REPORT OF
THE JOINT COMMISSION ON HEA

LONG-TERM CARE / AGING STUDY

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 28

COMMONWEALTH OF VIRGINIA
RICHMOND
1998

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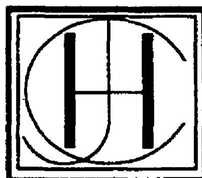


PREFACE

State government spends more than $500 million dollars annually on long-term care services, primarily on nursing home care financed by the Medicaid program. Approximately 77 percent of the state's long-term care related Medicaid expenditures are for nursing home care, and the Medicaid program finances approximately 70 percent of the nursing home care in the Commonwealth. The Medicaid program also finances an array of home and community based services, including adult day care, respite care, and assisted living care. In addition to the Medicaid program, the state provides long-term care related services through five other Health and Human Resources agencies including the Department for the Aging; the Department of Mental Health, Mental Retardation, and Substance Abuse Services; the Department of Health, the Department of Rehabilitative Services, and the Department of Social Services.

In addition to long-term care, which affects a number of populations including but not limited to the elderly, aging issues will be an increasingly important area of concern for state government. Virginians over age 85 are the fastest growing segment of the state population. Aging issues potentially impact many if not most of the areas of state government, including education, public safety, transportation, and economic development, in addition to health and human resources.

Past studies of long-term care and aging issues have tended to treat the two issues as synonymous. While there are important areas of overlap between these two issues; the two issues are distinct. Long-term care effects populations other than the elderly (such as the mentally disabled), and most of the elderly do not require long-term at any given time. At the same time, Aging issues include a variety of issues such as programs for older drivers and employment opportunities that are not long-term care related.

Senate Joint Resolution 316, House Joint Resolution 655, and Item 12 of the 1997 Appropriation Act directed the Joint Commission on Health Care to examine long-term care and aging issues. The Commission formed a subcommittee to examine these issues. The subcommittee's work included site visits to a nursing home, assisted living facilities, a continuing care retirement community, a local Department of Social Services, and an Area Agency on Aging. The subcommittee also held four meetings during the fall of 1997.

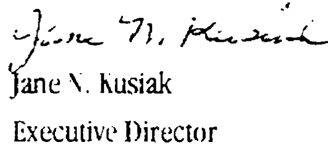
This study examines financing and coordination issues related to long-term care. The study also examines aging and elder rights issues. The study resulted in a number of statutory changes, resolutions, and budget amendments to be introduced during the 1998 General Assembly. These legislative actions were adopted by the Joint Commission on Health Care during its January 6, 1998 meeting. These include:

- a bill establishing a Deputy Secretary of Health and Human Resources for Long-Term Care and charging the Secretary of Health and Human Resources with (1) coordinating the implementation of the state's long-term care policy as established by the General Assembly, and (2) developing a long-range plan for financing long-term care for the elderly and frail elderly (companion budget amendments for $100,000 to fund the position and $350,000 for small demonstration projects were also approved);
- a bill eliminating the Department for the Aging's statutory responsibilities for coordinating long-term care (these responsibilities would now be assigned to the Secretary of Health and Human Resources);
- a bill strengthening the Governor's Advisory Board on Aging by clarifying the powers, duties, and membership of the Board;
- a bill strengthening the statutory foundation of the adult protective services program;
- a bill improving enforcement of health and safety standards in adult care residences by empowering the Commissioner of the Department of Social Services to more quickly impose intermediate sanctions;
- a resolution continuing the Joint Commission on Health Care's long-term care subcommittee and a companion budget amendment funding staff for the subcommittee;
- a resolution directing the Joint Legislative Audit and Review Commission to study the mission and operation of the Department for the Aging;
- resolutions directing the Department of Health and the Department of Social Services to report on past studies of their long-term care licensure programs and the staffing and training needs of these programs;
- a resolution directing the Virginia Retirement System to study the feasibility of offering a long-term care insurance program for state and local government employees and retirees;

- a budget amendment directing the Department for the Aging to privatize the elder rights program and providing $130,000 (GF) in each year of the biennium to fund an elder rights hotline program;
- a budget amendment providing $180,000 (GF) in each year of the biennium for the expansion of the long-term care ombudsman program statewide;
- a budget amendment providing $2.79 million (GF) in each year of the biennium for the expansion of the case management program through Area Agencies on Aging statewide.

Our review process for this study included an initial public briefing followed by a public comment period during which interested parties forwarded us written comments on the report. In many cases, the public comments, which are provided at the end of the report, provide additional insight into the various topics covered in this study.

On behalf of the Commission and its staff, I would like to thank the Department of Medical Assistance Services, the Department for the Aging, the Department of Social Services, and the Department of Health for the assistance they provided during this study.



Jane N. Kusiak
Executive Director

January 9, 1998

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I. AUTHORITY FOR THE STUDY

House Joint Resolution 655, Senate Joint Resolution 316, and Item 12 of the 1997 Appropriation Act direct the Joint Commission on Health Care to establish as task force within the Commission to "address outstanding long-term care and aging issues pertaining to the licensing, financing, organization, and regulation of long-term care facilities and community-based services." SJR 316 and HJR 655 are shown in Appendix A.

II. OVERVIEW OF LONG-TERM CARE AND AGING SERVICES IN VIRGINIA

Virginia's system for long-term care and aging issues involves a number of different state and local agencies. This chapter examines the financing, organization, and regulation of long-term care in Virginia, as well as the State's involvement in aging issues. In a recent report on long-term care, the U.S. General Accounting Office defined long-term care as "many different services aimed at helping people with chronic conditions compensate for limitations in their ability to function independently." The Commonwealth's policy on long-term care for the elderly is articulated in House Joint Resolution 602, approved by the 1995 General Assembly, which states:

> The Commonwealth's policy for long-term care is to provide service to elderly individuals with programs and in settings which maximize their ability to function as independently as possible and which encourage the principles of personal dignity, a decent quality of life, individuality, privacy, and the right to make decisions.

In recent years, however, the state has recognized as a matter of policy that there are a variety of reasons other than aging that cause people to require long-term care services. This includes physical injury, physical disability, chronic illness, or mental disability. Therefore the policy for long-term care for the aging, articulated by HJR 602, should also apply to all persons in need of long-term care services.

Demand for Services Is Expected to Increase Significantly

Demand for long-term care services for the elderly is expected to increase, because the number of elderly Virginians is growing rapidly. For example, the number of Virginia taxpayers claiming the taxpayer exemption for being over 65 increased from 283,441 in 1985 to 396,245 in 1994. The 1990 U.S. Census estimated the number of Virginians over age 60 at 869,630, with 59,705 over age 85. By 2010, estimates are that the number of Virginians over age 60 will increase by about 50 percent when compared to 1990, and the percentage of Virginians over aged 85 will more than double when compared to 1990.

All Virginians over age 60 are potential consumers of services for the aging. However, not all elderly Virginians will require long-term care, particularly institutional care. According to the Secretary of Health and Human Resource's report *Aging in the Twenty First Century* (House Document 45, 1995):

> 50 % of all persons aged 65 and older may spend some of their remaining life in a nursing home. About 32% will stay at least three months, 24% at least a year, and 9% at least five years. At any one time, about 5% of the elderly are in nursing homes and 22% of those are 85 or older. Because in the future there will be a greater number of persons aged 85+, a corresponding increase in the need for and use of nursing home care can be expected.

According to the 1990 U.S. Census, approximately one-fifth of elderly Virginians reported having at least one mobility limitation or self-care limitation in 1990 (Figure 1). Mobility limitations refer to conditions lasting greater than six months that limit a person's ability to leave the home. A self-care limitation is a health condition lasting greater than six months that limits a person's ability to attend to personal needs such as bathing, dressing, or toileting.

Studies since the 1980's have indicated that the incidence of long-term care utilization among the elderly may be declining.[1] The U.S. General Accounting Office's 1995 Study *Long-Term Care: Current Issues and Future Directions* [2] stated:

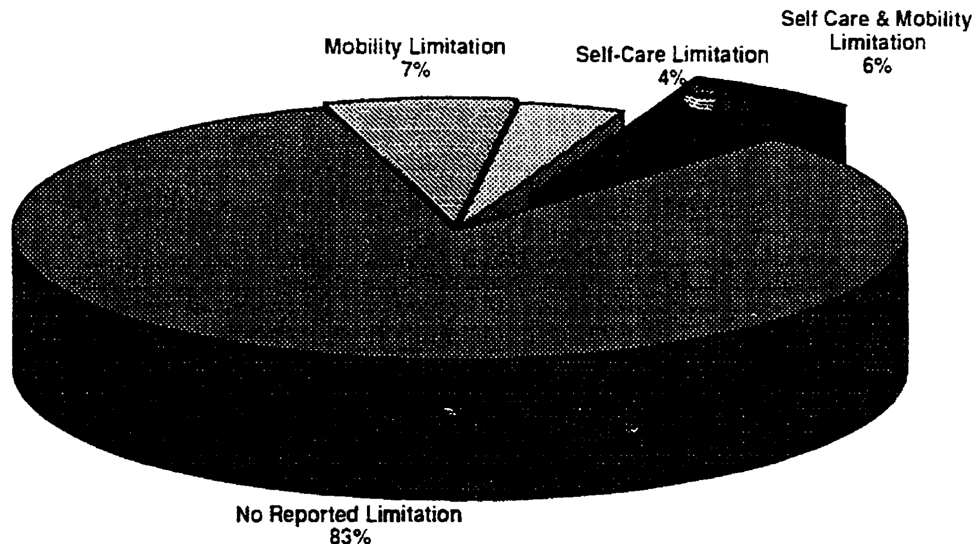
> the extent of the nation's future long-term care needs is clouded by uncertainty about medical and technological advances. For example, breakthroughs could result in longer, healthier lives for baby boomers as well as an increase in the number of younger disabled persons who survive low birth weight or accidents.

A person's need for long-term care services is often assessed using two indices: activities of daily living and instrumental activities of daily living. Activities of daily living (ADLS) refer to seven basic activities of life: bathing, dressing, toileting, bladder function, bowel function, transferring (moving between the bed, chair, wheelchair, and/or stretcher), and eating/feeding. Instrumental activities of daily living (IADLS) refer to eight basic activities of life that require higher cognitive functioning than ADLs: meal preparation, housekeeping, laundry, money management, transportation, shopping, using the phone, and home maintenance.

[1] *Bruce C. Vladeck; Nancy A. Miller; and Steven Clauser; "The Changing Face of Long-Term Care," Health Care Financing Review, Summer 1993, p. 7.*

[2] *U.S. General Accounting Office. Long-Term Care: Current Issues and Future Directions, GAO/HEHS-95-109, p. 3.*

FIGURE 1
IMPAIRMENT STATUS OF VIRGINIA'S ELDERLY

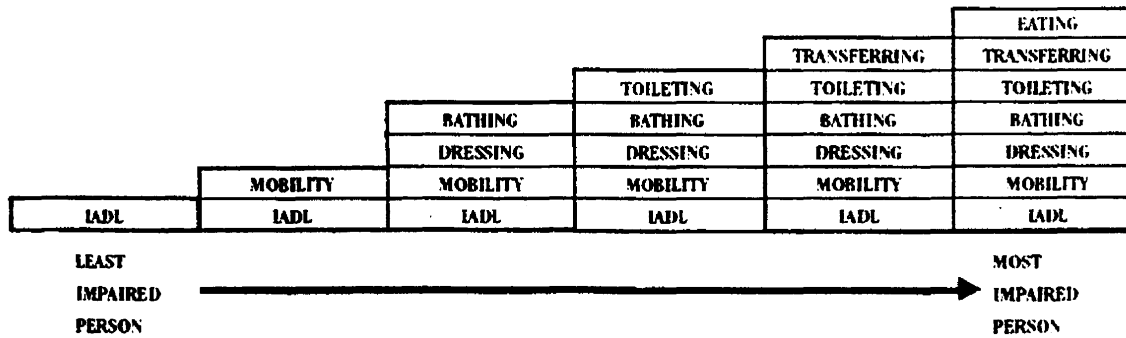


Source: 1990 U.S. Census.

A person's level of need for services will vary with the number of ADLs in which the person is dependent. Exhibit 1 shows a sample of how impairments can be ranked by severity. It is important to understand, however, that level of impairment is not necessarily a linear process. A person recovering from a severe illness, for example, may be dependent in four ADLs, and with appropriate rehabilitative care may recover either full functioning or only require assistance with one or ADLs.

As noted previously, not all Virginians in need of long-term care services are elderly. Non-elderly who potentially need long-term care services include mentally disabled people, people with chronic illnesses, and the physically disabled. At present, the State Medicaid program finances long-term care services for children (who may require private duty nursing services under the technology assisted waiver), young adults, and middle aged persons in addition to the elderly.

EXHIBIT 1
IMPAIRMENTS CAN BE RANKED BY SEVERITY
(A PERSON WITH MORE SEVERE IMPAIRMENTS OFTEN HAS ALL OR MOST OF THE LESSER IMPAIRMENTS)



Financing of Long-Term Care Through Medicaid

The primary vehicle through which the State finances long-term care services is the Medicaid program. The national Medicaid program was authorized as part of the Social Security Act Amendments of 1965. Medicaid provisions are found in Title XIX of the Social Security Act, Public Law 89-97, as amended. The Department of Medical Assistance Services administers the Medicaid program for the state.

In FY 1997, Virginia's Medicaid long-term care related expenditures totaled $500,585,819 million, which represented approximately 22 percent of total Medicaid expenditures. The state share of these long-term expendiures was $243,034,415 with a 1997 match rate of 51.45 percent federal and 48.55 percent state. Of these long-term care expenditures, approximately 79 percent were allocated for nursing home care. The remaining 21 percent of Medicaid long-term care expenditures in FY 1997 provided an array of home and community-based services. Table 1 shows 1997 Medicaid long-term care expenditures.

TABLE 1
FY 1997 MEDICAID LONG-TERM CARE EXPENDITURES

Category	*Amount*
Nursing Facility Care	$397,311,396
Personal Care	$85,375,987
Private Duty Nursing	$13,854,807
Adult Day Care	$1,538,349
Respite Care	$1,362,502
ACR Intensive Assisted Living	$1,142,777
Total	$500,585,819

Home and community based services are provided through the Medicaid program as a result of home and community based service (HCBS) waivers granted to the state by the U.S. Health Care Financing Administration (HCFA). Medicaid HCBS waivers allow states to implement alternatives to placing Medicaid recipients in nursing facilities. Medicaid waivers for HCBS are allowed under Section 1915 (c) of the Social Security Act. States are allowed flexibility in determining the mix of services offered, the eligibility criteria, and the geographic area in which the waiver service are offered. In order to obtain waiver approval, according to HCFA guidelines:

> State Medicaid agencies must assure HCFA that, on average, the cost of providing home- and community-based services will not exceed the cost of care for the identical population in an institution. The Medicaid agency must also document that there are safeguards in place to protect the health and welfare of beneficiaries.

Forty-nine states[3] have received a total of more than 200 HCBS waivers. As of this writing, Virginia has received five waivers to provide home and community based services. These waivers are summarized in Exhibit 2.

As mentioned earlier, the Virginia Medicaid program finances long-term care services for both the elderly and non-elderly. To illustrate the age range of persons receiving long-term care services through Medicaid in the Commonwealth, Figure 2 shows unduplicated recipients of Medicaid skilled nursing facility

[3] *According to HCFA, "All States except Arizona have at least one such [HCBS waiver] program. Arizona is a technical exception, though, because it runs the equivalent of an HCBS waiver program under section 1115 demonstration waiver authority."*

services for FY 1996, by age group. As can be seen from Figure 2, Medicaid skilled nursing services, which are typically associated with the elderly, actually include all age groups. Similarly, adults of all age ranges receive Medicaid adult day care services. Figure 3 shows the number of unduplicated recipients receiving Medicaid adult day care services in each age group.

