JOINT COMMISSION ON HEALTH CARE

AFFORDABILITY OF ASSISTED LIVING FACILITIES

TO THE GOVERNOR AND THE
GENERAL ASSEMBLY OF VIRGINIA

COMMISSION DRAFT

COMMONWEALTH OF VIRGINIA
RICHMOND
2022

Code of Virginia § 30-168.

The Joint Commission on Health Care (the Commission) is established in the legislative branch of state government. The purpose of the Commission is to study, report and make recommendations on all areas of health care provision, regulation, insurance, liability, licensing, and delivery of services. In so doing, the Commission shall endeavor to ensure that the Commonwealth as provider, financier, and regulator adopts the most cost-effective and efficacious means of delivery of health care services so that the greatest number of Virginians receive quality health care. Further, the Commission shall encourage the development of uniform policies and services to ensure the availability of quality, affordable and accessible health services and provide a forum for continuing the review and study of programs and services.

The Commission may make recommendations and coordinate the proposals and recommendations of all commissions and agencies as to legislation affecting the provision and delivery of health care. For the purposes of this chapter, "health care" shall include behavioral health care.

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Affordability of Assisted Living Facilities

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Affordability of Assisted Living Facilities

Key terms and definitions

AAL – Alzheimer's Assisted Living waiver

ADL – Activities of Daily Living

AFC – Adult Foster Care

AG – Auxiliary Grant Program

AGS – Auxiliary Grant Supportive Housing

ALF – Assisted Living Facilities

ARPA – American Rescue Plan Act

CCC+ – Commonwealth Coordinated Plus

CMS – Centers for Medicare and Medicare Services

CHOICES – Tennessee Medicaid's program in Long-Terms Services and Supports

COLA – Cost of Living Adjustments

CPI-W – Consumer Price Index for Urban Wage Earners and Clerical Workers

CSB – Virginia Community Services Boards

DAP – Discharge Assistance Program

DARS – Department of Aging and Rehabilitative Services

DBHDS – Department of Behavioral Health and Developmental Services

DMAS –Department of Medical Assistance Services

DOLPHIN – Licensing Program Management System

DSS – Department of Social Services

FMR – Fair Market Rent

HUD – United States Department of Housing and Urban Development

IAL – Intensive Assisted Living

LASER – Locality Automated System Expenditure Reimbursement

LTSS – Long-Term Services and Supports

MCOs – Managed Care Organizations

NF LOC – Nursing Facility Level of Care

OSSP – Optional State Supplementation Program

PNA – Personal Needs Allowance

SA – State/County Special Assistance

SLRF – State and Local Fiscal Recovery Funds

SPA – Medicaid State Plan Amendment

SSI – Supplemental Security Income

UAI – Uniform Assessment Instrument

VACIS – Virginia Client Information System

VDH – Virginia Department of Health

1115 waiver – Medicaid Experimental, Pilot, Demonstration Waiver

1915(c) HCBS waiver – Medicaid – Home and Community Based Waiver

Affordability of Assisted Living Facilities

POLICY OPTIONS IN BRIEF

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

Option: Increase the base AG rate to $2,500 per month
(Option 1, page 12)

Option: Provide a one-time, lump sum payment to ALFs that serve a new AG resident, above the number of AG residents that they currently serve
(Option 2, page 14)

Option: Expand the list of eligible living arrangements for the AG program to allow AG recipients to remain in the community and coordinate their own care as needed and direct DBHDS and DARS to develop a plan to create a separate increased rate for AG supportive housing
(Options 3-4, page 22-23)

Option: Increase the personal needs allowance and include language tying the personal needs allowance to federal cost of living adjustments for the SSI program
(Option 5, page 26)

FINDINGS IN BRIEF

The Auxiliary Grant rate is insufficient to cover the cost of assisted living in Virginia, resulting in limited access

The AG rate has remained relatively flat for the last 13 years with the exception of small cost of living adjustments to comply with federal requirements. During that time period, the AG rate increased just 28% while the typical cost of assisted living increased by 64%, after adjusting for inflation. As a result, there has been a 41% decrease in facilities that participate in the AG program and the number of AG recipients since 2010. ALFs that do accept AG often have to rely on outside services or financial support, and they are more likely to have licensing violations.

Leveraging Medicaid payments to cover services in assisted living would require significant changes

Medicaid can pay for services to eligible individuals who live in an assisted living facility, but it cannot pay for the cost of room and board. ALFs would have to meet federal criteria as a home and community-based setting for residents to be eligible for Medicaid-funded LTSS. A limited number of ALF residents would be eligible for Medicaid-funded services, unless eligibility criteria are expanded.

Other community settings could be more cost-effective for individuals seeking AG payment in ALFs

Funding community-based services could meet the needs of the AG population with lower functional needs such as adult foster care. Adult foster care and AG supportive housing are already allowable community settings for AG recipients, but their availability is extremely limited. Other states allow residents to reside in more community settings, and modify their rates based on the setting.

Increased personal funds can improve quality of services for current AG recipients

The personal needs allowance for AG residents has not increased since 2014, reducing individual's ability to pay for necessary personal items and services not provided by ALFs. These are the only personal funds AG residents have after paying the ALF.

Affordability of Assisted Living Facilities

There is a growing need for affordable community-based living arrangements for adults in need of physical or behavioral health supports. Assisted living provides an opportunity for individuals to receive coordinated support and personal care services in a non-medicial, residential setting. Assissted living is often cheaper than a nursing facility, however many adults have difficulty accessing assisted living due to the cost. The Joint Commission on Health Care directed staff to study strategies to increase the affordability and accessiblity of assisted living facilities. The study resolution (Appendix 4) specifically directs staff to:

- identify challenges assisted living facilities (ALFs) face in offering the auxiliary grant (AG) program;
- assess whether residents could potentially be more appropriately served in other supportive housing or congregate care setting;
- understand the different ways that other states structure and finance their assisted living programs and the feasibility of implementing those models; and
- recommend changes to Virginia's current structure, financing, and regulation of ALFs to futher the state's goals.

ALFs in Virginia vary significantly in size and scope of care

The assisted living population is diverse, often serving older adults and people with disabilities. Assisted living is not a federally regulated industry, therefore states have the authority to create their own regulations. In Virginia, there are two levels of service – residential living care and assisted living level of care. ALFs that meet assisted living level of care standards can adhere to additional requirements to provide a "safe, secure environment." ALFs that have contained special care units may have one unit in the facility, or the entire facility may serve individuals who require special care units. Individuals are assessed using the uniform assessment instrument (UAI), either by a private ALF provider, a local Department of Social Services (DSS) worker, or other qualified assessor to determine what level of services best suits their needs.

Assisted living facilities (ALFs) are residential congregate care settings that provide care to four or more adults by coordinating personal care services, health care services, and provide 24-hour supervision. ALFs are regulated by the Department of Social Services (DSS). ALFs are separate from congregate care facilities that are licensed by the Department of Behavioral Health and Developmental Services (DBHDS) and nursing facilities licensed

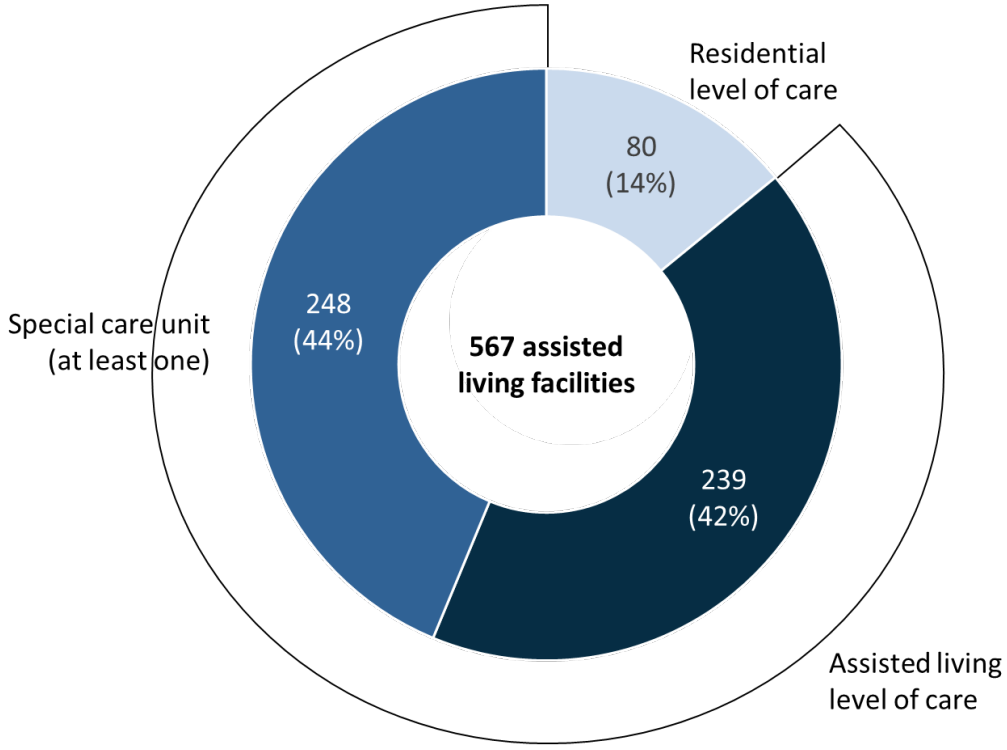
Levels of care in assisted living:

- **Residential living care** serves adults who are dependent in medication administration and may require little or no physical assistance with activities of daily living (ADLs).
- **Assisted living care** serves adults with physical or mental impairments and requires at least moderate assistance with their ADLs.
- A **"safe, secure environment"** is a self-contained special care unit for residents that exhibit serious cognitive impairments due to a primary psychiatric diagnosis of dementia who cannot recognize danger or assure their own safety or welfare.

by the Virginia Department of Health (VDH). DSS does not allow ALFs to admit or retain residents with certain prohibitive conditions. (See Appendix 2 for a list of these conditions.)

As of June, 2022 there were 567 ALFs in Virginia. Approximately 80 ALFs (14.1%) are licensed as residential living care. The remaining 487 ALFs (85.9%) are licensed as assisted living level of care. ALFs have the flexibility to develop their resident mix based on their staff or other factors. ALFs that are licensed as assisted living care may serve a mix of residents who need residential living care, assisted living care, or a special care unit in a safe, secure environment. There are 248 of the 567 ALFs (43.7%) that have at least one special care unit in their facility (FIGURE 1). DBHDS also funds 8 ALFs operated by 3 community services boards across the state.

