REPORT OF THE
JOINT COMMISSION ON HEALTH CARE

STUDY OF LONG-TERM CARE ISSUES PURSUANT TO HJR 156/SJR 97

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

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Preface

Senate Joint Resolution (SJR) 97 and House Joint Resolution (HJR) 156 of the 1998 Session of the General Assembly directed the Joint Commission on Health Care to examine a number of long-term care issues. These include several long-term care licensure, certification, and financing issues. Specifically, the Joint Commission on Health Care was requested to examine: (i) long-term care licensure and improvements in existing agencies; (ii) the feasibility of and necessity for a separate Department of Health Care Quality; (iii) the advantages and disadvantages of "deemed status" where accreditation is accepted in lieu of state licensure or federal certification; (iv) long-term care financing strategies, including long-term care insurance, blending Medicaid and Medicare for dually-eligible individuals, and creative use of Medicaid waivers; (v) strategies for increasing the number of graduates of Virginia medical schools who specialize in geriatric medicine; and (vi) other issues as may seem appropriate.

Based on our research and analysis during this review, we concluded the following:

- long-term care services in Virginia, including waiver services such as personal care, nursing facilities, and adult care residences need additional funding in order to allow providers to attract quality staff, particularly at the nursing assistant level;

- deemed status for long-term care licensure offers one potential option for improving the licensure process, though deemed status for federal certification for nursing facilities is not likely to be allowed by the federal government in the near term;

- additional staffing is needed at both the Department of Health and the Department of Social Services to improve long-term care licensure and certification; additional training is also needed for DSS licensing staff;

- Virginia faces a significant shortage of geriatric medicine specialists that needs to be addressed at each of Virginia's medical schools. State funding for additional academic geriatricians may well be required, due to the low level of Medicare reimbursement for geriatric medical care.

A number of policy options were offered for consideration by the Joint Commission on Health Care regarding the issues discussed in this report. Sets of policy options related to various long-term care issues addressed in this study are listed at the conclusion of each major section of the report.

Our review process on this topic included an initial staff briefing, which comprises the body of this report. This was followed by a public comment period during which time interested parties forwarded written comments to us regarding the report. The public comments received, which are provided in Appendix B, provide additional insight into the various issues covered in this report.

On behalf of the Joint Commission on Health Care and its staff, I would like to thank the staff of the Virginia Department of Health, the Department of Medical Assistance Services, and the Department of Social Services for their assistance during this study. I would also like to thank the Virginia Adult Home Association, the Virginia Association for Home Care, the Virginia Association of Area Agencies on Aging, the Virginia Association of Nonprofit Homes for the Aging, the Virginia Health Care Association, and the Virginia Hospital and Health Care Association for their assistance.

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Executive Director

February 3, 1999

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Authority for the Study

Senate Joint Resolution (SJR) 97 and House Joint Resolution (HJR) 156 of the 1998 Session of the General Assembly directed the Joint Commission on Health Care to examine a number of long-term care issues. These include several long-term care licensure, certification, and financing issues. Specifically, the Joint Commission on Health Care was requested to examine: (i) long-term care licensure and improvements in existing agencies; (ii) the feasibility of and necessity for a separate Department of Health Care Quality; (iii) the advantages and disadvantages of "deemed status" where accreditation is accepted in lieu of state licensure or federal certification; (iv) long-term care financing strategies, including long-term care insurance, blending Medicaid and Medicare for dually-eligible individuals, and creative use of Medicaid waivers; (v) strategies for increasing the number of graduates of Virginia medical schools who specialize in geriatric medicine; and (vi) other issues as may seem appropriate.

Chapter One examines the first three issues identified by SJR 97 and HJR 156. These are improvements in existing agencies, the feasibility of and necessity for a separate Department of Health Care Quality, and the advantages and disadvantages of deemed status.

Chapter Two examines long-term care financing issues, concentrating on care in nursing facilities and adult care residences. This chapter also examines means for increasing the number of graduates of Virginia medical schools who specialize in geriatric issues.

II.
Introduction

Chapter One Outline

This chapter is divided into five sections. The first section discussed the authority for the study. This section has provided a general overview of long-term care licensure in Virginia as well as past legislative action and previous studies. The third section discusses the potential advantages and disadvantages of deemed status for long-term care facilities. The fourth section discusses the need for and feasibility of a separate Department of Health Care Quality. The fifth section discusses other policy options for improving long-term care licensure in existing agencies.

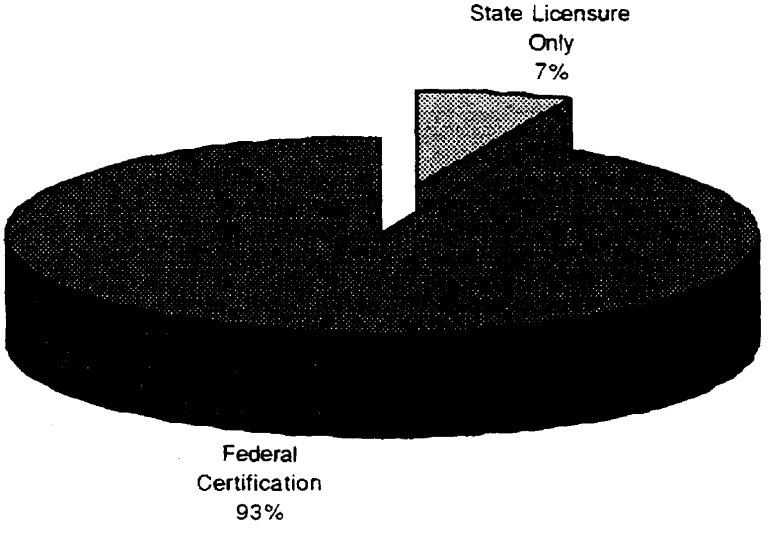
Long-Term Care Licensure in Virginia Is Split Between Two Agencies

Long-term care licensure in Virginia is a shared responsibility between two agencies. The Department of Social Services licenses adult care residences (ACRs), adult day care centers, and district homes for the aged. The Virginia Department of Health (VDH) licenses nursing homes, home health agencies, as well as hospitals, hospices, and ambulatory surgery centers. VDH also certifies nursing homes on behalf of the U.S. Health Care Financing Administration (HCFA) for participation in Medicare and Medicaid.

Regulation and licensure of adult care residences and adult day care centers is a responsibility of state government. Conversely, regulation of the vast majority (93 percent) of nursing homes in the Commonwealth who receive Medicaid and/or Medicare is driven by federal regulations. Only 20 of Virginia's 295 nursing facilities are not certified for either Medicaid or Medicare (Figure 1).

This section outlines the different regulatory programs for adult care residences/adult day care centers and nursing homes, and it reviews past state government reports on and legislative action regarding these programs.

Figure 1
Medicaid and/or Medicare Certified Nursing Facilities in Virginia



The Department of Social Services Regulates Adult Care Residences and Adult Day Care Centers

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." Adult care residences in Virginia were previously referred to as "homes for adults." The homes for adults industry had its origins in "board and care" facilities that would provide living accommodations, meals, and a minimal level of supervision for adults without other family members. During the 1970's, as the state's mental hospitals and training centers began reducing patients census and deinstitutionalizing patients into the community, homes for adults became a de facto part of the behavioral health care continuum of care, representing a middle ground between institutionalization in a state facility and independent living in the community.

Two JLARC Studies (1979 and 1990) Raised Concerns About DSS Licensure of Homes For Adults (Now Called Adult Care Residences)

In 1979, the Joint Legislative Audit and Review Commission (JLARC) completed a study of the regulation of homes for adults in Virginia (*Homes for Adults in Virginia, 1979).* This report identified a number of weaknesses in regulatory oversight of Homes for Adults by the Department of Welfare [now the Department of Social Services]. In particular, the report found:

- compliance inspections conducted by licensing specialists were of limited value,
- inspections were typically announced in advance,
- licensing sanctions were ineffective,
- intermediate sanctions were not an option for less serious violations,
- licensing standards were not uniformly enforced by regional staff, and
- licensing staff were not adequately trained.

Due to continued concern about the DSS licensing program for adult care residences, Item 545 of the 1990 Appropriation Act directed JLARC to conduct a follow-up study of homes for adults. JLARC's 1990 study found that some of the problems raised in the 1979 report had been corrected, however, a number of problems remained with the DSS licensure program. In particular, the department still lacked recourse to intermediate sanctions, and the licensing program was found to lack adequate staff, funding, and training. However, notwithstanding these problems, JLARC concluded that the adult care residence

licensing program should continue to be housed within the Department of Social Services.

Three Long-Term Care Consolidation Proposals Have Been Proposed in the Past Five Years; None Was Successful

During the 1994 Session of the General Assembly, the Joint Commission on Health Care introduced legislation recommended by former Secretary of Health and Human Resources Howard Cullum that would have created a consolidated Department of Aging and Long-Term Care Services (HB 1267/SB 575). This consolidated agency would have been responsible for licensure of all long-term care facilities, and these responsibilities would have been removed from the Department of Social Services and the Department of Health. This proposal was carried over by the 1994 General Assembly, at the request of the incoming administration.

In November 1994, Secretary of Health and Human Resources Kay James proposed consolidating most state long-term care functions, including licensure, as a division within the Department of Medical Assistance Services. The 1995 General Assembly did not act on either the Cullum or the James proposal. However, in 1996 the Joint Commission on Health Care introduced a more limited structural change for long-term care (SB 367), which would have consolidated long-term care licensure within VDH by transferring the regulation of adult care residences and adult day care centers from DSS to VDH. SB 367 was strongly opposed by representatives of the ACR industry, who argued that the effect of the legislation would be to impose the "medical model" of the nursing home industry on ACRs, which were viewed as primarily being operated according to a "social model." This proposal was defeated in the Senate during the 1996 General Assembly Session.

Two Recent Studies of Long-Term Care Licensure Also Raise Concern About the DSS Licensing Program

The 1996 General Assembly also requested that JLARC study services provided in ACRs for mentally disabled residents. 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 (inspections conducted to determine whether or not to renew a license).

In 1997, the Joint Commission on Health Care also examined long-term care licensure (SD 37). The 1997 study examined several options for improving long-term care licensure. The Long-Term Care Subcommittee of the Joint Commission on Health Care concluded in 1997 that licensure problems were best addressed at existing agencies, without making structural changes.

Nursing Home Regulation Is Driven by Federal Regulations

Section 32.1-125(A) of the *Code of Virginia* states:

> No person shall own, establish, conduct, maintain, manage or operate in this Commonwealth any hospital or nursing home unless such hospital or nursing home is licensed or certified as provided in this article.

Section 32.1-126 of the *Code of Virginia* further states:

> B. The Commissioner shall cause each and every hospital, nursing home, and certified nursing facility to be inspected periodically, but not less often than biennially, in accordance with the provisions of this article and regulations of the Board.
>
> C. The Commissioner may, in accordance with regulations of the Board, provide for consultative advice and assistance, with such limitations and restrictions as he deems proper, to any person who intends to apply for a hospital or nursing home license or nursing facility certification.

While all nursing facilities in the Commonwealth must be licensed, state licensure regulations promulgated by the Board of Health are relatively modest when compared with federal regulations for participation in Medicaid and Medicare. These regulations are promulgated by the HCFA, pursuant to its regulatory authority established in the Omnibus Budget Reconciliation Act of 1987 (OBRA 87). According to a 1998 HCFA study, OBRA 87 and ensuring regulations resulted in:

- new standards for quality of care, facility practices, resident rights, resident assessment, and quality of life,
- the resident assessment instrument and the Minimum Data Set, a standardized assessment instrument for all residents in nursing homes,
- an outcome-oriented survey process,

- training standards for nursing assistants,
- additional intermediate sanctions, and
- a new enforcement regulation.

Views of the New HCFA Enforcement Regulations Are Mixed

The new enforcement regulation for nursing homes took effect on July 1, 1995. HCFA's 1998 report included an analysis of stakeholder perceptions of the impact of the 1995 enforcement regulation. This analysis found that "many administrators commented that the world view of the survey process is based on a general distrust of providers, emphasizing punishment rather than a collaborative effort towards the joint goal of quality care." Conversely, HCFA's report found that "consumer advocates and ombudsman expressed concerns with inadequate enforcement, the predictability of the survey, and inadequate staffing." However, HCFA's report also provided some empirical evidence of improved resident outcomes as a result of the revised survey process that resulted from the 1995 enforcement regulation.

In July 1998, the U.S. General Accounting Office (GAO) released a report that is quite critical of HCFA's implementation of the 1995 enforcement regulation. The GAO report, *California Nursing Homes: Care Problems Persist Despite Federal and State Oversight,* concludes that:

- certain California nursing homes are not adequately monitored to guarantee the health and safety of residents;
- a number of potentially avoidable deaths occurred due to unacceptable care;
- nearly one in three California nursing homes were cited by state surveyors for having serious or potentially life threatening care problems;
- HCFA's enforcement policies have not been effective in correcting deficiencies; and
- problems identified in California appear to be "indicative of systematic survey and enforcement weaknesses."

HCFA generally concurred with most of GAO's conclusions. The state of California disagreed with many of them, and the American Health Care Association questioned the methodology employed by the report. As a result of this GAO report, the Chairman of the Senate Select Committee on Aging directed GAO to expand its review of nursing home enforcement nationwide, focusing on the implementation of the 1995 enforcement regulations.

DMAS/UVA Study Made Recommendations for Improving Virginia's Nursing Home Survey Process

The 1996 General Assembly directed the Department of Medical Assistance Services (DMAS) to study the implementation of the revised survey process in Virginia that resulted from the 1995 enforcement regulation. DMAS contracted with the University of Virginia's Department of Health Evaluation Sciences to conduct the study. The report was completed in September 1997, and it contained 14 recommendations. These recommendations emphasized the need for improved consistency, communication, and training in the survey process.

In a preliminary briefing to the Long-Term Care Subcommittee, the Director of VDH's Center for Quality Health Care Services and Consumer Protection indicated that VDH has implemented training for both its own surveyors (medical facilities inspectors) and for providers. In addition, in April 1997 VDH formed a Long-Term Care Advisory Group composed of nursing facility providers, consumers, and VDH staff. This group meets six times per year to discuss concerns and to resolve problems.

III.
Advantages and Disadvantages of Deemed Status for Long-Term Care Facilities

Definition of Deemed Status

Deemed status is the acceptance of private accreditation by a governmental entity in lieu of licensure or certification by a government agency. Deemed status is the predominant regulatory approach for the hospital industry, where hospitals accredited by the Joint Commission on the Accreditation of Health Care Organizations (JCAHO) are deemed eligible to participate in Medicaid and Medicare. The Virginia Department of Health, at the behest of HCFA, validates a five percent sample of hospital surveys conducted by the JCAHO, and VDH investigates complaints made against hospitals. However, for nursing homes, deemed status is not currently allowed for participation in Medicaid or Medicare; state agencies certify nursing homes for participation in these programs on behalf of HCFA.

