REPORT OF THE
JOINT LEGISLATIVE AUDIT AND REVIEW COMMISSION

Impact of an Aging Population on State Agencies

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

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COMMONWEALTH OF VIRGINIA
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In Brief…

Impact of an Aging Population on State Agencies

House Joint Resolution 103, enacted by the 2004 General Assembly, directed JLARC staff to review the impacts of an aging population on the demand for and cost of State agency services. The proportion of Virginia's population that is elderly is projected to increase substantially over the next 25 years. This phenomenon is not unique to Virginia, but is also anticipated at the national level and globally.

This report seeks to frame some of the key factors and issues surrounding the likely impacts of Virginia's aging population. A continuance of existing State policies is expected to exert considerable fiscal pressures upon the State. For example, the State's expenditures on Medicaid are projected to rise from one billion dollars per year to between four and eleven billion dollars per year by 2030. Further, tax exemptions and deductions, as well as decreasing consumption expenditures that are associated with older Virginians, are likely to impact revenue levels.

However, an important point to note is that the impact that an aging population will ultimately have upon State services will depend to a great extent upon the decisions that are made by State policymakers. The extent to which the State will be seen as responsible for funding or providing services demanded by older Virginians is still an open question. Evidence from the review indicates, however, that the current level of service in some areas is not able to match existing demand.

JLARC on the Web:
http://jlarc.state.va.us

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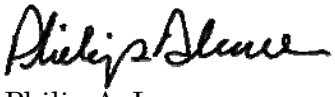
Preface

House Joint Resolution 103 from the 2004 Session directs the Joint Legislative Audit and Review Commission (JLARC) to study the impact of Virginia's aging population on the demand for and cost of state agency services, policies, and program management. The number of older Virginians, those persons age 60 and above, has been increasing as a proportion of the State's overall population. HJR 103 notes that the number of older Virginians is projected to increase at even faster rates over the next 30 years, and that the older population may require an even greater amount of State agency services.

This document is the final report for the JLARC review of the impact of an aging population on State agencies. This report provides information on the ability of State agencies to meet current service demands, and also provides information on factors which may affect future service demands. An ancillary report on the impact of an aging State workforce is also available, and additional background information is contained in the interim report which was presented in 2004. Finally, a supplementary appendix which contains the responses of State agencies to a survey regarding services for older Virginians is available on the JLARC website at http://jlarc.state.va.us/Reports/AgingSupAppdx.pdf .

On behalf of the JLARC staff, I would like to thank the State and local agency staff that have provided information and data for this review. I would especially like to thank the staff at the local departments of health and social services, the community services boards, and the area agencies on aging who assisted JLARC staff during the course of this study.



Philip A. Leone
Director

January 4, 2006

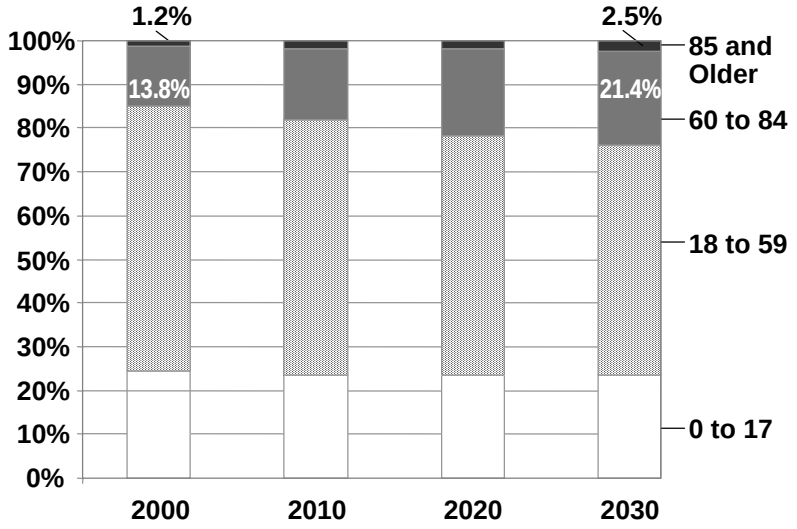
JLARC Report Summary

Impact of an Aging Population on State Agencies

The number of older Virginians (those persons who are age 60 or older) will increase substantially over the next 25 years, according to U.S. Census Bureau projections. By 2030, it is projected that there will be about 1.3 million more older Virginians than in 2000 – a 120-percent increase. Older Virginians are also expected to account for a larger proportion of the State's overall population. At present, older Virginians comprise 15 percent of the State's population, but this is projected to increase to 18 percent by 2010, and 22 percent by 2020. By the year 2030, older Virginians will comprise almost one of every four people in the State. This increase is illustrated in the figure below.

Projected Increase in Older Virginians as a Proportion of State's Population

Source: JLARC staff analysis of U.S. Census Bureau Projections.



House Joint Resolution 103, enacted by the 2004 General Assembly, directs JLARC to study the impact of Virginia's aging population on the demand for and cost of State agency services, policies, and program management. To assess this impact, JLARC staff examined the existing services provided by those State agencies which are most directly involved in providing services to older Virginians. JLARC staff defined State services to include those that are directly provided by State agencies, as well as those that are funded by State agencies

but are provided by local counterparts. The interim report for this study, which was presented in October 2004, provides more background about these services.

Increases in service provision are not inevitable, but instead rest upon policy choices about the role of the State in ensuring a minimum safety net, and what minimum quality of life for older Virginians is considered to be desirable, necessary, or affordable.

There are a number of factors, including an increase in the aging population, but also including potential trends in disability rates, the availability of federal funding, the ability of seniors to pay for services, and the availability of caregivers, which likely will affect the demand for State service provision or funding.

The impact that older Virginians now have upon agencies, as determined by the ability of agencies to provide services to eligible persons, indicates how well positioned State agencies are to respond to potential increases in the demand for services. A review of existing services indicates that the State is not well positioned to meet a potential increase in demand for services, because existing services are provided through a patchwork approach that does not consistently provide appropriate services.

However, the impact that an aging population will have upon State agencies in future years is not clear, in large part because the extent of the impact will ultimately be determined by State policymakers. This is because in most cases, increases in service provision are not inevitable, but instead rest upon policy choices about the role of the State in ensuring a minimum safety net, and what minimum quality of life for older Virginians is considered to be desirable, necessary, or affordable.

Certain Factors Will Likely Affect the Extent to Which an Aging Population Will Impact State Agencies (Chapters I to III of the Report)

The extent to which an aging population will impact State agencies will likely be influenced by certain factors. Some of these factors are largely outside the control of State agencies and policymakers. If the type of services, their availability, and the eligibility criteria do not change, then certain demographic and economic trends will likely influence the extent of impact. These include changes in disability rates, or in the ability of future retirees to pay for health care and other services. Similarly, changes in the availability of federal funding will likely influence the extent to which an aging population will impact State agencies. For example, if Social Security benefits are reduced, there may be an increase in demand for State-supported services, particularly if Medicare premiums account for a larger share of Social Security checks.

However, the extent to which an aging population will impact State agencies will ultimately be determined by State policymakers. For example, changes in Medicaid eligibility or services will have a large impact on the State's budget as well as

on the services provided by other agencies. The decisions of State policymakers will shape the extent of an aging population's impact in other ways. For example, the future availability of informal caregivers, who currently provide the majority of care to older Virginians, may be influenced by the availability of State services, such as respite or caregiver grants. State policymakers may also be influenced by changing expectations among baby boomers about the role of State agencies in service provision, or the type and availability of services.

In Virginia, estimates prepared by the Virginia Department for the Aging (VDA) indicate that the prevalence of Alzheimer's will increase between 2000 and 2030, from 2.6 to 4.3 percent of the State's population.

Chapter I: Demographic and economic factors, as well as the level of federal funding, will influence the impact that an aging population has on agencies. Chapter I of the report discusses certain factors that are largely outside of the control of State policymakers. If the services provided to older Virginians, and the eligibility criteria, do not change, these factors will likely shape the extent of an aging population's impact.

- Future trends in disability rates. In recent years, disability rates among older persons have decreased, but it is not clear whether this trend will continue. In part, this uncertainty results from differences between today's seniors and baby boomers, who will be tomorrow's seniors. One difference is the rate of obesity among baby boomers, which may increase disability rates in future years. The rate of Alzheimer's disease is also projected to increase, which may impact State agencies if policymakers decide to increase the services available for persons with dementia.

After 2015, the long-run impact of federal fiscal policies, and spending on services for older persons, has been described as "unsustainable" by the Congressional Budget Office, the Government Accountability Office, and the Social Security and Medicare Trustees.

- The availability of federal funds. Social Security, Medicare, and Medicaid programs benefit a large number of older Virginians – 91 percent of Virginians over the age of 65 receive Social Security benefits – and the federal government provides about half of the funding for the State's Medicaid program. Projections of federal spending, however, indicate that these programs and federal debt interest costs will account for an ever-larger share of federal spending. This trend may result in calls by federal policymakers for additional changes to services or eligibility criteria. More immediately, the federal fiscal year 2006 executive budget proposed reducing funding for most major federal programs that directly benefit seniors. For example, funding was reduced for Veterans Administration long-term care services, and for the Older Americans Act that funds area agencies on aging.

- The ability of baby boomers to pay for health care in retirement. Some future retirees may outlive their accumulated savings, and find that they are unable to pay for necessities in retirement. This may result in part from increases in health care inflation, as well as a growing trend toward the use of co-pays (such as Medicare premiums). In 2004, staff at the Urban Institute, and at the Social Security Administration, published studies which indicated that some baby boomers will have less savings as a percentage of their pre-retirement income than today's retirees. These studies also indicate that the percentage of retirees who fall below the poverty line will likely decrease because of the manner in which the poverty threshold is calculated, which could limit future eligibility for programs such as Medicaid. To begin addressing this, the General Assembly has recently provided State employees with long-term care insurance.

Chapter II: Possible Future Shortages of Informal Caregivers and Health Care Workers May Impact Agency Services. Chapter II of the report provides information on informal caregivers, such as family and friends, who provide the majority of care to older people who need assistance. In addition, paid health care workers, such as nurses, also provide direct care to older Virginians in nursing homes and individual houses. Shortages of caregivers or health care workers could affect the demand for and cost of services. The availability of State services – such as caregiver respite or nurse scholarships – could influence the number of caregivers and nurses, and hence the impact that an aging population will have on State agencies.

In Virginia, the AARP estimates that 21 percent of adults provided unpaid care in 2003, and 41 percent of the care recipients were over the age of 75.

- The assistance provided by informal caregivers often allows individuals to remain in their homes and communities by preventing or delaying the need for institutional care. The ability of informal caregivers to continue to provide this care will have a direct impact on State agencies, and this could be affected by demographic trends and the extent of State support. For example, increased workforce participation could mean fewer available caregivers, or it could mean that caregivers have fewer hours available to provide care. Furthermore, the availability of spousal caregivers could be affected by rising divorce rates and declining marriage rates. These and other trends suggest that fewer caregivers may be available in the future to assist older Virginians. In addition to demographic trends, State support could also affect the willingness or

ability of individuals to serve in this role. Currently the State provides respite and support to caregivers through area agency on aging or Medicaid waiver services, and through the Virginia Caregivers Grant. It appears, however, that current State support may not be adequate to meet the needs of all caregivers.

- A possible consequence of the potential decrease in availability of informal caregivers could be an increase in demand for services provided by formal health care workers, particularly those positions that work more closely with older Virginians. Some State agencies and long-term care providers report difficulty recruiting and retaining nurses and other types of health care workers. It is also important to note that there appears to be a general shortage of many types of personnel with geriatric training. Institutions of higher education also report an inability to train all qualified applicants, particularly students interesting in nursing fields, and a nursing shortage is projected through at least the year 2020. These factors may increase the need for additional State support, such as funding for nursing scholarships and other efforts to increase the supply of nurses.

The State Council of Higher Education for Virginia reports that by 2020, the State will need 69,000 registered nurses, but will have only 47,000 if current trends continue.

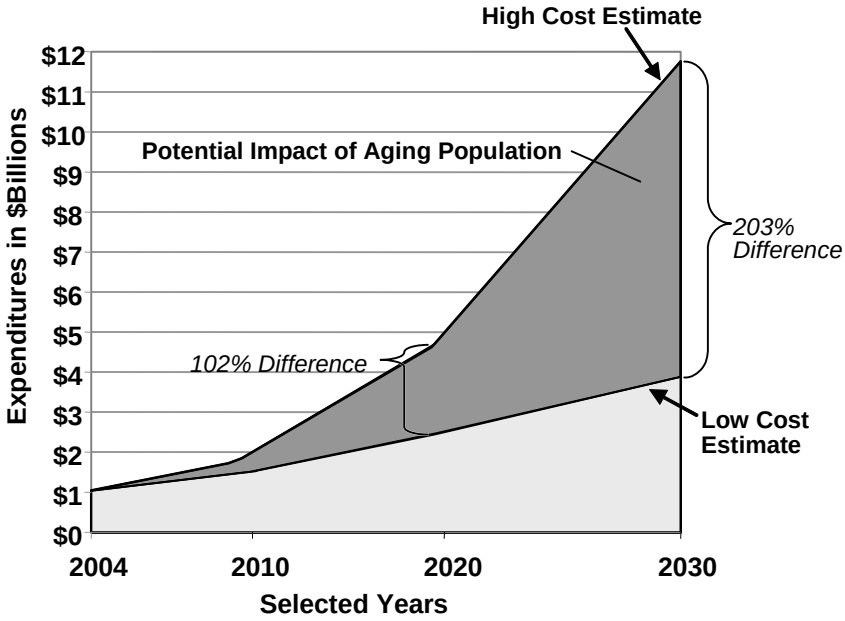
Chapter III: Medicaid Expenditures and State Tax Revenue Will Be Impacted by an Aging Population. Chapter III of the report discusses two potential fiscal impacts of an aging population: as the number of older Virginians increases, and as they comprise a larger share of the State's overall population, their impact upon Medicaid expenditures and tax collections will also increase. The extent to which these impacts occur will be determined by State policymakers, and these decisions will likely affect the availability of Medicaid-funded services, as well as the availability of funding to pay for other State agency services discussed in this report.

- According to the Department of Medical Assistance Services (DMAS), Medicaid's $4.02 billion in total expenditures for State fiscal year (FY) 2004 accounted for 19.7 percent of the State's operating expenditures, up from 7.6 percent in FY 1987. DMAS projections indicate that the impact of an aging population upon State and federal Medicaid expenditures for people age 65 and older could increase substantially. The magnitude of this impact is illustrated in the figure on the next page. The low cost estimate assumes that aged recipients (age 65 and older), as a proportion of all Medicaid recipients, will remain constant and that costs will in-

crease with overall inflation. The high cost estimate indicates costs if the proportion of older Medicaid recipients increases at the same rate that older persons increase in the State's population, and if costs increase with medical price inflation. These projections assume that no changes are made to the services provided by Medicaid or the eligibility criteria.

Estimated Impact of Aging Population on Total Medicaid Expenditures for the Aged

Source: DMAS projections of Medicaid cost components.



- As the number of older Virginians increases, annual State income tax collections will be impacted by existing deductions and exemptions that are available to older Virginians. Currently, older taxpayers are allowed to deduct Social Security benefits and take an age deduction when determining their Virginia Adjusted Gross Income. Based upon Tax Department data for tax year 2002, approximately $8.65 billion in income was deducted or exempted by older Virginians. This resulted in approximately $443 million in foregone revenue, at the average tax rate. Recent changes to the age deduction policy may result in some enhancements to tax revenue, but the impact appears to be limited based on tax year 2002 data. Adults age 65 and above are also allowed to exempt $800, in addition to the $800 personal exemption for all taxpayers. State sales and use tax collections may also be affected, because older persons typically spend less money

than younger persons, and their spending is more likely to be for non-taxable services.

Unmet Demand for Publicly Funded Services Suggests That Some State Agencies Are Not Well Positioned to Respond to Future Impact (Chapters IV to X of the Report)

In addition to the factors discussed in the first three chapters of the report, over which State policymakers have varying degrees of control, State agency services are more completely under the control of policymakers. For some State agency services, such as those provided by local area agencies on aging, federal law directs the nature of services provided and sets eligibility criteria. However, as with Medicaid-funded home and community-based services, State policymakers have some influence over the extent to which State funds are used to support these services. Moreover, the State can often shape the eligibility criteria.

The remaining chapters of the report (Chapters IV to X) discuss several services for older Virginians that are provided or financed by State and local agencies. The chapters are generally organized to first address services in which the State is extensively involved in meeting the impact of older Virginians now (through funded services), and then to address areas in which the State is currently involved to a lesser degree.

The role of the State varies within each of these services, and in all cases it appears that the demand for the services is not being met. Additionally, the availability of some services varies statewide. These indicators suggest that State agencies are not well positioned for a potential increase in the demand for services that will likely result from an aging population.

Local pre-admission screening teams around the State indicate that the main reason older Virginians they screen enter a nursing home is the lack of an informal caregiver.

Chapter IV: Shortages of State-Funded Nursing Home and Assisted Living Beds Are Reported. Nursing homes provide comprehensive long-term care services, and Medicaid will pay for nursing home care for eligible older Virginians. Assisted living facility (ALF) services are an option for seniors who are unable to receive needed care in their homes, and who either do not require or are not eligible for nursing home care. Virginia's auxiliary grant program assists individuals with the costs of ALF services. State and local agency staff expressed concerns, however, that there are not enough auxiliary grant beds in assisted living facilities, and that it is difficult to find Medicaid-funded nursing home beds.

- More than 90 percent of licensed nursing home beds are certified for Medicaid reimbursement, and the average daily net revenue to nursing homes in 2003 was $110 for a Medicaid resident. However, nursing homes are reported to prefer private-pay

and Medicare residents, for whom the daily revenue was $148 and $329, respectively. In addition, some nursing homes are reported to be unwilling to take certain patients with complex needs, particularly those with behavioral problems. While this is true for all persons seeking nursing facility care, it appears to disproportionately affect Medicaid residents. These factors may limit the availability of Medicaid-funded nursing home beds in some parts of the State, and is reported to impact the discharge efforts of State correctional facilities as well as State and private mental health hospitals. Data provided by the Virginia Department for the Aging and the Department of Medical Assistance Services indicate that the number of nursing home residents is expected to increase.

- Local agency staff report that some areas of the State do not have enough auxiliary grant beds, and this is reported to result from the insufficiency of the rate. However, the Department of Social Services does not maintain accurate locality-based data on the availability of auxiliary grant beds, which hinders the State's ability to assess whether this program is meeting the demands of older Virginians.

Chapter V: Mental Health, Mental Retardation, and Substance Abuse Services Will Be Impacted by Older Virginians. At the present time, resource constraints limit the provision of mental health, mental retardation, and substance abuse services, and the lack of community-based options for older adults appears to increase the reliance on institutional services for some persons. Additionally, few providers, including health care providers in general, have geriatric training. Staff of the Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services, and at the local Community Services Boards, indicate dementia is not within their mission because it is a medical rather than a mental disorder. It was also reported that the current community services for persons with mental retardation (MR) provided through the Medicaid MR waiver are often not appropriate for the needs of older Virginians who need supervision rather than the training services (prevocational and habilitative) that are federally required components of the MR waiver. These problems are compounded by the challenges created by the greatly increasing life expectancy of persons with MR, and the aging of their caregivers. Moreover, as the number of older Virginians increases, substance abuse problems will likely increase, resulting in part from the interactions of multiple prescription medications taken by seniors and the greater incidence of substance abuse among baby boomers.

According to the United States Surgeon General, behavioral problems in persons with Alzheimer's disease occur with a high frequency:

• 30 to 50 percent experience delusions,

• 10 to 25 percent have hallucinations, and

• 40 to 50 percent have symptoms of depression.

As the number of older Virginians increases, additional services will likely need to be developed to better serve older Virginians with mental health illnesses such as behavioral problems due to dementia, MR, and substance abuse. State policymakers will ultimately determine the extent to which these services are provided.

Chapter VI: Impact of the Aging Prisoner Population. The number of older prisoners in Virginia's correctional system has been increasing at a faster pace in recent years than the overall inmate population. It appears that the primary impact of an aging prisoner population will be an increase in the cost of providing health care. Because a 1976 Supreme Court ruling requires states to provide health care to inmates, State policymakers may be confronted with the need to provide services to a population that is deemed too dangerous to be released, but for whose care the State will not receive Medicare or Medicaid reimbursement. To address the potential financial impact of an aging inmate population, the General Assembly created the Geriatric Release Program, which gives qualifying older inmates the option of early release from incarceration. Because of the severity of the crimes committed by many older inmates, however, very few have been released through this program.

Chapter VII: Not All Seniors Who Are Eligible for Home and Community-Based Services Are Able to Receive Them. Some of the publicly provided services discussed in the report are intended to enable low-income, disabled seniors to receive needed long-term care in their homes and communities, rather than in institutions. However, concerns raised by State and local agency staff indicate that not all seniors who are eligible for these services are able to receive them because of funding limitations, the impact of Medicaid co-pays, and the difficulty some older Virginians may have in locating services. As the number of older Virginians increases, and if current trends continue toward greater provision of home and community-based services instead of institutional services, State policymakers may choose to provide additional funding or support for these services.

In 18 localities, the waiting list for companion care provided by the local department of social services was between 10 and 12 months. Another 36 localities reported that their waiting list for companion care exceeded one year in length.

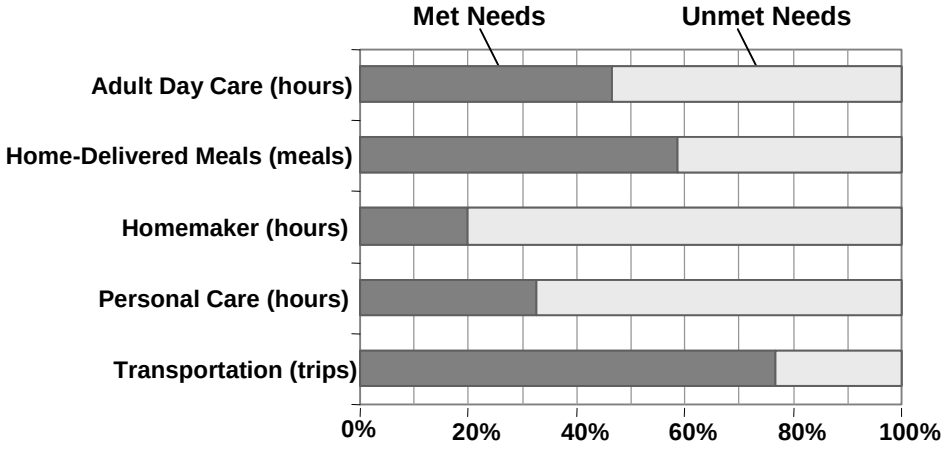
- Virginia's 120 local department of social services (DSS) adult services programs, and 25 area agencies on aging (AAA), provide home and community-based services to older Virginians. Data maintained by both types of agencies indicate, however, that there are extensive unmet demands for these services in many parts of the State. For example, 54 local DSS offices reported having waiting lists for their services in excess of ten months in length.

In addition, as shown in the figure below, the unmet demands for some in-home services provided by AAAs exceeded the total number of met service demands by 217 percent in federal fiscal year 2004.

- Persons eligible for the Medicaid Elderly and Disabled with Consumer Direction (EDCD) waiver are reported to have unmet service demands as a result of the waiver's "patient pay" requirement, which requires service recipients to contribute all income in excess of $579 per month to the cost of their care. They are allowed to keep the $579 as a monthly "personal maintenance allowance" (PMA) to afford such expenses as housing, food, and clothing. Virginia Housing Development Authority data indicate that as of October 2004, 47 Virginia localities were determined to have a Fair Market Rent value for a one-bedroom housing unit in excess of $579 per month. Seniors' inability to afford in-home waiver services due to the patient pay requirement could have a negative fiscal impact on the State if nursing home placement is sought instead. Local agency resources are negatively affected as well, as some DSS and AAA staff estimated that between six and 25 percent of their in-home clients are actually eligible for Medicaid-funded services, but declined services because of the patient pay.

Proportions of Statewide Met and Unmet Demands for AAA Services, FFY 2004

JLARC staff analysis of Virginia Department for the Aging data.



- Local agency staff report that many older Virginians seek publicly funded services as a result of a crisis that increases their need for services, or limits the

ability of their caregiver to provide assistance. Formal approaches to case management, such as AAA case management or Virginia's Program of All-Inclusive Care for the Elderly, are not available in all parts of the State. Several State and local agency staff stated that the increased availability of formal case management services would improve access to needed services by older Virginians, and possibly prevent the future need for more expensive or restrictive services.

Chapter VIII: The Availability of Services for Vulnerable Older Adults Is Limited. State and local agency staff report that they are not always able to provide certain key services for vulnerable older Virginians, including adult protective services, ombudsperson services, and public guardianship services. These services are critical because the persons who qualify for them are among the most vulnerable citizens in the Commonwealth. As older persons increase as a proportion of the State's population, and if the number of caregivers decreases, there will likely be an increase in demand for these services.

- Local departments of social services are directed by the *Code of Virginia* to provide adult protective services, but funding is reported to be inadequate to purchase needed services.

- The State's Long-Term Care Ombudsman program is required by statute to respond to service complaints by persons in institutions as well as home and community-based service recipients. A minimum staffing ratio of one ombudsperson to every 2,000 long-term care beds is established in law, but the actual ratio was one to 3,376 in FY 2004. Inadequate staffing levels contribute to less attention to the needs of persons receiving home and community-based services.

- The Virginia Public Guardian and Conservator Program (VPGCP) has been effective in providing guardianship services to many eligible individuals, but the program is not adequate to meet existing need. As a result, some older Virginians may not be able to receive all the medical or supportive services, which may increase the cost to the State. Although comprehensive data are not available, it appears that existing need for guardians in Virginia is over 2,000, but only 213 individuals are served. Furthermore, the program is available in only 54 of

the State's 134 localities, despite the *Code of Virginia's* "statewide" designation of the program.

Chapter IX: Rising Housing Costs May Affect the Ability of Seniors to Live Independently. Older homeowners and older renters were reported to have difficulty affording housing costs in addition to other necessities such as food, clothing, and medications. Rising housing prices and real estate tax assessments were reported to burden older homeowners, especially those living in Northern Virginia. Additionally, the costs of home repairs and modifications such as wheelchair ramps were often reported to be unaffordable to many older homeowners. Many older Virginians also require assistance with the cost of utilities, especially in the winter.

Census data indicate that 32 percent of all renters in Virginia age 85 and older pay more than 50 percent of their income on housing costs.

At the State level, the Department of Housing and Community Development (DHCD) and the Virginia Housing Development Authority both provide financial assistance to developers to build affordable housing. However, rental assistance is primarily provided through the federal Section 8 housing voucher program, for which funding has been decreasing. In addition, the Director of DHCD states that affordable housing may not benefit older adults unless supportive services such as meal preparation and transportation are also available and affordable. State and local government agencies also provide funds for housing repair and weatherization programs, and local governments provide real estate tax relief for the elderly and disabled. Although the extent of need for housing assistance is not known, some of these programs have documented current unmet needs.

Census data indicate that a vehicle is not available in five percent of all households in Virginia in which there is at least one person over the age of 65.

Chapter X: Older Virginians May Be Disproportionately Affected by a Lack of Alternative Transportation Services. Many older Virginians depend upon alternative forms of transportation, or upon rides from caregivers, to remain mobile and live independently. For persons not eligible for Medicaid, a lack of transportation is reported to result in missed medical appointments, and some local agency staff indicated that seniors will forego the purchase of necessities like medications in order to pay for transportation. Even for older Virginians with Medicaid, a lack of transportation can result in an inability to travel to the grocery store or pharmacy, and may also prevent some health care workers from reaching the homes of seniors who are eligible for in-home long-term care services. As a result, a lack of available transportation services could have detrimental effects on seniors' health and well-being, and require greater and costlier State intervention in their care.

The State's role in the provision of transportation services is primarily limited to providing funding, through the Department of Rail and Public Transportation (DRPT), for the operation of

local transportation services. However, only 0.07 percent of all State transportation funding is specifically allocated to the transportation needs of the elderly and disabled. As shown in the figure below, public transportation is not available in several localities that have a high percentage of seniors without access to a vehicle. Local land-use planning decisions and a lack of sidewalks have also resulted in instances where transit routes are not located near needed services.

In future years, more public transportation will likely be needed, as noted by the Commonwealth Transportation Board: "in maintaining and expanding the transportation system it is essential to be cognizant of the differing requirements of older Virginians and to . . . consider alternative means of providing basic transportation services." The ability of policymakers to determine whether State agencies should play a larger role in meeting the transportation needs of older Virginians is hindered by a lack of comprehensive data on the demographic and socioeconomic characteristics of public transportation users, or the location of public transportation routes.

Virginia Localities Served by Public Transportation

Source: JLARC staff analysis of data from the Department of Rail and Public Transportation and U.S. Census Bureau.

▲ Localities without public transportation that also have a higher than average proportion of elderly-headed households without access to a vehicle.

The exhibit on the next page provides a summary overview of the topics covered in the report.

Current and Potential Future Impacts Associated with an Aging Population

Supply of Caregivers and Health Care Workers May Affect State Services
Informal, unpaid caregivers provide the majority of care, but demographic trends suggest there may be fewer caregivers in future years. Projections also indicate a shortage of nurses in Virginia. These factors may affect the cost and availability of State-funded services, suggesting a possible need for additional State support for caregivers and health care workforce development.
Increasing Medicaid Costs and Possible Decrease in Tax Revenue
An aging population may greatly increase Medicaid costs, but the future availability of federal funding is uncertain. Increasing eligibility for age-based income tax preferences, and the impact of age-related spending patterns on sales and use taxes, may limit the tax revenue available to pay for services.
Cost of State-Funded Nursing Home and Assisted Living Beds May Increase
Shortages of Medicaid-funded nursing home beds and auxiliary grant assisted living beds are reported by local agency staff, and these may result from low reimbursement levels. Additional State funding may be needed if these concerns persist, to ensure availability.
An Aging Population Is Straining Mental Health, Mental Retardation, and Substance Abuse Services
State and local agencies, as well as providers, report that needed services for older Virginians are not available because of funding limitations and a lack of age-appropriate services. An increase in persons with dementia, the aging of caregivers, and other factors will likely increase the demand for additional and more appropriate services in order to prevent institutionalization.
An Aging Prisoner Population May Continue to Increase Costs
The number of older prisoners is increasing at a faster rate than younger prisoners, and the cost of health care and other services is reported to be higher for older prisoners. The Geriatric Release Program, which may curtail costs, has resulted in the release of three inmates.
Funding Limitations and Co-Payments Affect the Availability of Home and Community-Based Services
Documented unmet demand indicates that some eligible seniors are not receiving services which are designed to promote independence, and limit the use of more costly and restrictive services. Medicaid co-payments are also reported to limit access. Greater use of case management and preventive services, which are also limited by funding, may be needed as demand increases.
Services for Vulnerable Older Virginians Are Not Consistently Available
Funding limitations are reported to affect the ability of adult protective services to provide or purchase services for persons who may be abused or neglected. Also, public guardians are only available in 54 localities, and fewer ombudsmen are available than called for by the *Code of Virginia*. Demand may increase as older population increases.
Rising Housing Costs May Affect the Ability of Seniors to Live Independently
State and local agencies report shortages of affordable rental housing, and a need for housing that provides services. Older homeowners on fixed incomes are reported to be particularly affected by rising property taxes and unmet needs for home repair and modification. State agencies now have a limited role, but impact may increase if housing costs affect the ability of seniors to stay in their homes.
Demand for Transportation Services May Increase as Population Ages
The ability of some seniors to obtain needed services, such as groceries or prescription drugs, was reported to be hindered by a lack of public transportation and sidewalks. State funding for elderly and disabled transportation is limited, but demands for public transportation as well as improvements in land-use planning may increase if more seniors stop driving.

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I. Introduction

House Joint Resolution (HJR) 103 from the 2004 General Assembly Session requires the Joint Legislative Audit and Review Commission (JLARC) to "study the impact of Virginia's aging population on the demand for and cost of state agency services, policies, and program management" (Appendix A). As part of the study efforts pursuant to the mandate, an interim report was completed in October 2004. This final report takes a closer look at the State agency services described in the interim report, which provided background information and data on many of the services discussed in subsequent chapters of this report. This chapter begins with an overview of issues that State policymakers may face as a result of Virginia's aging population. The second section of this chapter provides some information on certain demographic and economic factors associated with an aging population that could impact State agencies. The final section describes the study mandate and the organization of the report. A glossary of terms is also included as Appendix C.

THE CHALLENGE OF AN AGING POPULATION IN VIRGINIA

State and local agencies provide a variety of publicly funded services to older Virginians (persons age 60 and older). For example, about $500 million in State Medicaid funds are expended each year to provide health care services to eligible low-income older Virginians. In 2003, nine percent of Virginians age 60 and older (103,943 people) received Medicaid-funded health care services. Older Virginians also benefit from many other State and local services. For example, in 2003 the State's local area agencies on aging provided various types of assistance to 54,825 seniors. In addition, community services boards provided mental health, mental retardation, and substance abuse services to 11,249 older Virginians, and 4,036 seniors received supportive home-based services from local departments of social services.

Although State and local agencies serve several thousand older Virginians each year, only a small percentage of the State's entire population age 60 and older receive publicly funded assistance. This is largely because the majority of assistance that is given to older Virginians is provided by informal, unpaid caregivers, such as family members and friends, and their role will likely remain important in future years. Moreover, many older Virginians are reported to be served by faith-based and nonprofit organizations, and so may not seek publicly funded services. Further, many older Virginians will not require services. However, for older Virginians who require assistance and do not have the means to pay for their needs, or lack caregivers to assist them, publicly funded services may be required.

This report describes the existing impact that older Virginians have upon State and local agencies. The concept of "impact" is used in this report to include (1) the actual demand by older Virginians for publicly funded services, such as Medicaid, and (2) the ability of agencies to respond to those demands. The current capacity of State and local agencies to meet the service demands of older Virginians

indicates the extent to which the Commonwealth is prepared to respond to the future impact resulting from a growing number of older Virginians.

Several Factors Could Result in Increased Service Demand, But Current Service Capacity Indicates that Agencies May Not Be Prepared

In order to assess the extent to which an aging population may impact agencies in future years, the study team interviewed State and local agency staff, surveyed State agencies, analyzed service program data, and consulted economic and medical studies. This research identified certain factors that are likely to affect the extent to which an aging population will impact agencies. These factors are discussed in Chapters I and II, and include trends in overall disability rates, as well as the prevalence of obesity and Alzheimer's disease. Other factors include the likelihood that the federal government may reduce its role in funding certain services, projections that an increasing number of retirees may be unable to pay for long-term care, and the possibility that the availability of informal, unpaid caregivers may decrease.

These factors suggest that an aging population will likely increase the demand for and the cost of currently-provided State and local agency services. In addition, although some State agencies currently have a limited role in directly providing some services with State funds, such as housing and transportation services, the above factors could result in increased demands for State assistance.

At the present time, however, State and local agency staff report being unable to meet current levels of service demand, largely because of insufficient resources. The current State and local service-delivery system for older Virginians has been characterized by some local agency staff as a "patchwork" approach to service provision. It has been characterized this way because resource constraints and eligibility restrictions result in many clients who receive either none, or only some, of the services they need. Agency staff report that they respond to resource constraints by rationing resources to ensure that services can be provided to as many clients as possible. In some cases, it appears that this may lead to instances where older Virginians are shifted back and forth among more than one resource-constrained public agency or nonprofit organization. In addition, funding limitations reportedly limit agencies' use of preventive services or outreach activities. As a result, State and local agencies do not appear to be well positioned to respond to an increase in older Virginians' service demands.

State Policymakers Will Ultimately Determine the Extent To Which an Aging Population Will Impact State Agencies

The impact of an aging population on State and local agencies will ultimately be determined by State policymakers' decisions regarding the appropriate role of government in providing a minimum quality of life for older Virginians. This includes decisions regarding the amount of State funding that will be dedicated to meeting this population's needs. In responding to the impact of an aging population, State policymakers will likely have to consider factors such as disability rates,

federal funding commitments, and retiree wealth, as mentioned above. For example, if disability rates increase among future older Virginians, then a greater proportion of older Virginians could seek State and local agency services. Alternatively, if federal Medicaid funding is reduced, as discussed later in this chapter, service levels may decline unless other funding sources are identified. Additionally, the federal and State governments have emphasized the importance of ensuring that individuals who need publicly supported long-term care services are given an adequate array of choices regarding their care. In some cases, current funding constraints and eligibility restrictions appear to already limit older Virginians' options for publicly funded long-term care services. These factors indicate the complexity of the challenge that will likely face State policymakers.

The Needs of Future Older Virginians May Be Met Through a Combination of Public, Private, and Personal Resources. Approaches to meeting older Virginians' future service demands are likely to include some combination of State and local agency resources. In particular, older Virginians who do not have an adequate network of informal caregivers, or who are unable to afford private long-term care costs, are more likely to depend upon publicly funded assistance. However, State policymakers could also seek to increase the role of non-governmental organizations, such as faith-based entities, in supporting older Virginians and their informal caregivers. The State could also further develop incentives for Virginians to play a greater role in preparing for their future health care needs through the purchase of long-term care insurance. Additional emphasis on prevention and outreach activities could also promote more healthy aging, which could affect the demand for services or improve the quality of life.

Some Current Initiatives May Enhance State and Local Preparedness, But the Use of Best Practices Is Mixed. Despite indications that many agencies are under-prepared for the impact of the aging population's future service demands, some best practices were identified that could enhance State and local preparedness. (It should be noted, however, that an evaluation of the effectiveness of these practices was beyond the scope of this study.) Some of these initiatives are discussed in this report, including the State's participation in the federal United We Ride initiative, which will enhance the coordination between various human service transportation programs (Chapter X). In addition, Chapter VII discusses several activities that are designed to improve the coordination of services for older Virginians, such as the Program of All-Inclusive Care for the Elderly, the State's No Wrong Door initiative, and the practice by some local agency staff of providing informal case management services to their more vulnerable clients.

Other practices mentioned by State and local agency staff include using staff at one State mental health institution to provide psychiatric services to older Virginians in nearby nursing homes (Chapter V) and the use of "cluster care" in-home service provision by some local agencies in urban localities. Through cluster care, agencies assign a single in-home service aide to assist a geographically-defined set of clients, which increases the number of clients that can be served at a given time. In addition, several local agencies noted that they actively coordinate their

services with local faith-based and nonprofit organizations, such as the Salvation Army and the United Way.

It appears that the extent to which State and local staff identify and use best practices is mixed. The "patchwork" nature of the service delivery system appears in some cases to have necessitated a greater focus on meeting existing demand rather than looking for ways to improve service delivery. This inability to develop or use best practices in service delivery is also an indicator that State and local agencies do not appear to be well positioned to respond to an increase in demand for services by older Virginians.

Given the potential for reductions in federal funding, and the likelihood that an aging population will increase the demand for and cost of services, State policymakers could continue to emphasize steps that improve the efficiency and effectiveness of agency operations. As identified throughout this report, the extent to which State agencies have developed plans and policies that identify and prioritize the current and future service demands of older Virginians vary. There are also very limited data on the characteristics of agencies' older clients, their service needs, the extent to which agencies are able to meet those needs, and the associated costs of service delivery. Therefore, policymakers could require that greater attention be paid to the need for coordinated planning across agencies and improvements in data collection and analysis.

INCREASE IN LIFE EXPECTANCY AND DISABILITY RATES WILL ADD TO THE IMPACT OF AN INCREASING NUMBER OF OLDER VIRGINIANS

Between 2000 and 2030, the number of older Virginians (people age 60 and older) will increase, and they will also constitute a larger proportion of the State's population. State agencies may be impacted by an aging population in part because increases in age are often associated with increases in the need for assistance with certain activities. Although not everyone will need assistance, a greater incidence of health issues and disabilities that occur with older age means that many older Virginians may require assistance. Unpaid caregivers, such as family and friends, provide the majority of this care. However, some older Virginians do not have family or friends who can assist them, and some cannot afford to pay for the care they need. As a result, these individuals may rely upon State-supported services.

Many services provided or financed by State and local agencies are referred to as long-term care services. These services generally have high per-person costs, and include nursing home services, Medicaid home and community-based services, and some mental health and mental retardation services, among others. Long-term care services can be provided in a nursing home, in a community-based setting, such as an adult day care facility, or a person's home. The Supreme Court's 1999 *Olmstead* decision and an increasing preference for in-home services have also contributed to an increase in State support for home and community-based services.

In addition, agencies provide or finance other services to older Virginians that are not strictly considered long-term care, such as assistance with housing and

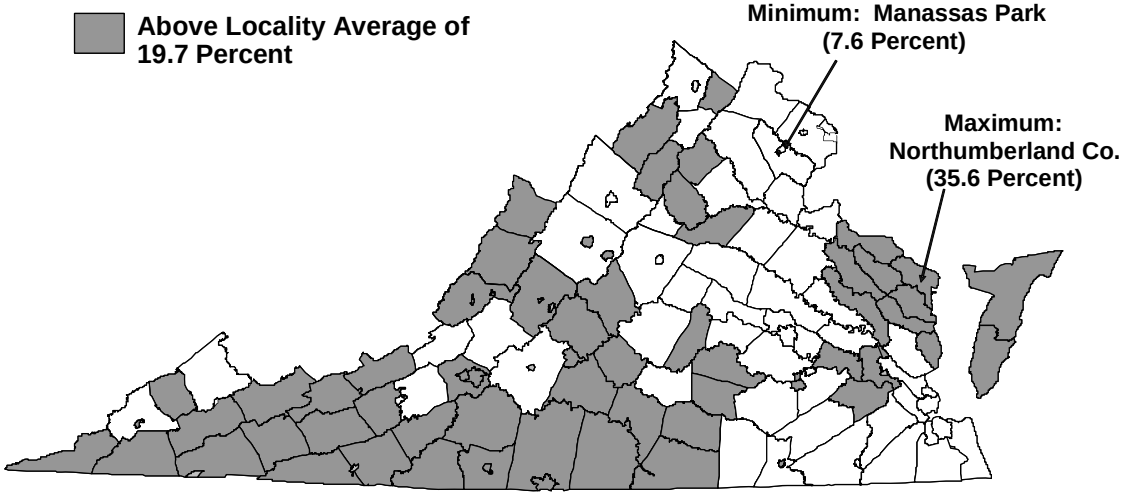
transportation needs. For example, a wheelchair ramp may be needed for some older Virginians to enter and exit their house, or public transportation may be the only available means of going to the grocery store or doctor's office. These additional services need to be considered in conjunction with the long-term care structure because of the increasing provision of State-supported long-term care services in an individual's home, such as Medicaid home and community-based services.

The Proportion of Older Persons in the Population Has Been Increasing for Many Decades, Both Nationally and in Virginia. The number of Americans age 60 or over has grown from about 5 million in 1900 to approximately 46 million in 2000. The proportion of Americans over 60 years of age as a percent of the U.S. population also increased during that time, from 6.4 percent to 16.3 percent. In Virginia, older persons comprised 15.8 percent of the population in 2004 (about 1.2 million people), compared to 11.6 percent in 1970.

At a locality level, however, there is a substantial amount of variation in the percentage of persons who are age 60 and older. Based on 2004 estimates developed by the U.S. Census Bureau, at the locality level older Virginians are 19.7 percent of the population, on average. In contrast, at the State level older Virginians comprise about 16 percent of the State's population. The City of Manassas Park has the smallest percentage of people age 60 and older at 7.2 percent. The highest percentage is in Northumberland County, where 35.6 percent of residents are age 60 or older. Figure 1 presents information on the distribution of the older population in Virginia for the year 2004, with the darker shading indicating those localities that have a percentage of older persons that is higher than the locality-level average of 19.7 percent.

Figure 1

Older Virginians as a Percentage of Population in 2004



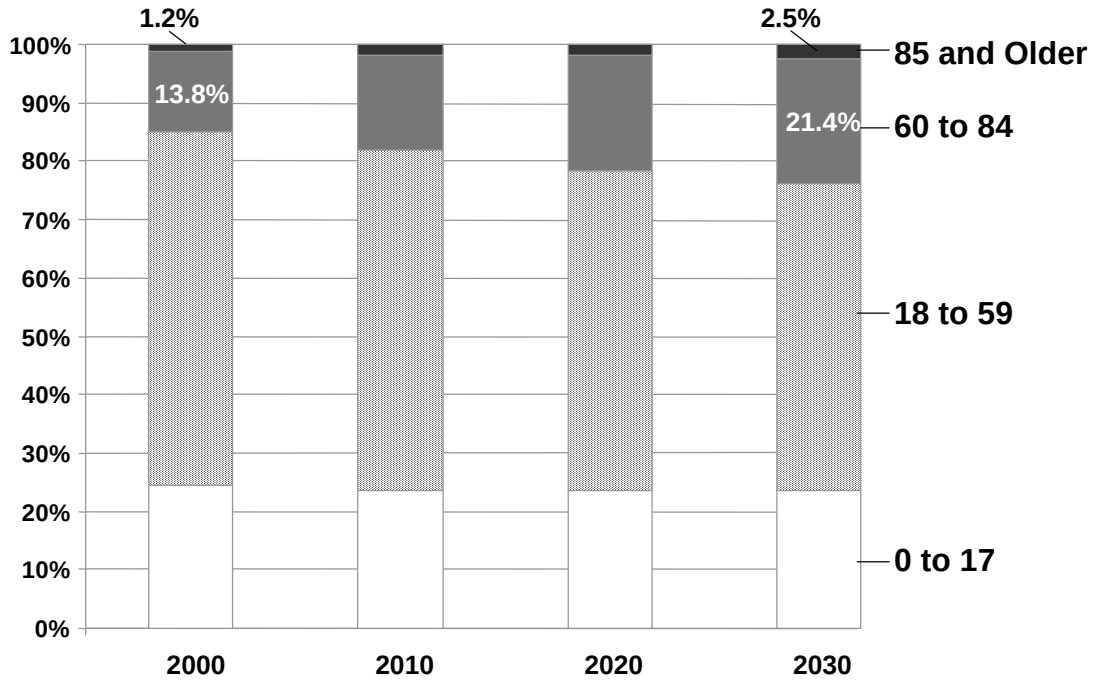
Source: JLARC staff analysis of U.S. Census Bureau Annual Estimates of the Population for Counties of Virginia.

Increase in the Number of Older Virginians Will Be Driven By the Aging of the "Baby Boom" Generation

The Baby Boom generation was born between 1946 and 1964, and the first members of this generation will begin to turn age 60 in 2006. As this generation ages, older Virginians are expected to account for 18 percent of the population by 2010, and 22 percent by 2020 – nearly twice their percentage in 1970. By the year 2030, there will be approximately 1.3 million more Virginians age 60 and older than in 2000. The increase in older Virginians as a proportion of the State's population is illustrated in Figure 2. To look at these changes in another way, in 2030 Virginia will have more seniors as a percentage of its population (24 percent) than Florida does today (22 percent).

Figure 2

Projected Increase in Older Virginians as a Proportion of State's Population



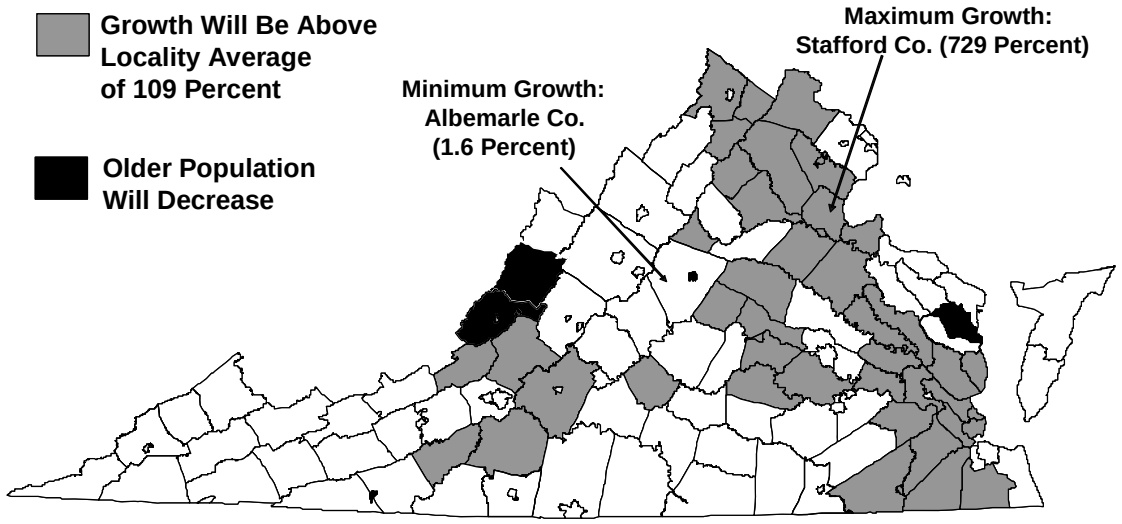
Source: JLARC staff analysis of U.S. Census Bureau Interim State Population Projections, 2005.

As this large cohort of baby boomers ages, State agencies may be impacted by an increase in the number of persons seeking services. Increases in life expectancy will also play a role in the level of future service demands, because age is often associated with an increase in disability as well as expenditures on health care.

As the Baby Boom Ages, the Rate of Growth in the Older Population Is Projected to Vary Across Virginia. According to projections by the Virginia Employment Commission, Albemarle County will have the smallest percentage increase in the number of older persons by 2030 – 1.6 percent (207 people). In contrast, Stafford County is projected to have the State's largest percentage increase. In 2000, Stafford had 7,932 older persons. By 2030, Stafford is projected to have 65,715 people age 60 and older – an increase of 729 percent. Figure 3 illustrates the localities that are projected to have a growth rate in the older population between 2000 and 2030 that is above or below the locality average of 109 percent. Most of this growth is projected to occur in Virginia's "Urban Crescent."