FIGURE 1: More than 85% of ALFs are licensed for assisted living level of care

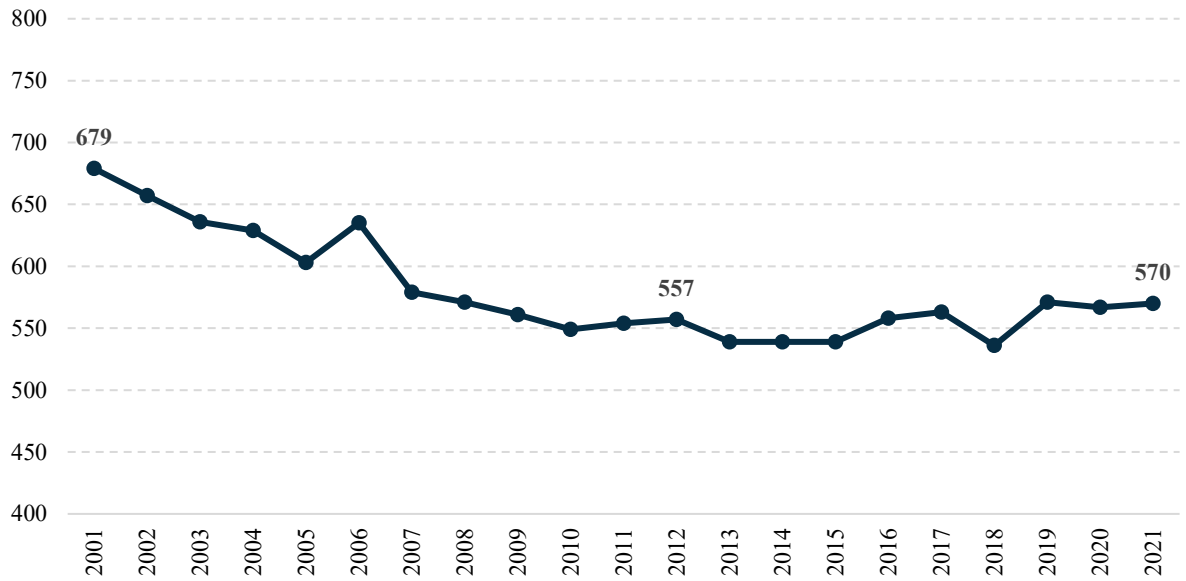


SOURCE: JCHC staff analysis of DSS VACIS and DOLPHIN data.

The number of ALFs in Virginia decreased but total residents increased slightly over the last 20 years

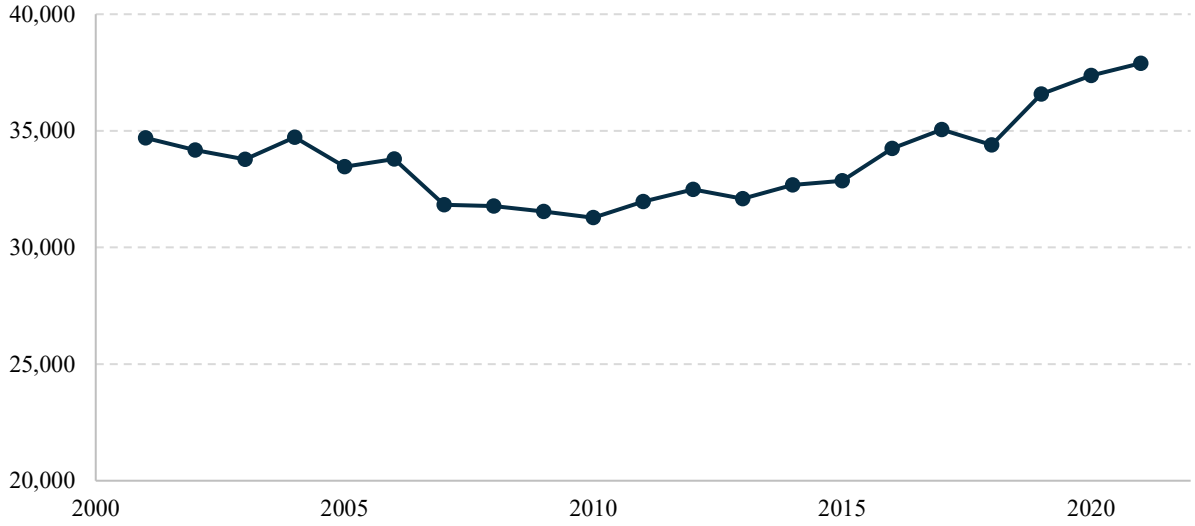
There has been a decline in the total number of assisted living facilites in Virginia in the past 20 years (FIGURE 2). However, these facilities are serving more residents on average. Despite concerns over facility closures, DSS recorded the highest total resident capacity of assisted living over the last 20 year in FY21 (FIGURE 3).

FIGURE 2: Number of ALFs in Virginia decreased over the last 20 years



SOURCE: JCHC analysis of DSS VACIS and DOLPHIN data.

FIGURE 3: Total Resident Capacity in all ALFs across Virginia (2001-2021)



SOURCE: JCHC analysis of DSS VACIS and DOLPHIN data.

Resident needs within assisted living vary substantially and include adults with physical and behavioral health needs

Nearly half (47%) of adults assessed through the public UAI (used to determine eligibility for the AG grant) had a behavioral health diagnosis. As a result, about 55% of assisted living staff reported caring for a resident with at least one mental health or substance use disorder, and about 38% of assisted living staff reported caring for at least one resident with an intellectual or developmental disability. Data on private pay UAIs are not collected in any system or central repository, and the majority of Virginia ALF residents are private pay.

The Auxiliary Grant rate does not cover the typical cost of assisted living in Virginia, resulting in fewer AG beds

There have been longstanding concerns about the Auxiliary Grant (AG) rate being insufficient to cover the cost of assisted living care in Virginia. Understanding the difference between the AG rate and the actual cost of care for individuals residing in ALFs is the first step in developing policy solutions to increase access to assisted living, and mitigating any adverse effects of the insufficient AG rate on residents and ALF staff.

How AG Payment is calculated

The AG payment is calculated by subtracting the AG rate from total net countable income. The remaining amount is the AG payment. The personal needs allowance is above and beyond the AG rate and is given to the individual.

The following example considers a single individual with other sources of income:

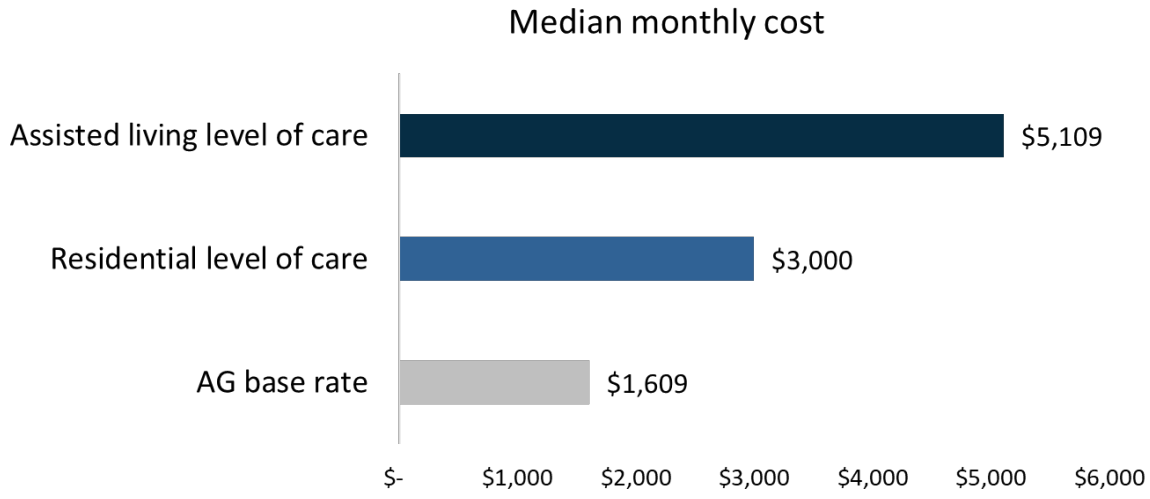
AG Rate			**$1,609**
Supplemental Security Income (SSI)	$604		--------
Pension	$103		--------
Social Security	$700		--------
Net Countable income		-	**$1,407**
	AG payment		***$202***

The AG program provides cash payments for individuals who receive Supplemental Security Income (SSI), and certain other aged, blind, or disabled individuals who reside in an ALF, approved adult foster care home, or other certified supportive housing setting. The AG payment is issued monthly, and it is funded by 80 percent state funds and 20 percent local funds. An AG provider is required to accept the AG payment to cover all services rendered including room, board, maintenance, and care, therefore, not all ALFs accept individuals funded through AG payments. The AG rate is currently set at $1,609, however there is a 15% increased cost of living differential for ALFs in planning district 8 (northern Virginia), bringing the planning district 8 AG rate to $1,805.

The median monthly assisted living cost varies between $3,000 and $5,100, depending on level of care

Monthly assisted living costs vary between the levels of care provided in the facility. Facilities that only provide a residential level of care, which serve a lower need population, report a much lower median monthly rate of about $3,000. This is compared to $5,100 for facilities serving only assisted living level of care (FIGURE 4). ALFs with memory care units generally have a higher monthly rate. However, none of the ALFs that operate a safe and secure unit accept the AG as a form or payment.

FIGURE 4: Monthly rates for assisted living facilities range between $3,000 and $5,100, depending on the level of care

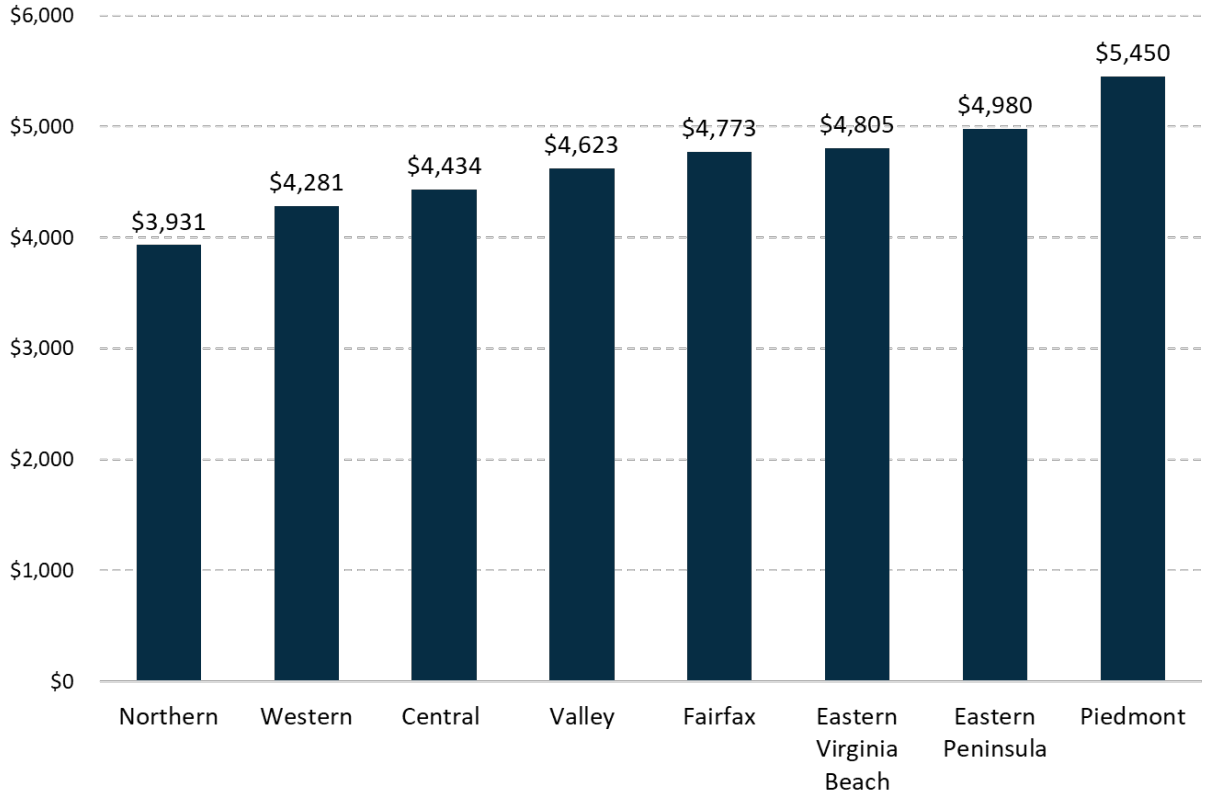


SOURCE: JCHC survey of assisted living facilities.