Deemed status is not currently a means of regulating assisted living facilities (termed adult care residences in Virginia), because there has not yet emerged a widely accepted organization or organizations to conduct the accreditation. However, unlike the case with nursing homes, states have broad discretion on how they choose to regulate assisted living. This conceivably includes adopting some type of deemed status approach.

Some Nursing Homes Are Voluntarily Accredited

At least three organizations currently offer voluntary accreditation for nursing homes. The JCAHO accredits nursing homes either as part of a hospital's accreditation process (in the case of hospital-based facilities) or separately. According to the JCAHCO internet site, there are currently 83 JCAHO accredited long-term care facilities in Virginia. Of these, six are government facilities (three VA Medical Centers, the Virginia Veterans Care Center, and two state mental health facilities).

In addition to JCAHO, a more recently formed group, the Long-Term Care Evaluation and Accreditation Program (LEAP) also accredits nursing homes. Finally, the Continuing Care Accreditation Commission (CCAC) accredits continuing care retirement communities (CCRCs). This accreditation includes reviews of the CCRC's nursing home and assisted living components. As of August 1, 1998, there are seven CCAC accredited continuing care retirement communities in Virginia, according to the CCAC internet site.

In 1996 Congress directed HCFA To Examine Deemed Status for Long-Term Care Facilities

HCFA's 1998 report on deemed status and other issues related to nursing home regulation concluded that JCAHO accreditation surveys were not as effective as state inspectors in identifying problems in nursing homes. The report also concluded that:

- JCAHO standards do not fully meet HCFA standards,
- JCAHO standards emphasize structure and process measures, while HCFA standards are more resident-focused,
- HCFA's survey process is more rigorous in taking steps to correct deficiencies,
- JCAHO does not conduct complaint investigations (though it has recently instituted a "sentinel event" policy to sometimes conduct follow-up visits after events such as patient suicides and surgery on the wrong part of the body)
- public access to JCAHO survey findings is severely limited.

Despite these negative conclusions about deemed status, the HCFA report did acknowledge that JCAHO has higher minimum qualification requirements for surveyors than HCFA does. The study also acknowledged that its findings with regard to deemed status applied only to JCAHO surveys, not accreditation by other organizations.

Based on this report, which was conducted for HCFA by Abt Associates, an evaluation contractor, the Secretary of Health and Human Services announced at a presidential press conference that HCFA will not grant states waivers to experiment with deemed status and suggested that the President would veto any legislation requiring HCFA to allow deemed status for nursing homes.

Views of Deemed Status in Virginia Are Mixed

In Virginia, interviews conducted by Joint Commission on Health Care staff suggest that deemed status would be strongly opposed by consumer groups. Joint Commission staff spoke with representatives of the American Association of Retired Persons (AARP), the Virginia Association of Area Agencies on Aging (V4A), the Coalition for the Aging, and the Office of the State Ombudsman, and the Northern Virginia Aging Network (NVAN). The concerns expressed by these groups tended to echo the findings of the HCFA study in terms of concern about lack of rigor, lack of independence, lack of a complaint investigation process, and lack of public access to accreditation survey findings.

Conversely, provider groups expressed support for the use of deemed status as an option for nursing home care. Joint Commission staff spoke with representatives from the Virginia Association of Non-Profit Homes for the Aging (VANHA), Virginia Health Care Association (VHCA), Virginia Hospital and Healthcare Association (VHHA), INOVA Health Systems, and Sentara Senior Services. These groups all offered support for exploring the concept of deemed status.

According to provider groups, deemed status potential offers several advantages. These include:

- higher minimum qualifications for surveyors,
- reduced expenditure for government, as facilities pay for the accreditation survey rather than government expending funds to hire inspectors,
- the potential for more flexible and responsive regulation,
- provider "buy-in" to the accreditation standards adopted, and
- a less adversarial regulatory climate.

A challenge facing the state with respect to exploring policy options for deemed status is that, with respect to nursing homes, there are clearly identifiable organizations to conduct accreditation surveys, but the state has limited authority for implementing deemed status. On the other hand, with respect to adult care residences, the state has discretion to implement deemed status, but there is no clearly identifiable accrediting body to confer accreditation on facilities seeking such status (the exception to this statement would be the assisted living component of continuing care retirement communities, which would be reviewed as part of the overall accreditation of the CCRC).

The question of deemed status for nursing homes is largely a federal question, as all but 20 nursing homes in Virginia are certified for either Medicaid or Medicare. The state has the option of "deeming" nursing homes that are accredited to meet state licensure regulations. However, most of these facilities would still need to pursue federal certification in order to receive reimbursement for Medicare or Medicaid patients. As indicated earlier in this chapter, HCFA's current position is to oppose deemed status for nursing homes. Therefore, any state action would be limited in its applicability to the 20 facilities that are not currently receiving Medicaid or Medicare. However, of these 20 facilities, two intend to seek certification. This would leave 18 nursing facilities potentially impacted by deemed status legislation. Of these 18 facilities, eleven are part of CCRCs.

As for adult care residences, there is no legal or regulatory barrier to implementing deemed status. However, the practical barrier is a significant one; there is no clear accrediting body to confer the accreditation. The JCAHO is in the process of developing assisted living standards. Moreover, there is some movement among some provider organizations to develop accreditation standards for assisted living (though a separate organization would need to be set up to actually conduct accreditation reviews). One option for the state with regard to deemed status would be to direct the Department of Social Services to issue a request for proposals to conduct accreditation reviews of interested adult care residences in the Commonwealth, or perhaps in a targeted region of the state. This would allow the state to obtain real world experience with which to judge the value of deemed status.

Policy Options for deemed status are listed below.

Policy Options for Deemed Status

Option I: **Take No Action.**

Option II: **Introduce legislation allowing the Commissioner of Health to deem eligible for state licensure any nursing home accredited by a national accrediting body which, in the opinion of the Commissioner, has accreditation standards that meet or exceed state licensure requirements. Under this option, the Commissioner of Health would retain authority to investigate complaints and to revoke the license when appropriate.**

Option III: **Introduce a budget amendment directing the Commissioner of Social Services to issue a Request for Proposal (RFP) to conduct accreditation for a targeted area of the state to develop accreditation standards and conduct accreditation reviews of interested adult care residences. The General Assembly may choose to accept this accreditation in lieu of state licensure.**

IV.
The Need for and Feasibility of a Separate Department of Health Care Quality

Three Past Consolidation Proposals Have Not Been Enacted

As noted in Section II, during the past five years, there have been three legislative proposals to consolidate licensure functions for nursing homes and adult care residences. Each of these proposals would have placed long-term care licensure and certification functions in a different organizational location. The 1994 Cullum proposal (SB 575/HB 1267) would have consolidated licensure within a newly created Department of Aging and Long-Term Care Services. The 1994 James proposal to consolidate long-term care licensure/certification (and other long-term care functions) within the Department of Medical Assistance Services was not acted upon by the 1995 General Assembly. Finally, the 1996 General Assembly defeated a proposal by the Joint Commission on Health Care (SB 367) that would have consolidated long-term care licensure/certification within the Virginia Department of Health.

SJR 97/HJR 156 asks the Joint Commission on Health Care's Long-Term Care Subcommittee to examine the "feasibility of and necessity for a separate Department of Health Care Quality." Such a department could potentially encompass a range of functions. These include the two discussed above: licensure of adult care residences/adult day care, and licensure/certification of nursing homes. In addition, a consolidated Department of Health Care Quality could encompass the licensure functions of the Department of Mental Health, Mental Retardation, and Substance Abuse Services as well as other licensure functions of the Department of Health.

There Are Some Potential Advantages to Consolidation

The arguments in favor of a consolidated department were discussed at length in last year's Joint Commission on Health Care report on *Long-Term Care/Aging Study* (SD 28). These arguments can be briefly summarized as:

- enhanced opportunities for cross-training and potential for staffing efficiencies,
- the opportunity for a team approach to licensure, particularly with regard to facilities that combine long-term care and behavioral health care services,
- increased consistency in terms of the protection offered to residents in various long-term care settings, and

- increased consistency in terms of the qualifications, compensation, and training of long-term care licensing staff.

One particularly compelling finding from SD 28 is that a majority of Department of Social Services adult care residence licensing program staff responding to the September 1997 Joint Commission on Health Care survey indicated that they believed the best organizational location for the adult care residence licensing program would be somewhere other than DSS. All DSS staff were asked to respond to the survey item "What is the best organizational location for the adult care residence licensing program." Eighty-five percent of DSS staff surveyed responded to this item. Of these respondents, 33 percent indicated that the program was best located within DSS, 14 percent indicated the best location was the Department of Health, and 43 percent identified a separate licensing agency as the best location. Ten percent indicated the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) as the best location or indicated no preference.

Conversely, only nine percent of VDH staff indicated that the best location for the nursing home licensure/certification programs would be somewhere other than VDH. Ninety-one percent of VDH staff identified VDH as the best location for the nursing home certification/licensure programs. Only nine percent indicated that a separate agency would be the best location.

Any Proposal to Create a Separate Department Would Face Opposition

In assessing the feasibility of a separate Department of Health Care Quality, the legislative history of consolidation proposals is not an encouraging one. The General Assembly has defeated or not acted upon three consolidation proposals in five years. In addition, the 1998 General Assembly deleted language from SB 464 which would have created a position of Deputy Secretary for Long-Term Care. The concern was expressed that this position would add to the size of government, contrary to current trends of downsizing the size of government. It would therefore be particularly difficult to argue in favor of creating an entire separate department, because this department would necessarily involve additional administrative, logistical, and managerial expenditures that are not currently incurred by licensure programs within larger departments.

This is not to say that the creation of a separate department is impossible. However, a proposal to create such a department would need to overcome significant obstacles, not the least of which is potential opposition from affected provider groups. Organizations representing the assisted living industry have traditionally opposed any legislative action that would place regulation of adult

care residences within the same agency that regulates nursing homes, arguing that to do so would impose the "medical model" of the nursing home industry on the primarily "social model" of assisted living.

Locating the Licensure Function Within the Secretary's Office Would Have Advantages and Disadvantages

Another potential option for locating a consolidated licensure function would be within the Inspector General's office within the Office of the Secretary of Health and Human Resources. This office was created at the request of the Governor by the 1998 General Assembly and is to be responsible for overseeing improvements in quality of care in state mental hospitals and training centers. There are, however, several potential concerns about placing licensure programs within this office. First, the Inspector General will presumably be hired with behavioral health expertise as a chief qualification. This type of expertise is helpful but not necessarily all that is required for oversight of other types of long-term care settings. Second, the offices of cabinet secretaries have not traditionally performed line functions in Virginia State Government. Third, staff within the office of a cabinet secretary have traditionally been replaced by each newly elected governor, something that would not be appropriate for career licensing staff. With these caveats in mind, location of licensure within the Secretary's office would be consistent with the Secretary's responsibilities for long-term care coordination as established by Senate Bill 464, approved by the 1998 General Assembly. Placement in the Secretary's office would potentially also increase the visibility and importance of licensure and certification issues by commanding a higher level of management attention.

Structural Changes Are Not The Only Option for Improving Licensure; Improvements Can Be Pursued in Existing Agencies

Structural changes are not the only potential solution to concerns about existing licensure and certification programs. Were the General Assembly to pursue deemed status as a long-term approach to long-term care licensure, the organizational configuration of state agencies would be of less importance with regard to long-term care licensure and certification. Moreover, there are opportunities for improvement within existing executive branch licensure programs.

During 1997, the Joint Commission on Health Care considered a number of options for improving long-term care licensure and certification. One of these options was to pursue improvements at existing agencies, and this option was selected by the Commission. To this end, the Joint Commission on Health Care introduced one bill and two resolutions aimed at long-term care licensure. HB

780 empowered the Commissioner of Social Services to more quickly impose intermediate sanctions on violators of adult care residence regulations. SJR 119 directed the Department of Social Services and the Joint Commission on Health Care to examine adult care residence regulation and enforcement to identify opportunities for improvement. HJR 224 directed the Virginia Department of Health and the Joint Commission on Health Care to examine the nursing home survey process in light of last year's University of Virginia study in order to identify opportunities for improvement. Preliminary staff policy options regarding improvements in existing agencies are identified in the next section.

Policy options regarding a separate Department of Health Care Quality are shown below. It is noted that these options are mutually exclusive. Selecting one of these options necessarily involves rejecting other potential options within this section.

Policy Options for a Separate Department of Health Care Quality

Option I: Take no action.

Option II: Introduce legislation creating a separate Department of Health Care Quality within the executive branch. This agency would consist of the following existing organizational units: (i) the Division of Long-Term Care within the Department of Health's Center for Quality Health Services and Consumer Protection (31 FTE), (ii) the staff of the adult care residence licensing program within the Department of Social Services (17 FTE), and (iii) the licensing program staff from the Department of Mental Health, Mental Retardation and Substance Abuse Services (15 FTE). The new agency would require significant additional FTE (estimated 15 to 20) for administrative support, management and direction, and to address staffing shortages within existing programs.

Option III: Introduce legislation creating a separate Department of Health Care Quality consisting of the following organizational units: (i) the Division of Long-Term Care within the Department of Health's Center for Quality Health Services and Consumer Protection (31 FTE), and (ii) the staff of the adult care residence licensing program within the Department of Social Services (17 FTE).

Option IV: Introduce a joint resolution requesting the Secretary of Health and Human Resources to prepare a reorganization plan for long-term care licensure and certification. The Secretary would be

requested to consider: (i) consolidation within an existing agency, (ii) consolidation within the newly created Office of the Inspector General within the Secretary's Office, and (iii) consolidation within a separate Department. Under this option, the Secretary would be required to report to the Governor and General Assembly by October 1, 1999.

V.
Potential Improvements Within Existing Agencies

In addition to examining deemed status and the creation of a separate Department of Health Care Quality, the Joint Commission on Health Care was directed to examine improvements in existing agencies. However, based on research to date, three opportunities for improvement exist within current licensure programs. The first opportunity is in appropriate staffing; this applies to both the DSS adult care residence program and the VDH nursing home program. The second opportunity involves enhanced efforts towards compliance assistance, particularly on the part of VDH with respect to the nursing home survey process for federal certification. The third opportunity is with regard to enhanced training, particularly with regard to DSS adult care residence licensing staff.