Figure 3

Projected Growth of Older Population, 2000 – 2030



Source: JLARC staff analysis of data compiled by VDA from Final Population Projections prepared by VEC.

A Prominent Cause of an Aging Population Is Increased Life Expectancy

National data indicate that in 2002, average life expectancy at birth for all persons was at a record high of 77 years. In contrast, life expectancy in 1900 was 47 years, and in 1950 it was 68 years. The lifespan of individuals with developmental disabilities is also increasing. For persons with Down syndrome, for example, life expectancy in the U.S. has risen from nine years in the 1920s, to 31 years in the 1960s, and to 56 years in 1993. More recent data from the United Kingdom and Australia indicate that life expectancy for persons with Down syndrome in those countries had risen to 59 in 2000, and that some persons with Down syndrome were living into their seventies.

Increasing Life Expectancy and Aging of Baby Boomers Will Lead to Continued Increase in Virginia's "Dependency Ratio." The dependency ratio is often used to measure changes in the age structure of a society. This ratio is defined as the number of persons who are not of working age for every person of working age. Between 2000 and 2030, the number of "working age" Virginians (defined by the U.S. Census Bureau as ages 18 to 64) is projected to increase by only 25 percent. In contrast, the number of Virginians age 65 and older will increase by 133 percent, and Virginians under the age of 18 will increase by 34 percent. The relative differences in the rates of increase are more clear when individual decades are considered. For example, between 2010 and 2020, the number of children will increase more than twice as fast as the number of working age adults, and Virginians age 65 and older will increase almost eight times as fast.

As a result of these differences in growth rates, there will be fewer Virginians of working age to pay for and provide services to people in younger and older age groups. As measured by the dependency ratio, in 2000 there were 55.6 people not of working age for every 100 people who were of working age – a dependency ratio of 55.6 to 100. Projections indicate that the ratio will not change substantially by 2010, when it is projected to be 56 to 100. However, by 2020 it is projected to be about 65 to 100, increasing further to about 74 to 100 by 2030. Population aging is also a global phenomenon, as projections for 2050 indicate that for the first time in recorded history there will be more people worldwide age 60 and older than 14 and below.

Growing Number of Virginians Age 85 and Older May Have the Largest Impact on Service Demands and Costs

In addition to increases in the overall population of older Virginians, substantial increases are expected in the population age 85 and older. Specifically, from 2000 to 2030 the number of people 85 and older is projected by the U.S. Census Bureau to more than double from about 87,000 to about 250,000 persons. Presently, the oldest Virginians account for about 1.2 percent of the population. This share is projected to increase to 1.9 percent in 2020 and to 2.5 percent in 2030.

Persons age 85 and older are anticipated to have the highest demand for State agency services and the highest cost per person. This impact results from the fact that increases in age are often associated with increases in disability, and health care expenditures increase as the number of disabilities increases. Presently, eligibility for many publicly financed long-term care services are based in part upon the need for assistance with activities of daily living (ADL) such as bathing, dressing, eating, and walking. As a result, current projections of increasing rates of disabling conditions such as obesity and dementia may increase the demand for, and the cost of, publicly financed long-term care. It is important to note that current trends, such as obesity rates among the baby boomers, may impact State agencies in future years as this generation ages. This is discussed in more detail below.

Based on self-reported data from the 2000 Census, the percentage of persons reporting a disability increases with age. Thirty percent of Virginians age

60 to 64 reported having one or more type of disability, such as blindness, difficulty walking or climbing stairs, or memory problems. The rate of disability increases with age, and 74 percent of Virginians age 85 and older reported one or more disabilities. Health care costs typically increase with the number of disabilities. This can be seen by looking at 2001 data on Medicare enrollees age 65 and over. People who did not have any disabilities incurred $3,837 in annual health care costs, on average. In contrast, the annual cost for serving persons who needed assistance with five or more ADLs was about four times higher ($15,784).

Future Trends in Disability Rates Are Not Well Understood. Disability rates among older persons have been decreasing nationwide in recent years, although the number of people with disabilities has increased as a result of population growth. However, published studies disagree over the extent to which the disability rates for older persons in future years will differ from those of today's seniors. For example, a 2003 study published in the journal *Medical Care* argues that new medical treatments and projected increases in educational attainment will result in a continued decrease in disability rates, and that rates may begin to decline more quickly in future years. Another set of studies looks at trends in the behavior of today's younger population and argues that, at a national level, health care costs will increase as a result of population growth and increases in disability rates among today's younger persons. One such study, published by the National Bureau of Economic Research and RAND, states that "more disability at younger ages almost certainly translates into more disability among tomorrow's elderly, and disability is a key predictor of health care spending."

Increasing Rates of Alzheimer's Disease and Obesity May Increase the Impact of an Aging Population on State Agencies. In contrast to the apparent disagreement about overall trends in disability rates, there appears to be more agreement that, absent medical breakthroughs or lifestyle changes, the incidence of both Alzheimer's disease and obesity will increase and will negatively impact health care costs at a national level. According to a 2003 article in the *New England Journal of Medicine*, by 2010 national Medicaid spending on Alzheimer's disease will grow by 80 percent over costs in 2000. In addition, Medicare spending will increase by 54 percent.

In Virginia, projections prepared by the Virginia Department for the Aging (VDA) indicate that the number of persons with Alzheimer's will double between 2000 and 2030, from 2.6 to 4.3 percent of the State's population. However, the State does not presently have a clear policy on what role, if any, State agencies should have in providing services to persons with Alzheimer's and other forms of dementia, particularly if they have behavioral problems. As the number of persons with dementia increases, the State may face pressures to begin providing a broader array of services, including those that may reduce nursing home or other institutional placement.

Obesity may increase the disability rates among today's seniors, and could increase disability rates among future seniors if current rates do not decrease. Data from the federal Centers for Disease Control and Prevention (CDC) indicate that 13 percent of Virginians age 75 and older were obese in 2002. (Obesity is defined as

having a body mass index of 30 or higher, which is based upon a person's weight and height.) The obesity rate was much higher, however, among baby boomers than among older Virginians. According to the CDC, 26 percent of Virginians age 45 to 64 were obese in 2002.

Although the impact of obesity on overall disability rates is not clearly established, it appears that obesity persists into later life and increases the likelihood that individuals will spend more of their lifetime in a disabled condition. For instance, a 2005 study in the journal *The Gerontologist* found that obese women at age 80 had a 27 percent likelihood of becoming disabled, while non-obese women had an 18 percent likelihood. The CDC notes that obesity increases the risk of many diseases and health conditions, including hypertension, type II diabetes, coronary heart disease, and stroke. Obesity may also increase nursing home costs, which could affect State Medicaid expenditures. A 2005 study in the *Journal of the American Geriatrics Society* found that obesity is associated with not only increased risk of other conditions such as diabetes, but that obese individuals "typically require the assistance of two or more people to perform most ADLs safely."

IMPACT OF HEALTH CARE SPENDING AND DEBT ON THE FEDERAL BUDGET MAY AFFECT THE LEVEL OF FEDERAL FUNDS IN VIRGINIA

Several federal agencies have expressed concern that the federal budget will be increasingly strained by the aging of the population. The resulting fiscal stress may have a ripple effect in Virginia, a possibility which was expressed by the Virginia Department of Planning and Budget (DPB) in its response to a survey of State agencies conducted for this report. DPB observes that recent budgetary trends suggest that "the federal government intends in the long run to reduce its responsibilities for the aging population and to shift costs to the states and localities, even for existing services." Older Virginians may also receive reduced Social Security benefits, in part because of premium increases for Medicare that the federal Medicare Trustees indicate will be needed unless federal revenues increase.

The federal fiscal year (FFY) 2006 executive budget proposal may indicate the direction of federal spending. Of note, most major federal programs that directly benefit seniors are targeted for reduction or held at earlier levels:

- Reductions were proposed for Medicaid, the Older Americans Act that funds area agencies on aging, some elderly subsidized housing programs, and Veterans Administration long-term care services.

- The Social Services Block Grant, which funds some of the State's Department of Social Services programs for the elderly and disabled, remains at FFY 2004 levels.

- In contrast, it appears that federal transit funding for the elderly and disabled may increase.

The remainder of this section provides a brief description of the major components of federal spending for older Americans – Social Security, Medicare, and Medicaid – followed by information on their projected impact on the federal budget.

Social Security Provides Benefits to 91 Percent of Virginians Age 65 and Older

The Social Security program provides monthly benefits to retirees and their family members, as well as younger disabled persons. A study by the National Bureau of Economic Research suggests that Social Security has been the primary reason why poverty among older Americans has generally decreased since 1960. Social Security is a pay-as-you-go program, in which payroll taxes from current workers are used to pay benefits to recipients. For persons born in 1937 or earlier the "full retirement age" is 65. For people born afterwards it has been increased to age 67. Based on national data from June 2005, Social Security provides more than half of all income for two-thirds of all beneficiaries and is the only source of income for 22 percent of beneficiaries. In Virginia, retired workers received an average of $908 per month, and a total of $700 million in monthly benefits for persons age 65 and older was distributed in December 2004.

Individual retirees age 65 or older who receive Social Security and whose monthly income in 2005 is less than $579 may also receive Supplemental Security Income (SSI) in order to bring their income up to $579. To qualify, individuals must have less than $2,000 in assets (excluding items such as their home and one car). In Virginia, 1.2 percent of all persons age 65 and older (35,775 people) were receiving SSI as of December 2004.

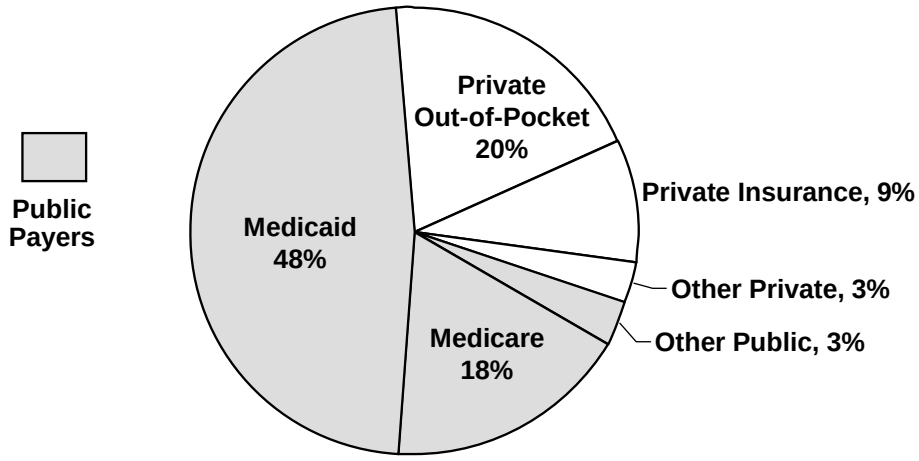
Medicare Provides Assistance With Health Care Costs for Eligible Persons

Medicare has three parts (A, B, D) that cover different health care expenses. Like Social Security, Medicare is also a pay-as-you-go program, funded through a combination of payroll taxes and premiums charged to recipients. Medicare spending accounted for 18 percent (about $33 billion) of national long-term care expenditures in 2003 (Figure 4). Individuals typically qualify for Medicare at age 65. In Virginia, about 96 percent of all people age 65 and older were enrolled in Part A and/or Part B in 2003.

Medicare premiums are deducted from monthly Social Security checks. Recipients age 65 and older do not have to pay the premiums for Medicare Part A, but must pay the premiums for Part B. Medicare Part A covers hospital stays, short-term nursing home stays, and some home health care. Part B covers doctors' services, outpatient hospital care, and some other medical services. In addition, Medicare recipients who choose to enroll in the new Part D prescription drug benefit are scheduled to begin paying those premiums in January 2006. In 2006, the monthly premiums for Parts B and Part D will be $88.50 and $32.50, respectively.

Figure 4

Funding Sources of National Long-Term Care Costs (2003)



Source: Government Accountability Office (GAO).

Medicaid Provides More Extensive Long-Term Care Services to Eligible Persons

Medicaid provides health care coverage that differs from the coverage provided through Medicare, although some persons may receive services from both programs. Medicaid is jointly funded by the State and the federal government. In Virginia, the State and the federal government each pay for half of program expenditures. Medicaid continues to be the largest financing source of long-term care nationwide, paying 48 percent (about $87 billion) of total long-term care costs for persons of all ages in 2003. Nationally, about 57 percent of Medicaid long-term care spending in 2002 was for older persons.

Certain services are required to be covered by Medicaid as a result of federal regulation, but states have some discretion to add or modify services through waivers. Persons who qualify for Medicaid can receive an array of services including long-term nursing home services, home health services, mental health and mental retardation services, and transportation services. However, some services are not available in Virginia to older persons. For example, dental care is only provided to persons under 21 years of age, and substance abuse services are only covered for pregnant and post-partum women.

Individuals can qualify for Medicaid if they receive certain federal assistance. For example, older Virginians who qualify for SSI or the State's auxiliary grant will generally qualify for Medicaid. (The State's auxiliary grant program assists certain low-income persons pay for the costs of care in assisted living facilities, as discussed in Chapter IV.) Older Virginians who are low-income Medicare beneficiaries are eligible for some Medicaid coverage of their premiums,

deductibles, and co-insurance. An older Virginian who is not an SSI or auxiliary grant recipient can obtain Medicaid eligibility if his or her income is at or below 80 percent of the individual Federal Poverty Limit (which equals $638 per month in 2005), if he or she has less than $2,000 in resources, and if he or she also meets the definitions of "aged, blind, or disabled." To qualify as "aged" an individual must be age 65 or older. An older Virginian who is between the ages of 60 and 64, however, must be either blind or disabled to receive Medicaid coverage.

Two other groups that include many persons age 60 and older are covered at the State's option: institutionalized individuals (such as nursing facility residents) and individuals receiving home and community-based waiver services who have incomes at or below 300 percent of SSI (which equals $1,737 per month in 2005). In order to meet Medicaid eligibility through either category, individuals must meet a certain level of disability and require ongoing assistance with a medical condition. Virginians, including persons age 60 and older, who have income that excludes them from other Medicaid eligibility categories may "spend down" their excess income to obtain Medicaid benefits.

Long-Term Federal Spending After 2015 Is Described as Unsustainable

According to an August 2005 report by the Congressional Budget Office (CBO), the aging of the population, as well as continued increases in health care costs, will cause spending on Social Security, Medicare, and Medicaid to increase substantially. The CBO estimates that this spending may account for 55 percent of all federal spending by 2015, compared to 42 percent in 2004.

As the population continues to age between 2015 and 2030, both the CBO and the Government Accountability Office (GAO) state that spending on Social Security, Medicare, and Medicaid will exert pressure on the budget that will make current fiscal policy "unsustainable." This conclusion has also been reached by the Social Security and Medicare Trustees, whose membership includes the Secretaries of Treasury, Labor, and Health and Human Services. As the trust funds used by both programs are depleted and as health care costs continue to increase, the Trustees add that:

> The pressure on the Federal budget will intensify. We do not believe the currently projected long run growth rates of Social Security and Medicare are sustainable under current financing arrangements.

Two Additional Factors Contribute to This Projected Fiscal Stress at the Federal Level. The first factor is demographic change, which will be seen in an increasing national dependency ratio: as the growth in the working age population slows there will be fewer taxpayers available to support pay-as-you-go programs such as Medicare and Social Security. A further consequence of demographic change is projected declines in real economic growth because of the retirement of the baby boom, which will cause the growth in the nation's workforce to decrease. The CBO projects that economic growth will decline from an annual

rate of 3.2 percent before 2010, to 2.6 percent starting in 2011 when the first boomers retire. Recent studies suggest that the average retirement age is beginning to increase, following a decrease over several decades, but it is not yet clear if this is a long-term phenomenon.

According to a 2002 study on the national security implications of global demographic change by the National Intelligence Council, "within two decades much of the industrialized world could find itself with increased debt or higher taxes, which could lead to slower economic growth worldwide." The Organisation for Economic Co-operation and Development (OECD) projects that the impact of aging on Gross Domestic Product (GDP) growth rates will be a decrease in Europe to 0.5 percent, in Japan to 0.6 percent, and in the United States to 1.5 percent in the years 2025-2050.

The second factor is medical price inflation, which is largely driven by the cost of new medical technology and techniques. As discussed by the Social Security and Medicare Trustees, this will strain the federal budget because "underlying health care costs per enrollee are projected to rise faster than the wages per worker on which the payroll tax is paid and on which Social Security benefits are based."

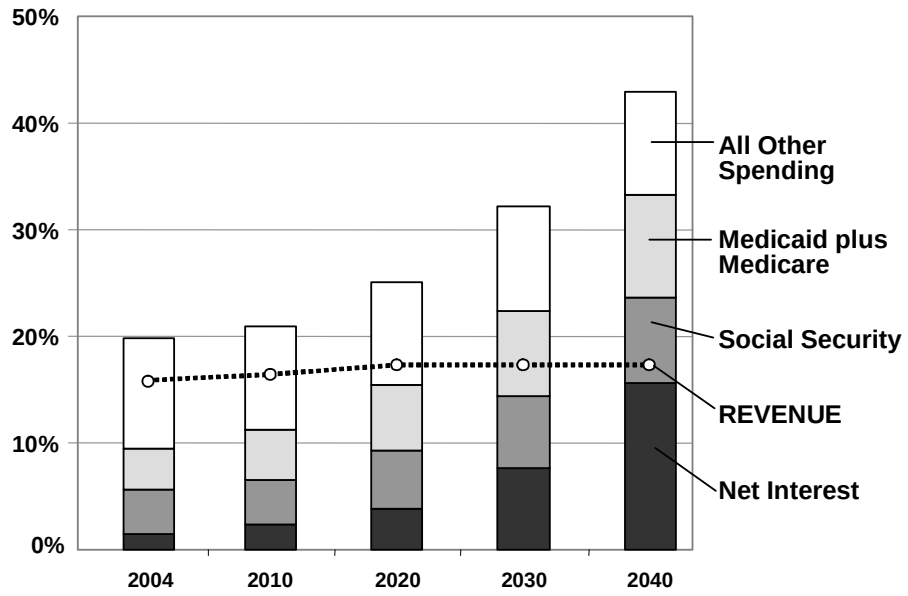
Social Security, Medicare, Medicaid, and Federal Debt Are Projected to Account for a Much Larger Share of the Nation's Economy. By 2030, Social Security, Medicare, and Medicaid are projected to be about 15 percent of the nation's overall economy, as measured by Gross Domestic Product, compared to 8 percent in 2004. By 2035, the GAO projects that federal spending for Medicaid, Medicare, and Social Security will nearly double as people live longer, spend more time in retirement, and hence collect more benefits. Figure 5 illustrates projected expenditures on four components of federal spending from 2004 to 2040: net interest, Social Security, Medicaid plus Medicare, and all other spending. The horizontal dotted line depicts projected revenues under current tax law. These revenues by 2040 will be just enough to cover either the net interest costs for federal government borrowing – or the combined costs of Social Security, Medicare, and Medicaid – but not both. The GAO notes that unless federal retirement and health programs for the elderly are changed, "federal budgetary flexibility will become increasingly constrained." The CBO has concluded that these programs "will exert pressure on the budget that economic growth alone will not eliminate."

These pressures at the federal level strongly suggest that State agencies may be directly impacted by a reduction in federal funding for public programs and indirectly impacted by potential reductions in individual retiree benefits. This could lead to an increase in demand by the baby boom for State-funded services for older Virginians in place of federally-funded programs. Although the nature and extent of impact resulting from population aging can only be estimated, many observers have noted that nations and their governments face a long-term challenge. As noted in a 2003 report from the Center for Strategic and International Studies:

> We live in an era defined by many challenges, from global warming to global terrorism. But none is as certain as global aging. And none is as likely to have as large and enduring an

Figure 5

Projected Growth in Federal Spending Compared to Growth in Revenue (as a Percentage of Gross Domestic Product)



Source: Government Accountability Office (GAO) Long-Term Simulations.

effect — on the size and shape of government budgets, on the future growth in living standards, and on the stability of the global economy and even the world order.

SOME BABY BOOMERS MAY BE LESS ABLE TO PAY FOR LONG-TERM CARE AND OTHER SERVICES WHEN THEY RETIRE

If the trends in disability rates discussed above continue, the aging of the baby boomers will likely increase the demand for and cost of long-term care and related services. This will put pressure on federal funding for Medicare and Medicaid, and federal policymakers may respond by reducing the federal government's share of long-term care expenditures. A greater use of private long-term care insurance has been advanced as a possible solution to the need for additional sources of financing. However, recent studies at the national level suggest that some boomers may not be able to pay for their care needs, and that long-term care insurance may not be a sufficient source of financing. As a result, there may be an increased demand for State-funded services.

Other factors that will likely affect the federal government result from the collective effect of the actions taken by private sector corporations. If an additional

number of businesses default on their pensions, the federal government may be pressured to assume more responsibility for providing pensions to private sector retirees through the Pension Benefit Guaranty Corporation (PBGC). As of September 2004, the PBGC had a deficit of $23 billion. In addition, federal and State policymakers may both have to respond to the declining percentage of private-sector employers that offer health care benefits to retirees and current employees. According to the Employee Benefit Research Institute (EBRI), the percentage of private-sector employers that offered retiree health benefits to early retirees (people under 65 years of age) decreased from 22 percent in 1997 to 13 percent in 2002. The availability of health benefits to Medicare-eligible retirees (people age 65 or older) also decreased, from 20 percent in 1997 to 13 percent in 2002.

Although the percentage of all health care spending that comes from out-of-pocket payments has been decreasing since the introduction of Medicare and Medicaid, it still represents a major expense for many persons, particularly people with lower incomes. Individuals' out-of-pocket payments accounted for 20 percent (about $38 billion) of national long-term care expenditures in 2003. The vast majority (82 percent) of these payments were used for nursing home care. However, spending on home care was also substantial, and for persons over age 85, one-third of all spending on home health care was paid out-of-pocket. In 2001, among people age 65 and over who had out-of-pocket expenditures:

- People with incomes below 125 percent of the poverty level paid 22 percent of their household income on out-of-pocket long-term care expenditures, on average; and

- People with higher income levels paid eight percent of household income for out-of-pocket long-term care expenditures, on average.

Increases in health care inflation, as well as a growing trend toward the use of co-pays, may limit the ability of some individuals to pay for their care in future years. For example, a January 2005 analysis done for *BusinessWeek* by the Urban Institute found that if healthcare costs continue to climb, typical retirees could be paying nearly 22 percent of their Social Security benefits for Medicare premiums by 2040. (This analysis assumed that Social Security benefits are not reduced.) In comparison, Medicare Part B premiums accounted, on average, for about nine percent of a Virginia retiree's monthly Social Security payment in 2004.

Factors That Affect Retiree Wealth May Influence the Ability of Individuals to Pay for Health Care

Despite the decrease in poverty rates among older persons since the 1960s, about one of every ten people age 65 and older had a monthly income below the poverty limit of $776 for individuals in 2004. Poverty and income levels are directly related to the potential impact of an aging population because the savings and income that older persons have in future years could affect the demand for publicly funded services. Between 1960 and 2004, the official poverty rate for Americans age 65 and older fell from 35 percent to 10 percent. Using data from the Census

Bureau's Current Population Survey, among older Virginians the poverty rate in 2004 was about 11.5 percent – higher than the rate of 8.2 percent among other adults, and higher than the rate of about 11.2 percent for children.

Some Future Retirees May Outlive Their Accumulated Wealth. In 1950, retired men and women could expect to spend 12 and 14 years in retirement, respectively. By 2000, the average number of years in retirement had increased to 18 years for men and 22 years for women. In 2004, two studies were published by staff at the Urban Institute and at the Social Security Administration which indicated that some baby boomers will have less savings as a percentage of their pre-retirement income than today's retirees. The financial planning literature cited by the studies states that a retiree needs to have at least half of their pre-retirement income in order to avoid hardship. Among current retirees, 12 percent have less than half of their pre-retirement income, but this is projected to increase to 17 percent of people born after 1935 – an increase of 42 percent. The studies point to several current trends to explain this projected shortfall:

- The savings of baby boomers at retirement are projected to be smaller than for today's seniors because baby boomers tend to have a lot of credit card and student loan debt, and home equity loans decrease a major source of traditional wealth; and

- The availability of traditional pensions is decreasing, but there are statutory limits on contributions to individual retirement accounts.

In line with these trends, the nation's annual personal savings rate (measured as a percent of personal income) in 2004 was 1.75 percent – its lowest level since 1934. For comparison, the personal savings rate was 4.8 percent in 1994 and 10.8 percent in 1984. When personal saving is negative, as it was during July 2005 (-0.6), this indicates that personal spending is financed by borrowing, such as credit cards or home equity loans.

Poverty Rates Are Projected to Decrease If the Current Definition of Poverty Remains in Place. In apparent contrast to the projections of decreasing retirement income, the Urban Institute and Social Security Administration studies project that poverty rates at age 67 will decrease from eight percent among current retirees to between two and four percent among retired boomers. Additionally, the percentage of persons receiving SSI at age 67 is projected to decrease from five percent of today's retirees to two percent of boomer retirees. These projected decreases suggest that fewer older Virginians will qualify for services such as Medicaid, for which eligibility is determined by an individual's poverty status and eligibility for SSI. If these projected trends are accurate, then State agencies may face increased demand for services by people who lack financial resources, but fewer people may be able to qualify for State agency services if eligibility continues to be based on poverty status.

However, these decreases result in part from the manner in which poverty rates and SSI eligibility are calculated, and may not be indicative of an increase in the ability of future retirees to pay for long-term care:

- The maximum benefit level for the poverty thresholds and SSI is indexed to annual changes in prices, as measured by the Consumer Price Index. Therefore, if compensation increases faster than prices, fewer people will qualify. Although it may appear that increasing compensation would increase the wealth of future retirees, the 2005 Social Security Trustees Report notes that take-home pay will continue to decline as a portion of total compensation (including benefits). This implies that boomers will have less discretionary income with each passing year that can be used to contribute to retirement accounts.

- An additional factor is that the asset level limit of $2,000 for SSI has remained constant since 1989, and has changed little from the $1,500 limit when the program was implemented in 1974. As a result, if the asset limit is not raised, fewer individuals will qualify for SSI for this reason alone as inflation increases the value of assets.

Promotion of Long-Term Care Insurance May Reduce Government Expenditures, But Obstacles Exist to Its Use

Private insurance (including traditional health insurance and long-term care insurance) accounted for nine percent of national long-term care financing in 2003 (about $16 billion). Some research indicates that a greater use of long-term care insurance may reduce public expenditures on long-term care. For example, a recent study published by the Virginia Health Care Association reported that $130 million to $254 million in Medicaid expenditures could have been saved in 2002 if half of the recipients of Medicaid-financed nursing home care had been covered by long-term care insurance.

In addition, there is other research which suggests that persons who have obtained long-term care insurance have a large percentage of their nursing home and assisted living expenditures covered by their insurance. For example, a 2000 study published by the U.S. Department of Health and Human Services, which looked at a sample of persons with long-term care insurance, found that the policy paid for 67 percent of the costs of nursing home care and 88 percent of the costs of assisted living care. In addition, for one in eight policyholders who were in a nursing home, and one in five policyholders who were in assisted living, the presence of insurance that covered home and community-based services was reported to enable them to delay their entry into an institution. However, one in ten individuals indicated that they entered an institution sooner than they otherwise would have, because insurance would pay for the cost of institutional care.

Current Trends Suggest Long-Term Care Insurance Will Not Substantially Reduce Public Expenditures. Although the number of people buying private long-term care insurance is growing, current trends indicate that such insurance will not substantially reduce public long-term care expenditures in

future years. A 2005 study by the Urban Institute found that only about nine percent of the population age 55 or older has long-term care insurance, and that this proportion will not change greatly over the next 20 years unless the costs of long-term care insurance decrease.

In Virginia, data provided by Bureau of Insurance staff at the State Corporation Commission (SCC) indicate that 168,932 Virginians were covered by long-term care insurance in 2003. This equates to 3.03 percent of all Virginians age 18 and older. (SCC staff state that data by age are not available for Virginia, but that national data indicate that the average age of a person who purchases an individual policy is 65.) However, because this number includes State employees (discussed below), the actual number of Virginians with long-term care insurance coverage through individual plans is closer to 107,000.

Automatic long-term care insurance coverage is provided to all full-time and part-time State employees for the duration of their State employment through the Virginia Sickness and Disability Program (VSDP) under the Virginia Retirement System. Using 2003 data, 62,280 people were enrolled in VSDP, and therefore had automatic long-term care insurance coverage while employed by the State as a result of legislation that was enacted in 1999. State and local employees and retirees can also purchase coverage for themselves or family members that would apply beyond the time of employment through a voluntary policy negotiated by the Department of Human Resource Management (DHRM). As discussed in the interim report, few employees have purchased long-term care insurance coverage that extends beyond the time of employment for themselves or family members through DHRM's voluntary program. In 2003, a total of 5,358 people were covered through the voluntary policy, including 231 retirees and their family members.

Two Barriers Exist to Greater Use of Long-Term Care Insurance. The barriers to greater use of long-term care insurance appear to result from two related factors: the cost of policies and the predominance of individual policies. The average cost of a good quality long-term care insurance policy bought at age 65 was $2,862 per year in 2002, according to the trade group America's Health Insurance Plans. Most policies are bought by older people, who therefore pay higher premiums than if the policies were purchased at a younger age. In part, the tendency for individuals to purchase long-term care insurance when they are older and more likely to need long-term care keeps the overall price of long-term care insurance high. This is because the prevalence of older policyholders means that insurance companies have less ability to cross-subsidize costs, and will therefore generally charge somewhat higher rates to all policyholders. As a result, the rates charged to younger persons, who are typically healthier and less likely to need insurance, are higher than they otherwise would be, and this may discourage them from purchasing a policy.

Annual premium rate increases can also create a barrier, and may hinder some individuals from keeping their coverage. According to SCC staff, the Commission must approve a rate increase before it can take effect, and this process requires a detailed actuarial review. However, SCC staff state that if a rate increase can be actuarially justified, there are no restrictions under Virginia law on the

amount by which a premium can be increased each year. For some older Virginians, premium rate increases may be burdensome. For example, a major national insurance company notified some of its policyholders that several series of long-term care insurance policies issued in Virginia will have a premium rate increase of 33 percent effective in February 2006.

In addition, the fact that 90 percent of policies nationwide are sold individually may mean that some people cannot get coverage. This problem is known as adverse selection, and it results from the fact that insurers use an individual's health status or history to determine if they are eligible to purchase a policy, or if the cost of a policy needs to be increased to account for their health status.

Public Subsidies Have Been Proposed to Encourage Use of Policies. Because the cost of long-term care insurance limits its purchase, public subsidies to promote its use have been proposed. One approach is to provide employers a tax subsidy for the purchase of long-term care insurance policies for their employees by allowing them to deduct insurance contributions as a business expense. A second strategy is to provide a tax deduction or credit to individuals for the purchase of private long-term care insurance.

In Virginia, legislation sponsored by the Joint Commission on Health Care has attempted to increase the incentives for the purchase of long-term care insurance by using both of these approaches. Currently, Virginia allows individual taxpayers, but not corporations, to deduct the amount paid annually in premiums for long-term care insurance. This is allowed to the extent that the individual has not deducted the cost of their premiums from their federal income taxes. During the 2004 Session, three bills (HB 1050, SB 263, and HB 1214) sought to create State income tax credits, instead of deductions, for the purchase of long-term care insurance. These bills were left in committee prior to the 2005 Session. During the 2005 Session, the companion bills HB 2513 and SB 1041 proposed an income tax credit to taxpayers who operate businesses in the Commonwealth that provide benefits to employees that include long-term health care insurance. Both bills were also left in committee.

At the federal level, the President's FFY 2006 budget proposed eliminating the federal ban on new Long-Term Care Partnership Programs. Through these programs, which have only been permitted in four states, individuals who purchase approved long-term care insurance can become eligible for Medicaid after their insurance coverage is exhausted, without having to divest all of their assets.

STUDY MANDATE AND CONTENT OF THE REPORT

House Joint Resolution (HJR) 103 from the 2004 General Assembly Session requires the Joint Legislative Audit and Review Commission (JLARC) to "study the impact of Virginia's aging population on the demand for and cost of state agency services, policies, and program management." The study mandate notes that Virginia's older population is expected to substantially increase over the next 30

years, and that older Virginians currently have unmet demands for State-supported services. The mandate further notes that the growing number of older Virginians, as well as increasing life expectancy, will result in a greater demand for State agency services. In conducting the study, JLARC is directed to consult with several State agencies:

- Commonwealth Council on Aging
- Department for the Aging
- Department of Corrections
- Department of Health
- Department of Human Resource Management
- Department of Medical Assistance Services
- Department of Mental Health, Mental Retardation and Substance Abuse Services
- Department of Social Services
- Virginia Retirement System.

The remainder of Chapter I describes the scope of the report, and the topics that will be addressed.

Scope of the Report

Assessing the impact of an aging population required a consideration of not only the services provided by the agencies specifically noted in the mandate, but, in some cases, the services provided by additional agencies. For example, the mandate directs JLARC to consult with the Virginia Department for the Aging (VDA), which provides services to older Virginians through its administration of federal Older Americans Act funding to local area agencies on aging (AAA). Many AAA services, however, are provided as a result of funds that are administered by agencies not listed in the mandate, such as the Department of Housing and Community Development, and the Department of Rail and Public Transportation. Without the housing and transportation funding provided by these additional agencies, many older Virginians would not be able to receive other AAA services. Consequently, these agencies were addressed in the review. (The impact of an aging population on the workforce of State agencies, which was also noted by the mandate, is addressed in a separate report.)

This review also required a distinction between the services older Virginians need, those they demand, and those they are eligible to receive. However, this study is not a needs assessment, for it does not comprehensively consider all the needs of older Virginians. However, to consider the impact over a 25-year horizon, this review does attempt to consider the potential for additional impacts upon State agencies if changing needs are not met through other means.

Furthermore, it is important to note that many older Virginians will never require State-supported services, while others will not demand these services from the State and will instead turn to family, faith-based organizations, or nonprofit organizations. Eligibility restrictions will also prevent some older Virginians from

qualifying for State-supported services. In some cases, older Virginians will not make their service needs known for a variety of reasons, such as self-reliance, pride, isolation, or a lack of awareness of service availability.

Lastly, a balance had to be struck between the three potential areas of impact noted in the mandate: cost, policies, and program management. For some State agencies, the largest impact will likely result from the cost of services. The Department of Medical Assistance Services (DMAS), which administers the State's Medicaid program, is largely impacted as a result of the demand for and cost of Medicaid services. Consideration of certain policies that guide the provision of Medicaid-funded services is also important, however, in those instances where they affect the services of other agencies included in this review.

Other agencies, in contrast, serve a relatively small group of older Virginians and at lower cost, but provide critical services that are not available elsewhere. For example, the State's public guardian program provides surrogate decision-makers to older Virginians who are not competent to make their own decisions. The cost of this program is very small in comparison to the services funded by DMAS, but without public guardians some older Virginians would not receive needed care.

Research Methods

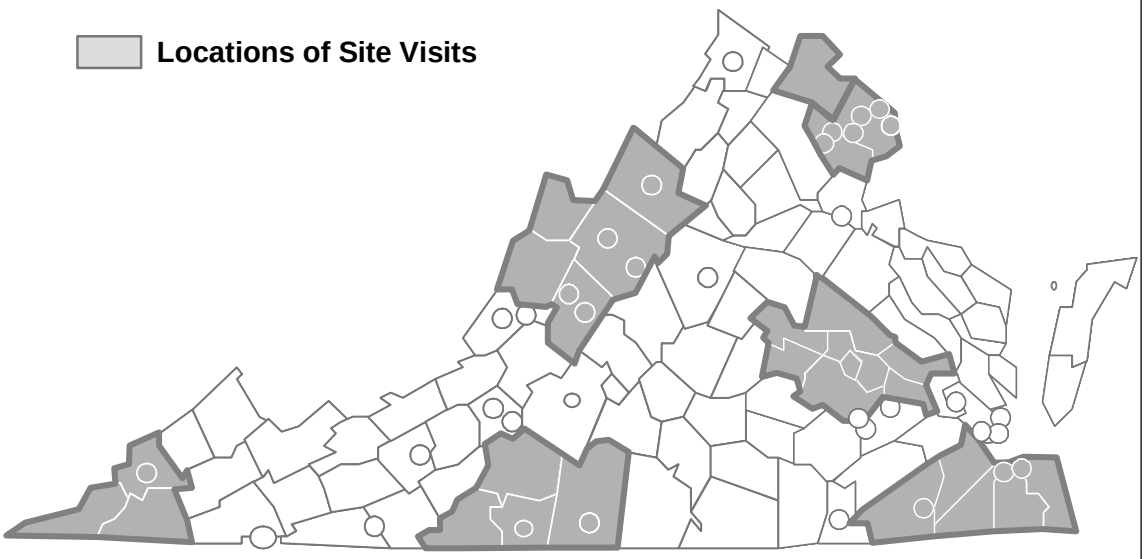
The information presented in this report was largely derived from site visits to local agencies throughout Virginia that provide State-funded or supervised services. JLARC staff interviewed staff at local departments of social services, community services boards, departments of health, and area agencies on aging. As indicated in the interim report, these agencies are most directly involved in providing services to older Virginians. These interviews were conducted in six geographically distinct regions of the State, as shown in Figure 6, and local agency staff from each locality in these regions were invited to participate in the meetings. Additional meetings were also held with local agency staff from the cities of Charlottesville, Fredericksburg, and Petersburg, and the counties of Albemarle, Culpeper, and Fauquier. JLARC staff also analyzed data provided by State agencies on service provision and cost. Relevant legislation and statutes were also reviewed, and staff read medical and economic journals as well as publications of State and federal agencies. Appendix D provides more information on the research methods used for this report, and Appendix E contains a bibliography. JLARC staff also conducted a survey of 62 State agencies. The individual survey responses are presented in a supplemental appendix to this report that is available on the JLARC website at http://jlarc.state.va.us/Reports/AgingSupAppdx.pdf .

Organization of the Report

The current report presents information on some of the key services for older Virginians that State agencies provide or finance. The role of State agencies in

Figure 6

Regions Chosen for Study Site Visits



Source: JLARC staff graphic.

service provision varies depending upon the type of service. Many of the State-supported services used by older Virginians are provided by local agencies that act under the supervision of State agencies or that utilize funding sources administered at the State level. This report builds upon the research presented in the interim report, which focused on State-level agencies, by examining the impact that older Virginians are reported to have upon the local counterparts of State agencies. The chapters in this report reflect the varied role of the State and local agencies in providing these services, as well as factors that influence that role. Table 1 provides a summary overview of the organization and content of the report.

Chapter II addresses the role of informal caregivers (family and friends) in supplementing or delaying the need for formal services provided by the State. This chapter also addresses the role of State agencies in recruiting and training health care workers, who often provide long-term care services to older Virginians. Informal (unpaid) caregivers provide the majority of care to older Virginians, but a potential lack of these caregivers may increase the demand for paid health care workers. However, the State faces a potential shortage of health care personnel, particularly nurses.

Chapter III discusses two possible fiscal impacts that the population of older Virginians may have upon the State. The first of these impacts, increases in expenditures for Medicaid recipients age 65 and older, may have a substantial impact upon the State's budget, but also upon the availability of Medicaid-funded services. The second impact is the potential for decreased State income tax and sales and use tax collections. Older Virginians receive age-related tax deductions

Table 1

Overview of Report Scope and Organization

Report Chapter	Topic	Identified Issues
Who Is Available to Care for Older Virginians?		
Chapter II	Informal caregivers and health care workers	Possible decreases in caregivers and nurses may affect availability of care.
What Is the Projected Fiscal Impact of An Aging Population?		
Chapter III	Medicaid expenditures and tax revenue	Aging Medicaid recipients may increase costs, and tax preferences and spending patterns may decrease revenue.
Is the Supply of State-Funded Nursing Home and Assisted Living Facility Beds Adequate?		
Chapter IV	Medicaid-funded nursing home and auxiliary grant beds	Reported shortages of public-pay nursing home and auxiliary grant beds may result from reimbursement levels.
Are Services Available for Older Virginians Who Need Mental Health, Mental Retardation, and Substance Services?		
Chapter V	Mental health, mental retardation, and substance abuse services	Funding limitations and lack of appropriate services both contribute to an inadequate availability of services that will be further stressed as aging population increases.
How Are Aging Prisoners Impacting the State?		
Chapter VI	Cost of services for aging prisoners and Geriatric Release.	An aging prisoner population is reported to increase costs. To date, the Geriatric Release Program has been rarely used.
What Barriers Exist to the Provision of Home and Community-Based Services?		
Chapter VII	DSS and AAA services, Medicaid waiver services, and case management	Limited funding for DSS and AAA services, and Medicaid regulations, may limit access by eligible persons and increase demand for more intensive and costly services. Case management may improve access.
Are Services Available for Vulnerable Older Virginians?		
Chapter VIII	Adult protective services, public guardians, and long-term care ombudsmen	Insufficient funding appears to limit availability of services, which may impact other State agency services.
Do Older Virginians Have Safe, Affordable, and Accessible Housing?		
Chapter IX	Affordable housing, property taxes, and housing repairs	Housing costs may hinder ability of seniors to live at home, and increase need for more intensive and costly services.
What Is the Impact of Unmet Transportation Demands?		
Chapter X	Public transportation, land use, and reimbursements for home health providers	Lack of transportation may limit access to needed services, and increase demand for more intensive and costly State services

Source: JLARC staff.

and an exemption that reduces State income tax collections. Sales and use taxes may also decrease as a result of the tendency of expenditures to decrease with age and to be focused on non-taxable services.

Chapter IV looks at publicly-funded beds in nursing homes and assisted living facilities. A shortage of Medicaid-funded nursing home beds was reported, and it is possible that availability may be limited by funding. It also appears that there may not be enough auxiliary grant beds, which are provided to low-income Virginians in assisted living facilities, in part because of limited funding.

Chapter V examines the State's role in providing facility- and community-based services for persons with behavioral health needs, such as mental health, mental retardation, and substance abuse services. It appears that insufficient funding, plus a shortage of appropriate services, limits the availability of services that are required by some older Virginians.

Chapter VI looks at the potential impact of an aging prisoner population, and the use of the Geriatric Release Program.

Chapter VII discusses home and community-based services that are provided through the local area agencies on aging and departments of social services, and through the Medicaid Elderly or Disabled with Consumer Direction waiver. These services are intended to allow recipients to remain at home or in their communities, instead of being placed in residential facilities such as nursing homes, assisted living facilities, or State mental health facilities and mental retardation training centers. This chapter also describes the extent to which decisions regarding the provision of these services are made at the local level.

Chapter VIII outlines the availability of locally provided services for older Virginians who have been declared incapacitated or are at risk of neglect and abuse. These services include adult protective services, long-term care ombudsmen, and public guardians. These services are often highly dependent on State mandates and funding. Individuals who are served through these programs are some of the Commonwealth's most vulnerable citizens.

Chapter IX discusses the availability of housing services that are used by older Virginians. These services include affordable housing for renters, property tax assessments, and home repairs and modifications. These services are needed by many older Virginians, including those who receive long-term care services in their homes and communities.

Chapter X concludes the report by examining the availability of transportation services for older Virginians who are unable to provide their own transportation. Not all older Virginians qualify for Medicaid transportation, which is only available for medical appointments, and public transportation is not available statewide. It also appears that land use decisions may affect the ability of older Virginians to safely access public transportation where it is provided. Some health care personnel, such as home health aides, are also affected by the availability of public transportation.

II. Availability of Caregivers and Health Care Workers Affects Agency Services

The majority of older individuals who need assistance rely on family and friends to provide this care. The ability of these informal caregivers to continue providing this care will have a direct impact on State funding if some older Virginians continue to be unable to pay for their care needs. Health care workers also have a key role in care provision, yet a shortage of these personnel, particularly nurses, is reported. Looking forward, demographic trends suggest that the pool of caregivers may decrease, and several studies project a shortage of health care workers. As a result, State policymakers may need to increase the services that support caregivers, as well as improve the recruitment and retention of health care workers, in order to ensure that older Virginians receive services.

INFORMAL CAREGIVERS PROVIDE THE MAJORITY OF CARE FOR OLDER VIRGINIANS

Informal caregivers, such as family and friends, provide the majority of care to older people who need assistance with activities of daily living (ADL) as well as meal preparation and transportation. The U.S. Department of Health and Human Services (DHHS) reports that 86 percent of seniors at greatest risk for nursing home placement live with others and receive informal (unpaid) care. In contrast, only 5.4 percent of older individuals rely solely on formal (paid) services. In Virginia, the American Association of Retired Persons (AARP) estimates that 21 percent of adults provided unpaid care in 2003, and 41 percent of the care recipients were over the age of 75. The assistance provided by caregivers allows individuals to remain in their homes and communities by preventing or delaying the need for institutional care. However, caregiving often interferes with other work and family responsibilities, and State and local agency services designed to provide respite and assistance to caregivers are limited. Additional funding for formal services may be needed in future years if the number of informal caregivers does not generally keep pace with the number of older Virginians needing assistance with basic activities of daily life.

Several Studies Have Found the Economic Value and Cost of Informal Caregiving to Be Significant

Several studies have estimated the economic value of services provided by informal caregivers, while others have noted that there are costs to caregivers and their employers. DHHS estimated that replacing unpaid long-term care services for seniors with professional care would cost between $50 and $103 billion (in 2004 dollars). Despite its value, informal caregiving can also have an economic cost for employers and working caregivers. Employers incur the costs of lost productivity and replacement costs when workers become caregivers. Working caregivers can also incur losses in career development, salary and retirement income, as well as substantial out-of-pocket expenses. The following findings demonstrate some of the estimated costs incurred by employers and caregivers:

- A 1997 study by MetLife estimated that U.S. employers lose between $11 and $29 billion per year in productivity among caregivers who work full-time.

- A subsequent MetLife study estimated that caregivers may spend as much as $364 a month assisting with rent or mortgage payments, and/or $322 a month for home care professionals for care recipients.

State Agencies Are Affected by the Availability of Informal Caregivers

The ability of informal caregivers to continue to provide care that prevents (or delays) the need for formal long-term care will have a direct impact on State agencies that provide these services. Several local agency staff around the State indicate that clients typically require services as a result of a crisis situation, which may be triggered by a caregiver returning to work or becoming ill. For example, an analysis by JLARC staff of data collected by DMAS suggests that individuals screened for long-term care services are often reported to have inadequate care. In 2004, 90 percent of those screened were assessed as having inadequate help from informal caregivers. Additionally, in the majority of screenings (62 percent), pre-admission screening teams (PAS) determined that providing care to the individuals being screened was "very much" a burden for caregivers, as compared to "somewhat" (32 percent) or "not at all" (6 percent) a burden. (PAS teams consist of local agency staff who determine if an individual meets eligibility criteria for Medicaid long-term care, and whether this would be most appropriately provided in an institutional setting such as a nursing home or provided through home and community-based waiver services.)

In other instances, agency staff suggest that informal caregiving is needed to supplement the assistance provided by State and local agencies. For example, Virginia's Elderly or Disabled with Consumer Direction (EDCD) Medicaid waiver allows eligible individuals to receive care in their homes instead of in a long-term care facility; however, waiver services are not intended to provide recipients with 24-hour care. Local agency staff report that EDCD waiver recipients need informal caregivers because the hours of care provided through the waiver are limited. According to the Department of Medical Assistance Service's (DMAS) provider manual for the EDCD waiver, recipients usually require between 3.5 and 5 hours of paid care per day. DMAS staff indicate, however, that some individuals receive as little as one hour of care a day, and some receive greater than 5 hours a day, depending on their level of need.

Local agency staff from several parts of the State observe that the absence of an adequate informal care network can affect the ability of pre-admission screening (PAS) teams to recommend a safe plan of care for these services. In fact, according to data collected by DMAS, individuals screened for long-term care services are more likely to be recommended for nursing facility care (68 percent) than waiver services (32 percent) when the caregiver's help is assessed as "not adequate to meet the client's needs." PAS teams in several localities say that

although they approve waiver services regardless of caregiver availability, concerns about liability cause some home care agencies or aides to stop serving individuals who appear to have inadequate support.

In addition to the concerns of PAS teams, staff at community services boards (CSBs) express a growing concern that caregivers (often parents) of their clients are aging and may no longer be able to provide care. As discussed in Chapter V, individuals with developmental disabilities and mental retardation are increasingly outliving their family caregivers, often resulting in a need for additional agency services. Furthermore, according to a report funded by the Administration on Developmental Disabilities, "the need to provide these services is frequently unanticipated by federal, state, and local agencies, often resulting in a crisis situation for families."

FUTURE AVAILABILITY OF INFORMAL CAREGIVERS IN VIRGINIA IS UNCERTAIN

The future availability of informal caregivers in Virginia will depend on several demographic trends, and may depend to some extent on the availability of State services to support caregivers. Spouses and adult children provide much of the informal care to older individuals, so trends that affect family structure, such as divorce rates and birth rates, could impact the future availability of caregivers. In addition, other responsibilities that place demands on caregivers' time, such as employment, will continue to affect their ability to provide care.

Although demographic trends could have the greatest impact on caregiver availability, the ability of the State to provide support to caregivers could also influence their future ability and willingness to continue providing care. As previously discussed, informal caregiving often offsets or supplements the need for formal services. For this reason, the State has recognized the need to assist informal caregivers through support groups, counseling, and respite. It appears, however, that these services may not be adequate to meet the needs of all caregivers, although the degree of unmet demand is unclear.

Several Demographic Factors Could Impact the Availability of Informal Caregivers

Certain demographic trends may influence the future availability of caregivers. For example, increased workforce participation of informal caregivers could mean they have less time for caregiving. This may be especially true of the "sandwich generation" – people who are raising children while providing care to aging parents. An evaluation of workforce trends suggests that participation rates are increasing among those middle-aged individuals who typically provide informal care for older individuals. At the same time, most informal caregivers are family members, and an analysis of trends in family structure suggests that the pool of individuals who typically provide support for older individuals may also be decreasing.

