Strategies to Support Aging Virginians in their Communities

POLICY OPTIONS IN BRIEF

There are 7 policy options in the report for Member consideration. Below are highlighted options.

Option: Develop a 1915(i) Medicaid state plan program to provide limited HCBS services to individuals with higher incomes and moderate functional needs (Option 1, page 16).

Option: Provide additional funding for home care and home modification programs and direct DARS to track unmet need (Option 3, page 19).

Option: Provide financial assistance to unpaid caregivers through tax credits, respite care, and grants to community organizations (Options 4-6, page 20).

Option: Direct DHCD to include older Virginians as a target population in the work of the Housing and Supportive Services Interagency Leadership Team (Option 7, page 21).

FINDINGS IN BRIEF

An increasing number of older Virginians need aging services, but non-Medicaid funding for services has decreased in real terms

An estimated 200,000 individuals in Virginia need aging services, with the number of older Virginians projected to grow by 22% over the next 10 years. Medicaid provides a spectrum of home and community based services for those with the highest functional and financial need, but only 12% of older Virginians in need of aging services are currently Medicaid-eligible for long-term services and supports. Inflation-adjusted, non-Medicaid funding decreased over the last 10 years, limiting Virginia's ability to meet the needs of the vast majority of older Virginians who are not Medicaid-eligible.

Affordable housing and home care are the greatest needs across the state

The most significant unmet need for older Virginians is home care, which includes assistance with chores, food preparation, and activities of daily living to remain in their communities. Many seniors also need affordable housing. Many rely on fixed retirement and social security incomes that have not increased at the rate of housing costs. Local staff indicate that nearly half of those seeking home care services, and most individuals seeking housing services wait more than 30 days to receive available services due to insufficient resources, or are unable to receive them at all.

Enhancing current programs can help address unmet needs

Virginia could consider expanding its Medicaid program to provide limited HCBS benefits to individuals with higher incomes and more moderate functional needs. Some existing programs could be supplemented with state funds to serve more individuals, and Virginia could increase support to unpaid caregivers, who already provide the majority of home care services. Increasing the supply of affordable housing will require coordination among state and local stakeholders, but is necessary to address this priority need for older Virginians.

October 2021

JCHC Analyst: Estella Obi-Tabot

Policy Options

Joint Commission on Health Care
Strategies to Support Aging Virginians in their Communities
Tuesday, December 7, 2021 – 10 AM
House Committee Room

OPTION 1 - Create a Medicaid state plan amendment for HCBS with broader eligibility criteria
JCHC could include language in the Appropriation Act directing DMAS to develop a plan for implementing a 1915(i) state plan home-and-community based services option that targets older Virginians up to 300% of SSI and with functional eligibility criteria that are less restrictive than the current criteria for the elderly home and community-based services waiver. The plan should include the eligibility criteria, services provided, utilization limits, and estimated cost of the program. The plan should be submitted to the Joint Commission on Health Care, and the Chairs of the House Appropriations and Senate Finance Committees no later than October 1, 2022. (pg.16)

OPTION 2 - Support DMAS rate study for the high needs supports waiver, that includes supportive housing services
JCHC could introduce a budget amendment providing funds to the Department of Medical Assistance Services to conduct a rate study for the section 1115 High Needs Supports waiver. (pg.17)

OPTION 3 - Increase state funding for home care and home modifications
JCHC could introduce a budget amendment to increase state funding for home care and home modification services, and include language in the Appropriation Act directing Department of Aging and Rehabilitative Services to estimate the amount of additional state funding necessary to address the current unmet need. (pg.19)

OPTION 4 - Provide state funding for family caregivers
JCHC could provide state funding for the Virginia Lifespan Respite Voucher Program that would supplement federal grant funds. (pg.20)

OPTION 5 - Provide family caregiver tax credit
JCHC could introduce legislation to provide a tax credit to eligible working family caregivers to offset the cost of eligible caregiving expenses. (pg.20)

OPTION 6 - Support community organizations that provide caregiver-like services
JCHC could introduce legislation to create a grant program to develop and expand community-based volunteer organizations that provide caregiver-like services in their communities. (pg.20)

OPTION 7 - Target older Virginians in current DHCD housing efforts
JCHC could introduce a budget amendment to include language in the Appropriation Act directing the Department for Housing and Community Development to update the current Housing and Supportive Services Interagency Leadership Team initiative to include older Virginians as a target subpopulation and add the appropriate stakeholders to develop proposals for increasing the supply of permanent supportive housing for older Virginians. (pg.21)

Public Comments on Report #463

Joint Commission on Health
Care Aging in Place Workgroup
Tuesday Decemer 7, 2021 – 10 AM
House Committee Room

Marcia Tetterton, Virginia Association for Home Care and Hospice

Thank you for the opportunity to provide comments madam chair and committee members. I am Marcia Tetterton, executive director for the Virginia Association for Home Care. I am a gerontologist and an End of Life Doula. I have been doing state and national policy work in long-term care settings for over 25 years.