There is significant variation in assisted living rates depending on several factors. About a quarter of assisted living facilities charge a flat rate while the remaining three quarters create customized rates primarily based on the level of care needed by residents. Some ALFs may consider room size, shared bedroom/bathroom, or any additional services that are needed when determining a rate. These additional services can include incontinence services, laundry, or grooming supplies.

ALF rates also vary across regions of the state. Six of the eight regions have a median monthly rate of between about $4,300 and $5,000 per month. The Piedmont region had the highest average monthly rate at $5,450 while the Northern region of the state reported the lowest monthly rate of ALF costs at $3,931. Survey data showing regional ALF rates should be used as a general guide due to limitations in response rate and the mix of different types of facilities that responded to the survey (FIGURE 5).

FIGURE 5: Average monthly ALF rates by region in Virginia



SOURCE: JCHC survey of assisted living facilities.

Nearly 60% of assisted living facilities also require an entrance fee for new residents. The median entrance fee is about $2000. However, it is important to note that AG recipients who enter a facility with AG funding are not allowed to be charged an entrance fee. A facility that accepts new AG resident would have to forego the entrance fee.

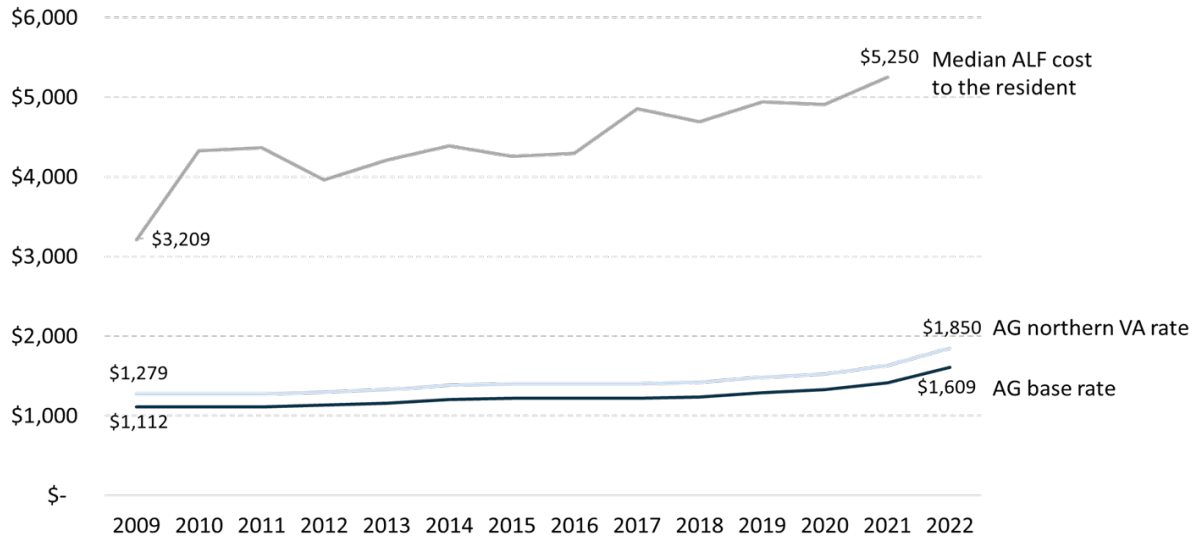
The AG rate has been significantly lower than the total cost of care in Virginia for over a decade

The AG rate has remained relatively flat for the last 13 years with the exception of small cost of living adjustments (COLA) to comply with federal requirements. During this time, the cost of assisted living facilities continued to increase (FIGURE 6). The increasing cost of assisted living care is consistent with broader trends showing an increase in the cost of other long-term services and supports. These factors create a significant gap between what an ALF receives as payment from an AG recipient and the total cost of providing services to that resident by the ALF.

One of the reasons that cost of living adjustments required by federal maintenance of effort provisions have not kept up with the cost of assisted living is that the cost of living adjustments are only applied to the federal, maximum SSI benefit, not the full AG rate. The

federal SSI maximum payment is currently $841. If a cost of living adjustment increases this by 10% to $925 (an $84 increase), Virginia is only required to ensure that its total SSI supplement program (the AG program) stays the same as the prior year. So Virginia can comply by increasing the AG rate by $84, which is only a 5% increase, half of the federal cost of living adjustment.

FIGURE 6: Inflation Adjusted AG rates compared to the median monthly assisted living cost in Virginia (inflation-adjusted to 2021 dollars)

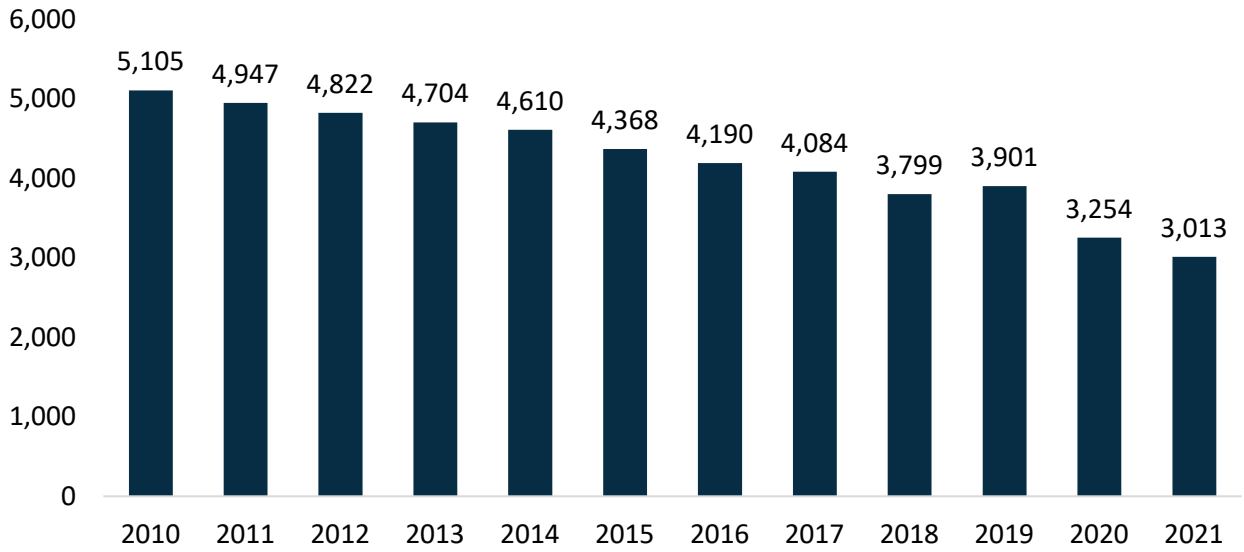


SOURCE: JCHC Analysis of the Virginia Department for Aging and Rehabilitative Services Auxiliary Grant Annual Reports adjusted for inflation and 2009-2022 Genworth Cost of Care Surveys.
NOTE: The Genworth Cost of Care Survey provides a statewide estimate of assisted living costs over time. The JCHC staff survey collected primary data from assisted living facilities and may have slightly different estimates due to sampling differences.

The number of available AG beds has decreased steadily due to the insufficient AG rate

There has been a 41% decrease in facilities that participate in the AG program since 2010. The number of AG recipients has declined steadily over this time period as well, as fewer assisted living facilities are willing to accept AG residents (FIGURE 7). When assisted living providers were asked about the primary challenge their ALF faces to support new or current AG residents, 72% of facilities stated the AG rate is too low to cover the cost of care. ALF providers cited rises in operating costs including insurance, utilities, groceries, facility upkeep, and requirements to meet state regulations. Notably, administrators cited concerns about retaining a reliable and qualified staff due to minimum wage increases and other competing labor markets that pay similarly, better, or have less demanding work duties. The next most cited reason that ALFs indicate is the administrative processes for the AG program are cumbersome.

FIGURE 7: Average monthly AG recipients (2010-2021)



Source: JCHC Analysis of LASER reports from Department of Social Services.

ALFs that serve AG recipients typically do not receive third-party payments from other sources to help subsidize their care

The AG program allows assisted living facilities to accept third party payments for AG residents, however these payments can only be used to cover additional care charges above what the facility typically provides. Even so, only 21% of ALFs that accept AG recipients reported they receive a third-party payment for an AG resident's care. Third-party payments could be from a family member, other relative, or other public funding source that is not included in their countable income. For example, some Discharge Assistance Program (DAP) residents may also receive AG payments. The median DAP payment to "AG-ALF" providers was $1,249. The highest DAP payment reported for an AG resident was $8,891 per month.

ALF closures can negatively impact other ALFs that accept AG recipients

When an ALF closes, it can have an impact on other facilities in the area as other ALFs accepting AG will be contacted to help find residents a new care facility. ALF administrators have to decide to either accept the resident or wait for an individual who can afford the facility at the private pay rate. Based on survey results, ALF providers that offer the AG program may accept more AG residents than the facility can financially accommodate when other ALFs close.

Over 43% of ALF providers reported accepting an AG resident that initially entered the ALF as private pay, further limiting bed availability

Some AG recipients enter assisted living as private pay residents, and only transition to the AG after they exhaust their financial resources. This further limits the availability of AG beds to individuals who need assisted living care for the first time, and are already financially eligible for the AG. About 43% of assisted living providers reported caring for at least one resident that entered the facility as a private pay resident before transitioning to the AG program. Of ALFs that do offer the AG program, about 12% have a policy that requires any new or current resident to live in their facility for a specified amount of time before agreeing to care for that resident by means of AG funding. The median length of time that the resident was required to be private pay before becoming eligible for the AG program was 24 months.

ALFs accepting AG residents are typically smaller, and often subsidized with other funding sources

ALFs that have continued to accept AG residents maintain a small capacity or are heavily subsidized by private and community-based organizations. There were approximately 221 ALFs that were recorded as accepting AG residents in FY21. About 52% of these ALFs reported 9 or fewer AG residents in their facility. Additionally, there were another 13 facilities that reported accepting AG residents but had zero AG residents in FY21.

ALFs that accept AG recipients have to carefully manage their finances to stay in operation and maintain their licensing requirements. "AG-ALFs" that have been able to stay in operation have cited:

- merging with a larger ALF to pool finances with revenue generating private pay facilities;
- receiving large monetary or food donations from private organizations;
- taking on additional clients with behavioral health needs to access DAP funding; and
- taking small business loans or home equity loans to afford facility maintenance required for licensure

Medicaid-funded community mental health services:

- Day treatment/partial hospitalization services
- Psychosocial rehabilitation
- Crisis intervention
- Mental Health skill building
- Intensive community treatment
- Crisis stabilization services
- Mental health peer support services

Another strategy used by some ALFs that accept AG recipients is to utilize Medicaid-funded community mental health services, to provide services to residents during the day. This provides the residents who are eligible for that service with a place to receive daytime services in a community setting and minimizes staffing costs during the day for the ALF.

CASE STUDY: Central Virginia ALF

This ALF has a capacity of 21 residents, but currently serves 13 residents, all of whom are AG recipients. During the day, most of the ALF residents attend a day program, and there are only 2 residents that remain in the ALF until about 4:30 pm. The ALF administrator indicated she is running the ALF after retiring from her other full-time job, and has not taken a salary for her work as an administrator in recent years. Instead she uses her social security benefits to maintain a living. To keep costs low, she does not staff the facility during the day when residents are away at a day support program and provides direct care to the remaining residents herself. Most of the food available was non-perishable and previously frozen foods. She indicated that a family member, who owns another facility in the region, helps her with covering remaining operating costs for building repairs, property taxes, and financial management.

SOURCE: JCHC staff site visit.