Workforce Participation Could Affect the Availability of Caregivers. A high level of workforce participation by potential caregivers could mean that fewer hours are available to provide informal care. For example, several studies by Georgetown University have found that employed caregivers provide fewer hours of care than non-working caregivers. Local agency staff throughout the State observe that more caregivers are working than in the past and have less time for caregiving. In addition to providing fewer hours of care, working caregivers may rearrange their work schedules, work fewer hours, or take time off without pay.

Several trends suggest that workforce participation is increasing for individuals who have traditionally provided informal care. For instance, women, who provide the majority of informal care, increased their participation in the workforce by 16 percent between 1970 and 2004 (though participation receded slightly between 1999 and 2004). Many studies have found that caregivers of older adults are typically middle-aged or older, so increasing workforce participation by that age group could also impact the availability of caregivers. According to data from the Bureau of Labor Statistics, workforce participation of men and women age 45 and older has increased over the last decade (by 3.7 and 6.3 percent, respectively). If this trend continues, caregivers of older adults may have less time for caregiving.

Changing Marriage, Divorce, and Birth Rates Could Affect the Availability of Caregivers. Since the majority of informal caregivers provide care to an aging or disabled relative, trends that affect family structure could play a key role in determining future availability of caregivers. Adult children often provide care to aging parents, so declining birth rates or increasing rates of childless women could mean fewer informal caregivers in the future. According to the Census Bureau, the percentage of women in the United States between age 15 and 44 who are childless has increased from 37 percent in 1980 to 44 percent in 2002. At the same time, the number of births per 1,000 women decreased from 71 to 61. Although the prevalence of spousal caregiving is reported to be lower than parental caregiving, rising divorce rates and declining marriage rates could also impact the future availability of caregivers. According to Census data, annual divorce rates have risen from 2.9 percent in 1970 to 9.3 percent in 2000. During the same time period, the percentage of women and men who have never married also increased, from 28 to 31 percent among men and from 22 to 25 percent among women.

Future trends in marriage and divorce rates may also be important because of their relationship to disability rates. For example, in 2005, the *Journal of Aging and Health* reported that "married individuals are better able to cope with poor health and maintain their current living arrangements than those without a spouse." Furthermore, 2000 Census data indicate that disabled older Virginians are less likely to live with a spouse and also more likely to live alone. A 2000 article in *Medical Care Research and Review*, which synthesized the findings of 78 studies of long-term care predictors, found that living alone increases the risk of nursing home placement and being married may reduce this risk.

Impact of Changing Mobility Rates on the Availability of Caregivers Is Unclear. In terms of informal caregiving, it is generally believed that increasing

mobility results in potential caregivers moving away from their families, leaving fewer people to care for aging relatives. It is also generally accepted that U.S. society as a whole has become more mobile. The data on mobility, however, suggest that fewer people are moving than in past years. In addition, it is difficult to assess whether some mobility results from individuals moving closer to their families, especially as they age and need more care.

Despite overall declines in mobility, a 2003 Census Bureau report found that Virginia ranked among the top ten states in terms of net gains through migration in the population of older people. Additionally, changes in migration patterns could impact counties in Virginia in different ways. For example, the 2003 Census Bureau report also noted that James City County was one of the counties in the country with the highest net in-migration rates for the older population. Furthermore, if young workers move out of rural areas in Virginia in search of better employment opportunities, future caregivers may be less available in those areas. A study of caregiving in Southwest Virginia indicates that "with decreasing opportunities for employment in rural areas and out-migration of younger workers, these informal networks of care may no longer be available to rural seniors in the future."

State Support for Informal Caregivers Could Affect Future Availability of Caregivers

Although demographic trends could have the greatest impact on the future availability of informal caregivers, State support could also affect the willingness or ability of individuals to serve in this role. For example, increased State support of caregivers through services such as adult day care, senior centers, caregiver support groups, and direct financial support could increase the number of individuals who are willing or able to serve as caregivers. In Virginia, several local agencies provide these services, including area agencies on aging (AAA), health departments, and local departments of social services (DSS). At the State level, respite services for caregivers are available through the Medicaid EDCD waiver, and the State Department of Social Services acknowledges the work of family caregivers through the Virginia Caregivers Grant program.

It appears, however, that caregiver support services may not be meeting existing needs, although the extent of unmet demand is unclear. Local staff indicate that adult day care can be a valuable service for working caregivers or caregivers in need of respite, yet it is not available or utilized in all parts of the State. Local and State DSS staff also note that the Virginia Caregivers Grant program has not been consistently funded. In addition, local agency staff in many parts of the State also identify a need for more respite care services. According to a 2003 AARP survey, the greatest unmet demand reported by caregivers in Virginia was finding time for her or himself and getting a break from caregiving responsibilities.

The EDCD Waiver Provides Respite and Allows Some Caregivers To Be Compensated for Providing Care. At the State level, respite services for caregivers of qualified individuals are available through the Medicaid EDCD waiver.

Under this waiver, older individuals who meet Medicaid criteria can receive personal care services which act as a form of respite for their caregivers. The emphasis of this service is on supporting caregivers who need a break from providing care. In State fiscal year (FY) 2004, 3,152 waiver recipients received respite care services, a 46-percent increase from FY 2003.

In addition to respite services available through this waiver, the EDCD waiver also supports informal caregivers by allowing some family members to be compensated for providing personal care. One feature of this waiver is that it allows individuals to hire and manage their own workers (consumer-directed care). As a result, some consumers may choose to hire family members or friends who are not employed by formal service providers, as long as they meet certain requirements. In areas of the State where a shortage of personal care aides is reported, this waiver may encourage family caregivers to continue providing care.

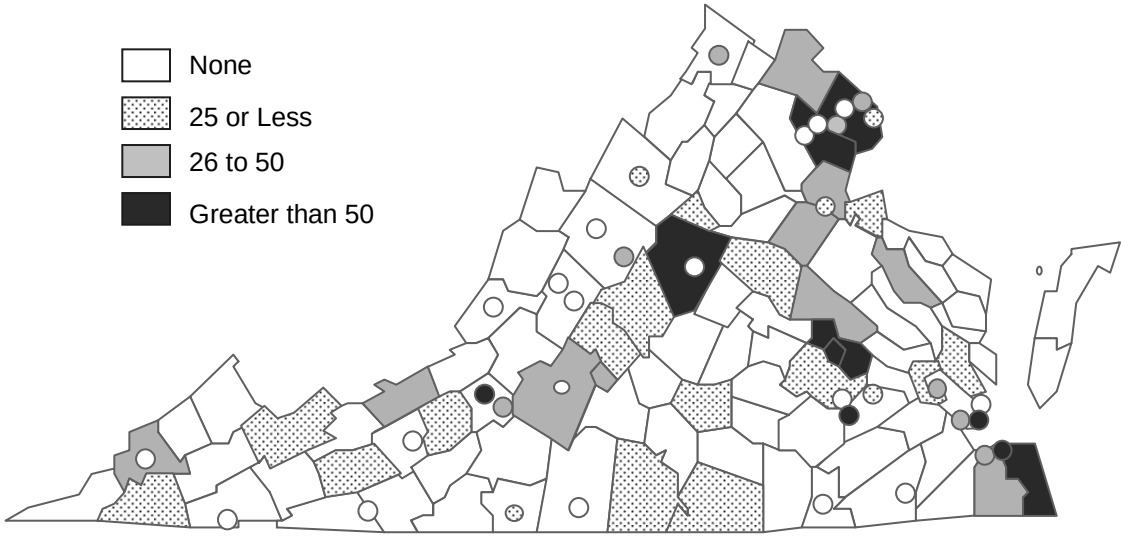
Respite Services Are Available Through the Area Agencies on Aging, But Unmet Demands Are Reported. Area agencies on aging or their contractors provide a number of services to help caregivers care for individuals who are 60 years or older in their homes and communities. AAAs provide these services through a combination of funds, including federal Older Americans Act funding. AAA services for caregivers include: information about available services; assistance in gaining access to services; individual counseling, support, and training; and respite care for temporary relief from caregiving responsibilities. Local AAAs provide various combinations of these services, including respite services at adult day care centers. It is important to note that local DSS agencies also purchase a limited amount of adult day care services for their eligible clients.

Although interviews with local agency staff and adult day care providers indicate that few older Virginians utilize adult day care, these facilities are not available to all Virginians. For example, the total capacity of licensed adult day care facilities was just 2,406 individuals as of June 2004. Moreover, these facilities were available in only 36 percent of localities (Figure 7). One provider interviewed by JLARC staff reports that no adult day care centers in Virginia have waiting lists. However, AAAs have documented unmet demands for this service, as will be discussed in Chapter VII. In federal fiscal year (FFY) 2004, AAAs provided approximately 136,000 hours of adult day care as respite for caregivers.

In several instances, agency staff indicate that facilities did not generate sufficient revenue because of a lack of interest in the service, or that high start-up costs made it difficult for facilities to open. Staff at the Richmond AAA note that although they have funding to provide scholarships for adult day care, a lack of start-up funding has prevented facilities from opening. According to staff at the Virginia Department of Business Assistance (DBA), the number of requests for start-up assistance for adult day care centers has decreased in recent years. DBA staff also note that their most successful child day care client lost money when they began offering adult day care, due to low enrollment. Some organizations faced with high start-up costs may benefit from the Respite Care Grant Program, administered by VDA, which provides financial assistance for "the development, expansion, or start-up operation of adult day care services or other services that provide respite

Figure 7

Number of Adult Day Care Facilities, by Locality



Note: The statewide capacity for all licensed adult day care facilities as of June 2004 was 2,406 people.

Source: JLARC staff analysis of DSS data on licensed adult day care facilities as of June 2004.

care to aged, infirm, or disabled adults" (Section 2.2-715 of the *Code of Virginia*). Through this program, organizations can receive annual grants up to $100,000. The General Assembly appropriated $391,691 for this program in both FY 2005 and FY 2006.

Local staff indicate that there are older Virginians and caregivers who could benefit from these services, but providers state that local agency staff may not always refer individuals to this service. Local staff maintain, however, that individuals are not always interested, and in some cases coordination is too difficult. A national survey conducted by the AARP in 1996 found that only 9.5 percent of caregivers reported using adult day care centers or senior centers. Agency staff indicate that many older Virginians choose not to attend adult day care because they would prefer to stay at home, are not aware of the service, or have difficulty obtaining transportation. Although transportation is provided for some adult day care services, it is not uniformly available. In addition, local agency staff report that individuals may require personal care assistance in the morning, and caregivers still need to provide care in the evenings. For example, PAS staff in Richmond explain that there have been times when they could not authorize EDCD services unless a caregiver was at home when the waiver recipient was dropped off from the center.

State Funding for the Caregivers Grant Has Been Inconsistent. In 1999, the General Assembly created the Virginia Caregivers Grant program to provide financial assistance to family caregivers. This program provides annual

grants of up to $500 to caregivers who provide unreimbursed care to a needy relative for at least six months of a calendar year. In order to qualify, caregivers must provide care to a relative who has a mental or physical impairment, and the caregiver must have annual earnings of not more than $50,000. State DSS staff indicate that the intent of the program is to acknowledge the work of lower-income family caregivers. Although the program could be used as a means of preventing or delaying the need for formal services, the program has not been assessed to determine whether the size of the grants is sufficient to achieve this purpose.

Several local agency staff indicate that caregivers have not been able to consistently benefit from the Caregivers Grant because it has not been adequately funded. Data provided by DSS indicates that there were 2,961 grant recipients during the first year of the program (FY 2000) and each received $318 in grant funds (Table 2). In FY 2001 and FY 2002, applications for the program were received, but funding was not appropriated for the program. In FY 2003, no funding was appropriated, and DSS did not solicit grant applications. In addition to limitations in appropriated funds, grant recipients were also affected by a change made during the 2002 Session of the General Assembly. Prior to 2003, caregivers who were not allocated the full amount of their grant could receive this amount in the following year, as a result of Section 63.1-334 of the *Code of Virginia* which stated that "the unpaid portion of the grant to which the caregiver was eligible shall be carried forward by the Department to the following year." However, the 2002 General Assembly struck this section of the law and as a result 3,754 applicants approved in 2001 and 2002 were not awarded the grant.

Table 2

Caregivers Grant Payments, by Year

Fiscal Year	Number of Approved Applicants	Amount Paid Per Applicant	Total Amount Paid
2000	2,961	$318	$941,598
2001	2,576	0	0
2002	1,178	0	0
2003	0	NA	0
2004	0	NA	0
2005	811	500	405,500

Source: DSS data and Acts of Assembly for various years.

Subsequently, the 2005 General Assembly appropriated $150,000 for FY 2005 and $350,000 for FY 2006 for the program, and also extended the period of time for which grants could be provided from 2005 to 2010. According to DSS, grants for $500 were paid to 811 caregivers in FY 2005. The remaining $194,500 from appropriations in FY 2004 to 2006 will be rolled over for next year's applicants. However, if the same number of applicants is approved for the grant, but no additional money is appropriated, each caregiver will receive only $240.

Furthermore, DSS staff indicate that "when caregivers learn that grants are again available, several thousand applications are expected in the 2006 cycle."

THE STATE FACES AN INCREASING SHORTAGE OF HEALTH CARE WORKERS

A possible consequence of a decreasing supply of informal caregivers is an increase in demand for services provided by formal health care workers, particularly those positions that work more closely with older Virginians. At present, it appears that there is a shortage of some health care workers, and some State agencies and long-term care providers report difficulty recruiting and retaining these personnel. Institutions of higher education also report an inability to train all qualified applicants. Looking forward, several national and Virginia-based studies indicate that there will be an increasing shortage of nursing as well as other health personnel. This section focuses on nursing personnel – registered nurses (RN), licensed practical nurses (LPN), and certified nurse aides/assistants (CNA). However, the content of this discussion may also apply to the reported shortages of other health care workers, such as physical and respiratory therapists.

The nursing shortage is related to the aging population because older persons are the most likely to use health care services, as noted by the U.S. Department of Health and Human Services:

> The greatest per capita demand for health care, and thus the services of RNs, will quite naturally come from the very old, those 85 and over. This is the fastest growing segment of the population and a major user of long-term care facilities, home health care, and other employers of RNs.

Nationally, RNs and LPNs represent approximately 28 percent (527,000) of direct care workers in long-term care settings. RNs and LPNs are responsible for direct patient care and supervision of paraprofessional staff in hospitals, nursing homes, and other health care facilities. In Virginia, there are three educational tracks available to a person who wishes to become an RN: Associate's degree programs offered at some community colleges, colleges, and a proprietary (private) school; Diploma programs offered by hospitals; and Baccalaureate degree programs offered in some colleges and universities. Educational programs for LPNs are offered in public schools, community colleges, and proprietary schools and take between 12 and 18 months. To be eligible to practice as an RN or LPN, an individual must also pass a national licensing examination. All nurse aides in Virginia are required to complete a 120-hour training course. In order to become certified, nurse aides must subsequently pass a State competency test.

It is also important to note that agency staff, as well as representatives of provider associations, identify an immediate need for more doctors, nurses, and other personnel with geriatric training. Few health care professionals receive geriatric training, and, as a result, common complaints among older persons – such as memory loss, incontinence, or depression – may be considered part of "normal

aging" and therefore go untreated. For example, health care personnel may not recognize the effects of polypharmacy (taking multiple medications, often prescribed by different providers), which is common among older persons. Health care staff may not be aware of potential drug interactions or the differing rate of metabolism in older persons, factors which can increase the risk of falls, depression, and other medical complications. (More information on substance abuse issues among older Virginians is provided in Chapter V.) One option to address the need for more geriatricians is for the State to require medical schools and other training sites to have rotations and coursework in geriatrics. The Joint Commission on Health Care is currently studying the supply of geriatricians in Virginia.

Nursing Shortage Is Affecting Virginia and Other States

Interviews with agency staff and other individuals indicate that there is a shortage of nursing personnel. National studies indicate that this shortage, combined with high turnover rates, may be decreasing the quality of health care as well as increasing its cost. National and state-level studies indicate this phenomenon is occurring in most states, and that the decreasing pool of working-age adults will exacerbate this shortage. Several studies have observed that inadequate staffing levels are associated with poorer nutrition and preventable hospitalizations among nursing home residents.

Some State agencies in Virginia, as well as the long-term care providers that serve older Virginians, are reported to have difficulty recruiting and retaining nurses. For example:

- A December 2004 report of the Inspector General for the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) stated that at some institutions, "nursing staffs frequently work mandatory overtime to meet current staffing patterns," and that the agency "identified nursing recruitment and retention as a systemic issue among all our facilities."

- A July 2005 report by the Virginia Health Care Association noted that Virginia has the highest turnover rate among Directors of Nursing of any state. Using 2002 data, the annual turnover rate for directors was 143 percent. The report noted that this turnover results in part from the frustrations caused by high turnover rates in supervised personnel. In Virginia, annual turnover rates for RNs and LPNs averaged 56 percent, and averaged 73 percent for CNAs.

Several Projections of Nurse Supply in Virginia and Nationally Indicate a Persistent Shortage

According to the 2004 SCHEV report, the State faces a substantial nursing shortage as a result of an aging population, overall population growth, and the

current inability to train, recruit, and retain nurses. As noted by SCHEV: "If current trends continue, the demand for full time-equivalent registered nurses (FTE RNs) in Virginia is projected to be 69,600 by the year 2020, while supply is anticipated to reach only 47,000." SCHEV has also noted that "evidence also exists for a need for more Licensed Practical Nurses," and that efforts need to be undertaken to address shortages of both RNs and LPNs.

Similar findings have been reported by other studies, including one conducted for the Northern Virginia Health Care Workforce Alliance, which funded a study by PricewaterhouseCoopers. This study found a current shortage of 2,763 health care workers in Northern Virginia, of which 1,000 are RNs. The overall health care worker shortage is expected to grow to 7,791 by 2010 and to 16,595 by 2020. The largest vacancies are projected to be for RNs, for which 4,429 vacant positions are projected by the year 2020. To address these projected shortages, the study identified the need to increase the number of annual graduates in nursing and several other health care fields in Northern Virginia by more than 600 by 2009.

National studies have also noted a shortage of nurse aides. For example, a 2004 report by DHHS found that the existing demand for nursing aides will "continue well beyond 2010" because of projected growth in the number of long-term care positions and the need to replace departing workers. The report also noted that some of the demographic factors discussed earlier in this report will likely affect the supply of nurse aides: "The pool, however, from which such workers have traditionally been drawn – largely women between 25 and 50 without post-secondary education – continues to shrink."

The Role of State Agencies in Addressing Nursing Shortages

The projected shortages of nurses, in addition to the increased attention to this issue in other states, suggests that State policymakers may wish to consider directly addressing the shortage of nurses and other health care workers. Several State agencies have a role in ensuring an adequate supply of health care personnel. In particular, secondary and post-secondary educational agencies train nursing staff and other health professionals, as regulated by the boards of the Department of Health Professions (such as the State Board of Nursing). Other agencies also play a role, such as DMAS which has provided "pass-through" funding that was given to health care providers as a means of increasing the salaries of some long-term care staff. As noted earlier in this chapter, DMAS has also promulgated regulations that allow some Medicaid waiver recipients to hire their own in-home aides, through a process known as consumer-directed care.

One apparent cause of the nursing shortage is the inability of State educational institutions to train every qualified nursing applicant. Interviews with staff at the Virginia Community College System and SCHEV, as well as individual schools of nursing, indicate that nursing programs are turning away eligible students. For example, Northern Virginia Community College (NVCC) staff report that over the last several years the college has been unable to meet the demand for

Registered Nursing, Radiological Technology, and Dental Hygiene. Several reasons have been offered for the inability of schools to meet demand:

- Difficulty recruiting and retaining nursing faculty, which has been attributed to uncompetitive salaries and a shortage of nurses with advanced degrees.

- Aging of nursing faculty and resulting impact on retirement. According to a 2004 SCHEV report on the shortage of nurses, the average age of nursing faculty was 53.2 years in 2002.

- Too few clinical sites and inadequate student aid. These two factors are discussed below.

Shortages of Clinical Sites Hinder Nursing Programs, But More Flexibility May Be Available. Interviews with educational staff indicate that nursing education programs may often be limited in their ability to train students because of a shortage of clinical sites. These sites, which are typically at hospitals, are an integral part of nursing education. Regulations promulgated by the Board of Nursing require that nursing programs include a practical component that gives students hands-on experience in nursing. However, because these sites are at hospitals and other health care facilities, colleges and universities cannot assure their availability.

The lack of clinical sites has been attributed to the inability of health care providers to find enough staff to provide the training, because these providers are already understaffed. Some educational personnel suggest that one way to increase the number of clinical sites is to locate them in alternative settings, such as nursing homes, schools, or community clinics. These personnel also advocate the use of human simulators, which would decrease the amount of time students are required to spend at clinical sites. SCHEV staff report that they have been working on collaborative efforts between public and private higher education institutions and healthcare foundations, and that some of these efforts may result in a greater availability of simulators. For example, Radford University has proposed the creation of two simulation laboratories as joint ventures between the region's educational institutions and healthcare facilities. However, staff at several agencies indicate that the use of human simulators is not currently allowed by the State.

Board of Nursing staff indicate otherwise, and state that the *Administrative Code* does not require that practical experience be in an acute care inpatient setting. Instead, geriatric experience could be attained in a nursing home, and pediatric experience could be attained in a school clinic. Similarly, Board staff state that the regulations do not prevent the use of simulators for a portion of the practical training component, so long as they are used to augment but not replace the required number of clinical hours. However, staff at George Mason University's School of Nursing note that any flexibility in State regulations may be offset by the requirements of accrediting bodies or the hospitals that host the clinical sites.

Related factors noted by staff at several State and local educational agencies are inadequate public transportation and the effects of traffic congestion. Staff at NVCC state that the college needs to build new locations in Loudoun and Prince William counties because traffic hinders students' ability to get to the existing location in Fairfax County or to available clinical sites during operating hours. This concern is also expressed by the Chancellor of the Virginia Community College System (VCCS), who states that "building community colleges on the highways was the right thing to do 40 years ago, but now they need to be built on the transit lines."

Availability of Nursing Scholarships Is Limited by a Lack of Funding. The *Code of Virginia* directs the Virginia Department of Health (VDH) to administer State scholarship programs for nurses, but there are usually more applicants for scholarship awards than there are funds available. These scholarships are funded by a combination of general and special funds, with the latter based upon a $1 fee charged by the Board of Nursing for every RN and LPN license. Not every eligible recipient receives an award, and VDH staff state that on average there are about 25 to 50 eligible applicants who do not receive an award. Award amounts may be reduced in order to allow more people to receive an award, and for FY 2005 there were 95 RN scholarships awarded at $1,120 each, and 18 LPN scholarships awarded at $678 each. Although these scholarships do appear to enable more persons to become nurses, the number of awards in FY 2005 represents only about ten percent of the estimated vacant positions in Northern Virginia alone.

Limited funding also appears to curtail the use of the CNA and LPN training offered by secondary schools. Some Virginia school divisions provide several different types of health care education through career and technical (vocational) courses. In 48 of Virginia's 134 divisions, students can take coursework to become a nurse aide/assistant. After graduation, students can become certified as CNAs and then become LPNs by pursuing further education. However, staff at the Virginia Department of Education state that there are limited opportunities to continue into post-secondary education because of the lack of scholarships for CNAs and LPNs. A scholarship program for CNAs was established by the General Assembly in 1994 (Section 32.1-122.6:01 of the *Code of Virginia*), but no funds have been appropriated.

Better Data Are Needed on the Availability of Nurses and the Demand for Nursing Education. The State's ability to gauge the extent of the nursing shortage, as well as the extent of unmet demand for nursing and allied health education, is hampered by the lack of data. Looking forward, the continued lack of comprehensive data will likely limit the ability of policymakers to assess the effect of State funding and policy changes on efforts to address the supply of nurses. In response to a direct query by JLARC staff, NVCC staff were able to provide the list of health care fields noted above for which demand exceeds capacity, but were not able to quantify the extent of unmet demand. Data on the extent to which community colleges are unable to admit all qualified applicants are not available system-wide, according to the VCCS Chancellor, who states that "at this point the VCCS does not collect data on the number of eligible applicants for healthcare

courses." The Chancellor notes, however, that the Chancellor's Taskforce on Nursing is studying the issue and may provide guidance to the colleges.

In addition, data on the extent of the nursing shortage is hindered by the discrepancy between the number of licensed nurses and the smaller number of licensed nurses who are employed full-time. As noted by staff at the Board of Nursing, the current shortage of nurses results in part from a shortage of persons who are licensed as nurses and who wish to remain employed as such, or who wish to work full time. However, existing data on the number of nurses result from the licensure renewal process, and these data can only consistently indicate the number of persons who are licensed, not the number of licensed nurses who work full time.

To enhance ongoing efforts that address the nursing shortage in Virginia, State policymakers may wish to provide additional funding for nursing scholarships, including for CNAs, and provide funding for pilot studies on the efficacy of using human simulators for health education training. Policymakers may also wish to direct that schools of nursing maintain unduplicated data on the number of eligible students who apply for, but are not accepted at, nursing programs because of limitations in space, faculty, or other factors.

III. Aging Population Will Impact State Medicaid Expenditures and Certain Tax Revenues

This chapter addresses Medicaid expenditures for older Virginians and certain State tax revenues, two areas that are impacted by an aging population and that have important State budget implications. In addition to the pressures that Medicaid has at the federal level, Medicaid expenditures are also placing an increasing strain on the State's budget. These pressures appear likely to continue. It can also be anticipated that an increase in the number of older Virginians may impact certain State tax collections.

MEDICAID EXPENDITURES FOR THE AGED ARE PROJECTED TO INCREASE

In Virginia, State expenditures on Medicaid for persons of all ages constitute a substantial and growing proportion of the State's budget. According to the State's Medicaid agency, the Department of Medical Assistance Services (DMAS), Medicaid's $4.02 billion in total expenditures for State fiscal year (FY) 2004 accounted for 19.7 percent of the State's operating expenditures, up from 7.7 percent in FY 1985. As noted in the most recent JLARC report on State spending, Medicaid represented the second largest part of Virginia's overall operating budget in FY 2004. Medicaid spending will continue to grow in FY 2005 and FY 2006, with appropriations of $4.56 and $5.01 billion, respectively.

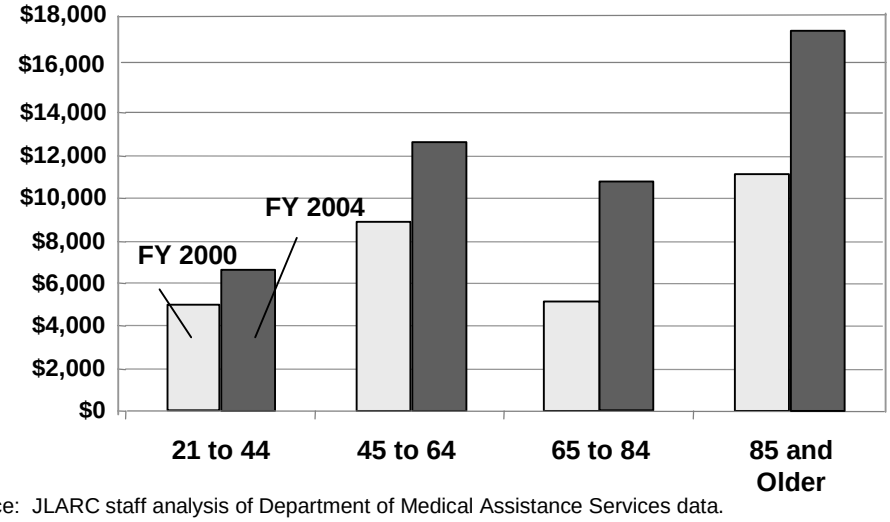
Medicaid Expenditures Are Generally Driven by Older Recipients

Although persons younger than age 65 comprise the largest share of Medicaid recipients and expenditures, older recipients constitute a disproportionate expense to the program. As described in Chapter I, one route to obtaining Medicaid coverage in Virginia is to meet the criteria for the "aged" group, which consists of eligible persons age 65 and older. Using FY 2004 DMAS data, the average expenditure per recipient generally increases with age, and Figure 8 illustrates this trend by comparing four age groups. (Figure 8 also shows that per-person Medicaid costs have increased for all age groups since FY 2000.) In FY 2004, the average annual per-person expenditure was $2,043 for recipients under age 21. This average cost increases to $8,763 among recipients ages 21 to 64, and to $12,097 for recipients age 65 and older (including persons age 85 and older). Of note, recipients age 85 and older have the highest average annual expenditure of $17,575.

Persons ages 45 to 64 are the second most costly age group to serve, with an average annual expenditure of $12,782. This is slightly higher than the average of $12,069 for persons age 75 to 84. Some of the higher cost among recipients age 45 to 64 may be attributed to the cost of services for persons with mental retardation (MR) and other developmental disabilities. Based on FY 2004 data provided by DMAS, MR waiver recipients between the ages of 46 and 65 are more costly than MR waiver recipients of other ages. (Data on MR waiver costs use slightly different age ranges.)

Figure 8

Average Medicaid Cost Per Person for FY 2000 Compared to FY 2004, by Age Group



Source: JLARC staff analysis of Department of Medical Assistance Services data.

In fact, recipients between the ages of 60 and 65 are the most costly age group to serve on the MR waiver, with an average per person cost of $56,157 in FY 2004. In contrast, the average annual cost for MR recipients over the age of 76 is $50,035.

During interviews with staff at DMAS and other agencies, the increasing life expectancy of persons with MR was frequently mentioned as a likely cost driver among the older population in future years. However, the trend toward a greater number of persons with MR who are living into their 60s has begun only recently, and the impact they may have upon future costs is not clear. DMAS staff note that the mix of services might need to change in future years, and further information on this topic is provided in Chapter V. DMAS staff add that the combination of costs associated with providing MR services and the health care costs typically associated with age will make this population very challenging to serve.

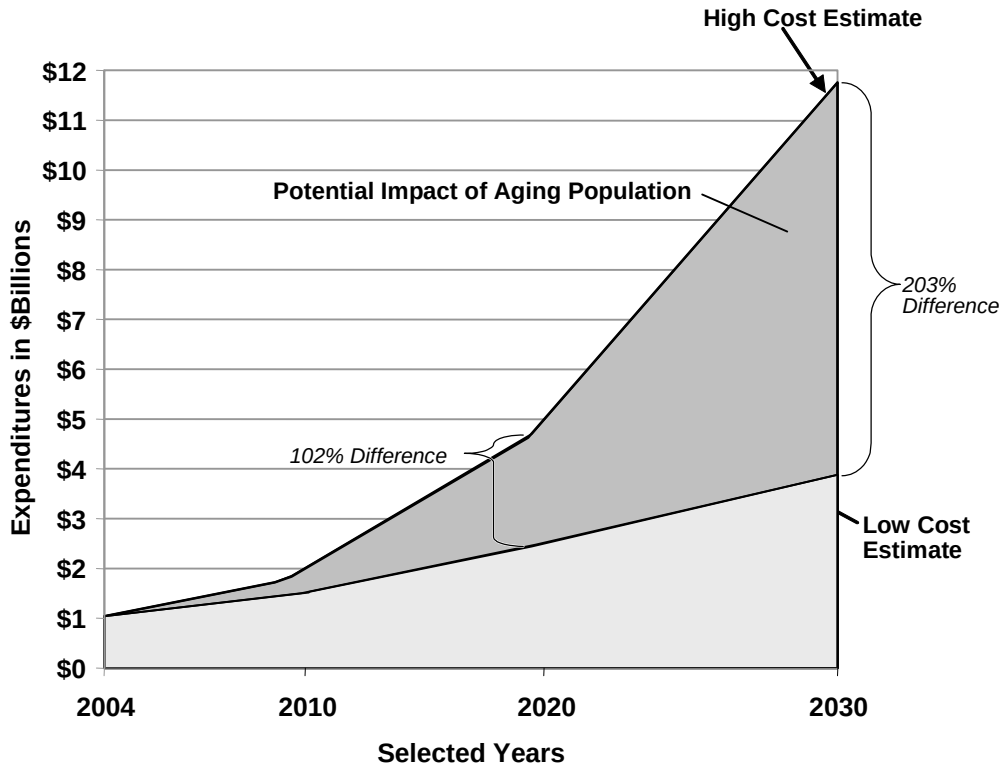
Expenditures for Older Recipients Are Projected to Continue Increasing

The projected increase in the number of older Virginians, particularly the doubling in the number of persons age 85 and older by the year 2030, has substantial cost implications for Medicaid. In order to assess the potential increase in costs, DMAS staff were requested to estimate the future costs of serving persons in the "aged" category, based upon FY 2004 costs. (These expenditures reflect both State and federal costs.)

Figure 9 shows the range in expenditures projected by DMAS. The "low cost" estimate provides the most conservative estimate of future expenditures for

Figure 9

Estimated Impact of Aging Population on Total Medicaid Expenditures for the Aged



Source: JLARC staff analysis of DMAS estimates.

Medicaid recipients age 65 and older, based upon current eligibility criteria and availability of services. The low cost estimate is based upon (1) the historical annual growth rate in the number of Virginia's aged Medicaid recipients, and (2) an inflation factor based on DMAS assumptions of projected annual growth in the Consumer Price Index (4.2 percent).

It is important to note that the low cost estimate is not adjusted for the projected increase in Virginia's aging population. Instead, the low cost estimate assumes that aged recipients, as a proportion of all Medicaid recipients, will remain constant. This assumption results from concerns expressed by DMAS staff that it may not be appropriate to create estimates of the future number of aged Medicaid recipients by using the Census Bureau's projections of the population growth of all older Virginians. As noted by DMAS in a letter provided to JLARC staff:

> Virginia's Medicaid population has historically been smaller than average when compared to other states (it currently has the smallest Medicaid population as a percentage of its total

population). As a result the Census growth rates may be significantly greater than the actual growth rates observed in the Commonwealth over the next thirty years.

By reflecting the fact that Virginia has traditionally had very low Medicaid enrollment, the low cost estimate provides the most conservative estimate of expenditure growth.

In contrast, the "high cost" estimate is based upon: (1) the projected annual growth rate in the number of all Virginians age 65 and older, as exhibited by the latest Census Bureau projections, and (2) an inflation factor based on DMAS projections of annual growth in the medical price index (6.5 percent). This estimate assumes that the proportion of aged Medicaid recipients will increase at the same rate that the proportion of older persons increases in Virginia's overall population. The projected costs of nursing home services discussed in Chapter IV and of mental health and mental retardation services discussed in Chapter V are components of these overall cost estimates.

These estimates indicate that Medicaid expenditures for aged recipients will continue to increase, even if Virginia's historically low growth rates continue. Table 3 presents the low cost and high cost estimates for selected years. Using either estimate, the increase in expenditures begins to accelerate after 2010 when the first group of baby boomers are 65. The divergence between the two estimates is clearly apparent by 2020, at which time the impact of an aging population is estimated to result in a 102 percent difference in annual expenditures, or an additional $2.4 billion per year.

Table 3

Estimated Impact of an Aging Population on Total Medicaid Expenditures for Aged Recipients (Age 65 and Older)

Fiscal Year	Low Cost Estimate ($ Millions)	High Cost Estimate ($ Millions)	Percentage Difference Between Estimates
2004	$1,049	$1,049	N/A
2008	1,303	1,494	15
2010	1,440	1,792	24
2020	2,355	4,764	102
2030	3,872	11,751	203

Note: DMAS estimates are for all Medicaid expenditures (State and federal) for recipients in the aged eligibility category (age 65 and older).

Source: JLARC staff analysis of DMAS estimates.

Medicaid Expenditure Estimates Are Affected by Several Factors

It is important to keep in mind, however, that estimates of future spending are imprecise due to the difficulty of projecting the effect of the factors mentioned earlier in this report, such as projected poverty and disability rates. Another source of imprecision is the extent to which there will be changes in the supply of, and demand for, different types of long-term care services. In recent years, home and community-based alternatives to institutional care have become more widely available. These services are designed to cost less than institutional care. However, an increase in the availability of home and community-based services may increase the overall cost of Medicaid if there is an increase in the use of these services by people who would otherwise not have used long-term care services. Changing social preferences and other factors such as the effects of the Supreme Court's *Olmstead* decision may also affect future demand for long-term care services.

Medicaid expenditures may be affected by changes in the number of persons who are eligible for Medicaid and changes in the cost of medical care. As indicated in Chapter I, projected decreases in the poverty rate among baby boomers and in the percentage of boomers qualifying for SSI may decrease the number of persons eligible for Medicaid. Finally, changes in Medicaid policies at the federal and State level may also impact future Medicaid costs.

THE AGING OF THE POPULATION IS EXPECTED TO IMPACT CERTAIN STATE TAX REVENUES

The aging of the population is expected to impact State general fund revenues as a result of Virginia's age-based income tax deductions and exemptions, which have the effect of lowering the taxable income of eligible older Virginians. Additionally, sales and use tax revenues could be affected because national data indicate that older adults generally spend less money and tend to concentrate their expenditures on non-taxable services such as health care. (At a local level, some older Virginians are allowed property tax exemptions or deferrals, as discussed in Chapter IX.) These factors suggest that as the number of older Virginians increases, certain sources of State tax revenue may be impacted.

Forgone Revenues Due to Age and Social Security Deductions May Increase in Size

As a result of age deductions and exemptions, the amount of untaxed income may increase as Virginia's population ages. This could impact State general fund revenues, because about 59 percent of the general fund will come from individual income taxes in the 2004-2006 biennium. The impact that seniors may have on government revenues has been noted by several organizations. For example, a 1998 joint publication by the National League of Cities, the National Conference of State Legislatures, and the National Governors' Association stated:

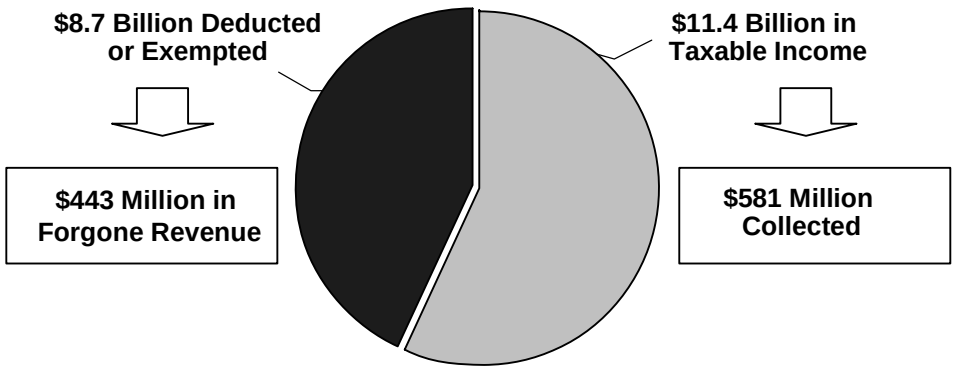
As more Americans become eligible for age-specific tax preferences, they will diminish the public sector revenues that states and cities may need to provide public services to all citizens, including seniors.

The actual impact of an aging population may be mitigated, however, by the fact that older Virginians represent a small portion of State income tax collections. Data provided by the Virginia Department of Taxation (TAX) for tax year 2002 (the most recent year for which data by age are available) indicate that tax returns filed by taxpayers age 65 and older represented about 15 percent of total tax returns, but only eight percent of all taxes owed (tax liability). In 2002, total individual income tax liability was over $6.4 billion, of which eight percent ($499 million) was from individuals age 65 and older.

Older adults account for a relatively smaller portion of State income tax liability in part because Virginia law allows taxpayers to exempt Social Security income from their total income, and claim an age deduction, when determining their Virginia Adjusted Gross Income (VAGI). Older adults are also able to claim an age exemption (in addition to the personal exemption available to all taxpayers) after VAGI is determined. Based upon an analysis of TAX data for tax year 2002, approximately $8.65 billion in income was deducted or exempted by Virginians age 65 or older. This resulted in approximately $443 million in forgone revenue, at the average tax rate of 5.12 percent in 2002 (Figure 10).

Figure 10

Income Tax Revenue and Forgone Revenue from Virginia Taxpayers Age 65 and Above (2002)



Source: JLARC staff graphic based on estimates provided by the Virginia Department of Taxation.

These forgone revenue estimates were calculated by accounting for the following deductions and exemptions that were in place for tax year 2002:

- Deduction of Social Security Benefits. According to TAX data, about $2.2 billion in Social Security income was deducted from tax year 2002 returns on which at least one age exemption was

claimed. This represents missed revenue of $111 million based on the average tax rate for that year of 5.12 percent. Twenty-four other states and the District of Columbia also allow taxpayers to deduct all income from Social Security benefits.

- Age Deduction. In 2002, adults age 65 and older were eligible to claim an age deduction of $12,000. A married couple could claim an age deduction of $24,000 if both people were over age 65. These deductions could be claimed regardless of income level. As a result, TAX data indicate that $6.1 billion in income was deducted in tax year 2002. This represents missed revenue of $313 million at the average tax rate.

- Age Exemption. Adults age 65 and older are allowed to exempt $800. This is in addition to the $800 personal exemption for all taxpayers. A total of 481,647 age exemptions were filed in tax year 2002, resulting in $385 million of income that was not taxed. This equates to $20 million in missed revenue at the average tax rate.

In addition to these deductions and the exemption, in FY 2002 State income taxes did not have to be filed by single taxpayers whose VAGI was $5,000 or less, or by married couples filing jointly whose VAGI was $8,000 or less. The thresholds, combined with the available deductions, allow some older Virginians to be exempt from State income tax, as indicated by the following example:

- In 2002, retired workers in Virginia received an average monthly Social Security benefit of $895, and spouses of retired workers received $439. This equates to $16,008 which could be deducted when determining VAGI. The median income of couples age 70 to 74, based on national data, was $30,212 in 2002. A Virginia couple in this situation would have been exempt from filing State income taxes in 2002, because the Social Security deduction ($16,008) plus the age deduction ($24,000) would have resulted in a VAGI that was under the $8,000 threshold.

The General Assembly increased these thresholds in 2004, and the current income limits are $7,000 for an individual taxpayer and $14,000 for a married couple. In addition to the example presented above, some married couples can still have a sizable income but may not have to pay State taxes. For example:

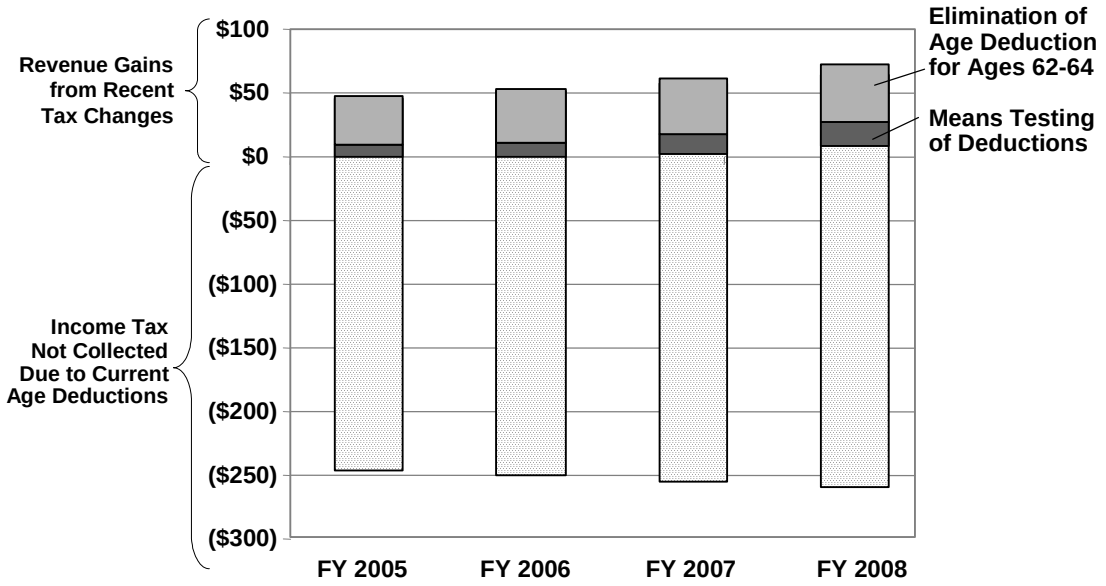
- A married couple, who are both age 70 and contributed to Social Security, could have an income of $58,000 and not have to pay State income tax. At the average annual Social Security income, each person could deduct approximately $10,000 in Social Security benefits, and another $24,000 because of the age deduction. This would reduce their VAGI to the threshold of $14,000.

Changes to the Age Deduction Policy Have Increased Revenue Collections

Recent changes to the age deduction policy may result in some enhancements to tax revenue, but the impact appears to be limited based on tax year 2002 data. As illustrated in Figure 11, in FY 2005 approximately $249 million in potential tax revenue will not be collected because of existing age deductions. This will increase by FY 2008 to approximately $258 million.

Figure 11

Net Impact on State Income Tax Revenues of Recently Amended and Continuing Age-Related Deductions (Projected, in $ Millions)



Source: Virginia Department of Taxation.

Legislation passed in 2004 subjected the amount that could be deducted to a means test for persons turning age 65 after January 1, 2004. (The total deduction per person remained at $12,000.) For an individual, the deduction is reduced by one dollar for every dollar of adjusted federal AGI over $50,000 ($75,000 for a couple). TAX estimates that subjecting the age deduction to the means test will result in an increase of $8.9 million in revenue in FY 2005 and an increase to $19.4 million by FY 2008.

Changes to tax policies in 2004 also eliminated the age deduction of $6,000 for individuals between the ages of 62 and 64. Persons already between the ages of 62 and 64 on January 1, 2004, were allowed to continue claiming the deduction until they reached age 65. Eliminating the $6,000 age deduction is estimated to result in

an increase of $36 million in FY 2005, and this is projected to increase to $45 million in FY 2008.

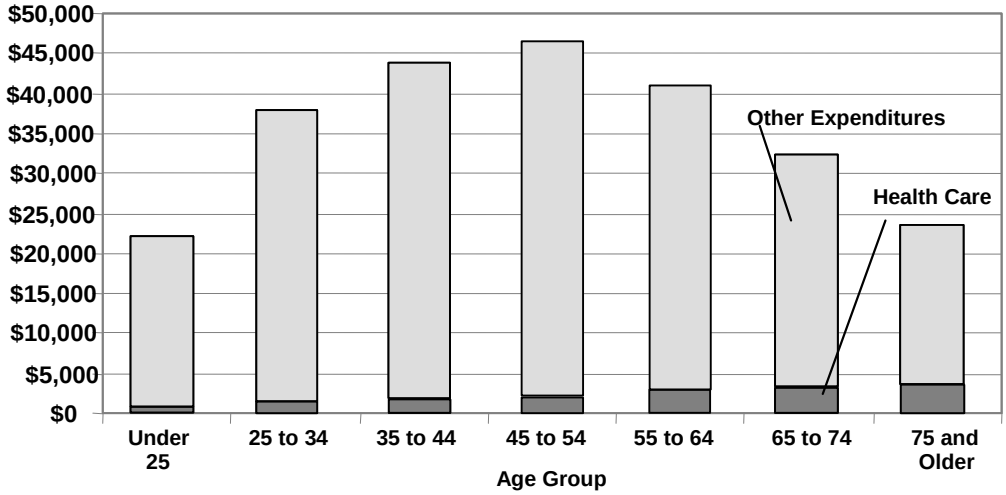
Older Adults Typically Pay Less in Sales and Use Taxes

The aging of the population could also decrease State sales and use tax revenue, because older adults typically spend less money than younger persons, and their spending is more likely to be for non-taxable services. On a national level, adults age 65 and older on average spend less of their income on taxable goods than younger persons, according to a 2005 report by the federal Bureau of Labor Statistics (BLS). In Virginia, during FY 2004, sales and use taxes accounted for 22 percent of total tax revenues, according to the Commonwealth's Comprehensive Annual Financial Report.

Future revenue derived from this source could decrease as the population ages, because average consumer expenditures decrease among older adults (Figure 12). According BLS data for 2003 to 2004, adults between the ages of 45 to 54 spent the most of any age group: $45,824 on average. In contrast, adults age 75 and older spent $23,651 on average. As indicated in Figure 12, older adults spent less than almost all other consumers for every major category except for health care expenditures, which are often not taxable. Of note, alcohol and tobacco taxes combined represented another 0.8 percent of Virginia tax revenues in FY 2004, and expenditures on these items uniformly decrease with age. This may negatively impact State revenues as older Virginians begin to make up a larger share of the State's overall population.

Figure 12

Average Annual Expenditures, By Age Group (2003 - 2004)



Note: Other expenditures include housing, transportation, food, apparel and other services, and alcohol and tobacco. Average annual expenditures for these individual categories decrease with age.

Source: JLARC staff analysis of Bureau of Labor Statistics data from 2003-2004 Consumer Expenditure Survey, Southern Region.

IV. State-Funded Nursing Home and Assisted Living Care

Nursing homes and assisted living facilities provide residential care to older Virginians who typically cannot receive care at home because of more advanced health care needs or a lack of formal or informal community support. Although the State does not directly provide nursing home or assisted living services, it does regulate their operation. Through Medicaid and the Auxiliary Grant, the State also provides financial support to assist lower income persons with the cost of their care in these facilities. Staff from local departments of social services (DSS) and health departments are responsible for determining eligibility for this public assistance. Local agency staff in several parts of the State report a shortage of these public-pay nursing home and assisted living beds. The reported impact of these shortages on agencies results from an increased demand for other agency services, such as DSS companion care.

LOCAL AGENCY STAFF REPORT A SHORTAGE OF MEDICAID-CERTIFIED NURSING HOME BEDS

Nursing facility services are an option for older Virginians in need of continuous medical care and supervision. Nursing facilities also increasingly are becoming options for people in need of additional short-term medical care subsequent to hospitalization. Because nursing homes provide 24-hour nursing care, they may be the only service option for older Virginians who lack adequate support in the community, such as an informal caregiver. As of June 2005, there were 270 licensed nursing homes and 31,279 beds in Virginia. These facilities are licensed, federally certified for Medicare and Medicaid reimbursement, and regulated by the Virginia Department of Health (VDH).