Staffing Levels of the VDH and DSS Licensure Programs Have Decreased, While the Number of Licensed Beds Has Increased

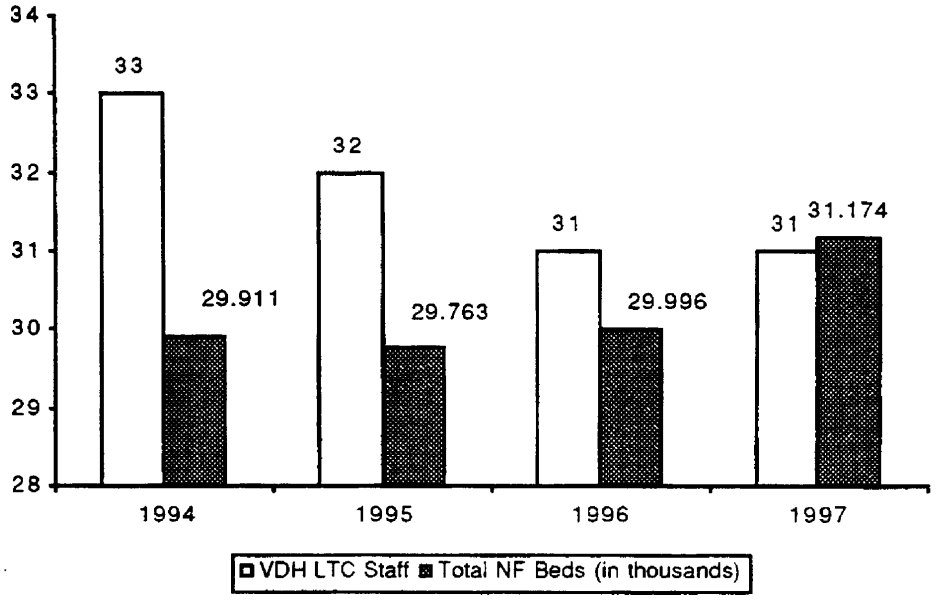
In surveys conducted by the Joint Commission on Health Care staff in 1997, both VDH and DSS staff expressed some concern about staffing. The staffing of both the adult care residence program and the VDH licensing/certification program for nursing homes has actually declined slightly during the past five years, while the number of beds has risen (Figures 2 and 3).

As can be seen from Figure 2, while the number of certified nursing home beds in Virginia has increased from 29,991 in 1994 to 31,174 in 1997, the number of long-term care staff (primarily inspectors) has actually decreased from 33 in 1994 to 31 at present. In addition, VDH is in the process of awarding more than 1,000 additional beds through the Request for Application process. Finally, HCFA's recent directive to states to conduct at least 15 percent of their surveys during nontraditional hours (nights, weekends, and holidays) will create additional staffing demands for VDH.

Similarly, as Figure 3 reflects, the number of licensed adult care residence beds has increased from 26,209 in 1994 to 29,298 in 1998. At the same time, staff for the adult care residence licensing program has decreased from 21 to 17. In addition, effective February 1, 1996, the Board of Social Services promulgated new adult care residence regulations. These regulations significantly increased the scope and complexity of the licensing program by strengthening health and safety regulations. Additionally, these revised regulations (as well as companion regulations promulgated by the Board of Medical Assistance Services) increased the scope of services potentially offered by adult care

residences by allowing ACRs to receive reimbursement for providing assisted living and intensive assisted living services.

Figure 2
VDH Long-Term Care Staff Compared to the Number of NF Beds, 1994 to 1997



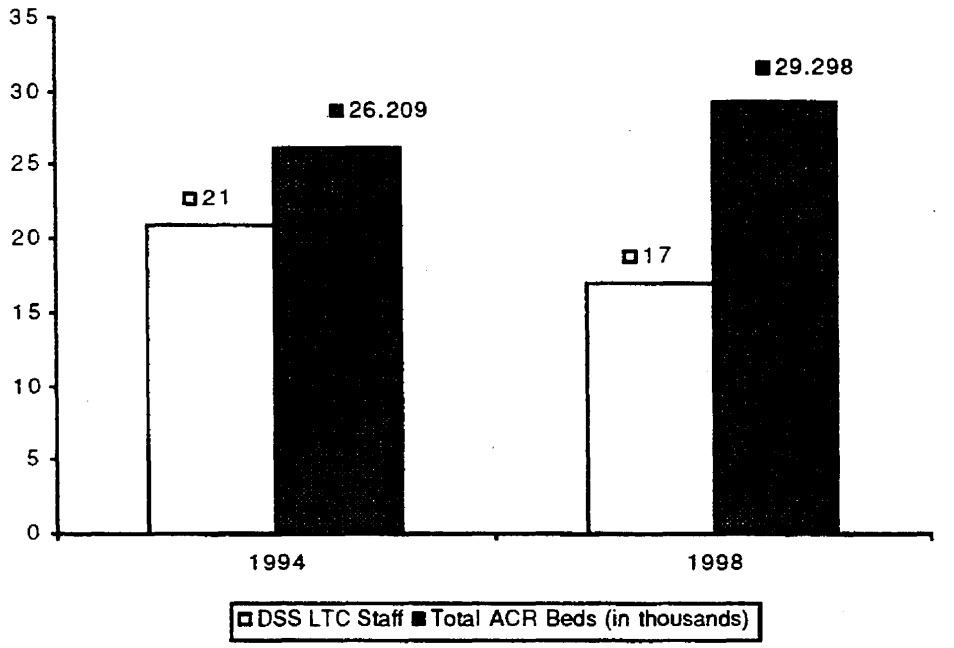
Source: Virginia Department of Health

DSS Requires Additional Staff Within the ACR Licensure Program

Based on interviews conducted during this review, additional staff appear to be needed in the DSS adult care residence licensure program. There are currently two vacancies in the program. In addition to filling these vacancies, DSS has a particular need for mental health expertise and for an additional specialist in the Roanoke licensing office, to allow three child care licensing specialists who are also responsible for inspecting adult care residences to devote themselves full-time to child care licensing. The additional position would be devoted full-time to the adult care residence program and would replace a position vacated and then eliminated when the previous incumbent retired under the provisions of the Workforce Transition Act. In general, assigning staff full-time to the adult care residence program is advantageous, due to the complexity of the program and the rapidly changing nature of the adult care residence program. It therefore appears that three additional staff are

needed for the DSS program, in addition to the need to fill the two existing staff vacancies in the adult program.

Figure 3
DSS Long-Term Care Staff Compared to the Number of ACR Beds, 1994 vs. 1998



Source: Virginia Department of Social Services

Additional Staff Are Needed To Improve Compliance Assistance Offered by VDH

With regard to shortage of staff, one consequence that is particularly striking in the VDH nursing home licensure/certification program is the difficulty in providing compliance assistance to problem facilities. Compliance assistance refers to the practice of regulators assisting a facility with making needed improvements to meet regulatory requirements. These efforts are not meant to be "quick fixes" to allow a facility to get through a one-time licensure or certification visit. Rather, effective compliance assistance involves helping facilities make lasting, systematic changes that will improve resident/patient outcomes in the long-term.

During the 1998 General Assembly Session, a budget amendment was introduced to fund a dedicated team of VDH staff to do "pre-survey" visits of

facilities to allow facilities to identify and correct deficiencies in advance of the actual survey for federal certification. While this budget amendment was not funded in 1998, it did identify one potential solution for addressing the perception of the survey process for federal certification as overly adversarial. Another option would be to generally increase the number of VDH inspectors, so that all teams had the option to provide informal compliance assistance. A final option would be to provide additional education staff to VDH to conduct a variety of educational programs, including compliance assistance and programs to ensure consistency among surveyors. It is estimated that, irrespective of which option is selected, an additional five FTE would be required to improve the VDH licensure program. It is noted that at least 60 percent of the cost of these positions would be funded by the U.S. Health Care Financing Administration.

Additional Training Is Needed to Improve DSS Long-Term Care Licensure

In addition to staffing needs, DSS also has significant training needs. Adult care residence staff members have primarily social work and/or regulatory backgrounds and do not usually have health care training. Such training is particularly important in meeting the needs of residents requiring assisted living or intensive assisted living services and in identifying residents who are inappropriately placed in ACRs (for example residents with a prohibited condition such as a stage 3 or 4 decubitus ulcer).

During the past several years, DSS has not had sufficient training funds to offer much in the way of educational programs for its staff. In fact, during the 1997 JCHC staff survey of DSS licensing specialists, 68 percent identified additional training needs. These training needs particularly focused on behavioral health and health care issues. While one option might be to provide an additional FTE and related funding to the department to provide training, it would probably be more cost effective to provide additional general funds to the department to allow it to contract for training services (including training from other state agencies or institutions).

Policy options for improving licensure and certification of long-term care facilities within existing agencies include those listed below. It is noted that these options are not mutually exclusive. The Joint Commission on Health Care may choose to pursue one or more of these options. It is also noted that additional options may be identified once the Department of Social Services completes its report required by SJR 119 and the Department of Health completes its report required by HJR 224.

Policy Options for Improvements Within Existing Agencies

Option I: Take No Action.

Option II: **Introduce budget amendments to address staffing needs within existing agencies. Introduce a budget amendment providing five FTE and $80,000 (GF) and $120,000 (SF) to the Virginia Department of Health for its long-term care licensure and certification program. Introduce a budget amendment providing three FTE and $105,000 (GF) to the Virginia Department of Social Services for its adult care residence licensing program.**

Option III: **Introduce a budget amendment providing $25,000 (GF) to the Virginia Department of Social Services to address training needs within the adult care residence licensing program.**

CHAPTER TWO
I.

Chapter Two Outline

This chapter is organized into six sections. This section discusses the authority for the study and provides an overview of the report. The second section discusses Medicaid financing of nursing facility care in Virginia. The third section discusses state financing of adult care residences (ACRs) in Virginia. The fourth section discusses other long-term care financing issues. The fifth section discusses policy options for long-term care financing of nursing facility and adult care residence care. The final section discusses the problem of providing an adequate number of health care providers trained in geriatric care to meet the needs of the growing number of elderly Virginians.

II.
Medicaid Financing of Nursing Facility Care

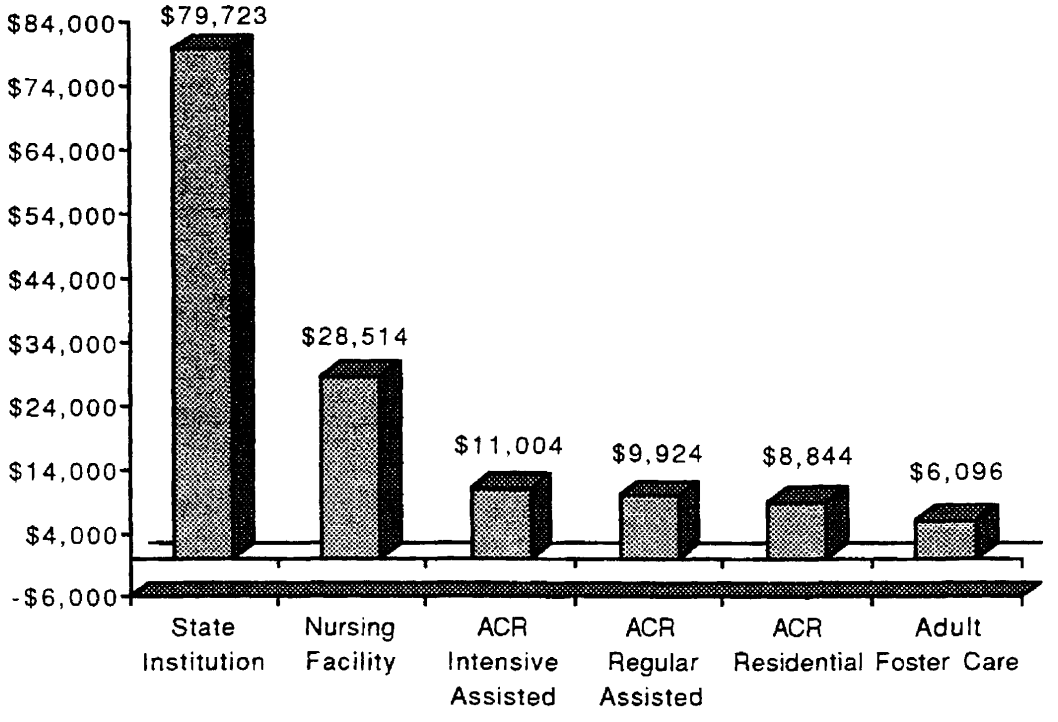
State Expenditures for Long-Term Care Vary Widely Depending on Where the Care Is Provided

The cost to the state of paying for various long-term care settings varies widely. For example, the annual cost of institutional care for mentally ill elderly patients in a state mental health institute averages $79,723. The average annual reimbursement by Medicaid for nursing facility care is $26,842. The maximum annual state reimbursement to an adult care residence outside of Northern Virginia is $8,844 for basic residential care, $9,924 for regular assisted living care and $11,004 for intensive assisted living care. Figure 1 shows these reimbursement levels.

It is important to note, however, that the services provided at each of these reimbursement levels vary. Direct care in a state mental health institute is often provided by registered nurses. Direct care in a nursing facility is typically provided by certified nursing assistants. Direct care in an adult care residence need not be provided by a nursing assistant, provided that the staff member has received other training (including medication management training). An individual in the basic residential level of care in an adult care residence requires and receives only minimal assistance with activities of daily living (ADLs). ADLs includes bathing, dressing, toileting, transferring (between a bed, wheelchair, or chair), bowel function, bladder function, and eating/feeding. An individual at the residential level of care may receive assistance with medication. Individuals receiving regular assisted living services require assistance with two

or fewer ADLs. Individuals receiving intensive assisted living care from an ACR are dependent in four or more ADLs.

Figure 1
State Reimbursement for Selected LTC Settings



Note: State Institution refers to geriatric care in a state mental health institute.
Source: JCHC staff analysis.

The State is the Majority Payor for Nursing Facility Care

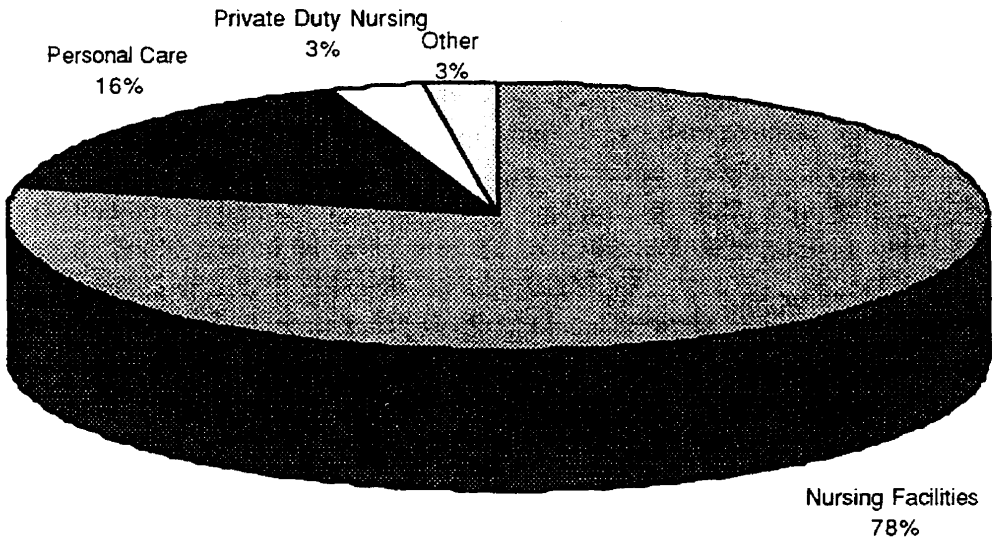
A nursing facility may provide skilled nursing care, intermediate care, or both. Nursing facilities may also have specialized care units for individuals with Alzheimer's or other cognitive impairments. The Virginia Medicaid program is the majority payor for nursing facility care in the Commonwealth. At present, the Medicaid program accounts for about 70 percent of the revenues and patient days for the nursing facility industry in Virginia. In many cases, nursing facility residents do not enter the nursing facility as Medicaid recipients; they become Medicaid recipients after "spending down" their assets to pay for nursing facility care.