We thank the Joint Commission for this study and applaud the staff for their efforts in bring to light the challenges we face as a Commonwealth.

Chronic disease impact on both the US economy and healthcare systems will explode. These conditions are now more likely expected to be diagnosed and treated than with previous cohorts. Chronic disease currently account for 76% of all hospitalizations with 12% of the Medicare population accounting for 69% of the cost. The degree of chronic illness and disability among seniors and individuals with disabilities is a key policy and budget issue for the Commonwealth. Seniors and individuals with disabilities make up 30 percent of the Medicaid population in the state, but 70 percent of the costs. The challenge is how to curb Medicaid growth in the long run without compromising access to services for vulnerable populations.

Currently in Virginia, most Medicaid seniors and individuals with disabilities receive acute and long-term care services through a patchwork of fragmented health and social programs that are not necessarily responsive to individual consumer needs. Acute care is provided in a different environment paid for by Medicare with no chronic care management.

As the report notes there are a number of opportunities that exist. The Virginia Association for Home Care and Hospice has been a champion for fare and equitable rates. It has also supported making personal care services part of Virginia's state plan. This would make more individuals eligible for the services similar to Option 1 and would meet the needs expressed in Option 2 both of which we support. We also support Option 3 that would provide funding for home modifications which are so necessary for a person to remain in their home safely.

Again thank you for the opportunity to provide comments.

Dana Parson, LeadingAge Virginia

Thank you for the opportunity to provide comments on the policy options included in the Joint Commission on Health Care's recent study, Strategies to Support Aging Virginians in their Communities. LeadingAge Virginia is an association of not-for-profit aging services organizations representing the entire continuum of aging services, including nursing homes, assisted living, adult day centers, life plan/continuing care communities, senior affordable housing, and home and community-based services.

We agree that there is a growing need to provide aging supports to older Virginians. However, we will not resolve this issue until we take a holistic approach to creating solutions for aging Virginians. Currently, Virginia is concentrating on aging services from a fragmented perspective. We are tremendously grateful that the Joint Commission on Health Care is making aging a priority, but the issue needs to be comprehensively reviewed. This study along with the recent Workforce Challenges in Virginia's Nursing Homes report need to be considered together to determine the best approach to accessing and providing long-term care services and supports to aging Virginians.

We appreciate the recognition that "middle market" older adults do not currently have access to quality long-term services and supports (LTSS) because they have too much to qualify for a subsidy and not enough to pay privately. This group needs special attention, including consideration of new options for financing beyond the current Medicaid program. We are also supportive of an enhanced home care benefit that will allow increased access to personal care services to older adults. Home care is one of the most critical assets within our system that allows individuals to age in place.

LeadingAge Virginia developed a Middle Market Playbook (attached) targeted with creating a financially viable and mission-consistent model for serving middle market seniors. The Playbook is intended to serve as a baseline that can be used to develop a series of assumptions unique to specific circumstances. We encourage the Commission to use this as a resource to explore opportunities for serving middle market seniors.

We need to provide wage increases for our front-line caregivers. We also need to provide more workplace flexibility for our unpaid family caregivers to meet the rapidly increasing care needs of our older adult population. As we look towards the future, we need to focus on programmatic infrastructure that would incentivize and train clinical staff to enter our field, so that we have enough high-quality individuals to serve the entire continuum of aging services. This includes adult day, nursing homes, assisted living, senior affordable housing, home health and hospice.