CASE STUDY: Northern Virginia ALF

This facility has a capacity of 73 residents. This facility has a mission to provide affordable assisted living options for older adults and receives a subsidy from their local government. They are also certified as a HUD low-income housing subsidy facility and need to complete a HUD certification each year. This facility had mostly private pay residents but at the time served six AG residents, and other residents who paid a reduced rate (higher than the AG) due to lower income. At the time of the visit, the facility cited there was a long waiting list for AG funding.

SOURCE: JCHC staff site visit.

CASE STUDY: Eastern Virginia ALF

This facility has a capacity of 27 residents, and at the time of the visit was near capacity. Most residents were four to a room, and there was one private room available. This facility serves all AG residents who also have an established mental health diagnosis. All of the residents at the facility were away at a day program at the time of the visit. Staff members often transported residents in their own personal vehicles. The administrator cited they have operated at a deficit for years, and as a result, she has not taken a paycheck since she inherited the facility from a family member. The administrator is working another full-time job, and the money earned there often supports operating costs. Notably, the administrator cited that it would not be possible to operate without support from the community. A local food bank provides an estimated 50-60% of the total food provided to residents. The facility has also received a small business loan during the pandemic.

SOURCE: JCHC staff site visit.

State licensing inspectors cite differences in quality of care provided to those in "AG-ALFs" versus private pay ALFs

Almost two thirds of AG recipients reside in an ALF that serves at least 40% AG residents. State licensing inspectors indicated that they see more violations in facilities that serve a disproportionate number of AG residents. To assess this, JCHC staff compared a random sample of 50 assisted living facilities (25 that serve AG residents and 25 that do not) and found that there were more complaint-based violations and total administrative violations for ALFs that have accepted at least one AG resident (TABLE 1). Licensing violations include issues with the actual facility rather than its staff. Maintaining facilities is particularly challenging for those that accept AG recipients.

TABLE 1: Comparison of license violations between private pay ALFs and ALFs that accept AG

	Number of ALFs reviewed	Total Complaint-Related Violations	Total Administrative Violations
Private Pay ALFs	25	26	592
"AG-ALFs"	25	56	738

SOURCE: JCHC staff analysis of DSS Office of Licensure inspection reports.

The Department of Aging and Rehabilitative Services (DARS) has received $3.28 million in American Rescue Plan Act (ARPA) funds and State and Local Fiscal Recovery Funds (SLRF) to help provide one-time grants of up to $22,000 to ALFs. ALFs with at least 10% AG population (149 ALFs) have been deemed eligible, and administrators could use these funds to make necessary building updates or other improvements at their discretion. To date, there have been 4 ALFs that have been processed to receive funds, and 46 applications are in process. The grant applications include requests for new flooring or air conditioning units at the ALF.

The most direct strategy to increase AG bed availability is to significantly increase the AG rate, closer to the cost of care

In order to increase the number of AG beds available, the AG rate needs to be closer to covering the cost of care. There has been a direct relationship between the decline in the number of AG beds available over time in comparison to how close the AG rate is to covering the cost of care (FIGURES 6 and 7).

JCHC staff asked the ALF administrative staff what the rate would need to be in order for their facilities to take on one additional AG-funded resident, and the median value proposed was $2,500 a month. This would require an increase of $891 per AG recipient per month. For all current AG recipients, this would increase total AG expenditures by approximately $32.2 million, for a total cost of $59.4 million annually. This increase would be covered by 80% state funds and 20% local funds.

The Auxiliary Grant (AG) program does not maintain a waiting list.

An individual seeking AG funding may meet all of the requirements to live in an ALF, except the individual cannot find a setting that meets the requirements for AG funding. During this time, an individual may be looking for a facility and waiting for an ALF to accept them on the program. From the time an individual is screened as eligible for the AG program based on ADL needs, the individual has 90 days to find a facility and notify LDSS to begin AG payments.

If the AG rate were to increase, the number of AG beds available in the state could also increase. However, the actual demand of the program is unknown because the program does not maintain a waitlist. Therefore, it is possible that increasing the AG rate would increase the total number of individuals served. It is not possible to reliably estimate how much the AG rate would cost while factoring in the increase in individuals who could be served on the program, therefore, the total cost of the program could be higher than the previously mentioned estimates. To provide an order of magnitude, if the increase in the AG rate created 300 new AG beds across the state (approximately a 10% increase), and assuming the average total AG payment remained the same, total program expenditures would be an estimated $65.3 million.

An increase in the AG rate could be done on a tiered basis, because the cost of care is different for facilities that are only licensed for a residential level of care. The state could create a rate for residential level of care, and a higher rate for assisted living level of care. Because the AG rate is currently closer to the typical cost of the residential level of care, a greater percentage of residential ALFs accept the AG payment. About 80% of ALFs licensed as residential only accept the AG payment (65 out of 80) while about 65% of ALFs licensed for assisted living level of care only accept the AG payment (155 out of 239). No ALFs that operate secure units accept the AG payment. This results in even more limited access for low income Virginians with higher level of care needs.

➔**OPTION 1:** The Joint Commission on Health Care could introduce a budget amendment to increase the base Auxiliary Grant rate to $2,500 per month.

Providing incentives for ALFs to take new AG residents could improve access with a lower financial cost to the state

Another strategy to increase the number of AG beds available is to incentivize ALFs to take on more AG residents by providing one-time funds to help offset the loss in revenue that could occur when taking on those residents. Since ALF staff indicated they accept residents on the AG program after being on a private pay arrangement, providing a lump sum up front could help individuals who cannot afford to enter an ALF as private pay.

The amount of the incentive payment will have to be sufficient enough to incentivize ALFs to accept a new AG resident that they wouldn't have otherwise accepted. Based on the typical length of time ALFs require private pay residents to stay before transitioning to the AG program and the necessary rate increase discussed previously, a maximum payment of $21,000 per resident would provide a similar amount of funds to the facility as accepting a private pay individual for two years (multiplying the suggested rate increase of $891 by 24 months). Smaller amounts can be considered, as well as varying amounts depending on the type of facility, and the resident's needs. Any payment should be continually reassessed to ensure it is effective and is being adjusted with the cost of care. It is similarly difficult to develop a reliable estimate of how many new AG recipients may be able to find ALF placements under this program, and therefore what the cost would be. To provide an order of magnitude, if it increased AG recipients by 300, it would require a one-time investment of $6.3 million. Additional funding could be provided to continue to incentivize additional beds.

There are a number of implementation considerations for this policy option to become operational. First, although the AG is funded by a 20% local match of state funds, Members could consider creating this separate payment as a solely state-funded incentive. This is because localities have already voiced concerns over previous legislation to increase the AG rate due to the budget strain of increasing the local 20% match.

Second, this one-time payment would have to take into account the total number of AG residents in the state at the current time, the total AG resident population, as well as the total capacity of the ALF where an AG resident lives. ALFs have varying capacities and overhead costs, so it may not be equitable to provide an equal lump sum to one ALF that does not incur substantially increased costs to accept a new AG resident, and another ALF that requires a significant investment to make it financially viable to accept a new AG resident. For example, an ALF may increase their total licensed capacity and AG bed capacity by increasing the number of individuals in a room, but these ALFs may not incur substantial costs by taking on additional residents.

Third, there will be administrative work required to ensure those being served are new additions and not current AG recipients. For example, DARS would need to determine whether an ALF should receive the same one-time lump sum if the resident is a transfer from another ALF that has recently closed and already received a lump sum payment for that particular AG resident. DARS would also need to determine whether ALFs that close, or have residents that terminate the agreement during the first 24 months, would be responsible for returning a portion of the payment back to DARS.

DARS would need the ability to maintain a fund separate from the AG allocation that can roll over for a certain period of time. This would grant them the flexibility to award ALFs funds when needed. Lastly, DARS would need the capability to track AG clients monthly and report it in a way to enable them to identify the new residents and make timely payments to the ALF.

➔**OPTION 2:** The Joint Commission on Health Care could introduce a budget amendment to provide a one-time, lump sum payment to ALFs that serve a new AG resident, above the number of AG residents that they currently serve.

Leveraging Medicaid payments to cover services in assisted living would require significant changes

It is possible to leverage Medicaid funds for services offered in assisted living. Medicaid can pay for services to eligible individuals who live in an assisted living facility, but it cannot pay for the cost of room and board. As a result, any strategy to enable Medicaid payments for residents in assisted living would be supplemental to the AG program.

Medicaid authorities that could be used to fund services offered in assisted living:

- 1915(c) HCBS waiver
- 1115 demonstration waiver
- Medicaid state plan amendment

Note: Medicaid does not cover room and board in any instance outside of a nursing home.

States can implement a number of Medicaid authorities to cover services in assisted living that does not include payment for room and board. These include a 1915(c) HCBS waiver, an 1115 demonstration waiver, or a Medicaid state plan amendment (SPA). Virginia operates an 1115 waiver to provide a long-term services and supports (LTSS) managed care program. Developing new waivers or state plan amendments to cover services to Medicaid-eligible individuals in assisted living facilities would require changes to Medicaid eligibility criteria, and updates to DSS ALF regulations to comply with federal HCBS guidelines.

ALFs would have to meet federal criteria as a home and community-based setting for residents to be eligible for Medicaid-funded LTSS

The Centers for Medicare and Medicare Services (CMS) set guidelines on what is an appropriate home and community-based (HCBS) setting. This is broadly to ensure that individuals who prefer to get LTSS services in their home or community, rather than in an institutional setting such as in a nursing facility, can do so while promoting true community integration.

CMS HCBS Settings Requirements:

- Integrated in and supports full access to the greater community
- Selected by the individual
- Ensures individuals right to privacy, respect, and freedom from coercion
- Optimizes autonomy and independence

The Department of Medical Assistance Services (DMAS) conducted an assessment in 2016 of the six HCBS waivers that were in operation at the time as part of a federal requirement to evaluate whether residential and non-residential settings met federal HCBS guidelines. As part of their assessment, DMAS conducted site visits to 12 ALFs that previously offered the Alzheimer's Assisted Living (AAL) waiver, which sunset on June 30th, 2018. DMAS found the AAL waiver was not compliant with federal guidelines. It is possible to revisit the potential for ALFs to be

considered an appropriate HCBS setting, however ALF providers would need to address the areas of non-compliance and partial compliance identified by the DMAS review (TABLE 2).

TABLE 2: DMAS findings of AAL waiver partial and non-compliance with federal HCBS setting guidelines

HCBS settings requirement	DMAS findings:
Provide opportunities to control resources; choice between services and providers; optimizing interaction; autonomy and independence; choice of roommates; control over schedules; access to food at any time; physical accessibility; and modifications made in the person-centered service plan	*Partial compliance*
Settings are integrated into the community and individual participation in activities or services outside the setting	*Non-compliance*
Opportunities to engage in community life, freedom from coercion and restraint; allowing visitors at any time; and rooms with lockable entrance doors and individual keys	Varying degrees of *compliance*, *partial compliance* and *non-compliance*

SOURCE: JCHC analysis of Virginia's Statewide Transition Plan for Compliance with Home and Community-Based Services (HCBS) Final Regulation's Settings Requirements.

It is important to note, at the time when DMAS conducted their assessment of ALFs' compliance with CMS's HCBS final setting rule, the AAL waiver was the only HCBS waiver that operated in ALFs. This waiver did not meet federal criteria as an HCBS setting because the AAL waiver required an individual to reside in a self-contained special care unit that is secured through a locking device. An individual living with Alzheimer's is at risk for wandering, which provided justification for having locked units at the time. Therefore, it is possible that ALFs compliance to the HCBS settings rule could be re-evaluated in the future.

