuals described in
2 section 2103(a); minus

3 “(2) the amount reimbursed to such State with re-
4 spect to such services by the Federal Government
5 under section 1903 for fiscal year 1980.

6 “(b) An amount equal to the amount of the reductions
7 made under the provisions of subsection (a) shall be deposited
8 into the Federal Long-Term Care Trust Fund in accordance
9 with the provisions of section 2108.

10 “REGULATIONS OF SECRETARY

11 “SEC. 2111. The Secretary shall issue regulations as
12 may be necessary to carry out the provisions of this title.
13 Such regulations shall, to the extent feasible and consistent
14 with this title, be coordinated with regulations issued under
15 titles XVIII, XIX, and XX of this Act.

16 “ADMINISTRATIVE PROVISIONS

17 “SEC. 2112. Except where otherwise provided, the
18 Secretary shall carry out the provisions of this title in the
19 same manner as the Secretary is authorized to carry out the
20 provisions of title XVIII of this Act, and any individual or
21 other person shall have the same rights with respect to deter-
22 minations made by the Secretary as are provided under title
23 XVIII.

1 "PARTICIPATING STATES

2 "SEC. 2113. (a) This title shall be in effect only in ten
3 States selected by the Secretary, which shall consist of one
4 State in each of the ten regions of the Department of Health
5 and Human Services.

6 "(b) With respect to eligible individuals residing in such
7 States, no services or benefits which are services or benefits
8 described in section 2102(a) may be provided to such individ-
9 uals under any other program funded in whole or in part by
10 Federal funds."

11 MEDICARE AMENDMENTS

12 SEC. 3. (a) Title XVIII of the Social Security Act is
13 amended by adding at the end thereof the following new sec-
14 tion:

15 "COORDINATION WITH TITLE XXI

16 "SEC. 1884. Notwithstanding any other provision of
17 this title, no payment shall be made under this title to or on
18 behalf of an individual who is an eligible individual under title
19 XXI of this Act—

20 "(1) for any service defined in section 2102 of this
21 Act; or

22 "(2) for any extended care services unless such
23 individual undergoes a preadmission screening and as-
24 sessment as provided in section 2104 of this Act, and
25 the need for such services has been approved under

1 such individual's plan of care under such section
2 2104.”.

3 (b) Section 1861(e) of such Act is amended—

4 (1) by striking out “and” at the end of paragraph
5 (8);

6 (2) by redesignating paragraph (9) as paragraph
7 (11); and

8 (3) by inserting after paragraph (8) the following:

9 “(9) provides an adequate referral service for pa-
10 tients with respect to services available to them under
11 title XXI of this Act;

12 “(10) provides that every patient who is an eligi-
13 ble individual under title XXI of this Act, prior to dis-
14 charge from such institution, shall be screened and as-
15 sessed by a preadmission screening and assessment
16 team designated under such title XXI if the physician
17 attending such patient determines that such patient re-
18 quires any services provided under such title XXI;
19 and”.

20 (c) Section 1861(j) of such Act is amended—

21 (1) by striking out “and” at the end of paragraph
22 (14);

23 (2) by redesignating paragraph (15) as paragraph
24 (17); and

1 (3) by inserting after paragraph (14) the following
2 new paragraphs:

3 “(15) provides an adequate referral service for pa-
4 tients with respect to services available to them under
5 title XXI of this Act;

6 “(16) provides that every patient who is an eligi-
7 ble individual under title XXI of this Act, prior to or
8 upon admission to such institution, shall be screened
9 and assessed by a preadmission screening and assess-
10 ment team designated under such title XXI for the
11 purpose of determining if care in such institution is ap-
12 propriate for such individual; and”.

