JOINT LEGISLATIVE AUDIT AND REVIEW COMMISSION
OF THE VIRGINIA GENERAL ASSEMBLY

INTERIM STATUS REPORT:

Impact of Virginia's Aging Population on State Agency Services

House Document No. 35 (2004)

Members of the
Joint Legislative Audit and Review Commission

Chairman
Delegate Lacey E. Putney

Vice-Chairman
Senator Thomas K. Norment, Jr.

Delegate Vincent F. Callahan, Jr.
Senator John H. Chichester
Senator Charles J. Colgan
Delegate M. Kirkland Cox
Delegate H. Morgan Griffith
Delegate Frank D. Hargrove, Sr.
Delegate Johnny S. Joannou
Delegate Dwight C. Jones
Delegate Harry J. Parrish
Senator Walter A. Stosch
Delegate Leo C. Wardrup, Jr.
Senator Martin E. Williams

Mr. Walter J. Kucharski, Auditor of Public Accounts

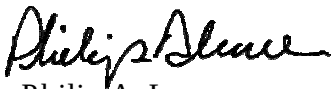
Director
Philip A. Leone

Preface

House Joint Resolution 103 from the 2004 Session directs the Joint Legislative Audit and Review Commission (JLARC) to study the impact of Virginia's aging population on the demand for and cost of state agency services, policies, and program management. The number of older Virginians, those persons age 60 and above, has been increasing as a proportion of the State's overall population. HJR 103 notes that the number of older Virginians is projected to increase at even faster rates by 2030, and that the older population may require an even greater amount of State agency services.

This document is an interim status update for the JLARC review of the impact of the older population on State agencies. This report provides background information on the types of services presently provided to older Virginians by State agencies. The report also provides a preliminary assessment of those State agency services for which the elderly demand for services at the present time appears to exceed the current capacity of the agencies to provide those services. The final report for this review is expected during the summer or fall of 2005.

On behalf of the JLARC staff, I would like to thank the State and local agency staff that have provided information and data for this review. I would also like to thank all of the individuals and organizations who have provided comments and information to JLARC staff over the past few months regarding the needs and aspirations of the Commonwealth's older residents.



Philip A. Leone
Director

November 10, 2004

Table of Contents

I. Introduction

House Joint Resolution (HJR) 103 from the 2004 General Assembly Session requires the Joint Legislative Audit and Review Commission (JLARC) to "study the impact of Virginia's aging population on the demand for and cost of state agency services, policies, and program management" (Appendix A). The study mandate notes that Virginia's older population is expected to substantially increase over the next 30 years, particularly in those areas of Virginia with higher concentrations of "baby boomers." The mandate also refers to existing unmet service needs of older Virginians, and further notes that the growing number of older Virginians, and increases in life expectancy, will result in a greater need for State agency services. The impact of these demographic trends upon the State workforce is also noted.

The current report is an interim status report, and the background information it contains is intended to provide a preliminary description of the impact of the aging population on State agency services. For this interim report, JLARC staff examined numerous services provided to older persons by State agencies and their local counterparts, as well as the extent to which agencies report being unable to meet the current level of service demand. JLARC staff are currently engaged in the data collection process for the study and, as a result, the interim report does not include substantive findings. A final report will be prepared for presentation during 2005. As part of the final report, JLARC staff will assess the current met and unmet demand for services by Virginia's aging population, describe how this population is anticipated to change by 2030, and identify the impact that this may have upon the future demand for State agency services. The final report will also consider the potential impact of aging trends within the State workforce itself, with regard to the delivery of services, and the demand for the financial resources of the Virginia Retirement System.

The remainder of Chapter I provides a preliminary estimate of the federal, State, and local expenditures on services or benefits received by older Virginians, as well as some information on selected demographic characteristics of older Virginians. The chapter also includes a background discussion of the federal and State laws that frame the services provided by State agencies. Chapter II provides an overview of some of the services provided by State agencies primarily involved in serving the aging population, such as the Virginia Department for the Aging. Agency descriptions are organized by the type of service provided, including mental and physical health, transportation, and housing, as well as services for State employees and retirees.

FUNDING FOR SERVICES OR BENEFITS RECEIVED BY OLDER VIRGINIANS

Federal and state programs which provide assistance to older persons have their roots in pension programs for Civil War veterans, as well as economic security programs created during the Great Depression to assist persons who had lost their

lifetime savings. Following the creation of state-level programs that provided pensions for unemployed older persons, the federal government began making grants to the states for general relief programs in the 1930s. The Social Security Act of 1935 created the first national program that provided economic assistance to the elderly, and this program was expanded during the 1960s to include Medicaid and Medicare. Another federal program that benefits older persons, the Older Americans Act, was also created during the 1960s. Language in the Act states that the program has been designed to provide services that reflect "our Nation's sense of responsibility toward the well-being of all of our older citizens."

In addition to health and social services, other services have been created at the federal and state level that benefit persons with limited incomes and persons with disabilities, including older persons, such as housing assistance and transit services. In Virginia, these services are provided through a combination of federal, State, and local funding. Table 1 presents JLARC staff preliminary estimates of funding and benefits received by older Virginians. Based on these estimates, at least $5.7 billion in government benefits and funding is provided on an annual basis to older Virginians. On a per-capita basis, this estimate equates to approximately $5,350 in funding or benefits for Virginians age 60 and above. This estimate is an average figure, however, and may not include all funding or benefits that are provided to this population. Clearly, there is a considerable range in the dollar value of services or benefits received by older Virginians – depending on factors such as the extent to which older Virginians receive services funded through programs like Medicare and Medicaid, and the extent to which older Virginians are eligible for and entitled to payments under Social Security.

SELECTED DEMOGRAPHIC CHARACTERISTICS OF OLDER VIRGINIANS

Since 1970, older Virginians have accounted for an increasingly larger proportion of the State's overall population. By the year 2030, it is projected that older Virginians – those individuals who are age 60 or older – will constitute one of every four Virginians. Presently, when compared to the national average a smaller percentage of older Virginians lives below the poverty line. Additionally, the percentage of older Virginians who have not completed high school is higher than the national average. The number of self-reported disabilities among older Virginians is comparable to the national average. However, the older population in future years may have more disabilities due to a number of factors, including increased life expectancy, because the incidence of disability increases with age. In addition, older Virginians may be more racially and ethnically diverse. The remainder of this section discusses these characteristics in more detail, and also describes the method used by the Virginia Employment Commission to create population projections.

Table 1

Estimated Annual Funding and Benefits That May Benefit Older Virginians[1]

Program	Federal	State	Local
Medicare[2]	$3,312,476,590	$0	$0
Medicaid[3]	467,861,361	453,851,329	0
Social Security[4]	663,033,000	0	0
Veterans Services	642,605,675[5]	5,537,025[6]	0
Social Services[7]	69,614,280	8,686,598	7,866,100[8]
Older Americans Act (OAA)	23,506,715[9]	14,708,326[10]	11,136,630[9]
Supplemental Security Income[5]	9,859,000	0	0
Housing[11]	3,587,084[12]	6,644,339[13]	Not Estimated
Public Transportation[14]	1,755,200	781,320	367,762
Total	$5,194,298,905	$490,208,937	$19,370,492

1 OAA funding is for persons age 60 and older. Housing funding is for persons 60 or 62 and older, depending on the program. All other funding is for persons age 65 and older. Medicare funding is for 2001, other funding is for 2003.

2 Data on the exact Medicare payments made to Virginians age 65 and older were not available. Because CMS data indicated that 85 percent of Virginia's Medicare beneficiaries in 2001 were age 65 or older, this funding estimate was calculated by taking 85 percent of the total Medicare funding received by Virginia's beneficiaries in 2001.

3 Estimated federal Medicaid funding was calculated by taking 50.76 percent of Medicaid expenditures for Virginians age 65 and older, which was the federal share of Medicaid payments in FY 2003.

4 Social Security and Supplemental Security Income funding is based on payments made in calendar year 2003 for benefits in current payment status as of December 2003.

5 Federal fiscal year data. Data on exact federal payments on behalf of veterans age 60 and older were not available. Because VA data indicated that 39.2 percent of Virginia's veterans in FFY 2003 were age 60 or older, this funding estimate was calculated by taking 39.2 percent of the total VA funding received by Virginia veterans in FFY 2003.

6 Estimated State general funding for older veterans, calculated by taking 39.2 percent of the agency appropriation in State FY 2003.

7 State fiscal year data. Includes expenditures for Food Stamps, TANF, Energy Assistance, Adult Services, Adult Protective Services, and Auxiliary Grant. Auxiliary grant expenditures are for persons age 65 or older and all others are for persons 60 or older. Energy Assistance expenditures are for households that contain someone age 60 or older. Because expenditures for Food Stamps, TANF, Adult Services, and APS were not available by age, these expenditures were estimated by taking the proportion of total expenditures equal to the proportion of service or benefit recipients who were age 60 or older. For example, because older persons are 75 percent of all adult services recipients, JLARC staff took 75 percent of total expenditures to estimate the cost of older clients.

8 This amount does not include all voluntary local contributions, which are not required to be reported to the State.

9 Federal fiscal year data obtained from the Virginia Department for the Aging.

10 Represents agency general funds received in State fiscal year 2003.

11 Does not include federal funding for housing vouchers. Does not include funding for the DHCD Indoor Plumbing/Rehabilitation Loan Program because funding for assistance to elderly households ($4,441,817) is not broken down by State General Funds and federal funds. Also, does not include funding to developers of housing that serves the elderly (tax credits, AHHP funding, CDBG funding, and VHDA loans to multifamily housing developers).

12 Federal housing funds are for State fiscal year 2003 except for federal Health and Human Services funds for weatherization assistance, which are for federal fiscal year 2003.

13 $6,458,357 of State funds represents loan funding from revenue generated by the Virginia Housing Development Authority and not State General Funds.

14 State fiscal year data. Includes total federal 5310 funding for the elderly and disabled and total State paratransit assistance funds for the elderly and disabled.

Source: JLARC staff analysis of data obtained from the Social Security Administration, the Centers for Medicare and Medicaid Services, the Administration on Aging, the Veterans Administration, the Virginia Department of Medical Assistance Services, the Virginia Department of Rail and Public Transportation, the Virginia Department of Housing and Community Development, and the Virginia Housing Development Authority.

Older Persons Are Projected to Account for One in Four Virginians by 2030

Since 1970, the number of older Virginians – those individuals who are age 60 or older – has steadily increased. Older Virginians have also accounted for a substantially increased proportion of the State's overall population. By 2030, the Virginia Employment Commission (VEC) projects that almost one in four Virginians will be over the age of 60. VEC staff caution that long-range estimates are less precise at the locality level. However, it is likely that the impact of the aging population will be unevenly felt across the State.

VEC Is Responsible for Creating Population Projections. The Virginia Employment Commission is directed by §60.2-113 of the *Code of Virginia* to "prepare official short and long-range population projections for the Commonwealth for use by the General Assembly and state agencies with programs which involve or necessitate population projections." In addition to the guidance stated in the *Code*, VEC has noted that the official projections "serve as common reference points in the planning, development, and implementation of state agency programs and facilities." For example, staff at the Virginia Department of Transportation indicate that VEC's projections are used as part of their long-range planning.

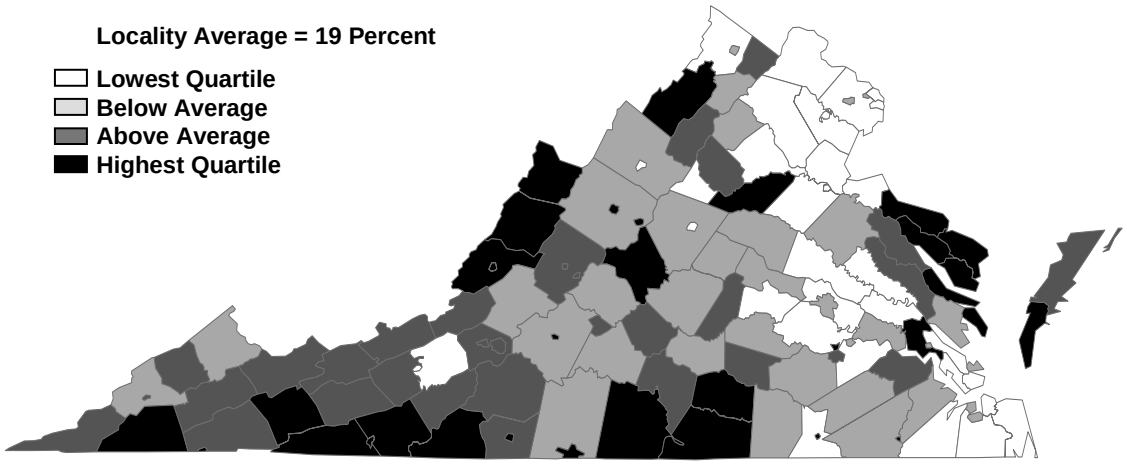
According to VEC staff, the data used to create the projections come from three inputs, and they are combined using a statistical model. The data elements used are fertility (birth) rates and survival (death) rates, which are produced by the Virginia Department of Health, and net migration. VEC staff state that the birth rates used in the projections are calculated by age and by locality, although a single set of survival rates are used for all localities. The net migration rate for each locality is calculated by VEC staff based on 1990 and 2000 Census data, and then that rate is applied to all subsequent years. Finally, the actual projections are calculated to 2010, 2020, and 2030, with a local review process in place that involves counties, cities, and planning district commissions.

VEC staff caution that the data on which the projections are based are subject to several external factors which cannot be anticipated and modeled when projections are made. Therefore, the projections are best interpreted as indicators of how the population may change based upon the influence of existing factors. For example, the VEC Commissioner noted that the economy exerts a large influence upon the behavior of individuals in a locality or region, and that events such as plant closings can have a large negative impact on the following year's net migration rate. As a result, the projections for a given locality may be less precise to the extent that these external factors vary among individual localities. At the State level, other factors may affect the projections as well. One of these factors is the relative attractiveness of Virginia as a retirement destination compared to other states. If the State, or individual localities, becomes more attractive in the future, then the number of older persons could exceed the current projections.

Figure 1

Distribution of the Older Population, 2002

(Based on Proportion of Population Age 60 or Older)



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

The Number of Older Virginians Is Projected to Increase Substantially. The number of older Virginians, and their corresponding percentage of the State's population, grew during the 1970s and 1980s, and then grew more slowly in the 1990s. Virginia's older population grew by about 35 percent from 1970 to 1980, and by about 25 percent from 1980 to 1990. In contrast, the State's overall population grew by about 15 percent during that time period. The growth rate of the older population then decreased, growing by only 17 percent during the 1990s. Figure 1 presents information on the distribution of the older population in Virginia for the year 2002, by quartile, with a darker shading indicating a higher percentage of persons age 60 or older. Tables 2 and 3 present additional information on Virginia's

Table 2

Virginia's Population by Age Group

Age Group	1990	2000	2010	2020	2030
0-19	1,704,603	1,937,189	2,020,471	2,169,302	2,349,714
20-59	3,572,849	4,075,669	4,423,820	4,537,766	4,666,961
60-84	850,197	978,373	1,303,155	1,722,226	2,035,728
85 +	59,709	87,268	145,454	172,607	222,697
TOTAL	6,187,358	7,078,499	7,892,900	8,601,901	9,275,100

Source: JLARC staff analysis of Virginia Employment Commission data.

Table 3

Percentage of Total Virginia Population by Age Group

Age Group	1990	2000	2010	2020	2030
0-19	27.5%	27.4%	25.6%	25.2%	25.3%
20-59	57.7	57.6	56.0	52.8	50.3
60-84	13.7	13.8	16.5	20.0	21.9
85 +	1.0	1.2	1.8	2.0	2.4

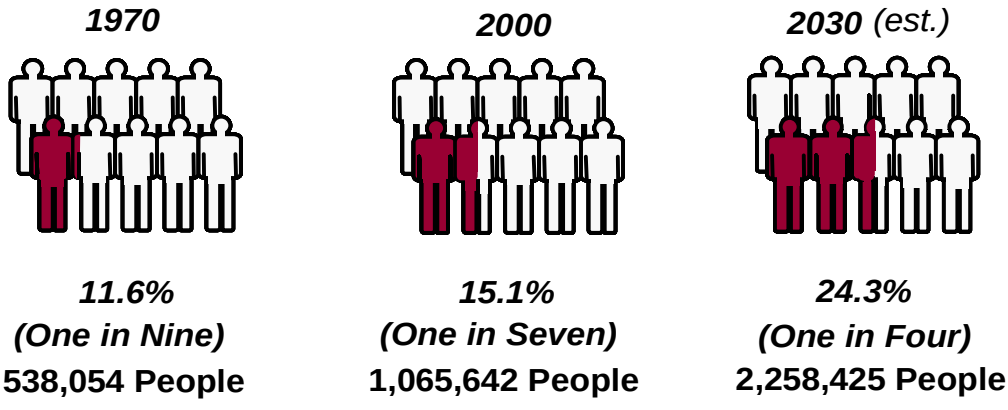
Source: JLARC staff analysis of Virginia Employment Commission data.

population by age group, with a focus on the growth that occurred from 1990 to 2000, and future projections to the year 2030 of age group population trends.

The number of older Virginians is anticipated to dramatically increase during the first decades of the 21st century, according to population projections by the VEC. The largest increases by 2030 are projected to occur in the population group known as the "Baby-Boom Generation" (those persons born between 1946 and 1964). After the first baby boomers begin to reach age 60 in 2006, the number of older Virginians is expected to surge by about 383,000 people between 2000 and 2010, at which time older Virginians are expected to account for 18.4 percent of the population. By 2020, VEC projects that the older population will grow by another 446,000 people, accounting for 22 percent of the population – nearly twice the percentage in 1970. Finally, the older population is projected to account for almost one of every four Virginians by 2030. The magnitude of these changes is illustrated in Figure 2.

Figure 2

Changes in the Ratio of Persons Age 60+ to the Entire Population, 1970 to 2030



Source: JLARC staff analysis of Virginia Employment Commission data.

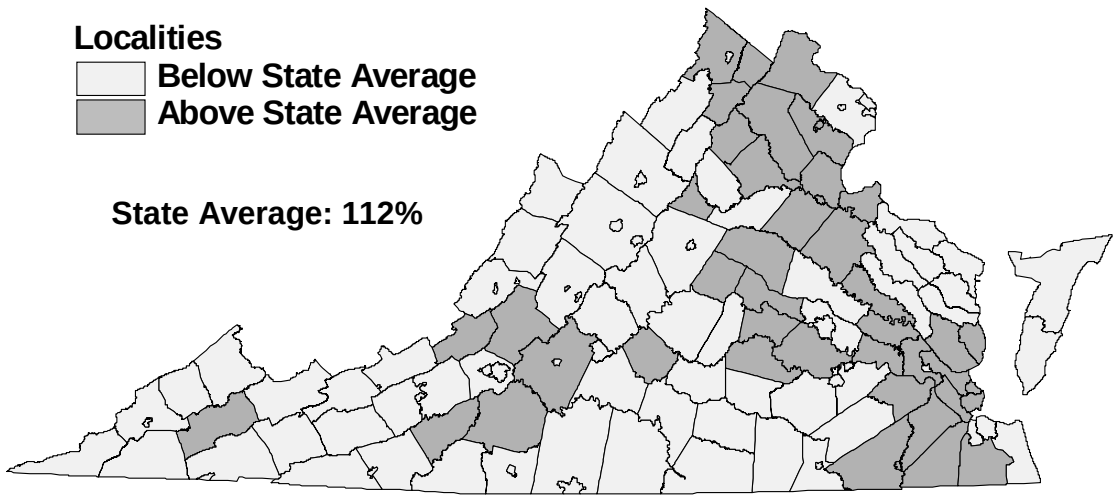
In addition to increases in the overall population of older Virginians, substantial increases are expected in the population age 85 and older. Because of the increased frailty of persons age 85 and older, this population group is anticipated to have the highest demand for State agency services. Specifically, from 2000 to 2030 the population 85 and over is expected to more than double, from about 87,000 to about 223,000 persons. Presently, the oldest Virginians account for about 1.2 percent of the population. This is projected to increase to two percent in 2020, and 2.4 percent in 2030.

The Rate of Growth of the Older Population Is Anticipated to Vary Across Virginia. The rate of growth in the older population is projected to vary across Virginia. Between 2000 and 2030, on a State level the average percentage change in the number of older persons is projected to be 112 percent. This compares to a 31 percent increase in the number of persons of all age groups. The locality that is projected to have the smallest positive percentage increase by 2030 is Nelson County, which is projected to increase from 3,246 older persons in 2000 to 3,442 in 2030 – an increase of 196 persons, or six percent. In contrast, Stafford County is projected to have the State's largest percentage increase. In 2000, Stafford had 7,932 older persons. By 2030, Stafford is projected to have 65,715 people over the age of 60 – an increase of 57,783 persons or 729 percent. In six localities – Albemarle, Alleghany, Bath, Charlottesville, Galax, and Lancaster – the number of older persons is projected to decrease by an average of 20 percent. Figure 3 illustrates the localities that are projected to have a growth rate in the older population between 2000 and 2030 that is above or below the State average.

According to population projections from VEC, of Virginia's 134 localities, 128 will see an increase in the number of older persons by 2030. However, when considering all age groups, only 104 localities will see an increase in their total population.

Figure 3

Percent Projected Growth of Older Population, 2000 to 2030



Source: JLARC staff analysis of Virginia Employment Commission data.

As a result, in 27 localities, as the overall population is decreasing, the number of older persons will be increasing, which may affect the types of services demanded in those localities.

The variation in the growth rate of older Virginians will largely result from the impact of the baby boom population. Those areas of Virginia that have higher concentrations of baby boomers relative to the existing older population are expected to experience more dramatic increases in their older population starting in 2006 when the first baby-boomers turn 60 years of age. For example, the Prince William area currently has more than four times as many baby-boomers as there are residents who are 60 and over. Assuming all other factors remain constant, areas such as Prince William will experience a greater demand for State and local services from older residents in the future.

Today's Older Virginians Often Differ from Other Older Americans

When compared to the national average for all older Americans, a smaller percentage of older Virginians live below the poverty line, and fewer older Virginians have completed high school. However, the rate of self-reported disabilities among older Virginians is comparable to the national average.

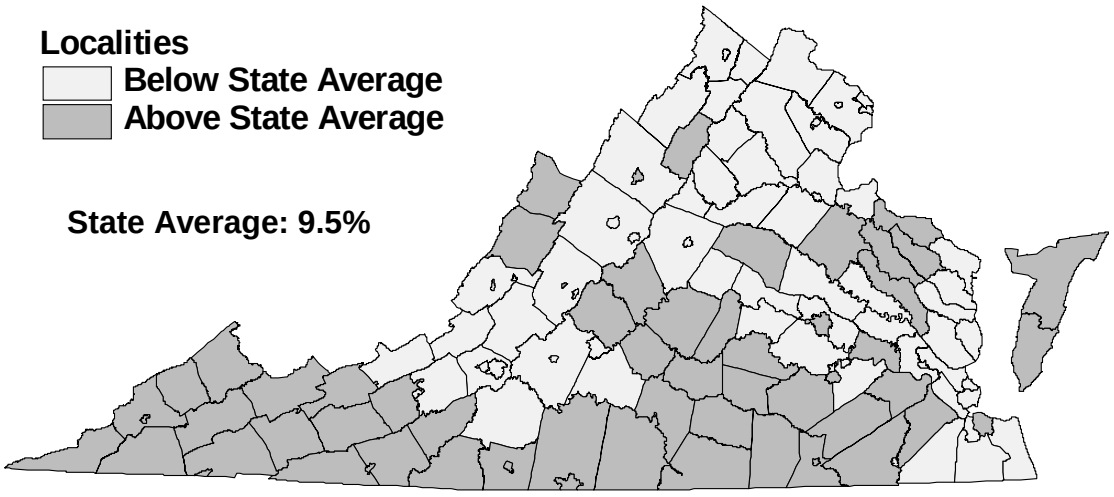
Older Virginians Have Lower Rates of Poverty Than the National Average. In 1999, a lower percentage of Virginians who were 65 or older lived below the poverty level than the national average, although the extent of poverty in Virginia varies widely. For a single person over age 65, the U.S. Census Bureau used a poverty threshold of $7,990 per year in 1999. At the national level, 9.9 percent of adults who were 65 or older lived below the poverty level in 1999, on average, compared to a State average of 9.5 percent for older Virginians. However, older women are more likely than older men to live in poverty. Women accounted for 71 percent of all persons age 60 or older who lived in poverty, although women constituted only 59 percent of all older Virginians.

The geographic distribution of Virginians who live in poverty varies widely. The percentage of older persons in poverty varies from a low of 2.1 percent in Fairfax City, to a high of 23.3 percent in Lee County. Figure 4 shows those areas of the State in which the percent of persons over the age of 65 are above or below the State average poverty rate.

Fewer Older Virginians Complete High School Than the National Average. In 2000, a higher percentage of older Virginians over the age of 65 had not completed high school when compared to the national average. Nationally, 34.5 percent of older adults had not completed high school, on average, compared to 37.3 percent of older Virginians. This percentage includes older Virginians who had not completed ninth grade (20.6 percent) as well as those older adults who completed some high school, but did not earn a diploma (16.7 percent). Additionally, the percentage of Virginians who had not completed high school was highest among older adults. For example, in contrast to older Virginians, only 17.4 percent of Virginians between the ages of 45 and 64 had not completed high school.

Figure 4

Percent of Persons Age 65 and Over in Poverty



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

The educational attainment of older Virginians also varies by gender and region within Virginia. Although the percentage of older men and women who had attained a high school degree or higher was similar (63.1 percent of men, 62.4 percent of women), there is variation based on the type of degree. A higher percentage of older women (31 percent) had attained a high school degree than older men (22 percent). In contrast, a higher percentage of older men (13 percent) had completed a bachelor's degree than older women (nine percent). Additionally, there is a substantial degree of variation in the educational attainment of older adults across Virginia. The percentage of older adults who have not attained a high school degree varies from a low of 19 percent in Northern Virginia (planning district 8), to a high of 65 percent in far Southwest Virginia (planning districts 1 and 2). Conversely, the percentage of older Virginians who have attained a bachelor's degree varies from a low of 4 percent in far Southwest Virginia, to a high of 19 percent in Northern Virginia.

Reported Disabilities Among Older Virginians Are Similar to Those of Older Americans. According to the U.S. Census Bureau, 42.1 percent of Virginians over the age of 65 reported that they had one or more disabilities in 2000. This percentage is comparable to the national average of 42 percent. According to the U.S. Census Bureau, these disabilities are grouped by type, and include sensory (blindness, deafness), physical (walking, lifting), mental (remembering, concentrating), self-care (dressing, bathing), and "Go outside home" disabilities (the ability to visit a doctor's office or run similar errands).

However, within Virginia the incidence of reported disabilities among persons over age 65 varies widely. Approximately 20 percent of older Virginians reported having one disability, while another 22 percent reported having two or more

disabilities. The percentage of older persons reporting one type of disability varied from a low of 13 percent in Charles City County, to a high of 35 percent in Norton City. In addition, the percentage of older persons reporting two or more types of disabilities varied from a low of 14 percent in Lancaster County, to a high of 43 percent in Buchanan County.

CHANGES IN VIRGINIA'S OLDER POPULATION MAY AFFECT FUTURE SERVICE DEMANDS

By the year 2030, the number of older Virginians is expected to increase substantially, and it appears that older Virginians in future years may have more disabilities due to a number of factors, including increased life expectancy. In addition, older Virginians may be more racially and ethnically diverse. As the number of older Virginians increases, service demands may be expected to increase proportionally. In addition, the types of services demanded may differ from current demands as the characteristics of older Virginians change.