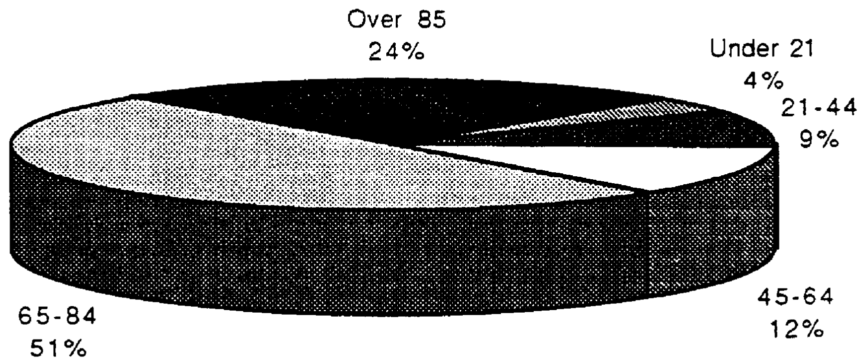
EXHIBIT 2

VIRGINIA'S HOME AND COMMUNITY BASED MEDICAID WAIVERS

Waiver	***Services Provided***
Elderly and Disabled Waiver	Granted in 1982 to cover personal care services for elderly or disabled persons who meet nursing home level of care criteria and for whom community services will allow them to remain at home. Modified in 1989 to cover adult day health care and respite care.
Technology Assisted Waiver	Granted in 1988 to provide private duty nursing services and respite care for persons under 21 who are dependent on technological support and require ongoing nursing care and otherwise would require hospitalization. Modified in 1995 to include personal care.
AIDS Waiver	Granted in 1991 to provide private duty nursing, personal care, respite care, and case management for HIV positive individuals at risk for institutionalization
Mental Retardation Waiver	Provides home and community care for mentally retarded persons who otherwise would require institutionalization. Services approved in 1991 include: residential support, habitation, day support, and therapeutic consultation. Services approved in 1994 include: supported employment, private duty nursing, personal care, respite care, assistive technology, and environmental modification services.
(Intensive) Assisted Living Services	Granted in 1996, this waiver covers services provided by a licensed adult care residence for low-income adults who require intensive assistance with the activities of daily living (dependent in four or more activities of daily living).

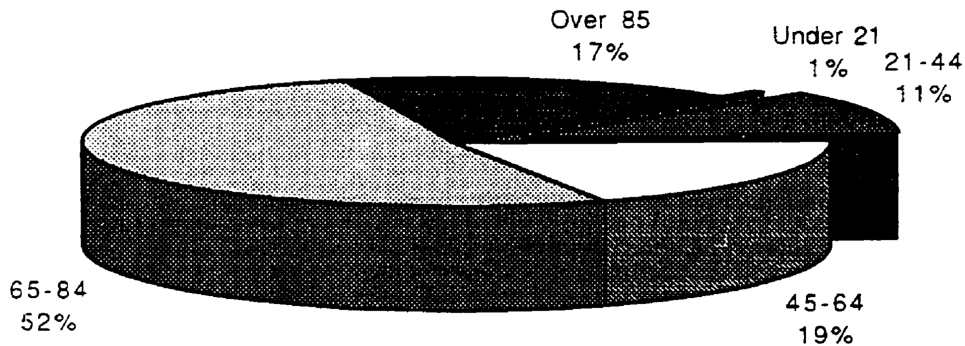
Source: *Virginia Department of Medical Assistance Services, Statistical Record of the Virginia Medicaid Program, October 1996*

FIGURE 2
FY 1996 UNDUPLICATED RECIPIENTS FOR MEDICAID SKILLED NURSING FACILITY SERVICES BY AGE OF RECIPIENT



Source: *The Statistical Record of the Virginia Medicaid Program, October 1996.*

FIGURE 3
FY 1996 UNDUPLICATED RECIPIENTS FOR ADULT DAY CARE SERVICES BY AGE OF RECIPIENT



Source: *The Statistical Record of the Virginia Medicaid Program, October 1996.*

In addition to Medicaid funding for long-term care services, other federal programs that provide funds for aging related long-term care services include the Older Americans Act and the Omnibus Budget Reconciliation Act (OBRA). Additionally, the General Assembly has provided general funds for certain long-term care related services such as the auxiliary grants program administered through the Department of Social Services, and the respite care, ombudsman program, and case management programs funded through the Department for the Aging.

Funding of Aging Services Through The Older Americans Act

The Department for the Aging (VDA) is Virginia's designated single agency to administer the Older Americans Act as amended. The Older Americans Act was approved by Congress in 1965 as part of the Great Society initiatives of the 1960's. In FY 1997, the Commonwealth expended $18,155,127 in federal funds under the Older Americans Act. These expenditures are summarized in Table 2.

Federal funds for individual care services and nutritional services are allocated by VDA to the 25 Area Agencies on the Aging using an allocation formula. This formula includes the following measures:

- population 60+ weighted 30 percent,
- rural residents 60+ weighted 10 percent,
- poverty rate among people 60+ weighted 50 percent, and
- minority population 60+ below poverty weighted 10 percent.

In most instances, this formula is also used to allocate state general funds appropriated by the General Assembly. However, three programs funded through the Department for the Aging are not allocated according to this formula but instead use a request for proposal (RFP) process where funds are provided to agencies that submit a successful RFP as determined by the VDA. These services are the ombudsman program, case management, and respite care.

TABLE 2
DEPARTMENT FOR THE AGING 1997 EXPENDITURES UNDER THE OLDER AMERICANS ACT

Category	*Expenditure Amount*
Agency Operations	$563,852
Individual Care Services	$8,225,367
Nutritional Services	$9,366,133
Total	$18,155,127

Source: Virginia Department for the Aging.

Funding Through The Omnibus Budget Reconciliation Act (OBRA) of 1987

The Omnibus Budget Reconciliation Act of 1987 included a number of long-term care related provisions. For example, OBRA established the regulatory framework through which nursing homes are certified for Medicaid and Medicare by the U.S. Health Care Financing Administration. In addition, OBRA

established the Preadmission Screening and Resident Review program (PASRR). The PASRR program screens nursing home residents to identify individuals in need of specialized mental health or mental retardation services. OBRA also provides federal funds for providing services to individuals with physical disabilities living in nursing homes. These services are provided by the Department of Rehabilitative Services (DRS) through a subcontract with the Department of Mental Health, Mental Retardation, and Substance Abuse Services.

General Fund Appropriations for Long-Term Care Services Through the Department for the Aging

The General Assembly has appropriated general funds for a variety of long-term care services, including such core Older Americans Act services as congregate meals and transportation. It is important to understand that services are long-term care related to the extent that they compensate for an individual's ability to function independently. These include services provided through the aging network such as the respite care program, case management, and local guardianship program. In addition, the General Assembly has appropriated general funds through VDA for specific programs including the pilot projects for adult guardianship, the Norfolk Senior Center, the Oxbow Center, and the Korean Intergenerational and Multi-Purpose Senior Center.

At present, the respite care program, case management program, and local guardianship program are awarded to local agencies (generally but not always Area Agencies on Aging) through a RFP process.

The Auxiliary Grant Program

The General Assembly also provides general funds for the auxiliary grant program for low-income residents of adult care residences. The auxiliary grant program provides a supplement between the resident's Supplemental Security Insurance (SSI) and the maximum auxiliary grant rate set by the Appropriation Act. For FY 1998, the Appropriation sets the maximum auxiliary grant rate at $725 per month for most of the state and at $799 per month in Planning District 8, which encompasses most of Northern Virginia.

Localities are responsible for funding 20 percent of the auxiliary grant supplement, with the remaining 80 percent provided by the general fund. The average monthly grant for FY 1996, the most recent year for data was available, was $236. For a grant of this amount, the state would pay $188.80 and the responsible locality would pay $47.20. In FY 1997, the auxiliary grant program expended $19,322,550. Of this amount, $15,458,040 came from the state general fund and $3,864,510 came from local governments.

In 1993, the General Assembly approved funding for assisted living services (sometimes referred to as levels of care) for ACR residents. This funding, which became available upon adoption of the neces-

sary regulations, provides a supplement to the auxiliary grant for residents assessed as requiring assisted living (regular assisted living) or intensive assisted living services. For ACR residents assessed as requiring "regular" assisted living services, the state provides a general fund supplement of $90 through the general fund to the basic auxiliary grant. For ACR residents assessed as requiring intensive assisted living services, the state provides a Medicaid supplement of $180 to the basic auxiliary grant. Exhibit 3 shows the composition of sample auxiliary grant. ACR residents in Northern Virginia (Planning District 8) can receive a higher auxiliary grant, with a maximum residential auxiliary grant for Northern Virginia of $799, as opposed to $725 for the remainder of the State.

EXHIBIT 3
COMPOSITION OF SAMPLE AUXILIARY GRANTS

Source of Funds	*Residential*	*Regular Assisted Living*	*Assisted Living*
Resident Income (SSI)	$444	$441	$441
Auxiliary Grant (State Share)	$224.80	$224.80	$224.80
Auxiliary Grant (Local Share)	$56.20	$56.20	$56.20
Assisted Living Supplement (General Fund)	n/a	$90	n/a
Intensive Assisted Living Supplement (Medicaid Funds, 51.49 federal share, 48.51 state share)	n/a	n/a	$180
Total	$725	$815	$905

Source: *JCHC staff analysis.*

REGULATION OF LONG-TERM CARE BY STATE GOVERNMENT

State government is involved in regulating several different aspects of long-term care service delivery. The state regulates long-term care insurance and continuing care retirement community contracts through the State Corporation Commission's Bureau of Insurance. The state licenses long-term care facilities and certifies nursing homes for eligibility for the federal Medicaid and Medicare program. Licensure of long-term care facilities is discussed in more detail in the next chapter. The state also regulates construction of new nursing homes or construction of additional nursing facility beds through the Department of Health's Certificate of Public Need (COPN) program.

The COPN program for regulating nursing home beds is closely related to the Medicaid program, because a goal of the COPN program is to minimize Medicaid nursing home costs. This is accomplished by restricting the supply of nursing home beds in each planning district. While this approval limits the Medicaid's potential exposure to nursing home costs, some may argue that the COPN program impacts industry charges on other individuals.

The General Assembly imposed a moratorium on nursing home beds from 1988 to 1996. The 1996 General Assembly lifted the moratorium on nursing facility beds and substituted a request for application process whereby the State Health Commissioner issues a request for application (RFA) for nursing facility beds within planning districts identified as needing additional nursing home beds.

ORGANIZATION OF STATE GOVERNMENT LONG-TERM CARE AND AGING SERVICES IN VIRGINIA

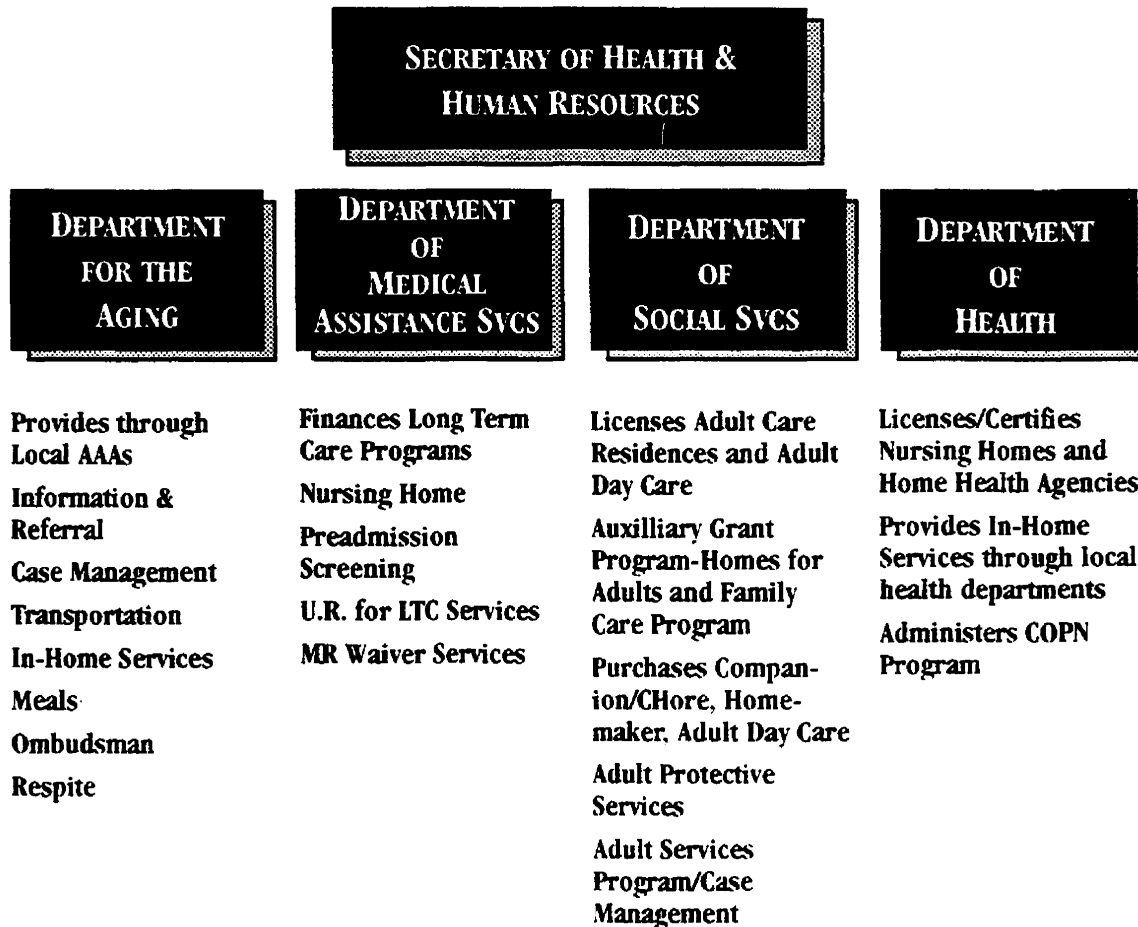
Long-term care services in Virginia include a network of six agencies within the Health and Human Resources Secretariat and four networks of local agencies. The networks of local agencies involved in long-term are services include 25 Area Agencies on Aging, 40 Community Services Boards, 35 local health districts of the department of health, and 122 local departments of social services. Aging services have a focal point in the Department for the Aging and the aging network, but aging issues potentially impact a wide range of state and local agencies.

Six State Agencies Are Involved in Long-Term Care

Six state agencies within the Health and Human Resources Secretariat are involved in providing long-term care services. These agencies include: the Department of Medical Assistance Services (DMAS), the Virginia Department of Health (VDH), the Department of Mental Health Mental Retardation and Substance Abuse Services (DMHMRSAS), the Department of Rehabilitative Services (DRS), the Department of Social Services (DSS), and the Department for the Aging (VDA). Figure 4 shows Virginia's long-term care system for the elderly.

Department of Medical Assistance Services: DMAS finances long-term care services through the State's Medicaid program. Medicaid long-term care services include skilled nursing care, nursing facility care, hospice, home health, personal care, private duty nursing, adult day care, respite care, case management, durable medical equipment and supplies, physical therapy, occupational therapy, and speech therapy. As mentioned previously, Medicaid also finances the intensive assisted living supplement for ACR auxiliary grant recipients assessed as needing intensive assisted living services. In addition to financing an array of long-term care services through Medicaid, DMAS administers the nursing home preadmission screening program and annual resident reviews.

FIGURE 4
VIRGINIA'S CURRENT LONG-TERM CARE SYSTEM FOR THE ELDERLY



Department of Health: VDH is responsible for licensure and certification of nursing homes and home health agencies, in addition to licensure of acute care facilities. VDH also administers the certificate of public need (COPN) program for nursing homes and certain other health facilities. Through local departments of health, VDH also provides nursing home preadmission screening, personal care, home health services, case management, and home health visits.

Department of Mental Health, Mental Retardation, and Substance Abuse Services: DMHMRSAS provides long-term care services for the geriatric mentally ill at three state mental health facilities: Catawba Hospital, Piedmont Geriatric Hospital, and Eastern State Hospital. DMHMRSAS also administers the OBRA

program for preadmission screening and review of nursing home residents who are mentally ill or mentally retarded. State training centers and mental health institutes also serve as long-term care facilities for some patients. DMHMRSAS also provides a variety of home and community based services for the mentally disabled and substance abuse dependent through 40 Community Services Boards.

Department of Rehabilitative Services: DRS administers three programs providing long-term care services. These are: personal assistance services, the long-term rehabilitative case management program, and the OBRA program for the physically disabled. DRS's OBRA program for the physically disabled is operated under a sub-contract from DMHMRSAS.