Nursing Facility Care Accounts for the Majority of the State's Medicaid Long-Term Care Expenditures

For the fiscal year ending June 30, 1998, nursing facility care accounted for approximately 78 percent of the long-term care expenditures through the Virginia Medicaid program (Figure 2). The remainder of Medicaid long-term care expenditures funded a variety of home and community based services offered under waivers from the U. S. Health Care Financing Administration (HCFA). These services included personal care, home health, adult day care, intensive assisted living care, companion services, and private duty nursing.

While the majority of Virginia Medicaid long-term care expenditures continue to be for nursing facility care (the institutional bias often referred to in the Medicaid program), the percentage of Medicaid long-term care expenditures going for facility care has decreased significantly during the 1990's. In 1990, nursing facilities accounted for 89 percent of Virginia Medicaid long-term care expenditures. As noted above, by FY 1998, this percentage had been reduced to 78 percent. The reason for this reduction is the state's pursuit of home and community based waivers.

Figure 2
FY 1998 Virginia Medicaid Long-Term Care Spending



Note: State Institution refers to geriatric care in a state mental health institute.
Source: JCHC staff analysis.

Home and Community Based Waivers Allow Medicaid to Pay for A Variety of Long-Term Care Services Other Than Nursing Facility Care

Virginia actually spends slightly less on nursing facility care (78 percent) as a percentage of total Medicaid long-term care spending than the nationwide average of 82 percent. Virginia currently has seven home and community based waivers granted under Section 1915(c) of the Social Security Act. These waivers are summarized in Exhibit 1.

Nursing Assistant Salaries in Nursing Homes Are Not Competitive

The long-term care issue brief presented at the August 27, 1998 Joint Commission on Health Care meeting described the new enforcement regulations that have been implemented as a result of the Omnibus Budget Reconciliation Act of 1987. One difficulty experienced by nursing homes in Virginia in complying with these regulations is in recruiting and retaining an adequate number of certified nursing assistants (CNAs). At present, CNA salaries in Virginia are slightly above the minimum wage level, with a median level of $6.71 per hour. This means that nursing homes must not only compete with other health care providers, such as hospitals and home health agencies, but also that nursing homes must compete with other low wage employers such as fast food establishments and retail stores.

Notwithstanding the inherent rewards of caring for other human beings, other low wage employers arguably offer less stressful working conditions, a more pleasant working environment, comparable or better wages, and more opportunity for advancement. This is not to say that there is no opportunity for advancement in a nursing facility for a CNA, only that the next logical step, becoming a licensed practical nurse, requires considerably more educational training and investment than would be required to advance from sales clerk to assistant manager of a store or fast food establishment. As a result, it is not surprising that the industry-wide turnover for nursing assistants averages (and in some facilities exceeds) about 80 percent. This high turnover presents additional challenges for facilities trying to meet regulatory standards and to deliver quality care.

It is therefore especially important that nursing facilities be able to offer competitive wages. During the 1998 Session of the General Assembly, a budget amendment was introduced that would have provided $6.7 million in each year of the biennium to fund an estimated increase of a dollar per hour in nursing assistant salaries. While this amendment was not funded, the 1998 Appropriation Act directed the Department of Medical Assistance Services (DMAS) to study "appropriate minimum nursing staff salaries across the state in order to permit nursing facilities to hire, train, and retain nursing staff sufficient to meet mandated state and federal quality of care standards." A preliminary

Exhibit 1

Virginia's Home and Community Based Medicaid Waiver

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).
Consumer Directed Personal Attendant Services	Effective July 1, 1998, this waiver covers services provided by a personal attendant who assists with a person's activities of daily living such as bathing, dressing, transferring, ambulation, and meal preparation.

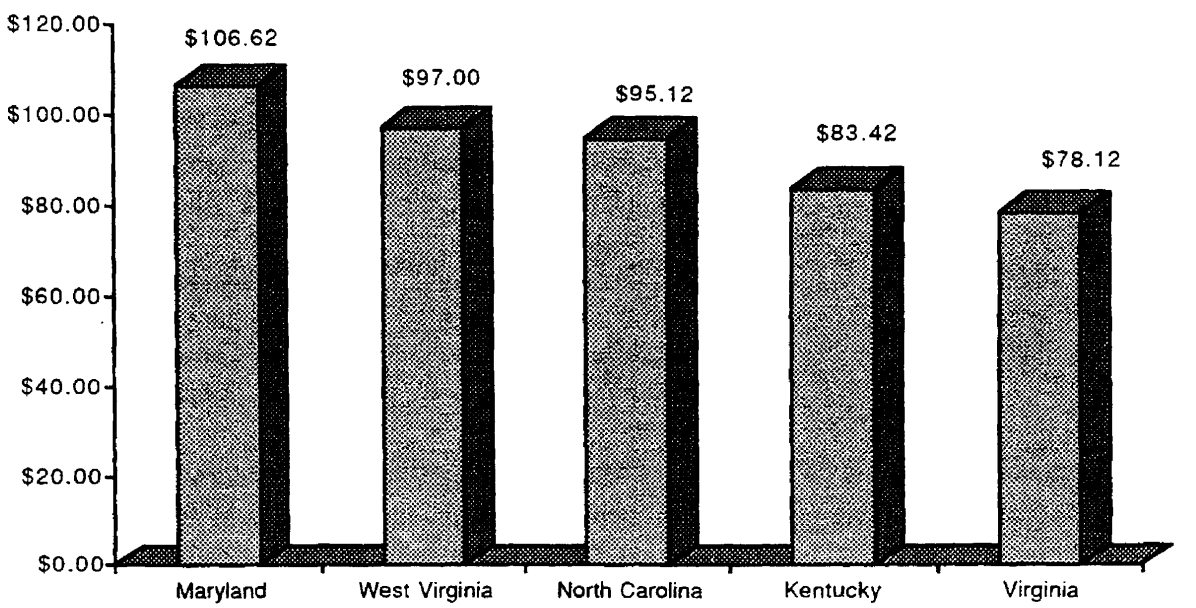
Source: Statistical Record of the Virginia Medicaid Program, October 1997

briefing by DMAS staff to the Joint Commission on Health Care's Long-Term Care Subcommittee indicated that nursing assistant salaries in Virginia trail salaries of retail sales clerks, home health aids, and food preparation workers (including fast food and restaurant employees). As noted above, CNA's in Virginia earn an average of $6.71/hour. Home health aides earned an average of $7.41 per hour. Food preparation workers earned an average of 7.58 per hour. Retail sales clerks earned an average of $8.06 per hour.

Virginia's Reimbursement for Nursing Facilities Is Relatively Low Compared to Neighboring States

In comparing Virginia's average reimbursement for nursing facilities to neighboring states, it could be argued that Virginia facilities are at a competitive disadvantage with regard to Medicaid reimbursement. Figure 3 compares average reimbursement rates for Virginia and neighboring states for 1998. As can be seen from Figure 3, Virginia has a lower average reimbursement rate than all of the neighboring states for which data was available (Tennessee's data was not available). For 1998, Virginia ranked 42 nationally in terms of the fifty states and the District of Columbia (D.C.) for nursing facility reimbursement.

Figure 3
1998 Average Medicaid Reimbursement for Nursing Facilities

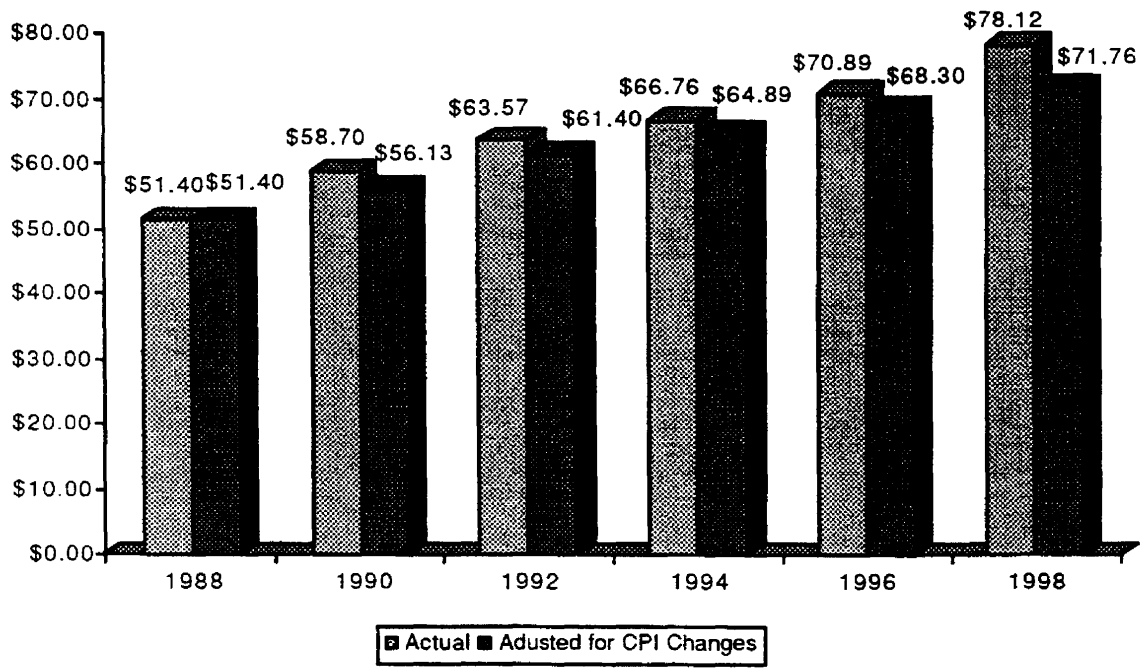


1998 Tennessee data not reported.
Note: Per Diem amounts may include different services in different states.
Source: American Health Care Association.

Figure 4 compares Virginia's average daily Medicaid reimbursement rate for nursing facilities with changes in the consumer price index and health inflation for the period 1988-1998. As can be seen from Figure 4, the rate of increase for nursing facility reimbursement has outpaced the changes in the consumer price index during the same period. However, changes in nursing facility reimbursement have been somewhat less than changes in health care inflation. Figure 5 compares increases in nursing facility reimbursement with nationwide changes in health care expenditures during the period 1988-1996. When changes in the nursing home reimbursement rate are compared to health inflation, health inflation significantly exceeds the rate of increase for Virginia Medicaid nursing facility reimbursement.

Figure 4

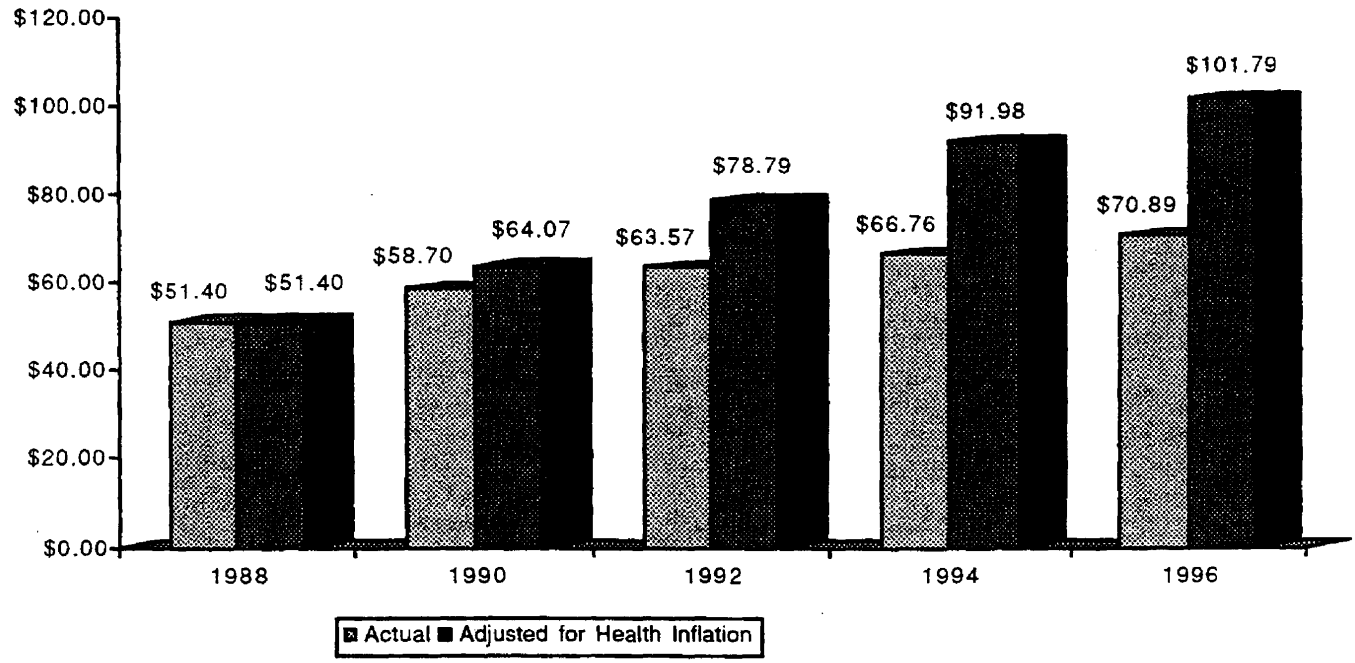
Actual Changes in Virginia Medicaid Average Nursing Facility Reimbursement Compared With Changes in the Consumer Price Index: 1988-1998



Source: Department of Medical Assistance Services and U.S. Bureau of Labor Statistics.

Figure 5

Actual Changes in Virginia Medicaid Average Nursing Facility Reimbursement Compared With Changes in Health Inflation: 1988-1996



Source: Department of Medical Assistance Services and U.S. Health Care Financing Administration.

III.
Public Financing of Adult Care Residence Care

Auxiliary Grants Help Fund Care for Public Pay ACR Residents

An auxiliary grant is a state government funding source for public pay residents of adult care residences. Adult care residences, once known in Virginia as homes for adults, provide maintenance and care for four or more adults who may be aged, infirm, or disabled. An auxiliary grant supplements resident income for those qualifying for the program; the resident income is typically provided through Supplemental Security Income (SSI). As of September 1998, there are 6,619 auxiliary grant recipients in Virginia, receiving an average auxiliary grant of $210. The maximum auxiliary grant that can be received is $737 for most of Virginia and $848 for Northern Virginia. In addition, public pay residents of ACRs receive a $54 personal care allowance.