An Increased Number of Older Virginians May Affect Future Service Demands

Virginians over 60 years of age are the fastest growing segment of the population, and they will therefore comprise a greater proportion of the overall population in the future. As a result, it is likely that a larger number of older Virginians will result in an increased demand for State services. Studies of the aging impact conducted in other states have indicated that the majority of agencies will likely be affected by the increase in the aging population, not just those that directly provide services to the aging. Direct service agencies that provide services such as guardianship services for incapacitated adults, adult protective services, Medicaid, and gero-psychiatric care will probably be most affected by the increase in the aging population. However, the increasing older population may also affect agencies that do not specifically serve the older population. For example, agencies that provide services such as housing, licensure of drivers, and incarceration of prisoners, as well as agencies that regulate or license nursing homes and health care providers, will also be affected.

The information from other states also suggests that an aging population may demand services that are not presently provided by those states, or are provided to a lesser extent than may be required in the future. For example, the Montana Department of Commerce, which has a consumer affairs office, expects that as the aging population increases, the number of senior citizens who are victimized by consumer fraud will also increase. Additionally, the New York Office of General Services, which assists the state in designing and building facilities, anticipates needing to retain specialized consultants to assist with unique age-related design of office or other facility space. In addition to modifying facilities, many agencies in other states anticipate having to make adjustments so that services and information they provide will fit the needs of, and be accessible to, the older population.

As employers, the state and local governments will likely be affected by the aging trends because a growing proportion of state and local public employees may be retiring. Other states anticipate that agencies with larger proportions of older staff will be impacted more than other agencies. Certain job categories may be impacted more as well. A study conducted by the Washington Department of Personnel in 2000 found that the aging trend is more pronounced in the public sector workforce than it is for the general workforce, and that more than 50 percent of the state's executive-level and 30 percent of mid-level managers would be eligible to retire by 2005.

At the locality level, it appears that the effects of the aging population will be uneven. Population projections by the Virginia Employment Commission suggest that the growth of the aging population will occur more substantially in particular parts of the State. For example, the counties of Loudoun and Prince William and the cities of Manassas and Manassas Park currently have approximately four times as many baby boomers as people age 60 and older. In contrast, certain rural areas have a much lower ratio of baby boomers to people age 60 and older. These areas include counties in Southwestern Virginia such as Bland, Carroll, Grayson, Smith, Washington, and Wythe; counties in Southside Virginia such as Brunswick, Halifax, and Mecklenburg; and counties in the Northern Neck and Middle Peninsula such as Essex, Gloucester, Lancaster, King William, and Richmond.

While rural areas may not be as impacted by large increases in the number of older Virginians needing services, the characteristics of rural older Virginians may mean that they will demand more intensive services. According to U. S. Census Bureau data, more rural elders than urban elders live alone. Older persons living alone are also more likely to be in poor health and less likely to have access to family members for assistance.

Changes in the Characteristics of Older Virginians May Affect the Types of Services Demanded In The Future

If the percentage of married older persons continues to decline in Virginia, in accordance with national trends, then the number of older persons living alone may increase. Because older people that live alone are more likely to have fewer social supports and have poorer health, this group of older Virginians may not only require more care, but also may have to rely more on paid care rather than unpaid care provided by family members.

One factor contributing to the rapid growth of Virginia's older population is increasing life expectancy. National data indicate that in 2000, average life expectancy at birth for all persons was at a record high of 76.9 years. In contrast, life expectancy in 1900 was 47.3 years, and in 1950 it was 68.2 years. However, life expectancies by age are higher for females than for males, and higher for white persons than black persons. In 2000, life expectancy in the United States for females was 79.5 years, while for males it was 74.1 years. According to a report by the U.S. Centers for Disease Control, life expectancy is increasing as a result of decreasing

trends for heart disease, cancer, stroke, accidents, and homicide, although the incidence of Alzheimer's disease and hypertension are continuing to increase.

As Life Expectancy Increases, the Number of Older Persons with Disabilities May Increase. As the size of the older population increases, the number of disabilities reported by older Virginians may increase as well. According to Census data, approximately 20 percent of older Virginians reported having one disability, while another 22 percent reported having two or more disabilities. The incidence of disability increases with age, with 32.6 percent of all older Virginians between age 65 to 74 years having a self-reported disability. This increases to 54.5 percent of those persons age 75 and older.

An increase in the number of disabled older Virginians may lead to a corresponding increase in the demand for long-term care and other supportive services. Although adults with developmental disabilities (those impairments that affect normal growth and development) are living longer, they are also at a higher risk for developing age-related chronic conditions and functional limitations. Many adults with developmental disabilities receive care from parents or other older family members, because previous choices for care were limited to family or institutions. The "dual aging" of people with developmental disabilities and their caregivers may increase demands on long-term care and other supportive services. In addition, the increasing prevalence of other disabling conditions such as Alzheimer's disease and diabetes may increase the demands for these services.

Older Virginians Will Be More Racially Diverse in the Future. Another factor that may affect future service levels is the changing racial and ethnic characteristics of Virginians. In coming years, older Virginians are expected to be more racially and ethnically diverse, and this may increase the demand for certain preventive and other health care services. According to the Centers for Disease Control and Prevention, minority groups suffer from more preventable diseases, deaths, and disabilities than non-minorities. Virginians under the age of 60 exhibit greater racial and ethnic diversity than older Virginians, suggesting that the older population will be more racially diverse in the future. Nearly 32 percent of Virginia's population age 60 and under is in a minority group, compared to 20 percent of Virginians over the age of 60. Presently, almost 16 percent of all older Virginians are black, 2.1 percent are Asian, and 1.3 percent are Hispanic. The number of older Virginians from racial and ethnic minority groups grew at twice the rate of older white Virginians over the past decade, reflecting the increasing diversity of the total population.

FEDERAL POLICIES THAT AFFECT THE OLDER POPULATION PRIMARILY FOCUS ON THEIR WELFARE

Starting in the 1930s, and increasingly since the 1960s, the federal government has assumed a more active role in shaping policy for the nation's older population. This increased recognition of issues affecting older adults has resulted in the creation of major federal programs like Social Security, Medicare, and Medicaid, and has also led to the growth of a national network of public service providers

dedicated solely to meeting the needs of this population. Major federal policy changes impacting the older population are described in Table 4 and are detailed further in the following discussion. As discussed earlier, it is estimated that approximately $5.2 billion in federal payments and funding is provided annually to older Virginians.

Social Security Program

The federal government's increased recognition of the needs of the nation's older population began with the passage of the Social Security Act in 1935. The initial purpose of the Social Security program was to provide coverage against economic insecurity by providing old-age insurance benefits. Social Security benefit eligibility has since expanded to include disabled persons and survivors of the deceased. However, the primary purpose of the program remains to provide income to persons age 65 and older upon their retirement. The exact age at which an individual qualifies for full Social Security benefits varies by date of birth, which is illustrated in Table 5.

The Social Security program is funded by federal taxes collected under the Federal Insurance Contributions Act (FICA). The Old-Age Survivors Insurance (OASI) tax is 5.3 percent of income and the Disability Insurance (DI) tax is 0.9 percent of income. Together, the total Old-Age, Survivors, and Disability Insurance (OASDI) tax paid by U.S. workers is 6.2 percent of gross income. Employers are required to contribute an additional 6.2 percent. Social Security benefits, on average, make up 40 percent of the income of retired individuals age 65 and over. The most recent data available from the Social Security Administration indicate that in December 2003, monthly benefits to Virginians totaled $905 million, 68 percent of which was paid to retired workers, who received an average of $903 in monthly Social Security benefits.

The Social Security Administration is also responsible for providing Supplemental Security Income (SSI) benefits. SSI is a cash assistance program financed through federal general tax revenues that provides monthly payments to low-income aged, blind, or disabled persons. The current maximum monthly payment is set at $564. In December 2003, 36,813 Virginians age 65 and older received SSI benefits.

Medicare Program

In 1965, recognizing the need for public health insurance benefits for the elderly, Congress created the Medicare program as Title XVIII of the Social Security Act. To qualify for Medicare benefits, individuals must be at least 65 years of age, disabled, or have permanent kidney failure. Individuals must also have paid into the Social Security System, generally through payroll taxes, for a total of ten years. Individuals who have not made the required contributions to Social Security, however, can purchase Medicare coverage. In addition to payroll taxes, which, like Social Security, are matched by employers, the program is financed by monthly premiums paid by recipients.

Table 4

Major Federal Policy Changes Impacting the Older Population

Year	Federal Action	Resulting Policy Change
1935	**Social Security Act**	Provided for Old Age Assistance and Old Age Survivors Insurance
1965	**Older Americans Act**	Established the federal Administration on Aging (AoA), created mandates for State and local governments on services for the aging population, and created a funding formula for allotments to states
1965	**Medicare, Title XVIII**	Health insurance program for the elderly added to the Social Security Act
1965	**Medicaid, Title XIX**	Health insurance program for low-income persons added to the Social Security Act
1990	**Americans With Disabilities Act**	First civil rights law for persons with disabilities. Prohibits discrimination against people with disabilities in employment, telecommunications, public services/accommodations
1999	**Olmstead v. L.C.**	Supreme Court decided that states are required under Title II of the ADA to provide community-based treatment for persons with mental disabilities when community-based treatment is appropriate, not opposed by the individual, and can be accommodated by current resources. Extends to all persons with disabilities, not just the mentally disabled
2000	**Older Americans Act Amendments of 2000**	Created the National Family Caregivers Support Program, which provides assistance to family members who care for aging persons through services such as counseling and respite services Adds focus to older persons in rural areas

Source: JLARC staff analysis.

Table 5

Retirement Age for Receiving Full Social Security Benefits

Year of Birth	Full Retirement Age
1937 or earlier	65
1938-1942	65 and 2 months – 65 and 10 months
1943-1954	66
1955-1959	66 and 2 months – 66 and 10 months
1960 or later	67

Source: Social Security Administration.

Medicare covers, among other things, expenses for inpatient and outpatient hospital care, short-term nursing facility and home health care, and physician care. According to the federal Centers for Medicare and Medicaid Services (CMS), 14 percent of the nation's population, or nearly 40 million individuals, were enrolled in Medicare in 2002. In 2003, 946,470 Virginians were Medicare beneficiaries, of whom 88 percent were age 60 and older. Most recent CMS data indicate that in FY 2001, nearly $4 billion in Medicare payments were made on behalf of Virginians. The Congressional Budget Office has predicted that, in 2004, Medicare costs nationally will increase approximately eight percent to $297 billion.

Medicaid Program

In 1965, along with Medicare, Congress added the Medicaid program to the Social Security Act. The Medicaid program is designed to provide health insurance for the nation's low-income residents, and states are mandated to provide coverage to certain groups of individuals that are likely to include older persons. These groups include low-income aged persons (age 65 and older), blind and disabled persons, and certain low-income Medicare beneficiaries. Nationally, older Medicaid recipients represent a disproportionate service cost relative to their proportion of beneficiaries. In 2000, persons age 65 and older constituted 10 percent of Medicaid beneficiaries nationwide, but were responsible for 30 percent of national Medicaid costs. A similar pattern is seen in Virginia, which will be discussed in more detail later in the report.

An important federal action regarding Medicaid that affects the nation's older population was the creation of the home and community-based service waiver program in 1981. Set forth in §1915(c) of the Social Security Act, this program is intended to allow eligible persons to receive needed care in a home or community-based setting rather than in a nursing facility or other institution. The federal government requires that a state's Medicaid services be equally available to all enrollees, and the waiver program allows states to "waive" some of these requirements so that persons in need of institutional care can receive services that differ from other Medicaid enrollees. In order to receive federal approval for the implementation of a

waiver program, states must assure the federal government that waiver services will not be more costly to provide than institutional care. Examples of services covered under waiver programs include home health aides, personal care, and adult day care. The use of Medicaid waiver services by older Virginians will be discussed in more detail later in the report.

Medicare Prescription Drug, Improvement, and Modernization Act

In December 2003, Congress passed the Medicare Prescription Drug, Improvement, and Modernization Act. The most notable provision of this law is the addition of prescription drug coverage to the expenses covered by Medicare. The new law will not only impact the older population, but may also have fiscal ramifications for states. For example, individuals currently enrolled in state Medicaid programs who are also eligible for Medicare ("dual eligibles") may receive the new Medicare prescription drug benefits. However, Medicaid will no longer provide drug coverage to these persons. Further, states will have to make payments to the federal government approximately equal to the amount that would have been spent each month on Medicaid prescription drug coverage in the absence of the Medicare bill. This is estimated to result in $88.5 billion being returned to the federal government between 2006 and 2013. Despite this, the Congressional Budget Office estimates that states will see a net savings of $17.2 billion in Medicaid costs between 2004 and 2013 as a result of the new prescription drug benefit.

The Department of Medical Assistance Services (DMAS), the State agency responsible for administering the Commonwealth's Medicaid program, estimates that Virginia will return more than $205 million to the federal government in 2006 as a result of this requirement. According to data provided by DMAS, in FY 2003 there were 153,932 Virginians dually eligible for Medicare and Medicaid, of whom 66 percent were age 60 or over.

Older Americans Act

In addition to Medicare and Medicaid, in 1965 Congress also passed the Older Americans Act (OAA). The OAA was enacted to improve the lives of older Americans in relation to income, health, housing, employment, long-term care, retirement, and opportunities for community service. The underlying purpose is to enhance the ability of older individuals to maintain their independence, while avoiding unnecessary institutionalization by remaining in their own homes and communities. This legislation created the federal Administration on Aging (AoA), established mandates for state and local services to older residents, and created a funding formula for the provision of federal assistance to states. In FFY 2003, $1.1 billion was allotted to the states in OAA funds.

The OAA encourages states to develop and implement comprehensive and coordinated systems to serve older individuals. The services and programs that provide assistance to older persons are specified in several sections of the OAA and include supportive services, transportation, case management, adult day care, personal care, homemaker/chore assistance, respite and family caregiver support,

home repair, congregate and home-delivered meals, and elder rights, including long-term care ombudsman programs. In order to receive OAA funding, each state must designate a State Unit on Aging to develop a plan to serve older individuals. (In Virginia, this agency is the Virginia Department for the Aging.) The state plan must give preference to older persons with the greatest economic and social needs. Further, each state is responsible for creating planning and service areas, and designating an Area Agency on Aging (AAA) to provide services in each area. The provision of OAA services will be discussed in more detail later in the report.

The Supreme Court's Olmstead Decision

In 1990, Congress passed the Americans with Disabilities Act (ADA), which was the first civil rights law for disabled persons. The ADA prohibits discrimination against the disabled in such areas as employment, public services, and public accommodations. In the 1999 *Olmstead v. L.C.* decision, the U.S. Supreme Court decided that under Title II of the ADA, each state must provide community-based treatment for persons with mental disabilities when such treatment is deemed appropriate, is not opposed by the individual, and can be accommodated with existing resources. This decision has been interpreted to apply to all disabled persons, not just the mentally disabled. It has also come at a time when the federal government is granting states greater options for community-based care through Medicaid waivers, as discussed above.

STUDIES OF THE OLDER POPULATION

The steady increase in the number of older persons has prompted research on the issue of service provision to this population, both in Virginia and in other states. During the 1990s, JLARC and other organizations conducted several studies that examined the services provided to, and needs of, older Virginians. Summaries of these studies are provided below.

Previous JLARC Studies Have Examined Some State Services for the Aging

Previous JLARC studies have examined the State's provision of long-term care services, as well as the State's implementation of the federal Older Americans Act. For example, JLARC studied Medicaid-financed long-term care in 1992, and the report noted that the projected increase in the State's older population was expected to result in an increased demand for long-term care services.

JLARC has also conducted two studies pertaining to the federal Older Americans Act (OAA) and the Virginia Department for the Aging (VDA), which serves as the single State agency responsible for implementing the OAA. In 1991, JLARC reviewed the funding formula for the OAA, which the VDA is required to develop as the means of distributing federal and State matching funds to 25 local area agencies on aging (AAAs). The 1991 study concluded that the formula was a reasonable means of distributing funds. A subsequent study examined the mission and

the effectiveness of the VDA. The 1998 review found that the executive branch needed to give a greater priority to VDA and aging issues.

Other Legislative Studies in Virginia

Since the early 1990s, a few other legislative studies have examined the impact that a growing older population would have on State government services. The study with the broadest scope was conducted 11 years ago, and studies conducted more recently have focused on a few narrower service issues. Studies have also considered the feasibility of attracting retirees as an economic development strategy, as well as plans for consolidating the aging and long-term care services systems.

More specifically, in 1993 the Secretary of Health and Human Resources conducted a study on "Aging in the 21st Century" (SD 45, 1995). Although no specific recommendations were provided, several issues were identified for State and local policymakers to consider, including: the impact that increasing life expectancy would have upon retirement policies and the health care system; the need to provide services that are accessible and culturally appropriate due to the increasing diversity in the older population; and the difficulty local governments with high concentrations of older persons and limited revenue capacity may have in meeting the needs of their older residents.

In 1993, the Virginia Department for the Aging conducted a study on the economic benefits of attracting retirees to Virginia. (Results of the study were included as an appendix to the report on "Aging in the 21st Century.") The study concluded that attracting retirees could result in increased tax revenues, investment, and employment opportunities, but could also result in increased demand for government services such as fire and police protection, health care, transportation, and income maintenance. The study recommended that State and local government officials consider the short- and long-term benefits of a retiree attraction program before making recommendations.

In addition to studies that focused solely on the aging population, other legislative studies have been conducted that have focused on services that are often used by older Virginians. The Joint Commission on Health Care has conducted a number of these studies, including studies of the personal maintenance allowance within the Medicaid Elderly and Disabled Waiver, assisted living and other services for vulnerable adults, and nurse staffing ratios in nursing facilities. The Virginia Housing Development Authority was directed by the 1999 General Assembly to study the financing of affordable assisted living options in the Commonwealth. The study noted that the rising health care needs of persons who resided in assisted living facilities, including older Virginians, would impact the financial assistance available from VHDA, because most of its resources are federally constrained to serving residential rather than health care purposes.

Studies of the Aging Population Conducted by Other States

In addition to the studies conducted by Virginia agencies, several other states have or are currently conducting studies to determine what impact the aging population will have on their states. These studies involve a range of issues, including the possible impact that the aging population might have on state and local government, as well as the state's overall economy.

Studies in Some States Indicate that the Aging Population Will Impact Most State Agencies. Some state agencies with a mission that is clearly linked to aging issues are obvious candidates to be impacted by an aging population. However, studies conducted in five states - California, Minnesota, Montana, New York, and Texas – have concluded that the aging population will actually affect most aspects of government. Agencies in these states were surveyed and asked to identify which of their services were affected by aging issues, what the agency was currently doing to address these issues, and what actions should be taken in the future. Agencies were also asked to consider which of these issues should be addressed through a collaborative or interagency approach, and to identify indicators that would measure progress on these issues. These studies suggest that the aging population will affect not only those agencies that provide direct services, such as health care, social services, and transportation, but also those agencies that provide indirect services such as licensing, regulating, and planning.

Several States Have Developed Strategic Plans to Enable State Government to Meet the Demands of the Aging Population. In addition to specific studies of the impact of the aging population, 14 states have or are currently preparing strategic plans to guide their response to the needs of the aging population. In addition to general strategic plans, some states have developed strategic plans specifically for long-term care. At least five states have developed strategic plans to address expectations of an increasing demand for long-term care services in general, greater demand for in-home services rather than institutional services, increasing costs for both institutional and in-home services, and a shortage of people trained to provide long-term care and other health care services.

JLARC REVIEW

This interim review of the impact of Virginia's aging population on State agency services has involved the identification and examination of State agencies services provided to older Virginians, including State government employees and retirees. Based on the study resolution, JLARC staff developed the following issues to be addressed by this interim report:

- What State and local agencies presently provide services to older Virginians, and what types of services are provided?

- What data are available on the number of older persons served and the associated cost per type and unit of service?

- What trends or themes exist in the types of services provided across all agencies, or by the subgroup served? To the extent that data are available, how do present service levels differ from those in prior years?

- What unmet needs exist, if any, for the totality of services provided by State and local agencies?

For this interim study, JLARC staff examined those State agency services that appear to be most impacted by older Virginians, with a focus on services provided by those State agencies and their local counterparts that are specifically identified in the study mandate. These agencies include the Department for the Aging, the Department of Medical Assistance Services, the Department of Social Services, the Department of Health, the Department of Mental Health, Mental Retardation and Substance Abuse Services, the Department of Corrections, the Department of Human Resource Management, and the Virginia Retirement System.

JLARC staff also identified several other service providers whose activities are integral to meeting the needs of older Virginians. These providers include churches and nonprofit organizations, private sector businesses, and family caregivers. Many of the services provided by the State agencies reviewed in this interim report are designed to complement or support the services provided by these organizations and individuals. In addition to the agencies discussed in this report, it should be noted that other State and local agencies provide services to older Virginians, including the Office of the Attorney General, the State Corporation Commission, the Virginia Department of Agriculture and Consumer Services, the State Board of Elections, the Department of Rehabilitative Services, the Council on Human Rights, as well as Virginia's institutions of higher education, and local public safety and emergency services providers.

Research Activities

This interim report examined the issues through three main research activities. These activities were: (1) document and literature reviews, (2) data analysis, and (3) structured interviews.

Document and Literature Reviews. The study team reviewed the literature that pertains to the demographic characteristics of older adults in Virginia and nationally. The team also reviewed the federal and State laws that govern service eligibility and provision, and agency documents that describe the services provided to older persons. Prior studies on services provided to older Virginians were also reviewed, as well as studies on the older population conducted by other states.

Data Analysis. JLARC staff conducted a preliminary analysis of data on the demographic characteristics of older Virginians, as well as federal and State agency data on services provided to older persons. Where data were available by age on the amount and cost of providing services, JLARC staff examined the extent to which the services provided to older Virginians differed from those provided to younger persons. Data on unmet needs were also examined, where available, to as-

sess the level of demand for services where demand appears to exceed current resource levels.

Structured Interviews. Structured interviews were conducted with staff at 16 State agencies, including the Virginia Department for the Aging, the Department of Medical Assistance Services, the Department of Mental Health, Mental Retardation, and Substance Abuse Services, and the Virginia Department of Health. Staff at selected Area Agencies on Aging and other local agencies were also interviewed.

II. Services for Older Virginians Are Provided by Several State Agencies

Many of the needs of older Virginians are presently met through an array of State agency services and programs. This chapter provides an overview of the agencies that most frequently provide services to the older population. The agency descriptions are categorized into several broad groups according to the type of service provided, such as mental and physical health, transportation, and housing. Some of the agencies discussed in this chapter, such as the Virginia Department for the Aging (VDA) and its local counterparts, the Area Agencies on Aging (AAAs), provide services that are targeted specifically to older Virginians, such as home-delivered meals. Other agencies, such as the Department of Social Services (DSS), the Department of Medical Assistance Services (DMAS), and the State's two housing agencies, provide financial assistance that better enables older persons to afford needed care or support, such as assisted living services, medical care, or housing. State agencies also address the transportation needs of older residents, by administering funds for public transportation and issuing drivers licenses. Finally, through the Department of Human Resource Management (DHRM) and the Virginia Retirement System (VRS), the State provides benefits to its employees and retirees. Figure 5 indicates, by secretarial area, those agencies which are discussed in this chapter.

This interim report is intended to provide an overview of the variety of State services provided to older Virginians, and also gives a preliminary assessment of this population's impact upon State agencies. As a result, the report does not include substantive findings or recommendations. However, it appears that older Virginians have a greater impact on some agency services than their younger counterparts. Furthermore, there are instances in which agencies report not being able to provide all of the services for which older clients are determined to be eligible, a situation which is termed an "unmet need." For example, DSS and the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) identified an unmet need for public guardians and conservators, who act as decision-makers for persons who have become incapacitated. DSS and VDA report an unmet demand by older adults for certain in-home services. Also, VHDA reports an unmet need for housing vouchers that provide rental assistance to older households, as well as to families with older household members.

OVERVIEW OF SERVICE PROVISION TO OLDER VIRGINIANS

Many of the State agency services described in this chapter supplement the care provided to older Virginians by informal caregivers, or assist older persons who may not have an adequate informal support network. The most prominent resource available to older Virginians who are in need of assistance is the support provided by informal caregivers such as family members or friends, and the support provided by private organizations such as churches. According to the Commissioner of the Virginia Department for the Aging (VDA), the vast majority of care for older persons

Figure 5

Overview: Selected State Agency Services Impacted by Older Virginians, by Secretariat

Administration

Department of Human Resource Management
- Workforce planning
- Health benefits
- Long-term care insurance

Department of Veterans Services
- Assistance obtaining benefits
- Veterans Care Centers

Commerce & Trade

Department of Housing and Community Development
- Emergency home repairs
- Indoor plumbing and rehabilitation
- Weatherization
- Grants and loans

Health & Human Resources

Department for the Aging
- Older Americans Act services
- Coordination of aging services
- Oversight of Area Agencies on Aging

Department of Health
- Public health programs
- Licenses medical facilities
- Certificate of Public Need

Department of Medical Assistance Services
- Administering Medicaid benefits, including assistance with nursing home, home health care, and prescription drug costs

Department of Mental Health, Mental Retardation, and Substance Abuse Services
- Facility and community services
- Licensure of providers

Department of Social Services
- Home-based adult services
- Adult protective services
- Licensure of facilities
- Auxiliary Grants
- Energy Assistance and Food Stamps

Public Safety

Department of Corrections
- Housing older prisoners

Transportation

Department of Motor Vehicles
- Research on older drivers
- GrandDriver
- Medical reviews
- Vision testing

Department of Rail and Public Transportation
- Public transportation funding
- Paratransit funding

Department of Transportation
- Highway design and maintenance

Independent Agencies

Virginia Retirement System
- Employee & retiree services
- Retiree health care credit
- Long-term care insurance

Virginia Housing Development Authority
- Housing vouchers
- Rental subsidies
- Tax credits and loans
- Funding for mortgage counseling

Source: JLARC staff analysis.

has been, and will continue to be given by family members, and a recent survey of caregivers in Virginia by the AARP estimated that 1.2 million adults in Virginia provide unpaid care to adult relatives or friends.

Based on the eligibility criteria for many of the services discussed in this report, older Virginians who receive some form of assistance from the State typically have either a low-income level, or have acute medical needs, or need assistance with activities such as eating, dressing, bathing, or toileting. This is true of many of the services provided to older Virginians by VDA, the Department of Social Services (DSS), and the Department of Medical Assistance Services (DMAS), and a number of other agencies. It should be noted, however, that older Virginians who do not fit this description are also eligible to receive some State agency services, including State retirement benefits and veterans' services. The nature of the services needed by this population also varies with age, and persons in their early 60s are likely to require different services than persons in their 80s or 90s.

Many of the State services discussed in this report are intended to allow older persons to remain as independent as possible and to receive needed care in their communities rather than in more restrictive and costly institutions. As discussed in Chapter I, the U.S. Supreme Court's 1999 *Olmstead* ruling has been interpreted to require states to provide community-based treatments for all persons with disabilities, when feasible and appropriate. In response, the 2002 General Assembly created the Task Force to Develop an Olmstead Plan for Virginia, which developed numerous recommendations for how the State could conform to the Supreme Court's ruling and to ensure that eligible persons were receiving this type of care. The provision of community-based care has been a trend in Virginia since the deinstitutionalization of the State's mental health facilities and mental retardation training centers in the 1970s. Since the inception of deinstitutionalization, the average daily census has decreased 73 percent for Virginia's mental health facilities, and 63 percent for the training centers which serve persons who are mentally retarded.