13 MEDICAID AMENDMENTS

14 SEC. 4. (a) Section 1902(a) of the Social Security Act is
15 amended—

16 (1) by striking out “and” at the end of paragraph
17 (42);

18 (2) by striking out the period at the end of para-
19 graph (43) and inserting in lieu thereof “; and”; and

20 (3) by inserting after paragraph (43) the following:

21 “(44)(A) provide that no service defined in section
22 2102 of this Act shall be provided or paid for under
23 the State plan for any individual who is an eligible in-
24 dividual under title XXI of this Act; and

1 “(B) provide that no long-term care services shall
2 be provided or paid for under the State plan for any
3 individual who is an eligible individual under title XXI
4 of this Act unless such individual has undergone a
5 preadmission screening and assessment as provided in
6 section 2104 of this Act, and the need for such serv-
7 ices has been approved under such individual’s plan of
8 care under section 2104.”.

9 (b) Section 1903 of such Act is amended by adding at
10 the end thereof the following new subsection:

11 “(s) The amount otherwise payable under the preceding
12 provisions of this section for each fiscal year shall be reduced
13 as provided in section 2110 of this Act for States participat-
14 ing in title XXI.”.

15 (c) The first sentence of section 1905(c) of such Act is
16 amended by striking out “and” before “(4)” and by inserting
17 before the period at the end thereof the following: “, (5) pro-
18 vides an adequate referral service for patients with respect to
19 services available to them under title XXI of this Act, and (6)
20 provides that every patient who is an eligible individual
21 under title XXI, prior to or upon admission to such institu-
22 tion, shall be screened and assessed by a preadmission as-
23 sessment and screening team designated under title XXI of
24 this Act for the purpose of determining if care in such institu-
25 tion is appropriate for such patient”.

1 SOCIAL SERVICES AMENDMENTS

2 SEC. 5. Section 2003(d)(1) of the Social Security Act is
3 amended—

4 (1) by striking out “and” at the end of subpara-
5 graph (J);

6 (2) by striking out the period at the end of sub-
7 paragraph (K) and inserting in lieu thereof “; and”;
8 and

9 (3) by inserting after subparagraph (K) the follow-
10 ing:

11 “(L)(i) provide that no service defined in sec-
12 tion 2102 of this Act shall be provided or paid for
13 under the State plan for any individual who is an
14 eligible individual under title XXI of this Act; and

15 “(ii) provide that no long-term care services
16 shall be provided or paid for under the State plan
17 for any individual who is an eligible individual
18 under title XXI of this Act unless such individual
19 has undergone a preadmission screening and as-
20 sessment as provided in section 2104 of this Act,
21 and the need for such services has been approved
22 under such individual’s plan of care under section
23 2104.”.

1 LIMITATION ON FEDERAL PARTICIPATION IN CAPITAL EX-
2 PENDITURES WITH RESPECT TO PROVIDERS OF SERV-
3 ICES UNDER TITLE XXI

4 SEC. 6. (a)(1) Section 1122(a) of the Social Security Act
5 is amended by striking out "title V, XVIII, and XIX" and
6 inserting in lieu thereof "titles V, XVIII, XIX, and XXI".

7 (2) Section 1122(d)(1) of such Act is amended by strik-
8 ing out "titles, V, XVIII, and XIX", by striking out "titles
9 V, XVIII, and XIX", and by inserting in lieu thereof in each
10 instance "titles V, XVIII, XIX, and XXI".

11 (3) Section 1122(d)(2) of such Act is amended by strik-
12 ing out "title V, XVIII, or XIX" and inserting in lieu there-
13 of "title V, XVIII, XIX, or XXI".

14 (4) Section 1122(e) of such Act is amended by striking
15 out "titles V, XVIII, and XIX" and inserting in lieu thereof
16 "titles V, XVIII, XIX, and XXI".

17 (b) Section 1122 of such Act is amended by adding at
18 the end thereof the following new subsection:

19 "(j) For purposes of this section the term 'health care
20 facility' includes any entity providing services for which pay-
21 ment may be made under title XXI, and the term 'capital
22 expenditure' includes the establishment of any such entity
23 providing services for which payment may be made under
24 title XXI without regard to the dollar amount involved."