Many Auxiliary Grant Recipients Have A Behavioral Health Care Diagnosis

JLARC's 1997 study of adult care residences found that 47 percent of auxiliary grant recipients analyzed had a behavioral health care diagnosis. The type of behavior health care diagnosis varied. The most common diagnoses were schizophrenia and mental retardation. Figure 6 shows the mental health diagnoses of public pay ACR residents. It is noted that these figures are not representative of all ACR residents in Virginia (including private pay), because public pay clients are younger and are often coming to the ACR from a state mental health facility. It is also noted that national studies have indicated a much higher rate of dementia (approaching 50 percent) among all assisted living residents than is the case for Virginia's public pay ACR residents. This difference could be partly explained by increased use in other states of assisted living as an alternative to nursing facility care and by the tendency of public pay clients to be younger and therefore less likely to have developed dementia.

Indeed, since the 1970s, ACRs have been a *de facto* part of Virginia's mental health care system. For example, between 1992 and 1996, there were 3,023 persons discharged from state mental health and mental retardation facilities who were placed in ACRs. JLARC's 1997 study made a number of recommendations to improve the services delivered to mentally disabled residents of adult care residences.

Figure 6
Mental Health Diagnoses of Public Pay ACR Residents

Diagnosis	Percentage
Schizophrenia	16.9%
Mental Retardation	11.1%
Other Psychiatric	4.4%
Bipolar and Personality Disorder	3.3%
Major Depression	3.2%
Non-Alzheimer's Dementia	2.8%
Alzheimer's	2.0%
Anxiety Disorders	1.4%
Epilepsy/Other Neurological	1.4%
Total	46.5%

Source: Joint Legislative Audit and Review Commission, *Services for Mentally Disabled Residents of Adult Care Residences* (HD 4, 1998).

Auxiliary Grant Recipients Account for 22 Percent of Licensed Adult Care Residence Beds

Unlike the nursing facility industry, the adult care residence industry is primarily funded by private pay residents. As of September 1998, there were 29,398 licensed adult care residence beds in Virginia and 6,619 auxiliary grant recipients. Therefore, auxiliary grant recipients account for 22 percent of ACR beds in Virginia.

The 22 percent figure is somewhat misleading. In most cases, an ACR either has very few auxiliary grant recipients or a large number of them. While the ACR industry is regulated and treated in statute as one industry, there are in fact several different types of ACRs which have as many differences as they do similarities. There is a segment of the ACR industry that is heavily dependent on auxiliary grants. JLARC's 1997 report found that 35 percent of all auxiliary grant recipients live in five localities: Richmond, Washington County, Roanoke, Roanoke County, and Petersburg. On the other hand, there are almost no auxiliary grant beds in the most heavily populated part of the state, Northern Virginia, though there is a growing number of licensed adult care residences. The problem of providing sufficient auxiliary grant beds for Northern Virginia is discussed later in this section.

Auxiliary Grant Expenditures Are Split Between the State and Local Governments

The uneven distribution of auxiliary grant recipients is problematic, because local governments are required to fund 20 percent of the cost of auxiliary grants. The heavy concentration of auxiliary grant recipients in a small number of localities has a disproportionate impact on those localities. This impact includes the direct cost of funding auxiliary grants and the indirect costs of additional CSB services and other related costs. While the "home" locality of an auxiliary grant recipient will fund the 20 percent share of a person's auxiliary grant even if the person is being cared for in another locality, in many cases, such as discharges from state mental health facilities, there is no identifiable responsible locality and the locality in which the receiving ACR is located absorbs the cost of the local share of the auxiliary grant. This is why localities near major state mental health facilities, such as Washington County or Smyth County, are paying far more for auxiliary grant recipients than would be expected given their proportion of the state's population. For example, Washington County, which has approximately 56,000 residents, expended $750,544 on the auxiliary grant program in FY 1998. This compares with $530,329 expended by Fairfax County for the auxiliary grant program in FY 1998. Fairfax has approximately 928,000 residents, or 16 times Washington County's population.

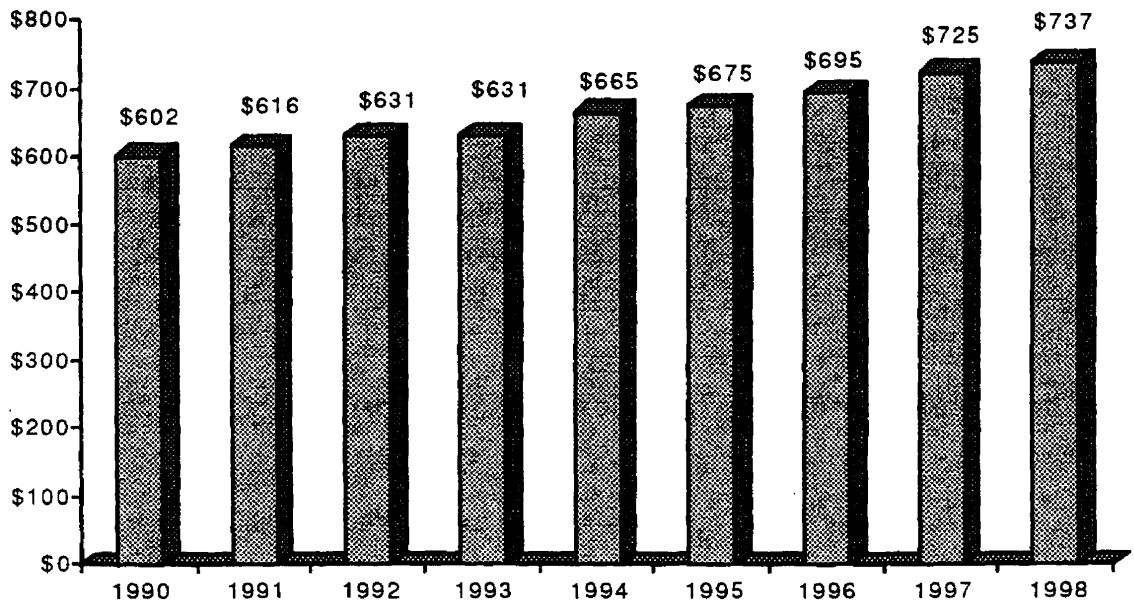
Auxiliary Grants Do Not Recoup the Cost of Care for Auxiliary Grant Recipients

For some years, the ACR industry has argued that auxiliary grants do not fully reimburse for the cost of care provided, to say nothing of providing a profit margin for proprietary ACRs. Analysis by the Department of Social Services of 1997 cost reports indicates that the median cost of basic residential care at ACRs is $846. These figures are currently being reviewed by DSS based on the results of 30 audits conducted to validate cost reports. DSS staff indicate that the median cost figure may vary slightly, but not significantly once the analysis of the audits is completed in October 1998. Assuming for illustrative purposes that the $846 median cost figure is correct, this means that the $737 maximum auxiliary grant payment rate in effect for all of the state but Northern Virginia reimburses only 87 percent of the median cost of care in ACRs.

Virginia's auxiliary grant rate has risen in the past decade, driven largely by the federal "maintenance of effort" requirement that state auxiliary grant spending keep pace as a proportion of the auxiliary grant program with the proportion provided by Supplemental Security Income. Figure 7 reflects the maximum auxiliary grant rate for most of the state (except Northern Virginia) from 1990 to present. As noted earlier, the maximum rate for Northern Virginia in any given year is fifteen percent above the rate for the remainder of the state.

Whenever the SSI rate is increased, there is a requirement for a corresponding increase in the state auxiliary grant rate. For example, Department of Social Services staff estimate that the maximum auxiliary grant rate will need to be increased from $737 to approximately $753 in 1999 order to meet the maintenance of effort requirement.

Figure 7
Maximum Auxiliary Grant Rate, 1990-1998
(Does Not Reflect the 15 Percent Northern Virginia Differential)



Source: Virginia Department of Social Services.

Most Northern Virginia Auxiliary Grant Recipients Are Housed Outside of Northern Virginia

As noted above, auxiliary grant payments do not fully cover the cost of care provided. This problem is magnified in Northern Virginia (NOVA), where the much higher cost of living makes the state's auxiliary grant rates, even with a 15 percent adjustment for Northern Virginia, unattractive. JCHC staff surveyed four Northern Virginia localities (Arlington, Fairfax, Alexandria, and Prince William) and found that most Northern Virginia auxiliary grant recipients are housed outside of Northern Virginia because there are no auxiliary grant beds available for them in Northern Virginia. For the four localities surveyed, 65 percent of residents were located outside of Northern Virginia (226 of 346 total). Figure 8 reflects these findings.

Figure 8
Northern Virginia Auxiliary Grant Recipients Housed Outside of Northern Virginia

Locality	Total Auxiliary Grant Recipients	Auxiliary Grant Recipients Housed Outside of NOVA
Alexandria	80	54
Arlington	50	38
Fairfax	174	114
Prince William	42	20
Total	346	226

Source: JCHC Survey of Northern Virginia localities.

The Fifteen Percent Differential for Northern Virginia Does Not Reflect the Cost of Living Differences Between Northern Virginia and the Remainder of the State

At present, the Appropriation Act allows a fifteen percent higher auxiliary grant payment for ACRs in Northern Virginia (Planning District Eight). As ACRs provide shelter and meals for residents housed there, it is reasonable to view cost of living differences as a proxy for the differences in costs of ACR care among regions of the state (though the nature of the facilities certainly will vary by region and further skew the average costs of ACRs within the region). From analyzing U.S. Census Bureau data on cost of living, it appears that the fifteen percent differential does not reflect the difference in cost of living between Northern Virginia and the remainder of the state.

Virginia has six metropolitan statistical areas (MSAs). While these six MSAs encompass only one-third of the land area in the state, they encompass 73 percent of the state's population. Therefore, comparison among MSAs reflects nearly three-fourths of all Virginians. Figure 9 shows the mean cost of living for 1996 in Virginia's six MSAs. As can be seen from Figure 9, five of Virginia's six MSAs are within nine percent of the nationwide average. Northern Virginia, on the other hand, is 34 percent above the national average.

Figure 9

Cost of Living Index for Virginia's Metropolitan Statistical Areas

Metropolitan Statistical Area	Cost of Living Index
Lynchburg	93.4
Roanoke	93.5
Bristol	94.4
Nationwide Average	100.0
Hampton Roads	103.9
Richmond	108.9
Washington, DC	134.2

Note: The Washington, D.C. MSA includes Northern Virginia.
Source: Virginia Statistical Abstract, 1996-97 Edition.

Differential for Assisted Living Care Is Not Tied To Services Provided To Residents

Based on interviews with state agency staff, as well as JLARC's findings from its 1997 report, the reimbursement levels for regular assisted living care and intensive assisted living care were arrived at in a somewhat arbitrary fashion. These reimbursement figures need to be more closely tied to the services that are expected to be delivered at each level of care. In particular, it appears that the reimbursement level for intensive assisted living services may be too low given the relatively high level of effort required to provide round the clock care to someone dependent in four ADLs. For example, Virginia Medicaid currently reimburses personal care at a rate of $9.50 per hour (a rate it is noted that the home care industry feels is too low). By comparison, Medicaid provides ACRs an additional $180 per month to provide intensive assisted living care reimbursed at $6.00 per hour with a limit of 30 hours per month. This is not to say personal care rates are too high, only that Medicaid intensive assisted living care does not appear to be adequately reimbursed. In particular, the 30 hour per month limit appears to be driven more by fiscal concerns than careful analysis of resident conditions and needs.

IV.
Other Long-Term Care Financing Issues

Long-Term Care Insurance Offers One Means of Promoting Family and Individual Responsibility in Meeting Long-Term Care Costs

As last year's Joint Commission on Health Care report on Long-Term Care and Aging issues noted, the long-term care insurance market is growing quickly, at a rate of 23 percent per year. The long-term care insurance market was virtually non-existent in 1986; since that time approximately 5 million policies have been written. In general, long-term care insurance pays a set amount per day, after a specified waiting period, to cover the cost of nursing facility care should such care become necessary. Many policies also cover home-based care, but the daily benefit available for such care is often less than the benefit provided for nursing facility care. A typical policy might pay $100 per day for nursing facility care and up to $50 per day for home care.

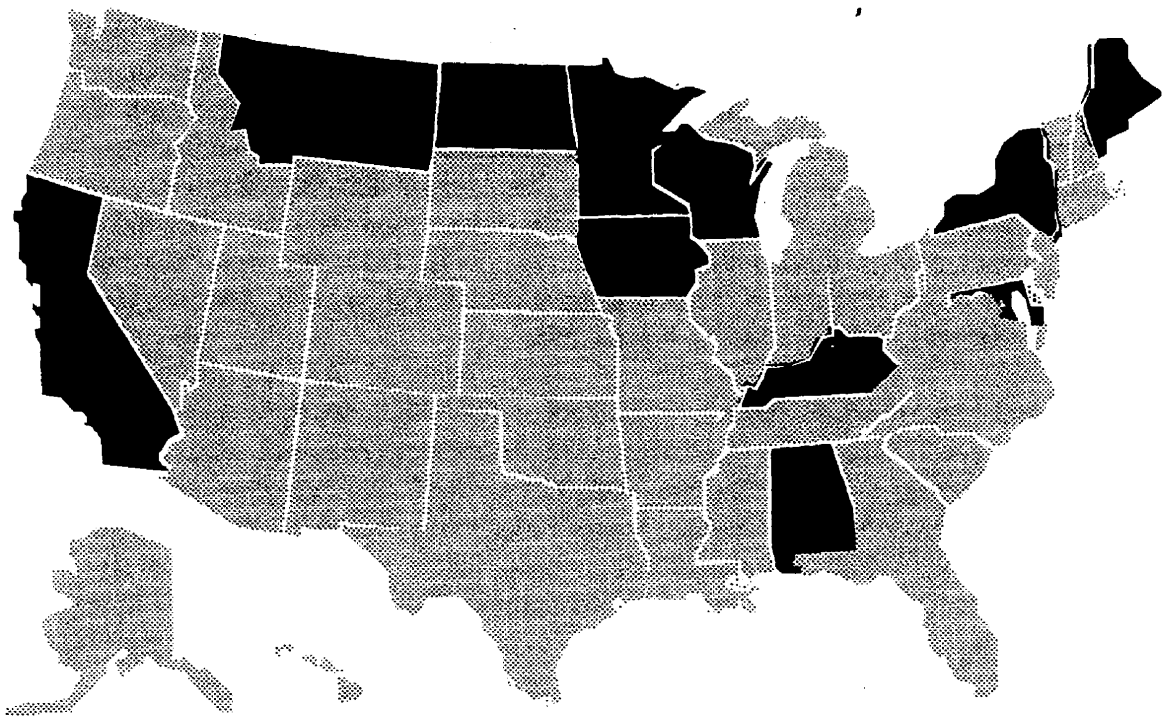
The federal government offers a tax deduction for long-term care insurance premiums for the limited subset of taxpayers whose medical expenses are large enough to qualify for a tax deduction (currently 7.5 percent of income or greater). During the past several years, there has been considerable interest among states in encouraging the purchase of long-term care insurance so as to reduce the future growth in Medicaid long-term care costs as the Baby Boom generation ages. At present, there are 11 states that offer tax incentives for the purchase of long-term care insurance, according to the Health Insurance Association of America. Figure 10 shows these states.