Limited number of ALF residents would be eligible for Medicaid-funded services, unless eligibility criteria are expanded

Each state crafts their own definition of nursing facility level of care (NF LOC), which is widely used as the threshold for eligibility for Medicaid reimbursement of home and community-based services. Some states have more flexible criteria for their Medicaid LTSS program, so an individual with moderate needs in assisted living in other states may be eligible to receive services under their

Assisted Living is not a federally regulated industry, therefore assisted living is used in this section as an umbrella term for the various terms states' may use for similar residential care settings.

state's Medicaid program. There are also a few states that either have tiered definitions for NF LOC or states that have created a more stringent criteria for their LTSS program.

There are scenarios in Virginia where ALF residents are high needs or could meet Medicaid LTSS criteria, but the number of individuals is likely small

It is possible for individuals to meet Virginia's Medicaid NF LOC criteria and still reside in an ALF. Generally, an individual has to be financially eligible for Medicaid as well as meet the NF LOC criteria when screened for Medicaid LTSS services. The individual must have a functional need, medical or supervisory nursing need, and be at risk of nursing facility placement within the next 30 days (Appendix 2). Virginia's definition of NF LOC is not determined by an individual's age or specific diagnosis.

NF LOC threshold in Virginia:

In order for an individual to receive Medicaid funding for LTSS in Virginia, all of the following criteria need to be met:

- Functional need
- Medical or supervisory nursing need
- Be at risk of nursing facility placement in the next 30 days

There are situations where an individual could meet NF LOC and reside in an assisted living facility. This could happen if a high needs resident, who does not meet financial eligibility for Medicaid, prefers the ALF environment due to cost or personal preferences. It is important to note however, being a resident of an ALF alone would preclude an individual from participating in Virginia's Medicaid managed LTSS program, known as the Commonwealth Coordinated Plus, regardless of financial eligibility as part of their waiver guidelines. Another exception is an individual receiving hospice care while residing in an ALF. Hospice services are funded by Medicaid or Medicare and the Virginia administrative code (12VAC30-60-130) specifies certain conditions that need to be met in order for Medicare or Medicaid to pay for hospice services.

There are also examples of where an individual in assisted living with a certain combination of needs could meet some of the criteria for NF LOC, but not all of them. These individuals have relatively high needs, but would not necessarily be eligible for HCBS under the current Medicaid NF LOC criteria (TABLE 3). An individual could be considered at risk of institutionalization if there is documentation such as hospital visits or reported findings to suggest their functional, medical or nursing needs are not being met, or there has been a significant change in their condition.

TABLE 3: Examples of moderate to high need ALF residents

	Functional Need	Medical Nursing Need	At risk of institutionalization
A: An individual who needs help with medication administration for a chronic condition.	**X**		**X**
B: An individual with a primary diagnosis of dementia who needs assistance dressing and bathing.	**X**	**X**	**X**
C: An individual suffering severe pain management under the supervision of a physician.		**X**	**X**

Note: This is for illustrative purposes only and not intended to provide guidance on individual LTSS eligibility.

Other state Medicaid programs pay for services in assisted living facilities, but through different eligibility criteria and assisted living regulations

JCHC staff analysis identified nearly 30 other states that cover services in various assisted living or other residential care settings. Tennessee and South Dakota use two different Medicaid authorities to allow for payment of services in an ALF. However these options could require significant financial investment since there is a potential to expand Virginia's definition of NF LOC criteria which would likely increase the number of people who would be eligible for services in a nursing home and HCBS setting. This would yield a significant budget increase due to increase in the number individuals on the CCC plus waiver. There would also be necessary administrative costs for DMAS to develop and implement the waiver changes. Without modifying the NF LOC criteria in Virginia, this option would have a limited impact because there is only a small subset of individuals who meet a NF LOC and Medicaid financial eligibility criteria while residing in an ALF.

Virginia has had two HCBS waivers to cover services in assisted living that were discontinued

DMAS established the Assisted Living Program to provide payments for assisted living services for residents under the AG program beginning in 1996. DMAS provided Medicaid payment directly to ALF providers to provide and arrange for ALF services. There were three levels of care: residential living, regular assisted living, and intensive assisted living. Residential living did not receive Medicaid reimbursement. For regular assisted living services, DMAS reimbursed up to $90 per month with solely Medicaid state funds because this population did not meet NF LOC criteria. For intensive assisted living (IAL), DMAS reimbursed up to $180 per month for ALF residents who met the criteria for nursing

facility placement. Federal matching funds were available for intensive assisted living services.

In FY98, 1,259 individuals received services under the IAL waiver. At the time, there were concerns over the adequacy of Medicaid reimbursement, and a review of the IAL waiver determined ALF residents would need more than the projected maximum reimbursable hours for services. During this review, DMAS also noted quality of care concerns for ALF residents enrolled on the waiver. DMAS conducted 12 random reviews of ALFs and found 11 of the 12 ALFs were not compliant with program requirements. Additionally, there were concerns that DSS licensing requirements did not accurately reflect the varying populations that were being served in ALFs. At the time, ALFs had minimal requirements for individuals with behavioral health needs, which largely have not changed.

The waiver was terminated, in favor of creating an HCBS waiver to serve the Alzheimer's population and strengthening the DSS and DMAS regulations to ensure providers could provide specialized care for this population. The Alzheimer's Assisted Living (AAL) waiver provided ALF services to individuals aged 55 and over who are financially eligible for Medicaid and meet the NF LOC. AAL waiver recipients had to reside in an approved ALF "safe and secure environment"; receive the AG; have a diagnosis of Alzheimer's disease or a related dementia; and have no diagnosis of serious mental illness, intellectual or developmental disability, or DSS prohibited condition to reside in an ALF.

Tennessee uses an 1115 demonstration waiver to provide services for their LTSS population

Tennessee's CHOICES program offers a set of home care services such as personal care, home care, and medication administration services similar to what is offered in Virginia's Commonwealth Coordinated Care Plus program. Notably, Tennessee's program covers services for individuals who live in a nursing home or variety of assisted living or other residential settings. These settings can include an individual's home, assisted living, a shared home in the community similar to Virginia's adult foster care program, a shared home or apartment in the community with a maximum of four people, or a critical care adult home that provides services specifically for those who are ventilator dependent or who have a traumatic brain injury.

An individual must qualify for at least one of three level of care groups to receive nursing facility or HCBS through the CHOICES program. Levels 1 and 2 require an individual to meet the need of Tennessee's definition of NF LOC and qualify for LTSS. An individual could qualify for Level 3 services if they do not qualify for NF LOC but may need a moderate level of home care services to prevent institutionalization. The managed care organizations (MCOs) help recipients determine what services can best suit their needs.

South Dakota's home and community-based options and person centered excellence (HOPE) waiver offers Medicaid funding for services in assisted living

South Dakota's HOPE waiver is targeted to adults age 65 years or older, or adults over the age of 18 with a qualifying disability. The HOPE waivers offer services based on an assessed need including but not limited to adult companion services, adult day services, assisted living (excluding room and board), chore services, and community transition coordination and supports.

Other community settings could be more cost-effective for individuals seeking AG payment in ALFs

Assisted living is only one of a variety of options to support adults who may qualify for services in an assisted living facility. ALFs are unlikely to increase the number of AG recipients served if the AG rate continues to be substantially lower than the cost of care. As a result, low to middle income adults who do not meet the functional criteria for Medicaid long term services and supports will have challenges accessing supports to maintain independence in the community. However, it is possible to meet the needs of this population by bolstering the quality and availability of community supports to help them remain in their community.

Funding community-based services could meet the needs of the AG population with lower functional needs

A 2021 JCHC report made several recommendations to support existing community-based services to meet the needs of a similar population that are served in ALFs (older adults in need of functional supports). ALF residents typically do not meet the functional need criteria for Medicaid-funded long-term care services, therefore, this population falls into an underserved group who may face challenges accessing support with their ADLs. The JCHC study found that home care and housing supports were the biggest unmet needs for older Virginians. Older adults in need of any type of home care services (e.g. companion or homemaker, personal care, home health care) are often unable to access the services in a timely manner, if at all. Local DSS and Area Agency on Aging staff cited the most significant housing need was affordable permanent supportive housing (58.4%), followed by home modifications (24.4%) to make their clients' current residence more accessible.

Adult foster care is an allowable, community setting for AG recipients but availability is severely limited

Adult Foster Care (AFC) is available in only 11 of the 120 local departments of social services (LDSS) (see Appendix 3). As a result, only 56 people received these services across Virginia in FY21. AFC residents can receive the AG, however, AFC is an optional local program. Each locality can set their own criteria for initial eligibility and continued

maintenance of the AFC relationship. AFC plans are usually tailored to identify specific needs within the community, and plans are submitted and reviewed by local boards of social services before approval. Consequently, adult foster care is less portable if a resident needs to move to another arrangement because the agreement is made between the AFC provider in the community and the local DSS. Additionally, this housing setting may best serve those who meet a residential assisted living level of care since the provider does not have to be licensed or required to provide any type of ADL support. Living with family members or independent living arrangements provides similar levels of support to AFC.

AFC could resemble other, existing community-based living arrangements such as living independently or with a family member. Unpaid family caregivers could provide housing, food, and personal care services to an individual in the community. It is also possible that if the individual already has a form of secure housing, one could coordinate their own personal care services which are similar to what is already offered in assisted living and adult foster care.

Other states provide supplemental SSI payments (similar to the AG program) in different community living arrangements, with benefits varying by setting

Most states have developed a Supplemental Security Income (SSI) state supplement, or optional state supplementation program (OSSP), similar to Virginia's Auxiliary Grant program. States can vary in what types of living arrangements are eligible for payment, and whether there will be any restrictions on the eligibility group (i.e. aged, blind, disabled) that can receive services. Virginia opted to allow payment for individuals in all three eligibility groups living in an ALF, AFC, or other certified supportive housing setting. It is also possible under federal rules to allow payment in different community living arrangements. Other states that have an OSSP may offer funding for individuals in other home and community-based settings, such as in the home or a licensed group home.

North Carolina's OSSP, called the State/County Special Assistance (SA) program is very similar to the Virginia's AG program. Notably, the North Carolina SA program expanded in 2000 to serve individuals at home as a demonstration project, and the program was codified in 2007. Prior to this change, recipients of North Carolina's SA program had to reside in an approved eligible living arrangement. Key highlights of Virginia's AG program and North Carolina's SA program are shown in TABLE 4. The legislation first allowed for up to 15% of the total statewide SA caseload to receive SA payments at home, and in 2021, the NC General Assembly removed the limit on the number of SA In-Home recipients.

TABLE 4: Comparison of Virginia and North Carolina's OSSP

	Virginia's AG program	North Carolina's SA program
Funding	Funded by 20% local dollars and 80% state dollars	Funded by 50% local dollars and 50% state dollars
Approved settings	Must reside in an assisted living facility, adult foster care home, or a certified supportive housing setting	Can reside in an adult care home, family care home, adult care home beds in some nursing and hospital facilities (combined), residential hospice facilities, certain mental health facilities, or at home
Rate structure	One standard rate for all settings	Provides an increased rate for those who live in a special care unit for Alzheimer's or a related disorder.

SOURCE: JCHC staff analysis of state law and program documents from Virginia and North Carolina.

New York's OSSP offers varying SSI supplement amounts based on living arrangement including residential care setting, living alone, or other shared housing options. New York's OSSP is available to all eligible SSI recipients except those living in medical facilities where Medicaid pays less than 50% of the total cost of care, publicly operated emergency shelters for more than 6 months during a 9 month period, and other residential care settings with greater than 16 residents.