1 EFFECTIVE DATES; REPORTS

2 SEC. 7. (a) The amendments made by this Act shall
3 become effective on January 1, 1982, and shall remain in
4 effect until December 31, 1987.

5 (b)(1) The Secretary of Health and Human Services
6 shall monitor the effect of the amendments made by this Act
7 with respect to any changes in the utilization of inpatient
8 services, any changes in the utilization of the various types of
9 services provided under titles XVIII, XIX, XX, and XXI of
10 the Social Security Act, and any other trends in costs or
11 utilization rates of various services, and shall also test and
12 evaluate the effects of implementing a copayment require-
13 ment beginning with the first visit as compared to a copay-
14 ment requirement under such title XXI beginning after
15 twenty-five visits. The Secretary shall submit an interim
16 report to the Congress with respect to such monitoring not
17 later than January 1, 1984, and a final report not later than
18 January 1, 1988.

19 (2) The Comptroller General of the United States shall
20 also conduct an ongoing evaluation of the effect of the
21 amendments made by this Act with respect to utilization of
22 services, and shall submit an interim report to the Congress
23 with respect to such evaluation not later than January 1,
24 1984, and a final report not later than January 1, 1988.

1 (3) The reports submitted under paragraphs (1) and (2)
2 shall each include a recommended strategy for implementing
3 title XXI of the Social Security Act on a national basis, with
4 particular emphasis on implementation at the State and local
5 levels. Such reports shall include—

6 (A) an analysis of potential obstacles to such im-
7 plementation;

8 (B) suggested legislative changes which may be
9 necessary to ensure effective and efficient implementa-
10 tion; and

11 (C) a detailed plan for such implementation.

12 (4) The Office of Management and Budget shall prepare
13 an analysis of the budgetary impact of the implementation of
14 such title on a national basis, and shall submit an interim
15 report to the Congress with respect to such analysis not later
16 than January 1, 1984, and a final report not later than Janu-
17 ary 1, 1988.

○

AUG 17 1981

PURPOSE: To establish under one title of the Social Security Act a new Title XXI, with the purpose of putting in place a 10 Statewide demonstration program to test over a five year period the implementation of an organized system of noninstitutionalized long-term care services, both health and social for persons 65 and over and persons who are disabled(as defined under the Social Security Act).

METHODOLOGY:

Under Title XXI, all non-institutional long-term care services, such as adult day services, homemaker-home health aide services etc., presently being provided under Titles XVIII, XIX or XX of the Social Security Act or under any other program would be combined and provided only under Title XXI.

WHO IS ELIGIBLE:

- (1) any person age 65 and over; or
- (2) any person who is disabled and who is qualified for benefits under either Titles II, XVI or XVIII of the Social Security Act; or
- (3) any person who is disabled(as defined under the Social Security Act) and is eligible for medical assistance under a State's Medicaid program.

BENEFITS: The services available under Title XXI include: . . :

- *intermittent nursing care
- *physical, speech or occupational therapy
- *homemaker-home health aide
- *adult day services
- *respite services
- *case coordination(case management)

*Also under Title XXI, two States under the demonstration program will be given greater "flexibility" with respect to service delivery. Therefore, these States will be able to provide more services than described above.

ASSESSMENT AND SCREENING:

The Title XXI demonstration program requires the establishment of a preadmission screening and assessment team (PAT). It is the purpose of a PAT to determine what kinds of services are necessary for a client to receive. The PAT also has the responsibility of developing a plan of care for each client, and periodically reviewing the needs of the individual.

As part of the demonstration, different team compositions will be tested. For example, utilizing a physician and a nurse, or a nurse practitioner and a physical therapist, or other kinds of PAT compositions to allow for appropriate testing. This is done to ensure that there is not an "over" medical bias in the PAT capacity and, to also examine the costs of utilizing different PAT compositions in conducting both the assessment and care plan development.