Tax Incentives for Long-Term Care Insurance Must Be Carefully Structured

States have structured tax incentives for long-term care insurance in a variety of ways. States offering tax incentives for the purchase of long-term care insurance have been least successful in encouraging purchase of long-term care insurance when the benefits of such incentives have been relatively low and the response cost has been relatively high. For example, North Dakota offers a relatively modest tax incentive for the purchase of long-term care insurance, a $100 tax credit. However, in order to claim the tax credit, tax payers must file the "long form." Therefore, tax filers who use a simpler format or who do not itemize their deductions are not eligible to claim the tax credit.

Figure 10

States Offering Long-Term Care Insurance Tax Incentives (States Shaded in Black Offer Some Type of Tax Incentive for Purchase of Long-Term Care Insurance)



Source: Health Insurance Association of America

Other states have targeted employers rather than individuals with their tax incentives. Maryland recently adopted this approach. The advantage of group policies is that they can help overcome one of the main barriers to purchase of long-term care insurance, the relatively high cost of the policies. Another advantage of offering group products is that trained benefit experts working for the employer can help screen the policies rather than individual consumers having to attempt to make decisions among the myriad of policies and options now available. The current thinking in the long-term care insurance industry is that long-term care insurance is the most marketable as a group benefit. Therefore, in addition to exploring tax incentives, states are also examining offering long-term care insurance to their employees and the families of their employees.

Long-Term Care Insurance Could Be Offered to State Employees and Their Families

At the request of the 1998 General Assembly, the Virginia Retirement System (VRS) is studied the feasibility of offering long-term care insurance to state employees as an optional employee benefit. At present, there are at least three states California, Florida, and Alabama that offer long-term care insurance to state employees. Florida and Alabama enacted their legislation during the past year. VRS reported in December 1998 that such a program was feasible, though VRS expressed some concern about the potential level of employee interest in this program. It is important to note that whatever policy selected for state employees should cover a range of services, not just nursing facility care.

Adult Protective Services at the Local Level Must Be Funded From Other Budget Line Items

The adult protective services program, overseen by the state Department of Social Services and implemented by all 122 local departments of social services, responds to reports of abuse, neglect, or exploitation of adults. At present, local social service departments must pay for the cost of adult protective services programs by using funds for other programs, because there is no line item budgeted for adult protective services. The cost of fully funding adult protective services would be significant ($5 million). However, given the importance of the program and the growing demands that will be placed on it by the rising number of elderly Virginians, it may be appropriate for the state to begin targeting funding to adult protective services. One means of beginning this process would be to appropriate $5,000 (GF) for each of the local agencies in the state for the second year of the biennium. The total cost of this option would be $610,000 (GF) annually.

Adult Foster Care Reimbursement Currently Lags Significantly Behind ACR Reimbursement

In terms of public pay rates for 24 hour long-term care, the lowest reimbursement level is for adult family foster care, more commonly known as adult foster care. Adult foster care involves the placement of aged or disabled individuals in private homes for care. Adult foster homes cannot care for more than three adults without being subject to licensure as an adult care residence. There are currently 110 homes approved to receive public pay clients, though there are only 106 clients currently placed in adult foster homes.

Adult foster homes are often referred to as unregulated. In actuality, oversight of these homes is provided by local departments of social services, though such oversight is admittedly minimal in some cases. The maximum reimbursement rate for this program is currently $508 per month for most of the

state and $584 for Northern Virginia. This translates to a daily payment rate of $16.70 for most of the state ($19.20 for Northern Virginia). Funding for the program, like most social services programs, consists of 80 percent state funds (general funds) and 20 percent local funds. In a limited number of cases, adult foster homes may receive additional reimbursement from community services boards. In fact, most public pay residents of adult foster homes have been placed there after discharge from a state behavioral health facility.

While the auxiliary grant rate is increased somewhat each year as a result of the SSI maintenance of effort requirement, there is no such requirement for adult foster care. Therefore, increases in the rate paid for this care are more infrequent. One option for addressing the low level of payment for adult foster care would be to link increases in this payment rate to increases in the auxiliary grant rate, so that when the auxiliary grant rate was increased, the adult foster care reimbursement level would also be increased by a similar percentage.

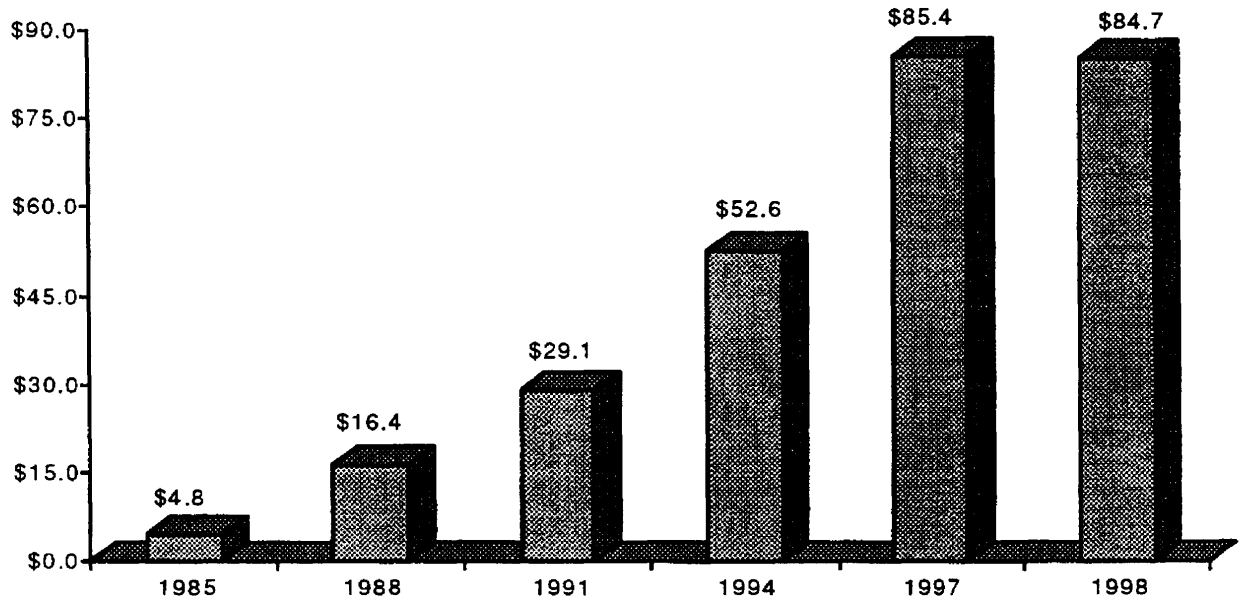
Personal Care Has Grown as a Component of Medicaid Long-Term Care Expenditures

During the past two decades, the state has adopted a conscious policy of redirecting Medicaid long-term care resources from nursing facility care to home and community based care. As noted previously, the share of Virginia Medicaid long-term care spending consumed by nursing facility services has decreased from 89 percent in 1990 to 78 percent in 1998. At the same time, nursing facility care as a percentage of overall Medicaid spending has been reduced from 36 percent in FY 1983 to 17 percent in FY 1997. During the same period, personal care expenditures have increased significantly (Figure 11).

Home Care Industry Has Expressed Concern About Its Reimbursement Level

At the September 17, 1998 meeting of the Joint Commission on Health Care's Long-Term Care Subcommittee, the home care industry expressed concern that the reimbursement level for personal care was inadequate. Personal care services involve the use of personal care aids to provide assistance with activities of daily living and related activities such as dressing, grooming, bathing, and toileting. This home care industry has expressed concern that the reimbursement level for personal care had not been increased in keeping with inflation.

Figure 11
Virginia Medicaid Personal Care Expenditures 1982-1998
(Dollars in Millions)



Source: Department of Medical Assistance Services.

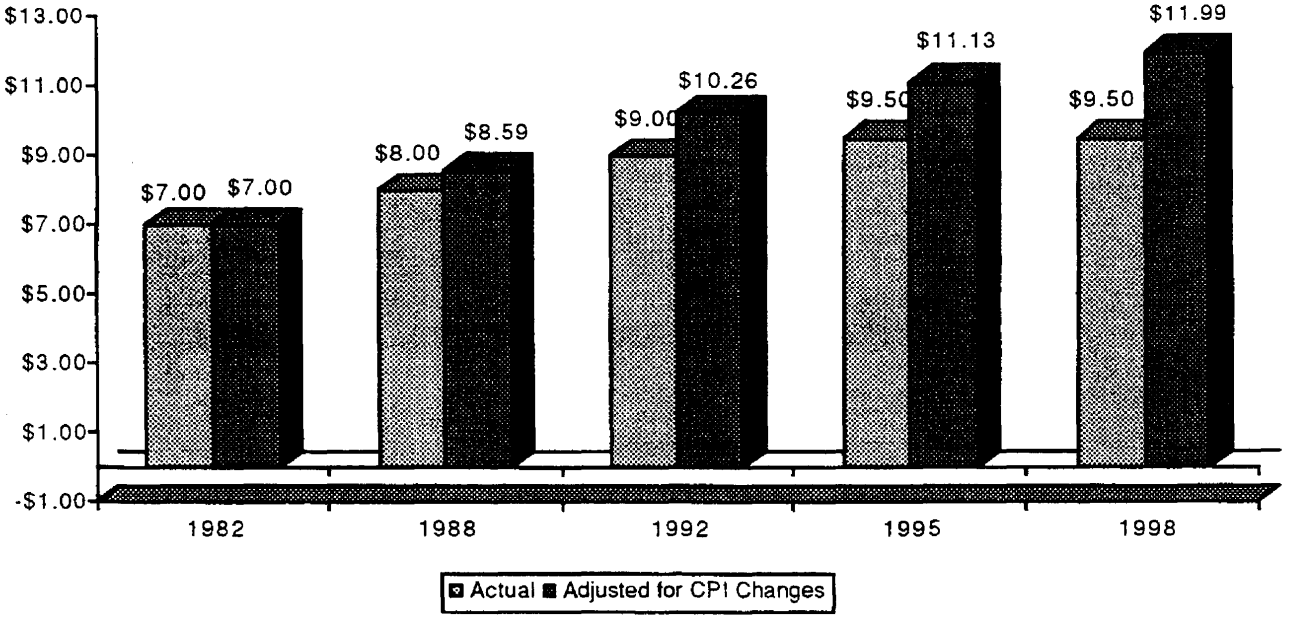
This concern is accurate in terms of home care reimbursement having not kept up with inflation. When personal care services became available under a Medicaid waiver in 1982, the reimbursement level for personal care was set at $7.00 per hour throughout the state. In 1988, the rates were increased to $8.50 for personal care services in Northern Virginia and $8.00 for the rest of the state. In 1990, reimbursement rates were set at $9.50 per hour for Northern Virginia (no change was made for the remainder of the state). In 1992 rates were increased to $11.00 per hour in Northern Virginia and $9.00 per hour in the remainder of the state. In 1995, the reimbursement rates for personal care rose to their current level, which is $9.50 per hour for most of the state and $11.50 for Northern Virginia.

As with the nursing home industry and the adult care residence industry, the home care industry has expressed concern about its ability to maintain staff due to the low wages that it is able to pay. This concern is not a new one. JLARC's 1992 report *Medicaid Financed Long-Term Care Services in Virginia* found that a formal rate setting process was needed for all of the state's long-term care waiver programs.

Reimbursement for personal care clearly has not kept pace with the increased cost of living (Figure 12). It is also noted that, to the extent that there have been increases in the personal care rate, these increases have tended to be driven by legislative action. At the direction of the General Assembly, the Department of Medical Assistance Services is currently studying its reimbursement methodology for personal care.

Figure 12

Increases in Medicaid Reimbursement for Personal Care Versus Cost of Living, 1982-1998



Source: JLARC, Medicaid Financed Long-Term Care Services in Virginia; U.S. Bureau of Labor Statistics, Virginia Association for Home Care.

V.
Policy Options for Long-Term Care Financing

Policy Options for Long-Term Care Financing

The following policy options represent policy options that the Joint Commission on Health Care may choose to pursue with regard to long-term care financing. Cost estimates for many of these policy options are presented in Appendix D. It is noted that these policy options are not mutually exclusive for the most part. The Joint Commission on Health Care may choose to pursue two or more of these options.

Policy Options for Long-Term Care Financing

Option I: **Take no action.**

Option II: **Introduce a budget amendment providing sufficient funding to the Medicaid program to fund an average increase in nursing assistant salaries to a level to be determined after reviewing the DMAS report on nursing salaries.**

Option III: **Introduce a budget amendment providing sufficient funds to increase the auxiliary grant rate to the median cost level for the industry as determined by the Department of Social Services after its review of audit data is completed.**

Option IV: **Introduce a budget amendment (language) stating that the policy of the Commonwealth is henceforth to fund increases in the auxiliary grant rate either (a) entirely from the general fund, or (b) 90 percent from the general fund in FY 2000 to increase to 100 percent in FY 2002. This amendment would not disturb the existing allocation of 80 percent state/20 percent local for the current auxiliary grant rate.**

Option V: **Introduce a budget amendment to allow a 25 percent higher auxiliary grant payment for ACRs in Planning District Eight, as opposed to the current 15 percent differential. The current fiscal impact would be minimal, as there are few auxiliary grant beds in this planning district.**

Option VI: **Introduce a budget amendment directing the Department of Medical Assistance Services, with the assistance of the Department of Social Services, to rework the assisted living supplements to the auxiliary grant rate considering (i) whether**

additional nursing facility patients can be served through assisted living, (ii) services covered by the assisted living payments and the extent to which payments reflect the services that need to be provided, (iii) adequacy of reimbursement for assisted living care, (iv) the appropriateness of the current two-tiered structure for assisted living payments, (v) the extent to which Medicaid funds could be used in lieu of general funds to provide assisted living care, (vi) best practices in other states, and (vii) the adequacy of the current regulatory structure if heavier care patients were to be cared for in adult care residences.

Option VII: Introduce a budget amendment providing $610,000 (GF) to the Department of Social Services to allocate $5,000 in adult protective services funding to each of the 122 local departments of social services.

Option VIII: Introduce a budget amendment (language) to increase the adult foster care rate annually by the same percentage as the auxiliary grant rate is increased. Fiscal impact of this option is minimal, as there are currently only 106 public pay clients in this program. For example, the estimated cost of an increase of 20 percent in the adult foster care rate is less than $150,000 (combined state and local) assuming no increase in the population served.

Option IX: Introduce a budget amendment to increase the personal care rate by an amount to be determined after review of the DMAS study.

Option X: Introduce a joint resolution directing the Department of Medical Assistance Services to examine (i) means of simplifying the current nursing home reimbursement formula and process, and (ii) simplifying the year-end reconciliation process. This option relates to calculations for basic per diem reimbursement only, not specialized programs such as wound care.