Partially as a result of deinstitutionalization, it has been the policy of many of the State agencies discussed in this report to offer community-based services as alternatives to institutionalization. For example, the programs and services provided by the Departments for the Aging and Social Services are intended to maximize the independence of older persons and to allow them to avoid institutional care as long as possible. Further, the Medicaid home and community-based care waivers administered by DMAS give persons in need of the level of care provided by an institution, such as a nursing home, the option of receiving community-based care instead.

The State agency services and programs most commonly used by older Virginians are typically provided by local counterparts, an arrangement which, to some degree, allows local providers to tailor their activities to the specific needs of their own residents. For example, while services provided to older Virginians under the federal Older Americans Act are administered by VDA, they are typically provided by local Area Agencies on Aging. Similarly, the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) contracts with re-

gional Community Services Boards to provide community-based mental health services. Other agencies, such as the Departments of Health and Social Services, provide services to older Virginians through local departments and offices.

In addition to the use of local counterparts, the provision of many State agency services requires the cooperation of other State agencies. This interdependent nature of State agency service provision can result in an older person's service demands impacting multiple agencies at once. For example, DMAS is dependent upon other agencies – local departments of health and social services – to assess an older person's eligibility for Medicaid services. Moreover, the degree of access to one service or program can impact access to others - while an older person may need assistance from their local social services department, an inability to drive coupled with a lack of access to public transportation could hinder their ability to be screened for program eligibility. Finally, the interdependent nature of many of these services is illustrated by the fact that policy changes that are made to one State program may trigger changes in others. For example, increases in the State-approved rates charged by assisted living facilities can increase the number of persons eligible for Medicaid assistance. This example is discussed in more detail in the section on DSS's administration of Auxiliary Grants.

To curtail any unnecessary duplication of service provision, legislation adopted in 1993 authorized health and human resources agencies to use the same standard form, called the Uniform Assessment Instrument (UAI), to screen persons for service eligibility. In addition to making service eligibility determinations, the UAI is intended to capture comprehensive information on individuals' needs and the services and benefits they are currently receiving, as well as to facilitate the coordination of service delivery among the responsible State agencies. Many of the agencies discussed in this chapter use the UAI, including VDA, DSS, and DMAS.

VIRGINIA'S NETWORK OF SERVICES FOR THE AGING

The Older Americans Act (OAA) of 1965 funds a wide range of services and programs with a special focus on low-income and minority older adults. Operating within the policy framework created by the OAA, and utilizing a combination of federal, State, and local funding, Virginia's network of aging services assists older adults in continuing to live independently in their communities and homes, while also avoiding more costly institutionalization. The network primarily consists of the Virginia Department for the Aging and the local Area Agencies on Aging. Virginia has also created an advisory body, the Commonwealth Council on Aging, which is charged with promoting an efficient and coordinated means of providing State services to older Virginians. The remainder of this section provides more information on these members of the aging services network.

Virginia Department for the Aging and Local Area Agencies on Aging

The responsibilities of the Virginia Department for the Aging (VDA), within the Secretariat of Health and Human Resources, are set forth in Title 2.2, Chapter 7 of the *Code of Virginia*. VDA's responsibilities include the administration of the federal Older Americans Act (OAA) of 1965, the provision of oversight and assistance to local Area Agencies on Aging, and staff support to the Commonwealth Council on Aging. Additionally, Senate Bill 382, which was passed by the 2004 Session of the General Assembly, named the Commissioner of VDA as the Governor's principle advisor on aging issues and requires the Commissioner to recommend actions appropriate to meeting the needs of an aging society. For FY 2004, VDA was appropriated approximately $13.9 million in general funds, and $29.8 million in nongeneral funds. The agency's nongeneral funding includes federal OAA funds, as well as grant funding from the federal Departments of Labor, and Housing and Urban Development. Agency staffing for FY 2004 includes a maximum employment level of 27 full-time equivalent employees.

A primary responsibility of VDA is the administration of the federal Older Americans Act, which was enacted to enhance the ability of older individuals to maintain their independence, and to remain in their own homes and communities. As the single State agency responsible for administering the provisions of the OAA, VDA is responsible for designating local agencies that will plan, coordinate, and administer aging services at the community level. VDA has designated 25 such local agencies, called Area Agencies on Aging (AAA), which operate within defined planning and service areas that usually correspond to planning district boundaries. In support of these services, VDA administers federal and State funding and provides other oversight and support to the AAAs. VDA is also responsible for providing other services, including the administration of the Virginia Respite Care Grant Program, and the operation of the Center for Elder Rights.

Each of Virginia's AAAs receive federal and State funds through a contract with VDA, called a Local Plan for Aging Services, that indicates the amount and type of services each AAA will provide. In addition to federal and State funds, AAAs receive funding from local governments, private donations, and fees. In FFY 2003 (October 1, 2002 to September 30, 2003), 133 of 134 localities provided funding to their AAA, ranging from $256 to $1.9 million, with an average contribution of $85,012, and a median contribution of $15,000.

Services Provided by VDA and the AAAs Are Directed Toward Persons with Greatest Need. Although every Virginian age 60 and over is eligible to receive services provided with OAA (Title III) funds, the OAA requires VDA and the AAAs to give preference to those persons with the greatest economic and social need. In addition, VDA's most recent *Virginia State Plan for Aging Services* refers to language in the 1995 Appropriation Act, in which the General Assembly directed that "Older Americans Act funds and general fund monies be targeted to services which can assist the elderly to function independently for as long as possible."

The federal OAA requires that preference be given to providing services to older individuals with the greatest economic and social need, with particular attention to low-income minority older individuals and older individuals residing in rural areas. Economic need is defined by the OAA as "the need resulting from an income level at or below the poverty line." Social need is defined as "need caused by non-economic factors" including disabilities, language barriers, isolation, and other factors that restrict an individual's ability to perform normal daily tasks or live independently.

AAAs are also directed by the OAA to pay particular attention to the services required by low-income minority individuals, and persons living in isolated rural communities. Minority groups suffer from more preventable diseases, premature death, and disabilities than non-minorities, and over one-third of older Virginians living in poverty are members of racial or ethnic minority groups. In addition, almost one-third of older Virginians live in rural areas of the Commonwealth. Rural Virginians may have lower incomes; decreased access to transportation, health care, and social services; and greater distances to travel to receive basic services.

Although many of the services funded through the OAA are available to low-income older Virginians at no cost, AAAs are permitted to implement cost sharing for all services funded by the OAA except for certain designated services. Under a cost sharing arrangement, recipients are expected to share in the actual cost of service provision. However, if an older person fails to make a cost-sharing payment, the OAA prohibits the AAAs from denying any service which is provided using OAA funds.

AAA Services Provide a Comprehensive System of Services to Older Persons. Virginia's AAAs serve as the primary entity under the OAA responsible for developing a coordinated system of community-based services for older adults. AAAs are intended to be service brokers, and not service providers, and are thus prohibited by Title 22, Chapter 20 of the *Virginia Administrative Code* from directly providing "any supportive services or nutrition services" unless a waiver is granted by VDA. As a result, VDA staff report that AAAs typically procure the services of subcontractors through competitive bids. In some areas of the State, however, particularly Southwest Virginia, VDA staff state that few contractors are available to provide the services. In these instances, AAAs provide the services directly.

The services provided by AAAs vary across Virginia depending upon local needs, and each AAA has an Advisory Council consisting of local citizens who assist in the preparation of the local plan. However, there are certain priority services for which the AAAs must spend a minimum amount of their OAA funding. These priorities include services which enable older persons to access other services, such as care coordination, transportation, and information and referral. Each AAA is required to expend at least 15 percent of its OAA grant funding on access services. Other priority services include in-home services, such as homemaker, home health, and visiting services, for which each AAA must expend at least five percent of its OAA funds. Each AAA must also expend at least one percent of its OAA funds on legal assistance.

The services most frequently used by AAA clients include the provision of meals, both congregate and home-delivered, and information and referral services. Information on the amount of certain services provided by Virginia's AAAs during federal fiscal year 2003 is presented in Table 6. As shown, the majority of AAA clients receive meals or Information and Referral services. Exhibit 1 provides descriptions of the services typically provided to AAA clients.

Table 6

Services Provided by Area Agencies on Aging (Federal Fiscal Year 2003)

Service	Persons Served	Service Units	Service Costs
Adult Day Care	662	348,321 hours	$1,958,000
Care Coordination	3,504	66,032 hours	3,135,000
Congregate (Group) Meals	17,319	969,290 meals	7,412,000
Home Delivered Meals	14,089	2,777,247 meals	10,766,000
Homemaker Services	2,896	231,400 hours	3,055,000
Information and Referral	28,886	178,636 contacts	3,482,000
Personal Care	1,650	181,613 hours	3,252,000
Transportation	11,135	672,383 trips	5,306,000

Source: Virginia Department for the Aging.

The majority of AAA clients are over the age of 70, and many require assistance performing activities of daily living (ADL), which are activities related to personal care such as bathing, dressing, getting in or out of bed or a chair, using the toilet, and eating. As indicated in Table 7, Virginia AAAs served 63,703 clients during federal fiscal year 2003. Table 8 presents information for FFY 2003 on the average age of AAA clients for certain services, as well as the average number of ADLs for which they required assistance.

Many AAA Services Have Waiting Lists. The eligibility of older individuals who request services from an AAA is evaluated by AAA staff through the use of the State's uniform assessment instrument (UAI). For persons who have applied for AAA services and were found to be eligible, but for whom the AAA does not have sufficient funds to provide services, an unmet need is identified and recorded. According to VDA staff, the greatest need is for transportation services as well as supportive services for the older population and their family members who care for them, such as adult day care programs. Table 9 contains average monthly unmet need data for calendar years 2001 through 2003 for each of the categories reported by the AAAs.

Exhibit 1

Descriptions of Selected AAA Programs

Adult day care programs provide supervised activities for older persons who cannot remain alone at home during the day.

Care Coordination/Case management services assist older persons with locating, applying for, receiving, and coordinating needed community services.

Chore services involve the provision of light housekeeping to older adults who, because of their functional level, are unable to perform these tasks.

Disease prevention and health promotion services help older persons adjust their lifestyles to prevent many of the physical losses often experienced with age.

Home health services provide intermittent skilled nursing care under appropriate medical supervision to acutely or chronically ill homebound older adults.

Homemaker services provide assistance with household tasks and other activities which enable an older person to remain at home.

Information and referral services assist older persons and their families with finding services which can help persons remain in their own homes.

Legal assistance activities provide legal advice, assistance, and representation in areas of public benefits, wills, and estate planning.

Meal programs and nutrition services provide hot and cold meals, as well as nutrition education, at a community center or the residence of individuals.

Personal care services provide assistance with critical activities of daily living such as bathing, dressing, eating, and toileting.

Residential repair and renovation programs assist older persons to maintain their homes or to adapt their homes to accommodate a wheelchair or walker.

Transportation services transport older persons to and from needed community facilities and resources.

Visiting/Checking services involve calling or visiting older persons at their residence to ensure they are well and safe, and provide reassurance.

Source: Virginia Department for the Aging.

Table 7

Number and Age of Area Agencies on Aging Clients (Federal Fiscal Year 2003)

Age	Number of Clients	Percent of Total
Under 60	3,035	4.8
60-69	13,772	21.6
70-79	19,595	30.8
80-89	17,080	26.8
90-99	4,138	6.5
100+	238	0.4
Indeterminate age	5,845	9.2
Total	63,703	100

This is an unduplicated count of clients who received at least one unit of service.
Source: Virginia Department for the Aging.

Table 8

Average Age and Number of ADLs for AAA Clients for Selected Services (Federal Fiscal Year 2003)

Service	Average Age	Average Number of ADLs*
Adult Day Care	79.5	3.5
Care Coordination	79	3.7
Chore	80	5.2
Home Delivered Meals	79	2.9
Homemaker	79.5	2.6
Personal Care Services	80	3.5

*ADLs are activities for which persons require assistance, such as bathing, dressing, getting in or out of bed or a chair, using the toilet, and eating.
Source: Virginia Department for the Aging.

Commonwealth Council on Aging

In 1998, the General Assembly created the Commonwealth Council on Aging as an advisory board to the VDA and to the Governor and General Assembly on issues affecting older Virginians. The Council replaced VDA's previous advisory board, which was created in 1974. Sections 2.2-2626 and 2.2-2627 of the *Code of Virginia* describe the duties and structure of the Commonwealth Council on Aging, which is responsible for promoting "an efficient, coordinated approach by state gov-

Table 9

Average Monthly Unmet Needs Reported by AAAs
(Calendar Years)

Service	Unit	2001	2002	2003
Adult Day Care	Hours	30,544	37,161	31,632
Home Delivered Meals	Meals	130,321	129,705	139,253
Homemaker	Hours	48,355	54,350	57,789
Personal Care	Hours	18,675	25,332	23,172
Residential Repair and Renovation	Homes	651	507	617
Transportation	Trips	9,464	11,502	15,569

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

ernment to meeting the needs of older Virginians." The Council also advises the Governor and the General Assembly on aging issues, including the activities of the VDA, advises the Governor on any proposed regulations that may have a substantial impact on older Virginians, and reportedly plays an important role in the State's planning activities for meeting the needs of this growing group of Virginians.

The Council consists of 19 voting members, and includes one representative from each of the 11 congressional districts appointed by the Governor, and eight members appointed by the Speaker of the House of Delegates and the Senate Committee on Rules. Nonvoting members of the Council include representatives from VDA, the Department of Medical Assistance Services, the Department of Social Services, and the office of the Secretary of Health and Human Resources.

The Council has identified six goals as part of its current strategic plan. These goals include: the development of an effective transportation system for older Virginians who do not have a driver's license or access to other means of transportation; the creation of "visitability" requirements for new, single-family housing in order to ensure that older Virginians can remain in their homes, and that new construction will be accessible as the population ages; the need to identify best practices for providing community-based services; the need to increase funding for local Ombudsmen programs; the creation of initiatives for successful aging; and increasing the visibility of aging issues in State government.

MENTAL AND PHYSICAL HEALTH SERVICES

State agencies and their local counterparts provide a variety of services that are designed to meet the health care needs of older Virginians. This section describes the general characteristics of the State's mental and physical health services and the older Virginians who receive them. These services can be grouped into four basic categories: the provision of services within an institutional setting, the provision of home and community-based services as an alternative to institutional care,

the provision of financial assistance to enable older persons to afford needed care, and the licensure and regulation of facilities that provide physical and mental health services.

Preliminary review indicates that older service recipients may have a greater impact on these agencies than their younger counterparts. For example, an analysis of data from the Department of Medical Assistance Services (DMAS) indicates that Medicaid recipients over the age of 60 are, overall, three times more costly to serve than younger recipients. Additionally, older Medicaid recipients represent a disproportionate share of Medicaid expenditures (33 percent) relative to their proportion of beneficiaries (15 percent).

In FY 2003, approximately 4,000 adults age 60 and over received community-based services through the Department of Social Services' (DSS) locally administered Adult Services Program, representing 75 percent of all such service recipients that year. In addition, older adults with medical needs that are too acute to be addressed by informal caregivers or home and community-based services, like those administered by DMAS and DSS, are likely to receive institutional medical care in Virginia's 267 nursing homes, all of which must be licensed by the Virginia Department of Health (VDH). As indicated in the following discussion, this is the primary manner in which older Virginians impact the State health department.

Data maintained by the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) indicate that older patients remain in State mental health institutions longer than younger patients. Also, staff from both the Department of Veterans Services and the Department of Corrections report that older persons have a greater impact on their agencies' operations than their younger counterparts, primarily in the provision of health care services.

The costs of meeting the mental and physical health needs of older Virginians are absorbed by the State, federal, and local governments, and sometimes the consumers themselves. For example, 50 percent of the State's Medicaid costs are shared by the federal government, which also assumed nearly half of all program expenditures for DSS adult services in FY 2003. Additionally, State general funds cover services for patients in mental health institutions who are between the ages of 60 and 64 and of limited means to pay for their care, but both the State and federal governments share the cost of the majority of patients ages 65 and older. Services and programs offered by these agencies are also supported with local funding, either as part of local match requirements or voluntary local contributions. Finally, service recipients are also responsible for sharing the costs of some services, such as those provided by local health departments or as part of a Medicaid waiver program.

Department of Medical Assistance Services

The responsibilities of the Department of Medical Assistance Services (DMAS), within the Health and Human Resources Secretariat, are set forth in Title 32.1, Chapter 10 of the *Code of Virginia,* and include the administration of Virginia's Medicaid program and other medical assistance programs for certain categories of

needy individuals, such as children in low-income families. For FY 2004, DMAS was appropriated $1.9 billion in State general funds and $2.1 billion in nongeneral funds. Agency staffing for FY 2004 includes 323 full-time equivalent employees. Agency activities that are affected by older Virginians primarily include the administration of medical assistance benefits through the State's Medicaid program, including home and community-based waiver services.

As discussed in Chapter I, Medicaid is a federal and state program that provides financial assistance for medical services to certain low-income individuals and to persons who, while not necessarily low-income, do not have the resources to meet their medical needs. Only certain groups of persons are eligible for Medicaid. As stated in the 2003 DMAS Statistical Record, Medicaid:

> does not cover everyone who is poor, but rather is available only to members of families with children and pregnant women, and to persons who are aged, blind, and disabled. Persons not falling into those categories...cannot qualify for Medicaid, no matter how low their income.

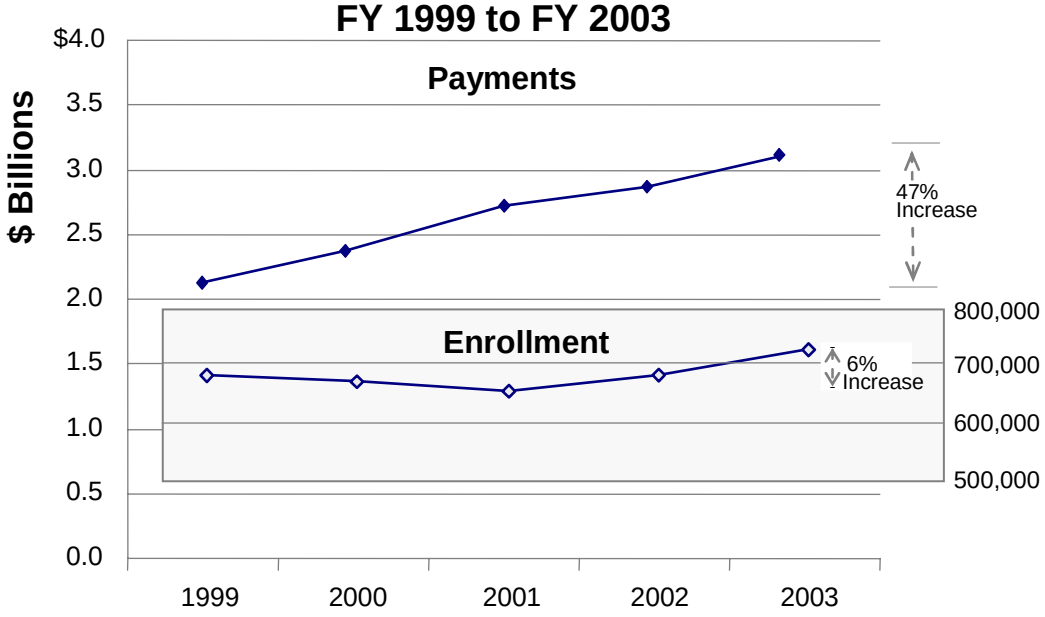
The costs of Medicaid are shared by the federal government and the State, and Virginia's current share is 50 percent. The impact of older Virginians on the State's Medicaid program is discussed in more detail below.

Despite Continued Growth in Enrollment and Cost, Virginia Ranks Low in Medicaid Spending Compared to Other States. In FY 2003, Virginia's Medicaid program assisted 682,851 persons with their health care expenditures, with payments for medical services totaling $3.2 billion. While over half of Medicaid recipients in that year were children under 19, only 15 percent of recipients were age 60 and over. As shown in Figure 6, from 1999 to 2003 Medicaid expenditures in Virginia increased 47 percent, compared to a six percent increase in program enrollment. Factors that contributed to this increase in Medicaid expenditures include inflation, federal mandates and State policy changes that added several new categories of Medicaid eligibility, reimbursement rate increases, and increased costs per client. Despite this growth in Medicaid, Virginia ranked 48th among all states in 2002 in both per-capita Medicaid spending and in Medicaid recipients as a proportion of the total population.

Many Older Virginians Receive Medicaid Services at the State's Option. In order to receive federal Medicaid funding, states are required to extend Medicaid eligibility to certain groups of individuals and to cover the cost of certain medical services. In addition to meeting these federal mandates, Virginia has added several optional elements to its State Medicaid plan, many of which benefit older Virginians. To be eligible for federal funds, states are required to provide Medicaid to certain groups of individuals that are likely to include older persons, including low-income persons who are aged, blind, or disabled, and low-income Medicare beneficiaries. The above groups are considered "categorically needy" and are characterized by low incomes. In FY 2003, Virginia provided Medicaid benefits to 62,247 "categorically needy" individuals age 60 and older.

Figure 6

Trends in Total Medicaid Enrollments and Payments for Medical Services, FY 1999 to FY 2003



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

The federal government also gives states the option of providing Medicaid coverage to other groups – federally defined as the "medically needy" and the "optional categorically needy." Virginia is one of 35 states to offer Medicaid coverage to "medically needy" individuals. These are individuals who typically have higher incomes and establish eligibility by spending the amount of their income that disqualifies them from Medicaid coverage on medical expenses - a mechanism known as "spend down." In FY 2003, over 9,000 persons qualified for Medicaid in this manner, including almost 5,000 persons age 60 and older. Virginia has chosen also to extend Medicaid coverage to persons meeting the federal definitions of "optional categorically needy," which include, for example, certain aged, blind, or disabled adults who have incomes above those requiring mandatory coverage, but below the federal poverty limit. Over 36,000 older Virginians received Medicaid benefits by establishing eligibility through "optional categorically needy" categories in FY 2003.

In addition to federal mandates that require Medicaid coverage of certain groups of people, there are also requirements that states cover the costs of certain medical services. These include hospital inpatient, outpatient, and emergency services, nursing facility care, some Medicare premiums, and transportation services, among others. Many Medicaid-covered services more commonly used by older Virginians, however, are not federally mandated. For example, coverage of prescription drugs, home health, and hospice services are optional services used by older Virgini-

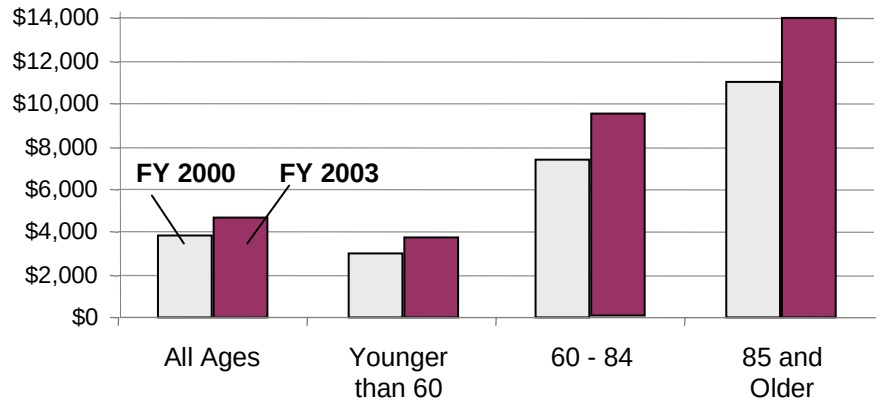
ans that the State has elected to provide. In FY 2003, approximately $1.3 billion was spent on the provision of optional services, of which more than $404 million (31 percent) was attributable to recipients age 60 and older. An analysis of DMAS fee-for-service data shows that 45 percent of Medicaid prescription drug payments made in FY 2003 were attributable to recipients age 60 and older.

Overall, Services for Older Medicaid Recipients Are More Costly to Provide. Medicaid payments in Virginia are made through two basic payment structures, fee-for-service or managed care. In FY 2003, although 55 percent of all Medicaid recipients received services through managed care, only seven percent of recipients age 60 or older were in managed care. According to DMAS staff, Medicaid managed care providers are allotted a lump sum by DMAS to pay for the services received by managed care enrollees. However, DMAS staff indicated that the data reported by the managed care providers on the exact medical services provided to recipients is unreliable, in part because some providers do not consistently report this information to DMAS. Therefore, DMAS staff were unable to provide expenditure and recipient data for the exact services provided under managed care. They were, however, able to provide aggregate data on managed care services. Therefore, any references in this discussion to individual medical services, such as prescription drugs or nursing home services, only refer to services provided through the fee-for-service structure. References to aggregate data, however, do include managed care expenditures and recipients.

Based on an analysis of DMAS data, in FY 2003 the average Medicaid payment per person for the 60 and older group was $10,382. For persons younger than 60, this figure was $3,708, making it almost three times as expensive to provide medical services to older persons. Figure 7 compares the average cost per person for these age groups in fiscal years 2000 and 2003. This shows that, when aggregating all service costs, older persons are more costly to serve on a per-person basis than younger beneficiaries. It should be noted, however, that the provision of

Figure 7

Average Medicaid Cost Per Person for FY 2000 Compared to FY 2003, by Age Cohort



Source: JLARC staff analysis of Department of Medical Assistance Services fee-for-service data.

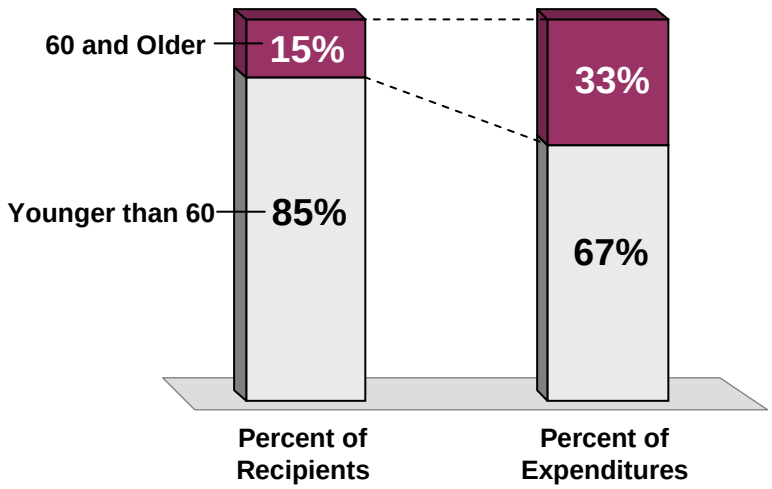
some individual services is actually more costly per person for younger recipients. For example, even though persons age 60 and older constituted 90 percent of Medicaid-covered nursing facility service recipients in FY 2003, younger recipients of nursing home services cost over $7,000 per person more to serve. This is likely due to the intense level of care needed by younger individuals who require nursing facility services.

Relative to their proportion of all service recipients, older Medicaid recipients constitute a disproportionate expense to the program. As demonstrated in Figure 8, while older Virginians represented 15 percent of all Medicaid service recipients in FY 2003 (103,943), they accounted for 33 percent of all Medicaid payments (approximately $1 billion). This higher cost for older Medicaid recipients may be because they are more likely than their younger counterparts to receive services that are more expensive to provide on average, such as nursing facility care and personal care.