The personal assistance services program operated by DRS provides allows individuals with severe physical and sensory disabilities to employ personal assistants. This program is a collaboration between DRS and the Centers for Independent Living (CILS). The CILS provide client skill development, assessment, counseling, and assist in recruiting and training personal assistants. DRS administers the program, assists in screening clients, and provides technical assistance.

The long-term rehabilitative case management program operated by DRS provides services to meet the needs of people with neurological and other severe physical disabilities. Two-thirds of the current clients have brain injuries, and one-half of the clients have multiple disabilities such as brain and spinal cord injuries. Services provided under the program include intensive, individualized case management, advocacy, and interagency coordination.

The OBRA program currently provides specialized services to 141 individuals with very severe physical developmental disabilities living in nursing homes or who are nursing home eligible and are receiving home and community-based services. Services provided to these individuals under DRS's OBRA program include customized wheelchairs, communication devices, and environmental controls.

Department of Social Services: DSS administers the auxiliary grant program, licenses homes for adults and adult day care centers, and oversees the adult services and adult protective services programs which are conducted by local departments of social services. The auxiliary grant program was described previously in this chapter. The licensing program is responsible for licensing 612 adult care residences in Virginia in addition to adult day care centers. The DSS adult licensing program will be discussed in more detail in Chapter III.

The state's 122 local departments of social conduct the activities of the adult services and adult protective services programs. The adult protective services program investigates complaints of abuse.

neglect, or exploitation of adults. The adult services program provides purchased home based services including companion, chore, and homemaker services, case management, nutrition services, transportation services, adult foster care, family care services, and adult day care. Local departments of social services also conduct preadmission screenings for nursing home placement and conduct assessments and assessments for adult care resident placement.

Department for the Aging: VDA is the State's designated single agency for administering the Older Americans Act. VDA allocates funds from the Older Americans Act to the 25 Area Agencies on Aging using a formula described previously. The department also allocates general fund appropriations for case management, respite care, and the state ombudsman program. At the direction of the General Assembly, the state ombudsman program is conducted by the Virginia Association of Area Agencies on Aging operating under a contract from the Department for the Aging.

Area agencies on the aging provide an array of services including advocacy, case management, information and referral, adult day care, home health services, personal care services, homemaker services, residential repair and renovation, transportation services, home delivered meals, financial counseling, legal assistance, home visits, chore services, job training and placement assistance, wellness services, and insurance counseling. While all AAAs provide transportation services and congregate meals, not all of the above-listed services are provided by all AAAs. For example, not all of the State is presently covered by the case management, respite care, and ombudsman programs funded through or initially funded through general fund appropriations by the General Assembly. Sixty percent of the state's local jurisdictions are covered by ombudsman services. Sixty-one percent are covered by case management services. Forty percent are covered by respite care services.

Aging Issues Potentially Impact a Number of State Agencies

While the State's role in long-term care is largely confined to the above mentioned six agencies within the Health and Human Resources Secretariat, a number of state agencies are potentially involved in aging issues. For example, the Department of Taxation administers the tax credit for older Virginians. The Department of Housing and Community Development is potentially involved in housing issues for older adults, and the Department of Motor Vehicles is potentially involved in transportation issues. The Virginia Community College System and other state institutions of higher education provide educational instruction that is of interest to many older Virginians. The Virginia Retirement System administers a pension program for retired state and local employees. Moreover, the aging of Virginia's population presents an economic development opportunity and challenge for the State's Commerce and Trade agencies.

III: Financing and Organization of Long-Term Care and Aging Services

Background

From 1982 until 1995, long-term care was coordinated by the Long-Term Care Council, which consisted of the agency heads of the health and human resources agencies responsible for long-term care. The Council was chaired by the Secretary of Health and Human Resources. The 1989 study of long-term care by the Commission on Health Care for All Virginians identified that the financing and administration of long-term care services at the state and local level were fragmented and that there was a need to establish leadership at the state level for this issue. In 1990, in an effort to provide this leadership through the Long-Term Care Council, the General Assembly established two positions to staff the Long-Term Care Council. The Council's staff members were housed within the Department for the Aging. These staff positions were eliminated when the Council was allowed to sunset in 1995.

Interviews with state agency staff suggested that the Long-Term Care Council eventually moved away from the model of agency heads meeting together, to coordinate long-term care policy. Apparently the practice developed where agency heads would send deputies or other lower ranking representatives in lieu of attending in person. Some state agency staff interviewed also perceived that the Long-Term Care Council suffered over time from time constraints on the Secretary's ability to provide full-time guidance to the Council.

The Long-Term Care Council provided a valuable discussion forum, but it did not prove to be effective in coordinating long-term care policy. A growing consensus formed in the early 1990's that a structural solution was needed to address the issues of long-term care coordination. Consequently, attention turned to structural consolidation of the state agencies involved in long-term care as a means for improving coordination of long-term care policy, as well as financing and delivery of long-term care services. The General Assembly passed HJR 603 which requested the Secretary of Health and Human Resources to develop a plan for state level consolidation by October 1993 and a plan for local level consolidation by October 1994.

Past Reorganization Proposals

There have been three consolidation proposals for long-term care services in state government, the first two of which would have also impacted aging issues. The 1994 General Assembly considered and deferred action on a proposal by the former Secretary of Health and Human Resources Howard Cullum that would have consolidated most long-term care services and responsibility for aging issues in a Department

of Aging and Long-Term Care Services. The second proposal, presented in November 1994, by Secretary of Health and Human Resources Kay James, would have consolidated most long-term care and aging services as a division within DMAS. The third proposal, presented to the 1996 General Assembly by the Joint Commission on Health Care at the request of the Secretary of Health and Human Resources, would have consolidated responsibility for licensure of long-term care facilities within the Department of Health. This proposal was defeated on the floor of the Senate.

1994 Cullum Proposal Would Have Created a Consolidated Agency

As noted previously, the 1993 General Assembly approved House Joint Resolution 603, which requested the Secretary of Health and Human Resources to present a consolidation proposal for state agencies involved in long-term care by October 1993. The Secretary was directed to develop a plan for local level consolidation by October 1994. To prepare this plan, the Secretary developed a Long Term Care and Aging Task Force.

The resulting plan was presented in HD 44 (1994) and is often referred to as the Cullum proposal. This proposal would consolidated most long-term care and aging services in a greatly expanded Department of Aging and Long-Term Care Services. This proposal was presented to the 1994 General Assembly in SB 575 and HB 1267. The proposal was strongly supported by advocates for the aging but was opposed by the nursing home industry and by the new administration, which requested that legislative action on the proposal be deferred until the 1995 General Assembly.

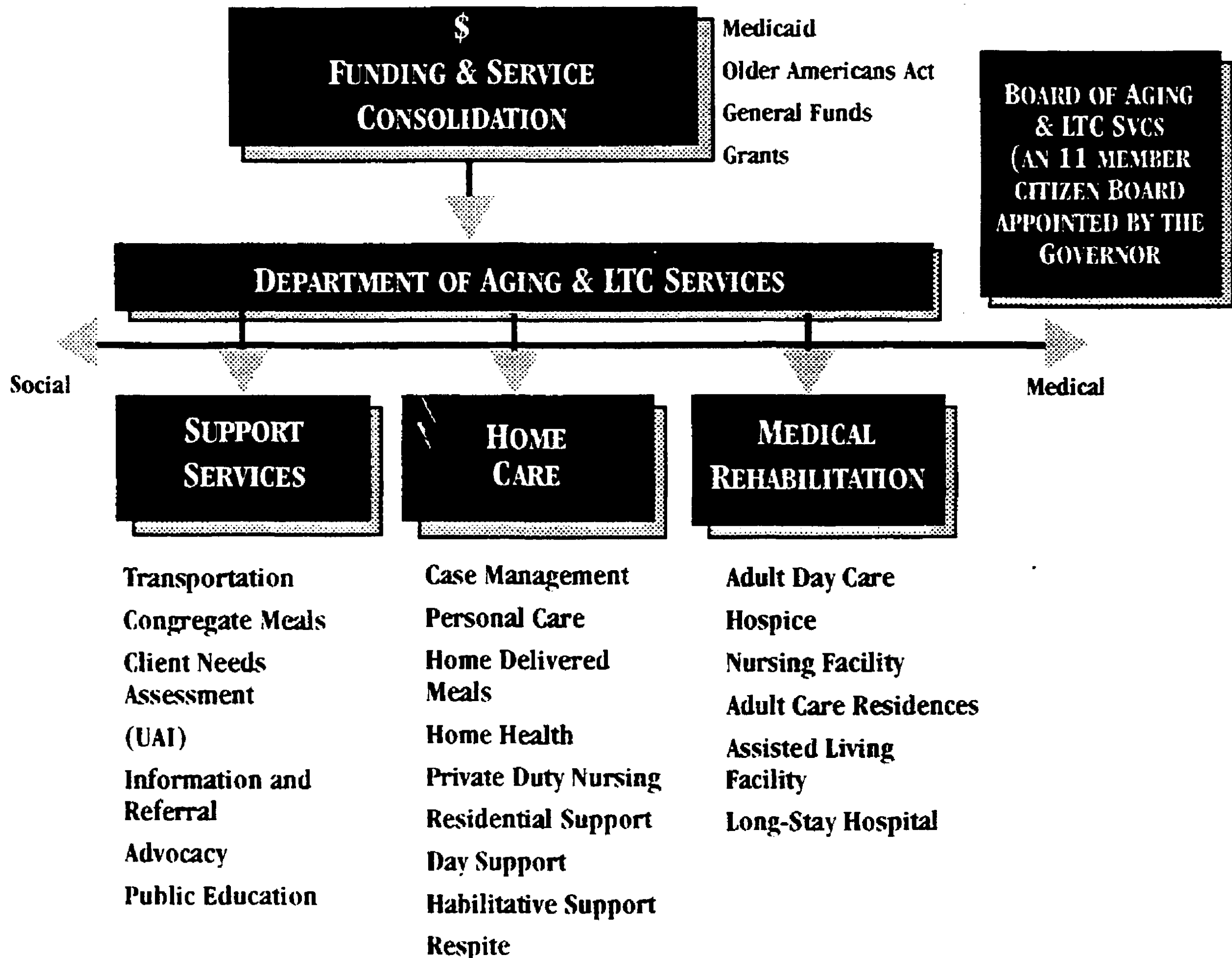
As proposed by SB 575 and HB 1267, the Department of Aging and Long-Term Care Services would have encompassed :

- all functions and programs in the Department for the Aging,
- the adult care residence and adult day care licensing program of the Department of Social Services,
- the long-term care financing and planning components of the Department of Medical Assistance Services, and
- the Department of Health's licensure and certification program for nursing homes and home health agencies.

Figure 5 shows the agency proposed by SB 575 and HB 1267. It is noted that HD 44 had recommended including the consolidation of the adult services, auxiliary grant, and adult protective services

programs from DSS. However, this aspect of the proposal was not included in the resulting legislation due to opposition from local social services departments and the perceived need for further study of these functions.

FIGURE 5: CULLUM PROPOSAL



November 1994 James Proposal Would Have Consolidated Long-Term Care, Aging, and Disability Services Within DMAS

When the General Assembly deferred action on SB 575 and HB 1267, it approved HJR 209, that requested the Secretary of Health and Human Resources to "review the plan for state-level consolidation of certain long-term care and aging services within a single state agency and develop a plan for the coordinated delivery of such services at both the state and local levels." The resulting plan was presented by the

Secretary in November 1994. This proposal recommended consolidation of most long-term care and aging services within the Department of Medical Assistance Services. The proposal would also have eliminated the Department for the Aging. These services would have been placed under a newly created position of Deputy Director for Aging, Disability, and Long-Term Care Services (Figure 6). This proposal recognized that long-term care services encompass more than the elderly population, and sought to broadly define the meaning of long-term care and the populations to be served by a consolidated agency.

In addition to the long-term care financing and planning functions already conducted by Department of Medical Assistance Services, this newly created division of DMAS would have included:

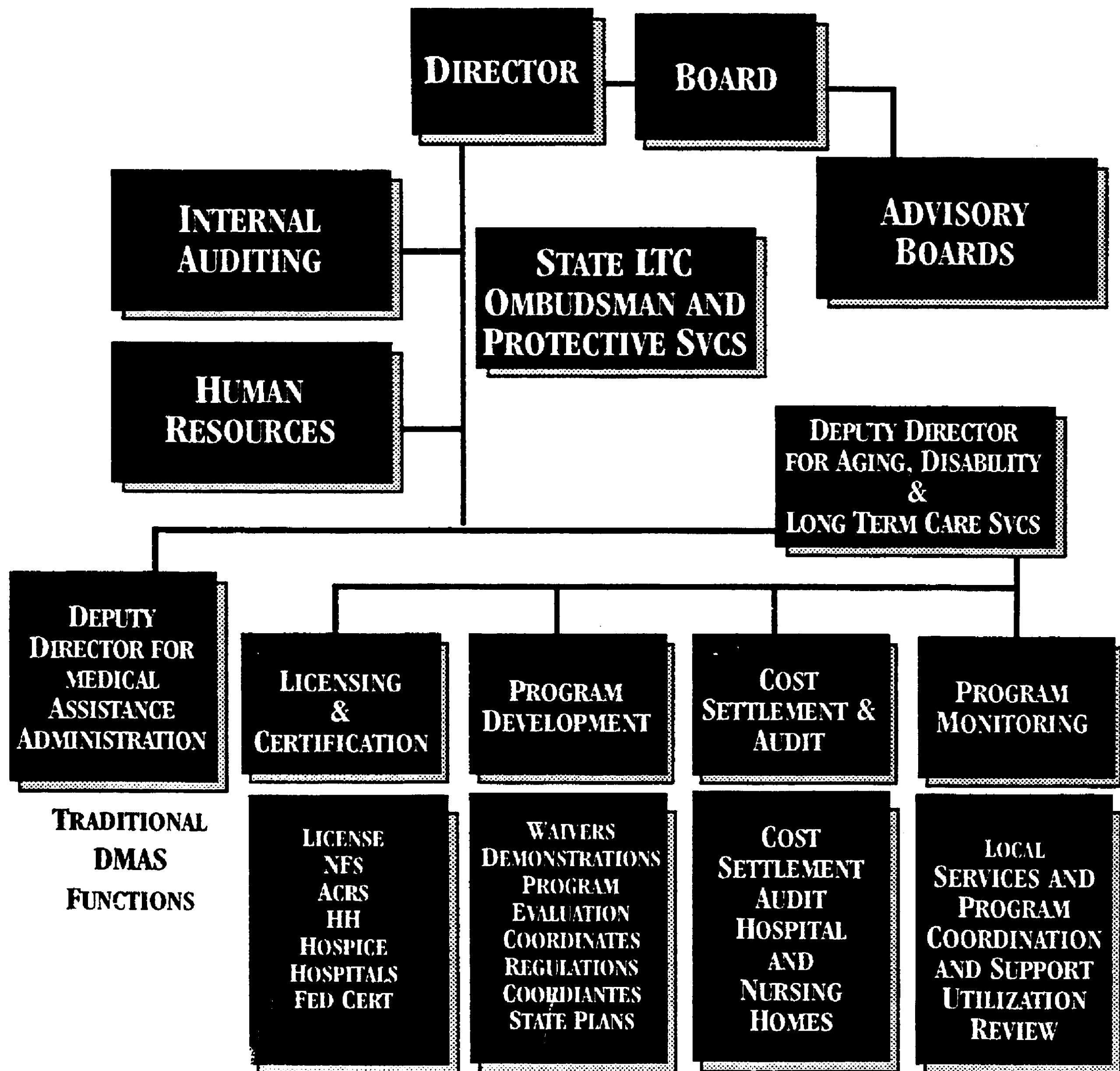
- all functions and programs of the Department for the Aging,
- adult services, adult protective services, auxiliary grants program policy, and adult care residence/ adult day care licensing program of the Department of Social Services,
- licensing and certification of acute and long-term care providers performed by the Department of Health,
- Personal Assistance Services and Centers for Independent Living programs from the Department of Rehabilitative Services, and
- utilization review of the Medicaid mental retardation waiver, Medicaid mental retardation state plan community option services, and utilization review of Medicaid mental health state plan option services conducted by DMHMRSAS.