South Dakota's OSSP is available for all eligible SSI recipients in independent living arrangements including the home, apartment, hotel room, room in a boarding house, or in the household of another who provides in-kind support or maintenance. However, persons living in adult foster care or assisted living arrangements are not eligible for benefits. Montana's OSSP is offered to all eligible SSI recipients in various types of residential care facilities, including assisted living, group homes, foster care homes, and transitional living services to persons with developmental disabilities.

Virginia could expand the Auxiliary Grant program to additional community settings

Virginia could expand the eligibility criteria for the Auxiliary Grant to include additional community settings, but there are a number of implementation considerations. First, expanding the types of eligible living arrangements would increase the total population who will become eligible for AG payments. According to the Social Security Office of Retirement and Disability Policy, there were approximately 155,200 SSI recipients in 2020. Approximately 36,000 SSI recipients are 65 years or older regardless of eligibility category. However, some SSI recipients may not be eligible for AG payments due to low functional need or their other financial resources being too high to receive AG funding. While it is

difficult to reliably estimate how many eligible recipients there may be, it is likely that it will be higher than the approximately 3,000 current recipients.

Second, with more eligible individuals in the program, there would be an increased need for staffing and oversight at the local and state level to ensure the funding provided to the individual is used to support their personal care needs. Lastly, there would also need to be more agency coordination to ensure individuals who are receiving AG payments have not been approved for a Medicaid LTSS waiver since those individuals should be able to access home care services through the waiver program.

It is also possible to develop criteria to control the total size of the program. The General Assembly could set a maximum number of slots available for this program or limit the eligibility category (for example to either aged, blind, or disabled) that can access AG payment in a home or community-based setting. DARS could also conduct an evaluation of the program periodically to determine whether or not the eligibility restrictions should change.

If the AG payment remained at the same level, the amount individuals are left with, after payment for living expenses,would likely not be enough to cover personal care costs. Therefore this policy option may only be helpful to individuals that have minimal housing costs such as those who may be living with a family member.

➔**OPTION 3:** The Joint Commission on Health Care could introduce legislation amending the Code of Virginia to expand the list of eligible living arrangements for the Auxiliary Grant program to allow AG recipients to remain in the community and coordinate their own care as needed. The legislation should include an enactment clause directing DARS to submit changes to the AG Program's eligible living settings to the Social Security Administration for approval.

Individuals in assisted living with behavioral health needs could be served in the community with supports

It is important to ensure individuals in assisted living with behavioral health needs have the same opportunity to receive services in the setting of their choosing. About 47% of individuals screened for public adult services, including assisted living, have a documented behavioral health need. Expanding AG funding to those in home and community based settings is similar to the existing AG supportive housing program. This program has already demonstrated success at serving individuals in the community even with limited availability of providers.

Auxiliary Grant Supportive Housing is already a viable alternative to ALFs, but it is only offered in certain areas with low cost of living

AG supportive housing is only available in 7 of the 40 CSB service areas. A total of 65 individuals participated in the program in FY21. For those in the AG supportive housing program, the AG covers rent and utilities as listed in the federal Housing and Urban Development (HUD) guidelines for Fair Market Rent (FMR). Any remaining AG funds that the recipient has after paying for rent and utilities would be used to cover basic living expenses and medical co-payments.

Auxiliary Grant Supportive Housing (AGSH) is intended for recipients to use in standard rental housing (e.g., apartments, single family homes, manufactured housing) that is solely occupied by the AGSH resident. A housing specialist, usually employed by a local community services board, is linked with the recipient to provide individualized support to cultivate independence. This housing option must be jointly approved by DARS and DBHDS.

The following settings are not allowed in the AG program:

- Congregate care settings (e.g., group homes, ALFs)
- Boarding homes
- Rented rooms in private homes

Increasing the allowable AG rate for supportive housing residents could make it a viable option in additional areas of the state. DBHDS staff cited AGSH participants have to be able to pay the entirety of their monthly rent, utilities and other expenses. This is different from ALFs and AFC where meals and some personal needs are covered by the provider. For AGSH recipients, food and other personal costs are their responsibility.

DBHDS staff stated they have difficulties finding placements for people seeking out this program because of the increased costs needed to live independently such as food, transportation, and personal care. As a result, program staff indicated that no more than 50% of their income (including the AG payment) should be going towards rent, to ensure there is enough left over for their other bills and personal needs. As a result, AGSH is only available in areas with lower FMR rents (Appendix 3). No localities where the HUD FMR accounts for 50% or more of the AG rate offer AGSH. However almost half (43%) of localities where the HUD FMR is below 40% of the AG rate offer AGSH.

➔**OPTION 4:** The Joint Commission on Health Care could introduce a budget amendment directing DBHDS and DARS to develop a plan to create a separate, increased rate for AGSH. The budget amendment should include language directing DARS to submit a rate change for AGSH to the Social Security Administration for approval.

Assisted Living Facilities are disincentivized to accept Auxiliary Grant residents because of the availability of Discharge Assistance Program funds

DBHDS funds local CSBs to find placements for individuals leaving state hospitals through the Discharge Assistance Program (DAP). DAP is intended to be a temporary funding source that can be combined with other funding sources. Individuals are typically referred to ALFs when structured community services are not available, because they provide 24-hour

supervision. In FY21, 1,386 individuals received DAP funding. Those on DAP who went to a private or CSB-run ALF spent a total of $26.2 million. This represents 83% of total DAP funds, and is larger than total AG expenditures for assisted living.

Discharge Assistance Program (DAP) is funded through a pool of state mental health funds allocated to each DBHDS region to implement community capacity and/or individualized services and supports that help adults receiving services in state hospitals to live in the community. DAP serves:

1. Individuals already discharged from state hospitals that are currently receiving DAP funds to transition them into non-DAP funded services
2. Individuals in state hospitals who are determined clinically ready for discharge and for whom additional funding for services and supports is required to place in the community

DAP can also fund start-up and/or ongoing costs for community based services and supports that enable individuals in state hospitals to be discharged to those services.

DAP reimbursement is much higher than the Auxiliary Grant rate

The insufficiency of the AG rate to cover costs creates a perverse incentive for ALFs to accept DAP residents over other forms of payment. In some instances, an individual may become eligible for AG funding and use DAP funds for the additional services they may need. However, due to increased costs and working with a higher need population, ALFs indicate it is better financially to refuse prospective residents leaving state hospitals with any form of AG payment. ALFs that either do not accept AG or choose not accept AG for a particular individual, could charge their local CSB the full private pay rate plus the cost of additional services based on the needs of the client. It is important to note that most ALFs do not provide behavioral health support, and there are not any licensing requirements to provide those supports. DSS licensing inspectors and CSB staff have voiced concerns that they cannot identify whether ALFs are truly providing increased services to those on the DAP program, compared to AG residents, or to the private pay population.

Individuals with both AG and DAP funding are more likely to transition off of DAP funding

DBHDS and CSB staff cited challenges transitioning individuals off of the DAP program if the individual is funded solely through DAP funds. If the individual does not have another method to pay for ALF room and board, the individual may stay on the program longer than necessary to ensure they have a safe, supportive place to live. In these cases, DAP residents are less likely to be transitioned from the program even when they are stabilized, even though the program is intended to be temporary. Individual DAP plans are reviewed by local CSB staff every 90 days to ensure the level of care provided is still appropriate.

ALF administrators that serve a disproportionately high AG population cite taking on higher needs residents through the DAP program. The main reason was the opportunity for an increased payment for that high need population. However, if an ALF accepts AG, the resident is more likely to transition off of DAP funding because there is another payment

method available for ALF costs once the resident is stabilized. If this occurs, the ALF now has a high need resident but an insufficient monthly payment to cover the cost of their care.

DAP payments are less burdensome to administer than the Auxiliary Grant

DAP payments, unlike AG payments, go directly to the facility from a local CSB, which is easier to manage. Rather than waiting on local staff to provide payment to the resident, who will then have to pay the ALF provider, ALF staff have direct contact with CSBs and receive a lump sum based on their resident population who are receiving DAP funds. Individuals who receive DAP funds have their care overseen by a local CSB. Additionally, if care needs increase, ALF providers can submit a new rate sheet to their local CSB to cover the increased costs. As a result, there has been significant rate variation between those receiving DAP funds across the state.

DAP funds are intended as a supplemental, temporary, transition service and not a long-term payment for ALFs. The potential negative consequence of ALFs being reluctant to accept DAP recipients who also have AG funding, could be detrimental to the ongoing efforts to discharge individuals from state hospitals. Rather than taking this step, DBHDS has already started the process to consider whether there are alternative ways to better coordinate AG and DAP funding as part of its rate study and associated recommendations.

Beginning FY23, DBHDS has allocated funds to conduct a rate study and provide recommendations to the General Assembly on implementation of an assessment, tiered rate system, and rate structure for services covered by DAP. The rate study has already outlined the need to use the auxiliary grant rate and services as a baseline. These services include primarily supportive residential services not covered by Medicaid, such as assisted living. Regions who currently utilize DAP have piloted a similar project with some success and are creating baselines for amounts of funding, but more importantly, what should be included in that funding in order to maximize total recipients that can be supported through the program.

Improved coordination and increased personal funds can improve quality of services for current AG recipients

There are opportunities to improve the safety, quality of services, and standard of living for current AG recipients by promoting state agency coordination. While these policies would not increase the availability of AG-funded services, these strategies can improve the AG program for current recipients.

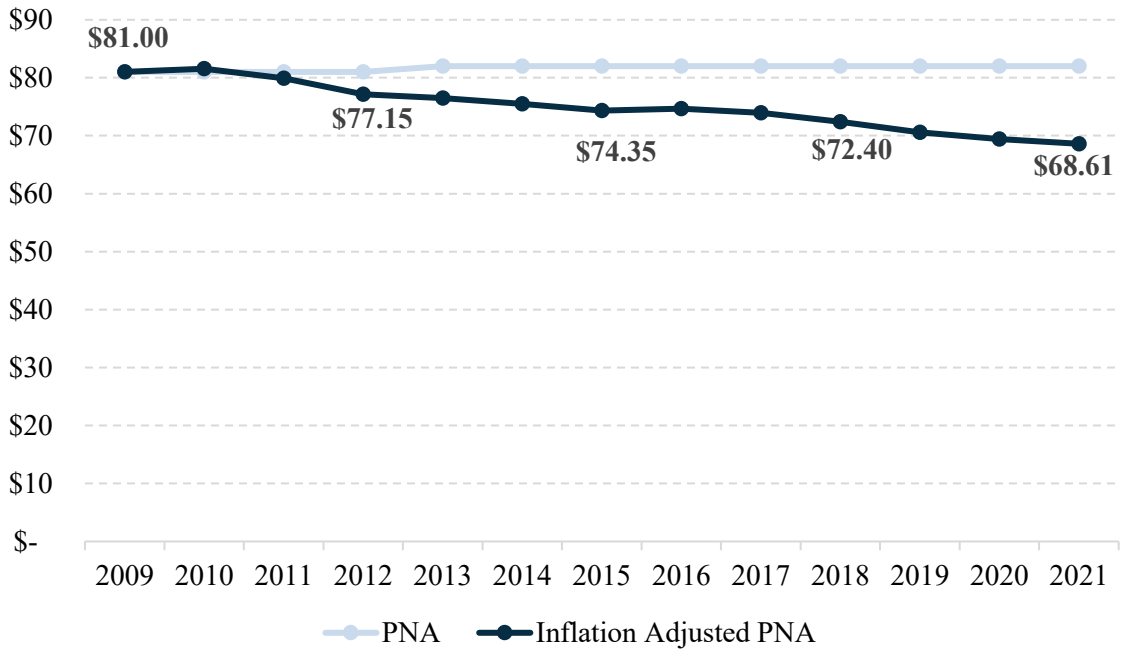
Auxiliary grant personal needs allowance has not kept up with the cost of goods and services that recipients need to maintain a standard of living

The personal needs allowance (PNA) for AG residents has been generally flat since 2009. The last PNA increase was by $1 following a five-year period where the PNA remained at

$81 (FY10 – FY14). When adjusted for inflation, the PNA has decreased in value to $68.61 since FY10 (FIGURE 8).