Virginia's Medicaid Waiver Programs Are One Resource for Community-Based Care for Older Virginians. One approach used by states to address rising Medicaid costs is the use of the federal Home and Community Based Services (HCBS) waiver program. Virginia has six of these waivers. In FY 2003, more than $130 million in State and federal funds was spent in Virginia on waiver recipients age 60 and older. Section 32.1-330 of the *Code of Virginia* requires that persons seeking Medicaid-covered institutional or community-based care, such as waiver services, be screened by a pre-admission screening team. For persons seeking Medicaid long-term care services from the community, the team comprises a

Figure 8

Proportion of Medicaid Enrollments and Payments by Age Cohort (FY 2003)



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

physician as well as staff of the local health and social services departments. For persons seeking Medicaid long-term care services from the hospital, the hospital completes the screening. Once an individual is determined to be eligible for waiver services by the pre-admission screening team, a service plan must be completed that ensures the individual's needs will be met in the community and determines the specific waiver services that a provider agency must provide. It should be noted that, according to DMAS, these services can only be authorized when there is a provider agency available to meet the individual's needs. Unlike traditional Medicaid, waiver benefits are not entitlements, and eligibility for waiver services is tied to eligibility for receiving institutional care, including care provided by nursing facilities, hospitals, and intermediate care facilities for the mentally retarded.

Table 10 shows recipient and cost data for the six HCBS waivers. The waiver program most commonly used by older Virginians is the Elderly and Disabled (E&D) waiver. In FY 2003, total waiver costs for the E&D waiver were $98,629,504. On average, it cost $16,205 to serve a single individual in this waiver program, compared to an estimated $25,003 per person for individuals receiving institutional care.

Some Waiver Recipients Contribute to the Cost of Their Care. Most waivers require recipients to contribute to the cost of care through the payment of a "patient pay." This is usually all income in excess of 100 percent of the SSI income level, currently set by the federal government at $564 a month. The State allows recipients to keep 100 percent of their SSI income to pay for expenses such as rent or mortgage and food, because waivers cannot cover the cost of room and board. This is called the personal maintenance allowance (PMA). An individual would have to contribute the total amount of their income above $564 as their patient pay amount. According to DMAS staff, in FY 2002 79 percent of all persons in the E&D waiver did not have a patient pay amount because their incomes were not above the personal allowance amount.

There has been some concern that the amount of the PMA in Virginia is insufficient. A 2003 Joint Commission on Health Care report, using data from a 1998 AARP study, stated that 31 states allowed a higher personal maintenance allowance within their E&D waivers than Virginia. While the JCHC study stated that "there is no comprehensive data available to determine the extent to which the personal maintenance allowance is a problem" the report included several case studies demonstrating the potential inadequacy of the amount of the allowance. As illustrated in the table on Medicaid waiver recipients, institutional costs, such as those incurred in nursing facilities, are higher per person than waiver costs. Therefore, if someone were to have to enter a nursing facility rather than receive care in a community setting because the amount of their personal maintenance allowance was insufficient for them to afford expenses such as rent and food, the cost to the State would likely increase.

Table 10

Medicaid Waiver Recipients and Associated Costs, All Ages
Fiscal Year 2003

Waiver	Description	Recipients	Waiver Cost	Other Costs[1]	Total Costs	Average Cost Per Person[2]	Average Institutional Cost[3]
Waivers Most Likely to Be Used by Older Virginians							
Consumer-Directed Personal Attendant Services	Provides consumer-directed community-based personal attendant services to persons 65 and older or persons who are disabled. Personal attendants are hired by the waiver recipient.	257	$2,690,983	$1,210,822	$3,901,805	$15,182	$22,745
Elderly and Disabled	Provides adult day care, personal care, respite care, and other services to persons 65 and older or persons who are disabled.	9,615	$98,629,504	$57,187,192	$155,816,696	$16,205	$25,003
Waivers Less Likely to Be Used by Older Virginians							
AIDS	Provides community-based case management, personal care, and other services to persons with AIDS or an AIDS related condition.	277	$946,873	$4,964,634	$5,911,507	$21,341	$25,771
Developmental Disabilities	Provides community-based care instead of care in an Intermediate Care Facility to persons with a condition related to mental retardation but not diagnosed with mental retardation.	241	$4,017,828	$1,425,768	$5,443,596	$22,588	$105,500

Table 10 (Continued)

Waiver	Description	Recipients	Waiver Cost	Other Costs[1]	Total Costs	Average Cost Per Person[2]	Average Institutional Cost[3]
Mental Retardation	Provides community-based care instead of care in an Intermediate Care Facility to persons diagnosed with mental retardation	5,496	$224,606,948	$45,379,119	$269,986,067	$49,124	$105,500
Technology Assisted	Provides private duty nursing, durable medical equipment, personal care, and other services to individuals who need both skilled nursing care and a medical device to compensate for a loss of a vital body function.	337	$20,269,064	$9,830,238	$30,099,302	$89,315	$61,393
Total		**16,223**	**$351,161,200**	**$119,997,773**	**$471,158,973**		

[1]Other costs include medical expenditures covered by Medicaid, but not paid for as part of waiver services (for example, prescription drug costs). When submitting a waiver program application to the federal Centers for Medicaid and Medicare Services (CMS), DMAS includes projected waiver costs and these other costs in its application to reflect the total expenditures necessary to provide all Medicaid-services required by persons on a waiver.

[2] Calculated using the total of waiver and other costs.

[3] Calculated by DMAS using all Medicaid costs for persons in institutions.

Source: Department of Medical Assistance Services FY 2003 data.

Recent changes to Virginia's home and community-based waiver programs may address concerns about the adequacy of the E&D waiver's personal maintenance allowance. As a result of legislation passed by the 2004 General Assembly, pending approval by the federal government, the E&D and Consumer-Directed Personal Attendant Services (CD-PAS) waivers will be combined. The new waiver will allow recipients to keep up to 300 percent of SSI from their earned income, not to exceed $1,692 a month, as their personal maintenance allowance, if they work 20 or more hours per week. DMAS is also working on the development of an Alzheimer's/Dementia Assisted Living Waiver to provide additional medical services to auxiliary grant recipients in assisted living facilities diagnosed with Alzheimer's disease or some form of dementia. This waiver must also meet the State and federal governments' approval before being implemented.

Department of Social Services

The responsibilities of the Virginia Department of Social Services (DSS), within the Secretariat of Health and Human Resources, are set forth in Title 63.2 of the *Code of Virginia* and include supervising the administration of both federally and non-federally funded public assistance and service programs by local departments of social services. Excluding the child support payments that are collected by DSS and provided to guardian adults for children, DSS was appropriated about $904 million in FY 2004, of which about 70 percent was federal funding, and about 20 percent was State general funds. Agency staffing for FY 2004 includes 1,648 full-time equivalent employees.

DSS activities that are affected by older Virginians include the agency's licensure of Virginia's assisted living facilities and adult day care centers, both of which provide needed assistance to older or disabled adults. Many older Virginians also benefit from the State's Auxiliary Grant program for assisted living and adult foster care residents, which is administered by DSS. In addition, with the aim of giving older or disabled adults in need of care the option of receiving care in a community setting, DSS supervises the local administration of the Adult Services Program. Other DSS programs for older adults include the Adult Protective Services Program and the Virginia Caregiver Grant Program. Those DSS programs and services principally consumed by older Virginians are discussed in more detail below.

Adult Day Care and Assisted Living Facilities Provide Support to Older Virginians. The Department of Social Services is responsible for licensing and regulating Virginia's adult day care and assisted living facilities, which are two options available to older Virginians for receiving needed care in a community-based (non-institutional) setting. Adult day care centers provide day-time care and supervision to four or more aged, infirm, or disabled participants in a congregate environment. Adult day care centers that operate on a for-profit basis or that accept Medicaid must be licensed by DSS.

As of June 2004, there were 70 adult day care centers licensed by DSS with a statewide capacity to serve up to 2,406 individuals. DSS was unable to provide data on the ages and care needs of Virginia's adult day care population. However,

national data for 2002 indicates that the average age of center attendees was 72, and that 93 percent of all residents either had dementia or were considered frail elderly (requiring assistance with two or more activities of daily living such as bathing or eating).

DSS is also responsible for licensing and regulating Virginia's assisted living facilities. Like adult day care centers, assisted living facilities provide personal and health care services to four or more adults who are aged or disabled. As opposed to care in a day-time only setting, assisted living facilities provide 24-hour residential services. There are two levels of State licensure for these facilities: those that provide "residential living" care and those that provide more intensive "assisted living" care. Residential care is for individuals who require only minimal assistance with activities of daily living (ADLs), and the assisted living level of care is for individuals requiring assistance with two or more ADLs. All facilities, regardless of the level of care they offer, are referred to as assisted living facilities.

As of June 2004, there were 629 assisted living facilities operating in Virginia. Of these, 298 were licensed to provide residential care only and 331 were licensed to provide both residential and assisted living levels of care. Agency data indicate that Virginia's assisted living facilities have the capacity to house 34,800 individuals statewide and are estimated to be at 86 percent of that capacity. According to a May 2004 study conducted by DSS, 48 percent of all assisted living residents at that time were diagnosed with a mental health illness.

Virginia's Auxiliary Grant Program Assists Older Virginians With Assisted Living and Adult Foster Care Expenses. The Department of Social Services is responsible for administering Virginia's Auxiliary Grant program, which is intended to aid lower-income assisted living and adult foster care residents with the cost of their care. (Adult foster care means room and board and supportive services that are provided to up to three adults in need of care. It is a locally optional service overseen exclusively by local social services departments.) Eighty percent of this program is funded by the State, with local governments contributing a required 20 percent match. The Auxiliary Grant program provides financial aid either to assisted living or adult foster care residents who receive federal Supplemental Security Income (SSI) benefits or who would be eligible for SSI based on age (65 and older) or disability, but who do not qualify because of excess income. Of the 6,698 persons receiving an Auxiliary Grant in FY 2003, 45 percent were age 65 or older, as shown in Table 11. DSS data also shows that, while approximately 60 percent of all of Virginia's assisted living facilities accept Auxiliary Grant payments, only 19 percent of all beds statewide are utilized by Auxiliary Grant recipients.

Assisted living facilities that accept Auxiliary Grant payments agree to charge public-pay residents no more than an amount determined for that facility by DSS, which is called the Auxiliary Grant rate. The maximum Auxiliary Grant rate is determined by the General Assembly, and for FY 2005 and FY 2006 it is set at $894 a month. Facilities in Northern Virginia (planning district 8) receive a 15 percent increase in their allowable rate to account for the higher cost of living in that

Table 11

Auxiliary Grant Expenditures and Recipients, All Ages Fiscal Year 2003

Recipient Age	Number of Recipients	State Expenditures	Local Expenditures	Total Expenditures
18 to 64	3,665 (55%)	$10,866,108	$2,716,527	$13,582,635
65 and older	3,033 (45%)	7,954,747	1,988,687	9,943,434
Total	6,698	18,820,855	4,705,214	23,526,069

Note: The Department of Social Services did not provide data on Auxiliary Grant recipients ages 60 and older. It is therefore possible that older Virginians constitute more than 45 percent of all Auxiliary Grant recipients.

Source: Department of Social Services.

region. According to DSS staff, all assisted living facilities are typically approved by the State to charge the maximum rate. Persons who are eligible to receive an Auxiliary Grant also receive a personal allowance of $62 to cover items or services not offered by the facility or covered by Medicaid, such as over-the-counter medication, personal toiletries, or clothing.

The Auxiliary Grant payment received by a resident of an assisted living facility or adult foster care home is calculated by summing the amounts of their personal allowance and the rate approved by DSS for that facility, and then subtracting the recipient's countable income. For example, if an individual who is eligible for an Auxiliary Grant receives the maximum federal SSI payment of $564 as his only income, and the facility is approved to charge the maximum Auxiliary Grant rate of $894, the State and local share of the Auxiliary Grant payment will be $392. (This is calculated by taking $894, plus the $62 personal allowance, less the $564 in income.)

The State has also provided additional financial assistance to Auxiliary Grant recipients who require a certain level of care. For example, the Department of Medical Assistance Services (DMAS) provides an additional three dollars per day ($90 a month) to Auxiliary Grant recipients dependent in two or more ADLs and receiving the "assisted living" level of care. Additionally, the 2004 General Assembly directed DMAS to establish a home and community-based waiver for persons with Alzheimer's disease or dementia that would supplement Auxiliary Grant payments by an additional $50 a day.

Changes To the Auxiliary Grant Rate Would Have a Fiscal Impact on the State and Local Governments. According to staff at DSS and the Joint Commission on Health Care, assisted living facility operators are often reluctant to accept Auxiliary Grant payments because the rate is considered insufficient to provide the kind of care needed by residents. Further, some operators of assisted living facilities have told DSS staff that if the State intends to increase its regulatory oversight of their facilities, then the Auxiliary Grant rate would need to be increased in

order to recover the additional costs. However, any increase in the maximum Auxiliary Grant rate that facilities are allowed to charge would have a fiscal impact on the State beyond the cost of a higher grant payment. This results from the fact that Auxiliary Grant recipients are automatically eligible for coverage under the State's Medicaid program. Because eligibility for Auxiliary Grant assistance is determined by whether an individual's monthly income is below the amount of the Auxiliary Grant rate, rate increases would boost the number of persons' eligible for the State's Medicaid program as persons with higher incomes become eligible. Rate increases would also impact local jurisdictions because they would see an increase in expenditures for their share of Auxiliary Grant payments.

Auxiliary Grant Residency Requirements May Disproportionately Burden Certain Localities. In part because of local match requirements for the Auxiliary Grant program, the Commonwealth's emphasis on the deinstitutionalization of persons committed to the State's mental health institutions in recent years has placed an added burden on areas of the State in which those facilities are located. According to staff at DSS and the JCHC, this added burden results from the manner in which responsibility for the 20 percent local match is determined. The locality of which a person is considered to be a resident is responsible for the local component of the Auxiliary Grant payment. However, this may differ from the locality in which the assisted living facility is located. If patients who are released from a mental health institution do not have any other identifiable locality of residence except the one in which the mental health institution is situated, then that locality is responsible for the local match. This may place a higher burden upon localities in the State where mental health facilities are located. It should be noted that localities are not only impacted by the 20 percent match requirement for the Auxiliary Grant, but by the fact that local departments of social services are responsible for assessing eligibility for admission to assisted living facilities and for providing other needed services.

As discussed previously, not every locality in Virginia has an assisted living facility and not all facilities accept Auxiliary Grant payments. If an individual resides in such a locality and enters a public-pay facility located elsewhere, then the locality in which the person is considered to have residence is still responsible for the local share of the person's Auxiliary Grant. This applies to all persons who seek care from an assisted living facility, not just individuals released from mental health institutions. This current practice may place a burden on Virginia localities that become the residence of persons from states that do not have an Auxiliary Grant program. According to DSS staff, such an impact is noticeable in Virginia localities that border other states, particularly Tennessee, Kentucky, and West Virginia.

The Majority of DSS Adult Services Recipients Are Age 60 and Older. Through the Adult Services Program, DSS is also responsible for supervising the provision by local departments of social services of certain home and community-based services to Virginians 60 years of age and older or disabled persons over the age of 18. Adult services staff from local departments of social services also participate in pre-admission screening teams for certain Medicaid-funded services and for persons wishing to enter an assisted living or adult day care facility.

Home-based care services provided by local adult services staff include companion, chore, and homemaker services, defined in Table 12. All 120 local departments of social services have an adult services program and are allowed to choose the combination of services they will provide. Companion services are the most commonly provided type of assistance, and were offered by all local social services offices in FY 2003. In that year, 5,391 individuals received assistance from Virginia's adult services programs, 75 percent of whom were age 60 or older.

Home-based care services are provided by local departments of social services through agency approved providers or through contracts with home health businesses. Agency approved providers tend to be family members or friends. If there are no providers available, the local department will purchase these services with available funds from another provider, such as a home health care business. While programs are permitted to charge recipients for home-based care services, no local program has implemented a cost-sharing requirement to date.

For all age groups, federal, State, and reported local expenditures for adult services totaled approximately $15.4 million in FY 2003. DSS was unable to provide adult services expenditure data by age group, so the amount spent on adult services recipients age 60 and over is unknown. Federal Social Services Block Grant funding

Table 12

Recipients of Local DSS Home-Based Care Services, Fiscal Year 2003

Service	Service Description	Recipients 18-59	Recipients 60 and Older	Total Recipients
Companion	Assistance with ADLs	1,318	3,889	5,207
Chore	Home-maintenance tasks such as window washing, yard maintenance, and snow removal	9	28	40*
Homemaker	Instruction in or provision of household maintenance activities, such as personal care, home management, and consumer education	25	119	144
Total		1,352 (25%)	4,036 (75%)	5,391

* Aggregate data provided by Fauquier County indicated that a total of three persons received chore services. The ages of these persons were not provided, however, and so these three recipients are only included in this table under "Total Recipients."

Source: Department of Social Services data and Long Term Care and Prevention Services 2003 Program Report.

constituted 47 percent of all program expenditures and the State contributed $478,621 (3 percent). Local funding made up the remainder of these expenditures. It should be noted that, in addition to providing a required 20 percent match for federal funding, local governments voluntarily contribute their own funds to these programs. While this funding is not required to be reported to DSS, agency staff stated that some voluntary local contributions are substantial.

Based on waiting list data maintained by local departments of social services, there does appear to be an unmet need for DSS adult services. DSS estimates that, in FY 2003, there were 1,739 persons on waiting lists for home-based services, and 44 percent of all agencies had a waiting list of a year or more. Persons on these lists have already been screened by social services staff and determined to be eligible for adult services.

The Majority of Cases Referred to Virginia's Adult Protective Services Program Involve Older Persons. Section 63.2-1604 of the *Code of Virginia* grants DSS responsibility for Virginia's Adult Protective Services (APS) program. Virginia's APS program is a resource for older persons and incapacitated persons who are at risk of abuse or neglect and are unable to protect themselves. Local social services agencies operate individual APS programs with State and local funding, and most of the funding is from State general funds. As with home-based care services, many jurisdictions provide a substantial amount of local-only money to support the local APS program. In FY 2003, $453,163 in general funds was expended for this program.

Local APS programs are responsible for receiving and investigating complaints of abuse or neglect against adults age 60 and older, as well as incapacitated persons age 18-59. APS staff are also charged with investigating reports of abuse or neglect and referring matters to appropriate authorities. In FY 2003, 11,949 cases were referred to APS, of which 8,597 (72 percent) involved adults age 60 and older. Data on the resolution of these cases are not maintained by age, but 61 percent of referrals across all age groups were substantiated cases of abuse or neglect.

In addition to local APS staff, court appointed guardians are required by §37.1-137.2 of the *Code* to file annual reports with local social services departments. DSS reports that of the 2,110 guardianship reports filed in FY 2003, 59 were opened for an APS investigation. Also in FY 2003, local social services agencies reported that 174 adults age 18 and older needed a guardian, but did not have one appointed.

The Virginia Caregiver Grant Program Has Not Been Consistently Funded. One element of the service network for older Virginians is the provision of support for their caregivers. In 1999, the General Assembly created the Virginia Caregiver Grant program to provide financial assistance to caregivers of needy relatives. Data provided by DSS indicate that in FY 2000, the first year of the program's operation, there were nearly 3,000 grant recipients and each received $318 in grant funds. In FY 2001 and FY 2002, applications for the program were received, but funding was not appropriated for the program. No funding was provided in FY 2003, and DSS did not solicit grant applications during that year. Most recently, the

2004 General Assembly appropriated $300,000 for the 2004-2006 biennium for the Caregiver Grant program.

Older Virginians Consume Fewer Public Assistance Benefits Than Their Younger Counterparts. DSS also administers those public assistance programs traditionally thought of as "welfare" benefits, including the Food Stamp and Energy Assistance programs (both federally funded) and the Temporary Assistance for Needy Families (TANF) program (jointly funded by the State and federal governments). The Food Stamp program provides financial nutrition assistance payments to low-income persons, the Energy Assistance program assists needy households with home heating and cooling costs, and the TANF program provides cash assistance to help low-income persons meet their basic needs.

Based on an analysis of DSS data, Virginians age 60 and older represented a smaller proportion of public assistance recipients in FY 2003 than younger persons. This group did, however represent a much larger proportion of Food Stamp recipients (16 percent) than they did of TANF recipients (less than one percent). Further, households with persons age 60 or older that received energy assistance in FY 2003 constituted 32 percent of all households receiving this type of assistance. In terms of total cost, the largest amount of public assistance funds were expended on older Food Stamp recipients at an estimated $54.2 million.

Virginia Department of Health

The responsibilities of the Virginia Department of Health (VDH), within the Secretariat of Health and Human Resources, are set forth in Title 32.1, Chapters 1 through 8 of the *Code of Virginia*. VDH is charged with administering a comprehensive program of public health services for all Virginians. More specifically, VDH is mandated to provide communicable disease control services, child health services, maternal health services, family planning services, and environmental health services. VDH also regulates health care services, including nursing homes. For FY 2004, VDH was appropriated approximately $138 million in general funds, and $298 million in nongeneral funds. Agency staffing for FY 2004 includes 3,553 full-time equivalent employees.

Most public health services are administered by the 119 local health departments that operate in the Commonwealth's 35 health districts and are provided based on contracts between VDH and the local governments. Employees of the local health departments are State employees, with the exception of the employees of the three localities (Richmond City and the Counties of Arlington and Fairfax), which administer their own health districts. Public health activities that are primarily affected by older Virginians include VDH's oversight of certain healthcare providers, and the participation by local health departments in the nursing home preadmission screening process.

State and Local Health Services Are Primarily Directed Toward Younger Virginians. Most of the programs and services administered by local health departments are primarily consumed by younger persons and are directed

toward women, children, and the indigent. However, some local health departments have extensive services for older persons. For example, Fairfax County's local health department provides adult day care and respite services, which are often used by older adults and their families. In addition, local health departments participate in the pre-admission screening teams that conduct eligibility assessments for persons requesting Medicaid funded nursing home or waiver services, many of whom are older Virginians.

According to the VDH Commissioner, most of VDH's programs and services for adults are primarily focused on prevention and control of chronic conditions for the "future elderly." Examples of these programs include the Virginia Arthritis Project, the Cardiovascular Health Project, the Cancer Treatment and Control Project, and the Diabetes Control Project. In addition, VDH's Center for Injury and Violence Prevention has an Older Adult Safety Program which conducts research and provides community education, such as information on how older adults can prevent falls. According to Center reports, falls accounted for 71 percent of total injury hospitalizations and 21 percent of injury deaths for Virginians age 65 and older (calendar year 2000).

Suicide Prevention and Emergency Response Planning Include a Focus on Older Virginians. While VDH's public health planning efforts are designed to protect the health of all persons, recent suicide prevention and emergency response planning have focused on high risk populations such as older Virginians. SJR 312 of the 2003 General Assembly session directed VDH and VDA, with participation from other State agencies, to develop a "Suicide Prevention Across the Life Span Plan." According to the draft plan, which was released in September 2004, the 2001 suicide rates in Virginia for persons age 85 and older were higher than the national rates, while suicide rates in Virginia for other age groups were similar to the national rates. In addition, the plan notes that suicide death rates, overall, have declined in Virginia since the 1970s, but suicide death rates for persons age 75 and older have not changed much during that time. Finally, the draft plan notes that a program which would use primary care physicians to identify signs of depression and suicide in older adults should be created in Virginia.

In September 2004, VDH received a $20 million grant from the U.S. Centers for Disease Control and Prevention which will be used to address various public health emergency issues. These issues include planning for the provision of healthcare to older and disabled Virginians during bioterrorism events, infectious disease outbreaks, or natural disasters. In addition, VDH currently has a form available on its Emergency Response and Preparedness web site that can be used by assisted living facilities, nursing homes, and other extended care facilities to prepare for emergency planning, response, and recovery.

Older Virginians Are Mostly Served Through VDH's Regulatory Role. The Virginia Department of Health is responsible for licensing and regulating facilities and providers of medical services, including long-term care services. Long-term care services include socialization, health care, nutrition, daily living, and supportive services that are provided on a continuing basis, and can be provided in fa-

cilities as well as residential settings. Exhibit 2 provides a brief description of the various types of long-term care facilities and providers regulated by VDH that are primarily utilized by older persons, as well as younger persons with chronic or disabling conditions. Long-term care facilities primarily utilized by older adults include nursing homes, and home-based long-term care services utilized by older adults include those provided by hospices and private home health care agencies. In 2002, 53 percent of Virginia nursing home residents were age 65 to 84, and 34 percent were age 85 and older at the time of admission. Although Virginia data are not available, national data for the year 2000 indicate that 81 percent of hospice patients and 71 percent of home health care patients were ages 65 and older.

Exhibit 2

Long-Term Care Facilities and Providers Regulated by the Virginia Department of Health

Home Care Provider: An organization that provides home health, personal care, or pharmaceutical services at the residence of the individual.

Hospice: A home or inpatient care organization that provides palliative (treatment directed at controlling pain and relieving symptoms) and supportive medical and other health services to terminally ill patients and their families. Hospice care is available 24 hours a day, seven days a week.

Nursing Home: A facility or any identifiable component of another facility licensed by VDH (such as a nursing home unit within a hospital) in which the primary function is the provision, on a continuing basis, of nursing services and health-related services for treatment and inpatient care. Nursing homes are also referred to as convalescent homes, skilled nursing facilities or skilled care facilities, intermediate care facilities, and extended care facilities.

Source: *Code of Virginia* and Virginia Administrative Code.

VDH conducts State licensure and federal certification of long-term care facilities and providers. All nursing homes operating in Virginia must be State licensed. In addition, the federal Centers for Medicare and Medicaid (CMS) require nursing homes to be federally certified before Medicare or Medicaid will reimburse for services, and VDH conducts this federal certification. According to VDH staff, the State licensure program ensures that Virginia nursing homes meet minimum standards to ensure the health, safety, and welfare of the residents. However, federal certification standards are much more stringent and include 400 deficiencies for which nursing homes can be cited. In addition, federal certification requires that nursing homes be inspected every year, while State licensure requires them to be inspected every two years. According to VDH data, as of March 2004 there were a total of 267 nursing homes containing 30,859 nursing home beds. Of these facilities, 94 percent are also federally certified.

Hospices and home health care agencies are also State licensed or federally certified by VDH. Both types of providers must be State licensed before they can be federally certified. However, once certified, there is no requirement that they continue to be State licensed. Table 13 shows the number of long-term care service providers that are licensed or certified by VDH.

Table 13

Selected Long-Term Care Service Providers Licensed or Certified by the Virginia Department of Health

Type of service	State Licensed	Federally Certified
Nursing home	267	251
Hospital long-term care units[1]	N/A	23
Home health agency	93	155
Hospice	66	54

Note: VDH certifies nursing home beds in mental health hospitals for reimbursement by Medicare or Medicaid. VDH also certifies beds in intermediate care facilities for persons with mental retardation for reimbursement by Medicaid. These beds are not included in this table.
[1]The nursing home beds within hospital long-term care units are covered under the hospital's State license.

Source: Virginia Department of Health.

Finally, the Commissioner of the Department of Health is responsible for overseeing the creation, expansion, and replacement of medical facilities, including nursing homes. This role is conducted through the Certificate of Public Need program. Since FY 1999, the Commissioner has approved 63 nursing home projects, including the approval of new nursing home facilities, the approval of additional nursing home beds within facilities, and transferring nursing home beds between facilities. VDH's regulatory responsibilities will likely be impacted by the aging population because these long-term care facilities and providers are often used by older Virginians.