Also as a part of the PAT's responsibility, the Title XXI program requires that each person, both public and private pay clients, before entering a nursing home be screened and assessed by the PAT to determine if such institutional care is necessary.

The Title XXI proposal will require the PAT to work with hospital discharge planners (when possible) prior to the release of a patient to a SNF or ICF to make sure that individual does not enter a SNF or ICF unless necessary. While we can not prohibit private pay clients from entering nursing homes, we can offer them options that exist in the community other than nursing home care.

REIMBURSEMENT METHODOLOGY:

As part of the Title XXI demonstration, 3 different reimbursement methodologies will be tested:

- (1) fee schedules
- (2) prospective reimbursement
- (3) capitation payments

COPAYMENTS:

Under the Title XXI program, a copayment system will be tested for individuals participating in the program. Such a copayment system will work as follows:

- (1) all persons who income qualify for Medicaid will not be required to make any copayments;
- (2) all persons with incomes of \$12,000 or below will be eligible to receive _____ number of free visits before they begin to make copayments;
- (3) all persons with incomes above \$12,000 will be required to make copayments under this program beginning with the first visit.

TO: Donald Linky, Esq.
FROM: Bruce G. Coe
SUBJECT: Congregate Housing

DATE: July 31, 1981

*Steve S
Please
review 2
attached
packages - What
should we do next?
8/12/81*

Please excuse my belated response to your letter concerning Congregate Housing. My reply is attached herewith. Should you have any additional questions, please contact me.

TO: Donald Linky, Director
 Governor's Office of Policy & Planning

DATE: July 28, 1981

FROM: Bruce E. Coe., Executive Director

SUBJECT: The Draft Bill Submitted by the Division on Aging to Establish a
 State Congregate Housing Services Program

I would expect the level of state support to the elderly to increase, not decrease, with the introduction of the congregate housing program proposed by the Division on Aging. This is likely to happen even if program costs per person are less than state Medicaid payments for nursing home care. In 1970, fewer than half of the nation's elderly population eligible for Medicaid assistance actually received it. State subsidies for congregate services in low and moderate income housing projects would increase access to supportive services by many elderly people who now need services but remain outside the system. This sub-group will grow as the elderly population as a whole grows.

The potential demand for support to the elderly appears to be insatiable, with the number and average age of our elderly population steadily rising. In New Jersey, people 65 years old and over now represent 12% of the state's population. The number of state residents in this age group has increased from 693,794 in 1970 to 859,682 in 1980, an increase of 23.9%.¹ Nationwide, the proportion of people over age 65 is not expected to peak until the year 2030, when from 14 to 22% of the total population will be elderly². The number of elderly people over age 75 -- the age-group most in need of supportive services -- is also growing. In 1976, 38% of the elderly were over 75 years of age. By the year 2000, the over-75 age-group will represent 45% of the total elderly population³. In view of these demographic projections, the demand for congregate services by frail elderly people should far exceed even the most ambitious plans for skilled nursing facilities.

Congregate service costs per person may also increase, depending upon how the Division on Aging's experimental program develops. Congregate housing services are defined broadly. The Division on Aging describes congregate housing as "a residential environment which incorporates shelter and services needed by the functionally impaired and socially deprived but not ill elderly to enable them to maintain or to return to a semi-independent lifestyle and to avoid institutionalization as they grow older."⁴ Future programmatic decisions concerning food service, eligible service components, resident participation and reimbursement for services, incentives to project management, and efforts to avoid duplication of existing health and social service activities will influence future costs.

The draft bill leaves a great deal of discretion to the Division on Aging for designing a program that is left relatively amorphous. The criteria for project, tenant and service eligibility are vague. There are no expense or reimbursement guidelines; no policy directives for ensuing regulations, nor reporting procedures for program evaluation by state government.