National and State level data indicate that nursing facilities are a substantial provider of care to older persons. According to research published in 2002 by the journal *Medical Care*, once a person turns age 65 they have a 46 percent chance of using a nursing home, typically for less than one year. This finding is similar to the 43-percent chance of lifetime nursing home entry noted in 1991 by the *New England Journal of Medicine*. According to 2004 data collected by the Department of Medical Assistance Services (DMAS) on persons age 60 and older who were screened for Medicaid covered long-term care services, nursing facility care was recommended for 73 percent of those screened.

Monthly nursing home costs vary according to the source of payment and the type of bed. The most recent estimates available from Virginia Health Information (VHI), the organization under contract with VDH for health care data analysis and reporting, indicate that the average monthly cost of a private nursing home bed in 2003 was $4,600. Statewide, monthly costs in 2003 ranged from $4,057 to $6,256 for a private bed, and from $3,696 to $5,343 for a semi-private bed. According to the Virginia Nursing Home Patient Origin Survey, a survey that the

regional health planning agencies conduct every four years, Medicaid reimbursed for the cost of care for 59 percent of Virginia nursing home residents in 2002. DMAS data show that the average monthly rate for Medicaid-reimbursed nursing facility care was $3,354 in calendar year 2003, which includes the average monthly portion paid by Medicaid-eligible residents (patient pay) of $650.

Future Nursing Home Bed Need and Expenditures Are Expected to Increase

Nursing home survey data since 1985 on characteristics of Virginia nursing home residents indicate that nursing home use rates have declined since that time, especially for persons age 80 years and older. In addition, occupancy rate data for years 1997 through 2003 from VDH indicate that nursing home occupancy rates have declined. Despite these decreases, the total number of older adults needing nursing home care in the future is still expected to increase because of the projected substantial increase in the size of the older population.

Number of Nursing Home Residents Is Projected to Increase 70 Percent by 2030. According to projections from the Virginia Department for the Aging (VDA), the total number of nursing home residents is projected to increase 70 percent (from 29,448 to 50,197) between 2003 and 2030. In its projection, VDA assumes the nursing home use rate will continue to decrease until 2010, after which the use rate remains constant. In addition, VDA projects that 54,208 nursing home beds will be needed in 2030, which represents a 73 percent increase over the number available in June of 2005.

Medicaid Nursing Home Expenditures for the Aged Could Surpass $1 Billion by FY 2012. For this study, DMAS staff projected the overall cost of Medicaid services until 2035, as well as the cost for several individual services. These projections were made using two assumptions about price inflation as well as two assumptions about the growth in aged Medicaid recipients. (The term "aged" is used by Medicaid to refer to recipients age 65 and older. More information on these projections is provided in Chapter III.)

Based on estimates using the medical price index and Census-adjusted growth in the aged population (high estimate), the total Medicaid cost of caring for aged recipients in nursing homes is projected to be $1.01 billion by as early as FY 2012. A more conservative estimate, using the Consumer Price Index and DMAS projections of growth in the number of aged Medicaid recipients (low estimate), indicates that Medicaid expenditures for nursing home services for aged recipients could exceed $1 billion by FY 2019. Table 4 provides estimates of Medicaid expenditures for nursing facility care for the aged for select years until 2030.

It is important to note that these projections do not take into account other factors that may affect nursing facility demand, such as the increasing availability of other types of services and declining disability rates. As mentioned in Chapter II, the presence of informal caregivers and their ability to provide care often impact the decision between nursing facility care and home care provided through a waiver.

Table 4

Estimates of Medicaid Nursing Home Expenditures for Aged Recipients

Fiscal Year	Estimated Range ($ Millions)
2004	$486 (Actual)
2008	604 – 692
2010	667 – 831
2020	1,091 – 2,208
2030	1,795 – 5,447

Source: Department of Medical Assistance Services.

Pre-admission screening (PAS) teams (local social services and health department staff who determine eligibility for Medicaid nursing home and waiver services) from all six regions of the State visited by JLARC staff indicate that the lack of an informal caregiver is the main reason older Virginians enter a nursing home. PAS teams also report that older adults often enter nursing homes if they are of advanced age, but this may be due to the increase in disability that often accompanies advanced age. As mentioned in Chapter I, disability rates among older adults have been declining, which could mean fewer older adults need nursing facility care, but it is not clear if this trend will continue. In addition, Virginia Health Care Association (VHCA), a membership organization for nursing homes and assisted living facilities, staff indicate that assisted living facilities are attracting individuals who would otherwise likely have become private-pay nursing facility residents.

Access to Nursing Home Beds Is Reported to Be Limited and Could Worsen in Future Years

Pre-admission screening teams throughout the State indicate that Medicaid recipients have some difficulty finding nursing home beds. Although the State does not maintain data (such as a waiting list) on the demand for Medicaid beds, a comparison of data on the number of certified Medicaid beds in relationship to all licensed beds does not appear to indicate a shortage. In fact, some nursing homes are reported to be reliant on Medicaid. Despite this, PAS staff report that some nursing homes had waiting lists for Medicaid beds, were accepting greater numbers of Medicare skilled care residents, and often preferred higher paying residents. PAS staff also report many nursing homes do not want to accept clients with behavioral problems or complex needs. As a result, they indicate that some Medicaid recipients have to go outside of their community to find a Medicaid bed. VDH's proposed revisions to the State Medical Facilities Plan, discussed below, may result in increased access to nursing home beds in some areas.

A High Proportion of Nursing Home Beds Are Medicaid Certified. Nursing home beds must be certified by VDH as meeting Medicaid standards in order for the nursing facility to receive reimbursement for serving Medicaid-eligible residents. A review of available data on nursing home bed certification indicates

most nursing home beds are certified for Medicaid reimbursement. For example, almost 91 percent of existing licensed nursing home beds are Medicaid-certified, as are 92 percent of all hospital-based nursing home beds. Moreover, in 85 of the 114 localities that have a nursing home, all beds are Medicaid-certified. Lastly, among nursing homes themselves, 80 percent have all of their beds certified for Medicaid reimbursement, and fewer than 10 percent of nursing homes have no Medicaid beds.

Despite the fact that most nursing home beds are Medicaid-certified, PAS teams from several areas indicate shortages of Medicaid beds, and indicate that nursing homes have waiting lists for these beds. For example:

- VDH data indicate that all of the beds in nursing homes located in the counties of Henry and Pittsylvania and the City of Danville are Medicaid-certified, yet PAS staff serving these areas indicate all nursing homes have waiting lists for these beds.

- VDH data indicate that 79 percent of the beds in nursing homes in the Northern Virginia planning district are Medicaid-certified, but Northern Virginia PAS staff state that the lack of Medicaid beds in their region often means that older adults have to go outside of their community to find a bed.

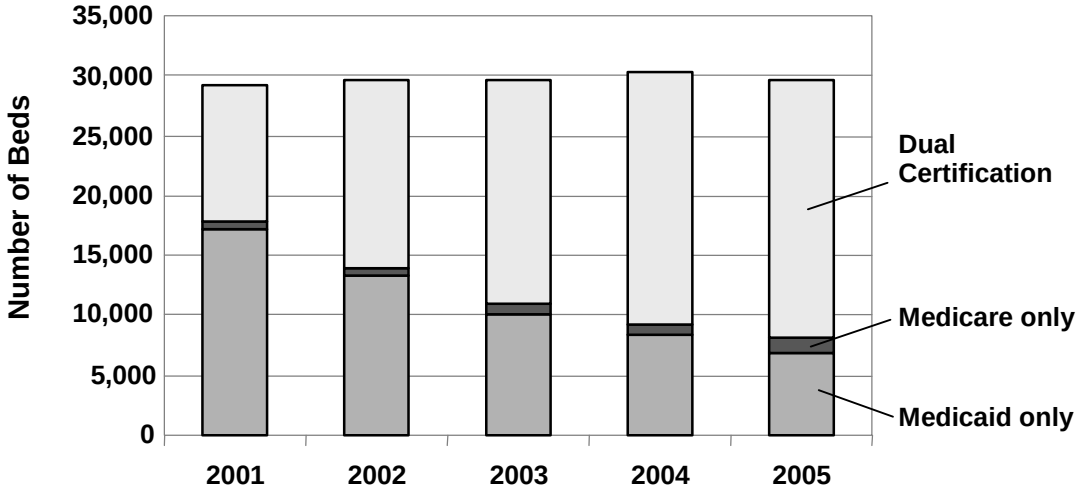
Many Nursing Facilities Rely Upon Medicaid Beds. Although no State requirement exists that nursing facilities must have Medicaid-certified beds, VHCA staff indicate that many nursing homes need a minimum number of beds that are certified for Medicaid reimbursement. Several studies have indicated that approximately one-fourth of private pay nursing home residents will spend down to Medicaid eligibility during that stay or subsequent stays. In addition, federal regulations state that a facility cannot discharge residents once they become Medicaid eligible unless other conditions are met, such as the inability of the facility to continue meeting their needs, or if residents no longer require a nursing home level of care. As a result, most nursing homes need to ensure that they have a minimum number of Medicaid-certified beds.

In some areas of the State, nursing homes are highly dependent upon Medicaid residents, a point made by PAS staff from the Lenowisco Health District serving the counties of Lee, Scott, and Wise, and the City of Norton. According to the data from the most recent nursing home survey, Medicaid was the primary payer for over 80 percent of the nursing home residents in those localities in 2002. In comparison, Medicaid was the primary payer for 59 percent of all Virginia nursing home residents in that year.

The Majority of Medicaid-Certified Beds Are Also Certified for Medicare Reimbursement. Although a bed may be Medicaid-certified, it may not be available to a Medicaid recipient at the time he or she is seeking one because Medicare recipients and private-pay residents also may be served in these beds. Seventy-six percent of beds in Virginia nursing homes that are certified for Medicaid reimbursement are dually certified for Medicare reimbursement. The number of beds that are dually certified has increased 89 percent since 2001, as shown in

Figure 13, and it appears this is due to increased demand for these beds. According to the results of the nursing home surveys mentioned above, the proportion of patients entering nursing facilities from the hospital between 1985 and 2002 has increased, and it is likely that many of these patients are receiving skilled nursing care reimbursed through Medicare.

Figure 13
Number of Federally Certified Nursing Home Beds (2001 to 2005)



Source: JLARC staff analysis of Virginia Department of Health data.

PAS teams from several areas report that the increase in nursing homes providing Medicare skilled nursing care has made it difficult for Medicaid recipients to access nursing home care. For example, PAS staff from localities in the Richmond City, Northwestern, and Northern Virginia regions visited by JLARC staff indicate that they have noticed an increase in the number of nursing homes that provide Medicare skilled care. Richmond City PAS staff indicate that the increase in Medicare residents is making it harder for Medicaid recipients to find beds.

Nursing Facilities May Prefer Higher Paying Patients. During interviews with State and local agency staff, as well as industry representatives, it was indicated that Medicaid-eligible individuals sometimes have difficulty locating a bed because some facilities may prefer patients who can pay the higher private rate or patients for which Medicare pays a higher reimbursement. This point is supported by the medical research, and a 1998 article published in the journal *Medical Care* specifically notes that:

> Nursing homes most often prefer higher paying private payers and Medicare patients instead of Medicaid patients, so the resulting access problems will fall primarily on those eligible for Medicaid support.

The average revenue that nursing facilities in Virginia receive for serving Medicaid patients is less than that of other payers. Data from VHI indicate that the average net revenue per day in 2003 for a Medicaid resident was $110. In contrast, the average net revenue was $148 for a private-pay resident and $329 for a Medicare resident. It is important to note, however, that Medicare only reimburses for skilled nursing care, and the cost of providing this level of care is greater. According to a 2005 report by the American Health Care Association, nursing homes in Virginia lost an average of over $11 per day for each Medicaid client served in 2002 because the cost of their care exceeded the Medicaid reimbursement. While VHCA staff did not dispute the claim that nursing homes preferred patients with higher reimbursements, they indicate that nursing homes need to fill their beds with a mixture of clients in order to stay in business.

Some Nursing Homes Are Unwilling to Serve Persons With Acute or Complex Needs or Behavioral Problems. Local agency staff in all six of the regions visited by JLARC staff report that nursing homes often are unwilling to serve patients with acute or complex needs or those with behavioral problems, particularly those with a history of mental illness. In particular, staff from local agencies, the VHCA, and the Virginia Hospital and Healthcare Association (VHHA) report that nursing homes also might refuse to readmit patients after a period of psychiatric treatment. As a result, persons with behavioral problems may remain in psychiatric facilities longer than hospital-based care is needed. According to DMHMRSAS staff, many nursing homes do not have staff that are adequately trained to serve clients who need mental health treatment.

It is important to note that these factors could limit access to anyone seeking nursing home placement, but were reported to mostly affect Medicaid recipients. According to the director of the Health Systems Agency of Northern Virginia, patients with these situations are often considered "hard to serve" and likely represent many of those having difficulty finding a Medicaid nursing home bed. According to VHCA and VDH staff, a nursing home can refuse to accept a person if the facility does not have qualified staff to serve the person's needs or does not have an adequate number of staff to accommodate the person in addition to the other residents in the facility. VDH staff state that if nursing homes do not have adequate or qualified staff to serve persons with complex or behavioral health needs, they are "doing a disservice" to the person and other residents in the nursing home by admitting them. It was also reported to JLARC staff that nursing homes, out of concerns for the safety of other residents, may choose not to admit someone from a psychiatric hospital or from the correctional system, regardless of whether the person currently is exhibiting behavioral problems.

The reluctance of nursing homes to accept persons with behavioral problems is reported to affect the discharge efforts of the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHRSAS) and the Department of Corrections (DOC). According to DOC discharge planning staff,

finding nursing homes that will accept geriatric former inmates is very difficult. In fact, the discharge planner quoted one facility administrator as stating, "We don't hire anyone with felonies – why would we allow anyone with a felony to live here?" In addition, DOC staff state that if an inmate requires placement in a nursing home, they are guaranteed to remain in the correctional system for at least 30 days past their release date. More information on the impact of this issue on DMHMRSAS and DOC is in Chapters V and VI, respectively.

VDH Is Currently Taking Steps to Address Access to Nursing Home Beds. Nursing home occupancy rates are one of the primary factors identified in studies as affecting the accessibility of nursing home beds for Medicaid patients. At the request of providers, VDH has proposed changes to the State Medical Facilities Plan, one of which would lower the occupancy rate standard for determining where nursing home beds are needed. Under the current plan, one of the factors for determining bed need in a planning district is that the annual occupancy rates of beds in Medicaid-certified facilities in that district have been at least 95 percent or greater. The proposed plan would lower the occupancy rate standard to 93 percent. According to VDH's calculation of occupancy rates in 2003, the average occupancy rate for eight planning districts was 93 percent or greater, but only Planning District 19 had an occupancy rate over 95 percent. As a result, additional planning districts will likely be identified by VDH as meeting the occupancy standard for consideration of adding nursing home beds.

A SHORTAGE OF AUXILIARY GRANT BEDS WAS REPORTED, BUT A LACK OF DATA HINDERS A COMPREHENSIVE ASSESSMENT

Assisted living facility (ALF) services are an option for older Virginians who are unable to receive needed care in their homes and who either do not require or are not eligible for nursing home care. These facilities, also known as homes for adults or adult care residences, provide 24-hour support in a community-based environment. As of June 1, 2005 there were 610 ALFs in Virginia, with the capacity to serve 33,821 individuals.

Assisted living facilities are licensed by the Department of Social Services (DSS), and the most recent DSS estimates indicate that the average monthly cost of a private bed in 2003 was $1,560. Statewide, monthly ALF costs ranged from $824 to $5,931. This cost typically covers administrative expenses, room and board, and medical and other supportive services provided to residents. However, for many individuals, particularly older or disabled persons on fixed incomes, these rates are unaffordable.

Virginia's auxiliary grant (AG) program, which is funded with both State and local dollars, assists eligible individuals with the costs of ALF services. State and local agency staff expressed concerns that there are not enough AG beds to meet demands for affordable ALF care. However, an absence of data on unmet demands, as well as the location of AG beds around the State, hinders a comprehensive assessment of their availability or projections of future need.

The Auxiliary Grant Program Provides Financial Support to Eligible Assisted Living Facility Residents

The AG program is designed for certain persons who cannot afford private rates and whose needs are not acute enough to be eligible for Medicaid-covered nursing facility or home-based care. Effective July 1, 2005, the State implemented a new Alzheimer's and Related Dementia Medicaid waiver targeted to ALF residents with dementia. The waiver will supplement the AG by adding $50 per day for ALF residents who meet the functional criteria for admission to a nursing facility, who are diagnosed with dementia, and who are eligible to receive the AG. Although an additional $90 per month in State-only Medicaid funds is provided to AG recipients who require assistance with two or more ADLs, the new Alzheimer's and Related Dementia waiver is the only source of Medicaid funding for ALF residents for which the State receives the federal funding match. According to DMAS staff, 42 other states pay for ALF services partially through Medicaid, and 37 of these do so through a waiver program.

Facilities that choose to accept the AG agree to charge no more than the monthly "auxiliary grant rate." This statewide rate is established by the General Assembly and is currently set at $944. (A different rate is set for Northern Virginia localities in Planning District 8, where rates are $1,086 per month.) An individual's "auxiliary grant payment" is the difference between what an individual is able to pay for assisted living services and the monthly AG rate charged by the facility. Persons with income in excess of the monthly AG rate are therefore ineligible for the program. In FY 2004, AG expenditures totaled approximately $24 million, and 41 percent of that amount was attributed to recipients age 65 and older. More detailed information on obtaining eligibility for the AG is included in this study's interim report.

Access to Auxiliary Grant Beds Is Reported to Be Limited in Many Areas

According to State and local agency staff, as well as representatives of various sectors of the long-term care industry, not enough beds are reserved by ALFs for AG recipients. Representatives of the Virginia Association of Nonprofit Homes for the Aging and the Virginia Health Care Association state that many ALF operators are reluctant to accept the AG as payment because the rate is insufficient. Further, in more affluent areas of the State, there are reported to be a sufficient number of persons willing to pay private rates, making it unnecessary for these facilities to accept the AG. These factors have reportedly resulted in a lack of AG beds in some parts of the State.

A Lack of Auxiliary Grant Beds in One Area May Result in Some Older Virginians Moving to Other Parts of the State. Many local staff who report a lack of AG beds in their localities observe that their clients eventually become residents of ALFs elsewhere in the State. Prince William County DSS, health, and area agency on aging (AAA) staff state that senior residents generally have to relocate to another locality to find an AG bed. DSS staff from Southwest Virginia also report that "a lot of people have to go outside of the area for assisted

living." Arlington County AAA staff note that when older Virginians can no longer live independently in their own homes, they have to move out of the area because they cannot afford the area's high assisted living costs, and few ALFs in Northern Virginia are reported to accept the AG.

It should be noted that having to relocate to another locality to receive AG assistance may present a unique obstacle to some residents of Northern Virginia localities. Because eligibility for the grant is tied to having income that is less than the AG rate, persons who qualify for the grant in Northern Virginia, where the rate is set at $1,086, may have incomes that are too high to qualify for the grant in other parts of the State, where the rate is set at $944. In other words, their monthly incomes are between $944 and $1,086. This appears to be a consequence of the State's policy of requiring an individual's locality of residence to be responsible for paying 20 percent of the AG, even if the individual is placed in an ALF elsewhere in the State.

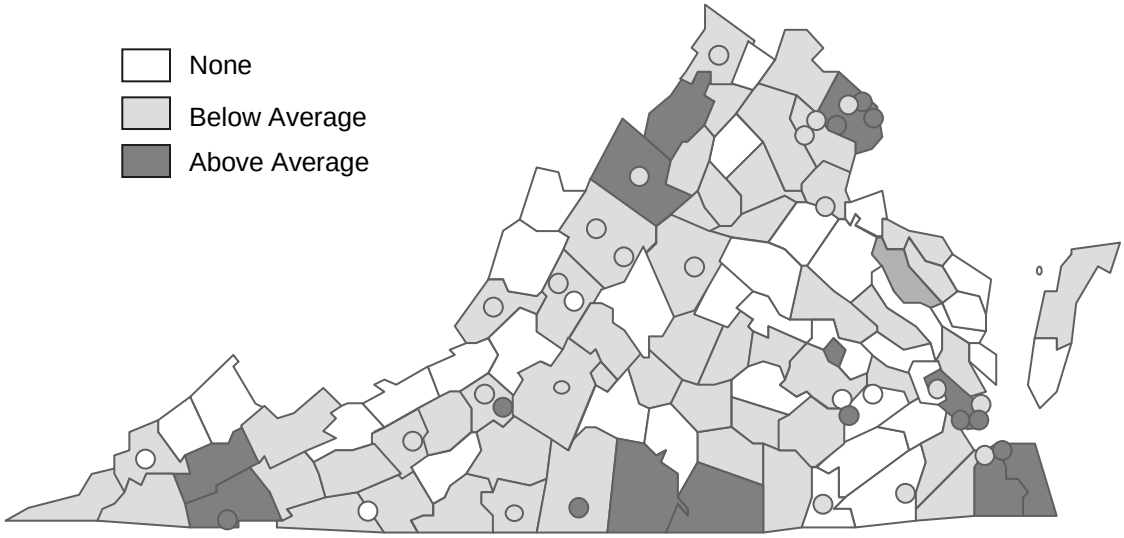
Local Agency Staff Report Being Affected by a Shortage of Auxiliary Grant Beds. A shortage of AG beds also appears to affect local agencies. For example, in lieu of relocating clients, staff from several localities visited by JLARC report using their local DSS companion care program as an alternative resource for clients who cannot locate affordable assisted living services. A local DSS staff person from Culpeper County states that she "relies upon companions to keep our elderly residents safe" because there are no facilities for them. DSS staff from the Tidewater area also take this approach. In addition, local agency staff from Richmond City, Henrico, and Alexandria state that no facilities in their localities have reserved AG beds for individuals who require emergency placement or have become an adult protective services (APS) case. A DSS worker from Alexandria estimates that 65 to 70 percent of her APS clients could benefit from ALF placement, but that there are no affordable facilities in the area.

Data Are Not Available to Determine If There Are a Sufficient Number of Auxiliary Grant Beds

Because of the level of concern raised about this issue by both agency staff and providers, JLARC staff requested data from DSS on the number of AG beds currently available for each ALF. This would have allowed the study team to determine the extent of geographic variation in the acceptance of AG payments. This analysis was not possible, however, because DSS does not maintain data on the number of available AG beds reserved by each facility. In addition, although DSS staff were able to provide a list of facilities that accept the grant, the data maintained by DSS could be incomplete because they are based on the agency's analysis of cost reports that facilities submit to DSS. According to agency staff, while facilities are required to submit these cost reports, there are no sanctions that can be imposed upon them for failing to do so. According to these data, however, 344 (56 percent) out of 610 facilities accepted the AG as of June 2005. Based on these costs reports, JLARC staff created the map in Figure 14 to estimate the number of ALFs that accept the AG in each locality.

Figure 14

Number of Assisted Living Facilities That Accept the Auxiliary Grant



Note: On a locality-by-locality basis, an average of four ALFs accept AG payments.

Source: JLARC staff analysis of Department of Social Services data on cost reports submitted by ALFs as of June 2005. Of 610 ALFs, 344 submitted cost reports indicating that they accepted the AG, and those facilities are illustrated in the graphic.

As a proxy for the number of AG beds statewide, DSS was able to provide JLARC staff with historical data on the total number of AG *recipients* per month, by locality of original residence, for 2000 to 2004. However, these data are limited in their utility as a proxy for the number of beds: in a given month, not all beds may have been occupied, and a single bed may have been used by different individuals at different times. Moreover, these data are not a complete indicator of the number of AG beds in a given locality. As indicated previously, the locality in which a person is considered to be a resident is responsible for paying 20 percent of the AG payment. However, if there were not enough beds in a person's original locality of residence to meet his or her needs and that person had to go elsewhere for an AG bed, the individual's original locality of residence – not the locality in which the facility is located – is responsible for the payment. This is a common scenario, according to local agency staff. However, DSS collects these data in a manner that only allows them to identify the locality that is responsible for the AG payment, not the locality in which the facility is located.

Although an analysis of the statewide distribution and availability of AG beds is not possible, JLARC staff were able to estimate the ratio of AG beds to all assisted living beds. Using DSS data on the number of AG cases per month as a proxy for the number of AG beds, it appears that approximately 18 percent of all assisted living beds in the State (33,821) are used by AG recipients. Using this methodology, since 2000 the ratio of AG beds to the total number of assisted living

beds has remained fairly consistent at approximately one to five. However, the number of average monthly AG recipients has decreased by seven percent since 2000. As noted, data are not available to indicate whether the decrease in AG recipients represents an actual decrease in the number of AG beds. This could be explained, for example, by decreasing turnover rates among assisted living residents or the fact that the number of ALF beds has decreased by over two percent since 2001.

It should also be noted that DSS does not maintain data on unmet demands for this program. It does appear, however, that some facilities maintain their own waiting lists for AG beds. One facility in Henrico estimates that there are 50 to 60 people on the waiting list for the seven AG beds in that facility.

Assessing the adequacy of the AG reimbursement and the reported burden it places on localities due to the local match requirements was beyond the scope of the study. It does appear, however, that the AG rate established by the State creates a barrier to accessing services in some cases. Moreover, the absence of locality-specific data on the availability of AG beds hinders the State's ability to assess the outcomes of recent and future adjustments to the AG rate. In particular, this will limit the ability to measure the impact of rate increases on the supply of beds. Insufficient data also limit the accuracy of future cost projections of the AG program. DSS should therefore consider developing a policy for ensuring that agency data comprehensively identify those ALFs that accept AG payments. Moreover, DSS should consider collecting data on AG recipients in a manner that will allow the agency to identify both the original locality of their residence and the locality in which they are receiving assisted living services.

The State Has Recently Made Changes to Its Assisted Living Policies

Virginia has recently taken several steps to improve access to assisted living services and their quality of care. In 2004, the Secretary of Health and Human Resources formed the Aging Action Agenda Task Force, which developed several recommendations specifically regarding assisted living services. In response to the findings of the task force, as well as media reports critical of the quality of care in Virginia's ALFs, the 2005 General Assembly passed legislation that, among other actions, increased the monthly AG rate from $894 to $944 ($1,086 for Northern Virginia). The 2005 General Assembly also requested that JLARC conduct a review of the impact of the new ALF regulations passed in that Session on the cost of providing services, access to services, and improvements in the quality of care delivered in facilities. A final report for that study is scheduled for 2006.

V. Mental Health, Mental Retardation, and Substance Abuse Services Will Be Impacted by Older Virginians

In Virginia, the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) is responsible for the provision of publicly funded mental health (MH), mental retardation (MR), and substance abuse (SA) services. DMHMRSAS operates ten State mental health hospitals and five State training centers for persons with MR. In addition, DMHMRSAS contracts with and licenses the services of 39 community services boards (CSBs) and one behavioral health authority (BHA). These are the local agencies that provide services to individuals residing in the community.

The majority of publicly funded MH, MR, and SA services in Virginia are received by younger adults and children, and most of these services are designed to serve a younger population. According to DMHMRSAS and CSB staff, Virginia does not have specific funding or services that are uniquely available to meet the needs of older Virginians. Gero-psychiatric services provided in some State mental health hospitals are the only exception. The lack of unique services, particularly for community-based services, often means older Virginians receive services that are designed for younger persons and that are provided by staff who may not be trained in geriatrics. Medical research indicates that the unmet demand for these services by older adults is extensive and that disability or the worsening of other medical conditions can result if services are not provided. Additionally, because of increasing life expectancies most people with MR are reaching an advanced age for the first time.

Because specific MH, MR, and SA services for older Virginians are lacking, the State does not appear to be well positioned to respond to an increase in demand for services by an aging population. It appears that there are three broad areas that State policymakers may need to address in order for Virginia to have an appropriately functioning system that is responsive to the present and future needs of older Virginians. There are concerns with regard to:

- Resource constraints. With the exception of gero-psychiatric services provided by State hospitals, specific services do not currently exist for older Virginians. CSBs, nursing homes, assisted living facilities, and State and private facilities are constrained by funding limitations and a lack of providers.

- Services that are not currently designed for an aging population. Appropriate services, especially community services, to meet the needs of older Virginians with mental illness, behavioral problems due to dementia, mental retardation, and substance use disorders largely do not exist.

- Lack of specific plans to address future needs. Although the demand for services is likely to increase, State, local, and other service providers do not appear to be prepared for additional service demands.

This chapter addresses these three areas of concern, focusing on the particular issues that were raised during the review. Table 5 provides a description of key agencies and providers of MH, MR, and SA services, and discusses the challenges that State policymakers may confront in order to create a system that can effectively respond to the needs of older Virginians. Table 5 notes the role of assisted living facilities, but the role of these providers largely is not addressed in this chapter, because most residents with mental illnesses in these facilities are reported by agency staff to be younger adults.

RESOURCE CONSTRAINTS ARE REPORTED TO LIMIT THE PROVISION OF EXISTING SERVICES

Several resource constraints – an over-reliance on Medicaid funding, a lack of community providers, and reductions in services provided at State facilities – are reported to limit access to services for older Virginians, as well as younger persons. DMHMRSAS and CSB staff indicate that Virginia's system for providing MH and MR services relies heavily on Medicaid funding, and CSB staff indicate that this limits the assistance they are able to provide to their older clients who are not Medicaid recipients. The lack of CSB staff and other providers who are trained in serving older clients with mental illnesses reportedly means that some older Virginians have difficulty accessing services in the community. The reduction in State and private MH hospital beds is reported to make it difficult for some older Virginians to access hospital-based services as well. These factors indicate that State agencies are not well positioned to respond to the additional service demands that will likely be requested in future years.

Reliance on Medicaid Reimbursements Is Reported to Limit the Services Provided by CSBs and Nursing Homes

DMHMRSAS and CSB staff indicate that the reliance on Medicaid funding means that some community-based services are available primarily to Medicaid recipients. Reliance on Medicaid funding has also been reported to limit the availability of MH services for nursing home residents, including those discharged from State hospitals. However, this service limitation appears to primarily affect the availability of community-based and private-facility based psychiatric services, not those provided in State hospitals. This is because Medicaid will reimburse for geriatric (age 65 and older) services provided in State mental health hospitals, as well as services to Medicaid-eligible residents (regardless of age) in State mental retardation training centers.

Table 5

Challenges for the Provision of Mental Health, Mental Retardation, and Substance Abuse Services to Older Virginians

Resource Constraints Limit the Provision of Existing Services

Entity and Services Provided	*Older Adults Served*	*Resource Constraints*
Community Services Boards (CSBs) – local agencies that directly provide or contract for emergency, case management, day support, employment, and residential services.	In FY 2004, 10,796 clients were age 60 or older.	Dependence upon Medicaid funding often limits services to persons not Medicaid-eligible and also results in program or service restrictions. Few staff have geriatric training.
Nursing Homes – provide medical care and assistance with daily living skills to residents. Subset of residents have mental illnesses or mental retardation.	2002 data indicate 87 percent of residents were age 65 or older.	Dependence on Medicaid reimbursement reported to limit hiring of specialized staff to care for residents with behavioral problems.
State Mental Health Hospitals (DMHMRSAS) – provide psychiatric services to persons with serious mental illnesses, including substance abuse services to persons with co-occurring mental illnesses and substance use disorders.	Four of the ten hospitals provide care to clients age 65 and older (geriatric clients). In FY 2004, 869 residents were age 60 or older.	Current geriatric beds are operating at capacity. Lack of private inpatient services as well as community-based services results in over-reliance on State facilities.
State Mental Retardation Training Centers – provide residential care and training in life skills primarily to adults with severe or profound mental retardation. Provide short-term respite and emergency care to persons with MR living in the community in cases where their caregiver has a medical or other urgent condition.	DMHMRSAS staff indicated residents are aging. In FY 2004, 232 residents were age 60 or older.	Lack of appropriate community services for older Virginians results in reliance on training centers. Private ICFs/ MR, which could also provide services, are limited and mostly located in Northern and Southeastern Virginia, resulting in reliance on training centers.
Assisted Living Facilities (ALF) – provide assistance with activities of daily living. A 2004 study of assisted living facilities by the Department of Social Services indicated that 48 percent of residents had a mental disorder, and 25 percent had dementia.	As of November 2004, 106 ALFs had special care units for serving persons with dementia. ALFs will care for persons who receive the new Medicaid Alzheimer's waiver.	Current public assistance is limited to the auxiliary grant (Ch. IV). New Alzheimer's waiver will cover services, but not room and board.

Additional Services Need To Be Developed to Better Serve an Aging Population

Service Areas	*Status of Virginia's System / Approach*
Mental retardation	Active treatment may not be feasible for many older Virginians. Institutionalization can result.
Behavioral problems related to dementia	Gaps in services exist; institutionalization can result.
Substance abuse services	Services are primarily designed and targeted toward younger populations. Needs of older Virginians are under-identified.

Plans Are Lacking to Achieve an Effective System in the Future

Challenge	*Status of Virginia's System / Approach*
Demand for services among an aging population is likely to increase. Also, the need for coordination among multiple entities is likely to increase, as are costs.	State and local agencies, as well as other entities providing services, appear to lack specific formal plans to achieve a system that better responds to the needs of an aging population, and especially for older Virginians with MR and substance use disorders.

Source: JLARC staff.

Most CSB Services Are Designed Around Services Reimbursed by Medicaid, Which Limits Publicly Funded Service Options. DMHMRSAS, in its 2004-2010 Comprehensive State Plan, reported that Medicaid constitutes 50 to 70 percent of some CSB budgets. Overall, DMHMRSAS staff report that Medicaid represents only 39 percent of total funding for CSBs. The result of reliance on Medicaid funding for MH and MR services, according to CSB staff, is that many MH and MR services are designed around services for which Medicaid will reimburse. Several CSB directors indicate that a CSB is limited in the MH and MR services it can provide to a person who is not a Medicaid recipient. Staff from the Piedmont CSB indicate that the reliance on Medicaid places clients without Medicaid at risk. They also indicate that their older Medicaid clients "consider themselves lucky" because psychotropic medications, many of which are covered by Medicaid, are usually expensive.

CSB staff report that the proportion of clients receiving Medicaid depends on whether the client is receiving MH, MR, or SA services. CSB staff in the six regions estimate that 50 percent or fewer of their MH clients (including geriatric clients) are Medicaid recipients. In contrast, CSB staff report almost all of the clients for MR services are Medicaid recipients. SA services for older Virginians, however, are not reimbursed by Medicaid.

Most CSBs only provide MR services through the Medicaid MR waiver. According to staff from the Richmond Behavioral Health Authority (RBHA), if individuals with MR are not Medicaid recipients "they get slim to no MR services." As with other waivers, MR waiver services are provided to those who are financially and functionally eligible. Enrollment caps further limit access to this waiver. The MR waiver is currently capped at 6,571 slots, and 2,832 persons of all ages are on the waiting list. In FY 2004, 420 adults age 60 and older received MR waiver services, representing about seven percent of total recipients. As of June 2005, 72 adults age 60 and older were on the MR waiver waiting list.

CSB staff indicate that SA services may not be affordable to older Virginians, particularly older Medicaid recipients and those on fixed incomes. In Virginia, Medicaid will only reimburse for SA services for pregnant and postpartum women. CSB staff note that since many older Virginians have income through Social Security benefits, they would likely be assessed a fee for services. However, this fee would likely be unaffordable for many older Virginians, particularly those with little income in addition to Social Security.

Most adults age 65 and older have insurance through Medicare Part B, which covers MH and SA services. However, CSB staff indicate that Medicare does not cover most of the services provided by CSBs, which further limits access for older Virginians. According to staff from RBHA, Medicare does not reimburse for "rehabilitative" services, and most of the CSB services fall within this category. In addition, low-income older Virginians may not be able to afford MH or SA services through other providers that accept Medicare because the coinsurance is 50 percent, and this may be too costly for them.

Lack of Mental Health Services in Nursing Homes Appears to Result from Reimbursement Restrictions. Local agency staff, particularly staff from local departments of social services (DSS), express concern that adequate MH services are not available in Virginia nursing homes. In 2003, a Gero-Psychiatric Special Populations Work Group was convened by DMHMRSAS to make recommendations for developing services and supports for older Virginians with mental illnesses. In 2004, this group reported that "nursing homes . . . do not have sufficient numbers of staff to manage residents with severe mental illness, or a combination of severe mental illness and dementia." However, about 35 percent (184) of the geriatric residents (those age 65 and older) who were discharged from State MH hospitals in FY 2003 and FY 2004 were discharged into nursing homes, but data are not available to determine the clients' diagnoses upon discharge. In addition, according to 2004 data from the American Health Care Association, 47 percent of residents in Virginia nursing homes had a diagnosis of depression and 17 percent had a psychiatric diagnosis. Staff from the Virginia Health Care Association (VHCA) indicate that their member nursing facilities say that "no one will help," including CSBs, private psychiatrists, and inpatient hospitals, when they have a resident who needs psychiatric services.

DMHMRSAS staff indicate the lack of MH services in nursing homes results from low Medicaid reimbursement rates. Nursing home representatives and AAA, local DSS, and CSB staff also report Medicaid rates for nursing home care are too low. According to VHCA staff, almost all nursing home residents are bedridden or wheelchair bound, and some sleep the majority of the time. These residents typically do not require constant supervision. However, the director of Piedmont Geriatric Hospital, one of the ten State mental health hospitals in Virginia, indicates that nursing home residents with mental illnesses or dementia are often mobile and need additional supervision. According to DMHMRSAS staff, the low Medicaid reimbursement discourages nursing homes from hiring additional staff for supervision as well as staff who are trained in serving residents with mental illnesses or dementia.

Specialized MH services are available to eligible nursing home residents, but VHCA staff indicate nursing homes have difficulty finding adequate providers. Federal regulations require that prior to nursing home admittance persons with a serious mental illness, or who are suspected of having one, must receive additional nursing home screening. This "Level II" screening is conducted to determine whether the resident requires specialized MH services. Interviews with DMHMRSAS and CSB staff suggest that CSBs do not typically provide these specialized services. One reason may be that CSBs do not have psychiatrists or other staff who are trained in geriatrics, as discussed later in this section. VHCA staff also indicate that private psychiatrists and other MH professionals are often not willing to provide services in nursing homes due to the low Medicaid reimbursement for these services, and it also appears that few of these professionals have geriatric training.

Lack of Mental Health Services in Nursing Homes Appears to Impact DMHMRSAS Facilities and Increase State Expenditures. DMHMRSAS, in its 2004-2010 Comprehensive State Plan, noted that older

Virginians "remain in state hospitals even after they are stabilized because they require a level of services that is beyond the capacity of nursing homes to provide." In addition, the plan stated:

> To avoid over reliance on state inpatient care for these individuals, it will be important to create more flexible Medicaid reimbursement for community-based services that are appropriate for older individuals with mental illness.

According to data provided by DMHMRSAS and DMAS, gero-psychiatric care in a State hospital is more costly than care provided in a nursing home. In FY 2003, the average cost per day of providing gero-psychiatric care was $386 while the average Medicaid per diem for nursing home care in calendar year 2003 was $112 (including the average daily patient pay of $22). It is important to note that the Medicaid per diem does not include specialized MH services that may be provided to the nursing home resident. Nursing homes are reimbursed by Medicaid, through the per diem, for providing general medical and day-to-day care to residents. Providers of specialized services, such as specialized MH services, are reimbursed directly by Medicaid.

The State's Piedmont Geriatric Hospital in Burkeville, which is one of the hospitals providing gero-psychiatric services, is currently working on a model designed to increase access to MH services for nursing home residents. Another purpose of this model is to aid in discharging State hospital residents who need specialized care but do not need to be hospitalized. Piedmont staff are providing supportive MH services to residents of two nearby nursing homes as well as providing training to the staff of these facilities. The goal is to expand this model to other areas in the hopes that it will increase the willingness of nursing homes to accept persons with behavioral problems. The Piedmont director cautions, however, that nursing homes in rural areas may be more willing to use this model in order to ensure that an adequate number of their beds are filled. In addition, Piedmont staff are providing these extra services with no additional reimbursement, which other facilities may not be willing to do.

Services Are Limited in Part Because of a Lack of Staff with Geriatric Training

Older Virginians may not have access to community-based MH services because few CSBs provide specialized services to meet their needs. For example, Virginia Beach CSB staff indicate that many older clients have multiple medical issues, which often complicates their mental illnesses, that also have to be addressed to keep them stabilized. Few CSBs, however, report having staff trained in geriatrics, which could limit the effectiveness of services. In addition to limited community-based services, DMHMRSAS and CSB staff also indicate that inpatient MH care may be increasingly limited due to the reduction in the number of beds in both State and private hospitals.

Few CSBs have specialized geriatric mental health services or staff with geriatric training. Of the 17 CSBs interviewed by JLARC staff, only the CSB staff from Northern Virginia localities and Virginia Beach report having specialized programs or services for geriatric clients. Virginia Beach CSB staff indicate they have specialized services for geriatric clients due to additional local funding. Norfolk CSB staff, however, indicate they are in the process of developing specialized services for older clients because they already are experiencing increasing demand by them.

CSB staff interviewed by JLARC staff also indicate that their CSBs have few staff who have geriatric training or who are currently assigned to serve older clients. For example, CSB staff from Henrico and Prince William counties state each CSB has only one staff person with geriatric training. The staff person from Prince William County CSB indicates that she is the only person who serves geriatric clients at her CSB. RBHA staff indicate that they "consider themselves lucky" to have two case managers who serve geriatric clients. In contrast, Arlington CSB staff report having a whole unit serving geriatric clients. Furthermore, Virginia Beach CSB staff indicate that the city's Department of Human Services, of which they are part, offers distance-learning coursework in Gerontology through Virginia Commonwealth University. Approximately 20 staff from that department are expected to complete their master's degrees in Gerontology in 2005.

Availability of Inpatient Gero-Psychiatric Care Is Limited for Several Reasons

It appears that three factors primarily account for the limited availability of inpatient gero-psychiatric care that is reported by staff at CSBs, nursing homes, and private hospitals. (Private and nonprofit psychiatric hospitals and acute hospitals with psychiatric units are referred to in this report as private hospitals.) The first reason is the reduction in the number of gero-psychiatric beds in State facilities and private hospitals. State hospitals have been downsizing, and private hospitals appear to be reducing the number of gero-psychiatric beds because of the reported financial risk that they incur in treating gero-psychiatric patients. A second reason for limited availability is the reported reluctance on the part of some hospitals to accept older Virginians with mental illnesses or behavioral problems due to dementia because of the difficulty hospitals may have discharging these individuals. The third reason results from geographic limitations in the availability of inpatient beds in State facilities.

Reductions in the Number of Gero-Psychiatric Beds in State Facilities and Private Hospitals. State and private hospitals that provide psychiatric and gero-psychiatric care have been downsizing, and CSB staff report this has limited the access of older Virginians to inpatient psychiatric services. Between FY 1998 and FY 2004, the number of operational geriatric beds in State hospitals was reduced by almost 28 percent (from 629 to 455 beds). According to data provided by DMHMRSAS, during this time period the number of persons age 65 and older who received services in State MH hospitals decreased by 20 percent (from 802 to 639). However, the opposite trend occurred for persons age 50 to 64,

and the number of persons in this age group who received services in State MH hospitals increased 26 percent (from 784 to 988).

Private hospitals are used to reduce dependence on State hospital care for persons needing short-term inpatient services. However, CSB and DMHMRSAS staff, as well as staff of the Virginia Hospital and Healthcare Association (VHHA), indicate that a number of private hospitals have recently closed their psychiatric or gero-psychiatric units. According to these staff members, private hospitals are at a financial risk, particularly if they serve a large number of Medicaid patients. Federal regulations limit Medicaid reimbursement for inpatient psychiatric care to 21 days, unless the facility is considered an institution for mental disease (IMD). (IMDs are facilities or units of more than 16 beds that primarily provide treatment to persons diagnosed with mental illnesses.) In Virginia, Medicaid only will reimburse for care in IMDs for recipients age 65 and older, and recipients age 21 and younger.

Although Medicare Part A will reimburse for inpatient psychiatric care provided to eligible persons (recipients age 65 and older or recipients of Social Security Disability Insurance), limitations in this coverage were reported. Medicare Part A will reimburse for the first 60 days of care, minus the client deductible. After that, Medicare only reimburses for a portion of care, and the patient or other insurance (Medicaid or private) is charged the remainder. Private hospital staff indicate that many older residents, particularly those with dementia, remain in the facility beyond the time period for which Medicare provides full coverage. In addition, private hospital staff indicate Medicare often does not reimburse if the person has dementia.

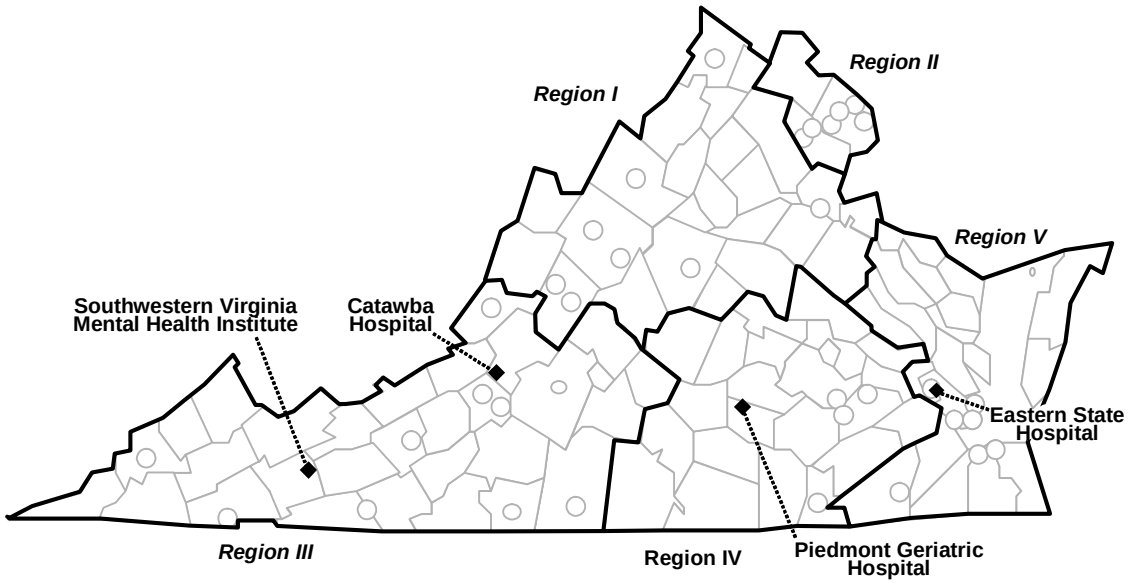
The closing of private psychiatric hospital beds is of most concern to CSB staff in the Northern and Eastern parts of Virginia where several psychiatric units in private hospitals have closed. If this trend continues, geriatric clients in need of acute psychiatric care could become more reliant on State hospitals, yet the DMHMRSAS response to the JLARC survey of State agencies indicated that all State geriatric beds are operating at capacity.

Reluctance of Private Hospitals to Accept Certain Older Virginians Because of Discharge Problems. CSB staff report it is more difficult, if not impossible, to find a private hospital willing to serve older Virginians with mental illnesses or behavioral problems due to dementia, especially if they are likely to need nursing home placement upon discharge. According to CSB staff, it often is difficult to admit geriatric clients to private psychiatric wards because they often become "discharge problems." Additionally, as mentioned in Chapter IV, nursing homes were reported to often refuse to readmit residents after a period of psychiatric treatment. Both DMHMRSAS and CSB staff indicate that older Virginians with behavioral problems who are admitted for psychiatric care often have "burned bridges" with family or other care providers, such as nursing homes. As a result, the private hospitals fear they will be "stuck" with a patient they cannot discharge. Private hospital staff indicate that older clients often remain in their facilities long after inpatient treatment is no longer needed.

Limited Geographic Availability of Gero-Psychiatric Beds in State Facilities. Inpatient care for gero-psychiatric clients in State hospitals is not available in some areas according to CSB staff. The DMHMRSAS survey response states that "geographic differences in the availability of geriatric psychiatric inpatient services vary based upon distance to a facility" and that "there are many situations where the facility serving a region may be many hours from the consumer's home and family." Currently, as shown in Figure 15, no State mental health hospitals provide gero-psychiatric services in the Northwestern or Northern health planning regions (Region I and II). According to Northern Virginia CSB staff, gero-psychiatric clients must be sent to Eastern State Hospital in Williamsburg to receive acute inpatient services. Geographic differences in availability are further exacerbated by the lack of gero-psychiatric beds in private hospitals. VHHA staff conducted an ad-hoc survey of its member hospitals with psychiatric units (37 facilities) for this study. Of the 23 facilities that reported serving gero-psychiatric clients, only five reported having gero-psychiatric beds. Only 78 gero-psychiatric beds were reported out of the 1,086 staffed adult acute psychiatric beds in the surveyed facilities.

Figure 15

State Health Planning Regions, and State Mental Health Hospitals That Provide Geriatric Care



Source: JLARC staff graphic based on DMHMRSAS data.

AGING POPULATION MAY INCREASE DEMAND FOR ADDITIONAL SERVICES

According to local agency staff, the current public MH, MR, and SA services system does not address the needs of some older Virginians, nor are services targeted to them. The present lack of services may hinder the ability of the State to

respond to an increase in demand for these services by an aging population. For example, older Virginians with behavioral problems due to Alzheimer's disease or other dementias are typically not served by State institutions or CSBs. However, projections indicate that the number of Virginians with Alzheimer's disease may double by 2030. In addition, it appears that there are limited services for older Virginians with substance use disorders (SUDs), but federal estimates state that that the number of adults age 50 and older who will need SA treatment may triple by 2020. CSB staff indicate that currently available MR services do not meet the needs of older Virginians with MR. However, most of these persons are living longer than in the past, and age-appropriate services have not been developed.