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

The responsibilities of the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS), within the Secretariat of Health and Human Resources, are set forth in Title 37.1 of the *Code of Virginia,* and include the provision of publicly-funded services to persons with mental illness, mental retardation, and substance use disorders. DMHMRSAS operates ten mental health (MH) facilities, five mental retardation (MR) training centers, and the Hiram Davis Medical Center. In addition, DMHMRSAS licenses and contracts with 39 community services boards (CSB) and one behavioral health authority (BHA), which are the local agencies that provide mental health, mental retardation, and substance abuse services to individuals residing in the community. (In this interim report, community services board or CSB means CSB and BHA.) For FY 2004, DMHMRSAS was appropriated approximately $408 million in general funds and $321 million in non-

general funds. (Funds for community services are included in this appropriation, as well as a specific appropriation of $34 million for geriatric care services to patients age 65 and older in mental health facilities.) Agency staffing for FY 2004 includes 9,868 full-time equivalent employees. (This number includes State facility employees, but does not include employees of CSBs because they operate as entities of local governments.)

State facility and CSB services are provided to persons of all ages. In FY 2003, older Virginians primarily received mental health and mental retardation services, and few older persons received substance abuse services. In contrast, a greater number of younger Virginians received mental health and substance abuse services than received mental retardation services. State mental health facilities provide psychiatric, psychological, nursing support, and ancillary services to adults with a serious mental illness, and to children and adolescents with a serious emotional disturbance. In addition, MH facilities provide substance abuse treatment to patients who have a mental illness as well as to those who have a co-occurring alcohol and/or drug abuse problem. MR training centers provide residential care and training in life skills primarily to adults with severe or profound mental retardation. In addition, MR training centers provide temporary respite care and emergency care to persons with MR whose caretaker has a medical or other urgent condition. All MR training centers in Virginia are intermediate care facilities for the mentally retarded (ICF/MR) and provide more intensive training and supervision than may be available in other types of residential settings.

Community services provided through CSBs include emergency services, local inpatient services, outpatient and case management services, day support services, residential services, and prevention and early intervention services. CSBs either provide services directly or contract with other providers to provide services. However, CSB staff are directly responsible for case management services, discharge planning from State facilities into the community, pre-admission screenings for entrance into State facilities or into local inpatient psychiatric hospitals, and determining eligibility for Medicaid waiver services.

Most State Facility Services Are Provided to Younger Adults, But an Increasing Number of Older Adults Are Being Served in MR Training Centers. Adults between the ages of 18 and 49 constituted more than 70 percent of all adults in mental health (MH) facilities and mental retardation (MR) training centers in FY 2003, as shown in Table 14. While older adults represented a smaller proportion of adults receiving services in MR training centers, the number of adults between the ages of 50 and over receiving services in MR training centers increased between FY 1998 and FY 2003 (Table 14). One explanation for this increase, according to DMHMRSAS staff, is the aging of adults residing in MR training centers. Despite this increase, the overall number of adults served in MH and MR facilities decreased approximately six percent during that time.

Table 14

Number and Percent of Adults Served in State Facilities by Age Group in FY 1998 and FY 2003

Age Group	FY 1998	FY 2003	Percent Change
Mental Health Facilities			
18-49	4,300 (73%)	3,930 (71%)	-9%
50-59	602 (10%)	739 (13%)	23
60-84	875 (15%)	765 (14%)	-13
85 and Older	109 (2%)	65 (1%)	-40
Mental Retardation Training Centers			
18-49	1,296 (78%)	1,086 (69%)	-16%
50-59	212 (13%)	300 (19%)	42
60-84	153 (9%)	174 (11%)	14
85 and Older	1 (0.06%)	7 (0.45%)	600

Source: JLARC staff analysis of DMHMRSAS data.

Older Adults Remain in Mental Health Facilities Longer than Younger Adults. Older patients (age 60 and older) typically have longer lengths of stay in MH facilities, as determined by using average length of stay (ALOS) data provided by DMHMRSAS. The ALOS for FY 2003 represents the number of days that a person was served in a State facility as of June 30, 2003. Two factors affect the differences in average length of stay (ALOS) by age group: the type of admission, either civil or forensic, and the diagnosis.

The first factor affecting the differences in average length of stay among younger (age 18 to 59) and older patients is the type of admission. Civil patients are those patients who are admitted to MH facilities under Title 37.1 of the *Code of Virginia*, either voluntarily or through the civil commitment process, while forensic patients are admitted under Title 19.2 of the *Code*, or through the criminal justice system. In FY 2003, ten percent of older adults served, and 23 percent of younger adults served, were forensic. (Persons served includes those persons admitted or readmitted during FY 2003, and those persons who were admitted in a previous fiscal year and were still being served in FY 2003.) The average length of stay for older adult patients admitted under civil commitment to MH facilities in FY 2003 was just over three years (1,216 days), but the average length of stay for younger adults admitted under civil commitment was approximately six months (or 184 days). For FY

2003, older adult forensic patients were served in MH facilities two years longer, on average, than younger adult forensic patients, at 1,083 days and 418 days, respectively.

The second factor in determining length of stay is the patient's diagnosis. One of the most common diagnoses for all patients at MH facilities in FY 2003, regardless of age and admission status, was schizophrenia. However, for older civil patients diagnosed with schizophrenia, the ALOS was over four and a half years, while the ALOS for younger adult civil patients with the same diagnosis was only 11 months. Similarly, for older forensic patients diagnosed with schizophrenia, the ALOS was over five years, while the ALOS for younger adult forensic patients with the same diagnosis was over a year and a half. A similar pattern was present from FY 1998 to FY 2002.

Older Adults and Younger Adults Typically Remain in Mental Retardation Training Centers for Many Years. In contrast to the average length of stay for patients in MH facilities, which is typically between six months and five years, both older and younger adults in MR training centers have, on average, been served for more than 25 years. Similar to MH facilities, however, the length of stay appears to depend on the diagnosis. While the diagnoses for MR range from mild to profound, the majority of persons at MR training centers are diagnosed with profound MR. As of FY 2003, older adults with mild MR had an ALOS of 27 years, while younger adults with the same diagnosis had an ALOS of 19 years. A large number of younger and older adults are identified as "unspecified MR," which indicates that the person is functioning at a level that is too low to permit testing. The ALOS for older adults identified with unspecified MR was 50 years, while the ALOS for younger adults identified with unspecified MR was 34 years. In addition to an MR diagnosis, a significant number of older adults in MR training centers were also diagnosed with a mental illness.

In Fiscal Year 2003, 153 Older Adults in State Facilities Had Discharge Barriers. According to DMHMRSAS data, 106 adults age 60 and older in MH facilities were identified as having an extraordinary discharge barrier in FY 2003 that prevented them from being placed in a less restrictive setting. In addition, 47 older adults in MR training centers were identified as appropriate for community placement, but had a barrier to discharge. In MH facilities, the most common extraordinary discharge barrier for older adults was the unavailability of another placement such as a nursing home bed (55 older adults) or an assisted living facility bed (13 older adults). Additionally, 17 older adults needed a legally authorized representative, or guardian, to make care decisions, before a nursing home or assisted living facility would accept them. In MR training centers, the majority (28 out of 47) of older adults with a discharge barrier had not been discharged because of insufficient funding, such as that provided through the Medicaid waiver. In addition, 19 older adults had not been discharged from a MR training center because a legally authorized representative was not available.

Specialized Mental Health Services Are Provided to Older Adults. Geriatric psychiatric (gero-psychiatric) services, which are mental health services

provided to adults age 65 and older, are similar to services provided to other adults, but are adjusted to meet the psychological, physical, and medical needs of the elderly. The four mental health facilities that provide geriatric services are Catawba Hospital (Catawba), Eastern State Hospital (Williamsburg), Piedmont Geriatric Hospital (Burkeville), and Southwestern Virginia Mental Health Institute (Marion). The Hiram Davis Medical Center in Petersburg provides medical and skilled nursing services to patients referred by State MH and MR facilities, and it also provides some mental health services to geriatric patients.

DMHMRSAS began a reinvestment and restructuring initiative in 2003 with the goal of reducing reliance on State facilities for the provision of services that could be provided in the community. As a result, several special population work groups were created, including one for the geriatric population. According to the DMHMRSAS Comprehensive Plan, persons with mental illnesses may begin to experience complications with physical illnesses as they age. In addition, older persons with medical conditions as well as mental disorders are likely to need services over and above what some nursing homes and assisted living facilities can provide.

The gero-psychiatric work group was created to develop a strategic plan for improving both community and facility services to geriatric consumers, as well as strengthening coordination and planning between community and facility providers. Though efforts are ongoing, the work group issued a report in August 2004 that identified nine problems with the current system of services to geriatric consumers. The problems include inadequate data availability for planning Statewide geriatric services, and a lack of trained specialists and other caregivers. The work group also noted that many older adults experience acute psychiatric problems that go undetected and untreated. The work group made several preliminary recommendations for improving the system of geriatric services, including increasing coordination among agencies that deliver services to geriatric patients, strengthening the training and ongoing education of providers, and developing partnerships with primary care physicians.

Geriatric Patients Receive Less Costly Mental Health Services. Geriatric patients are less costly to serve, on average, than adult patients (defined as persons age 18 to 64). Table 15 indicates the average cost per day for providing mental health services to a geriatric patient was 15 percent less than the cost for providing services to adult patients in FY 2003. According to DMHMRSAS staff, the lower cost impact of geriatric patients is likely attributable to the different service needs and types of services they are provided as compared to services provided to younger patients. Also, as indicated in the table, gero-psychiatric services in FY 2003 represented 25 percent of the total annual costs of psychiatric services provided to geriatric and younger adult patients. (Total costs for serving patients in State facilities were available by age only for mental health services.)

Medicaid will reimburse for services in State MH facilities that are provided to Medicaid-eligible individuals who are age 65 and older, and age 21 and younger. However, under the institutions for mental diseases (IMD) exclusion, Med-

Table 15

Costs for Mental Health Services* in State Facilities, FY 2003

	Adult Psychiatric (Age 18-64)	Geriatric (Age 65 and older)
Total Annual Cost	$166,006,254 (75%)	$54,183,710 (25%)
Total Patient Days	366,125 (72%)	140,195 (28%)
Cost Per Patient Day	$453	$386

*Note: Medical services provided at mental health hospitals and forensic services provided at Central State Hospital are excluded from this table. Cost data by age was not available for these types of services.
[1]Cost per patient day is calculated by dividing the total annual cost by total patient days.

Source: JLARC staff analysis of DMHMRSAS data.

icaid will not reimburse for MH services when they are provided to adults between ages 22 to 64 in certain institutions that primarily provide treatment for persons diagnosed with mental diseases. (This exclusion does not apply to MR training centers.) In the absence of third party or out-of-pocket payments, State mental health facility services provided to persons age 22 to 64 are deemed charitable and are covered by the State General Fund. According to data provided by DMHMRSAS, 196 adults age 60 to 64 were served in State MH facilities in FY 2003.

Younger Adults Are the Largest Recipients of Community-Based Services, But an Increasing Number of Older Adults Receive Community-Based Mental Retardation Services. Community Services Boards (CSBs), or their contractors, serve relatively few older adults, as shown in Table 16. For those older adults who received community-based services in FY 2003, most received MH services, and few older adults received SA services. In addition to the increasing number of older adults being served by MR training centers, CSBs or their contractors are also providing community-based MR services to a larger number of older adults. Between FY 1998 and FY 2003, the number of older adults receiving MR services increased by 22 percent, compared to an increase of only nine percent for adults age 18 to 59.

According to data provided by DMHMRSAS, 544 older adults were on a waiting list for community-based MH services on April 11, 2003. As shown in Table 17, fewer older adults were on a waiting list for MR or SA services. Overall, however, the number of older adults on waiting lists was much smaller than the number of younger adults. Several reasons were given by DMHMRSAS staff for why persons would be on waiting lists for community-based services, including the lack of a guardian to make care decisions, and the presence of an aging caregiver age 55 or older and who can no longer provide adequate care. Seventy-eight older adults were on waiting lists for MH or MR services because of the lack of a guardian, and 676 adults were on waiting lists due to an aging caregiver. CSB waiting lists include

Table 16

Number and Percent of Adults Receiving Services from Community Services Boards in FY 1998 and FY 2003

Type of Service	18-59	60 and Older
Fiscal Year 1998		
Mental Health	77,122 (89%)	9,741 (11%)
Mental Retardation	11,682 (93%)	872 (7%)
Substance Abuse Services	56,494 (98%)	1,037 (2%)
Fiscal Year 2003		
Mental Health	75,097 (89%)	9,318 (11%)
Mental Retardation	12,758 (92%)	1,059 (8%)
Substance Abuse Services	48,018 (98%)	872 (2%)

Note: Adults receiving services from private providers that contract with CSBs are included in this table.

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

Table 17

Number of Adults on Waiting Lists for Community Based Services as of April 2003

On Waiting List For:	18-59	60 and Older
Mental Health Services	4,231 (89%)	544 (11%)
Mental Retardation Services	1,745 (97%)	63 (3%)
Substance Abuse Services	2,908 (99%)	37 (1%)

Note: A person can be on a waiting list and also receive some community-based services. The numbers represent an unduplicated count by type of service. In addition, this table only represents those persons on waiting lists whose age was known.

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

persons who have sought services and were assessed as needing services, but who are not receiving all or any of the services they required.

Older Adults Represent Ten Percent of Adult MR Waiver Recipients Served by CSB Providers, and Five Percent of Adults on MR Waiver Waiting Lists. Individuals with mental retardation who are at risk of institutionalization in an intermediate care facility for the mentally retarded (ICF/MR) and who are eligible for Medicaid are also eligible for the MR Waiver, which is one of the six Medicaid home and community-based waiver programs in Virginia. The MR waiver allows individuals to remain in the community and receive needed services, such as day support services, supported employment, personal assistance services, respite care, skilled nursing services, and pre-vocational services. The Department of Medical Assistance Services (DMAS) administers the waiver, but DMHMRSAS manages the day-to-day operations.

Data available from DMHMRSAS include the number of adults, by age, receiving MR Waiver services by type of provider (CSB or private). JLARC staff analysis of data by provider indicated that in FY 2003, adults age 60 and older represented ten percent of the 2,738 adult recipients of MR Waiver services from CSB providers, and eight percent of the 3,466 adult recipients of waiver services from private providers, as shown in Table 18. Older adults also represented five percent of all adults that were on the waiting list for the MR Waiver in FY 2003.

Table 18

MR Waiver Services and Waiting Lists for Adults, FY 2003

Number of Adult MR Waiver Recipients			
CSB Providers		*Private Providers*	
Age 18-59	Age 60 and older	Age 18-59	Age 60 and older
2,461 (90%)	277 (10%)	3,184 (92%)	282 (8%)

Number of Adults on Waiting List	
Age 18-59	Age 60 and older
1,627 (95%)	88 (5%)

Note: The total number of recipients cannot be calculated from this data, because recipients can receive services from both CSB providers and private providers.

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

Department of Veterans Services

The responsibilities of the Department of Veterans Services, located within the Secretariat of Health and Human Resources, are set forth in Title 2.2, Chapter 20 of the *Code of Virginia*. Primary agency responsibilities that are affected by older

Virginians include assisting Virginia veterans and their dependents in obtaining benefits from the federal Department of Veterans Affairs, providing long-term care and assisted living services to veterans, and providing burial and perpetual care services to Virginia veterans and dependents. For FY 2004, the agency was appropriated approximately $2.2 million in general funds, and $11.8 million in nongeneral funds. Agency staffing for FY 2004 includes 282 full-time equivalent employees.

The Department of Veterans Services was created in 2003 as a result of merging the Department of Veterans Affairs, the Virginia Veterans Care Center (State Veterans Home) in Roanoke, and the Virginia Veterans' Cemetery in Amelia County. A new veterans home in the City of Richmond is being planned, and a new veterans cemetery in the City of Suffolk is scheduled for completion in November 2004.

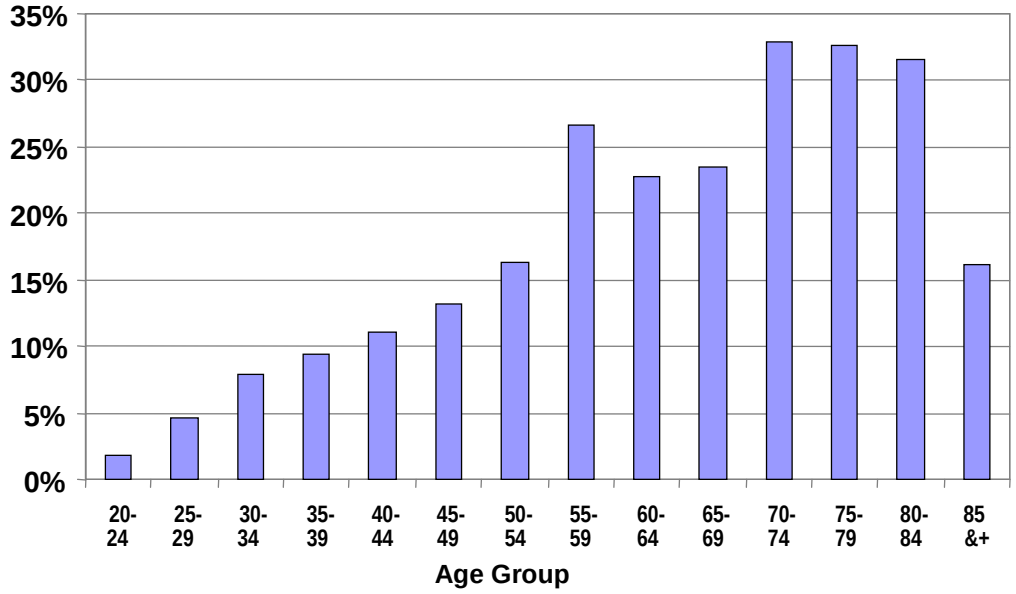
More than One in Four Older Virginians Are Veterans. Virginia has the nation's tenth largest population of veterans, many of whom are eligible for federal pensions and health benefits. In 2003, the federal Department of Veterans Affairs estimated that Virginia had 296,031 veterans age 60 or older, representing approximately 27 percent of all older Virginians. (A veteran is defined as a person who has served on active duty for any length of time, excluding active duty for training in the National Guard or Reserves, and who is not currently on active duty.) Across all age groups, veterans comprise only ten percent of the State's population, but as indicated in Figure 9 veterans constitute a much larger percentage of older Virginians. Within the State, most older veterans reside in the Northern Virginia, Metro Richmond, and Tidewater regions. At the locality level, the percentage of persons age 60 and over that are veterans ranges from 14 percent in Emporia City, to 39 percent in Stafford County.

Agency Workload Is Primarily Driven by Older Veterans. Through its 14 field offices, the department assists Virginia's veterans in pursuing claims for compensation, and provides services related to veteran pensions, education, medical services, and other veterans benefits. In addition to the services provided by the field offices, the agency provides nursing home services at the 240-bed Virginia Veterans Care Center in Roanoke. Services at the Care Center include: physical, occupational, speech, and respiratory therapy; a 60-bed Alzheimer's care unit; and a hospice program. Currently, the daily rate for semi-private skilled nursing care is $102. The federal government pays a daily per diem of $58, and the remainder of the cost is charged to the veteran.

The Commissioner of Veteran Services states that the department's workload is primarily driven by the needs of older veterans or their survivors who require assistance with existing claims, or who need to submit new claims because of worsening disabilities. For example, some World War II veterans require assistance completing the forms necessary to receive services, because they have a limited reading ability as a result of leaving school to serve in the armed forces. In addition to veterans over the age of 60, the Commissioner notes that the average Vietnam veteran is now 59 years old, an age when many persons begin to require additional levels of care.

Figure 9

Veterans in the Virginia Population as a Percent of their Age Groups



Source: JLARC staff analysis of Veterans Administration data.

The full impact of older Virginians upon the agency is not presently known, according to agency staff, because the central office has limited data on the claims processed by each field office. To address this, agency staff are conducting an analysis of the claims processed by each office as part of the ongoing reorganization of veterans services. However, the Commissioner has stated that the Care Center in Roanoke has a waiting list of approximately 18 beds, and he also indicated that veterans organizations have requested two more Care Centers, one each in the Northern Virginia and Tidewater regions. Some of this demand may be alleviated by the new Care Center in Richmond, which is being funded through a combination of State and federal funds. In February 2004, the U.S. Department of Veterans Affairs approved a grant of $14.8 million to support the new center, to which the State must contribute another $7.9 million. However, because of financial constraints, the number of beds in the facility has been reduced to 200 from the planned number of 240.

Department of Corrections

The responsibilities of the Department of Corrections (DOC), within the public safety secretariat, are set forth in Title 53.1 of the *Code of Virginia* and include the operation of the State's correctional facilities, which house adult criminal offenders. During FY 2003, DOC had an average daily inmate population of 31,645. For FY 2004, DOC was appropriated $776 million in State general funds and $62

million in nongeneral funds. Agency staffing for FY 2004 includes 13,302 full-time equivalent employees. Agency activities that are affected by older Virginians include housing a growing number of older inmates.

The primary funding source for DOC operations is the State's General Fund. The agency also receives funding for housing out-of-state inmates and from various federal grants. DOC reports that one budgetary trend is the increasing cost of medical care for inmates, which increased nearly 14 percent from FY 1999 to 2000 (the most recent data available). DOC partially attributed this increase to the impacts of an aging offender population, which will be discussed in more detail below.

The Issue of an Aging Prisoner Population Is Being Examined Nationwide. Among corrections professionals, an inmate age 50 or older is typically considered "geriatric" because certain lifestyle elements tend to make these offenders reach "old age" faster than normal. National literature indicates that there has been a steady increase in the number of the country's geriatric prisoners in recent years. A 1998 report by the Southern Legislative Conference (SLC) found that, in 15 of the SLC member states, the number of geriatric inmates increased 115 percent in six years from 12,107 in 1991 to 26,044 in 1997. This is compared to an increase in the overall inmate population in those states of 83 percent. This study reported that corrections officials are primarily concerned about their ability to adequately meet federal mandates that sufficient health care be provided to all inmates, as well as a shortage of facilities and trained staff that can accommodate the unique needs of this population.

An Increasing Geriatric Prisoner Population Creates Challenges for DOC. In line with national trends, Virginia's geriatric inmate population has been steadily increasing. According to DOC data, between FY 1999 and FY 2003, the number of geriatric prisoners increased 56 percent (from 2,399 to 3,733), compared to an increase in the overall prisoner population of only 18 percent. Some characteristics of older inmates are shown in Exhibit 3.

Exhibit 3

Facts about Geriatric Inmates in Virginia

- Most Common Offense Types and Number of Offenders

Homicide:	729	(20%)
Rape:	293	(8%)
Robbery:	279	(8%)
Aggravated Sexual Battery:	257	(7%)

- Oldest geriatric inmate is 86 and serving a ten-year sentence for malicious wounding
- Four geriatric inmates were sentenced to death, and 517 were serving life sentences

Source: Department of Corrections data, as of mid-year 2003.

Although geriatric prisoners are present in all of DOC's major institutions, only four facilities are capable of meeting the medical needs of older inmates. In mid-2003, the Greensville Correctional Center in Greensville County, which has a skilled nursing facility, housed 372 geriatric inmates, the most of any facility, but only ten percent of inmates in this age group. The second largest geriatric population, 303 offenders, resided at the Deerfield Correctional Center in Southampton County, which is a facility specifically designed to care for inmates in need of assistance with one or two basic activities of daily living. It provides a level of care similar to an assisted living facility. Only a small percentage of all geriatric inmates (8 percent) were housed at Deerfield in mid-2003. Other institutions with some ability to care for the more acute medical needs of older prisoners include the Powhatan Correctional Center in Powhatan County, which has a skilled nursing facility, and the Marion Treatment Correctional Center in Smyth County, which has an infirmary.

Inmates that need medical care beyond the capability of on-site services such as those mentioned above are transported to off-site medical centers. DOC staff report that most off-site services are provided in Richmond by the VCU Health System. In addition to being more expensive in terms of medical costs, staff stated that off-site treatment is more expensive due to transportation costs. Further, off-site facilities such as the VCU Medical Center reportedly do not schedule appointments for inmates in a block fashion, resulting in the need for many trips to be made for individual inmates. Staff report that they are developing an agreement between the state of Tennessee and two correctional centers in southwestern Virginia so that inmates in those facilities can receive closer off-site services.

In addition to meeting the medical needs of older inmates, DOC staff reported other challenges in managing this population. For example, many older inmates reportedly are physically unable to reach a top bunk and DOC staff state that there are waiting lists for bottom bunks throughout its facilities. Another difficulty is the development of an adequate release plan for older inmates who are released from the correctional system. DOC staff reported that nursing homes and assisted living facilities are reluctant to admit these inmates because of their criminal histories. As shown in Exhibit 3 above, 20 percent of geriatric inmates were convicted of homicide. Corrections officials also stated that, because family members of older inmates are often no longer present, there is difficulty in locating adequate community support systems for these inmates upon release.

Finally, another challenge faced by DOC in working with an aging prisoner population is the adequacy of training provided to correctional staff on geriatric inmate issues. With the exception of staff at Deerfield Correctional Center, most employees do not receive specific training on the potentially unique needs or characteristics of geriatric prisoners. DOC staff have acknowledged the need for additional training and cited one instance in which a correctional officer mistakenly charged an older inmate suffering from dementia and a hearing impairment with disobedience.

No Inmates Have Been Released Under the State's Geriatric Release Program. In 1994, the General Assembly created the Geriatric Release Program as a way to curtail rising costs for an aging inmate population. This program gives qualifying geriatric offenders the option of an early release from incarceration and even applies to persons who committed an offense after 1995, when parole was abolished in Virginia. To be eligible for geriatric release, an inmate must be at least 65 years old and have served at least five years of his sentence, or be 60 or older and have served at least ten years of his sentence. According to DOC officials, qualifying inmates are not automatically considered for this program. Rather, they must be aware of their eligibility and request early release for themselves. DOC staff have stated, however, that many older inmates are probably unaware of this program and reported that no one has been released under this program in the ten years since its creation. In 2004, 238 inmates will be eligible for early geriatric release.

The Medical Costs of Virginia's Geriatric Inmates Are Difficult to Determine. In 2001, DOC created the Geriatric Program and Management Committee to examine the overall management of Virginia's aging offenders. A primary issue being addressed by this committee is a determination of the cost of providing needed medical services to this population. This effort, however, has been encumbered by the fact that DOC does not maintain data by age on the cost of internally-provided medical services. Data by age are available only for services provided outside of DOC facilities. The absence of adequate cost data by age also hindered a 2003 study of the State's older prisoners by the Virginia Center for Excellence in Aging and Geriatric Health, which found that determining the medical costs of geriatric inmates was not fully possible due to these data limitations. This report did state, however, that care provided to geriatric inmates is likely to be more costly than for younger inmates, given the greater prevalence of chronic diseases and other health problems in this population. National literature has stated that the costs of older offenders are nearly three times that of the average offender, due to the fact that these prisoners require more continual care and observation.

TRANSPORTATION AND MOBILITY

As individuals age, they are likely to experience challenges in their ability to travel from place to place. The impact of older Virginians on the transportation and mobility services provided by State agencies is discussed in this section. While older Virginians adapt to the effect of aging on their mobility by various informal means, such as restricting the time of day when they drive or depending on family or friends for rides, they also draw upon the transportation services and programs provided by three of the State's transportation agencies: the Department of Motor Vehicles (DMV), the Department of Transportation (VDOT), and the Department of Rail and Public Transportation (DRPT).