The PNA is the only income an AG resident has after their AG funds go to their provider. Since ALFs are non-medical residential settings, an individual may use their PNA to cover grooming, laundry services, medication and appointment co-pays, or anything else. ALFs can charge up to $10 for laundry services from the PNA. When AG residents do not have adequate funds to maintain a basic standard of living, they may have to forego necessary medications or treatments.

FIGURE 8: Personal Needs Allowance for AG Recipients (2010-2021)



SOURCE: JCHC staff analysis of personal needs allowance and inflation using the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W).

By increasing the personal needs allowance, current AG residents can become more independent and maintain a basic standard of living. Increasing the PNA to $100 would cost an estimated $650,808 annually for the current AG population. This would require an increase in appropriations for the AG program, because the funds for the PNA comes out of the same appropriation as the base AG rate. This is because the total AG funds available will need to accommodate the PNA increase for the current participants of the program.

➔**OPTION 5:** The Joint Commission on Health Care could introduce a budget amendment providing funds to increase the personal needs allowance for AG recipients, and include language that the AG personal needs allowance will increase at the same rate as future cost of living AG rate increases.

Multiple agency staff identified challenges finding residents a placement in an ALF

When a facility closes, the ALF provider, DARS Adult Protective Services staff, and other local staff if necessary coordinate to find a new ALF placement for individuals. For individuals being discharged from state hospitals with DAP funds, hospital discharge planners and local CSB staff are also involved. However, local staff indicated that sometimes they do not get enough notice to find an appropriate placement. DSS regulations require an ALF to notify a licensing administrator as well as case managers and eligibility workers at least 60 days prior to closure. However, ALFs may not provide enough transparency when they are going through the process of a closure or change in ownership, and local staff indicate they are not always being notified. The regulations could be clarified to ensure ALFs are required to notify the appropriate DARS staff for AG recipients and local CSB staff for DAP recipients at the same time they notify their licensing inspector. DARS and the local CSBs will need to ensure ALFs can identify the appropriate contacts.

➔**OPTION 6:** The Joint Commission on Health Care could introduce a Chapter 1 bill directing DSS to update ALF regulations to require ALF administrators to notify the appropriate DARS and local CSB staff at least 60 days prior to closure if they currently have residents on the Auxiliary Grant or Discharge Assistance Program.

Program staff cite delays in receiving current DSS licensing records and identifying ALFs not meeting program requirements

The Virginia Department of Social Services (DSS) maintains all licensing records for assisted living facilities. However, two DARS full-time staff members who administer the AG program are responsible for ensuring that ALFs who want to participate in the AG program maintain a current license. Currently this is a challenge because they don't have a way to identify any changes in licensing status in real time. AG program staff cite delays in receiving licensing records, creating a challenge in identifying which facilities remain eligible for the program and where AG residents can go when they need a placement. This is particularly challenging in the event of a facility closure.

DSS awards 1-, 2-, and 3-year licenses based on routine inspections. However, an ALF license can be closed due to a change in administrative ownership, facility name change, change in address, or actual facility closure. Furthermore, DSS licensing records do not link facilities with similar information, such as name, administrator, address and city. As a result, it is common to see records of very similar facilities under different licenses over time. State licensing inspectors have cited this can happen so an administrator can avoid negative action on their facility. The administrator can "close" the facility by changing facility ownership or name, creating a new license record in the system. AG program staff cited concerns over this practice, because it is difficult to identify ALFs that may not be meeting AG program guidelines if they close and reopen under a different license.

➔**OPTION 7:** The Joint Commission on Health Care could introduce a Chapter 1 bill directing the Virginia Department of Social Services to share access to assisted living facility licensing data with Auxiliary Grant program staff at the Department of Aging and Rehabilitative Services to enable real-time access to the licensing status of ALFs across the state.

Appendix 1: Sources and methods

JCHC staff conducted this study by surveying assisted living facilities, analyzing data from multiple state agencies, interviewing program staff at the state and local levels, and conducting site visits to assisted living facilities.

Survey methodology, sampling, and response rate

JCHC staff contracted with the Social Science Research Center (SSRC) at Old Dominion University to implement a survey of assisted living facilities in Virginia. JCHC staff developed the survey questions, received methodological consultation from staff at the SSRC, and then SSRC staff implemented the survey and provided the data to JCHC staff for analysis.

Assisted living facility data was retrieved from the Virginia Department of Social Services on June 28th, 2022. At that time, there were 568 total, licensed ALFs, and 221 (38.9%) ALFs were listed as offering the Auxiliary Grant program by the Department for Aging and Rehabilitative services.

The SSRC was provided with contact information for 567 ALFs. A total of 466 of those had email addresses and the survey was first distributed by email to these ALFs. SSRC staff then conducted phone surveys for ALFs that had not responded to the email invitation or had an email address that was not valid. A total of 215 ALFs responded to the survey (75 via telephone – including 12 administrators who were in charge of more than one ALF – and 140 via the web survey). , JCHC staff received the lowest response rate in the Northern (22%) and Fairfax (21%) regions. JCHC staff received the highest response rate in the Western region (61%).

Of the 215 total responses, 78 (36.3%) reported completing an annual Provider Certification through DARS and 93 (43.3%) respondents indicated that they provide care for at least one AG resident. This is consistent with the total percentage of ALFs that accept AG recipients statewide.

The survey asked each ALF several questions about the rates they charge for services. Responses were categorized by the type of license that the ALF holds, either residential or assisted living. Memory care assisted living facilities are not separated into a different category by DSS. An ALF can have one safe and secure bed in their facility, or the facility can consist entirely of safe and secure beds. JCHC staff did not report the rate for memory care ALFs because this distinction is not made within DSS licensing data.

Interviews and site visits

JCHC staff conducted exploratory interviews with many state and local staff. JCHC staff had routine meetings with DARS Auxiliary Grant Program staff and Adult Protective Services regional consultants. JCHC staff also attended regular mental health partnership

stakeholder meetings, which included local CSB staff, hospital discharge planners, Auxiliary grant program staff, and DSS licensing staff. JCHC staff spoke with DBHDS staff directly overseeing to the Discharge Assistance Program and the Auxiliary Grant Supportive Housing Program. DMAS staff related to complex and integrated care helped JCHC staff identify current challenges with using Medicaid LTSS waivers in Virginia to cover services provided in an ALF. To gather historical information on previous Medicaid programs in ALFs, JCHC staff spoke with the director of the Office of Aging and the previous DMAS Director.

JCHC staff visited 7 ALFs in the Central, Northern, Fairfax, Eastern Virginia Beach, and Eastern Piedmont regions. Six ALFs accepted the auxiliary grant, and one ALF was private pay with an attached memory care unit. JCHC staff also accompanied two state DSS staff while they conducted three annual ALF licensing inspections. JCHC staff also visited 4 local DSS and shadowed 10 annual ALF assessments and/or re-assessments with local eligibility workers. Local DSS staff facilitated site visits to two adult foster care sites with JCHC staff to the Eastern Virginia Beach region.

Sampling of ALF licensing inspections

JCHC staff conducted a random sample of ALF licensing inspection reports to analyze whether ALFs that accept AG recipients are more likely to have compliance problems. There were 220 facilities that reported accepting AG recipients continuously between 2014 and 2020. Of those 220 facilities, 196 facilities completed annual certification to the Department for Aging and Rehabilitative Services Auxiliary Grant Program Manager to report the number of Auxiliary Grant residents currently residing at their facility. JCHC considered these 196 ALFs as active AG facilities.

Active facilities were randomly selected and then the sample was reviewed to ensure representation across a number of factors: region, facility ownership, licensed capacity, average reported capacity, average monthtly Auxiliary Grant residents in FY21, percentage of total Auxiliary Grant residents in FY21, and percentage of the entire reported Auxiliary Grant population in Virginia. JCHC staff selected 25 active AG ALFs, and 25 ALFs that were not actively accepting AG recipients, for a total of 50 ALFs. A different staff member reviewed the most recent licensing inspection report for all 50 ALFs, with no knowledge of which facility has AG residents and which did not. The number and type of licensing inspection violations for each facility was recorded.

Data analysis

JCHC staff collected and analyzed programmatic data from multiple different agencies. The data was used to analyze total ALF capacity and AG bed capacity over time, the number of AG recipients over time, and funding for other state programs that support residents in assisted living (TABLE 5).

TABLE 5: Data sources for staff analysis

Title	Agency Source	Use
VACIS and DOLPHIN	Department of Social Services	Capacity of ALFs in Virginia 2001-2021 Number of ALFs in Virginia 2001-2021
Active ALF list	Department of Social Services	Total ALFs in Virginia Region Capacity License Type Facility name Ambulatory status
JCHC ALF Survey	Joint Commission on Health Care	Median and average ALF rates
Auxiliary Grant Program Data	Department for Aging and Rehabilitative Services	AG Rate 2009-2021 Total AG recipients AG annual reports APS annual reports
Genworth Cost of Care Survey	Genworth	Median monthly assited living cost in Virginia 2009-2021
Discharge Assistance Program	Department of Behavioral Health and Developmental Services	Total Allocation/Spending 2012-2022

Appendix 2: Supplemental information related to resident level of care

This appendix provides supplemental information about level of care requirements for assisted living and nursing facilities in Virginia.

List of Prohibitive Conditions in ALFs

ALFs in Virginia are prohibited from taking residents with any of the following conditions.

1. Ventilator dependency;
2. Stage III and Stage IV dermal ulcers except those stage III ucers that are determined by an independent physician to be healing;
3. Intravenous (IV) therapy or injections directly into the vein, except for intermittent intravenous therapy managed by a health care proefessional licensed in Virginia or as permitted.
4. Airborne infectious disease in a communicable state that requires isolation of the individual or rquires special precaustions by the caretaker to prevent transmission of the disease, included diseases such as tuberculosis and excluding infections such as the common cold;
5. Psychotropic medications without appropriate diagnosis and treatment plans;
6. Nasogastric tubes;
7. Gastric tubes except when the individuals is capable of independently feeding himself and caring for the tube or as permitted;
8. Individuals presenting an imminent physical threat or danger to self or others;
9. Indivduals requiring continuous licensed nursing care;
10. Individuals whose physician certifies that placement is no longer appropriate;
11. Unless the individual's independent physician determines otherwise, individuals who require a maximum physical assistance as documented by the UAI and Meet Medicaid nursing facility level of care criteria as defined in the State Plan for Medical Assistance Program (12VAC30-10); or
12. Individuals whose physical or mental health care needs cannot be met in the specific assisted living facility as determined by the facility.

More details can be found in the Standards for Licensed Assisted Living Facilities (22VAC40-73-310).