VI.
Options for Increasing the Number of Geriatricians

Geriatricians Are in Short Supply Nationwide

A geriatrician is a medical doctor who specializes in the care and treatment of older adults. Geriatric medicine is defined by the Institute of Medicine as "the total health and social care of elderly people. Geriatric medicine is primary care provided to the elderly by generalists." In order to effectively meet the health care needs of elderly Virginians, it is necessary to have an adequate number of trained geriatric specialists who have completed fellowships in geriatric medicine. At the same time, however, most care to the elderly is provided by generalist physicians, so it is also necessary to have adequate training programs in place to educate health care providers who are not geriatric specialists on how to meet the health care (and social) needs of the elderly. This includes training generalist physicians, nurses, allied health professionals, and direct care givers such as nursing assistants.

The term "geriatrics" was first coined in 1909 by Dr. Ignatz Nascher, and it refers to the "preventative, remedial, and research aspects of aging-related disease" (Alliance for Aging Research, 1996). Geriatric medicine first emerged as a medical specialty in the late 1970s, partly as a result of the 1978 report of the Institute of Medicine chaired by Paul B. Beeson (sometimes called the "Beeson Report"). While geriatrics has become widely accepted as a legitimate area of medical specialty, it has proven to be a difficult area to recruit physicians to specialize in. The difficulty in recruiting geriatric specialists is primarily attributable to low level of reimbursements offered by third party payors (primarily Medicare) for services provided by geriatricians. Low reimbursements for services is particularly a disincentive for new medical graduates to enter a given specialty because of the increasingly high level of debt the average medical school graduate carries upon graduation. In addition, geriatric medicine is not typically a required course in medical school, therefore aspiring physicians' exposure to geriatrics may be limited.

A 1993 study (Reuben, et. al.) estimated that the number of geriatricians being produced is less than half of that required to meet the need for training primary care providers and others who require some education in geriatrics. The effect of this shortfall is three-fold. First, there is not an adequate cadre of trained geriatricians to meet the specialty care needs of the elderly. Second, there is not an adequate number of geriatricians to serve as mentors for medical students and residents to encourage them to enter the field, thereby compounding the problem of short supply of geriatric specialists. Third, there is not an adequate number of geriatricians to train the primary care providers and other health professionals in geriatric care.

The Shortage of Geriatricians in Virginia Is Analogous to the Problem Addressed by the Virginia Generalist Initiative

In the late 1980s, there was concern expressed nationwide that only a small percentage (as low as 25 percent) of medical school graduates were choosing primary care career paths at the same time that the growth of managed care concepts made primary care physicians important gatekeepers to accessing health care. In particular, concern was expressed about the availability of generalist physicians in rural areas. The Virginia Generalist Initiative (VGI) is a collaborative effort of Virginia's three medical schools that is funded by a Robert Wood Johnson Foundation Grant and state matching funds. The goal of the VGI is to increase the number of medical school graduates in Virginia who enter a primary care residency to fifty percent of graduates. The VGI has an office on each of the state's three medical school campuses, with the VGI's coordinating office being located at the University of Virginia in Charlottesville.

The problem of attracting young physicians to geriatric medicine is analogous to the generalist initiative in that there are demographic needs for more physicians in the given area, economic disincentives to practicing in that area, and cultural barriers within the medical schools that mitigate against career choices outside of subspecialty career choices. In other words, because most potential faculty mentors are in fact subspecialists and few are generalist physicians or geriatricians, it is correspondingly more difficult to attract medical students to pursue training in this area.

In two ways the challenge for attracting geriatricians is even more difficult than the challenge of attracting generalisht physicians. First, unlike generalist physicians, there is not a trend towards better reimbursement/compensation for geriatricians. Second, unlike primary care practice, becoming a geriatric specialist involves at least an additional year of fellowship training.

Policy Options for Geriatric Training for Health Care Providers

Option I: Take No Action.

Option II: Introduce a budget amendment providing $300,000 (GF) in the second year of the biennium to provide one junior faculty member specializing in geriatrics for each of the state's medical schools. In addition to the normal teaching and research expectations, these positions would serve as resource persons for a broad range of health professions education in geriatric care issues and as resource persons for long-term care providers.

Option III: **Introduce a joint resolution requesting the state's three medical schools to consider expanding the generalist physician initiative to address geriatric training for medical students and other health professionals.**

APPENDIX A

HOUSE JOINT RESOLUTION NO. 156

Directing the Joint Commission on Health Care to continue its Long-Term Care Subcommittee and to continue its study of long-term care financing, licensure, and other issues.

Agreed to by the House of Delegates, February 17, 1998
Agreed to by the Senate, March 10, 1998

WHEREAS, the population of the Commonwealth is rapidly aging; and

WHEREAS, Virginians 85 years of age and older are the fastest-growing segment of the state's population; and

WHEREAS, the demand for long-term care services is expected to increase rapidly; and

WHEREAS, the Medicaid program finances approximately 70 percent of the nursing home care provided in the Commonwealth; and

WHEREAS, long-term care expenditures by state government exceeded $500 million in fiscal year 1996; and

WHEREAS, the Joint Commission on Health Care's Long-Term Care Subcommittee has begun a study of long-term care and aging issues; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Joint Commission on Health Care be directed to continue its Long-Term Care Subcommittee and its study of long-term care financing, licensure and other issues. In its deliberations, the subcommittee shall focus on (i) long-term care licensure and improvements in existing agencies; (ii) the feasibility of and necessity for a separate Department of Health Care Quality; (iii) the advantages and disadvantages of "deemed status" where accreditation is accepted in lieu of state licensure or federal certification; (iv) long-term care financing strategies, including long-term care insurance, blending Medicaid and Medicare for dually-eligible individuals, and creative use of Medicaid waivers; (v) strategies for increasing the number of graduates of Virginia medical schools who specialize in geriatric medicine; and (vi) other issues as may seem appropriate.

All agencies of the Commonwealth shall provide assistance to the Commission and its staff, upon request.

The Commission shall submit its findings and recommendations to the Governor and the 1999 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

An estimated $65,000 is allocated for the cost of staff support for the completion of the study to be funded by a separate appropriation from the General Assembly.

SENATE JOINT RESOLUTION NO. 97

Directing the Joint Commission on Health Care to continue its Long-Term Care Subcommittee and to continue its study of long-term care financing, licensure and other issues.

Agreed to by the Senate, March 13, 1998
Agreed to by the House of Delegates, March 12, 1998

WHEREAS, the population of the Commonwealth is rapidly aging; and

WHEREAS, Virginians 85 years of age and older are the fastest-growing segment of the state's population; and

WHEREAS, the demand for long-term care services is expected to increase rapidly; and

WHEREAS, the Medicaid program finances approximately 70 percent of the nursing home care provided in the Commonwealth; and

WHEREAS, long-term care expenditures by state government exceeded $500 million in fiscal year 1996; and

WHEREAS, the Joint Commission on Health Care's Long-Term Care Subcommittee has begun a study of long-term care and aging issues; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Joint Commission on Health Care be directed to continue its Long-Term Care Subcommittee. In its deliberations, the subcommittee shall focus on (i) long-term care licensure and improvements in existing agencies; (ii) the feasibility of and necessity for a separate Department of Health Care Quality; (iii) the advantages and disadvantages of "deemed status" where accreditation is accepted in lieu of state licensure or federal certification; (iv) long-term care financing strategies, including long-term care insurance, blending Medicaid and Medicare for dually-eligible individuals, and creative use of Medicaid waivers; (v) strategies for increasing the number of graduates of Virginia medical schools who specialize in geriatric medicine; and (vi) other issues as may seem appropriate.

All agencies of the Commonwealth shall provide assistance to the Joint Commission and its staff, upon request.

The Joint Commission shall submit its findings and recommendations to the Governor and the 1999 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

An estimated $65,000 is allocated for the cost of staff support for the completion of the study, to be funded by a separate appropriation from the General Assembly.

APPENDIX B

JOINT COMMISSION ON HEALTH CARE

SUMMARY OF PUBLIC COMMENTS: LONG-TERM CARE LICENSURE STUDY (SJR 97/HJR 156)

Individuals/Organizations Submitting Comments

A total of eight individuals and organizations submitted comments in response to the Long-Term Care Licensure study conducted pursuant to SJR 97/HJR 156.

American Association of Retired Persons
Mr. John B. Bell
Ms. Marjorie L. Marker
Ms. Terry Smith
Dr. Mickey Thomas Terry
Virginia Association of Nonprofit Homes for the Aging
Virginia Health Care Association
Virginia Hospital and Healthcare Association

Policy Options Related to Deemed Status

Option I: **Take No Action**

Option II: **Introduce legislation allowing the Commissioner of Health to deem eligible for state licensure any nursing home accredited by a national accrediting body which, in the opinion of the Commissioner, has accreditation standards that meet or exceed state licensure requirements. Under this option, the Commissioner of Health would retain authority to investigate complaints and to revoke the license when appropriate.**

Option III: Introduce a budget amendment directing the Commissioner of Social Services to issue a Request for Proposal (RFP) to conduct accreditation for a targeted area of the state to develop accreditation standards and conduct accreditation reviews of interested adult care residences. The General Assembly may choose to accept this accreditation in lieu of state licensure.

Policy Options for a Separate Department of Health Care Quality

Option I: Take no action.

Option II: Introduce legislation creating a separate Department of Health Care Quality within the executive branch. This agency would consist of the following existing organizational units: (i) the Division of Long-Term Care within the Department of Health's Center for Quality Health Services and Consumer Protection (31 FTE), (ii) the staff of the adult care residence licensing program within the Department of Social Services (17 FTE), and (iii) the licensing program staff from the Department of Mental Health, Mental Retardation and Substance Abuse Services (15 FTE). The new agency would require significant additional FTE (estimated 15 to 20) for administrative support, management and direction, and to address staffing shortages within existing programs.

Option III: Introduce legislation creating a separate Department of Health Care Quality consisting of the following organizational units: (i) the Division of Long-Term Care within the Department of Health's Center for Quality Health Services and Consumer Protection (31 FTE), and (ii) the staff of

the adult care residence licensing program within the Department of Social Services (17 FTE).

Option IV: Introduce a joint resolution requesting the Secretary of Health and Human Resources to prepare a reorganization plan for long-term care licensure and certification. The Secretary would be requested to consider: (i) consolidation within an existing agency, (ii) consolidation within the newly created Office of the Inspector General within the Secretary's Office, and (iii) consolidation within a separate Department. Under this option, the Secretary would be required to report to the Governor and General Assembly by October 1, 1999.

Policy Options for Improvements Within Existing Agencies

Option I: Take No Action.

Option II: Introduce budget amendments to address staffing needs within existing agencies. Introduce a budget amendment providing five FTE and $80,000 (GF) and $120,000 (SF) to the Virginia Department of Health for its long-term care licensure and certification program. Introduce a budget amendment providing three FTE and $105,000 (GF) to the Virginia Department of Social Services for its adult care residence licensing program.

Option III: Introduce a budget amendment providing $25,000 (GF) to the Virginia Department of Social Services to address training needs within the adult care residence licensing program.

Overall Summary of Comments

With regard to deemed status, most commenters expressing an option supported Option III. All three provider groups commenting supported Option II as well. With regard to a separate Department of Health Care Quality, four commenters supported Option I (take no action), one commenter supported Option III, and one commenter supported Option IV. With regard to improvements in existing agencies, all six commenters addressing the policy options supported Options II and III.

American Association of Retired Persons

Mr. William L. Lukhard, Mr. Jack R. Hundley, and Ms. Mary H. Madge commented jointly on behalf of the American Association of Retired Persons (AARP). With regard to deemed status, AARP supported Option III. With regard to the need for and feasibility of a separate Department of Health Care Quality, AARP expressed concern that "much of the draft material deals with the concerns of providers and past legislative experience concerning a independent agency . . . What is missing is concern for the citizen consumer who has to work through a complex and diverse system of long-term care." AARP supported Option III, creation of a separate department consisting of the current licensing staff for adult care residences and the long-term care unit of the Virginia Department of Health's Center for Quality Health Services and Consumer Protection. With respect to improvements in existing agencies, AARP commented in favor of Options II and III, though they questioned the adequacy of $25,000 to address training needs within DSS.

Mr. John B. Bell

Mr. Bell's letter did not address the policy options per se. Rather Mr. Bell related the experiences of his mother in a nursing facility. Mr. Bell expressed concern about the predictability of the timing of the Virginia Department of Health's survey visits to nursing facilities. Mr. Bell also expressed concern about the need for a more precise staffing standard for nursing facilities, stating that one recent day there was only one nurse and one nursing assistant on duty to care for 60 residents.

Ms. Marjorie L. Marker

Regarding deemed status, Ms. Marjorie Marker expressed concern about Option II. She indicated cautious support for Option III. With

regard to creation of a separate department of health care quality, Ms. Marker supported Option IV. With regard to improvements in existing agencies, Ms. Marker supported Options II and III.

Ms. Terry Smith

Ms. Terry Smith, adult services program manager with the Department of Social Services, supported Option III with respect to deemed status. Regarding a separate Department of Health Care Quality, Ms. Smith supported Option I. With respect to improvements in existing agencies, Ms. Smith supported Options II and III.

Dr. Mickey Thomas Terry

Dr. Mickey Thomas Terry wrote to express his concern about nursing home staff ratios and the lack of firm staff standards. In particular, Dr. Terry expressed concern about the practice of aggregating staffing ratios into a measure of staff per patient day rather than examining staff present at any discrete time. In particular, Dr. Terry expressed concern about staffing on weekends, holidays, and nights. Dr. Terry closed by stating "this is not just a legal issue, but a moral one."

Virginia Association of Nonprofit Homes for the Aging

The Virginia Association of Nonprofit Homes for the Aging (VANHA) expressed support for the concepts presented in Options II and III under deemed status. VANHA also recommended that ACRs be allowed deemed status via the same type of mechanism allowed nursing facilities (in Option II). With regard to a separate Department of Health Care Quality, VANHA supported Option I, expressing concern that a consolidated agency would be based only on a medical model. With regard to improvements in existing agencies, VANHA supported the concepts expressed in Options II and III.

Virginia Health Care Association

With regard to deemed status, the Virginia Health Care Association (VHCA) expressed support for Options II and III. With regard to creation of a separate Department of Health Care Quality, VHCA supported Option I.

With regard to improvements in existing agencies, VHCA supported Options II and III.

Virginia Hospital and Healthcare Association

The Virginia Hospital and Health Care Association (VHHA) supported Options II and III with regard to deemed status. With regard to a separate Department of Health Care Quality, VHHA supported Option I. With regard to improvements in existing agencies, VHHA supported Options II and III.

JOINT COMMISSION ON HEALTH CARE

SUMMARY OF PUBLIC COMMENTS: LONG-TERM CARE FINANCING STUDY (SJR 97/HJR 156)

Individuals/Organizations Submitting Comments

A total of 41 individuals and organizations submitted comments in response to the Long-Term Care Financing study conducted pursuant to SJR 97/HJR 156. This number does not include cases where the same social services agency submitted multiple, similar comments.