While the availability of congregate housing services would enhance the health and welfare of a growing number of state residents, a congregate services program will produce savings to the state only if it replaces more expensive services supported by Medicaid funds. Average 1981 Medicaid costs for a nursing home patient ranged from \$26 to \$33 a day; the average Medicaid cost of inpatient hospital care as of May, 1981 was \$161.00 a day. The state's share of these daily rates range from \$13 to \$39. Daily subsidies for congregate services currently average less than \$3 under the state programs sponsored by New Jersey and Maryland, and \$6 for HUD's federal demonstration congregate program.

Clearly, a well-managed program of congregate services for residents in subsidized housing projects could conserve state resources if funds were targeted to hospital or nursing home patients, or people who could not continue to live independently without support. These are also the people in greatest need. The bill submitted by the Division on Aging does not single them out. Some revisions to the bill that would guard against rising costs could include targeting people at risk of institutionalization, setting tenant income limitations and repayment schedules, and specifying services eligible for support. The disadvantage of this approach, however, is that it encumbers the program before its operational kinks have been resolved.

An alternative course is to create a different system - a tightly structured system that incorporates congregate services into the long-term care continuum by directing the services exclusively to low-income people who either are institutionalized or identified as needing the services to avoid institutionalization. This system could be implemented through HFA subsidized housing facilities. We would attempt to fill the gap in available services for the low-income elderly between totally independent living and institutional care, completing a spectrum of services to meet their changing needs. In this sequence of gradually increasing support, the support levels would correspond to each recipient's level of need, thus reaching individual goals while at the same time reducing state financial obligations.

HFA CONGREGATE HOUSING SERVICES PROPOSAL

I propose a program of congregate services in subsidized elderly housing projects that has the following objectives:

- I. Services will be extended to those who need them most - the low-income elderly who are faced with institutionalization.

Participants will have incomes comparable to those of Medicaid recipients⁵ and the medically indigent.⁶ Sample incomes in each income category are presented below, with an estimate of how monthly congregate costs might be shared between the state and program participants living in Section 8 and Section 236 federally-subsidized housing projects. State subsidies for services will vary widely depending upon the incomes and rental expenses of recipients. Low income residents of Section 8 projects, who pay only 25% of their adjusted incomes for rent, will usually have extra income to contribute toward the congregate services. Very low-income people cannot afford the high rents in Section 236 projects, and are normally not admitted without guarantees

from relatives that the rent will be paid. If this population were to gain admittance into Section 236 projects through the congregate services program, state service subsidies would increase substantially (to \$7.56 per day) but would still be less than average state costs for institutionalization (from \$15 to \$80 per day).

	<u>Medicaid Recipient</u>	<u>Medically Indigent</u>
<u>Section 8 Housing Project</u>		
Gross Monthly Income:	\$288.00	\$500.00
Adjusted Monthly Income: (Gross income minus 10%)	259.20	450.00
Deductions from Adjusted Income:	109.80	192.50
Rent (25% of Adjusted Income): 64.80		112.50
Personal Allowance* ((\$80 minus \$35):	45.00	80.00
	<u>109.80</u>	<u>192.50</u>
Remaining Income Available for Resident's Share of Costs:	149.40	257.50
Estimated Total Cost of Services (Based on Typical Monthly Costs of Maryland's Sheltered Housing Program):	216.00	216.00
Monthly State Subsidy (Difference Between Total Cost and Resident's Payment):	66.60	-0-
(Daily Subsidy)	(2.22)	(-0-)

*Standard Allowance of \$80 reduced by medical expenses that can be expected to be paid by Medicaid, as determined by the Bureau of Labor Statistics' analysis of annual medical costs for Urban Retired Low-Income Couples in the New York-Northeastern New Jersey Metropolitan area from autumn 1978 to 1979.