As recognized by the Virginia Commonwealth Transportation Board in its 2003 report to the Governor and the General Assembly ("VTRANS 2025 – Virginia's Statewide Multimodal Long-Range Transportation Plan"), the need to accommodate the demands of an increasing number of older Virginians will require changes to the

State's transportation systems. Noting that "high levels of mobility help create and sustain independence and freedom for seniors," the report identified a growing need for the integration of transportation and land-use planning to accommodate the transportation needs of older residents. The report also identified a need for more accessible public transit services and even specialized transportation services to meet the needs of older residents who are no longer able to drive.

The Departments of Motor Vehicles, Transportation, and Rail and Public Transportation are specifically impacted by the challenges faced by older Virginians. In 2004, DMV was responsible for administering the driver's licenses of more than 972,000 Virginians age 60 and over. Like DMV, VDOT is also affected by Virginia's older drivers, who may face certain challenges in navigating Virginia's roadways. As such, various VDOT studies on elements of traffic engineering and roadway design have incorporated older drivers' perspectives, although most VDOT initiatives that benefit older drivers are designed to benefit all users of the State's highways. Older persons who are no longer able to drive or have limited driving capabilities may benefit from the mass transit and paratransit funding administered by DRPT. In FY 2004, one percent of all federal and State funding for mass transit and paratransit projects in Virginia was dedicated specifically to the transportation needs of older persons.

Department of Motor Vehicles

The responsibilities of the Department of Motor Vehicles (DMV), located within the Secretariat of Transportation, are set forth in Title 46.2 of the *Code of Virginia*, and include the administration of the State's motor vehicle registration and title laws, the issuance of driver's licenses, the administration of fuels tax and dealer licensing laws, and those provisions of Title 46.2 relating to transportation safety. For FY 2004, DMV was appropriated approximately $196.7 million exclusively in nongeneral funds. Agency staffing for FY 2004 includes 1,984 full-time equivalent employees. Agency activities that are affected by older Virginians include driver's license examinations, vision testing, the review of individual drivers by the Medical Advisory Board, and the suspension of driving privileges.

Recent DMV Collaborations with Other Agencies Have Focused on Aging's Impact Upon Driving Ability. DMV has collaborated with other agencies and organizations to increase public awareness of aging issues. DMV and the Virginia Department for the Aging (VDA) are jointly developing a brochure on how forms of dementia, such as Alzheimer's disease, affect driving. Also, in May 2004, DMV and VDA launched the GrandDriver program, which is designed to increase the public's awareness of how aging affects driving abilities. The program is also intended to direct older drivers to resources that older drivers are more likely to require than younger drivers, such as physical therapy. According to DMV literature, Virginia is the first State to implement a state-wide campaign designed to focus on the needs of older drivers. DMV has also worked with the Center for the Advancement of Public Health at George Mason University (GMU) on several efforts that center on the needs of mature drivers. In 1998, GMU prepared a report for DMV on

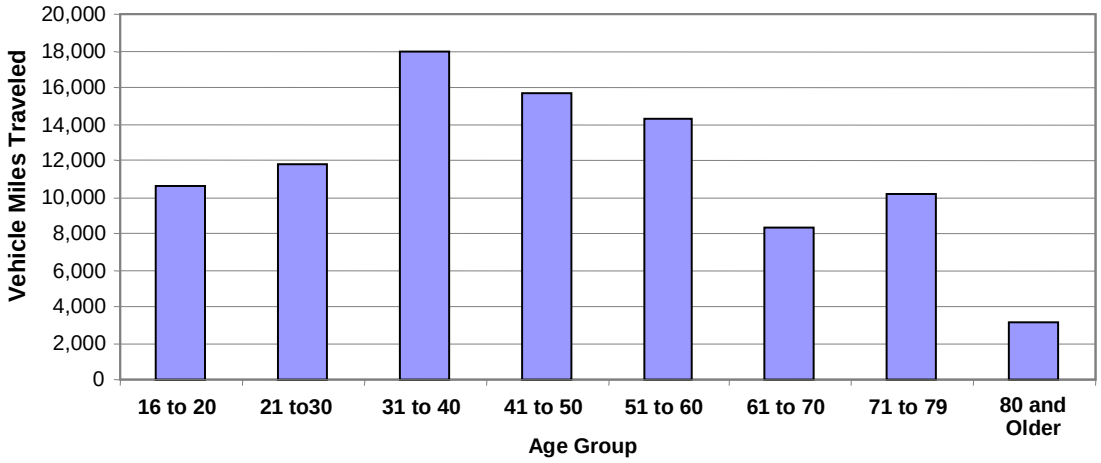
how safety issues associated with mature drivers were being addressed, as part of a review on driver's license options for applicants over the age of 70.

The Number of Miles Driven Annually Generally Decreases with Age. Older drivers constituted 17 percent of all Virginia drivers in 2001, similar to their proportion of the population. However, older drivers drove fewer miles as a group than younger drivers. As shown in Figure 10, the average number of miles traveled annually generally decreases after age 60. Drivers over the age of 60 traveled, on average, about 8,300 miles during 2001. In contrast, younger drivers traveled about 14,800 miles, on average. Drivers between the ages of 66 and 75 drive more miles than other drivers in the 60+ age group, with an average of about 11,000 miles annually. This may reflect increased leisure travel during retirement. However, after age 75 the average number of miles driven annually begins to decrease sharply. Drivers between the ages of 76 and 79 drive approximately 4,800 miles on average, and drivers over the age of 85 drive only 1,900 miles on average each year.

Aging Has Several Effects Upon Driving. Aging is associated with an increase in physical and mental impairments that may affect an older driver's ability to drive, but no clear link has been established between motor vehicle fatality rates and increased age. For example, aging is frequently associated with a number of changes to vision. According to the National Highway Traffic Safety Administration, the formation of cataracts causes a decline in acuity and greater vulnerability to glare. Macular degeneration can destroy central vision, and glaucoma reduces peripheral vision. Other age-related changes include a slower reaction time and a decreased range of head movement, which can affect a driver's ability to respond to other vehicles at intersections. Finally, the prevalence of Alzheimer's disease and other forms of dementia also increases with age.

Figure 10

Average Annual Vehicle Miles Traveled in Virginia By Age Group, 2001



Note: A Vehicle Mile Traveled is the movement of one privately operated vehicle for one mile, regardless of the number of people in the vehicle.

Source: JLARC staff analysis of the 2001 National Household Travel Survey, U.S. Department of Transportation.

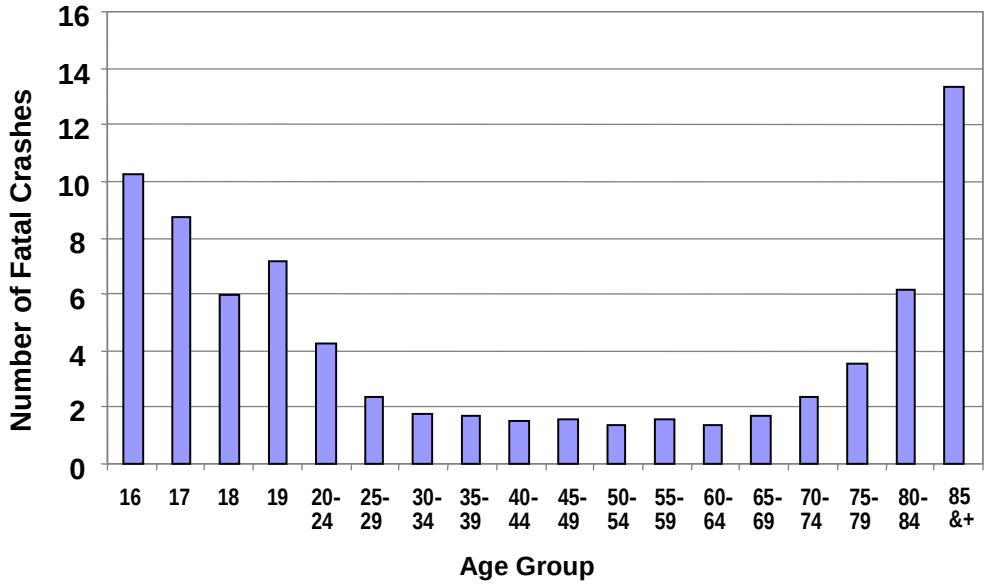
National data indicate that motor vehicle deaths are highest among the very youngest and oldest drivers. However, the higher level of motor vehicle deaths among older adults does not indicate that older drivers are poor drivers. Instead, as the Insurance Institute for Highway Safety notes, the increased number of fatal crashes among older drivers is largely due to their increased susceptibility to injury. The relationship between age and motor vehicle fatality rates is also affected by the choice of measures. On a per capita basis, older drivers have a low fatality rate. However, measured on the basis of miles driven, older drivers have a high fatality rate. In fact, drivers over 85 have a higher fatality rate per mile driven than any other age group, as indicated in Figure 11.

The difference between the fatality rate per capita and per mile driven is largely due to the nature of driving among many older drivers. Although older drivers can often compensate while driving for the physical effects of aging, DMV staff indicate that a frequent response is to limit the number of miles driven, take fewer trips, use familiar routes, or drive at a time of day that is more comfortable. As a result, older persons who no longer feel comfortable driving may have "self-regulated," and become dependant upon other forms of transportation.

DMV Has the Authority to Restrict or Suspend Driving Privileges Based Upon a Medical Review. Part of DMV's role in insuring motor vehicle safety is a review of drivers who may have medical conditions that affect their abil-

Figure 11

Number of Fatal Crashes Nationally per 100 Million Miles By Age Group, 2001-2002



Source: JLARC staff analysis of Insurance Institute for Highway Safety data.

ity to drive. Data provided by DMV on licensed drivers age 60 and older indicate that at least 2,410 older persons surrendered their Virginia driver's license for medical reasons during FY 2004. This represents approximately 0.3 percent of all licensed drivers in Virginia age 60 and older. DMV data also indicate that the number of licenses surrendered for medical reasons, as a proportion of all licensed drivers in a given age range, increases with age. For example, DMV data indicate that 212 persons age 65 to 69 surrendered their driver's license for medical reasons, which equates to 0.1 percent of licensed drivers in that age range. However, among persons age 85 to 89, 403 drivers surrendered their license for medical reasons, which equates to 1.1 percent of licensed drivers in that age range. DMV data also indicate that one person over 100 years of age surrendered their license for medical reasons, and that 42 other persons in that age range retained a valid driver's license.

Information about a driver who may have a medical impairment can be submitted to the staff of DMV's Medical Review Services from a law enforcement officer, a judge, a physician, a relative, or other persons. Upon receiving the information, DMV staff make an initial assessment and determine if more information is needed, such as a medical report, a written knowledge test, a vision exam, or a follow-up road test. Although most medical reviews are conducted by DMV staff, the Commissioner may refer individual cases to the agency's Medical Advisory Board. The Board is also responsible for developing medical and health standards for use in the issuance of driver's licenses. The Board is established by § 46.2-204 of the *Code of Virginia*, which states that the Board "shall consist of seven licensed physicians currently practicing medicine in Virginia." Persons undergoing medical review may also request an administrative hearing before a DMV hearing officer.

Although physicians are encouraged to report impaired drivers to agency staff, they are not required to do so. DMV staff indicate that it would be preferable if physicians were required to report impaired drivers to DMV, and this concern was raised as part of GMU's 1999 report on driver's license options for applicants over the age of 70. The GMU report also suggests that the Board should include physicians who are knowledgeable in dementia, physical therapy, and other geriatric issues, and DMV staff have stated that the *Code* should specify which medical specialties should be represented on the Board.

Vision Testing Is Required for Persons 80 and Older. DMV has recently been required to conduct vision testing for drivers who are 80 or older, in response to House Bill 257, which was passed by the 2004 General Assembly. Drivers are required to appear in person for renewal and must either pass a vision examination, or else present a vision report by an ophthalmologist or optometrist. DMV staff state that the mandatory vision screening will also allow those staff who conduct the vision test to look for indicators of other problems, such as limited motor skills, and refer the driver to DMV's Medical Review Services staff. However, DMV staff do not currently receive any training on how to identify or assess these types of problems.

Department of Rail and Public Transportation

The responsibilities of the Virginia Department of Rail and Public Transportation (DRPT), within the Secretariat of Transportation, are set forth in Title 33.1 of the *Code of Virginia* and include the distribution of State and federal funds for public transportation in Virginia. For FY 2004, DRPT was appropriated a total of $146 million exclusively in nongeneral funds. Agency staffing for FY 2004 includes 31 full-time equivalent employees. Agency activities that are affected by older Virginians include the distribution of State and federal funds targeted to the transportation needs of the elderly and disabled.

According to the National Highway Travel Study conducted by the United States Department of Transportation, 17 percent of Virginia residents age 65 and older did not drive in 2000. For these residents, and for older Virginians who choose to limit their driving, a central component of their ability to remain independent is the availability of public transportation. DRPT's responsibilities for meeting the public transportation needs of this population are discussed in more detail below.

Local Resources Account for the Largest Share of Virginia's Public Transportation Funding. Virginia's public transportation systems are funded with a combination of State, local, and federal resources. As illustrated in Table 19, State and federal funds are used to supplement the payment of fares by users of transportation services and local investments in transportation. Together, fares and local funding constitute the largest share of all funding (57 percent) for public transportation systems in the State. In FY 2004, DRPT distributed approximately $123 million in State funds to Virginia's public transportation systems. The majority of State funds for public transportation are set aside for operating assistance, which aids public transportation providers in the operation of their services. State funds are also dedicated to capital assistance projects, which support capital improvements to transportation programs, such as the purchase of new equipment.

Table 19

Funding for Public Transportation Improvement Projects in Virginia, FY 2004

Source	Funding Amount
Federal	$147,138,998 (24%)
State	123,051,308 (20%)
Local	159,517,777 (26%)
Fares	190,505,489 (31%)
Total	**620,213,572**

Note: Cities with populations of 50,000 people or more receive direct federal support for their public transportation programs. These funds do not pass through DRPT and so are not included in the General Assembly's appropriations. DRPT does, however, collect information on direct federal funding for these localities.

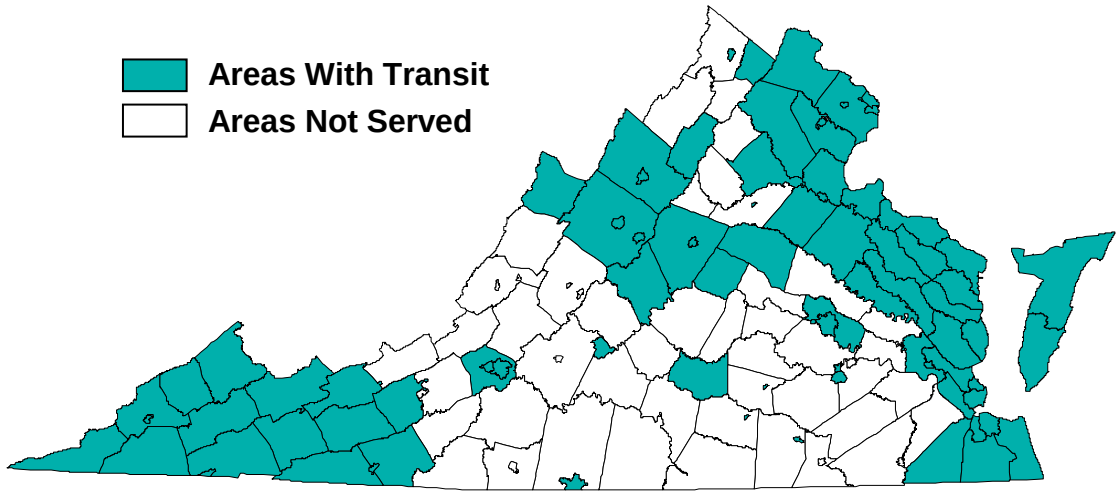
Source: Commonwealth Transportation Board FY 2004 Public Transportation Improvement Program report.

Older Persons Benefit From DRPT Funding For Local Human Services and Transit Agencies. According to DRPT staff, 83 percent of all Virginians have access to public transportation services. Further, staff stated that more than half of Virginia's transit systems "operate in rural areas where the vast majority of the riders are elderly, disabled, or otherwise transit dependent." These transit systems are supported by federal and State funding administered by DRPT, which totaled approximately $270 million in FY 2004. As shown in Figure 12, 108 Virginia localities have a public transportation system.

Both the federal and State governments also provide assistance specifically for the public transportation needs of older Virginians, although suchassistance is limited and constituted only one percent of federal and State funding for mass transit in FY 2004. The largest source of funding for these services is the federal Elderly and Persons with Disabilities Formula Program, also called Section 5310 funding (named after section 5310 in Chapter 49 of the *United States Code*.) This program, which requires a 20 percent local match, is intended to address the transportation needs of the elderly and disabled and provides funding exclusively to human service agencies like AAAs or CSBs for capital improvements to their programs. For example, in FY 2004, the Southern Area Agency on Aging in Martinsville received $127,200 for the purchase of four specially equipped vans. In FY 2004, human service transportation providers in Virginia received $1.9 million in Section 5310 funding. According to staff at DRPT, virtually every locality in Virginia is served by one or more human service agency that provides transportation for their clients. However, DRPT staff also stated that some human services agencies do not apply for this funding because they cannot provide the required 20 percent match.

Figure 12

Areas of Virginia Served by Public Transportation



Source: Department of Rail and Public Transportation.

The State also provides transportation assistance specifically for older Virginians. Since FY 2001, the General Assembly has appropriated $800,000 in State funds for the State Capital Assistance Program for Paratransit Services for the elderly and disabled. Paratransit is defined by the federal Americans with Disabilities Act (ADA) as "comparable transportation service required…for individuals with disabilities who are unable to use fixed route transportation systems." Fixed route transportation is a service that operates a traditional bus route anywhere from every six to 90 minutes depending on the location and time of day. The ADA requires that public entities operating fixed public transportation routes provide paratransit service within three-fourths of a mile of the fixed route. According to DRPT staff, the costs of operating paratransit services are between $15 and $20, compared to $2 to $3 for regular service.

Through the paratransit assistance program, the State provides financial support for making capital improvements to paratransit services, such as purchasing specially equipped vans or buses. Transportation operators receiving this assistance are required to contribute a five percent local match. While federal section 5310 funding is restricted to organizations providing human service transportation, State paratransit assistance is only available to public transportation providers.

Department of Transportation

The responsibilities of the Virginia Department of Transportation (VDOT), under the Secretary of Transportation, are set forth in Title 33.1 of the *Code of Virginia* and include the construction and maintenance of Virginia's highway systems. For FY 2004, VDOT was appropriated $73 million in State General Funds and $2.9 billion in nongeneral funds. Funding for VDOT operations is derived from a variety of sources, including State and federal gasoline taxes, vehicle title and license tag fees, a portion of the general tax revenue, and bond sales. Agency staffing for FY 2004 includes 10,522 full-time equivalent employees. Agency activities include several initiatives that are intended to account for the needs of older drivers during highway design, construction, and maintenance.

VDOT Considers Older Drivers in Developing Certain Designs and Specifications. VDOT has attempted to incorporate the views of older drivers in several of its planning and design activities. In a 1993 study, "The Transportation Needs of the Older Driver," the Virginia Transportation Research Council found that older drivers in Virginia primarily had difficulties stemming from the visibility or lack of lane markings, signs, and roadway signals. In addition, a recent study of pavement marking reflectivity found that "participating drivers over the age of 65 were generally less satisfied with the brightness of pavement markings." VDOT also gives older residents the opportunity to provide input into the agency's activities by holding public hearings.

VDOT staff have reported that the agency's efforts to incorporate the needs of older drivers in agency planning activities can be hindered by the need to coordinate State highway planning with local land development planning. As mentioned above, the Commonwealth Transportation Board's VTRANS 2025 report recognized

that better integration of transportation and land-use planning will need to occur to meet the transportation needs of Virginia's growing population of older residents. According to VDOT staff, however, because land-use decisions are made by local authorities, such integration can be difficult.

The needs of older drivers are considered predominantly in the agency's traffic engineering initiatives, according to VDOT staff, such as determining appropriate letter height on road-way signs. However, a 1999 study on older drivers conducted by George Mason University found that the current standards for letter height allow for letter heights that are too small and challenge the visual ability of many older drivers. VDOT staff indicated that federal specifications for letter-height on signs date from 30 to 50 years ago and that it may be necessary to consider increasing this standard in Virginia.

Although some standards may need to be changed, VDOT staff caution that certain recommended changes to roadway designs and specifications designed to benefit older drivers may not be feasible or necessary. For example, because some research indicates that older drivers are less likely to drive after dark, VDOT staff indicate that modifying elements of road design to better accommodate older drivers traveling at night may not be the most efficient use of resources. These staff also stated that recommendations calling for an increased use of large overhead signs to benefit older drivers may not be feasible because the supporting infrastructure for those signs may not withstand the added load in heavy winds. As a result, the total cost of larger signs may outweigh their benefit.

Most initiatives undertaken by VDOT that benefit older Virginians are not intended exclusively for this population. For example, a recent revision to the agency's policies on incorporating the needs of pedestrians and bicyclists in new road designs could benefit older Virginians who live in areas with limited public transportation options. Other examples of broader initiatives undertaken by VDOT that could benefit older drivers include using fluorescent signs in work zones and the use of reflective pavement markers on interstates and other high volume roads to improve night driving safety.

HOUSING ASSISTANCE

Older Virginians of low and moderate incomes often face a cost burden related to housing, or require assistance with needed repairs. According to DHCD's most recent Consolidated Plan, in 2002 approximately 75 percent of elderly (age 65 and older) renters and 51 percent of elderly homeowners in Virginia were low income. ("Low income" is defined as 80 percent or less of the median income for the area, adjusted for family size. Income includes wages, salary, interest, dividends, public assistance, retirement, and any other sources of income received regularly.) Funding for housing assistance for low and moderate income families and individuals is provided primarily by two State agencies, the Department of Housing and Community Development (DHCD) and the Virginia Housing Development Authority (VHDA). A large number of older Virginians have benefited from financial assis-

tance provided by these agencies. Older Virginia renters have benefited from lower rents as a result of grant or loan financing provided to developers by DHCD and VHDA in return for the construction of affordable housing units. DHCD and VHDA also provide assistance to older homeowners for home repairs in the form of grant assistance to local governments and other service providers, or home loans for repairs.

In addition to providing financial assistance for housing, DHCD and VHDA have jointly assessed the housing needs of low-income Virginians, especially the needs of the low-income elderly and disabled. Two documents resulted from these assessments, and both reports identified the need for safe and affordable housing as well as the need for supportive services that are tied to housing.

Department of Housing and Community Development

The responsibilities of the Department of Housing and Community Development (DHCD), within the Secretariat of Commerce and Trade, are set forth in Title 36, Chapter 8 of the *Code of Virginia*, and include the administration of the State's building and fire codes and the management of programs to improve housing and encourage community development. For FY 2004, DHCD was appropriated approximately $23 million in general funds and $71 million in nongeneral funds. Agency staffing for FY 2004 includes 121 full-time equivalent employees.

DHCD serves as the pass-through agency for federal and State funds for housing and community development assistance. The agency provides financial assistance to localities, developers, and other service providers that use the funding to rehabilitate or construct affordable housing. Most of the projects receiving assistance from DHCD are designed to serve low and moderate income persons, many of whom are older adults. Exhibit 4 describes DHCD programs from which older adults are most likely to receive assistance.

Elderly Households Represent at Least a Third of All Households Receiving Assistance from Most Housing Preservation Programs. The Housing Preservation Programs administered by DHCD serve a large number of elderly households, with the exception of the Lead-Safe Homes Program. In fact, more than half of the households served by the Emergency Home Repair Program in FY 2003 were elderly households, as shown in Table 20. Forty-two percent of the housing units receiving assistance from the Indoor Plumbing/Rehabilitation Program in FY 2003 were units with elderly residents, and 38 percent of the total number of households receiving weatherization assistance from both federal funding sources were elderly households.

DHCD Has Also Provided Assistance to Housing Developments Serving Older Adults. Three additional programs administered by DHCD provide assistance for multifamily housing developments, including those serving older adults. These include the Affordable Housing Preservation and Production Program

Exhibit 4

DHCD Programs that Provide Assistance to Older Adults

Affordable Housing Production and Preservation Program: Federal HOME Investment Partnership funds (including a 25 percent State match) are used to provide below-market rate loans for the acquisition, rehabilitation, or new construction of rental projects containing four or more units and congregate housing projects. These rental units are to provide housing for low and very-low income tenants. Funds from this program provide gap-financing and are intended to be used with other funding such as Low Income Housing Tax Credits, bond financing, and other sources of private or public funds.

Commonwealth Priority Housing Fund: Funds from the 2003 sale of the Virginia Housing Partnership Fund are used for a variety of housing projects that meet the needs identified in the housing needs analysis conducted by DHCD and VHDA. These funds provide gap-financing for hard-to-develop affordable housing projects. VHDA provides the funding, but DHCD determines how funds are allocated.

Community Development Block Grant Program: U.S. Department of Housing and Urban Development (HUD) Community Development Block Grant (CDBG) funds are used for competitive grants to fund projects addressing critical community development needs, including housing, infrastructure, and economic development. Eligible activities include rehabilitation, relocation, and demolition of homes and buildings. In addition, community facilities, such as senior centers, are eligible for project assistance.

Emergency Home Repair Program: State General Funds are provided to remove imminent health and safety hazards and barriers to habitability in the homes of lower income Virginians. Eligible repairs include plumbing, structural, and electrical work as well as the installation of wheelchair ramps and accessible appliances. Virginia Tax Check-off for Housing funds are also distributed through this program.

Indoor Plumbing/Rehabilitation Program: State General Funds and HOME Investment Partnership funds are used to provide zero interest, forgivable loans for the installation of indoor plumbing to lower-income owners of substandard housing where indoor plumbing does not exist or where the existing water delivery or waste disposal system has failed. This program also provides for the general rehabilitation of such units and for accessibility improvements to overcrowded units or those occupied by persons with disabilities. Indoor plumbing loans are only available to localities that are not eligible for CDBG assistance.

Weatherization Assistance Program: Federal grant funds from the U.S. Departments of Energy (DOE) and Health and Human Services (HHS) are used to reduce the heating and cooling costs and ensure the health and safety of low-income households, particularly the elderly, individuals with disabilities, and families with children. Fifteen percent of the HHS Low Income Home Energy Assistance Program (LIHEAP) funds are used for weatherization assistance. Services include sealing air leaks, repairing leaky duct systems, repairing or replacing unsafe or inefficient heating systems, and installing carbon monoxide and smoke detectors.

Source: JLARC staff analysis of information provided by DHCD staff and other agency documents.

Table 20

Assistance to Households in FY 2003 by Type of Household

Type of Household/Unit	Number Assisted	Estimated Cost of Assistance
Emergency Home Repair Program		
Households with no elderly residents	234 (47%)	$166,744 (47%)
Households with elderly residents (60 and older)	261 (53%)	185,982 (53%)
Indoor Plumbing / Rehabilitation Loan Program[1]		
Non-Elderly Units	130 (58%)	6,071,559 (58%)
Elderly Units (62 and older)	94 (42%)	4,441,817 (42%)
Weatherization Assistance Program – DOE		
Non-Elderly Households	831 (56%)	2,068,166 (56%)
Elderly Households (60 and older)	643 (44%)	1,600,278 (44%)
Weatherization Assistance Program – LIHEAP[2]		
Non-Elderly Households	1,317 (67%)	3,946,647 (67%)
Elderly Households (60 and older)	663 (33%)	1,986,808 (33%)

[1]Actual expenditures.
[2]Federal fiscal year rather than State fiscal year.

Source: Department of Housing and Community Development.