Older Virginians with Dementia Are Typically Excluded from Publicly Funded Mental Health Services

As indicated in Chapter I, estimates prepared by the Virginia Department for the Aging indicate that the prevalence of Alzheimer's will double between 2000 and 2030, growing from 2.6 to 4.3 percent of the State's population. However, the State does not presently have a clear policy on what role, if any, State agencies should have in providing services to persons with a primary diagnosis of Alzheimer's and other forms of dementia. DMAS recently created an Alzheimer's Medicaid waiver to serve persons with Alzheimer's disease or related dementias who meet the nursing facility level of care and are eligible for the Auxiliary Grant. The waiver, however, is currently capped at 200 slots. As the number of persons with dementia increases, State policymakers may need to consider providing a broader array of services, including those that may reduce nursing home or other institutional placement.

Local agency staff express frustration that older Virginians with Alzheimer's disease or other forms of dementia are excluded from MH services provided in State facilities and the CSBs unless they also have a primary diagnosis of a serious mental illness. Staff at several local DSS agencies indicate that CSBs often would not serve their older clients with dementia, even if the clients had behavioral problems that mirror psychiatric disorders. In fact, according to the U.S. Surgeon General, behavioral problems occur frequently in persons with Alzheimer's disease:

- 10 to 25 percent have hallucinations,
- 30 to 50 percent experience delusions, and
- 40 to 50 percent have symptoms of depression.

Local DSS staff indicate that they are typically the agency which provides services to these clients, and that local DSS staff are doing the best they can to handle the behavioral problems. Common behaviors may include agitation, wandering, anger, personality change, and lack of self-care. However, DMHMRSAS staff note these behaviors can result from other factors, including medication side-effects, and are not always the result of a mental disorder.

DMHMRSAS data indicate that some older Virginians with a primary diagnosis of dementia are being served in State MH hospitals, but that the number served has decreased over time. According to DMHMRSAS data, from FY 1998 to FY 2004, the number of clients age 60 and older with a primary diagnosis of dementia that were served in State hospitals declined by 69 percent (from 344 to 108). Data are not available for those clients who may have had dementia as a secondary diagnosis. DMHMRSAS staff suggest that some older Virginians with dementia are being served in State hospitals because there are few other options for people who also have behavioral problems.

CSB staff indicate that they serve few clients with dementia, and those they do serve are usually long-term clients who have acquired dementia. DMHMRSAS data indicate that in FY 2004, nine percent (914) of CSB clients over the age of 60 had a diagnosis of dementia, amnesia, or other cognitive disorders. According to DMHMRSAS staff, serving persons with dementia is not part of the mission of CSBs, because their mission is to serve psychiatric disorders not cognitive disorders. Furthermore, CSB and DMHMRSAS staff indicate that dementia is really a "medical condition." It is also important to note that the service manuals and guidance documents published by the Department of Medical Assistance Services (DMAS) and DMHMRSAS state that persons with dementia are not eligible for publicly-funded behavioral health services unless they have a primary diagnosis of serious mental illness.

The lack of services for persons with behavioral problems that result from dementia was identified by a number of persons interviewed by JLARC staff. According to DMHMRSAS staff and staff of private hospitals that provide psychiatric care, the service needs of this population are not the specific responsibility of any agency or provider. The result is that these persons often are "shuffled" among providers until they end up in the hospital emergency room, the psychiatric unit of private hospitals, or in State gero-psychiatric facilities. Staff from the Richmond DSS provided the following example:

> *Police in Richmond found a woman who appeared to have dementia and took her to the Virginia Commonwealth University Medical Center, where she was admitted for observation. The woman had no place to go, and her daughter, who lived in New York, was unwilling to pick her up, so she was provided an emergency placement in an assisted living facility. Soon after arriving at the ALF, the woman began refusing to eat or take medications and she began to wander and assault other residents and staff. The facility wanted to discharge her, but there was no place for her to go. The woman did not have a condition for which she could be admitted for regular medical care and she could not be involuntarily admitted to a psychiatric unit.*

As indicated above, private hospital staff also report that some families use hospitals as "way stations" when they can no longer handle a relative who has dementia, and as a result some people remain in the hospital beyond the time that they actually need inpatient services. While this also happens to older residents receiving inpatient care for psychiatric disorders, private hospital staff indicate that older

residents with dementia "overshadow" them. Other examples of the lack of services include:

- According to VHCA staff, nursing homes have experience handling residents with dementia but are not equipped to handle those who also have behavioral problems. Private hospital staff express similar concerns about assisted living facilities.

- The Norfolk CSB director indicates that older Virginians with dementia and behavioral problems are getting "kicked out" of nursing homes and are going to psychiatric units in hospitals. However, there is nowhere for them to go from there.

- Virginia Alzheimer's Association policy staff indicate that there are no services designed specifically for persons with dementia. Although some receive services through the area agencies on aging and local departments of social services, these services are not designed for persons with dementia, especially if they have behavioral problems. In addition, these services are limited.

In order to appropriately serve older Virginians with behavioral problems due to dementia, DMHMRSAS staff indicate that collaboration is needed between State and local human services agencies, the medical research community, and other providers.

Few Older Virginians Were Reported to Seek Substance Abuse Services Because of a Focus on Younger Populations

Although few older adults currently receive SA services, the number of older persons who will likely need these services is expected to increase. As noted in a 2003 study by the federal Substance Abuse and Mental Health Services Administration (SAMHSA), the number of adults in the U.S. age 50 and older who will need treatment for alcohol and substance abuse will triple by 2020, partly because substance abuse among the baby boomer cohort has been much larger than previous cohorts. Because of the projected increase in the number of older adults with substance use disorders, the SAMHSA report warns that treatment programs may need to shift away from their almost exclusive focus on younger populations. A review of the medical research also suggests that SA services for this population are important, because untreated problems may lead to other health conditions as a result of unrecognized drug interactions, and may also increase the likelihood of depression and suicide.

As in other areas, much of the current focus of SA services in Virginia is on younger persons. While CSB staff indicate that they serve few older Virginians, they also suspect that there is a lot of unmet demand for SA services for this population. Two factors noted in medical research may explain why some of this unmet demand exists. First, procedures for diagnosing substance use disorders largely have not been tested on older adults. As a result, some older persons may

not have been appropriately diagnosed, particularly if they try to hide their disorder or are unaware of the disorder themselves. Second, these disorders may be masked by other physical or mental health problems.

Staff from several CSBs characterize older Virginians with substance use disorders as a "hidden population." Additionally, Chesapeake CSB staff indicate that most of their SA clients are referred from their employers, or from the court system due to charges of driving under the influence. As many older Virginians are neither working nor driving, many are not being referred or requesting services. DMHMRSAS FY 2004 data indicate that less than one percent (808) of CSB SA clients were age 60 or older, while 68 percent were between the ages of 23 and 59. This current focus on younger adults may limit the State's ability to respond to a projected increase in the number of older Virginians with substance use disorders.

Medical research also suggests that many older adults are in need of SA services due to medication misuse. At the current time, according to the DMHMRSAS Comprehensive State Plan for 2004-2010:

> Abuse of alcohol and legal drugs, prescription and over-the-counter, is currently a serious health problem among older Americans, affecting up to 17 percent of adults aged 60 or older.

By applying these prevalence rates to data from the 2000 Census, it is estimated that 181,135 Virginians age 60 and older suffered from alcohol or legal drug abuse in 2000. Additionally, in combination with moderate or low alcohol use, interactions with prescribed drugs can create health problems even for those older adults who are not drug abusers. CSB staff also indicate that older Virginians are prone to prescription drug abuse, much of which is unintentional, because many physicians are not aware of all medications patients are taking, or how older adults react to the medications. The lack of awareness of the potential consequences of polypharmacy (taking multiple medications) is reported to result from insufficient numbers of health care personnel receiving geriatric training.

Services for Persons with Mental Retardation Are Not Designed to Meet the Needs of Older Virginians

CSB staff express concern regarding the recent phenomenon of aging persons with mental retardation (MR). Until recently, most persons with MR did not reach advanced age. The average lifespan of a person with MR increased from 19 years in the 1930s to 66 years in the early 1990s. CSB staff indicate that MR community services were designed to serve younger persons and are often not appropriate for older adults. In addition, CSB staff report that they and other MR waiver providers are struggling to serve older Virginians, especially as their medical needs increase. As a result, CSB staff report that some older Virginians may have to turn to institutional services because appropriate community-based services are not available.

Community MR Waiver Services Are Limited and Often Inappropriate for Older Virginians. As mentioned previously, almost all publicly funded community MR services are provided through the Medicaid MR waiver. As with other waivers, persons must meet the financial and functional criteria to be eligible for the waiver. The functional level of care for the MR waiver is the level of care required for admission to an intermediate care facility for persons with mental retardation (ICF/MR).

Medicaid requires MR services to include active treatment, which federal regulations describe as "aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services." In other words, active treatment requires individuals to participate in ongoing training and habilitation. However, CSB staff indicate that some older Virginians are becoming unable or unwilling to participate in the training and habilitation associated with the services provided through the waiver, such as day support, prevocational, and supported employment. This is particularly problematic for those older recipients who reside in MR group homes, because these are the only services included in the MR waiver that are regularly available during the day for these residents. CSB staff express concerns that older Virginians who are unable or unwilling to participate in these training and habilitation programs may be in jeopardy of losing their waiver.

DMHMRSAS staff report that the MR waiver does nor reimburse for general supervision. Therefore, persons who cannot or are not willing to participate in these programs may pose a challenge to many service providers in developing services that meet their true needs while also satisfying the interpretation of the current regulations. DMHMRSAS staff indicate that MR waiver recipients may switch from receiving congregate residential services, which are typically provided to recipients residing in group homes, and receive personal care assistance services which are also available through the waiver.

DMHMRSAS, in its 2004-2010 State Plan, indicates a desire to work with DMAS to revise the MR waiver to more appropriately serve older waiver recipients. DMAS staff also indicate it is possible to revise or use existing services to meet the needs of these individuals. In addition, DMAS staff report that the Centers for Medicare and Medicaid Services, the federal agency responsible for approving states' waiver programs, is starting to work with states to address this issue.

Institutional Care May Become the Only Option for Many Older Virginians With MR. As a result of the limitations in community-based services described above, CSB staff report that older Virginians with MR may be forced into a more restrictive setting such as a State training center, a private ICF/MR, or a nursing home. Staff from the RBHA state that if a MR group home says it can no longer provide services to an older person, RBHA staff are forced to look to the training center for admission.

In several areas of the State, CSB staff indicate that an immediate need exists for more ICFs/MR. One reason is that the MR waiver group homes and day programs are having difficulty serving aging waiver recipients whose medical needs

have also increased. CSB staff also indicate that ICFs/MR, which are designed to be more home-like than the larger State training centers, are needed in order to serve adults with MR in a more appropriate setting than a nursing home, but in a less restrictive setting than the training center. CSB staff indicate that nursing facilities often do not have staff trained to handle the needs of residents with MR, particularly those who also have behavioral problems. (CSB staff report that this dual diagnosis is common.) While agreeing that nursing homes are not appropriate placements, staff from Danville-Pittsylvania CSB state that their aging MR waiver clients often have to go into a nursing home because there is no ICF/MR in the region. Data collected by the American Health Care Association indicate that 4 percent of Virginia nursing home residents in 2005 had a MR diagnosis, although no data by age are available.

Although the number of ICF/MR beds has increased in recent years, unmet demand is still reported. While data from VDH indicate the number of community ICF/MR beds increased 76 percent between FY 2001 and FY 2004 (from 131 to 230), these facilities are located in only eight of the 21 planning districts in Virginia. In addition, 61 percent of the beds are located in Northern and Southeastern Virginia (54 and 85 beds, respectively). Despite the majority of ICF/MR beds being located in Southeastern Virginia, staff from the Virginia Beach CSB report that an ICF/MR expected to open in 2006 already has a waiting list of 30 persons.

In contrast to the concerns of CSB staff, disability advocates are concerned that the use of ICFs/MR indicates that the State is moving backward in its efforts toward deinstitutionalization. Advocates indicate that ICF/MR services are very costly and serve to reduce funding that could otherwise be made available for MR waiver services. According to DMAS, the average cost for serving an individual in an ICF/MR, including in a State training center, was $103,741 in FY 2004. In comparison, the average cost for serving an individual through the MR waiver, including waiver and other Medicaid services, was $54,438 in FY 2004. (Average costs by age for these services were not available.) Unlike nursing homes, which are reimbursed a per diem through Medicaid under a prospective payment system, Medicaid reimburses ICFs/MR retrospectively for the total cost of providing services.

SERVICE DEMANDS AND COSTS ARE PROJECTED TO INCREASE, BUT AGENCIES REPORT THEY ARE NOT PREPARED

According to projections from DMAS, Medicaid funding for aged recipients of MH services, and funding for intermediate care facility services for persons with MR, will continue to increase. (The term “aged” is used by Medicaid to refer to recipients age 65 and older. More information on these projections is provided in Chapter III.) CSB staff also expect the number of older clients needing these services to increase. However, CSB staff indicate that they are largely unprepared to serve additional older clients for the reason discussed above, such as the lack of geriatric providers and specialized services for older Virginians. Additional reasons why CSBs report being unprepared for the aging population are discussed in further detail in this section. It appears that DMHMRSAS is aware of the need for specialized MH, MR, SA services for older Virginians, there currently is no formal

plan to expand these services. However, DMHMRSAS staff report that the Service Plan they developed for the Department of Planning and Budget includes re-opening the office of geriatric services.

Medicaid Spending for Existing Mental Health and ICF/MR Services for the Aged Could Increase Substantially

As shown in Table 6, Medicaid expenditures for MH services and ICF/MR services for the aged are expected to substantially increase by 2030. The range of estimates according to various scenarios is from $193 million to $586 million for both services by 2030. As with projections of Medicaid nursing home expenditures, these projections were made using two assumptions about price inflation as well as two assumptions about the increases in numbers of aged Medicaid recipients. (More information on these projections is provided in Chapter III.) Additionally, these estimates do not account for certain factors that could affect future need, particularly for ICF/MR services. As mentioned previously, DMHMRSAS staff indicate that large numbers of older Virginians with MR are aging for the first time. Current service demand may not yet reflect this phenomenon, particularly if a lack of community-based services results in older Virginians receiving services primarily through ICFs/MR. As mentioned previously, CSB staff already indicate that unmet demand exists for ICF/MR services.

Table 6

Estimated Medicaid Expenditures for Mental Health and ICF/MR Services for the Aged

Fiscal Year	Mental Health ($ Millions)	ICF/MR ($ Millions)
2004	$19 (Actual)	$34 (Actual)
2008	23 – 27	42 – 48
2010	26 – 32	46 – 57
2020	42 – 85	75 – 52
2030	69 – 210	124 – 376

Source: JLARC staff representation of Medicaid estimates provided by the Department of Medical Assistance Services under various scenarios.

Staff at Community Services Boards Report Being Unprepared for the Aging Population

CSB staff interviewed by JLARC staff indicate that CSBs are not prepared for the aging population. According to a report issued by CSBs in Southwestern Virginia, "limited resources for [the] elderly and increasing needs for this population without infrastructure to support this" will strain the resources of the region's CSBs. Overall, CSB staff concerns include the impact resulting from the aging of caregivers for persons with MR, the increasing lifespan of persons with MR, and the fact that future demand is difficult to anticipate because many older Virginians currently do

not demand services from CSBs. In addition, CSBs also report being unprepared because many do not have staff with geriatric training, as discussed earlier in this chapter.

Demand for Services Is Expected to Increase When Current Caregivers Are No Longer Able to Provide Services. The primary concern of CSB staff related to the aging of the population appears to be the unknown number of persons with MR who are living with aging caregivers. Currently, there is little data on this population, and data are limited to only those persons who have requested CSB services. DMHMRSAS and CSB staff state that at one time, the only public service option for persons with MR was a State training center. Parents who did not want this option for their child provided what services they could at home, usually with little or no public assistance. Staff from the Virginia Beach CSB characterize this as a generation that did not reach out for help. Because it is suspected that many caregivers have never asked for public assistance, CSB staff believe that many persons are unknown to the services system. This assumption is supported by a 2004 report by the American Association on Mental Retardation:

> The aging of our society directly influences demand for developmental disability services. This occurs because the majority of people with developmental disabilities in the United States currently reside with family caregivers.

Although the potential demand for services is not known, DMHMRSAS does maintain data on the numbers of persons who have sought CSB MR services because of an aging caregiver but are currently on the waiting list. According to data collected in April 2003, 369 adults were on waiting lists for MR services because of an aging caregiver. This number more than doubled by April 2005 to 854 adults (30 of these adults were also age 60 or older).

CSB staff report often becoming aware of these clients after a crisis occurs. CSB staff indicate that many parents have not planned for the future service needs of their children with MR because many did not expect their children to outlive them. CSB staff also indicate that parents who are used to caring for their children with MR are often reluctant to ask for public assistance, even if they age to a point at which caring for their children has become increasingly difficult. CSB staff indicate that this often results in them serving two persons in crisis, the parent and the person with MR.

CSBs Report Older Virginians Currently Do Not Demand Services. CSB staff overwhelmingly report that older Virginians do not demand services. According to one CSB director, older adults are not "knocking down the doors" of CSBs. As shown in Table 7, this description is supported by DMHMRSAS data on the number of older Virginians receiving services and on waiting lists for services. If a greater number of older Virginians demand CSB services in the future, it appears that CSB staff will be impacted by more than just an increase in the number of clients. Several CSB staff indicate that it takes more staff time to serve older clients because they often have more medical problems, and often need to be escorted to doctors' appointments. Staff from CSBs in the Southeastern area of Virginia

indicate that serving older clients includes a lot of additional "hand- holding." One reason is that many do not have family members that can or are willing to help them. This type of support is needed to keep them stable.

Table 7

Clients Receiving and on Waiting Lists for Services from Community Services Boards in FY 2004, By Age

Service Area	Age 18-59	Age 60 and Older
Receiving Services		
Mental Health	75,242	8,971
Mental Retardation	12,068	1,017
Substance Abuse	43,866	808
On Waiting Lists		
Mental Health	3,977	387
Mental Retardation	3,294	150
Substance Abuse	2,951	41

Source: Department of Mental Health, Mental Retardation, and Substance Abuse Services.

National research indicates that unmet demand for MH services by older adults is extensive and the possible consequences, such as disability or exacerbation of symptoms of other illnesses, are expensive. The U.S. Surgeon General reported in 1999 that unmet demand likely exists for 63 percent of older adults with mental disorders. Research indicates that 20 percent of adults age 55 or older experience specific mental disorders, and about 5 percent of adults age 50 and older have a serious mental illness in a given year. By applying these prevalence rates to data from the 2000 Census, it is estimated that in 2000:

- 281,941 Virginians age 55 and older suffered from a mental disorder; and

- 92,952 Virginians age 50 and older suffered from a serious mental illness.

According to research conducted by the National Governor's Association, the national cost of untreated mental illness for adults age 60 and older is $47 billion annually.

It appears that older adults do not demand MH and SA services for several reasons, including the stigma associated with mental illness and SUDs and a failure to self-identify the problem. Older adults often appear to physicians or family members as having physical rather than mental illnesses. Other medical disorders they might have can further mask or complicate diagnosis.

CSB and other local agency staff indicate a need for more awareness that certain behaviors are not normal signs of aging but are instead signs of mental illness. The Gero-Psychiatric Special Populations work group convened by DMHMRSAS suggested that more primary care physicians (PCPs) should be encouraged to become knowledgeable about mental illnesses in older Virginians, including symptoms and treatments, particularly as the PCP is the first provider an older adult usually consults about mental health. The work group recommended that DMHMRSAS should work with medical schools, medical associations, and the Department of Health Professions regarding education and training in order to encourage more health care professionals to specialize in this field as well as to increase the knowledge of PCPs in making assessments and referrals.

DMHMRSAS Acknowledges that MH, MR, and SA Services Are Needed, But So Far Has No Specific Plan for Developing Them

It appears that DMHMRSAS is aware of the lack of MH, MR, and SA services for older Virginians. The 1998 Appropriation Act directed DMHMRSAS to develop a plan for serving geriatric clients. According to DMHMRSAS staff, a report was prepared by a contractor, but it was not accepted by either the agency or the General Assembly. In 2002, DMHMRSAS convened a number of special populations and restructuring work groups, one of which was the Gero-Psychiatric Special Population Work Group. The work group stated in its 2004 report that:

> No standard continuum of expected specialized services for geriatric patients has been provided to the Community Services Boards. Without a grand plan that sets higher expectations for geriatric services, and without funding to support the needed services, little will change. It's not that the Community Services [Boards] don't want to serve more geriatric clients, it's that the resources they have are already overwhelmed trying to treat younger populations, so the needs of the elderly get lost.

While most evidence indicates that MH services for older Virginians are needed, DMHMRSAS staff also report that MR and SA services for this population need to be developed. The DMHMRSAS Comprehensive State Plan for 2002-2008 states that older Virginians with MR are increasingly unable or unwilling to participate in the day or residential support programs and may be at risk of losing MR waiver services. The report also states:

> Virginia cannot afford to replace community-based services with institutional services, financially or morally, simply because a consumer needs to 'retire' from active treatment.

A more recent DMHMRSAS Comprehensive Plan for 2004-2010 states that "as Virginia's population ages, there will be increasing demand for specialized SA services for older persons with substance use disorders" and that "the Department must develop programs and services that are specifically designed . . . to recognize the needs of older populations."

DMHMRSAS is currently conducting strategic planning to improve the delivery of services. As part of these efforts, DMHMRSAS has created several special populations and regional work groups to provide recommendations for an "Integrated Strategic Plan" that will be finalized in late 2005. The Gero-Psychiatric Work Group recommended creating a master plan for geriatric services to improve the system of MH services for older Virginians. While MR and substance abuse special population work groups were also created, DMHMRSAS staff indicate that these groups have not focused on the needs of older Virginians with MR or SUDs. DMHMRSAS staff indicate sub-groups could be formed to address these needs.

VI. Impact of an Aging Prisoner Population

As noted in the interim report for this study, the number of older inmates in Virginia's correctional system has been increasing. From FY 1999 to FY 2003, the number of Virginia prisoners age 50 and older increased 56 percent, while the overall inmate population increased by only 18 percent. Over that same time period, the per capita cost of medical care for all Virginia inmates increased nearly 20 percent, which the Department of Corrections (DOC) partially attributes to the increasing number of older inmates. Because a 1976 Supreme Court ruling requires States to provide health care to inmates, State policymakers may be confronted with the need to provide services to a population that is deemed too dangerous to be released, but for whose care the State will not receive Medicare or Medicaid reimbursement.

Although State officials acknowledge that the growing number of older inmates will have a fiscal impact on the State, particularly with respect to health care costs, DOC does not currently maintain data on the cost of housing inmates by age, or the cost of health care provided in the State's correctional facilities. (Among corrections professionals, an inmate who is age 50 or older is typically considered "geriatric," because certain elements of the prisoners' lifestyles tend to cause them to age more quickly.) Moreover, the Geriatric Release Program, created by the General Assembly in 1994 to mitigate the cost of housing older inmates by granting early release to certain categories of older offenders, has had little impact to date. A total of three inmates have been released so far, and these have all occurred in the past year. Efforts to save money by granting early release to qualifying geriatric inmates are complicated by a lack of options for placing infirm ex-prisoners in appropriate care settings, such as nursing homes.

THE ISSUE OF AN AGING PRISONER POPULATION IS BEING EXAMINED NATIONWIDE

National studies indicate that in recent years there has been a steady increase in the number of geriatric prisoners nationwide. Several studies indicate that an increasing prevalence of mandatory minimum sentencing policies, "three strikes" sentences for felony convictions, and the abolition of parole have resulted in inmates remaining incarcerated for longer periods of time. A 1998 report by the Southern Legislative Conference (SLC) found that in 15 of the SLC member states, the number of geriatric inmates increased 115 percent in six years, from 12,107 in 1991 to 26,044 in 1997. This is compared to an increase in the overall inmate population in those states of 83 percent. The SLC reported that corrections officials are primarily concerned about their ability to adequately meet federal mandates that sufficient health care be provided to all inmates, as well as a shortage of facilities and trained staff that are needed to accommodate the unique needs of this population.

Several states have studied the impact of the increasing number of older inmates, including Florida, Georgia, Maryland, New York, Oklahoma, and Texas. A 2005 study of Pennsylvania's geriatric prisoner population found that federal funds, such as Medicare and Medicaid, that are unavailable to the incarcerated population could be used to subsidize the care of infirm inmates if they could be released on parole. The Pennsylvania report found that annual per person long-term care costs in that state's correctional facilities averaged $63,500. Although the cost of publicly funded nursing home care averaged $62,000 annually, if prisoners could be released to a nursing home then the federal government would pay for half of the cost.

THE COST OF HOUSING AGING PRISONERS WILL LIKELY INCREASE, BUT THE ACTUAL COSTS ARE NOT CLEAR

According to DOC staff, challenges in accommodating the unique needs of a growing geriatric inmate population are impacting the State in several ways. Additionally, national studies and those conducted by other states suggest that the primary impact of an aging prisoner population is an increase in the cost of providing needed health care to inmates. While DOC staff surmise that this is also true in Virginia, a comprehensive Virginia-specific analysis of the impact of geriatric inmates' health care costs is hindered by a lack of available data. Other areas in which the State is reportedly impacted by an aging inmate population include the need for specialized diets, additional staff training on the treatment of geriatric prisoners, and difficulties that hinder the development of appropriate discharge plans for offenders who have completed their sentences.

The Absence of Data on the Health Care Costs of Geriatric Inmates Hinders an Analysis of Their Impact on the State

According to the most recent data available from DOC, the per capita cost of medical care for all Virginia inmates increased nearly 20 percent from FY 1999 to FY 2003, which the department partially attributes to an increasing number of older inmates. According to research on this subject, older inmates place greater financial pressures on states because they are more prone to chronic or advanced health conditions, such as hypertension, diabetes, and cardiovascular disease. Although DOC does not track the health care costs of its older inmates, national research indicates that the costs of housing geriatric prisoners is two or three times more than that of the average inmate. These factors, in addition to the fact that states are mandated to provide health care to inmates (as affirmed by the 1976 United States Supreme Court case of *Estelle v. Gamble*), are predicted to exacerbate strains on state prison budgets, including Virginia's.

Virginia's Correctional System Has Four Facilities Capable of Meeting Older Inmates' More Acute Health Care Needs. Although geriatric prisoners are present in all of DOC's major institutions, only four facilities are capable of meeting the more acute medical needs of older inmates. In mid-2003, the Greensville Correctional Center in Greensville County, which has a skilled nursing facility, housed 372 geriatric inmates. This was the largest number of inmates of any facility, but only ten percent of all State inmates in this age group.

The second largest geriatric population, 303 offenders, resided at the Deerfield Correctional Center in Southampton County, which is a facility specifically designed to care for inmates in need of assistance with one or two basic activities of daily living. It provides a level of care similar to an assisted living facility, but only eight percent of all geriatric inmates were housed at Deerfield as of mid-2003. Other institutions with some ability to care for the more acute medical needs of older prisoners include the Powhatan Correctional Center in Powhatan County, which has a skilled nursing facility, and the Marion Treatment Correctional Center in Smyth County, which has an infirmary.

Inmates that need medical care beyond the capability of on-site services such as those mentioned above are transported to off-site medical centers. DOC staff report that most off-site services are provided in Richmond by the VCU Health System. In addition to being more expensive in terms of medical costs, staff state that off-site treatment for persons of all ages is more expensive due to transportation costs.

The Department of Corrections Does Not Maintain Data on the Cost of Providing Health Care to Older Inmates. Efforts to prepare for the fiscal ramifications of an increasing number of geriatric inmates will be hindered by the fact that DOC does not maintain data by age on the cost of prisoner health care provided in its facilities. In responding to the JLARC staff's survey of State agencies, DOC staff state that "because DOC aligns services according to individual needs [versus] age groups, [health care cost] information relative to the entire 60 and over population is not available."

In their survey response, DOC staff cite geriatric inmate cost projections calculated by the College of William and Mary's Center for Excellence in Aging and Geriatric Health in 2003. These projections estimated that the medical costs of Virginia inmates age 50 and older will increase to $10.6 million, or almost 21 percent of system-wide medical costs, by 2007. This would be double the proportion of medical costs attributable to geriatric inmates in 1997. However, these projections should be interpreted with caution. Because data on the cost of on-site medical services for geriatric inmates are not maintained by DOC, the William and Mary projections only included off-site medical costs collected by Anthem Blue Cross and Blue Shield. Because of these data limitations, William and Mary researchers concluded that determining the total medical cost of treating older prisoners is not possible.

In 2001, DOC created the Geriatric Program and Management Committee to examine the overall management of Virginia's aging inmates. According to comments made to JLARC staff in 2004 by one committee member, a primary issue being addressed by this committee was the absence of data on the specific costs of housing older inmates. According to the staff person, the committee intended to recommend that the agency maintain age-specific medical cost data. In a follow-up interview with this staff person in 2005, however, JLARC staff were told that the committee's final report, although still in draft form, does not recommend that DOC maintain age-specific cost data.

DOC Data Indicate That Inmates in the System's Assisted Living Facility Are More Costly to House. Corrections staff were able to calculate that the average cost of housing an offender at the Deerfield Correctional Center, the system's version of an assisted living facility, was about $25,834 per inmate per year, compared to a system-wide average of $20,401 per inmate per year. This is not an accurate measure of the annual per person expenditures for all geriatric inmates, however, because available data indicate that only eight percent of the State's geriatric prisoners were housed at Deerfield in 2003. For example, this estimate does not consider the per-inmate costs of caring for individuals in the Greensville Correctional Center, which has a skilled nursing facility and housed the largest number of geriatric inmates of any facility in 2003.

Corrections Staff Also Cited Staffing and Physical Plant Challenges to Accommodating Geriatric Inmates

In interviews with JLARC staff, DOC officials state that one challenge faced by the agency is the adequacy of staff training on the treatment of geriatric inmates. With the exception of staff at Deerfield Correctional Center, most employees do not receive specific training on the potentially unique needs or characteristics of geriatric prisoners. DOC staff acknowledge the need for additional training, and have cited one instance in which a correctional officer mistakenly charged an older inmate suffering from dementia and a hearing impairment with disobedience. They state that one obstacle to improving training efforts is the absence of an agency policy for managing older inmates. According to DOC staff, the final report of the Geriatric Program and Management Committee is intended to become the agency's written policy document on geriatric inmates. As noted previously, this report is still in draft form.

Corrections officials also express concerns about accommodating the physical needs of older inmates. For example, many older inmates are reported to be physically unable to reach a top bunk, and DOC staff state that there is a waiting list for bottom bunks throughout its facilities. According to data compiled by the SLC, 67 percent of beds in Virginia's correctional facilities are double bunked. In response to the State agency survey conducted by JLARC staff, DOC staff state that "housing adjustments, assisted living arrangements, adapted programming and community planning, dietary accommodations, and climate control" are all areas that may deserve special consideration as the number of older inmates continues to increase.

Difficulties in Developing Discharge Plans for Older Inmates Could Have a Negative Fiscal Impact on the State

In interviews with JLARC staff, DOC officials state that planning for the release of geriatric prisoners into the community is hampered by a lack of available resources to accommodate their needs. DOC has one staff person who is responsible for developing discharge plans for "hard to place" offenders, which includes older inmates. According to this discharge planner, older prisoners account for approximately 60 percent of her caseload. She indicates that developing discharge

plans for older inmates is more difficult because they may no longer have any family members to whom they can be released – siblings may themselves be in a long-term care facility, parents may be deceased, and they may have poor relationships with their children. In addition, she states that nursing facilities are often reluctant to accept Medicaid recipients, particularly those with criminal records. According to the previously mentioned study of Pennsylvania's geriatric inmate population, options for the placement of geriatric inmates in long-term care facilities are also limited in that state.

An inability to develop an appropriate discharge plan for inmates can have a negative fiscal impact on the State if it results in an extension of their incarceration period. According to DOC staff, if an inmate's crime was committed after the abolition of parole in 1995, the corrections system is allowed to house that inmate for up to 30 days past his or her scheduled release date. If the inmate's crime was committed prior to 1995, the inmate can remain incarcerated for up to six months past the end of his or her sentence if an adequate discharge plan cannot be developed. According to DOC staff, if inmates are allowed to remain in the correctional system for the maximum amount of time past the completion of their sentence, and an appropriate placement cannot be found, they will be released to an emergency room. This has reportedly occurred twice in the past two years.

One DOC staff person states that if the most appropriate discharge plan involves being released into a nursing facility, an inmate is guaranteed to remain incarcerated for at least 30 days past the completion of his or her sentence because of the difficulty of finding a facility willing to take a former prisoner. At an average cost per inmate of $55 per day in FY 2003, this increased incarceration time would cost $1,655 per person. If geriatric inmates are assumed to be, on average, three times more costly than younger inmates, this could amount to nearly $5,000 per person over the 30-day period. (As noted previously, no data are available to determine the actual cost of housing a geriatric inmate.) Based on data provided by the Department of Medical Assistance Services, the average per diem Medicaid reimbursement for a nursing facility resident was approximately $112 in 2003. Over a 30 day period, this would total approximately $3,360. Half of this cost would be borne by the federal government, whereas the State is responsible for 100 percent of costs incurred in the corrections system. The inability of DOC discharge planners to place geriatric inmates in nursing homes once their sentence is completed could therefore have a negative fiscal impact on the State, especially if recent trends in the growing number of older prisoners continue.

FEW OLDER INMATES HAVE BEEN RELEASED THROUGH THE STATE'S GERIATRIC RELEASE PROGRAM

To address the potential financial impact of an aging inmate population, the General Assembly created the Geriatric Release Program in 1994. This program gives qualifying geriatric inmates the option of an early release from incarceration. To be eligible for geriatric release, inmates must be:

- At least 65 years old and have served at least five years of their sentence; or

- At least 60 years old and have served at least ten years of their sentence.

The Virginia Parole Board provided JLARC staff with data on petitions for parole by geriatric inmates from January 1, 2002 to mid-August 2005. For those years for which a full 12 months of data were available (2002-2004), the number of petitions submitted to the Parole Board by geriatric inmates averaged 27. According to these data, as well as DOC and Parole Board staff, three inmates have been released to date under the Geriatric Release Program, and these releases were granted in the past year. Those three inmates were ages 69, 72, and 78, and had been sentenced to 10, 15, and 7 year sentences respectively. Parole Board data indicate that their respective offenses were malicious wounding, violating the Drug Control Act, and the sale of cocaine.

The reason given for the vast majority of geriatric release petitions that were denied by the Parole Board from 2002 to mid-2005 was the serious nature of the inmate's offense. According to the director of the Parole Board, older offenders who were sentenced to greater than five years in prison probably committed an offense too serious for the Parole Board to grant them geriatric release. The director stated that "the court knew how old they were when they sentenced them," so if they are now 65 and have been sentenced to more than five years (or are 60 and have been sentenced to more than 10 years), they probably committed an offense that will make them ineligible for geriatric release.

Additionally, some inmates who committed their offenses prior to the abolition of parole in 1995, and who have reached age 60 while serving their sentence, should have already been paroled. According to the director, if the Board denies parole because of the nature of an inmate's offense, it is highly unlikely that a petition for geriatric release would be successful. Parole Board data show that 23 of the 39 geriatric inmates who petitioned for early release in 2004 had committed homicide or some form of sexual assault. This was the case for 36 of the 52 geriatric inmates petitioning for early release as of August 2005.

It appears, therefore, that State efforts to curtail potential increases in the costs of an aging prisoner population may be thwarted by the serious nature of the crimes committed by these offenders. However, even if a greater number of geriatric inmates were approved by the Parole Board for early release, the discharge planning barriers discussed above would have to be addressed.

VII. Increasing Demand for Home and Community-Based Services May Impact Agencies

Some of the State's services and programs for the aging population are intended to enable low-income and disabled older Virginians to receive long-term care in their homes and communities, rather than more costly and restrictive institutions such as nursing homes. These include the Department of Social Services' adult services program, the home and community-based services provided by local area agencies on aging, and home and community-based services provided through Medicaid waivers such as the Elderly or Disabled with Consumer Direction (EDCD) waiver. These home and community-based services assist several thousand older Virginians each year and are consistent with the State's long-term care policy that was enacted through HB 2036 of the 2005 Session of the General Assembly, which stated that

> The Commonwealth shall seek to ensure that…service delivery, consistent with the needs and preferences of older adults, occurs in the most independent, least restrictive, and most appropriate living situation possible.

However, according to reports by State and local agency staff, as well as data on waiting lists that document unmet demand for services by eligible older Virginians, many individuals do not receive the home and community-based services for which they are eligible. In addition, local agency staff indicate that resource constraints result in many clients being underserved. This means that some older Virginians receive only some of the services they need, because agencies have to ration their resources to ensure that services can be provided to as many clients as possible. When one agency is unable to fully meet a client's service needs, local agency staff report that they sometimes refer the client to other agencies or nonprofit organizations. However, these other entities are often also faced with resource constraints.

Local agency staff characterize the resulting system as a "patchwork" approach to service provision. Unmet demand for these services appears to place unexpected demands on the resources of some State and local agencies and hinders their ability to most effectively manage their programs. However, none of the home and community-based services for older Virginians discussed in this chapter are considered entitlement services, meaning that the State is not financially obligated to provide these services to all eligible persons.

State and local agencies will likely experience increased demand for home and community-based services if the preference for this type of care over institutional care continues to increase in future years. In addition, because local agency staff report that some older Virginians first request services when a "crisis" situation exists, as described in Chapter II, additional case management services may be needed in the future to ensure that more vulnerable older Virginians receive needed long-term care.

SERVICES PROVIDED BY LOCAL AGENCIES HELP OLDER VIRGINIANS REMAIN IN THE COMMUNITY

In addition to Medicaid-financed services, home and community-based services offered by local departments of social services (DSS) and area agencies on aging (AAA) allow some older Virginians to receive needed care in their homes and communities. For example, according to the Virginia Administrative Code local DSS "adult services are designed to allow the adult to remain in the least restrictive setting and function as independently as possible." According to the Virginia Department for the Aging's (VDA) most recent strategic plan, AAAs are intended to "provide services to support frail, older Virginians in their homes for as long as possible in order to avoid institutionalization." The specific guidelines for service provision and eligibility are determined locally, and more information on these services is provided in the interim report for this study.

These services are supported with a combination of federal, State, and local funding. Total DSS adult services funding for FY 2004 was approximately $16.4 million, a decrease from approximately $18 million in FY 2002. This is primarily due to a decrease in State and local funding since 2002. Funding for VDA totaled $43.8 million in FY 2004, which represents an increase in funding over prior years. However, this increase results from a substantial infusion of federal funds, and State funding is now slightly lower than FY 2000 levels.

Although these services are generally not as comprehensive as those funded by Medicaid, nor are they designed to provide a comparable level of care, they are an important component of the services provided by State and local agencies to older Virginians. Local DSS and AAA services can enable older Virginians to remain in the community by preventing or delaying the need for more intensive and costly services. These services assist older Virginians and their caregivers by:

- Acting as a "stop-gap" when the resources of more suitable services have been exhausted;
- Bridging the time between the application for more intensive services and the actual receipt of those services; and
- Supplementing other types of care, such as informal caregiving or waiver services, thereby making these services more effective.

Available Data Indicate Unmet Demand for Local Agency Services

Data on unmet service demands for some local DSS and AAA services indicate that some older Virginians who are eligible for services are not served because of limited funds. For local DSS adult services programs, these data are gathered by the State DSS through an annual survey of local departments. This survey gathers data on the total number of persons who were unable to receive adult services for the year, as well as the length of service waiting lists. AAAs report similar data four times a year to VDA for six specific services. These data indicate

that there is extensive unmet demand for local DSS and AAA services in many parts of the State. There are flaws in how these data are maintained, but these problems most likely undercount the extent of unmet service demand.

Most Local DSS Offices Report Unmet Demand for Companion Care Services. In FY 2004, local DSS agencies reported providing in-home support services to 5,777 adults, 79 percent of whom were age 60 and older. The vast majority of these clients (93 percent) received companion care services, which provide in-home assistance with activities of daily living. On average, local DSS adult services clients received 12 hours of companion care services per week in FY 2004. The most recent available data on unmet demand for local DSS services indicate that 91 of the 120 local DSS agencies reported unmet demand for adult services for FY 2004. On average, 20 individuals were unserved in each local DSS. In total, the number of persons that adult services programs reported being unable to serve increased 25 percent from 2002 to 2004 (1,441 to 1,802). It is not known to what extent this increase is due to diminished local capacity to meet demands, or to changes in data collection methodologies.

According to local DSS staff, there is very little turnover within waiting lists for adult services. Staff from several different localities report that the most common reason for removing an individual from a waiting list for adult services is the death of a current service recipient. In some localities, a person would have to wait several months to receive agency services. In 18 localities, the waiting list for companion care in FY 2004 was between 10 and 12 months. Another 36 localities reported that their waiting list for companion care exceeded one year in length. Franklin County DSS staff reported having a have a two-year-long waiting list of 44 people. The demand for their services reportedly increases each year, but because people come off of the waiting list infrequently, it continues to lengthen.

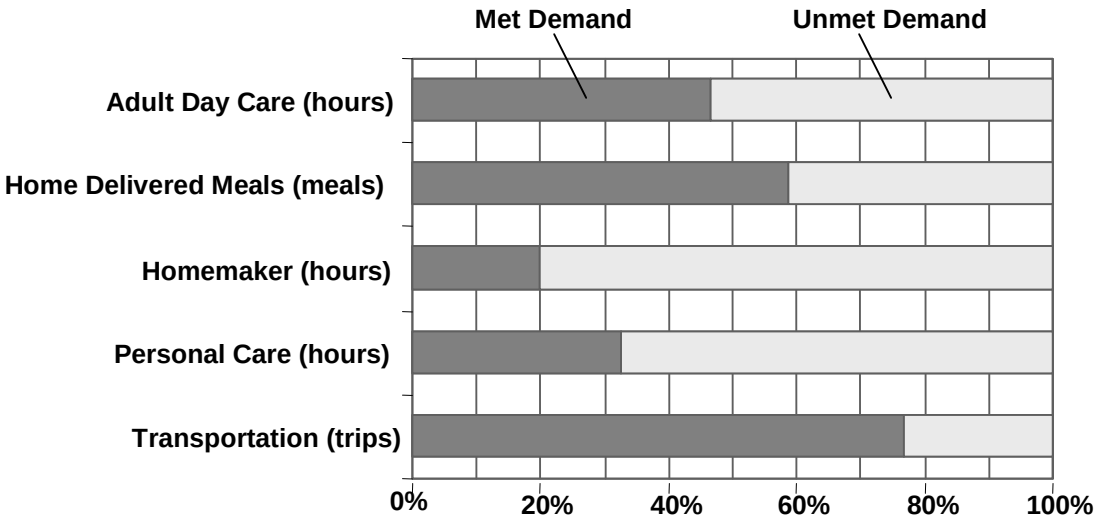
It is possible that some individuals who are not receiving a sufficient amount of companion care, or who are placed on a waiting list, may have to be placed in a more costly and restrictive environment instead. As noted by one State DSS staff member: "It's a delicate balancing act – providing enough services to keep them in the community, but still not providing all they need. When you lose the balance, you're looking at assisted living or nursing home placement."

Most Area Agencies on Aging Report Unmet Demand for Their Services. AAAs report data four times a year on the met and unmet demands of older Virginians who request their assistance. The AAAs report data to VDA on unmet demand for the six services deemed most critical: adult day care, home-delivered meals, personal care, homemaker, residential repair, and transportation. In federal fiscal year (FFY) 2004, AAAs reported providing nearly 165,000 hours of adult day care services, 2.6 million home-delivered meals, more than 282,000 hours of personal care and homemaker services, over 584,000 transportation trips, and repairs to 914 homes. These services were provided to older Virginians, their caregivers, and older caregivers of persons under the age of 60. For some of these services, however, the unmet demand for services exceeded met demand. For example, in FFY 2004 the estimated annual unmet demand for homemaker and personal care services exceeded annual met demand by more than 217 percent.

Figure 16 shows JLARC staff estimates of the total documented demand for each service by eligible older Virginians in FFY 2004. (Residential repair is excluded because of possible double-counting.) From FFY 2001 to FFY 2004, two of the five services indicated in Figure 16 had unmet demand that exceeded met demand: homemaker and personal care. In FFY 2003, adult day care also had unmet demand that exceeded met demand.

Figure 16

Proportions of Met and Unmet Demand at Area Agencies on Aging (FFY 2004)



Note: Estimates of demand were created by averaging the four monthly reports (January, April, July, and October) and multiplying by 12. Data refer to Title III programs only.

Source: JLARC staff analysis of Virginia Department for the Aging data.

The Demand For and Cost of AAA and DSS Home and Community-Based Services Are Likely to Increase

As the number of older Virginians increases in future years, it is likely that demand for AAA and DSS home and community-based services will also increase. Table 8 shows the number of older Virginians projected to be served by AAA and DSS home and community-based programs in future years, as well as the total cost of these services. These projections account for adjustments in Virginia's population age 60 and older, as well as an inflation factor of 4.2 percent per year. By 2030, the cost of providing these services to older Virginians and their caregivers could increase to $322 million.

In addition to projected future increases in the number of older Virginians, several other factors could increase the demand for local DSS and AAA home and community-based services. These include policies that emphasize the

Table 8

Projected Expenditures for Older Recipients of AAA and DSS Home-Based Services

Fiscal Year	Recipients	Expenditures ($ Millions)
AAA Services		
2004	57,538	$41.5
2010	71,828	66
2020	97,056	135
2030	117,721	247
DSS Adult Services		
2004	4,555	12.9
2010	5,542	20
2020	7,488	41
2030	9,083	75

Note: Projected expenditures for adult services recipients age 60 and older are based on a per capita cost for adult services recipients of all ages, because DSS does not maintain expenditure data by age.

Source: JLARC staff analysis of data provided by the Department of Social Services and the Virginia Department for the Aging.

deinstitutionalization of long-term care services and older Virginians' increasing preferences for receiving care in their homes. In addition, as discussed later in this chapter, unmet demand for Medicaid home and community-based waiver services due to eligibility criteria and cost-sharing requirements could increase demand for non-Medicaid services. Because the needs of waiver-eligible persons are more acute than what non-Medicaid services are designed to address, State policymakers could face increased demand to expand the scope and availability of AAA and DSS services. Finally, as indicated in Chapter II some local agencies use family members and friends to provide agency services, such as companion care, at a relatively low cost. If fewer individuals are available to provide these services in the future, agencies may have to rely more upon the costlier services of formal service providers.

Agencies Report Reducing Education and Outreach Efforts Because of Limited Resources

Outreach and education services ensure that older Virginians are aware of the services for which they are eligible and have the skills and knowledge to reduce preventable health conditions. Although local agencies provide information and educational materials to varying degrees, they report that these efforts are often scaled back when resources are limited. In addition, increased efforts could result in service demand that outpaces availability. As a result, local agency staff indicate that they often limit these efforts. However, limited outreach and education could

mean that existing waiting lists and unmet demands assessments may not reflect actual levels of need in the community and that preventable conditions are not addressed.

Local agency staff report limiting outreach because of existing waiting lists. For example, AAA and CSB staff interviewed in regional site visits to Richmond, Martinsville, and Southwest Virginia indicate that they do not want to promote services that they cannot provide. According to VDA staff, this is also true of the Virginia Public Guardian and Conservator Program, which is discussed in Chapter VIII. Additionally, education and outreach efforts are often limited to congregate settings, such as senior centers, churches, and support groups. The isolation, limited mobility, or lack of transportation options of many older Virginians could make them more difficult to reach through these approaches. Other factors may also make educating certain groups more difficult, such as language barriers.

Increased use of educational services could reduce the impact of an aging population on State and local agencies if it reduces the extent of preventable conditions. At present, resource constraints limit health education. In several parts of the State, staff from health departments, AAAs, and local DSS agencies identify a need for greater preventive education, indicating that existing efforts are not sufficient. Moreover, the need for more preventive measures has been recognized by the Virginia Board of Health, which recently adopted chronic disease prevention and control as its top priority. The Board Chairman notes that "Given the severe consequences for Virginia's economy and the quality of life of its residents, the Commonwealth cannot afford to ignore the threat posed by chronic disease."

Variations in Local Policies for Maintaining Data on Unmet Demand Hinder Comprehensive Assessment of Agencies' Service Capacity

There is no uniform statewide policy for how local social service agencies are to maintain their waiting lists, and it appears that there are inconsistencies in how the AAAs report data on unmet demand. These problems may limit the provision of services to persons who are in the most need and hinder the measurement of the extent of unmet demand.

Lack of State Policy Guidance on Local DSS Data on Unmet Demand Hinders Their Use. Although DSS advises local programs to update waiting lists at least annually, this does not appear to be carried out by all local programs, and approaches to updating waiting lists vary. For example, one local program annually mails notices to persons on the waiting list to make sure that they are still in need of services. Staff from two other local programs report relying upon obituary notices to keep their waiting lists current.

Additionally, DSS does not provide specific guidelines to local agencies for prioritizing the adults on their waiting lists. Such prioritization, however, could prevent some older Virginians from requiring adult protective services (APS) because of neglect or self-neglect. For instance, local agency staff report that APS is sometimes needed when individuals are not able to receive services for which they

are eligible, such as companion care. DSS workers in Franklin and Charles City counties and the City of Suffolk report that some individuals on waiting lists for companion care need APS when their conditions deteriorate to a point of neglect as they wait for services. State DSS staff agree that this occurs.