The November 1994 plan of the Secretary of Health and Human Resources is sometimes referred to as the James proposal. This proposal was strongly opposed by advocates for the aging. Advocates for the aging were concerned that organizational placement of the Department for the Aging's functions within DMAS would create an inherent conflict between VDA's advocacy mission and DMAS's mission of controlling long-term care costs. Concern was also expressed that collapsing the Department for the Aging into a division of DMAS would reduce the visibility of aging and long-term care issues in state. Additionally, concern was expressed that DMAS was an inappropriate location for long-term care and aging services, because the agency's focus was on financing of a public assistance program. The 1995 General Assembly did not take action on either the Cullum proposal or the James proposal (the James proposal was never introduced in the form of legislation).

Figure 6

Consolidation Proposal Presented by the Secretary of Health and Human Resources in November 9 of 1994

Department of Medical Assistance Services



Several Other States Also Examined Creation of A Consolidated Long-Term Care Agency

At approximately the same time that Virginia was examining consolidation of long-term care services in a single agency, other states were examining the same concept. For example, task forces studying long-term care in California, Idaho, New Mexico, and Texas recommended consolidation of long-term care services in a single state agency during the period 1993-1997. However, relatively few states have finalized action to consolidate long-term care services in a single agency. The two states most frequently associated with the concept of a single agency are Washington and Oregon. Both states viewed creation of a consolidated agency as a means to improving service delivery and controlling long-term care costs.

Washington created a single state entity to manage most long-term care services. This entity is the Aging and Adult Services Administration, which is part of the Department of Social and Health Services. This agency controls the state's entire long-term care budget, including general fund appropriations, Older Americans Act funds, and Medicaid long-term care funds.

Oregon also consolidated LTC responsibilities into one agency, the Senior and Disabled Services Division of the Department of Human Resources. Oregon also created a single point of entry for consumers to receive long-term care services. In Oregon, Area Agencies on Aging act as a single point of entry for LTC services and manage Medicaid long-term care programs.

Most states, however, have not been successful in creating a single agency to manage long-term care financing and delivery. It is important to note that in both Oregon and Washington the "single agency" is a subordinate unit within a larger health and human services agency rather than a free standing agency. Florida created a Department of Elder Affairs, that is involved in long-term care policy making and delivery of services. However, the agency does not have lead responsibility for either licensure or financing, two other major aspects of long-term care services.

There are several difficulties in creating a consolidated state agency. First, the needs of long-term care populations differ, and it is difficult for a single agency to tailor programs and solutions to meet the needs of different populations. Additionally, creation of a consolidated agency raises concerns about the advisability of housing functions such as licensing and financing or ombudsman services and licensing together. Another concern in creating a consolidated agency is the past experience in Virginia of attempting to consolidate multiple agencies within a Secretariat. The Department of Environmental Quality (DEQ) was created by the 1993 General Assembly to eliminate fragmentation of environmental protection services among four environmental agencies. DEQ has experienced a number of morale and management issues since the agency began operation, some of which are related to the merger itself.

Another concern in implementing a consolidated agency is that long-term care financing is rapidly evolving as states implement a number of innovative demonstration projects using Medicaid waivers. Some financing options that the state may choose to pursue in the future, such as managed care, would potentially reduce or even obviate the need for state level or local consolidation, because the managed care entity would act as the broker to purchase needed services at the local level, with the state paying a capitated rate for individual enrollees to the managed care entity. States, including Virginia, are also experimenting with blending acute and long-term care service delivery. The trend towards blending acute care and long-term care financing streams is antithetical to the notion of segregating long-term care funding from acute care funding by placing long-term care funding in a consolidated long-term care agency. Moreover, states are increasingly recognizing the importance of tailoring managed care projects to meet the needs of special populations, which may be more difficult to accomplish within a consolidated agency.

Nevertheless, a consolidated agency approach remains a policy option that the Joint Commission on Health Care may choose to pursue. If this option is selected, the need for a carefully crafted implementation plan cannot be overemphasized. The experience of DEQ should be examined to identify lessons learned in consolidation of multiple state agencies.

1996 Proposal Would Have Consolidated Licensure of Long-Term Care Facilities Into the Department of Health

After neither large-scale consolidation proposal was approved by the 1995 General Assembly, the Secretary of Health and Human Resources requested that the Joint Commission on Health Care introduce legislation to consolidate licensure of long-term care facilities within the Department of Health. This proposal, SB 367, would have removed responsibility for licensure of adult care residences and adult day care from the Department of Social Services, and placed this responsibility within the Department of Health, which already licenses and certifies nursing homes, home health agencies, and acute care facilities. This proposal was strongly opposed by the adult care residence industry and was defeated on the Senate Floor.

POLICY OPTIONS FOR STATE LEVEL CONSOLIDATION

The following options address state level consolidation. If Option II is selected, this would preclude a number of the policy options presented later in this chapter.

OPTION I: TAKE NO ACTION WITH REGARD TO CREATION OF A SINGLE STATE AGENCY FOR LONG-TERM CARE AND AGING SERVICES

OPTION II: INTRODUCE LEGISLATION CREATING A CONSOLIDATED STATE AGENCY FOR LONG-TERM CARE AND AGING SERVICES

FINANCING OF LONG-TERM CARE SERVICES

One of the key objectives of past reorganization proposals was to streamline state financing of long-term care services. The state is currently a significant payor for all long-term care services, and it is the majority payor for nursing home services. The state's financing structure for long-term care could be seen as institutionally biased, in that the majority of the state's long-term care related Medicaid expenditures are for institutional care. Financing of long-term care services will become increasingly challenging as demand for long-term care increases. One challenge for the state is promoting family in individual responsibility in meeting long-term care needs, where government would become a partner, not the majority payor, in financing long-term care costs. Another challenge for the state is blending various long-term care funding streams for long-term care services to both better meet the needs of long-term care consumers and to minimize risk for the State.

Notwithstanding the lack of state-level consolidation of long-term care, Virginia has pursued a number of innovative strategies for financing long-term care services and for minimizing the need for institutional care, which is both expensive and potentially unattractive for consumers. These strategies include preadmission screening for nursing home placement, Medicaid waivers, levels of care in adult care residences, case management, respite care, and the pre-PACE program.

VIRGINIA'S APPROACH TO LONG-TERM CARE FINANCING

Virginia has taken a number of innovative steps over the past two decades to improve financing of long-term care services, encourage consumer choice, and minimize costs. Exhibit 3 shows steps Virginia has taken in long-term care financing and service delivery since 1977. Each of these steps is discussed in more detail below.

EXHIBIT 3

VIRGINIA'S APPROACH TO LONG-TERM CARE

ISSUE	PAST ACTION	MOST RECENT ACTION
Nursing Home Preadmission Screening	(1977) Began Nursing Home Preadmission Screening	(1982) Expanded Preadmission Screening
Medicaid Waivers	(1982-1996) Obtained Five Medicaid Waivers to Provide Home and Community Based Services	(1996) Obtained Assisted Living Waiver
Case Management for Elderly Virginians	(1991) Pilot Case Management Program Initiated	(1996) Pilot Phase Ends, program now covers 82 localities
Assisted Living	(1993) Levels of Care Established for Adult Care Residences (Formerly Known as Homes for Adults)	(1995) General Assembly clarifies conditions that may be Treated in ACRs, Revises Staffing Required, and Requires a Needs Assessment for ACR Residents
Uniform Assessment Instrument (UAI)	(1993) UAI Development Begins	(1994) Implementation of UAI Training for 3,000 Persons Statewide
Program for All-Inclusive Care for the Elderly (PACE)	(1995) General Assembly directs DMAS to seek a waiver for a PACE demonstration project	(1996) Pre-Pace model developed with Sentara.

Source: *JCHC staff analysis.*

Nursing Home Preadmission Screening Assures Appropriate Placement, Minimizes Medicaid Costs

Virginia was one of the first states in the nation to implement nursing home preadmission screening. The purpose of preadmission screening is to ensure proper placement of residents and to prevent individuals from being placed in more expensive nursing home care when they would be more appropriately served by less expensive community options. Nursing home preadmission screenings are conducted by staff from local departments of health.

Medicaid Waivers Allow the State to Finance Home and Community Based Services

As Chapter II illustrates, the State has obtained Medicaid waivers to offer an array of home and community based services. These services allow individuals to receive needed services in their home or in the community, rather than in a nursing home. Some current waivers have the potential to be expanded. For example, the current waiver for assisted living services is restricted to individuals assessed as dependent in four or more activities of daily living (ADLs). Some other states have made more extensive use of Medicaid assisted living services, by using less restrictive criteria for eligibility.

Case Management for Elderly Virginians Project

The case management for elderly Virginians pilot project began in 1992, when the General Assembly appropriated $1.2 million to fund pilot case management projects. At present, 82 (61 percent) of the State's 135 localities are covered by the case management program. The purpose of the case management program is to assess the needs of elderly Virginians and to coordinate delivery of services to most effectively meet those needs. The case management program was initiated with general funds, and it is currently funded and implemented by Area Agencies on Aging. The case management program offers great potential for coordination of care at the local level, but it has not yet achieved statewide impact, because the program has not been funded for statewide implementation.

Uniform Assessment Instrument (UAI)

The purpose of the UAI is to standardize the assessment of persons in need of or in potential need of long-term care services statewide. UAI's are administered by a variety of service providers, including staff of long-term care facilities, Area Agencies on Aging, local health departments, community services boards, and local departments of social services. In 1994, statewide training was conducted for approximately 3,000 persons who anticipated administering UAI's.

Interviews with state and local agency staff suggested two opportunities for improved implementation of the UAI. First, continual, uniform training would help ensure consistency in UAI training (the state initially offered uniform training for the UAI, but this training is now conducted separately by different entities administering the UAI). Second, improved electronic access to the UAI database maintained by DMAS would assist local agencies.

In addition to these two suggestions from staff involved in administering the UAI, JLARC's 1997 report *Services to Mentally Disabled Residents of Adult Care Residencies* recommended improving the UAI to better assess the needs of the mentally disabled. JLARC recommended establishment of an inter-agency task force to "address the limitations of the Uniform Assessment Instrument for individuals with mental disabilities." This task force could also consider improved training for administration of the UAI.

Sentara Site Has Implemented a Pre-PACE Site

The Program for All-Inclusive Care for the Elderly (PACE) is a program which serves frail elderly in the community under a capitated financing arrangement, primarily under sponsorship from the Medicaid and Medicare programs. The PACE concept was started in San Francisco by the On Lok Program. The PACE program, which received approval as a HCFA demonstration project, has been replicated nationwide. The 1996 and 1997 General Assembly sessions enacted legislation fostering the establishment of a pre-PACE site in Norfolk that is operated by Sentara Senior Community Care. As of September 1997, the program enrolled approximately 50 at-risk elderly persons. The program provides adult day care and a combination of managed acute care and long-term care services to program participants. The 1997 federal budget agreement lifted a previously existing cap on the number of PACE sites nationwide, offering a potential for multiple PACE sites within the state.

The Department of Medical Assistance Services and the State Corporation Commission's Bureau of Insurance are currently researching issues that need to be addressed by the 1998 General Assembly regarding the PACE program. JCHC staff will report at a later meeting on needed legislative changes

DMAS Has Prepared a Grant Proposal for Blending Medicare and Medicaid Financing

In September 1997, DMAS submitted a grant proposal to the Robert Wood Johnson Foundation (RWJ) for blending Medicare and Medicaid delivery and reimbursement for individuals who are dually eligible for Medicare (by virtue of age or disability) and Medicaid (by virtue of income below Medicaid thresholds). The Virginia project is titled the "Virginia Medicare/Medicaid Integration program" and it designates DMAS as the lead agency.

The state's grant application requested $300,000 in funding from RWJ over a two-year period, with the state contemplating providing $150,000 in matching funds. The grant proposal would be implemented in cooperation with Sentara. The target population for the project will include Medicaid/Medicare dual eligibles in Tidewater, an estimated population of 12,000. If funded, the program expects enrollment of approximately 2,500 by year three of the project. The department is committed to involving all entities at the state and local level in implementing this proposal.

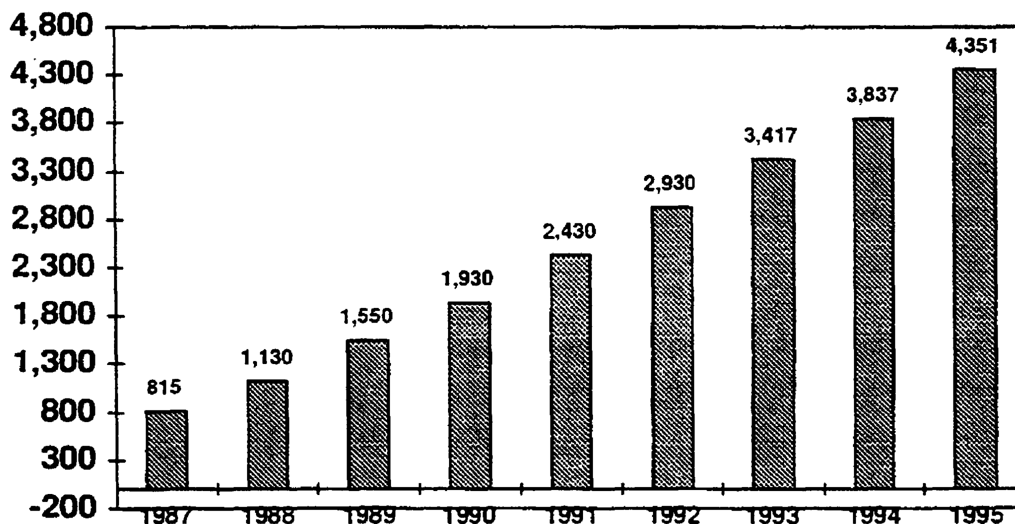
Blending Medicaid and Medicare funding is an exciting approach for more effectively leveraging all available funding streams to better serve the acute care and long-term care needs of dually eligible persons. The DMAS grant proposal, if implemented, could serve as a foundation for a program that would ultimately serve dually eligible persons statewide.

Encouraging Long-Term Care Insurance Offers A Means of Promoting Individual Choice and Personal Responsibility in Meeting Long-Term Care Needs

LTC insurance is an insurance policy that pays for the cost of receiving future long-term care. Long-term care insurance is offered in a variety of forms, including individual policies, policies through continuing care retirement communities, group policies, and as a rider to individual or group life insurance policies. Long-term care insurance was rare a decade ago, but nationally the number of policies sold nationwide has been increasing rapidly during the past decade, growing at an annual rate of approximately 23 percent per year (this rate of growth means that the cumulative number of policies sold doubles every 3.13 years).

FIGURE 7

Cumulative Number of LTC Policies Sold in the U.S., 1987 to 1995 (Figures in Thousands)



In 1995 (the most recent year for which data are available), long-term care insurance policies in Virginia paid about $44 million in claims, compared with approximately $470 million in Virginia Medicaid expenditures for long-term care in 1995. While the growth in the sales of long-term care insurance is encouraging, the continuing challenge regarding LTC insurance is how to encourage younger and/or healthier persons to purchase LTC insurance for themselves. Another possibility is to market long-term

care insurance as an employee benefit for younger, working adults to buy to cover aging parents. This option potentially benefits employers by relieving employees of some of the stress (and related lost productivity) associated with long-term care costs and uncertainty.

In 1996, Congress took a step to encourage purchase of long-term care insurance. The Health Insurance Portability and Accountability Act (commonly referred to as the Kennedy-Kassebaum bill) of 1996 allows a federal tax deduction for part or all of long-term care insurance premiums paid. There are limits on this deduction, however. First, the total amount of the deduction is limited. The federal limits on deductions allowed for long-term care insurance premiums range from $200 for a person 40 years of age or less to $2,500 for a person aged 71 and older. Not all taxpayers with long-term care insurance can claim the deduction, however. Taxpayers who do not itemize on their return cannot claim the deduction. Moreover, the deduction for long-term care insurance premiums is treated as a medical expense. A taxpayer cannot deduct medical expenses that do not exceed 7.5 percent of gross income. Therefore, a taxpayer without significant out of pocket medical expenses would not be eligible to claim the deduction for long-term care insurance. As Virginia tax law generally conforms to federal law, corresponding deductions are also allowed for filers who itemize on their Virginia income taxes.