(AHPP), the Community Development Block Grant Program (CDBG), and the new Commonwealth Priority Housing Fund. Between FY 1998 and FY 2003, 48 percent ($8,417,056) of the AHPP funding was used for projects oriented toward serving older adults. Recent CDBG grants have also provided assistance to projects serving older adults. For example, in FY 2001, a CDBG grant of $769,977 was provided for apartments for the elderly in Nelson County. Also, in FY 2002, $700,000 was provided for an assisted living complex in Wise County. Finally, the Commonwealth Priority Housing Fund was created from residual proceeds of the 2003 sale of the Virginia Housing Partnership Revolving Fund to the Virginia Housing Development Authority (VHDA). VHDA provides the funding, but DHCD determines the priorities for its usage. Loans and grant funding have been allocated from this fund for projects, including $500,000 for a senior apartment complex and $500,000 for an accessible housing development for low-income seniors.

Virginia Housing Development Authority

The responsibilities of the Virginia Housing Development Authority (VHDA) are set out in Title 36, Chapter 1.2 of the *Code of Virginia*, and includes addressing the shortage of safe, sanitary, and affordable housing for persons and families of low and moderate incomes. VHDA's primary activity is providing financial assistance for affordable housing, which is done by providing single family loans to homebuyers, as well as loans and tax credits to multifamily developers. VHDA also administers federal housing vouchers (Section 8 program) and other federal rental subsidies for areas of the State that do not have local public housing agencies. VHDA was created as an independent authority and receives neither general nor nongeneral State funding to fulfill its responsibilities. Instead, VHDA generates its own revenues by issuing tax exempt and taxable bonds to fund mortgage loans. Administration of the housing voucher and Low Income Housing Tax Credit programs is carried out with federal administrative funds.

Housing Developments Serving Older Adults Have Received Tax Credits and Loan Assistance from VHDA. According to VHDA staff, older adults benefit from assistance, such as tax credits and loan financing, that VHDA provides to developers of multifamily housing. As shown in Table 21, 176 (26 percent) of the existing multifamily housing developments that have received federal Low Income Housing Tax Credits (LIHTC) from VHDA are developments serving older adults. Since it was created in 1972, VHDA has provided loan assistance to 971 affordable multifamily housing developments of which 143 (15 percent) are housing developments serving older adults. VHDA loans can be financed through several means, including from the sales of taxable and tax- exempt bonds and funding from the Virginia Housing Fund. In many cases, these funding sources, including the tax credits, can be used together, or in combination with funding from DHCD. Exhibit 5 pro-

Table 21

Multifamily Housing Developments That Have Received Assistance From VHDA

Type of Development	Number of Developments	Number of Rental Units
Federal Low Income Housing Tax Credit		
Senior Developments (55 and older)	176 (26%)	12,504 (21%)
Other Family Developments	493 (74%)	47,823 (79%)
Loan Assistance		
Senior Developments	143 (15%)	13,564 (17%)
Other Family Developments	828 (85%)	68,261 (83%)

Source: Virginia Housing Development Authority.

vides a brief description of the funding sources that have been used to finance housing developments for older adults.

VHDA's Single Family Loan Programs Mostly Serve First-Time Homebuyers, Few of Whom Are Older Adults. According to agency staff, VHDA's single-family loans primarily serve first-time homebuyers. Federal law restricts the use of tax-exempt bonds to financing first-time homebuyer programs except in federally designated targeted areas. Because a large proportion of older adults already own their homes, few have benefited from VHDA's tax-exempt single family loans. In addition, VHDA's taxable bond financing primarily serves first-time homebuyers

Exhibit 5

Description of VHDA Multifamily Financing for Housing for Older Adults

Low Income Housing Tax Credit: Nine percent and four percent tax credits are provided to multifamily housing developers. The developers can sell these tax credits to reduce the amount of funding needed to borrow and lower the rental cost of the units. Nine percent credits are competitively allocated once a year. Under federal law, nine percent credits cannot be combined with tax-exempt bond financing. Instead, users of tax-exempt bonds are automatically eligible for four percent credits, which are available at any time, but on a first-come, first-served basis. The 2004 qualified allocation plan (QAP) for allocating the nine percent credits allocates up to 20 percent of the credits to be used for housing developments for older adults. LIHTCs are used to encourage new construction and rehabilitation of existing rental housing for low-income households.

SPARC: The Sponsoring Partnerships and Revitalizing Communities fund was created in May 2002 with VHF and tax-exempt bond funds. Loans from this fund are used for housing needs identified in the Housing Needs Assessment. One of the goals of the fund is to provide housing for special needs populations, including the elderly.

Taxable Bonds: Mortgage loans financed with taxable bonds carry a market rate of interest, but provide terms and conditions not generally provided by private lenders. Taxable bonds are used to finance construction, rehabilitation, or recapitalization of rental housing. These loans can be used to finance developments receiving the nine percent tax credits.

Tax Exempt Bonds: Mortgage loans financed with tax-exempt bonds carry a below-market rate of interest, and provide terms and conditions not generally provided by private lenders. Tax exempt bonds are used to finance construction, rehabilitation, or recapitalization of rental housing. These loans typically provide assistance for rental projects with 50 or more units and can be used along with the four percent tax credits.

Virginia Housing Fund: Loans from this fund are used to finance housing that serves very low income households and populations with special needs, such as the elderly, disabled, and homeless. These populations typically cannot be served using bond-mortgage programs because of risk limitations or the scale of development.

Source: JLARC staff analysis of information provided by VHDA staff and documents.

needing no-down payment loans. However, VHDA does offer several types of assistance to existing homeowners from which older adults benefit, and provides funding for reverse mortgage counseling.

The home repair, improvement, and accessibility loan program is a small program that serves low and moderate income homeowners. In FY 2003, VHDA issued a total of 19 home repair loans, of which five loans totaling $61,278 were to homeowners age 60 and older. According to VHDA staff, this program has not been expanded because federal reverse mortgage programs, as discussed below, are available. VHDA staff state that much of the unmet need for home repair is among homeowners who cannot afford a loan and would be better served by grant assistance. While VHDA does not provide grants, this type of assistance is available through the Emergency Home Repair Program, which is administered by DHCD.

VHDA has the authority to provide loans to non-first-time homebuyers in federally designated Areas of Chronic Economic Distress (ACED), which includes much of southwestern Virginia as well as certain urban areas. While taxable bond financing primarily serves first-time homebuyers, VHDA can also use this financing to serve non-first-time homebuyers. According to VHDA data, out of a total of 4,108 homeowner loans closed in FY 2003, 71 loans were issued to borrowers age 60 and older for a total of approximately $6.4 million.

Although VHDA no longer provides home equity conversion mortgages (HECM), also known as reverse mortgages, it provides funding for HECM counseling to counseling agencies in Virginia that are approved by the U.S. Department of Housing and Urban Development (HUD). Reverse mortgages allow older adults to use the equity in their home for financial security, including covering the costs of health care. To qualify for a reverse mortgage, the homeowner(s) must be at least 62 years old and live in a single family home that is either owned outright or the mortgage has a small balance. In addition, HUD requires that homeowners receive counseling from a HUD-approved counseling agency. According to HUD, 422 elderly households in Virginia received reverse mortgages in 2003.

Thirteen Percent of Households Receiving Housing Vouchers Are Older Adults. The federal housing voucher program (Section 8 program) provides rental subsidies (vouchers) directly to low income families, the elderly (age 62 and older), and people with disabilities. Voucher recipients are required to pay 30 percent of their income in rent and the voucher subsidizes the remaining rental cost. The current program is referred to as tenant-based because the tenant receives the voucher and must contract with a landlord who is participating in the program.

Thirteen percent of the total households that benefit from the voucher program are elderly-headed (adults age 62 and older), as indicated in Table 22. However, only six percent of the total number of household members that benefit from the voucher program are elderly, because elderly-headed households typically have fewer members than other households. In addition, monthly rental payments are higher for elderly voucher recipients, on average, as indicated in the table.

Table 22

Characteristics of Housing Voucher (Section 8) Recipients in Virginia

Characteristic	VHDA Administered Vouchers	Total Vouchers Administered in Virginia
Estimated Number of Households Receiving Voucher[1]		
Non-Elderly Headed Households	8,036 (87%)	38,327 (86%)
Elderly Headed Households	1,187 (13%)	6,168 (14%)
Ranges of Average Monthly Tenant Payments[2]		
Non-Elderly Tenant	$169 - $251	$204 - $270
Elderly Tenant	$198 - $257	$213 - $330

[1] Percentages are as reported by the U.S. Department of Housing and Urban Development.
[2] HUD reported averages for elderly and non-elderly households, with and without children, and with and without disabilities. The lowest average monthly payments were for disabled households without children, and the highest payments were for disabled households with children.

Source: JLARC staff analysis of U.S. Department of Housing and Urban Development data on Section 8 voucher resident characteristics as of July 31, 2004.

Elderly households with or without children who received vouchers administered by VHDA have higher average monthly rental payments than non-elderly households with or without children. This may indicate that elderly households receiving vouchers have higher incomes, on average, than non-elderly households receiving vouchers, because voucher recipients are required to pay 30 percent of their monthly income toward the rental payment.

Vouchers are locally administered on behalf of the U.S. Department of Housing and Urban Development (HUD) by 43 public housing agencies (PHAs) and VHDA. In Virginia, PHAs provide vouchers to recipients primarily in metropolitan areas. In areas of the State not served by a PHA, which primarily consist of suburban counties, small cities, and rural areas, VHDA provides housing vouchers, which currently serve 1,306 elderly persons. According to VHDA's Annual Plan for FY 2005, 372 households with elderly residents are on waiting lists for housing vouchers. VHDA staff indicated that waiting lists are often closed, meaning that persons may be in need of vouchers but are not included on the list.

VHDA also provides monthly rent subsidies to owners of developments, and 5,869 elderly-headed households benefited from these subsidies. These rental subsidies are provided to owners of developments which received VHDA-financing through HUD's former project-based Section 8 and the Section 236 programs. Under these programs, developers were able to receive low-interest loans for the construction or renovation of housing to serve low-income tenants. In addition, rent subsidies were provided to cover the difference between the rent amount paid by the

tenant (30 percent of income) and the total rent amount for the unit. While these programs have been phased out, owners of the developments entered into contracts with HUD to continue providing low-income housing. The terms of the contracts ranged from 15 to 40 years, and many owners of the developments are still receiving rental subsidies.

Housing Needs of Older Virginians Have Been Jointly Assessed by DHCD and VHDA

In the past several years, DHCD and VHDA have been directed to jointly assess housing needs of low-income Virginians, particularly those of the elderly and disabled. Safe, affordable, and accessible housing as well as supportive services tied to housing were identified as needs of older persons, especially as the number of elderly-headed households has increased, and as more older adults are expected to "age in place" by remaining in their homes as they age. These assessments have resulted in the following documents:

- "Analysis of Housing Needs in the Commonwealth", prepared by DHCD and VHDA in November 2001 at the request of the Secretary of Commerce and Trade, and

- "An Analysis of Means and Alternatives for Expanding Affordable, Accessible Housing for Persons with Disabilities and Frail Elders Statewide," prepared for DHCD and VHDA pursuant to HB 813, HJR 236, and HJR 251 of the 2002 session.

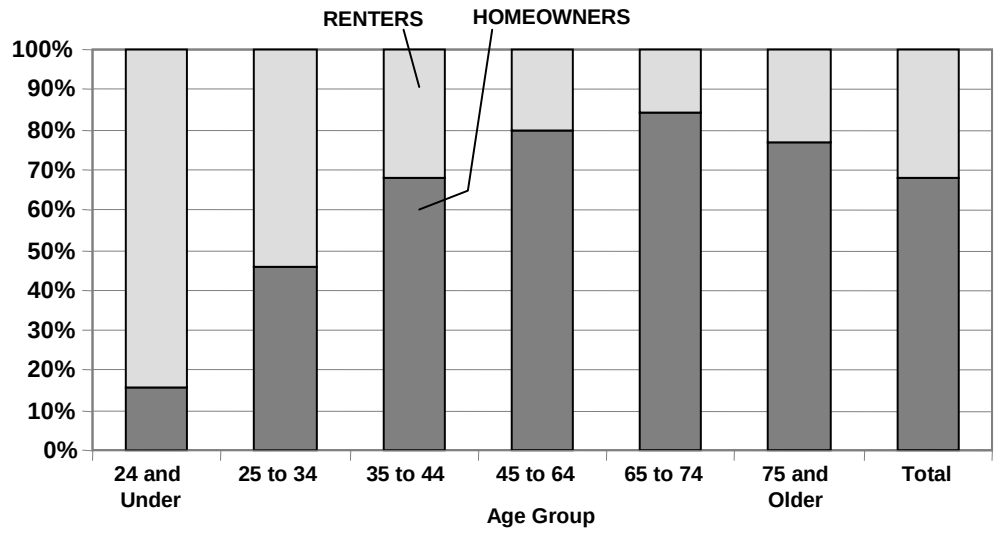
In addition to these assessments, DHCD is required by the U.S. Department of Housing and Urban Development (HUD) to prepare a consolidated plan in order to participate in certain federal grant programs. The Consolidated Plan for 2004-2007 also included information on the housing needs of older Virginians. Similar issues were raised in all three documents, including the lack of affordable and accessible housing for older adults, particularly for older renters, and the increasing numbers of older householders, especially for those age 75 and older.

Elderly Public Assisted Housing Units Represent One-Fourth of All Public Assisted Housing Units in Virginia. According to federal and state data compiled by DHCD and VHDA, there were 23,105 low-income elderly independent living units in 2000, representing 23 percent of the total number of low income units receiving federal and State rental housing assistance. The total housing stock in Virginia, according to the 2000 Census, was over 2.9 million, of which public housing represented less than four percent. According to more recent VHDA data, there are approximately 27,569 low-income elderly independent living units in Virginia.

Most Older Adults Own Their Homes, and Homeownership Rates Have Increased for Older Adults. As shown in Figure 13, 84 percent of adults age 65 to 74 own their own homes, as do 77 percent of adults age 75 and older. Between 1990 and 2000, homeownership rates for adults age 65 to 74 increased by 2.8 percentage points, and by 3.3 percentage points for adults age 75 and older. In addi-

Figure 13

Household Types in Virginia, by Age Group, 2000



Source: JLARC staff analysis of Census 2000 data and Housing Needs Analysis data.

tion to the increase in homeownership rates, the number of households headed by persons age 65 and older increased by 19 percent during that time, and the number of households headed by persons age 75 and older increased by 38 percent.

A Lack of Housing Combined with Supportive Services Exists for Persons with Special Needs, Including the Frail Elderly. DHCD and VHDA have raised concerns regarding the availability of housing combined with supportive services for persons with special needs, including persons age 85 and older. After age 85, increasing frailty often results in the need for more supportive services, and the frail elderly may require facilities that can provide both housing and health services, especially if these Virginians wish to avoid entering a nursing home.

DHCD and VHDA staff indicate that federal funding streams for housing and supportive services have historically been provided separately and are difficult to combine. This is especially apparent in financial assistance for the development of assisted living facilities (ALF). Financing for the development of ALFs is available through tax-exempt bonds and tax credits provided by VHDA. However, VHDA reported that development costs represent only 20 percent of total facility expenses, including rental costs. As a result, financial assistance for development costs alone will not lower the rental costs to a level affordable for many low-income older Virginians relying on Auxiliary Grants.

Many Older Adults Face a Cost Burden Related to Housing. DHCD and VHDA also indicate that special populations on fixed incomes, including the elderly, are experiencing a gap between their financial resources and housing costs, because housing costs are rising faster than their incomes. For example, elderly

renters often face a "severe" cost burden for rental housing, which is defined by HUD as rent that exceeds 50 percent of gross income. According to VHDA staff analysis, the 2001 average fair market rent in Virginia for a one-bedroom apartment was $599 per month, and a single person of any age receiving the maximum SSI monthly payment ($531 in 2001) would have a cost burden of 113 percent. JLARC staff estimate that an adult age 65 and older whose only income was OASDI benefits (average monthly payment of $821 in 2001 for Virginia) would have a cost burden of 73 percent, on average. According to the "Analysis of Housing Needs in the Commonwealth":

> There is no housing market in the State in which a disabled person dependent on Supplemental Security Income (SSI), a senior dependent on Social Security benefits, or a minimum wage worker, can afford an adequate one-bedroom apartment at the prevailing market rent.

In addition, the assessments indicated that elderly and other persons living on fixed incomes often live in substandard housing and do not have the resources for necessary repairs or for modifications to make housing more accessible.

SERVICES TO GOVERNMENT EMPLOYEES AND RETIREES

Virginia's older population, those persons age 60 and above, has been increasing at a faster rate than the population as a whole, and these trends have been more pronounced in the State and local government workforces than in the nongovernmental workforce. A greater proportion of the State workforce is over the age of 60 than in Virginia's private sector workforce, reflecting the fact that government workforces tend to be older than the private sector workforce. According to the Department of Human Resource Management, as the average age of the State workforce has increased, the cost of providing health care benefits has increased as well. Additionally, about seven percent of the State workforce is presently eligible to retire with full benefits. Once State or local government employees retire, they turn to the Virginia Retirement System for services related to the administration of retirement benefits. Although the average age of the State workforce has been increasing, more employees are retiring at a younger age than in previous years. This trend may be explained in part by several changes in the benefit structure which have allowed State and local government employees to retire at an earlier age.

Department of Human Resource Management

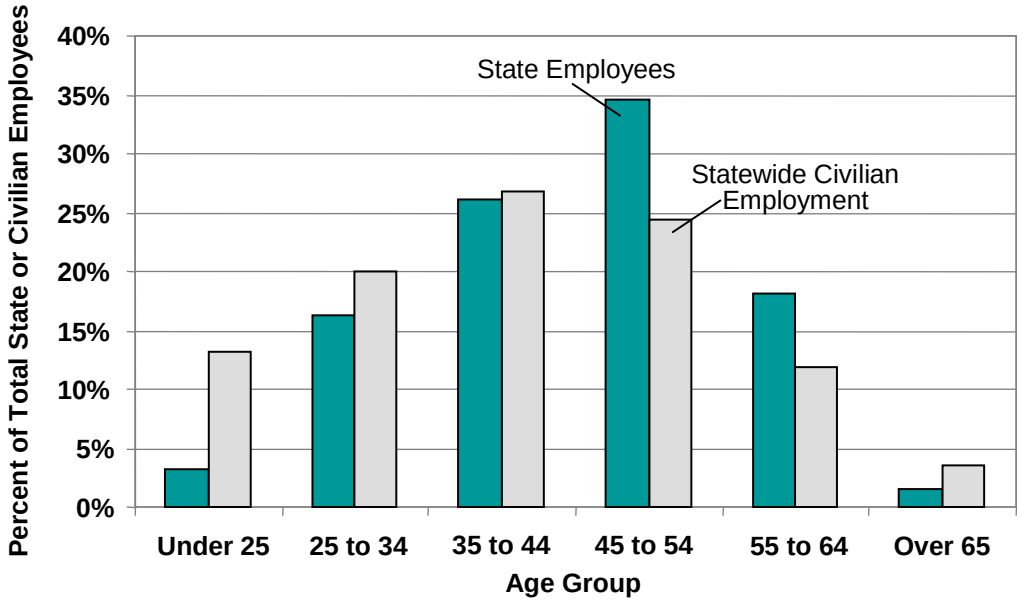
The responsibilities of the Department of Human Resource Management (DHRM) are set forth in Title 2.2, Chapter 12 of the *Code of Virginia*, and include the administration of the State's health insurance plans, workers compensation program, and the Commonwealth's Personnel Act. The agency also provides expertise to other agencies in the areas of compensation, equal employment compliance, and human resources policy and training, as well as information about the State's work force. For FY 2004, DHRM was appropriated approximately $4.2 million in general

funds, and $3.1 million in nongeneral funds. Agency staffing for FY 2004 includes 94 full-time equivalent employees. Agency activities that are affected by older Virginians include workforce planning, the administration of health benefit plans, and management of the voluntary long-term care insurance program.

The Average Age of the State Workforce Is Increasing. As of July 31, 2004, the State workforce ranged in age from 16 to 86, with an average age of 45. Since FY 1991, the average age of the State workforce has increased by four years. Approximately seven percent of the State workforce is 60 years of age or older, and a greater proportion of State employees are between the ages of 45 and 64 than in Virginia's overall employed labor force (Figure 14). This pattern is typical of government workforces, which tend to be older than the private sector workforce. In addition, the proportion of workers age 45 and older has been increasing faster in the government workforce than in the private sector. Approximately seven percent of the State workforce are presently eligible for retirement with unreduced benefits. This number includes persons who attained eligibility sometime in the past, but did not actually retire.

Figure 14

State Classified Employment Compared to Statewide Civilian Employment in Virginia, by Age Group



Note: Civilian employment includes State employees. Civilian employment is defined to include all persons 16 years of age and older who are not inmates of institutions (for example, penal and mental facilities and homes for the aged), and who are not on active duty in the Armed Forces. Civilian employment data are for calendar year 2003, and State Classified data are for July 2004.

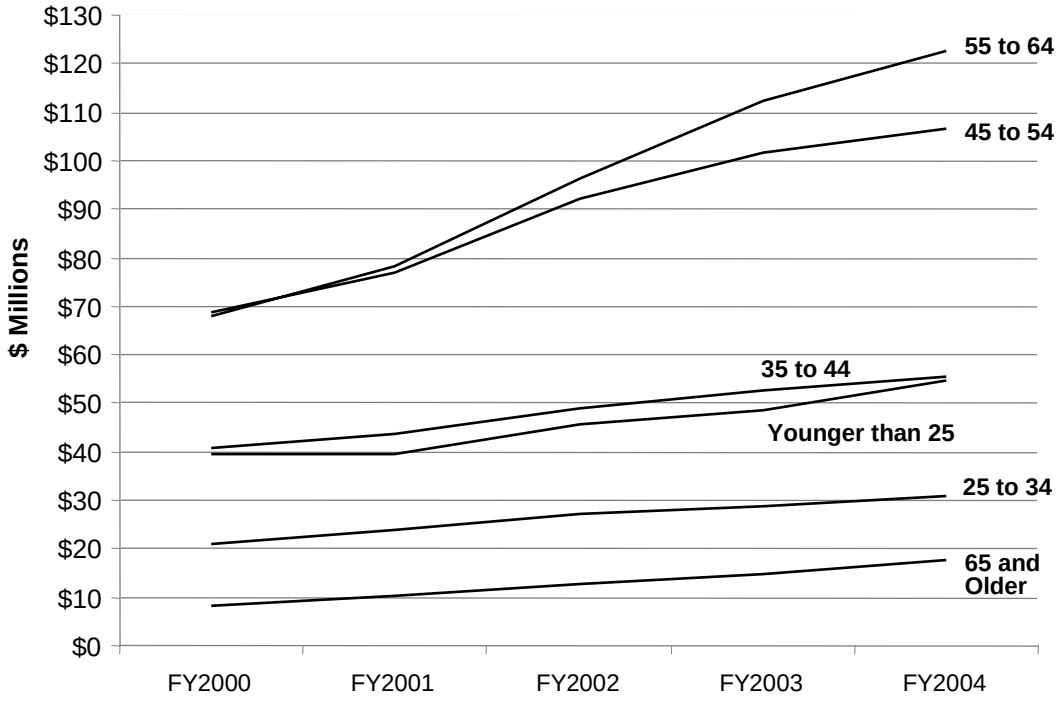
Source: JLARC staff analysis of data from Virginia's Department of Human Resource Management and the U.S. Bureau of Labor Statistics on employment in Virginia, categorized by age groups.

The Cost of State Employee Health Benefits Is Increasing as Plan Members Age. DHRM is responsible for developing and administering the State's health plans for active and retired employees of State agencies, local governments, and school boards, as well as local constitutional officers. Between FY 2000 and FY 2004, the total medical cost of the State's health plan increased by 58 percent, from approximately $246 million to $388 million. As shown in Figure 15, since FY 2000, persons between the ages of 45 and 64 have represented an increasingly larger proportion of claims, and the cost of providing health services to these age groups has been increasing more rapidly than for younger age groups. According to a December 2003 DHRM report, a "rise in both the average length of a hospital day and the cost per admission is due in part to an increasingly older employee population." Other factors include higher inpatient and outpatient facility expenses and increasing pharmacy costs.

Figure 16 shows the distribution of plan members by age for FY 2004, and the percentage of claims that are attributable to each age group. Although persons who are age 65 or older have a higher average cost per person than other age groups, they account for only four percent of the total cost. Persons between the ages of 45 and 64 have a lower average cost per person than older persons, but their total cost

Figure 15

State Health Plan: Total Medical Expenses by Age Group

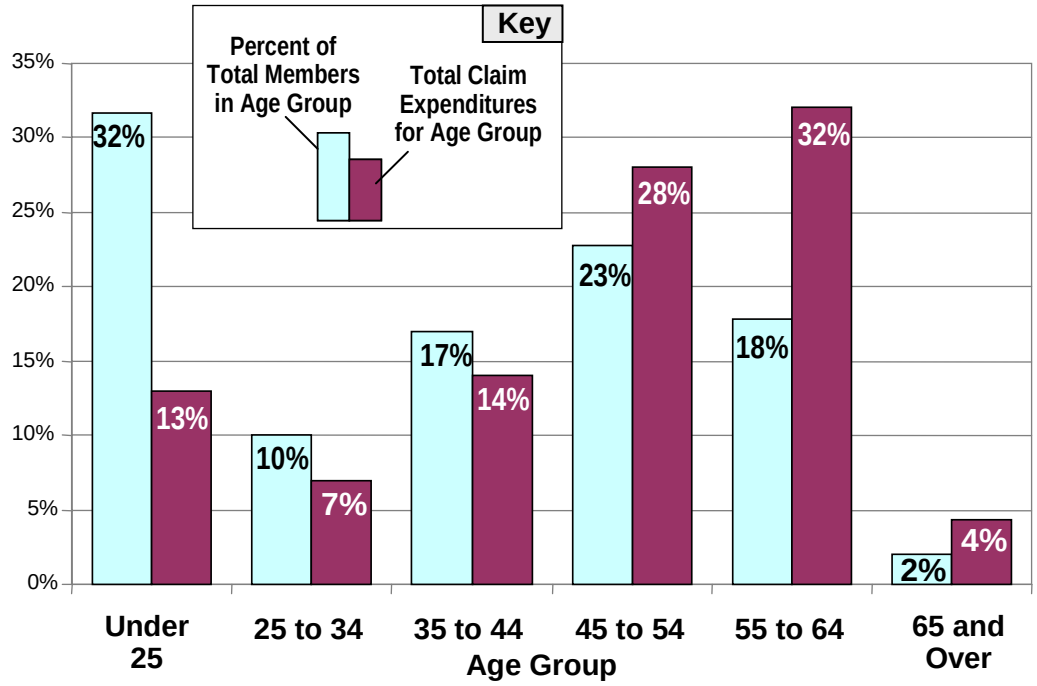


Note: Excludes data on expenditures for prescription drugs, which were not available by age for FY 2000 – FY 2002.

Source: JLARC staff analysis of Department of Human Resource Management data.

Figure 16

State Health Benefits Program: Percentage of Claims, by Age Group, FY 2004



Source: Department of Human Resource Management.

is higher than younger age groups. Persons between the ages of 45 and 64 also account for 60 percent of the cost of all claims, although they account for only 41 percent of health plan members.

Few State Employees Have Purchased Optional Long-Term Care Insurance. In addition to the automatic long-term care insurance program administered by the Virginia Retirement System, DHRM has administered a voluntary long-term care insurance program since July 1, 2000. Those eligible for the program are able to choose daily benefit options ranging from $50 to $200. Long-term care insurance provides benefits that cover a wide range of supportive, medical, personal and social services for people who need assistance for an extended period of time.