Waiting list data that are not updated, and an absence of policies for prioritizing individuals on waiting lists, may hinder effective service provision and lead to ineffective use of resources. Local agency staff report that the presence of waiting lists deters some older Virginians from seeking services and results in some persons remaining on waiting lists for longer than they should. To illustrate, a DSS adult services worker from Bath County estimates that "for every 20 who are on the waiting list, there are 20 who have declined to be placed on it" but who have requested services. If waiting lists appear longer than they actually are because they are not kept current, more people may be deterred from placing their names on the list than necessary. According to senior-level DSS staff, developing more specific guidelines for how local adult services programs are to maintain waiting list data would enhance State and local agencies' ability to measure unmet demand for adult services.

Limitations in AAA Data on Unmet Demand Hinder Analysis, But VDA Staff Report that Changes Will Be Made. The AAAs also appear to report data inconsistently, and limitations in existing data collection may hinder future policymaking. As mentioned above, AAAs report unmet demand data for six services four times each year. The six services were identified as the most critical AAA services, and the unmet demand reports are designed to produce a snapshot of "demand that was actually assessed, reassessed or requested during the month being reported." Further, AAAs are instructed to be able to tie each unit of unmet service demand to a single eligible individual.

The data appear to be reasonable indicators of the extent to which AAAs are unable to meet the demand for services requested by eligible individuals. However, there also appear to be several flaws that limit their utility for policymaking. VDA staff do not appear to audit these reports, and note on the published reports that "the Department is not responsible for the accuracy of the data provided by the Area Agencies on Aging." Moreover, AAAs may provide 25 or more services, and the decision to report unmet demand for only six services, and only for four months of the year, hinders a more comprehensive analysis of the unmet demands of older Virginians. VDA staff indicate that they will revisit the nature of their unmet demand reporting, and may broaden the list to include more services, or further refine the individual reports to indicate the nature of the unmet demand. For example, residential repair may be disaggregated into more discrete categories such as accessibility, roofing, or plumbing.

In addition, in interviews with AAA staff it became apparent that variations in the interpretation of VDA directions result in differing levels of reported unmet demand statewide. Staff at some AAAs indicate that they do not report unmet demand for services their agency does not provide. For AAAs that are organized as nonprofits, this interpretation seems straightforward. But for AAAs that are units of local government, and in which relevant services are provided by

another unit of that government, the interpretation is less clear. For example, staff at one AAA that is organized as a non-profit do not report data on unmet demand for adult day care although the AAA will use its funds to purchase this service, while staff at an AAA that operates as a unit of local government typically do not report unmet demand for transportation even though this service is provided by the local government itself. In contrast, staff at another AAA indicate they report unmet demand for housing repair services not provided by the agency if their case managers are aware of the demand.

Staff at several AAAs also report that they do not fully assess the needs of every older Virginian because of limited resources. Because only those persons who have been fully assessed can be reported to VDA, many people who are denied agency services are not counted in the unmet demand report. Some AAA staff report that they "go to the people who are easiest to serve and give them a Band-Aid." In other words, rather than keep people on a waiting list until their needs can be fully met, case managers will provide them with what limited assistance is available. These clients are counted as being "served," even though their needs have probably not been fully met. This notion of a "Band-Aid" approach to providing services is noted by staff from several AAAs, as well as staff from other local agencies.

Funding for Some AAA and DSS In-Home Services Has Reportedly Not Increased to Meet Growing Demand

Funding for DSS and AAA home and community-based services derives primarily from the Social Services Block Grant and Older Americans Act funding, respectively. According to program staff, funding for these services has failed to increase in proportion to the growth in service demand. Local DSS and AAA program staff indicate that the primary cause of the "Band-Aid" approach to service provision is the lack of funding for services. Budget constraints have reportedly caused some AAA staff to reduce their services, including discontinuing services for current recipients, as illustrated by these examples:

- The Waynesboro AAA is evaluating recipients of some services to see if they could have their services reduced or discontinued.

- The waiting list for in-home services at the Prince William AAA has recently grown because limited funding has caused them to discontinue serving some clients.

- The AAA in Southwest Virginia has asked some service recipients to accept a lesser amount of care so that AAA resources can be made available to serve persons on their waiting list.

DSS staff from some localities indicate that unmet demands are generally not the result of a lack of available in-home companion care providers, but result from an insufficient amount of funding to recruit new providers. For example, DSS staff in Southwest Virginia state that they have experienced an increased demand

for adult services, but their limited funding allocations prevent them from hiring new providers because they cannot offer a competitive wage.

Additionally, funding constraints limit the number of in-home service hours that a DSS client can receive each week – the maximum number of weekly service hours is determined at the local level and is based on the amount of adult services funding allocated to the local program from DSS. According to DSS staff from the West Piedmont Planning District, adult services clients receive "the bare minimum," and not the number of hours for which they are qualified.

Finally, as part of a related study on the operations of the State's social services system, JLARC staff administered a survey of all local departments of social services, to which 82 percent of all departments responded. The majority of local departments reported that funding for adult services is somewhat (41 percent) or not sufficient (38 percent) to support program operations. Further, 84 percent of responding agencies reported that funding levels limited the number of clients that could be served through the adult services program.

It appears that some local AAA and DSS programs are able to maintain current service levels primarily because of local government support. Data collected by VDA indicate that local governments provided $15.2 million to AAAs in FFY 2004. According to DSS data, local contributions for DSS adult services totaled approximately $6.2 million in FY 2004. This amount has averaged $7.2 million, or between 40 and 50 percent of all funding, for these services since FY 2000. This total reflects required local match contributions, which are equal to 20 percent of federal funding, as well as voluntary local support. It should be noted that voluntary local funding is not required to be reported to DSS, and DSS cautions that this number is "significantly understated."

Much of the funding for AAA and DSS home and community-based services derives from federal and local funding. In order to address both current and future levels of unmet service demand, additional funding may be needed. Given the static nature of federal support, additional State resources may be required as the size of the older population increases.

MEDICAID HOME AND COMMUNITY-BASED WAIVER SERVICES ARE AN ALTERNATIVE TO NURSING HOME PLACEMENT

Local agency staff estimate that, when given the choice of home and community-based Medicaid waiver services over nursing home care, 75 to 99 percent of older clients choose waiver services. Nearly all waiver recipients age 60 and older are enrolled in the Elderly or Disabled with Consumer Direction (EDCD) waiver. Several factors, such as projected increases in the number of older Virginians and an emphasis on the deinstitutionalization of long-term care, are likely to lead to an increase in older Virginians' demand for these services. This could cost over $1 billion by the year 2030.

Based on observations made by local agency staff, it appears that not all older Virginians who are determined to be eligible for EDCD waiver services are able to receive them. Local and State agency staff, as well as providers, indicate that a primary reason for older Virginians' unmet demands for these services is the State's requirement that they contribute all of their monthly income in excess of $579 to the cost of their care. For some older Virginians, this is reported to make the costs associated with living in the community unaffordable. If demand for these services by older Virginians increases, State policymakers may need to reduce or eliminate these cost-sharing requirements. However, this would increase State expenditures for EDCD waiver services.

Current and Projected Future Costs of the Medicaid EDCD Waiver

To be eligible for waiver services, in addition to meeting the income and resource criteria that apply to Medicaid recipients in institutions, individuals must be determined by local eligibility screening staff to be *functionally* eligible to receive comparable institution-based care. In the case of the EDCD waiver, this means that an applicant must meet the functional criteria required by Medicaid for nursing facility services. Broadly, eligibility for Medicaid-funded nursing home care in Virginia is defined as having an ongoing medical nursing need accompanied by dependency in at least two of seven activities of daily living, and at least semi-dependency in mobility, behavior, and orientation.

The EDCD waiver was created in 2005 by combining the Elderly and Disabled waiver and the Consumer-Directed Personal Assistance Services waiver. Because the most recent available data on older waiver recipients is for FY 2004, the data discussed in this section refer to the recipients of those two waivers. It should be noted that because an individual may only be enrolled in one waiver at a time, these data are unduplicated. Of the 13,038 recipients of these two waivers in FY 2004, 75 percent (9,825) were age 60 or older. In addition, older recipients of these two waivers accounted for 70 percent ($132 million) of the State and federal funds spent on these services FY 2004.

As noted in Table 9, costs for older recipients of the EDCD waiver could increase to between $481 million and $1.39 billion by the year 2030. These estimates are based upon the Medicaid projections created by DMAS staff, which were discussed in Chapter III. As such, the low-cost estimate for each year assumes that increases in waiver recipients will reflect recent growth rates in the number of older Medicaid enrollees. These figures are also adjusted for inflation at an annual rate of 4.2 percent. The higher estimate for each year assumes that Medicaid enrollment will increase at the same rate that the number of older Virginians increases as a proportion of the State's overall population. These estimates are also adjusted for medical price inflation at a rate of 6.5 percent per year.

When offering home and community-based services through a waiver, states establish a limit on the number of individuals that can be served. Virginia has currently set this limit at 10,579 recipients for the EDCD waiver. According to DMAS staff, the enrollment limit for the EDCD waiver is intended to be set so high

Table 9

Expenditure Estimates for Medicaid Elderly or Disabled with Consumer Direction (EDCD) Waiver Recipients Age 60 and Older

Fiscal Year	Estimated Range ($ Millions)
2004	$132 *
2008	162 – 177
2010	179 – 213
2020	293 – 565
2030	481 – 1,393

*Actual expenditure for recipients age 60 and older of the former Consumer-Directed Personal Assistance Services and Elderly and Disabled waivers, which were combined in 2005 to become the EDCD waiver.

Source: JLARC staff analysis of Department of Medical Assistance Services data.

that it will never be reached, "so that we don't have waiting lists and, therefore, steer people to higher cost institutional care." Demand for these services is likely to increase, however, given future projected increases in Virginia's older population and policies that emphasize deinstitutionalization and home-based care. It is therefore possible that EDCD waiver enrollment limits will eventually be reached. At that time, according to DMAS staff, "the decision would need to be made about increasing the number of available slots in order to avoid waiting lists." Therefore, the direct impact of older Virginians' future demands for Medicaid waiver services will be affected by whether or not the State continues to maintain enrollment limits that exceed the likely number of waiver recipients, as is currently the case.

Several other factors in addition to a potential increase in older Virginians' demand for EDCD waiver services may impact future costs. For example, changes to federal Medicaid spending could result in the State paying a greater share of Medicaid expenses than it does now. In addition, if the availability of family caregivers decreases in the future, as mentioned in Chapter II, State policymakers may need to increase the scope of waiver services, such as the maximum number of personal care hours that an individual can receive. Further, as housing costs and other expenses associated with living in the community increase, more older Virginians may be affected by the requirement that waiver recipients contribute to the cost of their care, as discussed in the next section.

The Patient Pay Requirement of the EDCD Waiver Program Was the Most Frequently Cited Reason for Older Virginians' Unmet Demands

Some recipients of Medicaid waiver services must contribute to the cost of their care through an expenditure known as the "patient pay." Individuals who are subject to these cost-sharing requirements have incomes that are too high to receive these services solely at Medicaid's expense, but they cannot afford private service rates. However, interviews with local agency staff, as well as providers, indicate

that some older Virginians cannot receive Medicaid services for which they are eligible because they cannot afford the patient pay. One social worker described these older Virginians as constituting a "hidden waiting list" because they refuse to go into a nursing home and instead stay at home until adult protective services is called.

For the EDCD waiver, which is the waiver program primarily used by older Virginians, the State has set an individual's patient pay as equal to any income in excess of the monthly Supplemental Security Income (SSI) level for one person. The SSI level is adjusted annually by the federal government and is set at $579 per month in 2005. The State therefore allows a waiver recipient to keep $579 of his or her monthly income as a "personal maintenance allowance" (PMA) to pay for his or her housing costs, transportation, food, clothing, and all other expenses that are not covered by Medicaid. The remaining income must be paid to the home and community-based service provider. Most recent available data indicate that, in 2000, only nine other states had a PMA as low as Virginia's.

Information provided by DMAS indicates that in FY 2002, 79 percent of waiver recipients did not have a patient pay, because their incomes were not above the monthly PMA amount of $545 (which was the SSI rate for a single individual in 2002). However, this percentage is likely a low estimate of the proportion of waiver recipients who were assigned a patient pay that year. This percentage is based on a DMAS analysis of Medicaid reimbursement claims submitted to the agency by Medicaid providers and, according to DMAS staff, providers do not systematically indicate in their claims whether a Medicaid recipient has been assigned a patient pay. In addition, local departments of social services do not report the names of waiver recipients who have been assigned a patient pay. Moreover, this figure does not account for the number of waiver-eligible persons who decline services because of the burden of the patient pay, since the State does not collect these data. DMAS staff acknowledge awareness of instances in which people "refuse to receive waiver services because they can't afford the patient pay amount."

Local Agency Staff Report that the Patient Pay Is a Barrier for Some Older Virginians. According to pre-admission screening (PAS) teams in several areas of the State, many older Virginians turn down Medicaid services once they learn they have a patient pay amount (which can be estimated prior to a screening). Local agency staff give the following estimates of how frequently individuals declined Medicaid home and community-based services due to the patient pay requirements:

Isle of Wight DSS	12 to 15 percent
Virginia Beach DSS	12 to 15 percent
Metro Richmond AAA	12 to 15 percent
Pittsylvania-Danville Health District	25 percent
Prince William Health District	25 percent
Waynesboro Health	25 percent
Patrick County DSS	30 percent
Franklin County DSS	50 percent
Alexandria DSS	75 percent

The City of Richmond's PAS team reports that from September 2004 to August 2005, 19 clients who were screened for Medicaid home and community-based waiver services could not afford the patient pay. They inform JLARC staff that:

> Some people meet the criteria for Medicaid long-term care services, but cannot afford the care because of [the] conflict between a co-pay and their living expenses. We are coming across more and more people lately who need the care, but because of [the] co-pay, rent/mortgage, utilities, etc. cannot afford it.

These staff provided specific examples of cases in which clients were unable to receive needed waiver services because of the patient pay.

> *Ms. A is a 63 year old who requires total care due to Gillian-Barre Syndrome and anoxic brain damage. She is bed bound, and must be moved by Hoya lift. She also has a catheter, is incontinent, is tube fed, and requires total care for bathing and dressing. A relative is staying with her as a caregiver, but needs assistance in providing care. Ms. A meets the criteria for Medicaid community-based waiver care. Her income is approximately $1,200 a month from a combination of Social Security and disability benefits. She would therefore have a patient pay. Her monthly expenses are $440 for rent, $75 for utilities, and $45 for phone. These expenses total $560 a month, leaving her $19 for such expenses as food and clothing. Ms. A cannot afford the Medicaid community-based care.*
>
> * * *
>
> *Mr. B is a 68 year old who has had brain surgery to remove a blood clot. He needs assistance with bathing, dressing, feeding, moving in and out of bed or a chair, and has some bladder incontinence. A friend is helping Mr. B, but needs relief in providing care. Mr. B meets the criteria for Medicaid community-based waiver care. His income is $721 a month Social Security, and he would therefore have a patient pay. His monthly expenses are $500 for rent, and $77 for non-medical insurance. These two expenses alone total $577 a month, leaving him $2 for all other monthly expenses. Mr. B cannot afford the Medicaid community-based care.*

In Some Cases, the Patient Pay May Result in Additional Burdens on Local Agencies. The resources of local agencies appear to be affected by older Virginians' inability to access needed wavier services as a result of the patient pay. For example, staff from one Northern Virginia DSS office report using adult services funding to cover the patient pay for several clients. In addition, both DSS and AAA staff report that some of their in-home services recipients, or clients on waiting lists for these services, are eligible for Medicaid EDCD personal care services, but decline to enroll because of the patient pay. The Senior Services AAA in Tidewater reports that 25 percent of its in-home services clients were actually eligible for Medicaid personal care. Agency staff from other localities report this to be true of six, ten, or up to 20 percent of their in-home services clients. It appears, therefore, that DSS

and AAA in-home providers sometimes serve clients whose needs are more acute than their agencies' services are intended to address. Additionally, if clients who could be receiving these services through Medicaid are using DSS and AAA resources instead, unmet demand could result for other older Virginians who could more appropriately benefit from DSS or AAA services.

In addition to a lack of data on the proportion of waiver recipients who have a patient pay and the extent to which it prevents persons from affording needed services, there are also no data on the consequences of these unmet demands for individuals or the State. However, an inability of older Virginians to receive Medicaid waiver services may result in a short-term impact upon local expenditures and a longer-term impact upon State Medicaid expenditures. According to local agency staff, possible impacts upon local agencies include:

- Increased demand for other local agency services such as DSS or AAA in-home services, for which Medicaid does not reimburse, and which are generally not designed to address the more acute needs of waiver eligible persons;

- Increased referrals to adult protective services;

- Requests for repeated eligibility screenings as needs grow more acute; or

- Use of rescue squads for non-emergency transportation.

These impacts are borne primarily by local agencies. However, since local governments and agencies determine the type and extent of their local services, and since many agencies contacted by JLARC staff report having waiting lists, older Virginians who would be eligible for Medicaid waiver services may not be able to receive other services instead. As a result, over a longer time frame these older Virginians may require State-funded nursing home services more quickly than if they had been able to receive care in the community. This consequence may not have a fiscal impact on the State in every instance, but it is likely that the individual's quality of life would be diminished.

Housing Costs Were Reported to be the Primary Reason Why Medicaid Services Were Turned Down. Local agency staff throughout the State report that the PMA is insufficient to allow older Virginians to remain in the community primarily because it does not realistically account for housing costs. This outcome is recognized by State agency staff as well. According to a staff member at DMAS, "A PMA of $579 is not high enough to cover rent or mortgage, utilities or any of the other basic necessities of day to day living." As indicated in Chapter IX, Census data indicate that 32 percent of all renters in Virginia age 85 and older pay more than 50 percent of their income on housing costs. In Northern Virginia, social services and health department staff report that because of the low level of the PMA, older Virginians can only afford to receive Medicaid personal care if they live with family or in publicly subsidized housing. There are also waiting

lists for publicly subsidized housing in some parts of the State, including Northern Virginia, as discussed in Chapter IX.

To further investigate the potential impact of housing costs, JLARC staff compared data on fair market rents obtained from the Virginia Housing Development Authority (VHDA) to the PMA amount of $579 per month. As of October 2004, 47 Virginia localities were determined to have a fair market rent value for a one-bedroom housing unit in excess of $579 per month. In 2005, the Center for Housing Policy found that an individual would need to earn an hourly wage of $13.87 and work a 40-hour work week to afford a one-bedroom apartment priced at the Richmond metro area's fair market rent of $721. An income of $579 per month, equal to the PMA, equates to an hourly wage of $3.61, only about a quarter of the hourly wage needed to afford that type of housing in the area, and $1.50 less than the federal minimum wage.

It should be noted that the federal government does not permit adjustments to the PMA to reflect variances in costs of living within a state. Further, although deductions from the patient pay are permitted for medical expenses that Medicaid does not cover, federal regulations do not allow such deductions for other necessities, such as housing costs. Federal Medicaid policy does, however, permit states to set the PMA at a maximum of 300 percent of SSI ($1,737 in 2005). Virginia does permit EDCD waiver recipients who have "earned income" or are working to keep up to this amount as a PMA. This is not likely to apply to many older Virginians, however, especially if their needs are acute enough to be eligible for nursing home care.

The PMA May Need to Be Raised If Demand for Home-Based Care Continues to Increase. If the number of older Virginians requiring some form of long-term care increases, and if the preference for home and community-based services instead of institutional care continues to increase, then there may be an increase in the number of persons who are eligible for Medicaid but who cannot receive services because of the PMA. An increase in the cost of housing may also contribute to a need to raise the level of the PMA.

Other organizations have previously expressed concern about the PMA, including the Joint Commission on Health Care, which reviewed the adequacy of the PMA in 2003. This review resulted in the submission of budget amendments from both houses of the 2004 General Assembly to increase the PMA to 150 percent of SSI. Amendments were also introduced by members of both houses of the 2005 General Assembly to increase the PMA to 300 percent of SSI for all recipients. Because the income threshold for obtaining eligibility for these services is equal to 300 percent of SSI, this increase would effectively eliminate the patient pay for all recipients. This would also reportedly reduce the burden on local DSS staff who must make periodic adjustments to individuals' patient pay amounts to reflect Social Security cost of living adjustments, or COLAs. The fiscal impact of the proposed increase in 2005 was estimated to be between $4.3 million and $4.5 million in general funds, or 0.24 percent of all general fund expenditures for Medicaid in FY 2004. These amendments were not included in either Session's final budget.

Increasing the PMA to 300 percent of SSI for all recipients may be a cost-effective approach to ensuring that individuals receive needed in-home services, particularly if this results in avoiding or delaying more costly nursing home placement. This could amount to $7,629 per person, which DMAS estimates is the difference in annual cost between nursing home and waiver care. If raising the PMA to 300 percent of SSI would make waiver services an affordable alternative to nursing home care for even two percent of the State's Medicaid nursing home residents (590 individuals), the State could save $4.5 million – equivalent to the estimated general fund cost of increasing the PMA to 300 percent of SSI. It should be noted, however, that this savings could be offset by increased enrollment in the waiver program by persons who could not have afforded waiver services because of the patient pay, but would have refused nursing home placement as an alternative. According to several senior-level DMAS staff, the agency would support raising the level of the PMA to 300 percent of SSI for EDCD waiver recipients, thereby eliminating the patient pay for the EDCD waiver, if the General Assembly appropriates the general funds required to cover associated expenditures.

CASE MANAGEMENT SERVICES MAY NEED TO BE EXPANDED IF THE USE OF HOME AND COMMUNITY-BASED SERVICES INCREASES

Case managers assess clients' needs and resources, develop and implement plans of care, and monitor the delivery of services to clients. Several State and local agency staff state that the increased availability of formal case management services would improve access to needed services by older Virginians and possibly prevent the future need for more expensive or restrictive services. Although some programs for older Virginians include formal case management services to identify needs and ensure that individuals receive the most appropriate services, this is not the case for all programs, including the EDCD waiver program. Many approaches to case management are instead ad hoc, informal, and inconsistently available. Additionally, formal approaches to case management are not available in all parts of the State, and eligibility criteria as well as local priorities restrict access to these services.

Long-Term Care Pre-Admission Screening Teams in Some Localities Provide Informal Case Management

In Virginia, eligibility for Medicaid-funded long-term care is determined by pre-admission screening (PAS) teams, which consist of a public health nurse and physician, and a local DSS social worker. The sole purpose of this screening, as defined in §32.1-330 of the *Code of Virginia*, is to determine eligibility for "community or institutional long-term care services." This screening primarily includes the completion of a Uniform Assessment Instrument (UAI) for the individual. According to statute, the DMAS PAS provider manual, and anecdotal reports from PAS team members, there is no requirement that PAS teams perform any type of assistance or case management to persons screened through the EDCD waiver, beyond giving the client a list of local Medicaid providers. Therefore, individuals who are screened, or their caregivers, must locate a Medicaid provider themselves and arrange for the receipt of services. While having to arrange for one's

own care may not be overly burdensome for all PAS clients, it may be challenging for individuals who seek Medicaid services in response to an emergency situation that the family cannot manage. According to local PAS staff, such scenarios are common and often involve a sudden decline in either the caregiver's or dependent's health status.

In some localities, PAS teams state that once the screening has been conducted, they do follow up with the client to determine whether they have successfully enrolled with an appropriate service provider. In these cases, PAS members report that case management becomes the responsibility of the Medicaid provider agency. As noted in the DMAS provider manual for the EDCD waiver, one responsibility of the personal care provider is to monitor "the recipient's need for support" in addition to care provided by that agency. The PAS team from Prince William County reports providing very little case management, and that they frequently receive repeat phone calls because people "bounce from agency to agency." These staff state that they close the case once they have provided the client with a list of available providers, and that people who "fall through the cracks" will eventually be referred to APS or to the AAA for case management services. As indicated below, the availability of AAA case management services is limited.

In contrast, some PAS teams provide various levels of case management to ensure that needed services are put into place. The provision of this additional assistance appears to result from past experiences in which clients required additional assistance to locate services. DSS staff from Waynesboro and Harrisonburg characterize it as a way to prevent clients from becoming APS cases. For example:

- The PAS team for the City of Richmond reports assisting their clients with the completion of Medicaid applications and assisting every person they screen with accessing needed services.

- PAS teams in the central Valley area contact the personal care agency to check the availability of staff before sending the required paperwork to allow the agency to initiate services;

- DSS staff from Tidewater assist clients in locating and arranging services if they find out that the client has been unsuccessful.

- In far Southwest Virginia, PAS cases remain open for up to 90 days. The PAS teams make sure that the provider agency has contacted the client, assist people with obtaining services, identify other needs clients may have, and connect them to appropriate community resources.

JLARC staff reviewed the concerns of local PAS teams with senior DMAS staff, who state that these types of case management services are part of the expected role of social workers in general. DMAS staff also state that they were not aware of any instances of individuals being referred to APS as a result of not being able to locate a personal care provider. As previously noted, however, the *Code of*

Virginia and the DMAS PAS provider manual do not require PAS teams to provide any assistance to clients beyond assessing their eligibility for Medicaid long-term care services and furnishing them with a list of available local providers. Senior DMAS staff indicate that the State should begin to take greater steps to ensure that appropriate services are received in an efficient manner, as discussed later in this section.

Medicaid Funding for Pre-Admission Screenings Was Recently Reduced. All PAS teams are reimbursed $100 by DMAS for each screening. This reimbursement level has remained the same since the program's inception in 1977, and is only intended to cover eligibility screening, not case management services. Teams that provide case management do not receive any additional funds. Based on interviews with PAS teams, it appears that the majority of additional follow-up or case management work that is done by PAS teams is conducted by the DSS social workers, who have historically received $31 of the $100 reimbursed to localities. However, as of June 2005, DSS reimbursements have been decreased to $23.25 as a result of federal directives.

Although the federal government determines its share of the overall reimbursement amount, the State could increase the overall amount of the screening reimbursement and leverage additional federal funds. According to DMAS staff, increasing the reimbursement rate would have to be justified by the workloads of screening staff. Senior DSS staff point to the increased burdens that have been placed upon screeners by deinstitutionalization policies and the growing number of older adults as justification for an increase in the reimbursement rate.

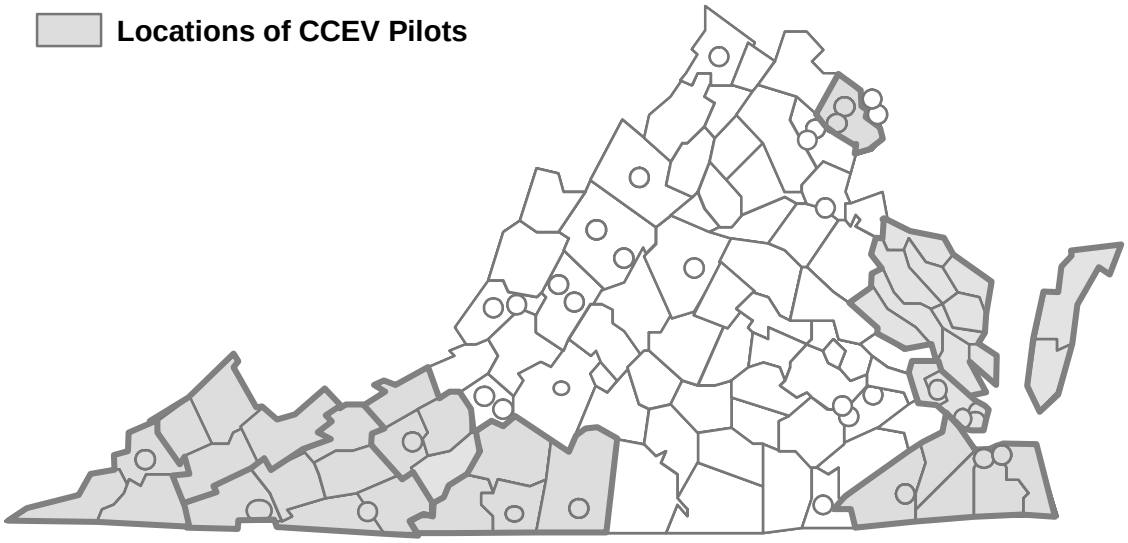
Some AAAs Provide Case Management to Their Older Clients

In addition to the informal case management provided by some PAS teams, most of the 25 AAAs provide some form of case management as well. In 1991, a case management pilot project – Care Coordination for Elderly Virginians (CCEV) – was implemented under the direction of the Virginia Long-Term Care Council in the 10 planning districts shown in Figure 17. (The Long-Term Care Council was created by the General Assembly in 1982 as part of the Commonwealth's policy to "support the development of community-based resources to avoid inappropriate institutionalization of the impaired elderly." The body was allowed to sunset in 1995.) The goals of the CCEV project were to target resources to older persons at the highest risk of institutionalization, coordinate the delivery of multiple services, and support family caregiving. The CCEV program is still in place and is operated by case managers who are usually AAA staff. This program is funded through VDA and Medicaid and requires that recipients be dependent in at least two activities of daily living. In addition, recipients must demonstrate that, without case management, they could not "reside safely in the community."

However, because the Medicaid portion CCEV pilot project was never expanded, only those ten sites can receive Medicaid funding, which is carried out through Medicaid's Targeted Case Management for Elderly Virginians program. AAAs that did not participate in the pilot provide case management either through

Figure 17

Locations of Care Coordination for Elderly Virginians (CCEV) Pilots



Source: JLARC staff analysis of Virginia Department for the Aging data.

Older Americans Act (OAA) funds, State general funds, or local funding. Eligibility guidelines for receiving OAA or State-funded case management are similar to those established for the Medicaid program.

Some AAAs report that State and federal eligibility guidelines for the receipt of case management are too strict and, as a result, they have expanded eligibility for their case management programs using local funds. For example, the Prince William AAA staff state that the agency does not provide Medicaid-funded case management because it was "frozen out of the original pilots." The AAA has instead developed a local definition of case management that emphasizes the lack of adequate caregiver support over the number of ADLs. The AAA in Southwest Virginia, one of the original CCEV pilot sites, has developed a similar approach to case management that focuses on caregiver support. The AAAs in Petersburg and Charlottesville also provide a less restrictive form of case management to their clients.

Additional Case Management May Be Needed If Demand for Home and Community-Based Services Increases

In addition to AAA case management, the State provides case management to clients of other human services agencies. The Department of Rehabilitative Services provides formal case management to initially assist clients with securing needed personal assistance services or enrolling in State benefits programs such as

Medicaid. The State also provides Medicaid-funded case management to persons diagnosed with a mental illness or mental retardation in the community, through the community services boards.

Because the federal government permits states to include case management services in their waiver programs, there are federal matching funds available for providing this service to EDCD waiver recipients. According to senior DMAS staff, however, the agency is pursuing federal funds to develop a comprehensive approach to case management for all long-term care recipients. DMAS staff indicate that this approach will attend to both long-term care and acute care needs and, if implemented, will address the need for some PAS clients to receive additional assistance in arranging for their long-term care services.

While the provision of case management services for older Virginians should be uniform and consistent, one of the recommendations of the CCEV pilot project participants was that the State not take a "cookie cutter" approach across localities. Rather, in a 1994 report on case management for long-term care services, the Secretary of Health and Human Resources stated that "there is the need for some policies and procedures to be standardized across all case management services and others which should be left to local discretion." Any initiatives to expand and formalize the availability of case management services to older adults may benefit from incorporating this recommendation.

The PACE Program Is One Alternative to Case Management. One approach the State has taken to providing long-term care services that is akin to case management, and which DMAS staff describe as similar to the acute care/long-term care service delivery system just described, is the Program of All-Inclusive Care for the Elderly (PACE). PACE is jointly funded by Medicaid and Medicare and is geared toward assisting older persons who meet admission criteria for nursing facilities to remain in their homes and communities. PACE is considered a comprehensive service program, providing various types of services across different settings. Services include home health and personal care, prescription drugs, social services, and transportation, among others. One hallmark of the PACE program is an interdisciplinary team of providers that includes a physician, social worker, and therapists, among others.

Although Virginia's only PACE site is in Virginia Beach, providers in other areas of the State, including Northern and Southwest Virginia, are working toward becoming PACE sites. According to local staff interviewed by JLARC, however, one obstacle to establishing a PACE program is the start-up funding required. This obstacle may be alleviated, however, by the Community Options for Rural Elders (CORE) Act. This legislation was introduced in the U.S. Senate in May 2005 and proposes to assist providers in rural areas with the development of PACE sites, including the provision of start-up funds. If this Act does not become law, however, State policymakers may choose to provide start-up funding on a pilot basis.

Case Management May Be Improved Through Use of New Technology. The State is providing technical assistance and support for the implementation of a new web-based case management and information and referral

system for older Virginians being managed by Virginia's Senior Navigator program. This initiative, the Community-Based Coordinated Services project, was developed in tandem with the Secretary of Health and Human Resources' "No Wrong Door" initiative, and is intended to improve access to services for older Virginians and their caregivers. VDA received a $768,000 federal Aging and Disability Resource Center grant to assist with the development of this initiative. At the present time, no State funding is being used to implement the project. The project will be implemented in Virginia in three pilot communities (Peninsula, Central Shenandoah Valley, and Greater Richmond) in 2006. A new case management information system is also being implemented at DSS for adult services and adult protective services clients, which DSS states will "provide more and better information on service needs and delivery."

VIII. Services for Vulnerable Older Virginians Are Limited

State and local agency staff report that they are not always able to provide adult protective services and long-term care ombudsperson services, and that the availability of public guardianship services is also limited to serving individuals in only 54 of Virginia's 134 localities. Each of these services is critical because older Virginians who qualify for these services are some of the most vulnerable citizens in the Commonwealth. For example, according to a DSS document, adult protective services are provided to older persons and persons with disabilities "who are in danger of being mistreated or neglected, are unable to protect themselves, and have no one to assist them." The Long-Term Care Ombudsman program, a requirement of the federal Older Americans Act, responds to complaints made by individuals receiving long-term care services who may have no one else to advocate on their behalf. Individuals who qualify for public guardians are incapacitated, indigent, and have no one else to serve in this capacity. In many cases, these services are used as a last resort. Finally, demographic changes discussed throughout this report could result in growing demands for these services in the future.

UNMET DEMAND FOR ADULT PROTECTIVE SERVICES IS PROJECTED TO INCREASE

A lack of adult protective service (APS) funding, or limited availability of services that can be purchased through APS, appears to result in unmet demand by some of the most vulnerable citizens in the Commonwealth. As discussed in the interim report, APS programs are administered by local departments of social services. Local departments investigate complaints of abuse, neglect, and exploitation of adults age 60 and older, and incapacitated persons age 18 to 59. The majority (72 percent) of APS cases in 2004 involved older individuals.

APS referrals come from a variety of sources, including relatives, human service agencies, long-term care providers, health care staff, or the individuals being mistreated. Local APS staff investigate all valid reports, and assess the need to provide or purchase services such as companion care or homemaker services, adult day care, home-delivered or congregate meals, transportation, or emergency shelter placement to stop and prevent further mistreatment or self-neglect. Although DSS is required to investigate each APS case, Section 63.2-1605 of the *Code of Virginia* states that local departments shall provide services "to the extent that federal or state matching funds are made available to each locality."

In some cases, APS investigations involve the cooperation of other investigators such as law-enforcement agencies, the licensure divisions of State agencies, and other service agencies. In addition, cases of criminal or sexual abuse are referred to local law enforcement and Commonwealth's Attorneys. Most cases are not the result of abuse, however. In FY 2004, only eight percent of APS cases were the result of abuse, while 46 percent of cases were the result of self-neglect,

which occurs when individuals are not able to provide for themselves or maintain their physical and mental health. However, in 1996 the National Elder Abuse Incidence Study estimated that only 21 percent of all incidents of abuse, neglect, or self-neglect of individuals age 60 and older are reported to APS each year.

Current APS Funding Is Reported to Be Inadequate

Although total funding for APS has remained relatively consistent over the last few years, it appears that the current funding level may not be adequate to meet existing demand. In addition, the ability of local DSS staff to provide APS services also appears to be affected by the availability of local service providers. Funding for local APS programs has come from a mixture of federal, State, and local sources, and in FY 2004 total expenditures were approximately $1.1 million. According to DSS data, total funding and total APS reports remained relatively consistent over the past five years. State DSS staff indicate that although they have been able to maintain funding levels for APS and adult services, "inflation is eroding the value of the dollar."

Although funding is provided to local departments to investigate all APS referrals, local APS staff report that they are limited in their ability to meet the service needs of their clients. For example, local APS workers in some areas of the State report that they do not have adequate funds or staff to meet existing need:

- DSS staff in Alexandria report that they run out of APS money within the first four months of the fiscal year.

- DSS staff in Southwest Virginia describe having to "nickel and dime" their APS funds to handle emergencies.

- Staff in the Martinsville area state that if they were to provide the level of services that individuals need, they would run out of APS funding in the first couple months of the fiscal year. As a result, they provide "Band-Aid" solutions that do not meet all of a client's needs.

As part of a related study on the operations of the State's social services system, JLARC staff administered a survey of all local departments of social services, to which 82 percent of all departments responded. Most local departments rate overall funding for APS program operations (client benefits and purchased services) to be only somewhat sufficient (41 percent) or not sufficient (32 percent), while only 26 percent report funding to be sufficient. Additionally, 35 departments report that funding levels have limited the number of clients served over the last five years.

Senior State DSS staff agree that current funding levels could mean that individuals are not receiving all the services they need. They emphasize that local departments strive to investigate all valid reports, but acknowledge that limited local APS staffing and funding make it difficult to provide services to adequately prevent, stop, or alleviate all incidences of abuse, neglect, and exploitation. For

example, after an APS investigation, individuals may receive DSS companion care or other adult services in order to prevent further neglect or mistreatment, but limited APS funding does not usually permit the local department to purchase all the services needed by the individual. In addition, as indicated in Chapter VII, 38 percent of local departments report on the JLARC survey that adult services funding, which can be used to purchase needed services for APS clients, is not sufficient to support program operations. Inadequate funding for APS purchased services, coupled with waiting lists for the adult service companion care program, could mean that clients are not receiving the services they need through either program.

Although it appears that most unmet demand for APS results from a lack of funding to purchase services, APS may also be limited by the availability of local service providers. This is because APS workers develop service plans for their clients based on the local availability of service providers, both formal and informal. To the extent that availability varies across the Commonwealth, APS workers may be limited in their ability to meet their clients' needs. For example:

- DSS staff in Northern Virginia indicate that there are not enough affordable assisted living facilities, yet 65 to 70 percent of their APS caseload need placements in those facilities.

- In addition, local staff also report that non-governmental providers are not always able to provide services, especially on an on-going basis for the neediest clients. For example, AAA staff in Martinsville state that they receive client referrals from nonprofits, such as the Salvation Army.

In cases where services cannot be purchased because of limited funding or local services, APS workers may provide services directly or organize informal community support for individuals. For example, local APS workers in Northern Virginia indicate that there have been instances in which social workers had to clean the homes of clients who hoarded (collected and stored a large quantity of something) because there were not enough APS funds to purchase a cleaning service.

The Number of APS Reports Is Projected to Increase

Demographic and policy changes could mean increased demand for APS in the future, and meeting increased demands could be challenging without a commensurate increase in funding. For example, based on projected increases in the number of older Virginians, the number of APS reports for individuals age 60 and older is projected to increase by approximately 110 percent by the year 2030 (Table 10). Other demographic changes that affect the living arrangements of older Virginians such as changes in the proportion of individuals living alone, marriage rates, divorce rates, or birth rates could also impact APS through changing rates of abuse, neglect, or exploitation, or the availability of people to report such incidents. In addition, local departments of social services report that a growing number of

Table 10

Projected Number of Adult Protective Services Reports

Year	Total APS Reports	APS Reports for Age 60 and Older
2000-2004 Average	11,403	8,245
2010	14,605	10,561
2020	19,734	14,270
2030	23,936	17,308
Total Increase	**12,533**	**9,063**

Note: The 2000-2004 APS figures were calculated by averaging the total reports for those years based on DSS program reports data. The number of APS reports was then applied to Census estimates of the total population and the 60 plus population, which were averaged for those years. These proportions were applied to population projections to estimate future APS reports.

Sources: JLARC staff analysis of VDSS APS report data for 2000-2004 and data from the U.S. Census Bureau (Interim State Population Projections, 2005).

adults retiring to Virginia away from their informal support networks may become increasingly vulnerable to financial exploitation.

In addition to changing demographics, policy changes could also affect the number of APS cases. For example, the 2004 General Assembly passed legislation that expanded the categories of professionals that are required by law to report suspected APS cases. Mandatory reporters include people who provide long-term care services, hospital workers, social workers, mental health professionals, and law enforcement officers, among others. In FY 2004, mandated reporters filed 52 percent of all APS reports. While the impact of the legislation is not yet known, if a greater number of cases are reported to APS as a result, the program will be impacted.

OMBUDSMAN PROGRAM APPEARS UNDERSTAFFED, AND DEMAND MAY BE AFFECTED IF USE OF HOME-BASED CARE INCREASES

The Long-Term Care Ombudsman program was established as a requirement of the federal Older Americans Act to improve the quality of care in America's long-term care facilities. Originally established in 1979, the program's role in Virginia was expanded by the General Assembly in 1983 to include home and community-based long-term care services. The program responds to complaints made by or on behalf of individuals receiving long-term care services in facilities or in the community. In Virginia, the program is operated by the Virginia Association of Area Agencies on Aging (V4A), under a contract with the Virginia Department for the Aging (VDA). The Office of the State Long-Term Care Ombudsman (within V4A), as well as local staff, report that the program is understaffed. This reportedly limits the program's visibility in facilities and the ability of the Office to act proactively. For example, limited resources hinder the program from expanding

services for persons receiving home and community-based care. As the number of older Virginians who receive care in their homes and communities increases in the future, the program may have to respond to greater demand from consumers of those services.

Current Staffing Level of the Ombudsman Program Is Below What Is Mandated in the *Code of Virginia*

Section 2.2-703 of the *Code of Virginia* states that the Long-Term Care Ombudsman program "shall provide a minimum staffing ratio of one ombudsman to every 2,000 long-term care beds, subject to sufficient appropriations by the General Assembly." This ratio is based on one that was established by the federal Institute of Medicine in 1995 and does not account for home and community-based care recipients. According to data provided by V4A, however, the ratio of ombudspersons to long-term care beds in Virginia was approximately one to 3,376 in FY 2004. Meeting the goal of maintaining the recommended staffing ratio would cost the State approximately $736,000 in additional funding. This calculation is based on the FY 2005 estimate of long-term care beds (66,630) and the FY 2004 number of full-time equivalent (FTE) ombudspersons (19.9), as reported by V4A staff. Based on those numbers, the State would need approximately 13.4 additional FTEs. VDA estimates that each additional position would cost approximately $55,000, which includes benefits.

Increasing Emphasis on Home and Community-Based Care May Affect Demand for Ombudsman Services

As the contractor of the State's program, V4A is required by Section 2.2-704 of the *Code of Virginia* to serve recipients of home and community-based services, in addition to facility-based clients. However, the State Ombudsman, as well as local staff, indicate that the program's emphasis is on serving clients in long-term care facilities. Staff indicate that a facility emphasis is a factor of both the program's traditional role as well as inadequate staffing levels. For example, as discussed above, current staffing levels are below the recommended ratio, which does not account for home-based clients.

Data from V4A suggest that less than two percent of all complaints come from home and community-based care clients. Although the program responds to complaints it receives from home and community-based clients, interviews with local agency staff suggest that few older Virginians are aware that the program covers home and community-based care. As discussed in Chapter VII, agencies reportedly scale back education and outreach efforts when resources are limited because they do not want to promote services they cannot provide. Local staff in the Waynesboro area say they do not actively promote services to home-based clients. Rather, they focus on the "loudest squeaking wheel," which is the facility-based clients. In addition, in several areas of the State, local agency staff such as PAS teams, who refer clients to home and community-based services, report that they do not typically provide information to clients about ombudsperson services.

In addition to a general lack of awareness among home and community-based care recipients, there may be other reasons why the program receives fewer complaints from those clients. For example, some local agency staff report that there are few home care agencies in their localities, and care recipients fear that if they complain about the quality of services they receive, the agencies may retaliate by not serving them. Furthermore, a 1995 report by the Institute of Medicine suggests that some individuals receiving services in their homes may fear that complaining could cause them to lose services and therefore necessitate a move to a nursing home.

Despite the program receiving few complaints from home and community-based care clients, staff from local departments of social services, AAAs, and health departments indicate that problems exist with the quality of home and community-based services. For example, they indicate that turnover among home-care aides is common, and there are times when aides do not show up for scheduled visits. In addition, it appears that consumers of home and community-based services could require similar levels of advocacy and protection as those residing in long-term care facilities. Many consumers of home and community-based services have impairments similar to those of nursing home residents. For instance, those receiving Medicaid waiver services experience levels of physical and cognitive impairments that would qualify them for nursing home care. According to the 1995 Institute of Medicine report:

> For members of the elderly population who need these home- and community-based services, the nature of their vulnerability may be different from, and in selected cases, even greater than, that for persons residing in LTC facilities.

Furthermore, older Virginians' preferences to receive care in their homes, as well as the State's efforts to comply with the *Olmstead* decision, could mean that increasing numbers of individuals will receive long-term care services in their homes and communities. Based on DMAS data on projected changes in Medicaid enrollments, the number of EDCD waiver recipients age 60 and older is projected to increase between 27 and 118 percent by 2030 (Table 11). Demand is also expected to increase for in-home services provided by AAAs and DSS due to population growth, as discussed in Chapter VII. VDA staff suggest that as the State realizes the full impact of the *Olmstead* decision, the program will need to respond to concerns about quality of care in home and community-based settings. V4A staff express concern, however, that the program may not be able to respond to a significant increase in volume of home-based complaints without additional resources.

PUBLIC GUARDIANSHIP SERVICES APPEAR INADEQUATE TO MEET CURRENT NEEDS OR A FUTURE INCREASE IN DEMAND

Individuals who are incapable of making decisions concerning their health or financial affairs may have a guardian or conservator appointed by a circuit court. Conservators are typically only responsible for managing a person's financial affairs, although one person can serve as both guardian and conservator. (Throughout this

Table 11

Projected Recipients of Medicaid Elderly or Disabled with Consumer Direction Waiver

Fiscal Year	Recipients Age 60 and Older
2004	9,825
2010	10,538 – 11,505
2020	11,419 – 16,291
2030	12,443 – 21,408

Note: Low estimates assume that increases in Medicaid enrollment will reflect historic enrollment rates of aged recipients. The high estimates assume that enrollment will increase at the same rate that the older population grows as a proportion of the State's overall population.

Source: JLARC staff analysis of Department of Medical Assistance Services data.

report, the term "guardian" will also refer to conservators.) In some cases, it is difficult to find people willing to serve as guardians, especially for individuals who are indigent and do not have family or friends who are willing or able to serve. In response to a need for a guardian of last resort, in 1998 the State established the Virginia Public Guardian and Conservator Program (VPGCP) to provide guardianship to indigent individuals who do not have family or friends who are willing or able to fill this role. Although this program has been effective in providing guardianship services to many individuals, it appears that the program is not adequate to meet existing need. Furthermore, individuals with unmet demands for guardians may not be able to receive all the medical or supportive services they need, and a lack of guardians may increase the cost to the State of caring for some people.

Public Guardianship Programs Are Designed To Ensure Continuity of Services

The VPGCP consists of nine regional programs that serve a total of 54 localities. The programs are operated primarily by AAAs and nonprofit organizations that contract with VDA. Even before the inception of the VPGCP, public resources were used to provide guardians to indigent individuals. At that time, the guardian of last resort in Virginia was the sheriff. One apparent benefit of appointing a program as the guardian, rather than an individual, is that it helps assure accountability and continuity of services.

Serving as guardian can be a tremendous responsibility. In 1988, the Department of Social Services' Task Force on Guardianship observed that, given the implications of being a guardian, "it is not surprising that there is a chronic, state-wide problem in locating individuals who are available, willing, and suitable to serve." Typically, guardians are family members, but they can also be friends, attorneys, and volunteers. Some individuals who do not have friends or family members who are willing or able to serve as guardians are able to employ private

guardians. For indigent individuals, however, it can be particularly difficult to find individuals to serve as guardians. In 1990, the Department of Social Services concluded that:

> When family and volunteer efforts and available private guardians are insufficient to meet the need for an increasing number of vulnerable adults, public guardians become a last resort, i.e. the only other source for this service.

The majority of individuals served by the VPGCP are 60 years and older, and almost half have dementia. Clients of the program appear to benefit from the variety of services they receive. For example, one local program that operates in the Hampton Roads area provided the following example of one of their older clients who was able to remain in the community with a higher quality of life as a result of public guardianship services:

> *One woman has been a client of the public guardianship program since its inception. Before obtaining a guardian, the woman with mental illness lived in a trailer, where she left the oven open for heat. In addition, the woman was hoarding. Because the woman suffered from paranoia and visions, she would leave her trailer while dressed inappropriately. Now the woman lives in a senior apartment, where she has made friends with some of the other residents. The guardianship program provides many of the services she needs. For example, they pay all her bills, have arranged a pre-paid funeral, and provide a support system. The woman relies heavily on the program, since she has no family and few friends. The woman's quality of life and financial situation have greatly improved as a result of the program, and she has been able to remain in the community.*

Alternatives to Public Guardianship Exist, But They Appear Inadequate to Fully Address Need

Individuals who would otherwise need guardians can sometimes be served in a less restrictive way. For example, AAA services such as money management, counseling, and case management could offset the need for public guardians for some individuals. However, these community services are not always available. Additionally, although family members and friends are often granted power-of-attorney or advance medical directive, there will always be some individuals who lack family and friends who are willing and able to serve in these roles.

According to studies on public guardianship, it also appears that these programs cannot be fully replaced by volunteer guardianship programs. For example, providing guardianship services can be time consuming and emotionally demanding, so it may not be realistic to expect volunteers to assume total responsibility for that service. In addition, volunteer guardians are particularly difficult to find when individuals have a history of violent behavior, alcoholism, or

drug abuse. In a 2002 assessment of the VPGCP, the Virginia Department for the Aging, Virginia State Bar, and the Virginia Bar Association jointly noted that:

> It is a misconception to think that the [Public Guardianship Program] could be replaced by a fully volunteer effort at no cost to the public. Experience shows that any credible volunteer guardianship program must be adequately funded.