	<u>Medicaid Recipient</u>	<u>Medically Indigent</u>
<u>Section 230 Housing Project</u>		
Gross Monthly Income:	\$288.00	\$500.00
Adjusted Monthly Income: (Gross income minus 10%)	259.20	450.00
Deductions from Adjusted Income:	270.00	305.00
Rent:	225.00	225.00
Personal Allowance (\$80 minus \$35):	<u>45.00</u>	<u>80.00</u>
	270.00	305.00
Remaining Income Available for Resident's Share of Costs:	-10.80	145.00
Estimated Total Cost of Services:	216.00	216.00
Monthly State Subsidy (Difference Between Total Cost and Resident's Payment):	226.80	71.00
(Daily Subsidy)	(7.56)	(2.37)

II. An Advisory Committee of interested state agencies will be created to establish a coordinated system of services, linking support levels to the levels of need. The system would facilitate easy movement from one support level to another and back again, i.e., to and from hospitals, nursing homes and congregate facilities as the need arises.

The success of the program will depend upon an effective assessment and referral system that places people in the appropriate living environment and permits unrestricted access to each facility as needed. This would be accomplished through a state agency advisory committee, which would develop and promulgate standardized criteria for placing congregate services in the long-term care system. Existing local referral agencies - Medicaid offices, hospitals, state institutions, home health aide services, County Welfare Boards - would use these criteria to refer clients to projects in their areas. Project managers would be instructed to fill their quota of congregate residents either from residents in the project who meet the established criteria or from these local agency referrals. In return, the project managers should be able to negotiate agreements with local health care facilities for priority placement of these congregate residents when they need to be institutionalized.

III. Service components will be determined by the essential unmet needs of the target population that can be effectively and efficiently provided by project management.

Typical congregate services include meals, personal care and housekeeping assistance. Project management will be responsible for providing these services to congregate residents. When making their service arrangements, managers should involve other residents who are capable of performing light chores and willing to assist. Some tasks connected with food service and personal assistance are especially well suited to a resident volunteer or paid workforce. Moreover, the program will benefit from reduced service costs.

Sponsors are also urged to bring community-based services, such as transportation, recreation and health, into their projects. Many state and local service providers must cooperate to assure that available health and social service programs are integrated into the project environment. The Advisory Committee of state agencies, mentioned above, would be an appropriate body for directing these efforts. Project and community needs would be considered together when funding decisions are made for nutrition sites, meals-on-wheels, senior aides and senior centers. The State of Maryland has achieved substantial savings (See Maryland Shelter Housing budget, Page 6) by coordinating these separate funding sources.

The Advisory Committee should also investigate potential benefits from providing certain health services on site. It has been suggested that the introduction of preventive health and health care resources into the congregate services package would produce direct reductions in Medicaid costs for long-term hospitalizations, nursing home placements and doctor's and emergency room hospital visits.

IV. Continuing adjustments will be made to the program's operation that will resolve problems in service delivery and identify the most economical procedures.

Further experimentation should decide the number of meals served daily and the means of providing them. Food service is crucial to many elderly people to allow them to continue living in a residential environment. Operational problems have arisen from the need to supply food to a small minority of project residents and to arrange for meal service delivery on weekends and holidays.

The monthly service costs of congregate programs in New Jersey and Maryland are shown below:

Maryland

Sheltered Housing Program

Food (3 meals per day)	\$189.50
Personal Care	32.50
Housekeeping	34.00
Administration	<u>9.00</u>
	\$265.00
Minus Income from Other Sources	<u>49.00</u>
	\$216.00

New Jersey

Pilot Congregate Services Program

Food (1 meal per day)	\$ 77.50
Personal Care and Housekeeping	60.00
Administration	<u>25.00</u>
	\$162.50

There will be financial advantages when congregate services are introduced into new projects. Sponsors, managers and residents will be committed in advance to support the program's purposes. Advance planning for congregate needs will incorporate congregate spaces into building designs and produce savings through the purchase of appropriate kitchen equipment. These amenities will also make the program more attractive to participants. Subsidy amounts may be reduced through pledges of support from syndication funds or surplus operating monies.