We support the policy options included in the study; however, we encourage the Commission to take a holistic approach to aging services by:

- Addressing workforce shortages.
- Providing funding for and pay a living wage to direct care staff.
- Promoting high-quality housing, care, and services across the continuum regardless of consumers' ability to pay.
- Promoting LTSS financing reform to ensure that aging Virginians at all economic levels can access services when they need them.
- Identifying and creating solutions to enhance provider access to high-quality aging and LTSS options for the middle market.
- Creating policies that enable consumers to transition to different types of services within the continuum.
- Encouraging and reward innovation, best practices, and excellence.
- Supporting the work of family caregivers.

We appreciate your continued consideration to support aging Virginians in their communities.

Emily Slunt, LOWLINC President
Mary-Jane Atwater, LOWLINC Co-founder

As one of 17 Virginia nonprofit community-based volunteer organizations (commonly known as Villages) that coordinates caregiver-like services to older adults, LOWLINC (Lake of the Woods Living Independently in Our Community) endorses Option 6 in the JCHC 'Report on Strategies to Support Aging Virginians in Their Communities.' Since 2016, LOWLINC has provided a range of volunteer services to older adults at Lake of the Woods in Orange County, allowing them to remain in their homes and avoid the need to access state-provided home caregiving services. LOWLINC services include transportation, light home maintenance, check-in calls and friendly visits, tech support and social/educational activities. We are also a referral source for screened service providers such as plumbers and electricians, and we assist members with meals and other support as they transition home after hospitalization. LOWLINC members, most of whom are not Medicaid eligible, pay a modest annual fee with subsidized memberships available for those with demonstrated need. LOWLINC is supported primarily through these membership fees, donations and small grants. The Village Model works! LOWLINC members, like older adults in other Villages, consistently report significant positive impact on their well-being and quality of life as a direct result of their participation in the Village. Starting a Village typically takes about two years of planning and a financial investment to cover marketing, website, insurance and other start-up costs. A grant program such as proposed in Option 6 would enable LOWLINC to expand the continuum of our home-based care services with care coordination that includes personal care, companion, and homemaker services. It also would provide support for extending the Village model to new and under-resourced communities, including in rural areas, with home and community-based care for older Virginians. Respectfully submitted, Emily Slunt, LOWLINC President, and Mary-Jane Atwater, LOWLINC Co-founder

Stephen Burns, Virginia Academy of Elder Law

Change Medicaid Rule so that eligibility for Community Based Care is the same for Nursing Facility Care The Department of Medical Assistance Services (DMAS) policy differentiates how it determines income spend-down for nursing facility care versus community-based care (CBC). This rule limits many applicants with higher incomes from accessing community-based care. It unnecessarily forces applicants for Medicaid coverage of long-term care into nursing facilities. This has a negative impact in two ways. First, these applicants would much prefer to receive long-term care services in their home and they have the social means to keep them safely at home. Second, the cost of care for Medicaid community-based care is less costly than nursing facility care. Therefore, there is a negative budget impact because of this rule. Medicaid policy under M1460.710B as interpreted by the Virginia Medicaid Manual is the issue. It states: The spenddown procedures for facility patients differ from the spenddown procedures for CBC patients. The expected cost of facility care is projected at the beginning of the month. The cost of care is not projected and must be deducted daily as incurred. This difference in the projection of the cost of care between facility patients and CBC patients denies access to CBC to many applicants. CBC patients rely on home care agencies that are willing to accept for payment the low Medicaid rates. Each month the patient must calculate the monthly home health care cost at the private rate, submit that to Medicaid, and hope for Medicaid approval for that month of care. Home health care agencies must bill at a private rate and submit the bill to the patient. The home care agency must then wait while DMAS compares the private rate cost of care to the patient's monthly income. Only then does DMAS pay the home care agency. Home care agencies do not want to bill at a private rate that they will never receive and do not want to wait retroactively for payment. This must occur every month. Home care agencies are unwilling o provide services under this rule. This prevents many applicants from obtaining CBC coverage. The only exception to this rule is for applicants with a monthly income less than 300% of the SSI rate or about $2,250. These applicants are allowed to project expenses and therefore automatically receive Medicaid coverage for CBC. Home Care agencies are paid without delay. Applicants with higher incomes should be treated no differently. If the projected cost of monthly home care is greater than the applicant's monthly income, then eligibility should be automatically provided all other criteria for eligibility is met. VAELA has confirmed with CMS that no federal rule or law prevents this proposed Virginia Medicaid change in policy. VAELA proposes the following: The spend-down procedures for CBC patients shall not differ from facility patients. The expected monthly cost of home care shall be projected at the beginning of the month.