Other states have considered a variety of approaches to encourage the purchase of long-term care insurance. These include tax credits, modified Medicaid spend down provisions for persons who have purchased long-term care insurance, and long-term care insurance for state employees. Alaska and Utah currently offer long-term care insurance as an optional benefit for state government employees. The General Assembly has considered offering long-term care as an optional benefit for state employees. Information about this option for future use continues to be collected for future use by the Commission on the Management of the Commonwealth's Workforce.

Long-term care insurance is not an ideal product for everyone. Individuals whose assets are already at or near Medicaid spend down limits would gain relatively little from purchase of long-term care insurance, according to the National Association of Insurance Commissioners publication *A Shopper's Guide to Long-Term Care Insurance*. However, from the state perspective and from the perspective of many individuals with more substantial assets, long-term care insurance is potentially a "win-win" proposition. From the state perspective, increasing the number of Virginians who have long-term care insurance reduces the future costs of the Medicaid program. For individuals, long-term care insurance offers a means of protecting hard-earned assets from being depleted by long-term care costs, and it offers a means of enhancing their consumer choice in selecting long-term care options.

Managed Care is One Option for Financing and Delivery of Long-Term Care Services

States have generally been more aggressive in implementing managed care for acute care services than for long-term care services. Arizona is the only state at present that has implemented managed long-term care statewide. The Arizona Long-Term Care System (ALTCS) has been credited with producing cost savings, though some of these cost savings may be related to more restrictive eligibility criteria for the program.

Other states have experimented in a limited way with long-term care through demonstration projects such as PACE and Social HMO's. According to a study by the Urban Institute, however, it is not clear whether or not such demonstration projects have resulted in cost savings. While challenging to implement, managed care offers an interesting possibility for both controlling long-term care costs and improving service delivery.

One decision to be made in designing managed care programs for long-term care is the population or populations to be targeted. The PACE program targets persons eligible for both Medicaid and Medicare. The Arizona program targets both the elderly and the disabled who are in need of long-term care. Social HMO's typically target the frail elderly.

Virginia's current efforts with the pre-PACE program and the State's grant proposal for blending Medicaid and Medicare should prove to be useful laboratories for experimenting with managed long-term care. These projects should be carefully evaluated to glean lessons learned for the potential implementation of managed long-term care on a broader scale.

Repeal of the Boren Amendment Provides States With Additional Flexibility in Nursing Home Reimbursement

The 1997 federal budget agreement repealed the Boren Amendment. The Boren Amendment, named for former Senator Boren of Oklahoma, required state Medicaid programs to establish reimbursement rates for hospitals, nursing facilities, and intermediate care facilities that were reasonable and adequate to meet the costs incurred by efficiently and economically operated facilities. The Boren amendment had the effect of directing state reimbursement policy to consider nursing home costs, while not necessarily considering the costs of other long-term care settings in establishing reimbursement levels.

Repeal of the Boren amendment presents both a challenge and an opportunity for states. The challenge will be to design an appropriate reimbursement policy that both controls costs and funds quality care. The opportunity will be to consider long-term care reimbursement policy more holistically while controlling costs and providing quality care.

Voucher Proposal Identified By HJR 209 of the 1996 General Assembly

HJR 209, approved by the 1996 General Assembly, directs the Joint Commission on Health Care to study the concept of using vouchers for long-term care services. This proposal, which was conceived by an assisted living provider in the Commonwealth, would involve providing consumers eligible for government financed long-term care services (whether through Medicaid or Medicare's post-hospitalization 90 day coverage for nursing care) vouchers to purchase long-term care services. Each individual would be assessed, using the UAI or equivalent instrument, to determine the level of need and corresponding voucher amount. This amount would be capped for most individuals at a rate significantly higher than current ACR reimbursement, but significantly lower than current nursing home reimbursement. This would then provide an incentive for consumers to use assisted living facilities rather than nursing home care. The proposal is predicated on the belief that moving consumers from nursing facility care to assisted living care would reduce Medicaid long-term care spending, even with significantly increased levels of reimbursement for both residential and assisted living care in ACRs.

As noted earlier, this proposal would represent a major structural change in Virginia's system of financing and delivering long-term care. An analysis of the proposal in 1995 by DMAS staff indicated that the proposal would require both Medicaid and Medicare waivers. The originator of the proposal indicated that, to be fair to the nursing home industry, this proposal would involve either subjecting ACR's to the Certificate of Public Need process or eliminating the COPN requirement for nursing homes. This would represent a major structural change to Virginia's regulatory system for long-term care. The proposal, as described to JCHC staff, would not contemplate any enhanced or increased regulation of ACRs. However, this proposal would require changes to the *Code of Virginia* to modify or eliminate the provision of § 63.1-174.001 that prohibits ACRs from admitting or retaining individuals with thirteen specific conditions or care needs.

The proposal assumes significant cost savings (in excess of $100 million per year) from moving essentially all category A and B residents from nursing facilities into assisted living facilities. At this time, given the lack of experience in any other state with precisely this type of voucher proposal, it is difficult to test the proposal's assumptions regarding cost savings. However, the cost savings attributed to the proposal would need to be weighed against additional demand for services generated by the proposal. It is noted that the proposal would likely encounter significant resistance from a variety of long-term care providers, including the nursing home industry. The proposal might also meet significant resistance from the ACR industry, to the extent that the ACR industry might resist either absorbing nursing home eligible residents or being subjected to the COPN process.

The CSA Model for Pooling Long-Term Care Financing

The Comprehensive Services Act (CSA) was approved by the 1993 General Assembly. The purpose of the Comprehensive Services Act was to improve the case management of at-risk youth, control costs for services to at-risk youth, and improve service delivery. The CSA program is currently being studied by the Joint Legislative Audit and Review Commission, whose report is expected in mid-October 1997. According to JLARC's 1997 workplan,

> The goals of CSA include preserving the family unit, providing treatment services to at-risk children in the least restrictive environment, and providing greater local control and flexibility in the use of CSA funds. The impetus for the study resolutions has been persistent increases in the caseloads and cost of CSA. In response to these upward trends, JLARC has been directed to develop proposals that might help slow the growth of the program.

The JLARC report on the CSA program will merit careful study, as it may offer lessons learned for implementing a pooled funding approach for long-term care that would avoid some of the preliminary problems encountered by the CSA program.

Responsibility for Long-Term Care Policy Coordination Needs to Be Reallocated

At present § 2.1-373.4 of the *Code of Virginia* states that "The Virginia Department for the Aging is designated as the state agency responsible for coordinating all long-term care efforts of state and local human services agencies." Since the abolition in 1995 of the positions that staffed the Long-Term Care Council, this provision of the *Code of Virginia* has proven problematic. The department does not have the staff resources or expertise to effectively coordinate long-term care policy (though the department has produced a background report on long-term care coordination for the Secretary of Health and Human Resources). Moreover, the department, which is the smallest state agency involved in Virginia's long-term care system, does not have the authority needed to coordinate the efforts of larger agencies.

It is not clear that the Department for the Aging ever can or should be able to coordinate long-term care policy. VDA's stakeholders include all of the aging in Virginia, most of whom will either never require long-term care services or will require such services only episodically. Therefore, the department's mission is broader than simply long-term care.

Further, VDA has statutory responsibility for oversight of Areas Agencies on the Aging (AAAs). However, the department does not have oversight of the other principal agencies involved in local long-term care service delivery: local departments of social services, community service boards, and local health departments. In fact, VDA's close links with AAAs may make it difficult for VDA to be seen as a neutral broker between the various local agencies involved in long-term care service delivery.

At the request of the current Secretary of Health and Human Resources, the Commissioner of the Department for the Aging has convened a multi-agency task force regarding Long-term Care Coordination. Besides the Department for the Aging, other agencies represented on the task force include the Department of Medical Assistance Services, the Department of Rehabilitative Services, the Department of Social Services, DMHMRSAS, and the Department of Health. While this Task Force is chaired by the Commissioner of the Department for the Aging, the other task force members include second or third level managers and assistants to agency heads.

While the task force is a potentially useful exercise for long-term care coordination, it lacks staff, authority, and high-level representation. As such, the task force is not a long-term solution to long-term care coordination. To the extent that an individual or entity should be charged with responsibility for long-term care policy coordination, this responsibility should be assigned to the Secretary of Health and Human Resources and staff support for this responsibility should be housed in the Office of the Secretary.

Policy Options for Long-Term Care

Financing and Coordination

These policy options are not all mutually exclusive. They also do not represent the entire range of options that the Joint Commission on Health Care may chose to consider.

Option I: Take No Action

Option II: Direct Staff to Offer Any Needed Assistance to the Workforce Commission in Its Deliberations on Establishing a Program to Offer State Employees Long-Term Care Insurance as an Optional Employee Benefit.

Option III: Introduce A Joint Resolution Requesting the Virginia Retirement System to Study the Feasibility of Offering A Long-Term Care Insurance Option as a Rider to the State's Existing Group Life and/or Optional Group Life Programs for State and Local Employees.

Option IV: Introduce A Joint Resolution Requesting the Secretary of Finance, in Cooperation With the Secretary of Health and Human Resources, to Conduct A Cost-Benefit Analysis of the Costs and Benefits Associated With A Tax Credit for Purchase of Long-Term Care Insurance.

Option V: Introduce Legislation Designating DMAS as the Lead Agency

For Financing of Long-Term Care. Direct DMAS in Consultation With Appropriate State Agencies (including VDA), to prepare a five-year plan for financing long-term care services in the Commonwealth. The Plan Should Identify Additional Strategies for Blending Medicaid and Medicare for Dually Eligible Individuals and for Managed Long-Term Care.

Option VI: Eliminate the Statutory Provision the Department for the Aging is Responsible for Coordinating Long-term Care

Under Option VI, the Joint Commission on Health Care would introduce legislation to repeal § 2.1-373.4 of the *Code of Virginia*. Repealing this section would eliminate the Department for the Aging's statutory responsibility for coordinating long-term care efforts at the state and local level.

Option VII: Introduce Legislation Requiring the Secretary of Health and Human Resources to Coordinate Long-Term Care Policy and to Report Annually to the Joint Commission on Health Care Regarding Coordination Issues in Long-Term Care

Under Option VII, the Joint Commission on Health Care would introduce legislation giving the Secretary of Health and Human Resources specific statutory responsibilities for the coordination of long-term care. The Joint Commission on Health Care may also wish to consider requiring the Secretary of Health and Human Resources to report annually on coordination issues in Long-Term Care. Additionally, the General Assembly may wish to create a position in the Secretary's Office to assist the Secretary in long-term care coordination.

Coordination of Aging Policy

Prior consolidation proposals for long-term care and aging issues have tended to view the two issues as synonymous with respect to coordination of policy. However, the two issues can be viewed as distinct. State long-term care policy is inextricably linked with the Medicaid long-term care program and the state's role as a payor for long-term care services. Many of the individuals who require long-term care services are not aged, but instead require long-term care due to mental or physical disability.

Additionally, agencies primarily involved in long-term care policy are all located within the Health and Human Resources Secretariat. However, the state's aging policy must encompass the majority of seniors who either never require long-term care or require long-term care only episodically and who never receive Medicaid-financed services. Further, responsibility for aging issues is divided among agencies in the Commerce and Trade, Health and Human Resources, Finance, Education, and Transportation Secretariats.

Therefore, aging needs to be considered as a distinct policy arena for state government. In examining ways to improve aging policy and service delivery, one issue that stands out is the need to strengthen the Department for the Aging. A number of individuals interviewed during this study suggested the need to strengthen VDA. In particular, concern has been expressed about the department's staffing, mission, and authority. Moreover, concern has been expressed about the extent to which a state agency can successfully provide advocacy for aging issues and forge the private-public partnerships that will be increasingly important to meeting the needs of older Virginians.

1996 Report of the Secretary of Health and Human Resources Recommended Strengthening the Department for the Aging Education Focus

A 1996 report of the Secretary of Health and Human Resources, House Document 64, recommended strengthening the Department for the Aging's

> focus on educating the public (including individuals, businesses, employers, policy makers, local governments, and elected officials) to increase public awareness of the issues facing an increasing larger older population, and to encourage personal responsibility and the development of policies, programs, services, and products for an aging society.

One challenge that the Department for the Aging faces in playing an increased role in public education and research is the significant staff reduction that the agency has undergone during the past several years. The Agency's maximum employment level (MEL) has been reduced from 33 to 22. Four positions within the department are currently vacant, giving the department 18 active staff. Of these positions, six are clerical or fiscal in nature, leaving only twelve program staff for the department to administer its responsibilities under the Older Americans Act and to conduct public education. To better understand the challenges that VDA is facing, JCHC staff conducted structured interviews with 11 of the department's 18 staff members. In interviews with JCHC staff, VDA staff consistently identified limited staffing and an unclear mission as two of the department's most significant challenges.

At present, it appears that the department's staffing may not be adequate to administer the Older Americans Act, much less assume other functions. In determining an appropriate staffing level for the department, the Governor and General Assembly will need to carefully consider the mission for the department and the extent to which that mission extends beyond administration of the Older Americans Act. The State's aging population has been increasing rapidly, as the department's staffing level has been declining. The continuing increase in the number of older Virginians creates a pressing need for more research, public education, and advocacy with respect to aging issues. There is also a need for aging policy coordination to allow the state to better meet the needs of aging Virginians.

The Department for the Aging is the logical entity to coordinate aging policy for the state. This is a

role best conducted by a state agency, which can serve as a clearing house for information on aging issues and as a facilitator of multi-agency initiatives. VDA is also the logical entity to conduct research and analysis of aging issues for the Commonwealth as well as to conduct public education.

The Governor's Advisory Board on Aging is Not Clearly Defined in Statute

The Governor's Advisory Board on Aging is presently a purely advisory body concerning aging issues implicitly established in § 2.1-373 of the *Code of Virginia* which states "the Governor is authorized to select such persons as may be qualified, as an advisory board, to assist the Department [for the Aging] in the performance of the duties imposed upon it herein." While the board plays a useful role in discussing aging issues, it has not historically been at the forefront of developing aging policy for the Commonwealth.

The General Assembly may wish to consider reconstituting the existing board to more clearly define its authority, responsibilities, and membership. One possible model to consider include the Board of the Virginia Retirement System, which has some members appointed by the Governor and others by the Joint Rules Committee of the General Assembly. This approach has succeeded in making governance of the retirement system a partnership between the executive and legislative branch.

Advocacy for Aging Issues May Be More Appropriate for the Private Sector

State agencies have inherent difficulties in conducting advocacy. A state agency is also not the optimal vehicle for forging the public/private partnerships that will be an increasingly important part of meeting the needs of elderly Virginians. The General Assembly may wish to consider creating a private sector entity such as a foundation or private authority to address the Department for the Aging's advocacy function. This private sector entity could also serve as a catalyst for private-public partnerships on aging issues. Creating a private sector entity to address these issues would allow the Department for the Aging to concentrate on addressing aging issues best handled within the purview of government: administration of the Older Americans Act, service to and technical support of Area Agencies on Aging, research and education on aging issues, and aging policy coordination throughout state government. The private sector entity would have the flexibility and freedom to best conduct advocacy and to forge private-public partnerships.

Policy Options for Aging Issues

The following policy options regarding aging issues are offered for consideration by the Joint Commission on Health Care. These policy options do not represent the universe of alternative directions that the Joint Commission on Health Care may wish to pursue, but they do provide a range of options. These options are not all mutually exclusive. The Joint Commission on Health Care may wish to select several of the options listed below.

Option I: Take No Action

Under Option I, no specific actions would be recommended by the Joint Commission on Health Care to the 1998 Session of the General Assembly.

Option II: Introduce Legislation Designating the Department for the Aging as the Focal Point for Coordination of Aging Policy Among State Agencies.

Under this option, the General Assembly would introduce legislation amending § 2.1-373 of the *Code of Virginia* specifying that the Department for the Aging was responsible for coordinating the Commonwealth's Aging policy. Under this option, it may be necessary to reallocate resources to the department or within the department for purposes of aging policy coordination. The Department for the Aging should also be strengthened to allow it to effectively conduct research into aging issues.