For existing projects, however, moving from a pilot program, with self-selected participants, to a state-wide program may give rise to difficult new demands. We will have to win the support of managers and tenants who may prefer the completely independent living environment to which they have become accustomed.

V. Up to 25% of the residents in existing and newly-constructed projects will be congregate residents.

The proportion of frail residents who need congregate services would be limited to avoid an institutional or medical atmosphere in residential buildings.

VI. Priority will be given to new construction projects located in areas with high hospital occupancy rates and long waiting lists for Medicaid placement in nursing homes.

Priority areas will be identified from monthly statistics (DHS) reported by county on the number of people in hospitals and the community waiting for entrance into nursing homes, and quarterly reports (DH) on county-wide hospital utilization rates.

VII. State service subsidies should be committed to projects for the entire mortgage term of projects to assure continued funding to participants. This will promote acceptance of the program by sponsors, managers and project residents.

The Division on Aging's pilot program has suffered from the lack of a long-term funding commitment. The possibility of discontinued subsidies places an intolerable burden on project management and residents who have grown to be dependent on the services. Housing sponsors are reluctant to initiate support services that could be abruptly terminated, forcing congregate residents into early institutionalization.

We propose to introduce the program described above initially on a demonstration basis in a few projects until critical new procedures are operating smoothly. The demonstration would involve projects in three different stages of operation: completed projects, projects with financial commitments from the Agency but not yet constructed, and projects that will be financed this year. The NJHFA would be responsible for program coordination and implementation, technical assistance, performance monitoring and evaluation. As a result of the demonstration, we will propose to the state a proven, audited program that would serve as the basis for state financial support.

The estimated total annual cost (at current dollar values) associated with the program, assuming six reconstruction projects would be \$172,800. These estimates are based on costs incurred by Maryland's Sheltered Housing Program, adjusted as described below:

	<u>ANNUAL COSTS</u>
24 congregate units in 6 projects: (20% of 125 units)	144 units
Estimated average annual subsidy per unit (\$100 * per month):	\$ 1,200 per unit
Estimated total annual subsidy (\$1,200 x 144):	\$172,800

*The estimated average monthly subsidy amount has been adjusted upward from Maryland's average of \$80 per recipient to reflect anticipated increased costs from targeting Medicaid recipients. Because the exact impact on costs is difficult to estimate, actual average subsidy amounts are subject to change.

-9-

FOOTNOTES

1. 1980 Census Report, "The Age of New Jersey's Population," by Connie O. Hughs, New Jersey State Data Center, Office of Demographic and Economic Analysis, New Jersey Department of Labor and Industry; published in New Jersey Economic Indicators, July 19, 1981.
2. "Facts About Older Americans 1978". Department of Health, Education and Welfare. Pub. No. (OHDS) 79-2006 (1978).
3. "Deomgraphics of Aging". Joint Hearings Before the House Select Committee on Population and the Select Committee on Aging, 95th Congress, 2d. Sess., (1978). Statement of Jacob S. Siegal.
4. Developed by the International Center for Social Gerontology, Inc.
5. Medicaid Recipient - One person living alone is eligible for Medicaid services in the community if the individual's countable resources do not exceed \$1,500 and his or her monthly income is below \$288. Individuals receiving certain kinds of unearned income, such as social security, qualify for Medicaid services with incomes as high as \$308 a month. New Jersey's SSI recipients receive \$288 a month if they have no other income.
6. Medically Indigent - People with incomes above the Medicaid eligibility standards of \$288 and \$308 but who cannot afford adequate medical treatment at home may be considered medically indigent. Individuals with monthly incomes up to \$794 qualify for Medicaid assistance in institutions. People with incomes between the Medicaid eligibility standards for necessary services in the community and the standard of \$794 for nursing services in institutions are particularly vulnerable to institutionalization when they become ill.

MR:mc/LOTHERS/H