Voluntary coverage may be purchased by State employees and retirees, employees of local governments and school systems, and eligible family members. As of July 1, 2004, certain former State employees may also purchase the voluntary coverage. Premium rates are based upon the employee's age at the time of enrollment, and do not increase as the employee ages. Employees enrolled in the volun-

tary program are responsible for all payments, and eligible family members may enroll even if the employee or retiree decides not to participate. As of June 2004, 4,467 active employees and their eligible family members were enrolled in the voluntary long-term care insurance program administered by DHRM. Another 244 retirees and their eligible family members were also enrolled.

Virginia Retirement System

The *Constitution of Virginia* requires that the General Assembly maintain a retirement system for State employees and employees of participating local governments and school divisions. This retirement system is administered by the Virginia Retirement System (VRS), an independent State agency, and the system's retirement benefit and membership structure are enacted through legislation. VRS is responsible for administering retirement programs, managing investments, and assisting members of the retirement system, as well as retirees and employers. These responsibilities are set forth in Title 51.1 of the *Code of Virginia*. For FY 2004, VRS was appropriated $250,000 in general funds, and approximately $29.8 million in nongeneral funds. (In addition to VRS agency funding, VRS receives monthly payments from each participating employer for the employer and employee contributions to retirement. Participating employers also make other payments that are received by VRS. For example, for FY 2004, the Appropriation Act provides approximately $69.3 million in funding for the State share of the employer's retirement cost for instructional personnel.) VRS's agency staffing for FY 2004 includes 233 full-time equivalent employees.

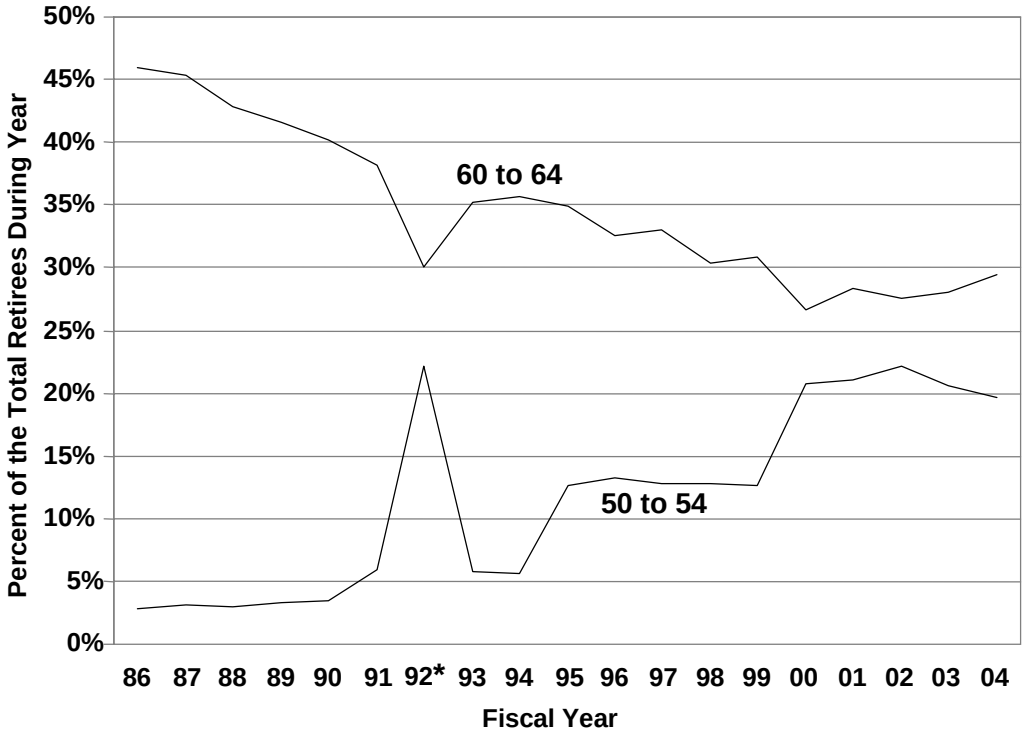
VRS administers four pension programs for public employees. The first program, which is provided for State employees, public school board employees, and employees of participating political subdivisions, is referred to by the same name as the agency itself (i.e., the Virginia Retirement System). Additionally, the agency also administers the State Police Officers' Retirement System (SPORS) for state police officers, the Virginia Law Officers' Retirement System (VaLORS) for designated State law enforcement and correctional officers, and the Judicial Retirement System (JRS) for judges. For the remainder of this section, the term "VRS members" refers to members of all four pension programs unless otherwise stated.

VRS Members Are Retiring at a Younger Age. An analysis of data provided by VRS indicates that VRS members are increasingly retiring at a younger age than in previous years. For example, in FY 1986, approximately 46 percent of VRS members (excluding members of SPORS, VaLORS, and JRS) retired between the ages of 60 and 64, compared to only three percent between the ages of 50 and 54. However, as indicated in Figure 17, this pattern has changed dramatically, and during FY 2004 only 29 percent of members retired between the ages of 60 and 64. In contrast, 20 percent of all members now retire between the ages of 50 and 54.

The trend toward a younger age at retirement may be explained by several changes in the benefit structure which have allowed VRS members to retire at an earlier age. In 1987, the age at which State employees and teachers became eligible for full (unreduced) retirement benefits was lowered from 60 years of age to 55, and

Figure 17

Annual Distribution of Retirees by Age at Retirement
FY 1986 – FY 2004



* The sharp changes in 1992 were in response to an early retirement incentive program that was implemented by the State.

Note: Other cohorts are not shown above, in order to simplify this chart. However, data indicating the change that occurred in the other cohorts follow: in FY 1986, 4 percent of retirees were under the age of 50, and this remained unchanged in FY 2004; in FY 1986, 21 percent of retirees were between the ages of 55 and 59, and this increased to 31 percent by FY 2004; in FY 1986, 27 percent of retirees were over age 64, and this decreased to 16 percent in FY 2004.

Source: JLARC staff analysis of Virginia Retirement System data.

then lowered again to 50 years of age in 1999. Although the retirement age has been lowered, employees are still required to have 30 years of service in order to qualify for unreduced retirement benefits. Additionally, in 1995 VRS members became eligible for a reduced retirement benefit at age 50, if they had earned ten years of service.

The purchase of prior service, which allows members to become eligible to receive retirement benefits at an earlier point in their career, may also contribute to a younger age at retirement. The ability to purchase prior service has been increased several times since the 1980s, and VRS members may purchase up to four years of credit for military or other public service employment and apply these years

to their total years of service. According to VRS staff, these changes have likely enabled members to retire at younger ages, although no data are available to indicate the extent of this relationship. During FY 2003, State employees, teachers, and employees of political subdivisions who were eligible for this benefit purchased an average of 15, 18, and 17 months of prior service, respectively.

As indicated in Table 23, VRS had a total of 317,343 active members as of May 2004, and 5.5 percent of all members were eligible for unreduced retirement benefits. All elementary and secondary school teachers are members of VRS, and slightly less than 7,000 teachers statewide had a sufficient number of years of service to qualify for full retirement benefits. Teachers also represent the largest group of active members, with 135,340 persons, or 43 percent of all members. Employees of political subdivisions constituted 29 percent of all members, and State employees constituted 24 percent.

Approximately Ten Percent of Retirees Choose the Advance Pension or Partial Lump-Sum Options. Upon retirement, VRS members presently have four options for receiving retirement benefits. Two of these options, the basic benefit and the variable survivor option, provide a uniform annuity to retirees throughout retirement. The other two options – the advance pension and the partial lump-sum (PLOP) – allow retirees to choose a higher payment during the early years of their retirement, followed by a reduced payment in later years. According to data provided by VRS, during the last ten years approximately ten percent of retirees have chosen one of the latter two options. The intent of the advance pension (level income) option is to provide a level benefit throughout retirement by increasing the monthly VRS benefit in the early years based upon the retiree's estimated Social Security benefit, and then reducing the monthly VRS benefit once the retiree reaches

Table 23

VRS Members Eligible for Unreduced Retirement (May 2004)

Retiree Category	Active Membership	Number Eligible for Unreduced Benefits	Percent Eligible for Unreduced Benefits
Teachers	135,340	6,931	5.1%
Political Subdivisions	93,388	4,358	4.7
State Employees	76,889	5,491	7.1
VaLORS	9,571	457	4.8
SPORS	1,757	230	13.1
JRS	398	72	18.1
TOTAL	317,343	17,539	5.5

Source: Virginia Retirement System.

the age where he or she may begin to collect Social Security. (This option was removed by the 2001 General Assembly, but was subsequently restored during the 2003 Session.) The Partial Lump-sum Option (PLOP) allows a member who works beyond the date they qualify for unreduced retirement to elect a partial lump sum payment payable at retirement. The member's monthly benefit is then reduced to reflect the amount of the lump sum payment.

The PLOP gives employers the benefit of retaining experienced workers rather than losing them to retirement, and both the PLOP and the advance pension option give employees the flexibility of receiving a temporary increase in the retirement benefit at the time they retire. However, VRS staff expressed concern that some retirees are not using the advance pension and PLOP options as planning tools, and instead are attempting to maximize the amount of benefits they can get shortly after retirement. As a result, VRS staff note that some retirees express surprise when their monthly benefit is reduced in subsequent years.

Most Retirees Receive a Health Insurance Credit. Retired State employees, eligible retired teachers, and other employees with at least 15 years of total service are eligible to receive a monthly health insurance credit. This credit is payable to retirees enrolled in the State's group health insurance plan or any other health insurance plan, and has a maximum monthly amount of $120 for State employees ($75 for teachers). As indicated in Table 24, as of May 2004 approximately 58 percent of all retirees were receiving some amount of health care credit. However, this percentage varies significantly between retiree groups, ranging from a low of 13 percent for political subdivision retirees to a high of 83 percent for State Police officers. According to VRS staff, one explanation for the lower percent of political subdivision retirees receiving the health insurance credit is the fact that the bene-

Table 24

Retirees Receiving Health Care Credit (May 2004)

Retiree Category	Number of Retirees	Number Receiving Health Care Credit	Percentage Receiving Health Care Credit
Teachers	47,728	32,797	69%
State Employees	38,326	28,064	73
Political Subdivisions	25,430	3,264	13
VaLORS	979	793	81
SPORS	866	715	83
JRS	388	259	67
TOTAL	113,717	65,892	58

Source: JLARC staff analysis of Virginia Retirement System data.

fit is elective on the part of the political subdivision employer, and only a small number of employers in this group have elected to participate in the program.

Few Members Have Received Benefits from the VRS Long-Term Care Insurance Program. In addition to the voluntary long-term care insurance program administered by the Department of Human Resource Management, VRS also manages a long-term care insurance program as part of VSDP. VRS staff indicate that only seven State employees qualified for benefits from this program in FY 2003. Since March 2002, long-term care insurance has been automatically available at no cost to members who participate in the Virginia Sickness and Disability Program (VSDP). (VSDP is available to full-time and part-time salaried State employees, in addition to qualified State Police officers and faculty at institutions of higher education.) Long-term care refers to a wide range of supportive, medical, personal and social services for people who need assistance for an extended period of time.

The VSDP policy, which has a two-year lifetime maximum, pays a daily benefit amount of $75. Employees become eligible for benefits when they become unable to perform two of six activities of daily living (ADL), such as bathing, dressing, eating, or toileting, or when the employee has a severe cognitive impairment, like Alzheimer's. The policy is also portable – when an employee leaves State service, or when a member retires, they may continue their coverage under the program provided they assume responsibility for the payment of the premium. The premium is determined based on the age of the individual at the time of enrollment in the plan and the premium rate at the time of retirement or separation from service. For employees leaving State service, the premium is based upon the employer's cost at the time of the employee's termination from State service. According to VRS staff, a total of 121 VSDP participants have opted to retain their coverage after termination or upon retirement.

CONCLUSION

This chapter has inventoried some of the existing State government services that are provided to older Virginians. Several functional areas in which State government currently has a role have been discussed, including aging network services, mental and physical health services, transportation and mobility services, housing assistance, and workforce and retirement services for State employees.

This preliminary overview shows that there is a wide range of existing State activities that provide services to the elderly, that some of these services are inter-related, and that there are presently some areas of unmet need that could present an even greater challenge as the elderly population grows. This overview also indicates that services provided to older persons can be more costly than those provided to younger persons, even for State agencies that primarily serve younger Virginians.

The final report will provide more information on the current impact of older Virginians on State agency services. It will also further examine some of the trends, patterns, and potential problem areas that the State may need to address in order to meet the service demands of an increasingly elderly population in the future.

Appendix A: Study Mandate

House Joint Resolution No. 103

2004 Session

Directing the Joint Legislative Audit and Review Commission to study the impact of Virginia's aging population on the demand for and cost of state agency services, policies, and program management.

WHEREAS, the 2000 census reported there were 1,065,502 persons who were age 60 or older in Virginia, comprising 15.1 percent of the state's population, and of that number, 87,266 Virginians were age 85 and older, comprising 8.2 percent of this older population and 1.2 percent of the total population of the Commonwealth; and

WHEREAS, Virginia's older population, those age 60 and above, increased by 17.1 percent between 1990 and 2000, growing from 909,906 to 1,065,502 individuals; and the population of Virginia age 75 and older increased at an even faster rate, 36.4 percent between 1990 and 2000, growing from 263,848 to 359,877 individuals; and

WHEREAS, Virginia's older population is projected to increase at even faster rates over the next 30 years, growing to 1,540,299 (19.91 percent of the total population) by 2010; to 2,101,193 (25.49 percent) by 2020; and to 2,611,774 (25.73 percent) by 2030; and

WHEREAS, the distribution of older Virginians varies tremendously across the State, ranging from 7.6 percent of the population in Prince William County to 23.7 percent in the Middle Peninsula and Northern Neck, with consequent disparate economic impacts and widely varying demands for services in different localities; and

WHEREAS, the growth of the older population also is projected to vary dramatically across the Commonwealth, such that those areas with higher concentrations of "baby boomers" in 2000 relative to the existing population age 60 and above will experience significantly greater increases in the older population beginning in 2006, when the first "baby boomers" turn 60 years of age (for example, Prince William County has more than four times as many "baby boomers" as persons age 60 and older, while the Eastern Shore has almost the same number of each); and

WHEREAS, in the 2000 census, 149,726 Virginians (19.9 percent of the population age 65 and over) reported having one sensory, physical, mental, self-care, or go-outside-of home disability and 167,359 (22.2 percent of the older population) reported having two or more such disabilities; and WHEREAS, the health risk conditions of older Virginians (age 65 and above) have increased between 1995 and 2001, for example, the percentage of those overweight grew from 39.2 to 40.5 percent and the percentage of those engaging in chronic drinking (60 or more alcoholic drinks per month) grew from 1.0 to 2.7 percent; and

WHEREAS, this growing older population, increasing dramatically in numbers as well as longevity, will experience ever greater needs of services, ranging from nursing home and assisted living arrangements to the services and supports needed for older persons to remain in their homes or in their communities and including increasingly complex and expensive health care, more frequent and intensive social services, expanded and more elaborate state facility and community geriatric mental health services, and enhanced advocacy and legal services; and

WHEREAS, for example, the Virginia Department for the Aging identified the following monthly unmet needs for services in 2002: 37,161 hours of adult day care, 129,705 home-delivered meals; 54,350 hours of homemaker services; 25,332 hours of personal care services; 507 homes in need of repairs; and 11,502 transportation trips; and

WHEREAS, state and local government workforces reflect these demographic trends, and, as a result, a growing proportion of public employees will be retiring in the next 10 years, with concomitantly increasing demands on the financial resources of the Virginia Retirement System and the state and local governments that support it; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Joint Legislative Audit and Review Commission be directed to study the impact of Virginia's aging population on the demand for and cost of state agency services, policies, and program management. In conducting its study, the Joint Legislative Audit and Review Commission shall consult with the Commonwealth Council on Aging, the Commissioners of the Departments of Health and Mental Health, Mental Retardation and Substance Abuse Services, the Department of Social Services, the Department for the Aging, the Department of Medical Assistance Services, the Department of Corrections, the Department of Human Resource Management, and the Director of the Virginia Retirement System. Technical assistance shall be provided to the Joint Legislative Audit and Review Commission by the Commonwealth Council on Aging. All agencies of the Commonwealth shall provide assistance to the Joint Legislative Audit and Review Commission for this study, upon request.

The Joint Legislative Audit and Review Commission shall complete its meetings for the first year by November 30, 2004, and for the second year by November 30, 2005, and the Chairman shall submit to the Division of Legislative Automated Systems an executive summary of its findings and recommendations no later than the first day of the next Regular Session of the General Assembly for each year. Each executive summary shall state whether the Joint Legislative Audit and Review Commission intends to submit a document of its findings and recommendations to the Governor and the General Assembly. The executive summaries and the documents shall be submitted as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents and reports and shall be posted on the General Assembly's website.

Appendix B

Agency Responses

As part of an extensive data validation process, the major entities involved in a JLARC assessment effort are given an opportunity to comment on an exposure draft of the report. Appropriate technical corrections resulting from the written comments have been made in this revision of the report.

This appendix contains the written responses of the Department for the Aging and the Department of Social Services.

COMMONWEALTH OF VIRGINIA

Department for the Aging

Jay W. DeBoer, J.D., Commissioner

October 1, 2004

Philip A. Leone, Director
Joint Legislative Audit and Review Commission
Suite 1100, General Assembly Building
Richmond, Virginia 23219

Dear Mr. Leone:

Thank you very much for providing the Virginia Department for the Aging with an exposure draft of the interim report on the *Impact of Virginia's Aging Population on State Agency Services.*

We are impressed with the depth and scope of data collected and analyses presented in the Interim Report, and commend JLARC staff, particularly Ashley Colvin, for their efforts. VDA is well aware that the subject of Virginia's delivery of services to our aging residents can be daunting, but we are comfortable with the presentation, and look forward to working with your staff as they further develop the materials and conduct additional investigations in the coming year.

We have attached a brief *errata* sheet for your use, and I hope that you will call on me if I may answer any questions or be of further assistance to you or the Commission.

With best regards, I am

Very truly yours,

Jay W. DeBoer
Commissioner

JWD:ssc

1610 Forest Avenue, Suite 100, Richmond, Virginia 23229
Toll-Free: 1-800-552-3402 (Voice/TTY) · Phone: 804-662-9333 · Fax: 804-662-9354
E-mail: aging@vda.virginia.gov · Web Site: www.vda.virginia.gov

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES

October 4, 2004

Mr. Philip A. Leone, Director
Joint Legislative Audit and Review Commission
General Assembly Building, Suite 1100
Capitol Square
Richmond, Virginia 23219

Dear Mr. Leone:

Thank you for providing my staff and me with the Department of Social Services description from the exposure draft of your report, *Interim Status Report: Impact of Virginia's Aging Population on State Agency Services.* My staff and I respectfully submit the following suggestions that may further enhance the accuracy and clarity of this section of your report.

- **Introduction – Department of Social Services**

  The second paragraph and other sub-sections indicate that older Virginians benefit from the Auxiliary Grant program for assisted living residents. It should be noted that the Auxiliary Grant program also provides assistance for residents of adult foster homes.

  The second paragraph and other sub-sections refer to "adult day health centers." In practice and statute, these facilities are known as adult day care centers. To avoid any confusion, we recommend omitting "health," from all applicable references.

- **Adult Day Health Care and Assisted Living Facilities Provide Community-Based Support to Older Virginians.**

  Generally, assisted living facilities are not considered community-based programs. Although residents are usually less dependent than nursing home residents and can exercise their rights, assisted living facilities are considered institutions. A more accurate sub-heading might replace reference to assisted living facilities with adult foster care or omit reference to community-based.

7 North 8th Street · Richmond, VA, 23219-1849
http://www.dss.state.va.us · (804) 726-7000 · TDD 1-800-828-1120

The first paragraph, second sentence, refers to adult day care center "residents." Use of this word implies that individuals who attend these facilities reside in them, when in actuality, they are participants.

The first paragraph, last sentence, indicates that inspection and enforcement of licensing requirements for adult day care centers are conducted by local departments of social services. The Department's Division of Licensing Programs, not local departments, conducts inspection and enforcement activities for these facilities.

- **Virginia's Auxiliary Grant Program Assists Older Virginians with Assisted Living Expenses.**

The second paragraph, last sentence, indicates that Auxiliary Grant recipients also receive a personal allowance to cover items and services not offered by the facility. For clarity, it should be noted that the personal allowance is provided monthly, and is used to cover not only items and services not provided by the facility, but also items and services not covered by Medicaid. In addition, the personal allowance would be used for medical co-payments and not generally for medication.

- **The Majority of Beds in Virginia's Assisted Living Facilities Are Not Reserved for Auxiliary Grant Recipients.**

The third paragraph identifies individuals who are discharged from Virginia's mental health facilities as a major burden on localities relative to the local match for the Auxiliary Grant. We believe that a much greater burden is created by the placement of out-of-state residents in Virginia's assisted living facilities, particularly in localities bordering Tennessee, Kentucky and West Virginia. These states do not have comparable Auxiliary Grant programs. By federal law, Auxiliary Grant rules must comply with SSI eligibility regulations, which do not impose residency requirements. When an out-of-state individual moves into a Virginia assisted living facility, the individual is considered to be a resident of the locality in which the facility is located. Acute care hospitals, mental health facilities and even prisons in the three bordering states place individuals in southwest Virginia assisted living facilities. This creates tremendous burden on some localities. In addition to the impact on Auxiliary Grant utilization, the local department of social services where the assisted living facility is located is also responsible for assessments and any adult protective services needed by the residents.

The third paragraph, third sentence, indicates that the locality of which a person is considered to be a resident is responsible for the local Auxiliary Grant match. It would be helpful to qualify this by noting that the locality of which a person is considered to be a resident *prior to institutionalization or chooses to relocate in after discharge* is responsible for the match.

- **The Majority of DSS Adult Services Recipients Are Age 60 and Older.**

  The second paragraph indicates that all adult services are provided by local departments of social services through contracts with members of the community, and that contractors tend to be family members or friends. As a point of clarification, home based care services are provided by local departments through agency approved providers or through contracts with home health agencies. Agency approved providers, rather than contractors, tend to be family members or friends.

Finally, I understand that a member of your staff received individual comments last week from one of my staff members. Please discard those comments, as they do not represent the agency's perspective as a whole. I regret any confusion this may have caused for you.

We thank you for the opportunity to respond to your report. Please do not hesitate to contact me or Karin Clark with any further questions or comments. Karin can be reached at 726-7904 or karin.clark@dss.virginia.gov.

Sincerely,

Maurice A. Jones
Commissioner

c: Ashley Colvin
Karin Clark

JLARC Staff

Director: Philip A. Leone
Deputy Director: Glen S. Tittermary

Division Chiefs: Harold E. Greer, III
● Robert B. Rotz

Section Managers:
Patricia S. Bishop, Fiscal & Administrative Services
John W. Long, Publications & Graphics
Gregory J. Rest, Research Methods
Walter L. Smiley, Fiscal Analysis

Project Team Leaders:
Aris W. Bearse
● Ashley S. Colvin
Justin C. Brown
Eric H. Messick
Nathalie Molliet–Ribet

Project Team Staff:
Janice G. Baab
Wendy N. Brown
Eileen T. Fleck
Michelle Hebert–Giffen
● Ellen M. Jackson
Brad B. Marsh
Jennifer N. Jenkins
Jason W. Powell
Kimberly A. Sarte
● Tracey R. Smith
Christine D. Wolfe
Kent S. Wyatt

Administrative and Research Support Staff:
Joan M. Irby
Betsy M. Jackson
Paula C. Lambert

● *Indicates JLARC staff with primary assignment to this project*

Recent JLARC Reports

Virginia's Welfare Reform Initiative: Follow-Up of Participant Outcomes, October 2000
Final Report: Child Support Enforcement, November 2000
Technical Report: The Cost of Raising Children, November 2000
Review of the Medicaid Inpatient Hospital Reimbursement System, December 2000
Special Inquiry: A Review of Child Support Enforcement and the Judicial Process, December 2000
Review of the Virginia Distribution Center, January 2001
Review of Construction Costs and Time Schedules for Virginia Highway Projects, January 2001
Review of RMA and Powhite Parkway Extension Toll Facility Operations, January 2001
Review of VDOT's Administration of the Interstate Asset Management Contract, January 2001
Review of Elementary and Secondary School Funding: Interim Status Report, January 2001
Special Report: Preservation of Revolutionary War Veteran Gravesites in Virginia, February 2001
Indigent Participation in Medical Research at Virginia's Medical Schools, July 2001
Review of State Aid to Public Libraries, July 2001
2001 Report to the General Assembly, October 2001
Review of the Virginia Small Business Development Center Program, December 2001
Equity and Efficiency of Highway Construction and Transit Funding, December 2001
Adequacy and Management of VDOT's Highway Maintenance Program, December 2001
Review of Virginia's System of Capital Punishment, January 2002
Interim Report: Review of State Spending, January 2002
Review of Selected Programs in the Department of Medical Assistance Services, January 2002
Review of Secondary and Elementary School Funding, February 2002
Review of State Spending: June 2002 Update
VRS Oversight Report No. 18: VRS Biennial Status and Semi-Annual Investment Report, July 2002
Special Report: Tax Compliance (October 2002)
Special Report: The Secretarial System (October 2002)
Special Report: State Business Incentive Grant Programs (November 2002)
Interim Report: Best Practices for the Support Service of School Divisions (December 2002)
Special Report: Higher Education (November 2002)
Special Report: Medical Supplies and Pharmaceuticals (December 2002)
VRS Semi-Annual Investment Report No. 19 (December 2002)
The Future of the Chesapeake Bay Bridge-Tunnel, January 2003
Review of Information Technology Systems Development, January 2003
Review of the Virginia Birth-Related Neurological Injury Compensation Program, January 2003
Review of Workforce Training in Virginia, January 2003
Review of the Charitable Gaming Commission, January 2003
Implementation of the Chesapeake Bay Preservation Act, January 2003
Special Report: State Spending on Regional Health Planning Agencies (June 2003)
VRS Semi-Annual Investment Report No. 20 (July 2003)
2003 Report to the General Assembly (September 2003)
Technical Report: State Funding Formula for Educational Technology (September 2003)
Review of State Spending: December 2003 Update
Implementation Review: Virginia Information Technologies Agency, December 2003 Status Report
Review of Virginia's Activity in Maximizing Federal Grant Funding (December 2003)
*Semi-Annual VRS Investment Report No. 21 (*December 2003)
Best Practices for the Support Services of School Divisions (January 2004)
Acclimation of Virginia's Foreign-Born Population (January 2004)
*Review of the State's Passenger Vehicle Fleet (*January 2004)
Review of Factors and Practices Associated with School Performance in Virginia (January 2004)
Benchmarks: Virginia Compared to the Other States (July 2004)
Semi-Annual VRS Investment Report No. 22 (July 2004)
Special Report: Tenure and Post-Tenure Review Policies at Virginia's Public Colleges and Universities (August 2004)
Special Report: Impact of Proposed Child Day Care Center Regulations in Virginia (September 2004)
Replacing Income Tax Revenues with Sales and Use Tax Revenues (November 2004)
Interim Status Report: Impact of Virginia's Aging Population on State Agency Services (November 2004)

JLARC
Suite 1100
General Assembly Building
Capitol Square
Richmond, Virginia 23219
(804) 786-1258 Fax: 371-0101
http://jlarc.state.va.us