According to that report, the professional expertise required to administer the program is not available on a volunteer basis.

Unmet Demand for Public Guardianship Services Is Reported Although the Extent of Need Is Unclear

Although comprehensive data are not available, it appears that the VPGCP program is unable to meet existing need. Local social service and community services board (CSB) staff indicate that there is a large unmet demand for guardians in many parts of the State. Two studies conducted in 1988 and 1997 estimated the statewide need for public guardians and other surrogate decision makers to be between 2,174 and 2,881, and data collected by several agencies suggest that the number of guardians needed in Virginia is still over 2,000. For example:

- The Virginia Association of Community Services Boards (VACSB) indicates that 2,000 individuals of all ages in the Commonwealth were identified by CSBs as needing assistance with informed consent from 2003 to 2004. (Informed consent is required for treatments that pose risk of harm greater than that ordinarily encountered in daily life, such as the prescription of psychoactive medications.)

- DMHMRSAS surveyed mental health and mental retardation facilities on August 15, 2005, and found that 92 individuals age 60 or older needed guardians or legally authorized representatives.

- In addition, local departments of social services reported that 130 adult clients had unmet needs for guardians as of May 2004. Historical data are not available.

VDA has also identified unmet demand for public guardians. For example, each year the nine public guardianship programs that comprise the VPGCP serve their maximum capacity based on a staff ratio of one to 20, and slots do not typically open unless a client passes away. Although VDA staff indicate that they do not maintain waiting lists for the local programs, 36 individuals have been approved for the program if a slot should open. VDA staff explain that programs do not maintain waiting lists because they "would produce unrealistically long waiting periods of several years based on current funding levels." Furthermore, an evaluation of the programs conducted by Virginia Tech in 2001 and 2002 found that agencies had already stopped referring people to the local programs because they were always full.

Although the State's support for this program has increased in recent years, it appears that the existing programs are underfunded. For FY 2006, the State's appropriation for the VPGCP increased by $290,000, a 42-percent increase over the FY 2005 appropriation. Forty-six percent of that increase ($132,000) is designated to be used to expand services to individuals with mental illness and mental retardation who are age 18 years or older. Some evidence exists, however, that local programs are underfunded:

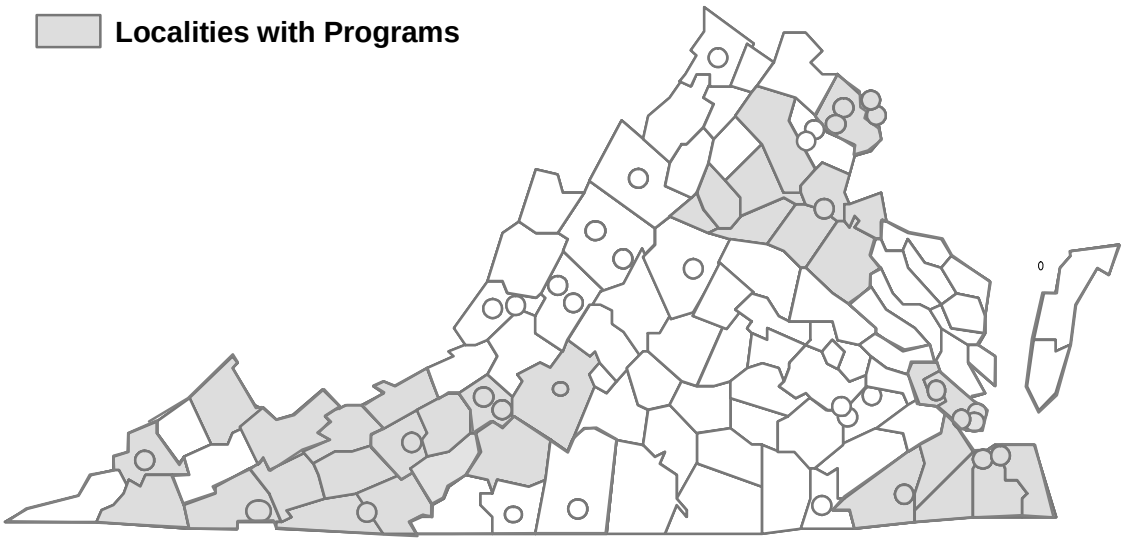
- In 2002, a legislative committee that studied the statewide system of providing substitute consent for people with mental disabilities reported that "because state funds are not sufficient, many of the nine entities [regional programs] subsidize the program."

- VDA staff state that local programs are underfunded by at least 10 percent. Furthermore, if unpaid hours donated by public guardians were included, as well as expenditures made from personal funds on behalf of clients, the actual costs would be substantially higher.

Although the impact of the additional funding is not yet clear, it does not appear to be sufficient to meet the State's policy goals for public guardianship. Presently, the nine regional guardianship programs serve a limited number of people throughout the State, and individuals in many areas do not have access to one of the nine programs. Figure 18 illustrates the areas of the State that are

Figure 18

Localities Served by Local Public Guardianship Programs



Note: Statewide, local programs are contracted to serve a maximum of 213 individuals at a given time.

Source: JLARC staff analysis of Virginia Department for the Aging data.

served by the programs. According to Section 2.2-711 of the *Code of Virginia*, a statewide program was established to ensure guardians are available to "all incapacitated persons" who are indigent and have no one else to serve in this role. Despite this policy, however, it appears that guardians are not available to all incapacitated persons in the Commonwealth. For example, the VPGCP is currently serving only 213 individuals statewide. Assuming a statewide need for over 2,000 guardians, it appears that the State is currently serving less than ten percent of incapacitated individuals in need. Furthermore, a program that serves individuals in only 54 localities does not appear to support the stated policy of establishing a statewide program.

Improved Data Collection Would Better Determine the Extent of Unmet Demand

Although there is a documented unmet demand for guardians in Virginia, it is not possible to precisely quantify the extent of unmet demand using existing data. For example, it is difficult to produce an unduplicated count of unmet demand because individuals may be served, and counted, by more than one agency. Furthermore, although the majority of public guardian clients reside in long-term care facilities, such as nursing homes or assisted living facilities, unmet demands of individuals in those facilities may not be reflected in the data described above. For example, neither statewide study surveyed long-term care facilities about unmet needs of their residents. Additionally, some clients identified by State agencies as requiring guardians could be residing in long-term care facilities, but those data would not reflect unmet demands of other residents who are not receiving State services.

Producing an unduplicated, statewide count of individuals who need public guardians would allow the State to allocate appropriate resources to meet that need. In order to produce a precise estimate of unmet demand, State agencies would need to maintain standardized data that includes unique identifying information. Additionally, agencies would have to identify only those individuals who would meet the criteria of the program. For example, to qualify for public guardianship, individuals need to be both indigent and incapacitated. Individuals who do not meet these criteria may be better served through counseling, case management, or money management, or through arrangements such as power-of-attorney or private guardians. Obtaining an accurate estimate would also require long-term care facilities to maintain these data, since the majority of public guardian clients reside in facilities (72 percent in 2002).

Unmet Demand for Public Guardians May Mean Some Individuals Are Not Receiving Needed or Appropriate Services

Individuals who require a guardian but who do not have one appointed may not be able to receive all the medical or supportive services they need. For example, individuals without guardians may receive emergency medical treatment or court-ordered treatment, but they may not receive non-emergency medical treatment. Furthermore, DMHMRSAS staff indicate that individuals without

guardians may not be able to receive some community services that require consent. In April 2005, there were 71 individuals with mental illness or mental retardation on a waiting list for community services for that reason.

Additionally, some individuals may receive services in inappropriate settings because no one is available to direct or make decisions about their care. For example, some individuals cannot be discharged from State mental health facilities to long-term care facilities because a guardian (or other legally authorized representative) is required for admittance. As a result, they may receive more costly and restrictive services than they need. CSB staff assist with these discharges, and DMHMRSAS staff estimate that about 32 clients a year are 60 or older and need a guardian prior to placement. In addition, some individuals with mental retardation cannot be discharged from State training centers without a guardian.

Public guardians could enable these individuals to receive less expensive and more appropriate services, while freeing up facility beds for others who need them. Table 12 illustrates how these individuals could be served at a lower cost if they could be admitted into nursing homes or assisted living facilities or served in the community through the Medicaid mental retardation (MR) waiver. These estimates suggest that, given the various scenarios, the State could serve certain individuals for $72,774 to $145,984 less per year. It is important to note, however, that the level of care provided in the settings varies. For example, as discussed in Chapter V, nursing homes may not provide the level of mental health services needed by some individuals. Nevertheless, each year CSB staff identify a number of individuals who no longer need the level of services provided by State mental health facilities and could therefore be better served in other settings. In addition, providing guardians to these individuals would also reflect a commitment to the Supreme Court's *Olmstead* decision to serve individuals in community-based settings when possible.

Demographic Changes Could Impact Future Demand for Public Guardians

Several demographic trends and changes described throughout this report could impact future demand for public guardians. For example, increasing rates of Alzheimer's disease could affect the need for guardians. When Virginia Tech evaluated the VPGCP in 2001 and 2002, they found that almost half of the clients had a diagnosis of dementia. Furthermore, over one-third of the clients were individuals with mental retardation, and nearly a third had other developmental disabilities. As discussed in Chapter V, individuals with mental retardation and other developmental disabilities are living longer than in the past, and often they are outliving family caregivers. In addition, family members are often appointed as guardians, so trends that affect the availability of family caregivers described in Chapter II could also affect the future demand for public guardians. It appears that the VPGCP is not adequately addressing existing need, so future increases in demand may be difficult to meet without commensurate increases in funding.

Table 12

Examples of How the State Could Serve Individuals Identified as Eligible for Discharge at a Lower Cost

Discharge From:	State Mental Health Facility ($415/day)		State Training Center ($349/day) [1]
Discharge To:	Nursing Home	Assisted Living Facility (ALF)	MR Waiver
Average Public Pay Rate	$90/day[2]	$262/month	$52,264/year
Savings Per Person	$325/day	$12,361/month	$75,121/year
Total Savings Per Year	$118,625	$148,331	$75,121
Cost for Public Guardianship Per Person Per Year[3]	($2,347)	($2,347)	($2,347)
Net Savings	**$116,278**	**$145,984**	**$72,774**

Notes: [1]Individuals who are discharged from training centers could also be discharged to other settings such as nursing homes or ICFs/MR, rather than the MR waiver.

[2]Total nursing home reimbursement ($112) minus average patient pay ($22).

[3]The annual public guardianship cost is based on State funding; however, the average cost of serving a person in this program may be higher if local contributions are considered.

Sources: The average cost data for State Mental Health Facilities (patients age 65 and older) and training centers (patients of all ages) were provided by DMHMRSAS for fiscal year (FY) 2004. The nursing home rate was based on data provided by DMAS on the net Medicaid reimbursement for calendar year 2003. The ALF rate represents the average monthly expenditure for auxiliary grant (AG) recipients in FY 2005 (average monthly AG expenditures divided by average monthly recipients), as provided by DSS. The MR waiver rate is based on data provided by DMAS on average costs by age group (61 and older). The cost for public guardianship per person per year was based on budget ($500,000) and client (213) data provided by VDA for FY 2004.

VDA staff indicate that guardianship can be more expensive than other options and should only be considered as a last resort. According to a study conducted by the Department of Social Services in 1990, "Court appointment of a guardian signifies a dramatic reduction in the basic civil rights of the ward," and therefore should only be considered when no other options exist. VDA staff indicate that funding is the primary barrier to expanding the program, but caution that even with increased funding it could be challenging to find people willing to serve as guardians, because serving in this role can be difficult and emotionally demanding. They indicate that proposals for new local guardianship programs request double or triple current program budgets.

IX. Rising Housing Costs May Affect the Ability of Some Older Virginians to Live Independently

Interviews with local agency staff indicate that some older renters and homeowners have difficulty affording the cost of housing and related services, and have to choose between paying for housing or other necessities. At the national level, a Congressional report indicates that the need for subsidized senior housing will increase by 2020, but that the supply of this housing is diminishing. According to staff of the Virginia Housing Development Authority, however, there is no clear evidence that the supply of subsidized senior housing is diminishing in Virginia. Although this may be true statewide, local agency staff report that the supply is diminishing in some areas of the State. There also appears to be a lack of senior housing that includes supportive services, such as assistance with transportation and meal preparation.

For some older homeowners on fixed incomes, rising property tax assessments may continue to be burdensome, which may place pressure upon the State to grant localities the ability to increase the eligibility for local property tax relief. Local agency staff also report waiting lists for services that assist older homeowners with repairs and modifications that are necessary to receive services in their home, such as wheelchair ramps and grab bars.

As the number of older renters and homeowners increases, State policymakers may face an increase in demand for affordable and accessible housing. Affordable housing is generally considered by federal and State housing agencies to be housing that costs no more than 30 percent of the combined gross income of household members. Housing is often made affordable through subsidies that lower development costs or through rental assistance that is provided to household members. Unmet demand for affordable housing may increase the demand for other government services if housing-related costs hinder the ability of older Virginians to live in the community.

The role of State agencies in providing housing assistance directly to Virginians is currently limited to administering federal housing vouchers and other rental assistance, and allocating federal and State funds for housing repair and weatherization programs. However, State housing agencies report that they provide a substantial amount of funding through tax credits, grants, and low-interest loans to developers for the construction and renovation of affordable housing.

OLDER RENTERS ARE OFTEN BURDENED BY HOUSING COSTS AND A LACK OF SUPPORTIVE SERVICES

Interviews with local agency staff suggest that some older renters have difficulty paying for housing costs. The percentage of income paid for rent (often referred to as rent burden or housing cost burden) is one measure of affordability.

As mentioned above, housing that costs 30 percent or more of an individual's income is not considered to be affordable. Census data for Virginia indicate that 21 percent of renters age 60 to 84 pay between 30 and 49 percent of their gross income on rent and utilities. This is also true of 19 percent of renters age 85 and older. More significantly, 20 percent of renters age 60 to 84, and 32 percent of renters age 85 and older, pay more than half of their income on housing costs. In addition to the burden of rent, the lack of publicly-assisted housing (subsidized and rent-assisted) and housing with supportive services may hinder the ability of older adults to live in the community.

Local Agencies Report Older Clients Choose Between Paying Rent and Other Expenses

According to local agency staff, some of their older clients, as well as other low-income older Virginians, must choose between paying for rent or for other necessities such as food, medications, and utilities. Local agency staff report that older adults sometimes do without one or more of their medications in order to pay rent. For example, local staff in Charles City County indicate that some older adults have disconnected their telephone because they saw it as one bill they could do without. Local agency staff in other areas note that older Virginians will go without medications. In Waynesboro, health department staff report that blood pressure medications are typically the first medication that older Virginians will stop purchasing, but that this can have serious health consequences. Additionally, as mentioned in Chapter VI, pre-admission screening teams from several areas indicate that some Medicaid-eligible older Virginians in need of long-term care services turned down home and community-based waiver services because they cannot afford both the waiver co-payment and the cost of rent.

Current Supply of Affordable Housing Units Is Inadequate, and State Agencies Play a Limited Role

Local agency staff report that many subsidized housing developments, including those for older residents, had long waiting lists. For example, a 2004 Fairfax County report noted that 548 older persons were on the local housing authority's waiting list. The report also stated that projected growth in this population could increase the number of older persons on the waiting list to 787 by 2010. New multifamily developments are also reported to be unaffordable for low income families or older households, and some developments are reported to be insufficiently accessible to older Virginians with disabilities. As a result, some older Virginians have had to move outside of their community to find affordable or suitable housing.

Some Older Virginians May Have Difficulty Finding Affordable and Accessible Housing in the Future. A 2002 report by a Congressional commission on affordable housing needs for seniors indicated that by 2020 the demand for rent-assisted housing for seniors will increase substantially. The report added, however, that the supply of affordable housing does not meet current demand, and that the number of rental units that are subsidized by federal Section 8 rental assistance

contracts is decreasing. The Commission report notes that "Federal programs as well as State and local programs must be used to erase shortfalls and meet expanding need."

According to data provided by the Virginia Housing Development Authority (VHDA), there were 41 publicly-assisted senior apartments for every 1,000 elderly-headed households in 2000. This varied by locality, and several localities had no publicly-assisted senior apartments. The following examples illustrate the lack of affordable and accessible housing:

- Staff from the Waynesboro area agency on aging (AAA) indicate that people have moved from Bath and Highland counties to other counties where affordable housing is available.

- Local agency staff from Fairfax County report that the proportion of townhouses has increased, but that townhouses are not accessible for many older persons because they have several flights of stairs. In addition, they said that some new apartments have accessible features, but they are generally more expensive.

- In Arlington, AAA staff state that a lack of affordable housing is a serious problem and is driving some people out of the county. Staff expect that this will continue as developers begin to convert affordable housing apartments into higher priced condominiums.

- Staff from local agencies in the City of Richmond and Southeastern Virginia also indicate affordable housing is being replaced with higher priced housing developments.

In addition, local agency staff report that the lack of affordable housing often impacts their ability, as well as that of other health care providers, to attract and keep staff. Staff from the AAA serving Tidewater Virginia indicate they had difficulty recruiting staff for two positions paying between $23,000 and $44,000 as persons interested in the positions could not find affordable housing in that area. Local department of social services staff in Loudoun County note that many of their employees cannot afford to live there, and instead live just over the State border in West Virginia.

State Agencies Currently Play a Limited Role in Providing Direct Rental Assistance. The State's primary role in providing affordable housing to low and moderate income renters is through the provision of funding to developers that is designed to lower the costs of constructing and renovating multifamily housing. Direct rental assistance to low-income renters, including adults age 62 and older, is primarily provided through the federally funded Section 8 housing voucher program, which is administered by VHDA and local public housing authorities. Recent data from the U.S. Department of Housing and Urban Development (HUD) indicate that 5,384 elderly households in Virginia received rental assistance through Section 8 tenant-based vouchers between April 2004 and July 2005, a decrease of 784 from the

number reported in July 2004. The total number of all households receiving vouchers also declined during this time period.

Local and State agency staff indicate that rental assistance through the Section 8 voucher program works well, but that many older Virginians as well as other people with low incomes are not able to access this assistance. Each public housing agency has a specific number of vouchers, authorized by HUD, that they can administer. The number of vouchers provided by HUD does not meet existing need, as noted by VHDA in its response to the State agency survey: the "demand for rent subsidy assistance through the federal Voucher program greatly exceeds supply." As a result, waiting lists have become extensive, and many are closed. The lack of supply around the State is illustrated by the following examples:

- Staff from Valley Community Services Board (CSB), which serves the counties of Augusta and Highland and the cities of Staunton and Waynesboro, indicate that "Section 8 vouchers work like a charm" but that the rent reimbursement and the number of vouchers have decreased.

- In Virginia Beach, staff from the Social Services Division report that waiting lists are 12 to 24 months long for senior Section 8 housing and six to 18 months long for senior subsidized housing. Chesapeake staff also report waiting lists.

- Fairfax AAA staff state that Section 8 housing has two-year waiting lists, and Arlington AAA staff indicate that the County has a three-year waiting list: they are just now working on applications filed in 2002.

Approximately 550 elderly households were on waiting lists for vouchers administered by VHDA as of July 2005. All waiting lists are closed and many have been closed for some time, which means that eligible persons are not being added to the waiting lists. Because of this, VHDA staff report these waiting lists are an undercount of need. VHDA staff also note that future need of older Virginians for rental assistance will be affected by their income and their homeownership rates, which have been increasing.

Additional Housing With Supportive Services May Be Needed to Enable Older Adults to Live in the Community

In addition to a general lack of affordable housing for older adults, there is a lack of housing combined with supportive services. While the number of persons requiring publicly funded supportive services in the future will depend on future disability and poverty rates, the 2002 Congressional commission on affordable housing indicated that 27 percent of Americans who currently live in rent-subsidized housing are likely to have a need for supportive services. The Congressional report also noted that the overall number of persons living in rent-subsidized housing will increase 60 percent between 2000 and 2020.

Earlier legislative studies in Virginia provided examples of supportive services that were needed by older residents. These include assistance with food preparation, laundry, personal and health care, transportation, shopping, bill paying, and socialization. According to VHDA staff, many senior housing developments cater to younger seniors who may not need supportive services. However, as these seniors age and become more functionally limited, needed supportive services often are not in place, as described in the following examples:

- In Fairfax, DSS staff state that the apartments which are designed for seniors are old, and the residents have "just remained there." The housing managers cannot provide the services that people need, and places that used to provide meals along with housing are trying to end this service.

- AAA staff in Martinsville report that "senior housing with supportive services is a critical need – none truly have supportive services."

Funding for housing and supportive services is limited, in part because funding allocations from the HUD-sponsored Congregate Housing Services Coordinator Program and the Elderly/Disabled Service Coordinator Program, have not been made since 1995. According to a 2005 report by the federal Government Accountability Office (GAO), the exception is the Section 202 program, also funded through HUD, which was designed to provide housing and "wrap around [supportive] services."

At the State level, the Department of Housing and Community Development (DHCD) administered a congregate housing program financed through the Virginia Housing Partnership Revolving Loan Fund. The congregate housing program only provided funding for capital costs of developing the housing, but the program applicants were required to provide supportive services to the residents throughout the funding term. This program has not received funding since at least 2002, as DHCD sold the outstanding loans and other assets of the fund to VHDA pursuant to the 2003 Appropriation Act. The Commonwealth Housing Priority Fund was created from the sale of the fund, and it focuses on underserved, special needs markets, and certain targeted areas of the State that were identified through a housing needs assessment conducted by VHDA and DHCD. While VHDA administers the funding, DHCD determines the priorities for how the funding is used.

VHDA staff indicate that housing assistance and supportive or residential services are combined in only a few areas in Virginia, including those served by the AAAs in Fairfax, Arlington, the Northern Neck-Middle Peninsula, and the City of Richmond. The Director of DHCD made a similar point in his response to the survey of State agencies, and also notes that resources for supportive services are needed so that both the housing and the services are affordable – otherwise, many older Virginians will not benefit. To encourage further development of these programs, VHDA indicates in its survey response that it will be creating a new staff position to serve as a liaison between the Virginia Department for the Aging, the Department of

Medical Assistance Services, the Virginia Department of Social Services, local AAAs, and other housing and service providers.

No Formal Strategy Exists for Meeting the Affordable Housing Needs of Older Virginians

Several mandates for creating plans to serve the housing needs of older Virginians and Virginians with disabilities have been established, but currently no plans exist. The 2002 General Assembly directed DHCD to develop "a strategy concerning the expansion of affordable, accessible housing for older Virginians and Virginians with disabilities, including supportive services." According to DHCD staff, a report was prepared for DHCD and VHDA by contractors, and this report is being used by the Disability Commission's Housing Work Group as a guide to developing priorities. However, no formal strategy has been prepared. Additionally, joint resolutions during the 2003 and 2004 General Assembly sessions directed the Virginia Housing Commission to develop a housing policy for the Commonwealth, which should include housing opportunities for low-income persons and persons with special needs. While the Housing Commission has studied these issues, among others, it has yet to develop a formal housing policy.

In his survey response, the Director of DHCD states that the majority of the agency's funding comes from federal sources which are currently constrained, and likely will be more constrained in the future. In addition, he indicates that without additional federal or State resources to address the needs of older Virginians, "it is unlikely that the agency would be able to commit more resources toward meeting these needs without simultaneously reducing the commitment to other sectors of the population with equally compelling needs in housing and community development." The Director also adds that, within available resources, the agency expects to continue providing housing-related services, especially to persons with lower income levels, and that the agency continues to work with other partners "to address needs that are now well-recognized and expected to grow over time."

OLDER HOMEOWNERS ARE OFTEN BURDENED BY HOUSING COSTS

Older homeowners, like older renters, are also burdened by housing costs. While the majority of older Virginians own their homes, 40 percent of Virginia homeowners age 60 and older were still paying mortgages in 2000. This was also true of 14 percent of homeowners age 85 and older. In addition, Census data indicate that 11 percent of homeowners age 60 to 84, and 14 percent of homeowners age 85 and older, paid between 30 and 49 percent of their gross income on mortgages, utilities, and taxes. Some older homeowners in Virginia pay 50 percent or more of their income on housing costs. This is true of eight percent of homeowners age 60 and older, and nine percent of homeowners age 85 and older. In eight Virginia localities, 20 percent or more of Virginians age 85 and older paid 50 percent or more of their income on housing costs. Local agency staff in Northern Virginia express concern that some older adults may need to leave their community

because of high housing costs, particularly if other affordable housing options are not available.

Rising Tax Assessments May Force Some Older Homeowners Out of the Community

According to local agency staff, housing affordability for older homeowners is affected by increasing property values in Virginia, which have risen to a considerable degree in some areas. According to an Arlington County report, in one year the average assessed value for all homes climbed 24 percent, from $369,600 in 2004 to $458,200 in 2005. Staff from the Loudoun Health District report that real estate taxes present a significant burden for older adults on fixed incomes, particularly since taxes are increasing at a rate of 15 to 20 percent a year.

The State allows localities to provide real estate property tax relief to elderly homeowners (age 65 and older) and disabled homeowners to ease the burden of paying these taxes. This authority is granted to localities in Sections 58.1-3210 through 58.1-3218 of the *Code of Virginia*. In 2004, all but 13 localities made this relief available. (Localities not providing this relief are predominantly rural counties, including the counties of Brunswick, Buckingham, Charlotte, Greensville, Highland, King and Queen, Lunenburg, Mecklenburg, Northumberland, Nottoway, Richmond, and Sussex, plus the city of Emporia.) While this relief does not impact State revenues, it does impact the revenues collected by local governments. Despite the availability of tax relief, local agency staff in Northern Virginia and in Hanover County indicate that older adults have been forced to move out of their communities due to increasing property values and tax assessments. CSB staff from Northern Virginia indicate that some older adults were selling their homes and moving south because there were no other affordable alternatives in the area.

As the number of persons eligible for local property tax relief increases due to the growth of the older population, and if housing costs and tax assessments continue to rise, State policymakers may be asked to increase the ability of localities to provide property tax relief by increasing the gross combined income and net worth limitations. These amounts were increased in 2004 by the General Assembly. However, localities that choose to offer greater tax relief may need to balance the need for relief with the need for revenue if localities continue to rely upon property taxes. At the present time tax relief for the elderly and disabled provided by Virginia cities and counties totaled $48.4 million, which represented less than one percent of total real property tax collections for FY 2004.

Local Agency Staff Report Unmet Demand for Repairing and Modifying the Homes of Older Virginians

As the population ages, the number of older Virginians who own homes will likely increase. This may increase the demand for assistance with home repairs or modifications by older persons who cannot make the needed repairs or modifications, or afford to pay someone else to make them. According to the Congressional study noted earlier, at the national level, the largest group of older adults who will likely

need services in 2020 will be homeowners. For older homeowners who own their homes outright or have small balances on their mortgages, reverse mortgages may be an option. Reverse mortgages allow older homeowners to use the equity in their home for financial security, including covering the costs of health care or making home repairs. However, the Congressional study adds that some seniors may have to choose between making repairs to their homes that address safety concerns, and paying for in-home long-term care services. In addition, although some seniors will be able to use reverse mortgages as a means of tapping home equity to finance repairs or modifications:

> For those with little equity or overwhelming housing problems, flexible forms of assistance . . . will need to be expanded and targeted to help senior homeowners adapt and maintain their homes and avoid the rolls of more costly long-term institutional settings.

Although the extent to which today's older homeowners in Virginia need assistance making home repairs or modifications is unknown, many local social services and AAA staff indicate that many of their older clients live in housing that needs repair or accessibility modifications. In some cases, repairs or modifications are needed in order for older Virginians to receive services in their home, or to address problems that compromise the safety of the home. Local agency staff gave several examples of the need for home repair and modifications:

- Staff from the Hanover Health District estimate that 50 percent of the homes they visit to conduct Medicaid pre-admission screenings need repairs or ramps. One home they recently visited had a hole in the floor, and another had no running water.

- Staff from the Southern AAA report that many homes have poor wiring. For some of their clients living in older mobile homes, the air conditioning and oxygen cannot be run at the same time. Twenty people are on waiting lists for home repairs, and most of these people need whole roofs. Local DSS staff from this area say that some homes lack indoor plumbing.

- DSS staff in the Shenandoah Valley report that there is a large demand for housing repairs but there are not enough resources. They indicate that they could probably recruit volunteers to make the repairs, such as roof repairs, but funding for materials is needed.

- AAA staff in Southwest Virginia state that it is difficult or impossible to serve someone who lacks indoor plumbing. DSS staff from that area indicate that they have personal care plans that include "taking the slop jar out to the outhouse."

Local staff also gave examples of instances in which there are conditions that could affect the resident's health and the willingness of personal and companion care aides to provide services.

- Staff from both the Southern AAA and the DSS offices serving the same localities indicate that safety and health hazards exist such as bug infestations. One DSS staff member instructs staff serving these clients to look for "a safe place to sit" such as un-upholstered furniture.

- Staff from the Waynesboro AAA report that, when sending in in-home services, they have had to use emergency funds to do exterminations so that the aides will go into the homes.

Staff from the Southern AAA indicate that they began providing chore services to address these situations and enable older persons to remain in their homes. Examples from other localities also indicate that there may be a need for chore services when the need for home repairs compromises both the safety of the home and the willingness of the providers to go into the home.

Local agency staff also express concerns that many older adults cannot afford to make modifications to their homes that would make them more accessible. Accessible features, such as ramps, wider doorways, lower cabinets, walk-in or roll-in showers, and other assistive technologies may be needed so that the resident can navigate inside and outside of the home. Accessible features are also needed so that others, including family, friends, and caregivers, can navigate inside and outside of the home as well, a concept that is often referred to as "visitability." According to some AAA staff, inaccessible housing often results in increasing the isolation of the residents, which one staff member characterizes as resulting in some older Virginians becoming "prisoners in their own home."

Although current building codes governing multifamily housing requires new developments to be accessible, there is no such requirement for single family housing. Several AAA staff indicate that builders need to be better educated about accessible design features, sometimes referred to as universal design. Currently, several State and local entities, including VHDA, DHCD, the Department of Rehabilitative Services, the Department of Professional and Occupational Regulation (which licenses and regulates builders and architects), the Disability Commission, and local centers for independent living and disability services boards report that they have made educating builders and architects in universal design a priority.

DHCD Administers Funding for Housing Preservation Programs, But Expenditures for Some Programs Have Decreased

DHCD administers several housing preservation programs that serve a large number of older Virginians. DHCD provides the funding to local entities, such as local governments, nonprofits, or housing organizations, which make the repairs. While most of these programs are funded through federal funds, the Emergency

Home Repair program primarily receives State funding. This program funds repairs such as plumbing, structural, and electrical work to remove imminent health and safety hazards from the homes of lower income Virginians. Data on program expenditures and persons served through this program indicate that the expenditures for this program decreased between fiscal years 1998 and 2004. As a result, the number of total households and elderly households served each year has decreased. In FY 2004, 262 households with elderly residents were served through the Emergency Home Repair Program, which is less than half the number served in FY 1998 (592). Data on unmet demand for this program are not documented by DHCD, but interviews with local agency staff indicate that unmet demands for this service exist, as illustrated in the above examples. To address unmet demand for home repairs, VHDA staff indicate their agency has provided additional funding to DHCD to use for this purpose in the indoor pluming and rehabilitation program discussed below.

Data on the number of persons served through DHCD's other housing preservation programs and through the AAA residential repair programs are also available (Table 13). Although DHCD collects data from the providers on the number of households served, the agency does not collect data on the number of households that are on providers' waiting lists. Data are available, however, on unmet demand for AAA residential repair services, and the unmet demand in April 2005 was 739 homes.

The data on persons served through the Low Income Home Energy Assistance Program (LIHEAP) are only for those persons receiving weatherization services through that program. Local departments of social services also administer

Table 13

Number of Elderly Households Served and Expenditures For Select Housing Programs (FY 2004)

Program	Elderly Households Served
Department of Housing and Community Development Programs	
Emergency Home Repair Program[1]	262
Weatherization Assistance Program	855
Low Income Home Energy Assistance Program[2]	1,001
Indoor Plumbing/Rehabilitation Loan Program	56
Area Agency on Aging Programs	
Residential Repair Program	914

[1]Number of households with elderly resident.
[2]Portion of program funded through the U.S. Department of Energy.

Sources: Department of Housing and Community Development and Virginia Department for the Aging.

funding from this program to low income households, including elderly households, to help with heating and cooling costs. The State DSS maintains a referral list of households eligible for LIHEAP assistance, and the most recent list available to DHCD as of August 2005 indicated that 18,395 elderly households were determined eligible for weatherization or energy assistance through this program. VHDA staff note that rising energy costs are becoming a much larger affordability issue for older adults, even more so than are increasing property taxes, as discussed earlier. As a result, State policymakers may be asked to provide additional funding for energy assistance.

X. Aging Population May Increase Demand for Public Transportation

In order to remain mobile and continue to live in the community, older Virginians require access to some form of transportation that allows them to get to grocery stores, medical appointments, and pharmacies, and engage in other aspects of daily life. Given projected increases in both the number and proportion of older Virginians and a potential decrease in the availability of family caregivers to assist with transportation needs, State policymakers may face an increase in demand from older Virginians who are dependent upon alternative forms of transportation.

The availability of transportation services for this population already appears to be a statewide problem. A needs assessment of the State's various transportation systems conducted by the Department of Rail and Public Transportation (DRPT) found that "the elderly population of Virginia is growing rapidly and their critical transportation service needs cannot be met at existing levels of service." Moreover, the Commonwealth Transportation Board (CTB) recently observed in its long-range transportation plan for the State ("VTRANS 2025") that:

> Nearly two-thirds of the elderly population lives in rural and suburban areas, where specialized transit services are limited, even nonexistent, and where traditional transit services are not well suited. Additionally, there will be a need to encourage land uses that reduce automobile dependence and to design transportation systems that accommodate the needs of older drivers.

Even in localities that have a public transportation service, many local agency staff interviewed by the study team also express concerns about the availability of transportation services for their clients. This is because service routes do not typically extend to all parts of a locality, leaving some residents of even more metropolitan areas without access to public transportation.

Although the State currently has a limited role in providing transportation services, a lack of these services could have potentially detrimental effects on older Virginians' health and well-being, and possibly result in greater and more costly State intervention in their care. Additionally, insufficient transportation options could undermine the effectiveness of State initiatives to provide individuals with an array of choices for receiving needed care.

MANY OLDER VIRGINIANS ARE UNABLE TO PROVIDE THEIR OWN TRANSPORTATION

Whether due to an inability to drive, self-imposed limits on driving, or lack of access to a personal vehicle, many older Virginians must depend upon some

alternative form of transportation to remain mobile and continue to live in the community. In Virginia, Census data indicate that 16 percent of all elderly-headed households did not have access to a vehicle in 2000. Research conducted by the National Institute on Aging indicates that people age 85 and older – the fastest growing segment of the population – are expected to outlive their ability to drive by up to 10 years. As a result, many older Virginians may rely on assistance provided by spouses or other informal caregivers, as well as local agencies and volunteer organizations. A lack of transportation creates a barrier to meeting the health needs of older adults, according to 38 percent of all state units on aging (the equivalent of Virginia's Department for the Aging). According to a report by the National Association of State Units on Aging:

> Unless adequate transportation is available, the services and activities provided to many seniors by home and community based service delivery systems will be insufficient to help them remain at home.

Additionally, research conducted by George Mason University found that, next to health, older Virginians cite options for transportation as the most significant issue they encounter with age.

For older Virginians without an adequate network of informal support, alternative forms of transportation such as public transportation are integral to their self-sufficiency and independence. This includes non-emergency medical transportation provided to Medicaid recipients. Medicaid-funded transportation is not an option for most older Virginians because of eligibility restrictions that are based on income, financial resources, and the level of disability. In fact, only nine percent of Virginians age 60 and older received Medicaid-funded services in 2003. To illustrate, staff at Catholic Charities of Hampton Roads report that most of their transportation-dependent clients are not eligible for Medicaid, and thus must depend upon public transportation to get to needed medical appointments. However, some of their clients are unable to use available public transportation because they cannot walk from their home to the bus stop, and the paratransit services provided by appointment by the area's public transportation provider are not always reliable.

GOVERNMENT FUNDING ALLOCATED TO TRANSPORTATION SERVICES FOR OLDER ADULTS IS MINIMAL

Transportation services for older persons can take different forms, such as traditional bus service operating on fixed routes and schedules, specialized paratransit services for persons with disabilities, or demand-response transportation services that are provided by appointment. In Virginia, these transportation services are provided at the local level, often by non-governmental agencies, but government sources provide much of their operating funding.

The State's role in providing these alternative transportation services is limited to the distribution of funds, as well as some policy research and technical

support. State and federal public transportation funds are primarily distributed to local agencies by DRPT. Staff at several local agencies indicate that they have been pleased with the support provided by DRPT, although not all local agency staff had heard of the agency.

According to data published in the CTB's "FY 2005 Rail and Public Transportation Improvement Program" document, State and local funding for all transportation services in Virginia (including road construction and maintenance) amounted to approximately 31 percent ($154.6 million) and 38 percent ($186.5 million), respectively, of government funding for these services in FY 2005. The remaining 31 percent ($153 million) was federally funded. However, an examination of the State's funding allocations for all agencies within the State's Transportation Secretariat shows that only 4.2 percent of the total $3.8 billion in transportation funding was allocated to DRPT in FY 2005. Of this amount, 1.8 percent – a total of $2.9 million – was specifically dedicated to transportation for the elderly and disabled. This equates to 0.07 percent of all State transportation funding. Nationally, federal funding for elderly and disabled transportation represents just 0.23 percent of transportation spending. (Appendix F contains more detailed information on transportation funding.)

LIMITED AVAILABILITY OF PUBLIC TRANSPORTATION SERVICES MAY DISPROPORTIONATELY IMPACT OLDER VIRGINIANS

Some evidence suggests that older Virginians may be disproportionately impacted by a lack of transportation options. Available Census data indicate that a disproportionate number of older Virginians do not have access to a personal vehicle. According to a representative of the Virginia Association of Local Human Services Officials, the availability of transportation services is particularly important for older Virginians, because they are less likely to use technologies such as direct deposit or mail-order pharmacy services. Older Virginians are therefore more likely to require transportation assistance for some tasks that younger persons may not. There is some evidence, however, that older Virginians may have difficulty using alternative forms of transportation even in those areas of the State where they are available.

Some Older Virginians Do Not Have Access to a Vehicle

Data from the 2000 Census also indicate that older Virginians may be more reliant upon alternative forms of transportation than younger persons. According to these data, although only 19 percent of all Virginia households are headed by persons age 65 and older, this group represents 39 percent of all households without access to a vehicle. According to the Census data, relatively high percentages of elderly-headed households (age 65 and older) without access to a vehicle exist in both urban and rural areas of the State (Table 14).

Table 14

Virginia Localities with the Highest Percentage of Elderly-Headed Households Without Access to a Vehicle (2000)

Locality	Percentage of Households	Number of Households
Richmond City	33.3	6,085
Petersburg City	29.8	1,074
Arlington County	27.5	3,278
Covington City	27.2	258
Scott County	26.4	760
Alexandria City	26.2	1,987
Buena Vista City	25.9	185
Lee County	24.9	632
Norfolk City	24.0	4,232
Clifton Forge City	23.9	157

Source: JLARC staff analysis of 2000 Census Data.

At a local level, about 15 percent of all elderly-headed households reported on the 2000 Census that they did not have access to a vehicle. Moreover, as shown in Figure 19, public transportation is not provided in several localities in which there is a higher percentage of older Virginians without access to a vehicle than the locality-level average of 15.4 percent. For example, 16 percent of the nearly 6,000 elderly-headed households in Henry County, which has no public transportation, reported not having access to a vehicle.

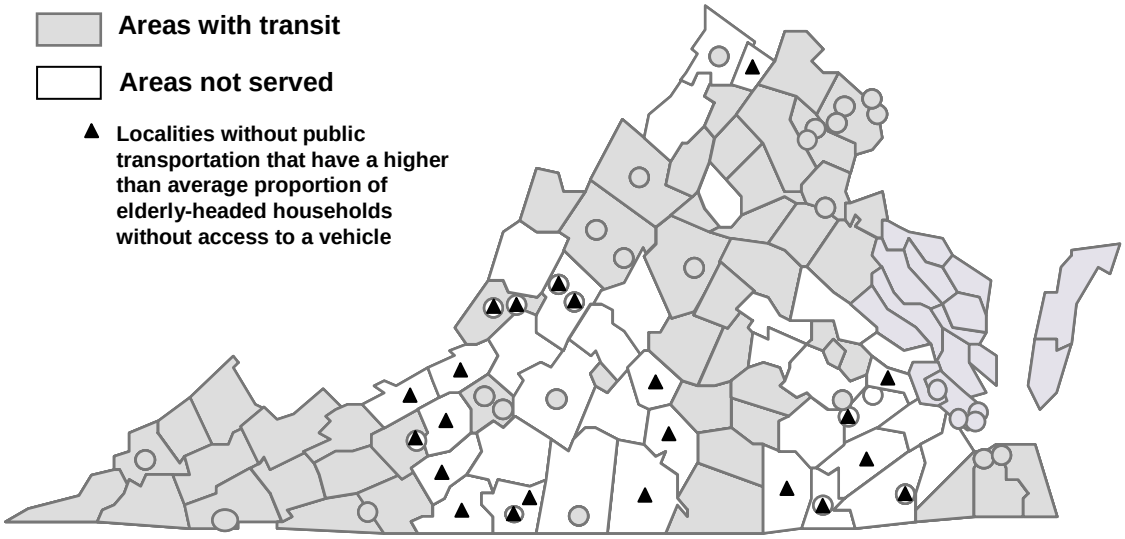
Even in Localities That Have Public Transportation, Services May Be Insufficient to Meet Some Older Virginians' Needs

The presence of public transportation in a locality does not necessarily mean that it provides sufficient access to needed services. In those localities that have transit services, such as Henrico County, only a portion of the locality is covered by the service. A needs assessment conducted by DRPT in 2004 found that there are "many areas [of the State] with very little service or with service that does not make the needed connections to employment, shopping, and medical centers." This could be partially explained by the fact that the manner in which available land is developed is largely dictated by local land-use planning decisions.

Improvements in Land-Use Planning May Address Some Transportation Needs. As noted in the interim report, the CTB recognized in its long-range transportation plan for the State that better integration of transportation and land-use planning will need to occur in order to meet the transportation needs of the growing number of older Virginians. According to Department of Transportation

Figure 19

Virginia Localities Served by Public Transportation



Note: The symbols denote those localities that have a proportion of elderly-headed households without access to a vehicle that is higher than the locality-level average of 15.4 percent, and which also do not have a public transportation system. However, even in those localities that provide public transportation, typically only a portion of the locality is served by public transportation routes.

Source: JLARC staff analysis of data from the Virginia Department of Rail and Public Transportation and U.S. Census Bureau.

(VDOT) staff, however, planning is hindered by the fact that land-use decisions are made locally. Local land-use planning decisions have resulted in instances where transit routes are not located near needed services. For example, the Harrisonburg-Rockingham Metropolitan Planning Organization's draft transportation plan for the year 2030 notes that "retirement home residents" have observed that "health care services are moving to professional parks in the County that are not served by City transit." The following two examples of land-use problems were provided by local agency staff:

- According to DSS staff from Albemarle County, a new DSS office has been built in the county, but it is not on the local bus route. Bus service was not extended to the new office because of the expense.

- According to Chesapeake City CSB staff, Chesapeake does not have an adequate sidewalk system and the nearest bus stop to the CSB office is one-third of a mile away. In order to visit the CSB, transportation-dependent clients have to walk along a four-lane divided highway, next to 55 MPH traffic, without sidewalks.

In its 2003 final report, Virginia's Olmstead Task Force recommended improving efforts to make sure that "public transit routes and stops [are] located near, and accessible to . . . social service agencies and programs."

It should be noted that a recent revision to VDOT's policies for incorporating the needs of pedestrians in new road designs could benefit older Virginians who live in areas with limited public transportation options. The policy states that VDOT will "coordinate with [DRPT] and local and regional transit providers to identify needs for bicycle and pedestrian access to public transportation services and facilities," which would address concerns expressed to JLARC staff that even in areas where public transportation exists, there are no sidewalks to allow older persons to reach designated stops.

Increased Availability of Paratransit May Be Required As the Population Ages. Some older Virginians, like persons of all ages, may have difficulty using typical fixed-route transit services. As noted in a 2003 study conducted by the Brookings Institution, seniors are likely to become too disabled to use public transportation services even before they become too disabled to drive. To address this issue, the Americans with Disabilities Act requires that complementary paratransit service be offered within three-fourths of a mile on each side of a fixed route.

However, these additional service corridors may not sufficiently extend public transportation to all areas of a locality where such services are required. For example, according to the Richmond Metropolitan Planning Organization for the Richmond Regional Planning District Commission, "There are a number of residents in Chesterfield County who would qualify for ADA paratransit service, but do not have access to it," because of the limited coverage area of the county's transportation services. Moreover, as noted by the Brookings study, "Most elderly people are ineligible for special transit services even if they live near existing bus routes" because of the eligibility restrictions for using the complementary paratransit services. According to the study, "being unable to drive or having minor handicaps rarely qualifies one for services."

Limited Availability of Transportation Services for Older Virginians May Negatively Affect Their Health and Well-Being

Staff from each local agency visited by the study team report concerns about the availability of alternative transportation options for older Virginians. As noted in Chapter VII, local agencies also report unmet demands for services that could alleviate the isolation resulting from a lack of transportation, such as home-delivered meals. Additionally, several agencies responding to JLARC's survey state that one of the primary steps that should be taken by all levels of government to meet the future demands of older Virginians will be to make alternative forms of transportation more available. For example, according to the Superintendent of the Virginia State Police:

> When senior citizens lose the ability to drive, their mobility and independence is severely limited. . . . Federal, state, and local governments should take steps to enhance public transportation to meet the transportation needs of older citizens. The availability of public transportation will enhance the quality of life for older citizens immeasurably. It will also improve highway safety by providing an alternative for older drivers who are reluctant to surrender their driving privileges.

According to local agency staff, inadequate access to transportation services commonly results in missed medical appointments, an inability to travel to the grocery store or pharmacy, and a reliance by older Virginians on friends or relatives to provide transportation (often at a cost). In some instances, local agency staff report having to become the transportation providers of last resort. A lack of transportation alternatives may result in the decision by some older Virginians to pay for transportation instead of other necessities such as prescription medications. In Culpeper, an adult services worker stated that people "will go without groceries to make sure that they can pay their friend to take them to dialysis." Similar situations were also reported by staff in the more rural areas of Virginia's Tidewater area, such as the counties of Charles City, Isle of Wight, and the City of Suffolk. As a result, some older Virginians are reported to be vulnerable to exploitation by members of their communities who overcharge for rides.

The State's Ability to Plan for Older Virginians' Transportation Needs Is Limited by the Lack of Data on Their Service Demands

Measuring the actual demand by older Virginians for alternative means of transportation is hindered because there are no comprehensive data on either the utilization of transit services or unmet service needs. According to DRPT staff, no data are available to document the extent of transportation services on a locality-by-locality basis. DRPT staff state that data are collected on the demographic and socioeconomic characteristics of public transportation users every three to five years when a transit system updates its transit development plan or plans new routes. Agency staff also note that it would be expensive to develop and maintain these data on a statewide basis, in part because DRPT has only one transportation planner. DRPT staff add that there are no requirements for how regularly providers are to update these transit development plans, but that DRPT receives copies of the plans and is usually involved in the planning process.

The only data available on the unmet transportation needs of older Virginians are maintained by the area agencies on aging (AAA), which report providing transportation services to 9,334 persons in federal fiscal year (FFY) 2004. AAAs also report being *unable* to provide transportation to 718 individuals, and able to only *partially* meet the transportation needs of an additional 1,062 individuals. These data, however, only include persons for whom AAA staff were able to fully screen for services, and some AAA staff report that limited resources prevent them from conducting a full needs assessment on every individual. Moreover, these figures only take into account the transportation needs of AAA clients, which

represented only 4.9 percent of Virginia's older population in FY 2003. As such, these data are limited in their utility as a planning tool.

LIMITED AVAILABILITY OF TRANSPORTATION FOR HEALTH CARE WORKERS REPORTEDLY HINDERS ACCESS TO HEALTH CARE

Local and State agency staff, as well as representatives of the long-term care industry, state that there are not enough transportation options for certain health care workers. This shortage of transportation options is reported to limit the availability of certain services for which older Virginians are eligible.

Some Health Care Providers Depend Upon Public Transportation to Reach Their Clients

Anecdotal reports suggest that the lack of public transportation services is a barrier to some older Virginians' ability to receive needed in-home care, although no data are available to document the extent of this problem. As mentioned previously, many Virginia localities offer public transportation, but these services are typically not available throughout the locality. Because some in-home service providers reportedly depend upon public transportation to reach their clients, some older Virginians who reside in localities that offer public transportation, but who live outside of the service routes, may be unable to receive needed in-home services. For example, although the Richmond metropolitan area has a public transportation service, service routes do not extend to all parts of the area. Staff at the AAA in Richmond state that this prevents some older Virginians in the more rural parts of the metropolitan area from receiving in-home services, because many home health aides depend upon public transportation. The following examples further illustrate that, even in Virginia localities that have a public transportation service, the fact that transit routes do not extend to all parts of a locality may make it difficult for older Virginians to receive needed in-home services:

- A pre-admission screening team member in Henrico County states that because the county's public transportation network does not extend to the more rural portion of eastern Henrico known as Varina, it has sometimes been difficult for Varina residents to receive home-based services.