Option III: Request an Independent Review of the Organization and Operation of the Department for the Aging

Under this option, the Joint Commission on Health Care would request an independent review to report to the 1999 General Assembly regarding the organization of the Department for the Aging. Alternately, the Joint Commission on Health Care could direct staff to conduct this review as part of the process of developing the fiscal impact of policy options. Staff could be directed to prepare the report for the 1998 Session of the General Assembly.

Option IV: Create a Private Authority to Serve as a Focal Point for Advocacy on Aging Issues.

Under this option, the Joint Commission on Health Care would introduce legislation creating or advocating a private authority to serve as a focal point for advocacy on aging issues. This authority could be based on the legislation that created the Virginia Health Care Foundation or the Virginia Economic Development Partnership. A private authority to address aging issues could also serve as a focal point for public-private partnerships in delivering aging services to meet the needs of elderly Virginians.

Option V: Introduce Legislation Strengthening the Governor's Advisory Board on Aging and Clarifying the Powers, Duties, and Membership of the Board.

The Governor's advisory board could be reconstituted as a executive-legislative branch partnership to help establish aging policy for the Commonwealth. Under this option the Joint Commission on Health Care would introduce legislation codifying the authority, responsibilities, and membership of the Governor's

Advisory Board. The Joint Commission may wish to consider specifying that a certain number of the members of the newly reconstituted Advisory Board on Aging be appointed by the Joint Rules Committee of the General Assembly (in a manner similar to appointments to the Board of the Virginia Retirement System). The Joint Commission on Health Care may also wish to consider legislation explicitly granting the Advisory Board on Aging a role in developing aging policy and may wish to require annual reports by the Board to the General Assembly.

REMAINING REORGANIZATION ISSUES

This issue brief has not addressed the issue of local service delivery or the purchase of services function at the state level, because these issues are closely related to financing options that may be pursued. The choice of financing policy options would influence local service delivery. Therefore, the General Assembly may wish to consider directing the Joint Commission on Health Care to extend its study of long-term care and aging issues to examine local service delivery and related financing issues.

IV. Licensure of Long-Term Care Facilities, Elder Rights, and Adult Protective Services

One of the key roles of state government is protecting the health, safety, and welfare of vulnerable persons. In the area of long-term care and aging services, the state licenses long-term care facilities. The state also provides funds for long-term care ombudsman services and programs for adult protective services and elder rights. This chapter discusses policy options for improving these services to better meet the needs of all Virginians in need of these services.

Licensure Issues

As noted previously, responsibility for licensure of long-term care facilities is divided between the Department of Health and the Department of Social Services. The Department of Health licenses nursing facilities (as well as certifying them for Medicaid and Medicare) and home health agencies, in addition to licensing acute care facilities. The Department of Social Services licenses adult care residences (formerly known as homes for adults), adult day care, and district homes for the aged.

Prior Reviews of DSS Licensing of Adult Care Residences Raised Concerns

The DSS adult licensing program has been the subject of concern since the Joint Legislative Audit and Review Commission's (JLARC) 1979 *Review of Homes for Adults*. This report raised concerns about DSS licensing staff training, use of sanctions, and uniformity of enforcement. In 1989, the Commission on Health Care for All Virginians directed JLARC to conduct a follow-up to the 1979 study. JLARC's 1990 *Follow-up Review of Homes for Adults in Virginia* also raised concerns about these issues, but concluded that the program should remain with DSS. JLARC's 1997 *Review of Services for Mentally Disabled Residents of Adult Care Residences* expressed concern that DSS enforcement and staff training were not adequate to meet the needs of ACR residents and to ensure compliance with standards. JLARC also raised concerns about the DSS enforcement program and the staffing of the program, citing the department's lack of use of intermediate sanctions and the informal practice of allowing certain facilities to operate with expired licenses due to lack of staff to conduct timely renewal studies.

Concerns Continue To Exist Regarding the DSS Licensing Program, Some Concerns Have Been Expressed Regarding the VDH Nursing Home Survey Process

During this review, JCHC staff identified five factors that raise concern about the organizational placement of the DSS adult licensing program. These are:

- feedback from DSS adult licensing staff, most of whom believe the program should be located elsewhere.

- the significant differences between the children's licensing program and the adult care residence licensing program that make it difficult for DSS staff to administer both programs,

- the compatibility of the adult licensing program with the overall mission of DSS (which increasingly focuses on welfare reform),

- the potential for increased economy and efficiency that would result from locating all long-term care licensure within the same agency, and

- reduction in the number of regulatory agencies with which long-term care providers need to interact.

Aside from the organizational placement of the licensing program, JCHC staff identified concerns regarding the enforcement sanctions available to DSS and the training of DSS staff. DSS has never attempted to use "intermediate sanctions," which would be sanctions such as a monetary fine that are more serious than a provisional license but not as drastic as loss of licensure. JCHC interviews with and surveys of DSS staff also identified concerns with the training received by DSS licensing staff, particularly with regard to mental health and medical issues.

However, some concerns were also identified regarding the Department of Health's licensing program. Representatives of the nursing home industry have expressed concern about VDH's current enforcement approach. A study conducted by DMAS and the University of Virginia's Department of Health Evaluation Sciences of the VDH nursing home survey process identified industry concerns "that the state survey process needed to be more consistent, educational, and outcomes oriented." In addition, the study recommended additional training for both state staff and nursing home staff and a shift to "promoting continuously improving outcomes" through the survey process. Improved communication between state staff and nursing home staff was also recommended, as was an improved process for transferring residents from facilities that lost certification as a result of the survey process.

It is important to emphasize that most of the activities of the VDH certification program for Medicaid and Medicare are driven by regulations promulgated by the U.S. Health Care Financing Administration. While issues of consistency, communication, and training are within the purview of the state to address, the overall survey process and the resulting penalties are matters of federal law and regulation, not state law or regulation.

JCHC staff conducted three major research activities as part of the review of the licensing function.

First, a mail survey questionnaire was administered to all VDH and DSS long-term care licensing staff. Responses were received from approximately 82 percent of VDH staff and approximately 85 percent of DSS staff. Second, JCHC staff observed a nursing home survey and a number of inspections of adult care residences. Third, selected staff within each program were interviewed, as were representatives of the relevant industries.

DSS Staff Expressed Concern About the Licensing Program

As part of the mail survey, long-term care licensing staff from both VDH and DSS were asked to identify the best organizational location for the licensing program in which they worked. Table 3 compares responses to this item from VDH and DSS staff. As can be seen from Table 3, 91 percent of VDH long-term care licensing inspectors responding to the survey indicated that the nursing home licensure and certification program should remain within VDH. By contrast, only 33 percent of DSS adult care licensing specialists responding to the survey indicated that the adult care residence licensing program should remain with DSS. The remaining 67 percent of DSS adult care licensing specialists responding to the survey were divided on whether the program belonged in a separate department (43 percent), VDH (14 percent), or DMHMRSAS (10 percent).

TABLE 3
RESPONSES TO THE ITEM:
WHAT IS THE BEST ORGANIZATIONAL LOCATION FOR THE LICENSING PROGRAM IN WHICH YOU WORK?

Preferred Location	*VDH Staff Responses*	*DSS Staff Responses*
Department of Social Services	N/A	33%
Department of Health	91 %	14%
Separate Department of Licensing	9 %	43%
Other	0%	10%

Source: *JCHC survey of VDH long-term care inspectors and DSS adult program licensing specialists, September 1997.*

A significant number of DSS licensing specialists also expressed concern about whether the DSS licensing program was adequate to protect the health and safety of ACR residents. Thirty-eight percent of DSS licensing specialists disagreed with the statement "the DSS licensing program is adequate to protect the health and safety of ACR residents." By contrast, only 18 percent of health department long-term care inspectors disagreed with the statement, "The VDH long-term care licensing/certification program is adequate to protect the health and safety of nursing facility residents." Table 4 presents these data.

DSS Has Never Imposed Intermediate Sanctions

Regarding enforcement of existing adult care regulations, several DSS licensing staff expressed frustration with the department's inability to use intermediate sanctions. As noted above, intermediate sanctions are sanctions less serious than revocation or denial of licensure, but more serious than placing a facility on a provisional license (the licensing equivalent of probation).

TABLE 4

**RESPONSES TO THE QUESTION:
IS YOUR AGENCY'S LICENSING (OR LICENSING/CERTIFICATION) PROGRAM ADEQUATE TO PROTECT THE HEALTH AND SAFETY OF RESIDENTS?**

Response	*DSS Staff*	*VDH Staff*
Strongly Agree	0%	36%
Agree	57%	45%
No Opinion	5%	0%
Disagree	38%	18%
Strongly Disagree	0%	0%

Source: *JCHC staff survey of DSS adult program licensing staff and VDH long-term care medical facilities inspectors, September 1997*

The *Code of Virginia* currently permits DSS to reduce licensed capacity of a facility, freeze new admissions, or petition to impose a civil charge. However, all of these intermediate sanctions are subject to the same administrative appeal process as a decision to deny or revoke licensure. Therefore, DSS's policy has been to seek denial or revocation of licensure rather than imposing intermediate sanctions. Recognizing that intermediate sanctions may often be more appropriate than closure of a facility, JLARC's recent adult care and child care reports recommended giving the DSS Commissioner unilateral authority to impose monetary fines or other intermediate sanctions in cases of serious licensing violations. Enforcement options to closure of facilities is particularly important for long-term care licensing programs, because of the potential disruption caused by transferring medically frail residents.

DSS Staff Expressed Concern About Training

In addition to concern about the sanctions available, DSS staff expressed concern about training needs. In interviews with JCHC staff, licensing specialists pointed out that the broad nature of the ACR industry required training in mental health, medical, and building code issues, among others. A number of

DSS staff have pursued training on their own such as medication administration training. However, 68 percent of DSS staff responding to the JCHC survey identified additional training needs. The most common needs identified were for medical training (particularly regarding medication), training on mental health issues, and training regarding aging issues.

DSS Licensing Staff Are Also Responsible for Licensure of Child Care Facilities

DSS's Division of Licensing licenses child day care facilities in addition to licensing adult care residences, adult day care, and district homes for the aged. In fact, the majority of DSS licensing specialists are allocated to the children's program. As of July 1, 1997, DSS allocated 49 full-time equivalent employees (FTE) licensing specialists to the children's licensing program and 17 FTE licensing specialists to the adult licensing program. In other words, 74 percent of the DSS licensing specialists are devoted to the children's program.

Additionally, many licensing division staff are required to work in both the children's and the adult licensing program. Forty-five percent of DSS adult program licensing staff responding to the JCHC survey indicated that they also have a caseload in the children's program. This is problematic due to the limited overlap between the two programs and the corresponding requirement that staff learn the regulations and master the technical knowledge associated with two unrelated programs.

Most DSS staff responding to the JCHC survey disagreed with the statement that "the DSS child care licensing program and adult care residence licensing program are closely related and should be carried out by the same agency." Responses to this item are shown in Table 5.

TABLE 5

DSS ADULT LICENSING STAFF RESPONSES TO THE STATEMENT:
THE DSS CHILD CARE LICENSING PROGRAM AND ADULT CARE RESIDENCE LICENSING PROGRAM ARE CLOSELY RELATED AND SHOULD BE CARRIED OUT BY THE SAME AGENCY

Response	*Percentage of Responses*
Strongly Agree	0%
Agree	33%
No Opinion	14%
Disagree	38%
Strongly Disagree	14%

Source: JCHC survey of DSS licensing staff, September 1997.

The Adult Licensing Program Is Not a Core Part of DSS's Mission

The Department of Social Services is the state's lead agency for implementing welfare reform and for addressing child care regulation and financing. The Department's protective services functions (child protective services and adult protective services) are part of its historical mission and are delivered by local social services agencies. Regulation of the adult licensing program, however, is delivered at the state level and is at best a peripheral part of the Department's overall mission. In interviews with JCHC staff, DSS adult program licensing staff frequently indicated that the adult program does not command DSS management attention and is not viewed as an important part of the department's activities.

The statute establishing the DSS licensing program makes the state's interest in protecting the health and safety of residents clear. Section 63.1-174, of the *Code of Virginia* states "The State Board [of Social Services] shall have the authority to promulgate and enforce regulations to carry out the provisions of this article and to protect the health, safety, welfare, and individual rights of residents of adult care residences and promote their highest level of functioning." Past proposals to transfer licensure of ACRs away from DSS have been criticized for failing to recognize the "social model" of DSS regulation and for trying to substitute a "medical model." However, legislative intent for regulation of adult care residents clearly goes beyond a purely social model, in that the *Code of Virginia* clearly directs that the adult licensing program protect the "health, safety, and welfare" of residents. This focus on health and safety issues has only increased with statutory and regulatory changes allowing ACRs to house residents who require assisted living or intensive assisted living services.

Increased Efficiency Potentially Would Result from Consolidation of Licensure

The presence of assisted living and intensive assisted living residents, who require a higher level of care, in ACRs highlights the changing nature of long-term care, where individuals are now cared for in a continuum of settings, rather than either remaining at home or being cared for in a nursing home. In fact, Continuing Care Retirement Communities (CCRCs), which include independent living, assisted living, and nursing home beds is a growing part of the state's long-term care system. CCRC's presently are regulated by both the Department of Health, which regulates the nursing home beds, and the Department of Social Services, which regulates the assisted living beds.

Consolidation of state-level licensure of long-term care facilities would be consistent with the changing nature of long-term care, which emphasizes diversity of long-term care settings, and with the state's policy of establishing a continuum of care for long-term care recipients. Consolidation would also allow for cross-training of staff, providing additional flexibility for two programs which historically have been understaffed. Moreover, a combination of the primarily medical backgrounds of VDH staff members with the primarily social work background of DSS staff members would allow for an improved approach to

regulation that emphasized both a medical and a social model. Just as ACR residents have medical needs that need to be considered in designing a regulatory program, nursing home residents also have social needs that need to be considered. Consolidation of the state's two long-term care licensing programs and associated staff would potentially allow the state to more efficiently and effectively serve the medical and social needs of long-term care residents.

Some Neighboring States Have Consolidated Licensure of Long-Term Care Facilities Into A Single Agency

States such as Oregon and Washington that have created single state agencies for long-term care have consolidated licensure of long-term care facilities into those agencies. Additionally, many Southeastern states have consolidated licensure of long-term care facilities into a single agency. For example, in North Carolina, the Department of Human Resources, Division of Facility Services licenses both nursing homes and adult care residences (in addition to home health agencies). Exhibit 5 shows the agency or agencies responsible for licensure of long-term care facilities in seven Southeastern states.

State	*Agency Licensing Nursing Homes*	*Agency Licensing ACRs (Assisted Living*
Florida	Agency for Health Care Administration	Agency for Health Care Administration
Georgia	Department of Human Resources	Department of Human Resources
Kentucky	Division of Licensing and Regulation	Department of Housing
Maryland	Department of Health and Mental Hygiene	Department of Health and Mental Hygiene
North Carolina	Department of Human Resources	Department of Human Resources
South Carolina	Department of Health and Environmental Control	Department of Health and Environmental Control
Tennessee	Department of Health	Regulations Pending to Require Department of Health to Certify

POLICY OPTIONS FOR LICENSURE ISSUES

The following policy options regarding Long-term Care licensure are offered for consideration by the Joint Commission on Health Care. These policy options do not represent the universe of alternative directions that the Joint Commission on Health Care may wish to pursue, but they do provide a range of options.

OPTION I: TAKE NO ACTION

Under Option I, no specific actions would be recommended by the Joint Commission on Health Care to the 1998 Session of the General Assembly. Option I recognizes the resistance that any proposal for consolidation of long-term care licensure would likely encounter. Option I does not preclude the Commission from directing the staff to conduct further research on consolidation issues.

OPTION II: INTRODUCE LEGISLATION TO CONSOLIDATE LICENSURE OF LONG-TERM CARE FACILITIES WITHIN THE DEPARTMENT OF HEALTH

Option II would involve introducing legislation to consolidate licensure of long-term care facilities within the Virginia Department of Health. Senate Bill 367, introduced by the Joint Commission on Health Care during the 1996 Session of the General Assembly, would serve as a model for this legislation. This option would also involve the Joint Commission on Health Care introducing budget language to provide necessary positions and funding the Department of Health to implement its new responsibilities. The failure of SB 367 to gain the approval of the 1996 Session of the General Assembly suggests that some modification of SB 367 may be necessary to temper the strong opposition of the adult care residence industry to consolidation of licensure within the Department of Health. This could involve modification of the bill to avoid concerns about the imposition of a purely "medical model" on the ACR industry.