Accomack County Department of Social Services (multiple responses)
American Association of Retired Persons
Amherst County Department of Social Services
Campbell County Department of Social Services
Capital Area Agency on Aging
Chesapeake Department of Social Services (multiple responses received)
Chesapeake Task Force on Aging
Culpeper County Department of Social Services
Danville Department of Social Services
Dinwiddie County Department of Social Services
Fairfax County
John Franklin, M.D., MACP, Eastern Virginia Medical School
Galax Department of Social Services
Grayson County Department of Social Services
Stephan Gravenstein, M.D., Director, Division of Geriatrics and Gerontology, Center for Geriatrics, Eastern Virginia Medical School
H. Desmond Hayes, M.D., Professor, Eastern Virginia Medical School
Gloria M. Myers
Isle of Wight Department of Social Services
James City County Department of Social Services
Newport News Department of Social Services
Norfolk Commission on Aging Long-Term Care Coordination Committee
Northern Virginia Aging Network
Portsmouth Task Force on Aging
Shenandoah Department of Social Services
Ms. Terry Smith

Spotsylvania County Department of Social Services (several responses)
Stafford County Department of Social Services
St. Francis Home
Staunton-Augusta County Department of Social Services
Sussex County Department of Social Services
Virginia Adult Home Association
Virginia Association of Counties
Virginia Association of Nonprofit Homes for the Aging
Virginia Coalition for the Prevention of Elder Abuse
Virginia Geriatrics Society
Virginia Health Care Association
Virginia Hospital and Healthcare Association
Virginia League of Social Services Executives
Virginia Municipal League
Virginia Poverty Law Center
Winchester Department of Social Services

Policy Options for Long-Term Care Financing

Option I: **Take no action.**

Option II: **Introduce a budget amendment providing sufficient funding to the Medicaid program to fund an average increase in nursing assistant salaries to a level to be determined after reviewing the DMAS report on nursing salaries. It is estimated that this increase will be approximately $1.00 per hour with an approximate general fund cost of $6.7 million annually.**

Option III: **Introduce a budget amendment providing sufficient funds to increase the auxiliary grant rate to the median cost level for the industry as determined by the Department of Social Services after its review of audit data is completed. Raising the auxiliary grant rate to $846 (the un-audited median cost) would have a fiscal impact of approximately $13.5 million (combined state and local impact).**

Option IV: Introduce a budget amendment (language) stating that the policy of the Commonwealth is henceforth to fund increases in the auxiliary grant rate either (a) entirely from the general fund, or (b) 90 percent from the general fund in FY 2000 to increase to 100 percent in FY 2002. This amendment would not disturb the existing allocation of 80 percent state/20 percent local for the current auxiliary grant rate. The fiscal impact of this option would depend on the increase in the auxiliary grant rate; for an increase to $846, the additional state cost of assuming the local share of the increase would be approximately $2.7 million (GF).

Option V: Introduce a budget amendment to allow a 25 percent higher auxiliary grant payment for ACRs in Planning District Eight, as opposed to the current 15 percent differential. The current fiscal impact would be minimal, as there are few auxiliary grant beds in this planning district.

Option VI: Introduce a budget amendment directing the Department of Medical Assistance Services, with the assistance of the Department of Social Services, to rework the assisted living supplements to the auxiliary grant rate considering (i) whether additional nursing facility patients can be served through assisted living, (ii) services covered by the assisted living payments and the extent to which payments reflect the services that need to be provided, (iii) adequacy of reimbursement for assisted living care, (iv) the appropriateness of the current two-tiered structure for assisted living payments, (v) the extent to which Medicaid funds could be used in lieu of general funds to provide assisted living care, (vi) best practices in other states, and (vii) the adequacy of the current regulatory structure

if heavier care patients were to be cared for in adult care residences.

Option VII: Introduce a budget amendment providing $610,000 (GF) to the Department of Social Services to allocate $5,000 in adult protective services funding to each of the 122 local departments of social services.

Option VIII: Introduce a budget amendment (language) to increase the adult foster care rate annually by the same percentage as the auxiliary grant rate is increased. Fiscal impact of this option is minimal, as there are currently only 106 public pay clients in this program. For example, the estimated cost of an increase of 20 percent in the adult foster care rate is less than $150,000 (combined state and local) assuming no increase in the population served.

Option IX: Introduce a budget amendment to increase the personal care rate by an amount to be determined after review of the DMAS study.

- For illustrative purposes only, based on 1997 hours used, an increase of 50 cents per hour in the personal care rate would require an annual increase of about $4.57 million in Medicaid expenditures (the state share would be approximately $2.2 million). This cost estimate does not take into account potential increased utilization as a result of an increase in the reimbursement rate.

Option X: Introduce a joint resolution directing the Department of Medical Assistance Services to examine (i) means of simplifying the current nursing home reimbursement formula and process, and (ii) simplifying the year-end reconciliation process. This option relates to calculations for basic per diem reimbursement

only, not specialized programs such as wound care.

Policy Options for Geriatric Training for Health Care Providers

Option I: **Take No Action.**

Option II: **Introduce a budget amendment providing $300,000 (GF) in the second year of the biennium to provide one junior faculty member specializing in geriatrics for each of the state's medical schools. In addition to the normal teaching and research expectations, these positions would serve as resource persons for a broad range of health professions education in geriatric care issues and as resource persons for long-term care providers.**

Option III: **Introduce a joint resolution requesting the state's three medical schools to consider expanding the generalist physician initiative to address geriatric training for medical students and other health professionals.**

Summary of Comments Regarding Financing

None of the comments addressing financing supported Option I. However, the Virginia Hospital and Health Care Association (VHHA) expressed concern that the specific options identified in this report should not preclude consideration of other, perhaps preferable options. Many of the commenters were local departments of social services. These commenters all supported Option VII (regarding adult protective services funding). In many cases, commenters from local social services agencies also supported other options (particularly Option IV). The Virginia League of Social Services Executives opposed Option III unless Option IV was also adopted (the League would also support gradually phasing in an increased

state share of the auxiliary grant). The Virginia League of Social Services Executives also supported Options IV, V, and VI.

There were three comments received from local government apart from social services agencies: Fairfax County, the Virginia Municipal League (VML), and the Virginia Association of Counties (VACO). These commenters all stated that the position of local government would be to oppose an increase in the auxiliary grant rate unless the increase was entirely funded through state funds. In addition, VML and VACO supported Options V, VI, and VII. VML also supported Option VIII, provided that the state assumed the increased costs associated with this option. Other than expressing concern about an increase in the auxiliary grant rate, Fairfax County did not support options per se; rather the comments from Fairfax pointed out strengths and weaknesses with respect to each option.

Three comments were received from provider associations. As already noted, VHHA did not single out options to support and opposed Option I. The Virginia Health Care Association (VHCA) supported Options II through IX, though it particularly commented on Options II, III, and VI. VHCA also noted some reservations about Option VI, given the relative lack of stringency it perceived in ACR regulations when compared to nursing home regulations. VHCA noted that adequate safeguards must be in place to protect the "increasingly frail, dependant residents in these facilities." The Virginia Association of Nonprofit Homes for the Aging (VANHA) supported Option II (while also requesting formation of a "Blue Ribbon Long-Term Care Labor Commission). VANHA also supported Options III, IV, V, VI, and IX, and X. The Virginia Adult Home Association (VAHA) expressed concern that Option III was unrealistically low and questioned reliance on a median versus an average. VAHA also supported Option IV. VAHA expressed concern about Option V and stated that, with regard to Option VI, the assisted living rate has no basis in actual cost and stated that providers have found additional requirements associated with assisted living to be overbearing and duplicative. VAHA also expressed concern that any long-term care insurance option for state employees include assisted living as an option.

A number of comments were received from consumer advocacy groups. The American Association of Retired Persons (AARP) expressed concern that the report did not address strategies for the dual eligibles and

did not include a policy option on a long-term care insurance tax credit. AARP supported Options II, III, IV, V, VI, VIII, and IX. However, AARP stated that "reimbursements should not be done in isolation of [sic] improved quality of care that can be accomplished through an improved licensure system." The Northern Virginia Aging Network (NVAN) supported Options II through X. NVAN also supported an option for protecting spouses of ACR residents from spousal impoverishment by using Medicaid rules for spousal protection. The Virginia Coalition for the Prevention of Elder Abuse supported Option VII. The Norfolk Commission on Aging Long-Term Care Coordination Committee supported Options II, III, IV, VI, VII, VIII, and IX but opposed Option V. The Capital Area Agency on Aging supported Option VII. The Portsmouth Task Force on Aging supported Options II, III, IV, VI, VII, and IX. Ms. Gloria Myers, writing on behalf of the Chesterfield Long-Term Care Council, supported Options V, VI, VII and VIII. The Chesapeake Task Force on Aging supported Options II, III, IV, VI, VII, VIII, and IX; this organization's top priorities were Options II, III, and VII. Virginia Poverty Law Center (VPLC) supported Option II (provided the funds go only to salaries), IV, VII, and IX (if the entire increase is received by personal care aids). VPLC supported Option V only if the increase is tied directly to new auxiliary grant beds.

Summary of Comments Regarding Policy Options for Increasing the Number of Geriatricians

The Virginia Geriatrics Society supported Option II. Three Eastern Virginia Medical School professors supported Option II. The Medical College of Virginia of Virginia Commonwealth University supported Option II and opposed Option III. The Portsmouth Task Force on Aging supported Option II. AARP supported Options II and III and recommended that geriatric medicine courses be required for all Virginia medical students. The Virginia Hospital and Health Care Association supported Option III. The Virginia Health Care Association supported Options II and III.

APPENDIX C

Medicaid Nursing Facility Reimbursement

Current Situation:

Medicaid nursing facility reimbursement in Virginia is calculated using a series of complex formulas that analyze both direct and indirect costs of providing care. Nursing facility reimbursement is expressed on a per diem basis. According to data provided by DMAS and the American Health Care Association, the average per diem reimbursement rate for nursing facility care through the Virginia Medicaid program in 1998 was $78.12 per day (this includes patient contributions). Virginia's reimbursement rate at that time was 39th among the 48 states reporting data.

Assumptions for Calculating the Increase:

The cost of increased Medicaid nursing facility reimbursement was calculated by using the projected number of Medicaid nursing facility bed days for FY 2000 (6,809,311); this number does not include bed days coded as skilled nursing facility (SNF) care. As noted in the discussion of personal care, the match rate (state share) projected for FY 2000 is .4835.

Amount of Increase	Estimated Medicaid Cost	Estimated State Share	Rank Among States Based on 1998 Data*
$1.00	$6,809,311	$3,292,302	39
$5.00	$34,046,555	$16,461,509	35
$7.50	$51,069,833	$24,692,264	32
$10.00	*$68,093,110*	*$32,923,019*	*29*
$15.00	$102,139,665	$49,384,528	27
$17.50	$119,162,943	$57,615,283	21
$20.00	$136,186,220	$65,846,037	17

*Assumes other state reimbursement remains constant, as there is not a basis for determining the level of increases in other states. Vermont, Tennessee, and Maine did not report data.

Auxiliary Grant Rate

Current Situation:

At present, for residential care, the maximum auxiliary grant is $747 per month for most of the state and $859 per month for Northern Virginia. For most auxiliary grant recipients, the auxiliary grant is the difference between the maximum allowable grant and their own income (typically SSI). At present, the average auxiliary grant is $267. As of January 1999, it is estimated that there are 6,800 auxiliary grant recipients. Total state and local auxiliary grant expenditures in FY 1998 were approximately $20.2 million (this does not include the DMAS fiscal impact of the auxiliary grant program, which includes eligibility for Medicaid services for auxiliary grant recipients, the regular assisted living supplement, funded by the general fund, and the intensive assisted living supplement, a Medicaid waiver service).

Assumptions for Calculating the Increase:

For each $5 increase in the auxiliary grant rate, DSS assumes that an additional 50 persons will become eligible for the auxiliary grant. The following cost estimates also assume that, based on the Commission's vote at the December 10, 1998 Commission meeting that the budget amendment would be drafted so that the state would assume 100 percent of the costs of any auxiliary grant increase.

Estimated Additional Costs for Increasing the Auxiliary Grant Rate Beyond Federal Maintenance of Effort Requirements

Maximum Auxiliary Grant Rate	Auxiliary Grant Recipients	Average Auxiliary Grant	DSS* Fiscal Impact (GF)	DMAS** Fiscal Impact (GF)	Total GF Fiscal Impact
$747	6,800	$267	***	***	
$800	7,333	$320	$6,360,000	$2,333,060	$8,693,060
$850	7,749	$370	$12,978,000	$4,534,060	$17,512,060
$900	8,249	$420	$20,196,000	$6,735,060	$26,931,060
$950	*8,749*	*$470*	*$28,014,000*	*$8,936,000*	*$36,950,000*
$1,000	9,249	$527	$36,432,000	$11,137,060	$47,569,060
$1,050	9,749	$577	$45,450,000	$13,338,060	$58,788,060
$1,100	10,249	$627	$55,068,000	$15,539,060	$70,607,060

**reflects 100 percent state share of the cost of the increase*

***auxiliary grant recipients are eligible for Medicaid; these figures include the fiscal impact on the generally funded regular assisted living supplement program included in the DMAS budget, as well as the Medicaid intensive assisted living supplement*

****the auxiliary grant rate increased to $747/month from $737/month in December 1998*

Medicaid Personal Care Reimbursement

Current Situation:

Personal care is reimbursement on an hourly rate by the Medicaid program. The hourly rate is currently $9.50 per hour for most of the state and $11.50 for Northern Virginia. In 1998, there were 10,946 unique recipients for Medicaid personal care services. Total 1998 Medicaid expenditures for personal care were $84,702,907 (state share estimated at $41,097,850). There is no automatic increase in the personal care rate to reflect changes in the cost of living. The last increase (50 cents per hour) took effect in 1995.

Assumptions for Calculating the Increase:

The Governor's budget does not recommend an increase in the personal care reimbursement rate. The fiscal impact of an increase is calculated by taking the number of personal care hours assumed in the Medicaid forecast (9,077,234) and multiplying by the amount of the increase. The match rate (state share) is projected at .4835 for FY 2000.

Reimbursement Rate	Amount of Proposed Increase	Cost in Total Medicaid Dollars	State Share
$10/hour ($12/hour in Northern Virginia)	$.50	$4,538,617	$2,202,137
$10.50/hour ($12.50/hour in Northern Virginia)	$1.00	$9,077,234	$4,404,274
$11.00/hour ($13.00/hour in Northern Virginia)	$1.50	$13,615,851	$6,606,411
$11.50/hour ($13.50/hour in Northern Virginia)	*$2.00*	*$18,154,468*	*$8,808,548*

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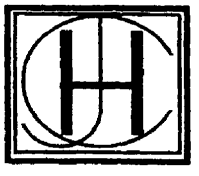

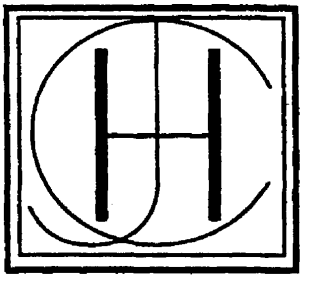

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