- In Arlington County, local AAA staff indicate that the northernmost part of the county has the largest cluster of single-family homes with older residents, but this area is difficult for providers to access because of the limited reach of the local transportation network.

- Staff from the Tidewater area AAA located in Norfolk report that the problem of finding an in-home service provider for a client due to the transportation issue occurs "weekly." Even though several localities in that area have a

public transportation service, it is not available in some parts of these localities, such as the more rural areas of Virginia Beach like Sandbridge.

- DSS staff from Loudoun County report that, in part because of the limited availability of public transportation in the county, they inform individuals who are screened for personal care services that they may be unable to get services. This is because personal care aides tend to live in Fairfax County, but there is no transportation service that crosses county borders.

- While AAA staff from Fairfax County report that most of their county is well served by transportation, AAA clients in some parts of the county are unserved by home care because aides may not have a car and there is no regular bus service.

- Albemarle County DSS staff report relying upon, and having to train, friends and family for the provision of home-based adult services, because transportation costs deter home care aides employed by formal provider agencies from serving the more rural areas of the county.

Transportation Expenses Are Reported to Make Some Services Too Costly to Provide

Some in-home service providers reportedly do not find it cost effective to operate in some rural parts of the State because of the lack of transportation services for their employees and the costs incurred of using personal vehicles to drive long distances. Local agency staff from several localities report that limited transportation services results in preferences by in-home aides to only serve clients who live near their own homes. This can exacerbate problems of access to these services, especially in rural areas that may have fewer personal care agencies, as illustrated by the following examples:

- Staff from the AAA which provides the bulk of in-home services to individuals in far Southwest Virginia (Planning District 1) report that the most common reason for unmet personal care demands is that clients live in more remote areas of the counties that aides will not visit, or to which it is not cost-effective for the agency to send workers. This issue reportedly contributes to agency turnover, once newly hired staff realize the travel demands that will be placed upon them as personal care aides.

- Staff from the AAA that serves Martinsville and surrounding counties report that the AAA requires the in-

home service aides that they hire to have their own personal vehicles. They state that the cost incurred for travel and vehicle maintenance is a barrier to the recruitment of new aides.

- AAA staff in the Shenandoah Valley and Charles City County DSS staff report that they have recently screened several people for home and community-based Medicaid waiver services who are having difficulty finding a provider because personal care agencies do not find it cost effective to operate in such a rural county with no public transportation services.

- Staff from the health district that serves Pittsylvania, Franklin, and Patrick counties state that if a person is eligible for three hours of personal care a day, but the aide has to drive 40 to 50 miles to get to that person, and there are no other clients in that area, the person may go unserved. Due to transportation costs, staff state that aides generally prefer to provide services to persons who live close to them.

Efforts by some local agencies to reimburse service providers for transportation costs are reported to have alleviated some difficulties with recruiting staff and serving clients. For example, the Prince William AAA reimburses aides if they have to travel beyond a ten-mile radius. Both the Norfolk and Waynesboro AAAs have similar initiatives. This, however, is only for AAA in-home services, and no DSS staff indicate that their agencies provide a transportation reimbursement. In addition, Virginia's Medicaid program does not directly reimburse aides for transportation costs.

The increasing number of older Virginians may make some areas that currently have low population density more cost-effective to serve in the future. However, in order to ensure that insufficient options for alternative transportation services do not result in individuals' premature institutionalization, State policymakers may wish to consider the feasibility of reimbursing local agencies and other providers of home-based services for their transportation costs. Staff at the Department of Medical Assistance Services indicate that this is not necessary for Medicaid home-based services, because providers currently receive a sufficient reimbursement, and that providers should instead increase the hourly wage of their employees to compensate for transportation costs. If the State were to provide a transportation reimbursement, one approach could be to target this incentive to "hard to serve" areas within a locality. However, designating these areas is hindered by the absence of uniform data on unmet demand for the services of all local agencies, especially the lack of data on a sub-locality level.

STATE AND REGIONAL-LEVEL PLANNING RECOGNIZES THE POTENTIAL IMPACT OF AN AGING POPULATION

The State has taken steps to address the transportation needs of some special populations, such as elderly and disabled persons who use the transportation services provided by local human service agencies. DRPT has recently begun participating in the federal United We Ride initiative, which is intended to enhance the coordination between various human service transportation programs. DRPT is using the $35,000 received in FFY 2004 to conduct an inventory of the State's human service transportation resources, including capital resources, system operation costs, and existing coordination efforts. This effort is intended to provide baseline data for use in improving the coordination of human service transportation systems. Although this program has the potential to augment the availability of transportation services to older Virginians, it does not fully address the lack of data on the use of, or unmet demand for, transportation services.

DRPT has also been involved in funding other research. In 2004, DRPT granted the Northern Virginia Transportation Commission (NVTC) $114,000 to study the transportation needs of seniors in Northern Virginia. According to the NVTC, the study will examine the current and projected gaps in available transit services for the area's older residents, and assess the need for service changes to meet the future transit needs of that demographic. The Hampton Roads Planning District Commission conducted a similar study in 2005, and found that all of the increase in the future number of non-drivers in the area would be from persons age 65 and older. The study found that local governments can address the mobility needs of older Virginians by improving public transit services and infrastructure for pedestrians, as follows:

- Improving pedestrian facilities and transit service;
- Ensuring that adequate portions of localities are zoned for higher densities; and
- Adjusting transit service to accommodate the elderly by changing the time of day that service is provided, the design of transit routes, and the marketing of the service.

The planning district intends to expand on its research with a $150,000 grant from VDOT.

Other planning district commissions have recognized the transportation needs of older Virginians as well. For example, the Metropolitan Planning Organization for the Richmond Regional Planning District Commission noted the potential for increased demand for public and paratransit services by the area's older population in its "2026 Long-Range Transportation Plan." The Crater District Planning Commission also recognized in its long-range transportation plan that elderly transportation programs may need to be expanded to accommodate land-use trends in which residential areas are no longer located near commercial districts.

These examples illustrate a growing awareness at the local level of the future impact of older Virginians' transportation needs.

As noted previously, a recent needs assessment completed for DRPT predicted that Virginia's current transportation systems will be inadequate to meet the potential growth in older Virginians' demand for assistance. However, the State's ability to assess and plan for the future transportation needs of older Virginians is limited by a lack of comprehensive statewide data on the availability of transportation services and the current transportation demands of older Virginians. In order to position the State to respond to the needs of older Virginians, State policymakers could require local transportation providers to provide DRPT with data on the ages of transportation users, as well as other relevant demographic and socioeconomic information. In addition, to assess the availability of transportation services, DRPT could begin collecting current and comprehensive data from all public transportation providers in the State on the location of transportation service routes, including paratransit services for the elderly and disabled. The Virginia Geographic Information Network could be used to provide mapping services.

Appendixes

Supplemental Appendix: State Agency Survey Results is available on the JLARC website at http://jlarc.state.va.us/Reports/AgingSupAppdx.pdf

Appendix A: Study Mandate

HOUSE JOINT RESOLUTION NO. 103
2004 SESSION

Directing the Joint Legislative Audit and Review Commission to study the impact of Virginia's aging population on the demand for and cost of state agency services, policies, and program management.

WHEREAS, the 2000 census reported there were 1,065,502 persons who were age 60 or older in Virginia, comprising 15.1 percent of the state's population, and of that number, 87,266 Virginians were age 85 and older, comprising 8.2 percent of this older population and 1.2 percent of the total population of the Commonwealth; and

WHEREAS, Virginia's older population, those age 60 and above, increased by 17.1 percent between 1990 and 2000, growing from 909,906 to 1,065,502 individuals; and the population of Virginia age 75 and older increased at an even faster rate, 36.4 percent between 1990 and 2000, growing from 263,848 to 359,877 individuals; and

WHEREAS, Virginia's older population is projected to increase at even faster rates over the next 30 years, growing to 1,540,299 (19.91 percent of the total population) by 2010; to 2,101,193 (25.49 percent) by 2020; and to 2,611,774 (25.73 percent) by 2030; and

WHEREAS, the distribution of older Virginians varies tremendously across the State, ranging from 7.6 percent of the population in Prince William County to 23.7 percent in the Middle Peninsula and Northern Neck, with consequent disparate economic impacts and widely varying demands for services in different localities; and

WHEREAS, the growth of the older population also is projected to vary dramatically across the Commonwealth, such that those areas with higher concentrations of "baby boomers" in 2000 relative to the existing population age 60 and above will experience significantly greater increases in the older population beginning in 2006, when the first "baby boomers" turn 60 years of age (for example, Prince William County has more than four times as many "baby boomers" as persons age 60 and older, while the Eastern Shore has almost the same number of each); and

WHEREAS, in the 2000 census, 149,726 Virginians (19.9 percent of the population age 65 and over) reported having one sensory, physical, mental, self-care, or go-outside-of home disability and 167,359 (22.2 percent of the older population) reported having two or more such disabilities; and WHEREAS, the health risk conditions of older Virginians (age 65 and above) have increased between 1995 and 2001, for example, the percentage of those overweight grew from 39.2 to 40.5 percent

and the percentage of those engaging in chronic drinking (60 or more alcoholic drinks per month) grew from 1.0 to 2.7 percent; and

WHEREAS, this growing older population, increasing dramatically in numbers as well as longevity, will experience ever greater needs of services, ranging from nursing home and assisted living arrangements to the services and supports needed for older persons to remain in their homes or in their communities and including increasingly complex and expensive health care, more frequent and intensive social services, expanded and more elaborate state facility and community geriatric mental health services, and enhanced advocacy and legal services; and

WHEREAS, for example, the Virginia Department for the Aging identified the following monthly unmet needs for services in 2002: 37,161 hours of adult day care, 129,705 home-delivered meals; 54,350 hours of homemaker services; 25,332 hours of personal care services; 507 homes in need of repairs; and 11,502 transportation trips; and

WHEREAS, state and local government workforces reflect these demographic trends, and, as a result, a growing proportion of public employees will be retiring in the next 10 years, with concomitantly increasing demands on the financial resources of the Virginia Retirement System and the state and local governments that support it; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Joint Legislative Audit and Review Commission be directed to study the impact of Virginia's aging population on the demand for and cost of state agency services, policies, and program management. In conducting its study, the Joint Legislative Audit and Review Commission shall consult with the Commonwealth Council on Aging, the Commissioners of the Departments of Health and Mental Health, Mental Retardation and Substance Abuse Services, the Department of Social Services, the Department for the Aging, the Department of Medical Assistance Services, the Department of Corrections, the Department of Human Resource Management, and the Director of the Virginia Retirement System. Technical assistance shall be provided to the Joint Legislative Audit and Review Commission by the Commonwealth Council on Aging. All agencies of the Commonwealth shall provide assistance to the Joint Legislative Audit and Review Commission for this study, upon request.

The Joint Legislative Audit and Review Commission shall complete its meetings for the first year by November 30, 2004, and for the second year by November 30, 2005, and the Chairman shall submit to the Division of Legislative Automated Systems an executive summary of its findings and recommendations no later than the first day of the next Regular Session of the General Assembly for each year. Each executive summary shall state whether the Joint Legislative Audit and Review Commission intends to submit a document of its findings and recommendations to the Governor and the General Assembly. The executive summaries and the documents shall be submitted as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents and reports and shall be posted on the General Assembly's website.

Appendix B: Agency Responses

As part of an extensive data validation process, the major entities involved in a JLARC assessment effort are given an opportunity to comment on an exposure draft of the report. Appropriate technical corrections resulting from the written comments have been made in this revision of the report.

This appendix contains the written responses of the Department for the Aging, the Department of Mental Health, Mental Retardation, and Substance Abuse Services, and the Department of Social Services.

COMMONWEALTH OF VIRGINIA

Department for the Aging

Jay W. DeBoer, J.D., Commissioner

November 7, 2005

Phillip A. Leone, Director
Joint Legislative Audit and Review Commission
Commonwealth of Virginia
General Assembly Building, Suite 1100
Capitol Square
Richmond, VA 23219

Dear Dr. Leone:

The Virginia Department for the Aging thanks you and JLARC staff for the opportunity to review the Exposure Draft of your report entitled "Impact of an Aging Population on State Agencies", dated October 31, 2005.

Our staff has suggested a number of recommended technical changes, and these are included with this letter as Attachment 1. Please do not hesitate to contact me should there be questions regarding these changes, or if you should require further documentation or clarification.

During this two year study, our agency was most pleased with the depth of investigation and expertise applied to these complex issues, as well as by the utmost professionalism and courtesy displayed at all times by the JLARC team. Special thanks is given to Ashley Colvin and all of the members of the study team, who became a familiar presence at nearly every event or function that we attended over the past two years.

It was a pleasure working with JLARC again on this matter, and I send my best wishes to the Members and to the staff.

With best personal regards, I am

Very truly yours,

Jay W. DeBoer

Jay W. DeBoer, J.D.
Commissioner

Attachment #1
VDA Comments on Exposure Draft:
"Final Report: Impact of an Aging Population on State Agencies"

p. 7. "Based on 2002 estimates developed by the ~~Virginia Department for the Aging (VDA)~~ U.S. Census Bureau …."

Explanation: VDA did not develop these estimates, rather we re-packaged data produced by the Census Bureau.

p. 9. move "the Virginia Employment Commission, Nelson County is projected to have the" to follow "According to projections by" following the next bold-faced sub-heading on the same page.

p. 9 . Change ….."65,715 people ~~over the age of 60~~ age 60 and over – an…"

Explanation: Re-wording includes persons age 60.

p. 11. Recommended addition: "Between 2000 and 2030, the number of working-age Virginians (approximately ages 18 to 64)…"

Explanations: Virginia's work force includes persons under age 18 and over age 64.

p. 12. Recommended rewording: "~~On~~ The 2000 Census reported 33 percent of Virginians age 65 to 74 ~~reported~~ having a disability…."

p. 12. Factual Error: "(Disability rates for Virginians in age groups greater than 75 were not separately reported.)" is incorrect. These data can be found in Table P0035 of the 2000 Special Tabulation on Aging (see http://www.aoa.gov/prof/Statistics/Tab/aoacensus2000.html)

p. 14. Recommended rewording: "In Virginia, ~~estimates~~ projections prepared by VDA indicate that the ~~prevalence of~~ number of persons with Alzheimer's will double…."

p. 16. Recommended rewording: "Published studies suggest that Social Security has been the primary reason why poverty among the elderly generally has decreased since 1960."

Explanation: Poverty levels have fluctuated over the years, not following a consistent pattern of decline year after year.

p. 21. Rewording for clarity: "The CBO projects that the econom~~ic~~y will decline…."

p. 25. Recommended rewording: "In comparison, Medicare Part B premiums accounted, on average, for about nine percent of a Virginia retiree's monthly Social Security payment in 2004~~,~~ ~~on average~~.

p. 65. Remove possible dangling sentence? "~~These areas are.~~"

p. 113. Recommended rewording: "As indicated in Chapter 1, ~~estimates~~ projections prepared by the Virginia Department for the Aging indicate the ~~prevalence~~ numbers of persons with Alzheimer's will double…"

p. 138. Table 9. Projection value of "75,781" for 2030 of recipients of AAA Services is probably too low, given the overall growth in the 60 and over population projected over the next 25 years unless services are constrained by limited future federal and state program funding. What was the VDA source data used by JLARC staff?

Page 161, next to last sentence.

"The program is funded through ***Virginia Department for the Aging and*** Medicaid and requires that recipients be dependent in as least two activities of daily living. In addition, recipients must…."

Page 162, first sentence.

However, because the Medicaid ***portion*** of the CCEV pilot project was never expanded, only those ***nine*** sites can…

> Background information on the Case Management for Elderly Virginians Program.
>
> The CCEV funding was initially appropriated to the Office of the Secretary of Health and Human Resources. The initial appropriation for FY 1992 was $3,000,000, however, because of budget reductions, funding was reduced to $2,000,000. The Secretary transferred $500,000 to Medicaid and $1,500,000 to VDA. Since 1992, Medicaid has reduced CCEV funding. VDA incurred a CCEV budget reduction before the program was expanded in the late 90's.

p. 176. Last sentence: Remove the phrase "…ensure the quality of care they receive". The ombudsman program does not ensure quality.

Page B-1: Definition of AAA: Remove "Local government agencies"

"Area Agency on Aging" means the public or private nonprofit agency created pursuant to the federal Older Americans Act of 1965, as amended (42 USC 3001 et seq.) and incorporated by reference in this chapter, which has submitted an approved Area Plan and is designated by contract with the Virginia Department for the Aging to develop and administer its area plan as approved for a comprehensive and coordinated system of services for older persons.

Page B-1: Definition of Home-Delivered Meals:

Instead of "Hot and nutritious", make it "Hot or shelf stable"

NOV - 9 2005

COMMONWEALTH of VIRGINIA

DEPARTMENT OF
MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES

JAMES S. REINHARD, M.D.
COMMISSIONER

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November 8, 2005

Phillip A. Leone, Director
Joint Legislative Audit and Review Commission
Suite 1100, General Assembly Building
Capitol Square
Richmond, Virginia 23219

Dear Mr. Leone:

I want to thank you for the opportunity to review the exposure draft of the final report, *Impact of Virginia's Aging Population on State Agency Services (HJR 103).* This report reflects a tremendous effort on your agency's part. The Department wishes to extend its appreciation for the collaboration and dialogue conducted with your staff throughout the study period. We want to compliment your staff for their genuine interest in understanding our complex system of care.

Your draft is successful in raising awareness about the service needs of the elderly with mental, cognitive or substance abuse disorders. Your attention to regional issues will be very helpful to our future strategic planning.

The report clearly points out the need for policy development across agencies including this Department, the Department of Medical Assistance Services, the Department of Social Services and the Department on Aging -- regarding state agency roles and responsibilities in serving the elderly with mental illness, cognitive disorders or substance abuse and especially those with dementia. I am confidant that based upon the policies adopted, planning and development of age-specific resources (especially for community based support and services) can occur.

As the report projections indicate, improvement in the availability and accessibility of specialized services for the elderly has grown in importance.

The Department has been, and will continue to be, committed to partnerships with key stakeholders to strengthen community services so that elderly individuals with mental, cognitive or substance use disorders can maintain connections, both personal and environmental, that are meaningful to their well-being. Workforce development is a critical area in this effort. With more timely and appropriate intervention, we may reduce the anticipated need for hospitalization. Ongoing partnership efforts between the healthcare industry, state and local public agencies, universities and medical schools over time are essential to improving the system of care for the elderly.

I understand your staff has been in contact with key staff of our agency in the review of this draft and they have been very receptive to our recommendations for clarification. Once again, thank you for your efforts in bringing this critical issue to the attention of the legislature and others.

Sincerely,

James S. Reinhard, M.D.

Cc: Jane H. Woods, Secretary
Frank Tetrick, Assistant Commissioner ,Community Services
Jerry Deans, Assistant Commissioner, Office of Facility Management
James Evans, M.D., Medical Director

COMMONWEALTH of VIRGINIA

DEPARTMENT OF SOCIAL SERVICES

November 7, 2005

Mr. Philip A. Leone
Director
Joint Audit and Review Commission
Suite 1100, General Assembly Building
Richmond, Virginia 23219

Dear Mr. Leone:

The following are comments of the Virginia Department of Social Services (VDSS) concerning the findings and recommendations of the Joint Legislative Audit and Review Commission (JLARC) staff from its review of VDSS services and programs related to the Impact of an Aging Population on State Agency Services in Virginia.

We found the review to be substantive, accurate and thorough, and we commend your staff for their analysis of the impending demographic, social and employment changes that already have begun to affect the services available to vulnerable adults in Virginia. Of particular note are the impacts of Virginia's position as a top-ten state for migrating older citizens; the Olmstead Act and the continuing drive for community integration of those in need of mental health services; and the aging of developmentally disabled persons and their family caregivers.

In Virginia, public social services are state supervised and administered by 120 local departments of social services (LDSS), including services provided to vulnerable adults over the age of 60 and those in ages 18 to 59 who have disabilities.

As JLARC's staff repeatedly point out in the study, services available to vulnerable adults in Virginia are directly correlated to the resources available to pay for those services, including state and federal funding and funds appropriated by local governments and their boards of social services. We concur with the staff's findings in this regard and appreciate the insight and candor demonstrated in the report. We also concur that the availability of informal and formal caregivers is a critical issue for state policymakers, especially in rural areas and stressed urban centers. The stated goal of VDSS services to vulnerable adults is to assist them in remaining in the least restrictive setting for as long as possible. As the report notes, Virginia's Elderly or Disabled with Consumer Direction Medicaid (EDCD) waiver and the new Alzheimer's waiver are crucial but under funded tools for accomplishing this goal.

We agree that improvements can be made in certain areas, including data collection, and positive and proactive steps are being taken, including the recent implementation of the statewide Adult Services-Adult Protective Services Web-based automated case management and reporting system (ASAPS).

Our comments on the sections of the report submitted to VDSS appear below:

II. AVAILABILITY OF CAREGIVERS AND HEALTH CARE WORKERS AFFECTS AGENCY SERVICES

The majority of older individuals who need assistance rely on family and friends to provide this care. The ability of these informal caregivers to continue providing this care will have a direct impact on State funding, if some older Virginians continue to be unable to pay for their care needs…State policymakers may need to increase the services that support caregivers…

VDSS concurs with the JLARC staff conclusion and offers the following points:

State Support for Informal Caregivers Could Affect Future Availability of Caregivers

1. *Local departments of social services report that the growing number of adults retiring to Virginia away from their informal support networks is increasing their vulnerability to financial exploitation. Outreach to the financial industry is a VDSS priority, especially since they were not included on the list of Adult Protective Services (APS) mandated reporters.*

Respite Services are Available through the Area Agencies on Aging, but Unmet Needs are Reported

1. *LDSS also purchase Adult Day Care(ADC) provided by an ADC facility or Agency Approved Provider. FY 2004 total expenditures were $225,190, from the same limited budget item used to purchase home-based care.*

State Funding for the Caregivers Grant Has been Inconsistent

1. *VDSS continues to support consistent funding of the Virginia Caregivers Grant program to meet growing demand. In addition, VDSS has recommended that the $50,000 annual earnings cap include household earnings, not just caregiver earnings and that guardians, many of whom are caregivers, be eligible for the grants.*

The State Faces an Increasing Shortage of Health Care Workers

1. *VDSS strongly supports increased geriatric and related training for direct care providers, especially Certified Nurse Aides*
2. *New definitions of home-based services as promulgated by the Virginia Department of Health and related VDSS regulations mandate expanded nurse supervision for home care providers, which could hamper service availability, especially in rural communities.*

A SHORTAGE OF AUXILIARY GRANT BEDS WAS REPORTED BUT A LACK OF DATA HINDERS A COMPREHENSIVE ASSESSMENT

1. *VDSS continues to believe that the disparity between the cost of Assisted Living Facilities (ALF's) and the Auxiliary Grant(AG) rate is the primary cause of the undersupply and regional disparities in the number of assisted living AG beds.*

   Further, VDSS agrees that the resulting limited ALF and Adult Foster Care availability does indeed set up a recurring cycle of declining health and safety which in turn results in a recurring need for Adult Protective Services, including more costly placement in a nursing or assisted living facility.

2. *To address the lack of Auxiliary Grant data, VDSS implemented, on October 1, 2005, a new statewide Web-based case management system and reporting (ASAPS) for Adult Services and Adult Protective Services. Proposed enhancements will enable VDSS to identify recipients' original locality and the locality where assisted living services are received.*

3. *Customers leaving mental health facilities account for a significant and growing percentage of Auxiliary Grant recipients and ALF placements.*

4. *Note: Auxiliary Grant recipients are allowed to keep $62 as a personal needs allowance.*

VI. INCREASING DEMAND FOR HOME AND COMMUNITY-BASED SERVICES MAY IMPACT AGENCIES

1. *VDSS strongly concurs that implementation of policy enacted through HB 2036 (2005) regarding "service delivery consistent with the needs and preferences of older adults, occurs in the most independent, least restrictive, and most appropriate living situation possible" is directly dependent on available state and local resources.*

   Lack of resources has indeed produced a "patchwork approach" and de facto "rationing" of services in many localities. It should be noted that LDSS staff are both creative and compassionate in their efforts to make every dollar count in protecting and providing care for vulnerable adults in their communities.

   In accordance with its Business Process Re-engineering initiative, VDSS has taken significant steps in seeking stronger communication and cooperation with partner agencies in Adult Services and Adult Protective Services, including new or in-progress memoranda of understanding with Department of Medical Assistance Services (DMAS), the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS), and the Virginia Office for Protection and Advocacy (VOPA).

VDSS is an active partner in the development and implementation of the "PACE," "Community-based Coordinated Services/No Wrong Door," and related case management initiatives.

Lack of State Policy Guidance on Local DSS Data on Unmet Demand Hinders Their Use

1. *The VDSS Policy Manual (Volume VII, Section I, Chapter B, Case Management, page 17) states:*

   "Prioritizing Need/Waiting Lists
   If an agency's funds are inadequate to maintain the level of services to customers of an optional service or service mandated to the extend funds are available, localities should maintain a waiting list. Service by date of application is an acceptable means of administering a waiting list."

   "Any other proposed policy for waiting lists, such as by degree of need or at-risk status, shall be sent to the regional office of the department for approval prior to submission to the local board of social services. Waiting list criteria must be uniformly applied to all customers requesting services. Waiting lists should be updated at least annually."

2. *To improve the reporting and collection of waiting-list data, proposed enhancements to the ASAPS automated system will collect standardized statewide data and replace current inconsistent data from hard-copy reports by local agencies.*

Long-term Care Pre-Admission Screening Teams in Some Localities Provide Informal Case Management

1. *The VDSS Policy Manual (Volume VII, Section IV, Chapter D, "Long-Term Care Services," page, 21) notes:*

   "The social worker and/or the nurse on the committee must collaborate with the adult and the adult's family to identify resources to meet the adult's needs. All community-based services are to be considered."

   The purpose of the 12-page assessment is to assess whether a placement is needed or what services are needed to keep the client in the community and provide or arrange for those services if requested by the client and/or family. Resources dictate service availability.

SERVICES FOR VULNERABLE OLDER VIRGINIANS ARE LIMITED

VDSS strongly agrees with the JLARC staff's conclusions that services for vulnerable adults, including Adult Protective Services, are limited by available resources. VDSS also concurs that strong Ombudsman and Public Guardianship programs are critical partners in the continuum of protection and care for Virginia's most vulnerable adults.

Note: " Local departments investigate complaints of abuse, neglect and exploitation of adults age 60 and older and incapacitated persons 18 to 59" across all settings and facilities except state correctional units. (p. 168).

1. On page 170, the paragraph beginning "Senior State DSS staff...emphasize that there are no unmet needs for APS investigations ...however, [that] local departments that cannot purchase needed services for their clients characterize this as an unmet need for APS..." appears to result from understandable confusion of the report and investigation phase of an APS case and the identification and provision of services phase. VDSS regrets any miscommunication and respectfully suggests that the attached revision be considered.

2. Note: The estimated increase in the cost of an APS report between 2004 and 2030 (@$92 per report) does not include the cost of services needed to protect the individual and alleviate the need for APS. (p. 172)

3. Mandated reporters also include all professionals licensed by the Department of Health professions except veterinarians. (p.173)

Finally, let me emphasize that we view the staff's report and conclusions as a unique and positive opportunity to forge a comprehensive state and local response to the impending demographic and social realities facing the Commonwealth in its treatment of vulnerable adults. We look forward to seeing the full report. If you, your staff, or members of the Commission have questions, I am available to discuss them.

Sincerely,

Anthony Conyers, Jr.
Commissioner

c: The Honorable Jane H. Woods

Appendix C: Glossary of Terms

Activities of Daily Living (ADL): Physical functions that an independent person performs each day, including bathing, dressing, eating, toileting, walking or wheeling, and transferring into and out of bed.

Adult Day Care Center: Non-residential facilities that provide a variety of health, social and related support services in a protective setting during part of the day to four or more aged, infirm or disabled adults.

Adult Protective Services (APS): Located within the Virginia Department of Social Services. Investigates reports of abuse, neglect, and exploitation of adults aged 60 and over and incapacitated adults over 18 years of age and provides or purchases services when persons are found to be in need of protective services.

Affordable Housing: Housing where the occupant is paying no more than 30 percent of gross income for gross housing costs, including utilities.

Alzheimer's Disease: A progressive and irreversible organic disease, typically occurring in the elderly and characterized by degeneration of the brain cells, leading to dementia, of which Alzheimer's is the single most common cause. Progresses from forgetfulness to severe memory loss and disorientation, lack of concentration, loss of ability to calculate numbers and finally to increased severity of all symptoms and significant personality changes.

Area Agencies on Aging (AAA): The public or private nonprofit agency created pursuant to the federal Older Americans Act of 1965, as amended (42 USC 3001 et seq.) and incorporated by reference in this chapter, which has submitted an approved Area Plan and is designated by contract with the Virginia Department for the Aging to develop and administer its area plan as approved for a comprehensive and coordinated system of services for older persons. In many cases, AAAs subcontract with other organizations to facilitate the provision of a full range of services for older people.

Assisted Living: Non-medical residential settings that provide or coordinate personal and health care services, 24-hour supervision, and assistance for the care of four or more adults who are aged, infirm or disabled. Facilities offer congregate dining and activity programs.

Auxiliary Grant: Supplement to income for recipients of Supplemental Security Income (SSI) and certain other aged, blind, or disabled individuals residing in assisted living facilities or adult foster care to help them afford the cost of their care.

Auxiliary Grant Rate: Rate assisted living facilities agree to charge to individuals who are eligible for auxiliary grant assistance.

Baby Boomer: A person born between 1946 and 1964.

Caregiver: A person, either paid or voluntary, who helps an older person with activities of daily living, health care, financial matters, companionship and social interaction. Most often the term refers to a family member or friend.

Case Management: Monitoring, reevaluation, revisions to the plan of care, and integration of services provided to recipient.

Certified Nursing Assistant (CNA): Provides personal care to residents or patients, such as bathing, dressing, transporting, and other essential activities. CNAs are trained, tested, and certified and work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN).

Chore Service: Non-routine, heavy home maintenance tasks which may include window washing, floor maintenance, yard maintenance, painting, snow removal, or minor home repair.

Companion Service: ADL and IADL assistance to older adults and adults with disabilities in their homes.

Congregate Meal: Free or low-cost, nutritionally sound meals served five days a week in easily accessible locations. Meal programs also provide daily activities and socialization for participants.

Consumer-Directed Services: Services for which the recipient or family/caregiver is responsible for hiring, training, supervising, and firing of the staff.

Consumer Price Index (CPI): An index prepared and published by the Bureau of Labor Statistics of the Department of Labor which measures average changes in prices of goods and services. Components include energy, food and beverages, housing, apparel, transportation, medical care, and entertainment.

Day Support: Training, assistance, and specialized supervision in the acquisition, retention, or improvement of self-help, socialization, and adaptive skills, which typically take place outside the home in which the individual resides. Day support services focus on enabling the individual to attain or maintain his maximum functional level.

Dementia: The loss of cognitive or intellectual function, including memory loss, and loss of physical coordination that interfere with daily activities. The symptoms can be brought on by degenerative diseases including Alzheimer's.

Developmental Disability: Physical or mental impairments that begin before age 22, and alter or substantially inhibit individuals' capacity to care for themselves, learn, make decisions, speak or be understood clearly, walk or move around, live on their own, or earn and manage an income.

Fee-for-Service: Method of charging whereby a physician or other practitioner bills for each encounter or service rendered. This is the usual method of billing by the majority of physicians.

Geriatric Release Program: Created by the General Assembly in 1994 to grant early release to certain categories of older prisoners in Virginia's correctional institutions.

Group Home: A congregate setting licensed by DMHMRSAS which provides supervision in a community-based homelike dwelling for residents with mental retardation or other developmental disabilities who need assistance, counseling, and training in activities of daily living.

Guardian: An individual appointed by a court of law to manage a person's financial and/or personal affairs because the court has found that the person is not competent to manage her or his own affairs. A conservator is similarly appointed, but only for financial affairs.

Habilitation: Assistance to individuals in acquiring, retaining, and improving self-help, socialization, and adaptive skills.

Home and Community-Based Services (HCBS): Non-medical services provided to older people still living in their own homes, including assistance with ADLs, meal preparation, housekeeping, adult day care, senior center, and other services designed to keep people as independent as possible.

Home and Community-Based Waiver: The federal government typically requires that a state's Medicaid services be equally available to all enrollees. Waivers, through §1915(c) of the Social Security Act, allow states to "waive" some of these requirements. The purpose of the HCBS waiver is to give states alternatives to placing persons in costly institutional care and to give individuals the opportunity to receive care in the least restrictive possible setting. In order to receive federal approval for the implementation of a waiver program, the state must assure that it will not be more costly to provide waiver services than institutional care. To be eligible for a waiver, an individual must be eligible for Medicaid and meet the criteria for admission to an alternative institution, such as a nursing home or mental retardation training center. Virginia has six 1915(c) waivers.

Home-Delivered Meals: Hot and shelf stable meals delivered to homebound persons who are unable to prepare their own meals and have no outside assistance.

Home Modification: Adaptation and/or renovation to the living environment intended to increase ease of use, safety, security and independence.

Homemaker Service: Instruction in or the provision of activities to maintain a household and may include personal care, home management, household maintenance, nutrition, and consumer and health care education.

Human Service Transportation: Transportation that is provided to clients of human service agencies, such as AAAs, for the purpose of attending the programs or receiving the services offered by the agency.

Intermediate Care Facility/Mentally Retarded (ICF/MR): A licensed facility with the primary purpose of providing health or rehabilitative services for people with mental retardation or people with developmental disabilities.

Instrumental Activities of Daily Living (IADL): Core life activities of independent living, including using the telephone, managing money, preparing meals, doing housework, and remembering to take medications.

Long-Term Care (LTC): The broad spectrum of medical and support services provided to persons who have lost some or all capacity to function on their own due to a chronic illness or condition, and who are expected to need such services over a prolonged period of time. Long term care can consist of care in the home, adult day care, or care in assisted living facilities or nursing homes.

Long-Term Care Facilities: A range of institutions that provide health care to people who are unable to manage independently in the community. Facilities may provide short-term rehabilitative services as well as chronic care management.

Long-Term Care Ombudsperson: Serves as an advocate for older persons receiving long-term care services in facilities, the community, or at home, and provides older Virginians and their families with information, advocacy, complaint counseling, and assistance in resolving care problems.

Medicaid: The federally supported, State operated public assistance program that pays for health care services to people with a low income, including elderly or disabled persons, who qualify. Medicaid pays for long term nursing facility care, home and community based care, and some limited home health services.

Medicaid-Certified Bed: A nursing facility bed in a building or part of a building which has been determined to meet federal standards for serving Medicaid recipients.

Medicare: The federal program providing primarily skilled medical care and medical insurance for people aged 65 and older, some disabled persons and those with end-stage renal disease.

Medicare Part A: Hospital insurance that helps pay for inpatient hospital care, limited skilled nursing care, hospice care, and some home health care. Most people get Medicare Part A automatically when they turn 65.

Medicare Part B: Medical insurance that helps pay for doctors' services, outpatient hospital care, and some other medical services that Part A does not cover (like some home health care). Part B helps pay for these covered services and

supplies when they are medically necessary. A monthly premium must be paid to receive Part B.

Medicare-Certified Bed: A nursing facility bed in a building or part of a building, which has been determined to meet federal standards for serving Medicare patients requiring skilled nursing care.

Nursing Home: A facility licensed with an organized professional staff and inpatient beds and that provides continuous nursing and other health-related, psychosocial, and personal services to patients who are not in an acute phase of illness, but who primarily require continued care on an inpatient basis.

Nurse, Licensed Practical (LPN): A graduate of a state-approved practical nursing education program, who has passed a state examination and been licensed to provide nursing and personal care under the supervision of a registered nurse or physician. An LPN administers medications and treatments and acts as a charge nurse in nursing facilities.

Nurse, Registered (RN): Nurses who have graduated from a formal program of nursing education (two-year associate degree, three-year hospital diploma, or four-year baccalaureate) and passed a state-administered exam. RNs have completed more formal training than licensed practical nurses and have a wide scope of responsibility including all aspects of nursing care.

Older Americans Act (OAA): Passed by Congress in 1965 to improve the lives of older individuals and enhance their ability to maintain their independence by remaining in their homes and communities, thereby avoiding unnecessary institutionalization. To receive OAA funding, states must designate a State Unit on Aging (Virginia Department for the Aging) and designate AAAs to provide services in each area of the State.

Olmstead Decision: In 1999, the U.S. Supreme Court decided that, under Title II of the Americans with Disabilities Act, each state must provide community-based treatment for persons with mental disabilities when such treatment is appropriate and can be accommodated with existing resources. The decision has been interpreted to apply to all disabled persons.

Paratransit: Transportation service with special accommodations for disabled persons. Paratransit is required by the Americans with Disabilities Act to be offered within three-fourths of a mile of every fixed-route public transportation service.

Patient Pay: The portion of the payment for services for which Medicaid waiver recipients are responsible. The amount of the contribution is set at any income in excess of the monthly SSI income level.

Personal Care: Long-term maintenance or support services necessary to enable the recipient to remain at or return home rather than enter a nursing care facility.

Personal Care Aides assist with the recipient's activities of daily living (ADLs), such as bathing, dressing, transferring, and meal preparation.

Personal Maintenance Allowance: Amount of income that Medicaid waiver recipients can keep for expenses such as rent or food.

Pre-admission Screening: An assessment of a person's functional, social, medical, and nursing needs, to determine if the person should be admitted to nursing facility or other community-based care services available to eligible Medicaid recipients. Screenings are conducted by trained pre-admission screening teams.

Prevocational Services: Services aimed at preparing an individual for paid or unpaid employment, but which are not job task-oriented. They are aimed at a more generalized result, and are provided to individuals who are not expected to join the regular work force without supports.

Private Pay Patients: Patients who pay for their own care or whose care is paid for by their family or another private third party, such as an insurance company. The term is used to distinguish patients from those whose care is paid for by governmental programs (Medicaid, Medicare, and Veterans Administration).

Program of All-Inclusive Care for the Elderly (PACE): A capitated, managed care benefit that provides a comprehensive service delivery system. Features integrated Medicare and Medicaid financing from State and Federal governments. PACE programs serve individuals with long term care needs by providing access to the entire continuum of health care services, including preventive, primary, acute and long term care. The focus is on keeping individuals living as independently as possible in the community for as long as possible.

Provider: Someone who provides medical services or supplies, such as a physician, hospital, x-ray company, home health agency, or pharmacy.

Publicly-Assisted Housing: Housing development or unit which has received subsidies or accepts rental assistance, such as Section 8 vouchers, so that rental costs are affordable.

Public Transportation: Transportation services for which all persons are eligible. Public transportation can be provided on a regular schedule through fixed and semi-fixed routes, or by appointment.

Residential Repair: Home repairs and/or maintenance**,** including weatherization, to assist older adults in maintaining their homes and/or adapting them to meet their needs.

Respite Care: Services specifically designed to provide a temporary, but periodic or routine, relief to the primary unpaid caregiver of an individual who is incapacitated or dependent due to frailty or physical disability. Respite services can include home-based care, adult day care, skilled nursing care, and short term institutional care.

Section 8 Housing Voucher Program: A rent assistance program funded by the Federal government through the Department of Housing and Urban Development (HUD). Vouchers are provided directly to eligible households. Voucher recipients pay 30 percent of their income in rent and the voucher subsidizes the remaining rental cost.

Skilled Nursing Care: Nursing and rehabilitative care that can be performed only by, or under the supervision of, licensed and skilled medical personnel.

Skilled Nursing Facility (SNF): Provides 24-hour nursing care for chronically-ill or short-term rehabilitative residents of all ages.

Subsidized Senior Housing: Housing that accepts Federal, State, or other funding to provide affordable housing for older people with low to moderate incomes.

Supplemental Security Income (SSI): A Federal income supplement program funded by general tax revenues. It is designed to help low-income aged, blind, and disabled people meet basic needs for food, clothing, and shelter.

Supported Employment: Work in settings in which persons without disabilities are typically employed. It includes training in specific skills related to paid employment and the provision of ongoing or intermittent assistance and specialized supervision to enable an individual with mental retardation to maintain paid employment.

Uniform Assessment Instrument: Assessment tool developed in 1994 to determine eligibility for publicly-funded long-term care services.

Waiver: See "Home and Community-Based Waiver".

Appendix D: Research Methods

The study team used four primary research activities to examine the impact of Virginia's aging population on State agencies, policies, and program management. These activities were: (1) document and literature reviews, (2) analysis of agency program data and Census data, (3) a survey of State agencies, and (4) structured interviews with State and local agency staff, as well as representatives of long-term care provider organizations.

Document and Literature Reviews. The study team reviewed the literature that pertains to the demographic characteristics of older adults in Virginia and nationally. Peer-reviewed medical journals were also consulted to obtain a better understanding of the medical needs of older persons. The team also reviewed literature on the use of federal benefits programs, such as Medicare and Medicaid, by older persons, and the anticipated impact of the growing number of older persons on these programs. The team also reviewed the federal and State laws that govern service eligibility and provision and agency documents that describe the services provided to older persons. Finally, prior studies on services provided to older Virginians were also reviewed, as well as studies on the older population conducted by other states.

Data Analysis. JLARC staff conducted an analysis of State and local agency data on the past, present, and projected future use of agency services by older clients. These data included number of older clients served, the agency services that were used, unmet agency service demands (such as documented waiting lists), and program expenditures.

The study team also analyzed data from the U.S. Census Bureau, the Bureau of Labor Statistics, and the Social Security Administration, in addition to other demographic and economic data, in order to better understand how certain factors might contribute to the older population's impact on State and local agencies. Examples of these variables include: disability rates of older Virginians, the proportion of elderly-headed households in Virginia reporting no access to a vehicle, the proportion of elderly-headed households in Virginia renting versus owning their homes, poverty levels of older Virginians, and the proportion of older Virginians living alone.

State Agency Survey. To assess the impact of Virginia's growing older population on individual State agencies, the study team conducted an open-ended survey of 62 different State agencies. Agencies were selected based on their having direct involvement in service provision to older Virginians, or fiscal year 2005 appropriations in excess of $1,000,000. Individual correctional institutions, State mental health and mental retardation facilities, and institutions of higher education were excluded. The survey asked agency staff to describe the impact of Virginia's aging population on agency funding streams, services, and policies, and agency responses are reproduced as a separate Supplemental Appendix to this report.

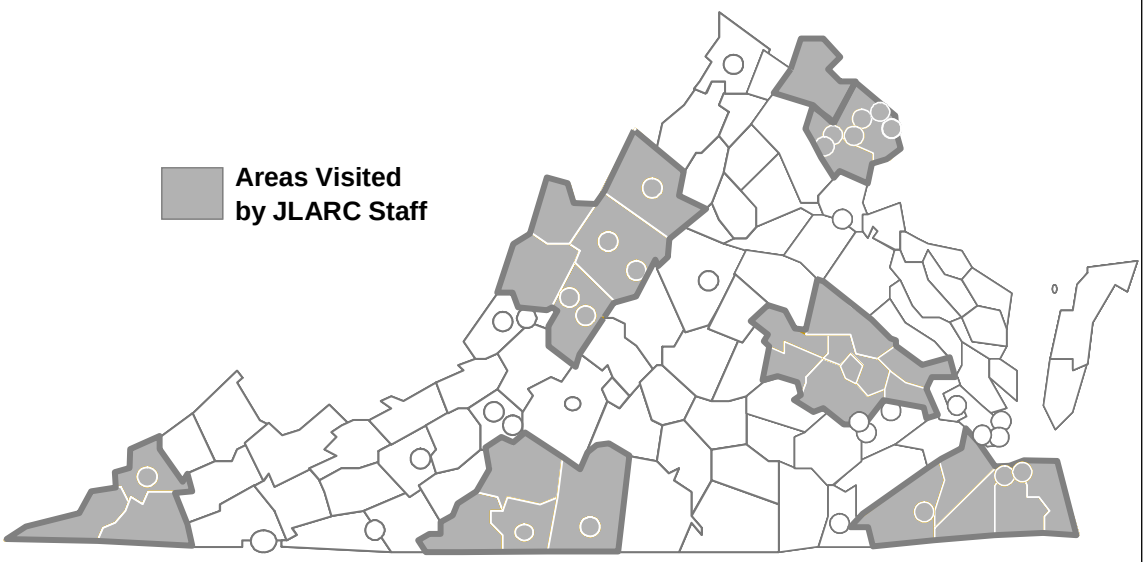
Structured Interviews with State Agency Staff. The study team conducted interviews with staff from the eight State agencies identified in the study mandate. The study team also identified several other agencies that were either involved in service delivery to the older population, or could be potentially impacted by an increase in the number of Virginians age 60 and above. These included the Department of Rehabilitative Services, the Department of Housing and Community Development, the Virginia Housing Development Authority, the Department of Rail and Transportation, the Department of Transportation, the Virginia Community College System, the Department of Taxation, the Virginia Employment Commission, and the Department of Veterans' Services.

Structured Interviews with Local Agency Staff. The study team also conducted structured interviews with staff from local area agencies on aging, departments of social services, community service boards, and local health districts in six different regions of the State. These four agencies were chosen because they are responsible for providing a number of services to older adults, as well as conducting eligibility assessments for services. (In some cases, the study team interviewed local government officials as well.) The purpose of these interviews was to gather anecdotal as well as case-specific information on the potential impact of increasing service demands by older Virginians. Interviews were also used to assess the availability of services for older Virginians, the ability of agencies to meet service demands, and the challenges agencies face in delivering services.

Area Agency on Aging Planning and Service Areas (PSAs) were used as the basis for selecting site visit locations. Figure D-1 shows the PSAs visited by JLARC staff. The PSAs reflect the State's geographic variation, incorporate localities of various jurisdictional types, and have an older population that is representative of

Figure D-1

Regions Chosen for Study Site Visits



Source: JLARC staff graphic.

the demographics and documented service demands and unmet needs of older adults statewide. Variables used when selecting locations for conducting site visits included: percentage of population age 60 and older, projected increase in older population from 2000 to 2030, proportion of older population receiving AAA services, percentage of older population with a disability, and percentage of older population in poverty, among others. The chosen PSAs were biased toward those regions with higher than typical growth rates for the older population, which allowed the team to concentrate on those areas that are more likely to be impacted by the aging population in the future.

In addition to interviewing AAA staff in each PSA visited by the study team, JLARC staff also held regional meetings with staff from the community service boards, and health and social services departments in each PSA. Local agency staff attending these meetings were asked similar questions about the ability of their agency to meet the service demands of their older clients, and the impact on older clients and State and local agencies of limited access to needed services. Additionally, staff were asked to submit written examples of cases in which an older client benefited from agency services and cases in which limited access to needed services negatively impacted both the client and the agency.

Structured Interviews with Long-Term Care Provider Representatives. Finally, to better understand issues that affect the ability of long-term care providers to meet the needs of seniors, the study team interviewed provider-group representatives, such as the Virginia Hospital and Healthcare Association, the Virginia Association of Nonprofit Homes for the Aging, and the Virginia Association of Home Care. The study team also visited nursing, assisted living, and adult day care facilities in the Richmond area and interviewed facility administrators. In addition, JLARC staff accompanied Medicaid long-term care pre-admission screening staff on four home visits in the City of Richmond.

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Appendix F: Summary of Funding for Transportation Services in Virginia

Government support specifically for the alternative transportation needs of older Virginians derives primarily from the following four sources:

1. Federal programs administered by the Department of Rail and Public Transportation (DRPT);

2. State program for capital improvements to paratransit services;

3. Federal and State support for Medicaid-funded transportation services; and

4. Federal Older Americans Act funding for transportation services administered by area agencies on aging.

Each of these sources of support, and associated FY 2004 expenditures, are illustrated in Table F-1.

Of the more than $50 million in State and federal funding spent on these specific transportation services in FY 2004, 52 percent came from the federal government, and approximately 87 percent of all funding was expended on non-emergency Medicaid transportation. JLARC staff were not able to estimate the proportion of State and federal funding expended for transportation services specifically for older Virginians, however, because non-emergency Medicaid transportation expenditures are not available by age.

Each of the programs described in Table F-1 has certain limitations in how it can be used and by whom. For example, Section 5310 funding can only be used by local human service agencies for their clients and is only to be used for capital assistance, such as the purchase of new vehicles. Of the 34 human service agencies that received Section 5310 funding in FY 2004, only 12 targeted their services specifically to seniors. Additionally, while all AAAs provide transportation services as part of their Title III-B grant obligations under the Older Americans Act, these services are typically only available for clients of the AAAs. Moreover, the scope and availability of these services vary across AAAs.

Table F-1

Primary Federal and State Transportation Programs for Older Virginians

Program	Description	Program Administrator	Limitations	FY 2004 Federal Funding	FY 2004 State Funding
Non-Emergency Medicaid Transportation	Medicaid-funded transportation for Medicaid recipients to and from medical appointments. Includes emergency and non-emergency services	DMAS	Available only to Medicaid recipients	$21,764,053	$21,764,053
Area Agency on Aging Transportation	Transportation to and from destinations that are defined by local AAAs	VDA	Only AAA clients are eligible	$2,340,599	$1,675,393
Elderly and Persons with Disabilities Formula Program (5310 program)	Provides funding only to human service agencies, such as Area Agencies on Aging, to enable them to make capital improvements to their programs for elderly and disabled clients	DRPT	Cannot be used for public transportation	$1,893,600	$0
State Capital Assistance Program for Paratransit Services	Financial support to providers of public transportation to make capital improvements to their paratransit services	DRPT	Cannot be used for human service transportation or transportation demand response services	0	$800,000
Total				**$25,998,251 (52%)**	**$24,239,446 (48%)**

Note: Non-emergency Medicaid expenditures are estimated because the expenditure category in which this service is tracked by DMAS also includes other administrative transportation costs. According to DMAS staff, however, the majority of expenditures in this category are for non-emergency services to Medicaid recipients.

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