OPTION III: INTRODUCE LEGISLATION CREATING A SEPARATE DEPARTMENT OF HEALTH CARE AND LONG-TERM CARE QUALITY IMPROVEMENT

Option III would involve introducing legislation to create a separate Department of Health Care and Long-Term Care Quality Improvement to consolidate all licensure activities for long-term care and acute care (VDH staff point out that if long-term care licensure were removed from VDH, then acute care licensure would need to be removed as well). This agency could focus on outcome oriented continuous improvement in health care delivery. Legislation creating the agency would also need to create a board to promulgate the agency's regulations and to serve as a public forum for health care quality issues in Virginia. Option III would require directing the Secretary of Health and Human Resources to develop an implementation plan for creation of the new agency by a date certain (for example September 1, 1998).

with the agency to begin operation on January 1, 1999. Option III would involve the transfer of 34 FTE from the Department of Health and approximately 20 FTE from the Department of Social Services. However, additional FTE would need to be allocated to the newly created department to conduct the administrative tasks now handled by the licensing programs parent agencies and to provide mental health expertise.

OPTION IV: TAKE NO ACTION WITH REGARD TO CONSOLIDATION OF LICENSURE, BUT ADDRESS CONCERNS RELATED TO THE EXISTING LICENSING PROGRAMS

Under this option, the Joint Commission on Health Care would, under this option, introduce legislation granting the DSS Commissioner enhanced enforcement authority for licensing programs, such as the ability to impose intermediate sanctions without administrative appeals (appeals to circuit court would be permitted). This aspect of the legislation might be modeled on legislation approved by the 1996 General Assembly that gave the DEQ director unilateral civil penalty authority in cases of severe environmental violations. The Joint Commission on Health Care would also introduce legislation requiring DSS to contract with the Department of Health and the DMHMRSAS to assist in licensure of ACRs with assisted living residents (Department of Health) or a preponderance of residents presenting mental health or mental retardation diagnoses. Under this option, the Joint Commission on Health Care may also wish to introduce budget language directing DSS to identify training and staffing needs for the licensing program. Finally, the Joint Commission on Health Care would introduce a joint resolution requesting that VDH report to the 1999 General Assembly on its implementation of recommendations made by the DMAS/UVA review of the nursing home survey process.

It is noted that this option would not address a number of concerns about licensure, including fragmentation of licensure and the limited overlap between the ACR licensing program and the mission of DSS. Further, this option would not achieve the potential economies and efficiencies that could be realized from consolidation of licensure.

OPTION V: MOVE LICENSURE OF ADULT CARE RESIDENTS WITH RESIDENTS ASSESSED AS REQUIRING ASSISTED LIVING TO THE DEPARTMENT OF HEALTH AND REQUIRE THE DEPARTMENT OF HEALTH TO SUBCONTRACT WITH DMHMRSAS TO LICENSE FACILITIES WITH A PREPONDERANCE OF RESIDENTS PRESENTING MENTAL HEALTH OR MENTAL RETARDATION DIAGNOSES.

Under this option, the Joint Commission on Health Care would introduce legislation placing responsibility with the Department of Health for licensure of adult care residences with residents assessed as requiring regular assisted living or intensive assisted living services. The legislation would also require that the Department of Health subcontract with the Department of Mental Health, Mental Retardation, and Substance Abuse Services to provide assistance with licensure of facilities with a preponderance of resi-

dents presenting mental health or mental retardation diagnoses. The Joint Commission on Health Care would also introduce budget language to provide necessary positions and funding the Department of Health to implement its new responsibilities.

ELDER RIGHTS AND PROTECTIVE SERVICES ISSUES

Virginia's state system for protecting the rights of the elderly consists of four main elements:

- adult protective services within local departments of social services:
- the state long-term care ombudsman program, managed by the Virginia Association of Area Agencies on Aging (VAAAA);
- local long-term care ombudsman programs offered by Area Agencies on Aging; and
- the elder rights program within the Department for the Aging.

The *Code of Virginia* Presently Permits, But Does Not Explicitly Establish An Adult Protective Services Function for Social Services

One important structural issue related to aging issues concerns the adult protective services function. Adult protective services is a function of local departments of social services, who investigate complaints of the abuse, neglect, or exploitation of adults, including seniors. While this program is operating statewide, the program does not have a sufficient basis in statute. The *Code of Virginia* has not established a unit within the Department of Social Services to manage the adult protective services program (this is presently accomplished by the DSS adult services unit). In addition, the General Assembly has not created a central registry of adult abuse and neglect cases in the Commonwealth, though there is a central registry of child abuse and neglect cases. This is in contrast with the child protective services program, which is established in statute.

The only current statutory provision for adult protective services is found in Section 63.1-55.1, which states:

> Each local board, to the extent that federal or state matching funds are made available to each locality, shall provide, subject to supervision of the Commissioner and in accordance with rules prescribed by the State Board, protective services for persons who by reason of advanced age, impaired health, or physical disability cannot, unaided, take care of themselves or their affairs

and have no relative or other person able, available and willing to provide guidance, supervision or other needed care and for persons sixty years of age and older who are abused, neglected or exploited. The requirement to provide such services shall not limit the right of any individual to refuse to accept any of the services so offered, except as provided in §63.1-55.5.

A statute establishing an adult protective services program could be modeled on the statute establishing the child protective services program. It is important to emphasize that this would not be adding a new program, simply codifying and strengthening an existing program and emphasizing its importance within DSS and local departments of social services.

The State Ombudsman Program is Currently Conducted by the Private Sector (VAAAA), But the Elder Rights Function Remains Within State Government

The state long-term care ombudsman program is now carried out by VAAAA. The General Assembly directed the Department for the Aging to contract with VAAAA to administer the state ombudsman program. The purpose of the long-term care ombudsman program is to provide advocacy on behalf of long-term care residents. The state ombudsman program helps coordinate the efforts of long-term care ombudsman statewide and provides coverage in the 40 percent of the state that is not currently covered by a local ombudsman program.

According to most who are involved with ombudsman program, privatization of the program has been a success. One concern, however, involves the program being housed in a different organizational location from the elder rights program, which remains within the Department for the Aging. The elder rights program provides advocacy services for all seniors, not just persons in long-term care settings. The ombudsman and elder rights programs can be viewed as complementary programs, and they may benefit from being housed within the same entity. One of the rationales for moving the ombudsman program to the private sector was the belief that the functions of the program could best be implemented outside of government. This same logic may also apply to the elder rights program. Therefore, the General Assembly may wish to consider transferring responsibility for the elder rights program to VAAAA. VAAAA would then manage both the elder rights program and the state long-term care ombudsman program.

Significant Portions of the State Lack Ombudsman Coverage

At present, 60 percent of the state's jurisdictions are covered by ombudsman services provided through Area Agencies on Aging. The remaining 40 percent of the state receives ombudsman services from the Office of the State Ombudsman, located in VAAAA. However, the state ombudsman's office has only two staff members and is not sufficient to provide ombudsman services to 40 percent of the state, in addition to the duties of administering the overall ombudsman program. The General Assembly may wish to consider providing funding to extend the ombudsman program statewide.

Policy Options for Elder Rights and Protective Services

The following policy options do not represent the entire universe of options that the Joint Commission on Health Care may decide to pursue with regard to elder rights and protective service issues. Options II through IV are not mutually exclusive: the Joint Commission on Health Care could choose to implement any or all of these policy options.

Option I: Take No Action.

Under this option, the Joint Commission on Health Care would take no action during the 1998 Session of the General Assembly regarding elder rights and protective services issues.

Option II: Introduce Legislation Codifying the Adult Protective Services Function

Under this option, the Joint Commission on Health Care would introduce legislation codifying the adult protective services function. This legislation could be modeled on the legislation establishing the child protective services function.

Option III: Privatize the Elder Rights Program by Moving Responsibility and Funding for the Program from the Department for the Aging to the Virginia Association of Area Agencies on Aging.

Under this option, the Joint Commission on Health Care would introduce legislation and/or budget language transferring responsibility for the Elder Rights program from the Department for the Aging to the Virginia Association of Area Agencies on Aging.

Option IV: Introduce a Budget Amendment Providing $180,000 (General Funds) to Provide Statewide Coverage for the Long-Term Care Ombudsman Program.

Under this option, the Joint Commission on Health Care would introduce a budget amendment providing $180,000 to extend coverage for the long-term care ombudsman program statewide. The Joint Commission on Health Care may also wish to consider introducing a budget amendment expanding the case management program through Area Agencies on Aging statewide. The estimated cost of this expansion would be $2.8 million.

V. APPENDICES

APPENDIX A

SENATE JOINT RESOLUTION NO. 316

g the Joint Commission on Health Care to establish a task force to address outstanding long-term care and aging

Agreed to by the Senate, February 17, 1997
Agreed to by the House of Delegates, February 13, 1997

WHEREAS, consistent with national trends, the Commonwealth's population is aging; and

WHEREAS, over the next decade, the Commonwealth's elderly population is expected to increase four times as rapidly as the general population; and

WHEREAS, the provision and financing of long-term care services to the elderly and chronically disabled populations is one of the most important public policy issues facing the Commonwealth; and

WHEREAS, it is important for federal, state, and local government long-term care policy regarding the provision and financing of services to recognize both the health care and social needs of the elderly and chronically disabled; and

WHEREAS, the ultimate goal of the long-term care system is to maintain the functional status of the elderly and chronically disabled populations; and

WHEREAS, long-term care and aging services should be delivered in the communities where the elderly and their families live; and

WHEREAS, the Commonwealth's policy for long-term care, as adopted by the 1993 General Assembly through House Joint Resolution No. 602, is to provide service to elderly individuals with programs and in settings which maximize their ability to function as independently as possible and which encourage the principles of personal dignity, a decent quality of life, individuality, privacy, and the right to make choices; and

W AS, respite care is one method used to enable persons to stay in home settings and to avoid restrictive care as long as r e; and

WHEREAS, respite care works both for the client and the family by providing care, variety of schedule, and recreation; and

WHEREAS, respite care allows family and home caregivers to locate their loved ones in appropriate facilities for short periods of time when the caregivers cannot provide regular care; and

WHEREAS, respite care is being provided in a variety of long-term care settings; and

WHEREAS, long-term care insurance products are varied in what portions in the continuum of long-term care they cover; and

WHEREAS, the number of companies offering long-term care insurance and the number of policies sold continues to increase at a rapid rate, and such policies recently received favorable tax treatment from the 1996 "Kennedy-Kassebaum" health care reform bill; and

WHEREAS, long-term health care delivery has evolved and is now being provided in nursing facilities, assisted living facilities, and continuing care retirement communities; and

WHEREAS, regulatory provisions governing the construction and funding of long-term care beds must be designed to promote efficient and economic operation of these beds; and

WHEREAS, the complexity of the financing streams for long-term care services requires a careful and thorough analysis to ensure appropriate federal, state, and local government financing policy; and

WHEREAS, other states and the federal government are actively seeking ways to optimize the use of public funds to serve the growing elderly population; and

W EAS, a growing number of states are planning or implementing risk-based managed care programs for adults who are el. for both Medicaid and Medicare; and

WHEREAS, the recently established Pre-PACE site in Virginia is a program which fully integrates the use of health care and long-term care dollars, provides a comprehensive package of services to persons living in the community, provides incentives for quality and cost control, and provides a service delivery model that may be applicable to other elderly, chronically ill, and younger populations; and

WHEREAS, any changes in the long-term care and aging service delivery systems should be accomplished in a manner that maximizes the efficiency and effectiveness of the existing system and should not shift costs to localities or require any unfunded mandates for localities; and

WHEREAS, two proposals have been recommended to consolidate and restructure certain functions of the various state agencies currently involved in planning, administering, managing, regulating, licensing and funding long-term care and aging services, and neither proposal has been implemented; and

WHEREAS, the lack of a centralized locus of responsibility has hindered Virginia's progress in long-term care service development; and

WHEREAS, consolidation of the acute and long-term care delivery system holds much promise in serving the elderly and disabled, but requires significant role differentiation among various public and private service providers at the local level; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Joint Commission on Health Care be directed to establish a task force to address outstanding long-term care and aging issues pertaining to the licensing, financing, organization, and regulation of long-term care facilities and community-based services. In addition, the joint commission shall include in its deliberations study of additional ancillary long-term care issues such as the availability of and funding for respite care and the consistency to which long-term care insurance policies currently being offered in the Commonwealth meet the various needs of its citizens.

The joint commission's task force shall conduct its study in cooperation with the Secretary of Health and Human Resources; various state agencies, including the Department of Medical Assistance Services, the Department for the Aging, the State Department of Health, and the Department of Social Services; local governments; various long-term care and aging consumer and provider organizations; and other affected stakeholders.

An estimated $125,000 is allocated for the cost of staff or consultant support. Such expenses shall be funded by a separate appropriation by the General Assembly.

The Joint Commission on Health Care shall submit its findings and recommendations to the Governor and the 1998 Session of the General Assembly in accordance with the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

HOUSE JOINT RESOLUTION NO. 655

ecting the Joint Commission on Health Care to establish a task force to address outstanding long-term care and aging .sues.

Agreed to by the House of Delegates, February 20, 1997
Agreed to by the Senate, February 19, 1997

WHEREAS, consistent with national trends, the Commonwealth's population is aging; and

WHEREAS, over the next decade, the Commonwealth's elderly population is expected to increase four times as rapidly as the general population; and

WHEREAS, the provision and financing of long-term care services to the elderly and chronically disabled populations is one of the most important public policy issues facing the Commonwealth; and

WHEREAS, it is important for federal, state, and local government long-term care policy regarding the provision and financing of services to recognize both the health care and social needs of the elderly and chronically disabled; and

WHEREAS, the ultimate goal of the long-term care system is to maintain the functional status of the elderly and chronically disabled populations; and

WHEREAS, long-term care and aging services should be delivered in the communities where the elder'y and their families live; and

WHEREAS, the Commonwealth's policy for long-term care, as adopted by House Joint Resolution No. 602 (1993), is to provide service to elderly individuals with programs and in settings which maximize their ability to function as independently as possible and which encourage the principles of personal dignity, a decent quality of life, individuality, privacy, and the right to make choices; and

IEREAS, respite care is one method used to enable persons to stay in home settings and to avoid restrictive care as long as ;sible; and

WHEREAS, respite care works both for the client and the family by providing care, variety of schedule, and recreation; and

WHEREAS, respite care allows family and home caregivers to locate their loved ones in appropriate facilities for short periods of time when the caregivers cannot provide regular care; and

WHEREAS, respite care is being provided in a variety of long-term care settings; and

WHEREAS, long-term care insurance products are varied in what portions in the continuum of long-term care they cover; and

WHEREAS, the number of companies offering long-term care insurance and the number of policies sold continues to increase at a rapid rate, and such policies recently received favorable tax treatment from the 1996 "Kennedy-Kassebaum" health care reform bill; and

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WHEREAS, the complexity of the financing streams for long-term care services requires a careful and thorough analysis to ensure appropriate federal, state, and local government financing policy; and

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WHEREAS, any changes in the long-term care and aging service delivery systems should be accomplished in a manner that maximizes the efficiency and effectiveness of the existing system and should not shift costs to localities or require any unfunded mandates for localities; and

WHEREAS, two proposals have been recommended to consolidate and restructure certain functions of the various state agencies currently involved in planning, administering, managing, regulating, licensing and funding long-term care and aging services, and neither proposal has been implemented; and

WHEREAS, the lack of a centralized locus of responsibility has hindered Virginia's progress in long-term care service development; and

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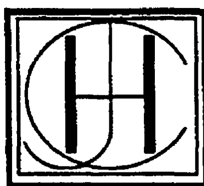
The Commission's task force shall conduct its study in cooperation with the Secretary of Health and Human Resources; various state agencies, including the Department of Medical Assistance Services, the Department for the Aging, the State Department of Health, and the Department of Social Services; local governments; various long-term care and aging consumer and provider organizations; and other affected stakeholders.

An estimated $125,000 is allocated for the cost of staff or consultant support. Such expenses shall be funded by a separate appropriation by the General Assembly.