Nursing Facility Level of Care in Virginia

In order to be eligible for Medicaid reimbursement for long-term services and supports (LTSS) to meet the nursing facility level of care criteria, three conditions must be met:

1. Have a functional need
    a. An individual meets the functional need criteria if one of the following are met:
        i. Dependent in 2-4 ADLs, ***and*** semi-dependent or dependent in behavior and orientation, ***and*** semi-dependent or dependent in joint motion ***or*** dependent in medication administration OR;
        ii. Dependent in 5-7 ADLs ***and*** dependent in mobility OR;
        iii. Semi-dependent in 2-7 ADLs, ***and*** dependent in mobility, and dependent in behavior and orientation.
2. Have a medical nursing need
    a. An individual meets the medical nursing need criteria if the individual has a medical or nursing supervision of care need that is not primarily for the care and treatment of mental disease.
3. Be "at risk" of nursing facility placement in the next 30 days.
    a. An individual is considered "at risk for institutionalization" if they are considered at risk of admission to a nursing facility, hospital, or an intermediate care facility for individuals with an intellectual disability (IFC/IID within 30 days if without the presence of HCBS services. It does not mean the individual has to be placed in one of those settings.

*Note: there are different criteria for children outlined in the DMAS Screening for Medicaid-Funded LongTerm Services and Supports (LTSS), Chapter IV

Individuals who meet all 3 criteria for nursing facility level of care are typically not housed in an ALF. However, if an individual meets a nursing facility level of care, and their needs do not fall within the list of prohibitive conditions, it is possible the individual's care can be coordinated within the ALF setting.

Appendix 3: Supplemental information on eligible community-based AG settings

The AG currently allows individuals to be eligible if they live in an approved Adult Foster Care or Auxiliary Grant Supportive Housing setting. However, these settings are currently only offered in certain localities in Virginia.

Localities that offer Adult Foster Care

- Chesapeake
- Fairfax
- Fauquier
- Hampton
- Henrico
- Montgomery
- Norfolk
- Prince William
- Scott
- Virginia Beach
- York/Poquoson

Source: 2021 Adult Protective Services Division Annual Report

CSBs that currently offer Auxiliary Grant Supportive Housing

Seven CSBs currently offer Auxiliary Grant Supportive housing. These are in regions where the AG rate can support the cost of living based on the rent in those regions (TABLE 6). DBHDS staff indicated that AGSH is typically not offered if the HUD fair market rent (FMR) exceeds 50% of the individual's income. For individuals eligible for the AG, their total income including the AG payment, is the AG rate.

TABLE 6: Auxiliary Grant Supportive Housing Providers and Fair Market Rents (FMR)

Locality Name	Currently Offers AGSH	HUD FMR 1 Bedroom	AG Rate	HUD FMR rent as a percent of AG rate
Accomack County	No	$632	$1,805	35%
Albemarle County	No	$1,063	$1,609	66%
Alexandria city	No	$1,567	$1,805	87%
Alleghany County	No	$587	$1,609	36%
Amelia County	No	$1,044	$1,609	65%
Amherst County	No	$743	$1,609	46%

Locality Name	Currently Offers AGSH	HUD FMR 1 Bedroom	AG Rate	HUD FMR rent as a percent of AG rate
Appomattox County	No	$743	$1,609	46%
Arlington County	No	$1,567	$1,805	87%
Augusta County	No	$734	$1,609	46%
Bath County	No	$562	$1,609	35%
Bedford County	No	$743	$1,609	46%
Bland County	Yes	$559	$1,609	35%
Botetourt County	Yes	$700	$1,609	44%
Bristol city	Yes	$546	$1,609	34%
Brunswick County	Yes	$534	$1,609	33%
Buchanan County	No	$616	$1,609	38%
Buckingham County	No	$631	$1,609	39%
Buena Vista city	No	$660	$1,609	41%
Campbell County	No	$743	$1,609	46%
Caroline County	No	$918	$1,609	57%
Carroll County	Yes	$597	$1,609	37%
Charles City County	No	$1,044	$1,609	65%
Charlotte County	No	$559	$1,609	35%
Charlottesville city	No	$1,063	$1,609	66%
Chesapeake city	No	$1,015	$1,609	63%
Chesterfield County	No	$1,044	$1,609	65%
Clarke County	No	$1,567	$1,609	97%
Colonial Heights city	No	$1,044	$1,609	65%
Covington city	No	$587	$1,609	36%
Craig County	Yes	$700	$1,609	44%
Culpeper County	No	$822	$1,609	51%
Cumberland County	No	$713	$1,609	44%
Danville city	Yes	$535	$1,609	33%
Dickenson County	No	$616	$1,609	38%
Dinwiddie County	No	$1,044	$1,609	65%
Emporia city	No	$581	$1,609	36%
Essex County	No	$685	$1,609	43%
Fairfax city	No	$1,567	$1,805	87%

Locality Name	Currently Offers AGSH	HUD FMR 1 Bedroom	AG Rate	HUD FMR rent as a percent of AG rate
Fairfax County	No	$1,567	$1,805	87%
Falls Church city	No	$1,567	$1,805	87%
Fauquier County	No	$1,567	$1,609	97%
Floyd County	Yes	$559	$1,609	35%
Fluvanna County	No	$1,063	$1,609	66%
Franklin city	No	$718	$1,609	45%
Franklin County	Yes	$602	$1,609	37%
Frederick County	No	$868	$1,609	54%
Fredericksburg city	No	$1,567	$1,609	97%
Galax city	Yes	$597	$1,609	37%
Giles County	No	$616	$1,609	38%
Gloucester County	No	$1,015	$1,609	63%
Goochland County	No	$1,044	$1,609	65%
Grayson County	Yes	$616	$1,609	38%
Greene County	No	$1,063	$1,609	66%
Greensville County	No	$581	$1,609	36%
Halifax County	Yes	$534	$1,609	33%
Hampton city	No	$1,015	$1,609	63%
Hanover County	No	$1,044	$1,609	65%
Harrisonburg city	No	$723	$1,609	45%
Henrico County	No	$1,044	$1,609	65%
Henry County	Yes	$534	$1,609	33%
Highland County	No	$562	$1,609	35%
Hopewell city	No	$1,044	$1,609	65%
Isle of Wight County	No	$1,015	$1,609	63%
James City County	No	$1,015	$1,609	63%
King and Queen County	No	$621	$1,609	39%
King George County	No	$848	$1,609	53%
King William County	No	$1,044	$1,609	65%
Lancaster County	No	$742	$1,609	46%
Lee County	No	$616	$1,609	38%
Lexington city	No	$660	$1,609	41%

Locality Name	Currently Offers AGSH	HUD FMR 1 Bedroom	AG Rate	HUD FMR rent as a percent of AG rate
Loudoun County	No	$1,567	$1,805	87%
Louisa County	No	$769	$1,609	48%
Lunenburg County	No	$616	$1,609	38%
Lynchburg city	No	$743	$1,609	46%
Madison County	No	$727	$1,609	45%
Manassas city	No	$1,567	$1,805	87%
Manassas Park city	No	$1,567	$1,805	87%
Martinsville city	Yes	$534	$1,609	33%
Mathews County	No	$1,015	$1,609	63%
Mecklenburg County	Yes	$631	$1,609	39%
Middlesex County	No	$724	$1,609	45%
Montgomery County	Yes	$801	$1,609	50%
Nelson County	No	$1,063	$1,609	66%
New Kent County	No	$1,044	$1,609	65%
Newport News city	No	$1,015	$1,609	63%
Norfolk city	No	$1,015	$1,609	63%
Northampton County	No	$685	$1,609	43%
Northumberland County	No	$685	$1,609	43%
Norton city	No	$574	$1,609	36%
Nottoway County	No	$663	$1,609	41%
Orange County	No	$713	$1,609	44%
Page County	No	$621	$1,609	39%
Patrick County	Yes	$616	$1,609	38%
Petersburg city	No	$1,044	$1,609	65%
Pittsylvania County	Yes	$535	$1,609	33%
Poquoson city	No	$1,015	$1,609	63%
Portsmouth city	No	$1,015	$1,609	63%
Powhatan County	No	$1,044	$1,609	65%
Prince Edward County	No	$665	$1,609	41%
Prince George County	No	$1,044	$1,609	65%
Prince William County	No	$1,567	$1,805	87%
Pulaski County	Yes	$616	$1,609	38%

Locality Name	Currently Offers AGSH	HUD FMR 1 Bedroom	AG Rate	HUD FMR rent as a percent of AG rate
Radford city	Yes	$801	$1,609	50%
Rappahannock County	No	$862	$1,609	54%
Richmond city	No	$1,044	$1,609	65%
Richmond County	No	$688	$1,609	43%
Roanoke city	Yes	$700	$1,609	44%
Roanoke County	Yes	$700	$1,609	44%
Rockbridge County	No	$660	$1,609	41%
Rockingham County	No	$723	$1,609	45%
Russell County	No	$534	$1,609	33%
Salem city	No	$700	$1,609	44%
Scott County	No	$546	$1,609	34%
Shenandoah County	No	$635	$1,609	39%
Smyth County	Yes	$588	$1,609	37%
Southampton County	No	$718	$1,609	45%
Spotsylvania County	No	$1,567	$1,609	97%
Stafford County	No	$1,567	$1,609	97%
Staunton city	No	$734	$1,609	46%
Suffolk city	No	$1,015	$1,609	63%
Surry County	No	$559	$1,609	35%
Sussex County	No	$1,044	$1,609	65%
Tazewell County	No	$540	$1,609	34%
Virginia Beach city	No	$1,015	$1,609	63%
Warren County	No	$784	$1,609	49%
Washington County	Yes	$546	$1,609	34%
Waynesboro city	No	$734	$1,609	46%
Westmoreland County	No	$667	$1,609	41%
Williamsburg city	No	$1,015	$1,609	63%
Winchester city	No	$868	$1,609	54%
Wise County	No	$574	$1,609	36%
Wythe County	No	$547	$1,609	34%
York County	No	$1,015	$1,609	63%

SOURCE: HUD Office of Policy Development and Research FFY 2022 Fair Market Rents (40th-Percentile).

Appendix 4: Study mandate

Affordability of Assisted Living Facilities

Authorized by the Joint Commission on Healthcare on December 7, 2021

WHEREAS, Virginia's goal is to provide a robust continuum of aging services including community-based alternatives to nursing facility care that are available to all Virginians regardless of where they live or their socioeconomic status; and

WHEREAS, individuals may be more appropriately served in a non-medical residential setting such as an assisted living community or other supportive housing setting; and

WHEREAS, funding for Auxiliary Grants, which are income supplements for individuals who receive Supplemental Security Income and certain other aged, blind, or disabled individuals who reside in a licensed assisted living facility, approved adult foster care home, or other certified supportive housing setting, is limited and the number of auxiliary grant beds available in such facilities has steadily declined in the last decade; and

WHEREAS, Medicaid waivers are successfully being utilized in other states to pay some of the costs of assisted living other than room and board; and

WHEREAS, reports from the Joint Legislative Audit and Review Commission and the Joint Commission on Health Care highlighted existing challenges for low-income adults to access assisted living facilities, now therefore be it

RESOLVED, by the Joint Commission on Health Care that staff be directed to study the accessibility and affordability of Virginia's assisted living facilities. The study shall (i) identify challenges assisted living facilities face in offering the auxiliary grant program and assess key factors contributing to auxiliary grant bed availability, (ii) assess whether residents may potentially be more appropriately served in other supportive housing or congregate care settings, (iii) understand the different ways that other states structure and finance their assisted living programs and the feasibility of implementing those models in Virginia, and (iv) recommend changes to Virginia's current structure, financing, and regulation of assisted living facilities to further the state's goals.

The Joint Commission on Health Care shall make recommendations as necessary and review other related issues as warranted.

In accordance with § 30-169.1 of the Code of Virginia, all agencies of the Commonwealth, including the Virginia Department of Aging and Rehabilitative Services, Virginia Department of Social Services, Virginia Department of Behavioral Health and Developmental Services, and the Department of Medical Assistance Services shall provide assistance, information, and data to the JCHC for this study upon request.

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