The Joint Commission on Health Care shall submit its findings and recommendations to the Governor and the 1998 Session of the General Assembly in accordance with the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

APPENDIX B



Joint Commission on Health Care

Summary of Public Comments: Long-Term Care / Aging Study Phase II Report

Individuals/Organizations Submitting Comments

A total of 33 individuals and organizations submitted original comments in response to the Phase II Issue Brief. In addition, approximately 375 employees of local departments of social services submitted form letter comments on the study.

American Association of Retired Persons

Arlington County Department of Human Services

Capital Area Agency on Aging

Central Virginia Area Agency on Aging

Department of Mental Health, Mental Retardation, and Substance Abuse Services

Mrs. Shirley H. Gary

Governor's Advisory Board on Aging/ Department for the Aging

Health Insurance Association of America

LOA Area Agency on Aging

LOA Area-Agency on Aging/New River Valley Agency on Aging Ombudsman Program

New River Valley Agency on Aging

Norfolk Long-Term Care/Commission on Aging

Northern Virginia Long-Term Care Ombudsman Program

Northern Virginia Aging Network

Portsmouth Task Force on Aging

Richmond Korean Senior Citizens Association

Ripening to Vintage Fund of Alexandria, inc.

Senior Services of Southeastern Virginia

Shenandoah Area Agency on Aging

Southern Area Agency on Aging

Valley Program for Aging Services, Inc.

Virginia Adult Home Association

Virginia Assisted Living Association

Virginia Association of Area Agencies on Aging

Virginia Association of Area Agencies on Aging, Office of the State Ombudsman

Virginia Association of Nonprofit Homes for the Aging

Virginia Association of Regional Health Planning Agencies

Virginia Coalition for the Aging

Virginia Department of Social Services

Virginia Health Care Association

Virginia Hospital and Healthcare Association

Virginia League of Social Services Executives

Mr. James G. Watkins

POLICY OPTIONS INCLUDED IN PHASE II ISSUE BRIEF

POLICY OPTIONS ON OVERALL CONSOLIDATION

Option I: .... **Take No Action**

Option II: .... **Introduce Legislation Creating a Consolidated Agency for Long-Term Care and Aging Services.**

Policy Options for Long-Term Care Financing/Coordination

Option I: .... **Take No Action**

Option II: .... **Direct Staff to Offer any Needed Assistance to the Workforce Commission in Its Deliberations on Establishing a Program to Offer State Employees Long-Term Care Insurance as an Optional Employee Benefit.**

Option III: .... **Introduce a Joint Resolution Requesting the Virginia Retirement System to Study the Feasibility of Offering a Long-Term Care Insurance Option as a Rider to the State's Existing Group Life and/or Optional Group Life Program for State and Local Employees.**

Option IV: .... **Introduce a Joint Resolution Requesting the Secretary of Finance, in Cooperation with the Secretary of Health and Human Resources, to Conduct a Cost-Benefit Analysis of the Costs and Benefits Associated With a Tax Credit for the Purchase of Long-Term Care Insurance.**

Option V: .... **Introduce Legislation Designating DMAS as the Lead Agency for Long-Term Care Financing and Development of Long-Term Care Financing Policy. Direct DMAS, In Consultation with Appropriate State Agencies (Including VDA), to Prepare a Five-Year Plan for Financing Long-Term Care Services in the Commonwealth. The Plan Should Identify Additional Strategies for Blending Medicaid and Medicare for Dually Eligible Individuals and for Managed Long-Term Care.**

Option VI: .... **Eliminate the Statutory Provision that the Department for the Aging is Responsible for Coordinating Long-Term Care.**

Option VII: .... Introduce Legislation Requiring the Secretary of Health and Human Resources to Coordinate Long-Term Care Policy and to Report Annually to the Joint Commission on Health Care Regarding Coordination Issues in Long-Term Care.

Policy Options for Aging Policy

Option I: .... Take No Action

Option II: .... Introduce Legislation Designating the Department for the Aging as the Focal Point for Coordination of Aging Policy Among State Agencies.

Option III: .... Request an Independent Review of the Organization and Operation of the Department for the Aging.

Option IV: .... Create a Private Authority to Serve as a Fc cal Point for Advocacy on Aging Issues.

Option V: .... Introduce Legislation Strengthening the Governor's Advisory Board on Aging and Clarifying the Powers, Duties, and Membership of the Board.

Policy Options for Licensure

Option I: .... Take No Action

Option II: .... Introduce Legislation to Consolidate Licensure of Long-Term Care Facilities Within the Department of Health

Option III: .... Introduce Legislation Creating a Separate Department of Health Care and Long-Term Care Quality Improvement.

Option IV: .... Take No Action with Regard to Consolidation of Licensure, but Address Concerns Related to the Existing Licensing Program.

Option V: .... Move Licensure of Adult Care Residences with Residents Assessed as Requiring Assisted Living to the Department of Health and Require the Department of Health to Subcontract With DMHMRSAS to License Facilities with a Preponderance of Residents Presenting Mental Health or Mental Retardation Diagnoses.

POLICY OPTIONS FOR ELDER RIGHTS AND PROTECTIVE SERVICES

Option I: .... **Take No Action**

Option II: .... **Introduce Legislation Codifying the Adult Protective Services Function**

Option III: .... **Privatize the Elder Rights Program by Moving Responsibility and Funding for the Program from the Department for the Aging to the Virginia Association of Area Agencies on Aging.**

Option IV: .... **Introduce a Budget Amendment Providing $180,000 (general funds) to Provide Statewide Coverage for the Long-Term Care Ombudsman Program.**

OVERALL SUMMARY OF PUBLIC COMMENTS

OVERALL CONSOLIDATION

Most commenters who addressed this issue supported Option I. Commenters supporting Option I included the Virginia Association of Area Agencies on Aging, the Virginia Coalition for the Aging, the Virginia Hospital and Healthcare Association, the Virginia Health Care Association, the LOA Area Agency on Aging, the Capital Area on Aging, the Central Virginia Area Agency on Aging, the New River Valley Agency on Aging, Senior Services of Southeastern Virginia, the Valley Program for Aging Services, the Southern Area Agency on Aging, the Portsmouth Aging Task Force, the Hampton Roads Legislative Advocacy Network, the Norfolk Long-Term Care/Commission on Aging, and the Adult Services Program of the Department of Social Services. Three commenters supported Option II. These were: the Virginia Association of Non-Profit Homes for the Aging (which specified the agency proposed by HB 1267/SB 575), the Ripening to Vintage Fund, Inc., and the Northern Virginia Aging Network (NVAN). NVAN supported Option II "in theory" but acknowledged difficulties in implementing it.

LONG-TERM CARE FINANCING AND COORDINATION

Options II, III, and IV, concerning long-term care insurance, were addressed jointly by most commenters who addressed these issues. Most of these commenters supported all three of these options. Option II was supported by 17 commenters, Option II was supported by 18 commenters, and Option IV was supported by 19 commenters. Commenters who supported all three options included: the Virginia Health Care Association, the Virginia Hospital and Healthcare Association, the American Association of Retired Persons (AARP), the Virginia Association of Area Agencies on Aging (V4A), the Virginia Coalition

for the Aging, the Virginia Association of Non-Profit Homes for the Aging, the Department for the Aging, the Governor's Advisory Board on Aging, the Capital Area Agency on Aging, the Central Virginia Area Agency on Aging, the New River Valley Agency on Aging, the Southern Area Agency on Aging, the Valley Program for Aging Services, and Senior Services of Southeastern Virginia. The Hampton Roads Legislative Advocacy Network supported Options II and IV. The Portsmouth Task Force on Aging supported Options III and IV. The Arlington County Department of Human Services supported Option III. The Norfolk Long Term Care/ Commission on Aging supported Option IV. NVAN supported Options II, III, and IV with the strong caveat that the General Assembly needed to address consumer protection issues with regard to long-term care insurance.

Regarding Option V, two commenters, the Virginia Health Care Association and AARP, supported the option as written. A number of commenters supported Option V with various wording changes. These commenters were: V4A, the Virginia Coalition for the Aging, the Hampton Roads Legislative Advocacy Network, the Arlington Department of Human Services, and six Area Agencies on Aging. The Norfolk Long-Term Care/Commission on Aging opposed Option V.

Option VI was supported by eight commenters: V4A, the New River Valley Agency on Aging, the Capital Area Agency on Aging, the Southern Area Agency on Aging, the Valley Program for Aging Services, the Virginia Coalition for the Aging, AARP, and the Arlington Department of Human Services.

Option VII was supported by four commenters: AARP, the Portsmouth Task Force on Aging, the Department for the Aging, and the Governor's Advisory Board on Aging. The Virginia Coalition for the Aging, V4A, and six Area Agencies on Aging supported Option VII with wording changes. The Norfolk Long-Term Care/Commission on Aging supported Option VII with an emphasis on local coordination.

The Virginia Hospital and Healthcare Association supported the concepts of Options V and VII but felt that legislation in these areas for 1998 would be premature, as a consensus did not yet exist. The Adult Services Program of the Department of Social Services supported Options III, IV, VI, and VII.

Policy Options on Aging Issues

Option I was supported by the Virginia Health Care Association. Option II was supported by the following commenters: V4A, the Virginia Coalition for the Aging, AARP, five Area Agencies on Aging, the Virginia Association of Nonprofit Homes for the Aging, the Hampton Roads Legislative Advocacy Network, the Department for the Aging, the Virginia Hospital and Healthcare Association, and the Governor's Advisory Board on Aging.

Option III was supported by V4A, the Virginia Coalition for the Aging, AARP, five Area Agencies on Aging, the Arlington County Department of Human Services, the Virginia Association of Nonprofit Homes for the Aging, and the Norfolk Long-Term Care/Commission on Aging. Several commenters suggested that this review be completed for the 1998 rather than the 1999 General Assembly.

Option IV was supported by two commenters: Senior Services of Southeastern Virginia and the Hampton Roads Legislative Advocacy Network. Several other commenters expressed general support for the idea but stated it required further study.

Option V was supported by: V4A, the Virginia Coalition for the Aging, seven Area Agencies on Aging, AARP, the Virginia Association of Non-Profit Homes for the Aging, the Hampton Roads Legislative Advocacy Network, the Adult Services Program of the Department of Social Services, the Department for the Aging, and the Governor's Advisory Board on Aging. AARP suggested that, under Option V, the General Assembly create an independent policy making Board on Aging to oversee the Department for the Aging, which would become an independent agency.

POLICY OPTIONS FOR LICENSURE

There was no clear consensus among the parties submitting public comments regarding policy options for licensure. Option I was supported by the Arlington County Department of Human Services. Option I was also supported by the Virginia Hospital and Healthcare Association, which noted that Option II was a reasonable basis for further discussion. Option II was supported by AARP, the Virginia Association of Regional Health Planning Agencies, and Senior Services of Southeastern Virginia. Option II was opposed by the Virginia Assisted Living Association and the Virginia Association of Homes for Adults. Option III was supported by V4A, NVAN, the Office of the State Ombudsman, two local Ombudsman programs, the Virginia Coalition for the Aging, and six Area Agencies on Aging. Most of these commenters emphasized the need for intermediate sanctions for licensure. Option III was opposed by Senior Services of Southeastern Virginia. The Virginia Assisted Living Association (VALA) indicated that more details on the implementation of Option III were necessary before it could take a position on this option. Option IV was supported by the Virginia Assisted Living Association, the Virginia Health Care Association, the Virginia Association of Non-profit Homes for the Aging, the Norfolk Long-Term Care/Commission on Aging, and the Portsmouth Task Force on Aging. Option V was not supported by any of the public comments.

The Virginia Association of Homes for Adults (VAHA) did not support any of the policy options for licensure listed in the draft issue brief. Instead, VAHA suggested "giv[ing] the Commonwealth of Virginia the authority to contract with willing and capable adult care residences to care for those frail adults whose

levels of ADLS, physical, and mental disabilities place them outside of the population we are permitted to serve at present."

POLICY OPTIONS FOR ELDER RIGHTS/PROTECTIVE SERVICES ISSUES

Option I was supported by the Virginia Health Care Association. Options II, III, and IV received relatively broad support in the public comment. All three of these options were supported by: V4A, eight Area Agencies on Aging, AARP, the Northern Virginia Aging Network, the Richmond Korean Senior Citizens Association, the Office of the State Ombudsman, two local ombudsman programs, the Adult Services Program of the Department of Social Services, and the Arlington County Department of Human Services. Several of these commenters suggested that the Commission consider the "Guardianship of Last Resort Program" and its potential as a statewide system.

The Virginia League of Social Services Executives, the Adult Services Program of the Department of Social Services, and more than 375 local social services employees supported Option II, codifying adult protective services, but cautioned against creation of a central registry. These commenters suggested enhanced use of the Uniform Assessment Instrument in lieu of creation of a central registry. The Virginia Association of Non-Profit Homes for the Aging also supported Option II.

The Department for the Aging and the Governor's Advisory Board on Aging opposed Option III was written but indicated flexibility regarding contracting out specific aspects of the program while retaining overall responsibility for it.

Option IV was supported by the Virginia Association of Nonprofit Homes for the Aging and the Virginia Association of Regional Health Planning Agencies. Several commenters also recommended expanding Option IV to include funding statewide access to the Case Management program offered through the Area Agencies on Aging.

The Adult Services Program of the Department of Social Services supported Options III and IV.

OTHER COMMENTS

Mr. Jim Watkins, an adult care residence operator, wrote in support of the voucher proposal described in the draft issue brief, suggesting that this proposal could save $100 million per year, by his calculations, by transferring nursing home residents to assisted living settings. Mr. Watkins stated, "I favor being licensed by the Health Department or under a consolidated agency if and only if the playing field is

leveled between Nursing Homes and Intensive Assisted Living." He further noted that "a voucher system will decrease the amount of regulation required in both Intensive Assisted Living and Nursing Homes. This will foster competition and increase the quality of care from all facilities because they will have to compete for residents." Mr. Watkins suggested that implementing the voucher system would require a minimum reimbursement level of $900 for Level I, $1,250 for Level II, and $1,500 for Level II (b). Mr. Watkins also expressed concern about the Department of Social Services' position against locked wings on Alzheimer's units within facilities licensed as adult care residences.

With regard to the issue brief's discussion of the Boren Amendment repeal and the voucher proposal, the Virginia Hospital and Healthcare Association offered the general comment that "the focus should be not on using the lowest cost long-term care setting but on selecting the most appropriate setting to meet the needs of the long-term care population."

Mrs. Shirley Gary, the daughter of a nursing home resident, commented on the need for regulations concerning staffing ratios within nursing homes. Mrs. Gary's letter included the signature of five other citizens concerned about this issue.

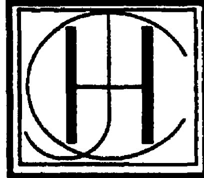
The Health Insurance Association of America (HIAA) provided a document outlining HIAA's "principles for a shared public-private responsibility for financing long-term care." HIAA supported efforts by the state to educate consumers about the need for long-term care insurance and to promote purchase of long-term care insurance.

The acting Commissioner of the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) commented that it would be more accurate to state that Community Services Boards provide an array of community based services and supports to individuals with mental disabilities and substance abuse dependence with public funds provided by the department and local governments as well as other revenues and client fees. DMHMRSAS also commented that it supports improving the Uniform Assessment Instrument (UAI) to better assess the needs of individuals with mental disabilities. DMHMRSAS also supported greater involvement by the department in the licensure of adult care residences that accept persons with mental disabilities. However, the department cautioned that Options IV and V under licensure would have budgetary implications for the department that need to be explored.

The program manager for the Adult Services program of the Virginia Department of Social Services, offered several suggested wording changes to the draft issue brief regarding preadmission screening, auxiliary grants, case management, and the uniform assessment instrument.

The Virginia Association of Homes for Adults (VAHA) supported continued training of licensing specialists in ACR settings, continued funding of any new regulations by the state, adjusting the existing regulations according to size of the facility. VAHA also opposed monetary fines for licensing violations.

NVAN supported creation of a seamless system for elder rights and endorsed the concept of an Elder Rights hotline that is currently under study. NVAN also emphasized the need for flexibility in articulating the Department for the Aging's mission.



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