JLARC
JOINT LEGISLATIVE AUDIT AND REVIEW COMMISSION

REPORT TO THE
GOVERNOR AND THE GENERAL ASSEMBLY OF VIRGINIA

Funding Options for Low-Income Residents of Assisted Living Facilities

HOUSE DOCUMENT NO. 12
COMMONWEALTH OF VIRGINIA
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In Brief

House Joint Resolution 580 (2011) directed JLARC staff to study third-party payments to assisted living facilities (ALFs) on behalf of individuals receiving the auxiliary grant (AG), Virginia's supplement to the federal Supplemental Security Income (SSI) program. Additional funding may help improve the availability of assisted living for low-income Virginians, which has been declining over the last decade.

While third-party payments should be allowed, they would only benefit fewer than ten percent of AG recipients. In order to address concerns about retaining SSI eligibility and how ALFs will use the additional funds, third-party payments should be limited to covering the provision of goods and services other than food or shelter, and ALFs should be required to provide additional services beyond those specified by the AG program.

The options most likely to provide significant financial assistance to ALFs serving low-income individuals will require State funding. One option is to increase the AG rate. Due to a declining caseload, the AG rate could be increased a modest amount without increasing the FY 2012 AG appropriation. For more meaningful financial assistance, the State could increase the AG further by appropriating additional State funds.

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This report is available on the JLARC website at http://jlarc.virginia.gov

COMMONWEALTH of VIRGINIA

Glen S. Tittermary
Director

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January 31, 2012

The Honorable Charles J. Colgan
Chair
Joint Legislative Audit and Review Commission
General Assembly Building
Richmond, Virginia 23219

Dear Senator Colgan:

House Joint Resolution 580 of the 2011 General Assembly directed the Joint Legislative Audit and Review Commission (JLARC) to study third-party payments for assisted living services in Virginia. JLARC was specifically asked to examine the services provided by assisted living facilities and the sources of payments for these services, including third-party payments, and the potential impact of third-party payments on recipients' eligibility for the State's auxiliary grant and Supplemental Security Income. In addition, JLARC was asked to recommend ways to encourage development of additional revenue sources for providers of assisted living services.

This final report was briefed to the Commission and authorized for printing on December 12, 2011.

On behalf of JLARC staff, I would like to thank staff of the Departments of Social Services, Medical Assistance Services, Behavioral Health and Developmental Services, Rehabilitative Services, and the Board for People with Disabilities for their assistance with this study.

Sincerely,

Glen S. Tittermary
Director

GST/mle

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JLARC Report Summary:

Funding Options for Low-Income Residents of Assisted Living Facilities

Key Findings

- The availability of assisted living for low-income Virginians is declining. The number of assisted living facilities (ALFs) that accept the auxiliary grant (AG), Virginia's financial assistance program for assisted living residents with low incomes, and the average monthly AG caseload have both decreased over the last decade. (Chapter 1)

- Payments to ALFs by third parties such as family or community members on behalf of an AG recipient will have a limited impact because fewer than ten percent of AG recipients have such support. (Chapter 2)

- Program requirements could permit third-party payments and address concerns about retaining individuals' eligibility for the federal Supplemental Security Income and how ALFs will use the additional funds. Third-party payments should be restricted to items other than food or shelter and ALFs should be required to provide additional services beyond those required by the AG. (Chapter 2)

- The options most likely to provide significant financial assistance to ALFs serving low-income individuals will require State funding. One short-term option for increasing the AG by a modest $37 per month would require "freezing" the current appropriation and assumes continued caseload decline. (Chapter 3)

With a licensed capacity of 32,000 residents in 2011, Virginia's 561 assisted living facilities (ALFs) provide assistance and care for persons with limited functional capabilities. Virginia's auxiliary grant (AG) program, a State supplement for individuals receiving federal Supplemental Security Income (SSI), is the primary State funding available for assisted living for low-income individuals.

House Joint Resolution 580, enacted by the 2011 General Assembly, directs the Joint Legislative Audit and Review Commission (JLARC) to study third-party payments for assisted living services. Third-party payments are typically made by a family or community member to an ALF on behalf of an AG recipient. Specifically, the resolution directs JLARC to

- identify revenue sources currently available for ALFs,
- identify services that third-party payments can cover,
- determine how third-party supplemental payments affect eligibility for SSI and State AGs, and

- recommend ways to encourage additional development of revenue for ALFs.

This report focuses on how families or other third parties can supplement the AG without affecting the recipient's SSI eligibility.

AVAILABILITY OF ASSISTED LIVING FOR LOW-INCOME VIRGINIANS IS LIMITED

The availability of assisted living, especially for low-income Virginians, has decreased during the last ten years. The number of ALFs has declined by 118, from 679 in 2001 to 561 in 2011, and the number of beds in ALFs has declined by more than 2,600, from 34,696 in 2001 to 32,049 in 2011. Low-income persons who need assisted living are especially affected by the decline because they often have few alternative places to live. Not all ALFs accept AG recipients, and the number of ALFs that do accept them declined from 349 in 2005 to 312 in 2011. The number of localities with no ALFs that accept AG recipients increased from 41 in 2006 to 48 in 2011.

A key reason for the declining availability of AG beds is that the AG rate is widely considered inadequate. Although the AG, currently $1,112 per month for most areas of the State, is intended to cover the cost of room, board, and basic services, many ALFs that depend on this funding struggle to comply with State standards, as documented in past JLARC reports. The AG rate is well below Virginia's market prices for assisted living, currently averaging about $3,700 per month. According to numerous stakeholders, the AG rate is so low that more ALFs have stopped accepting AG recipients, while others will only care for relatively high-functioning AG recipients or will struggle to meet standards unless the facility has some special circumstance or additional sources of funding.

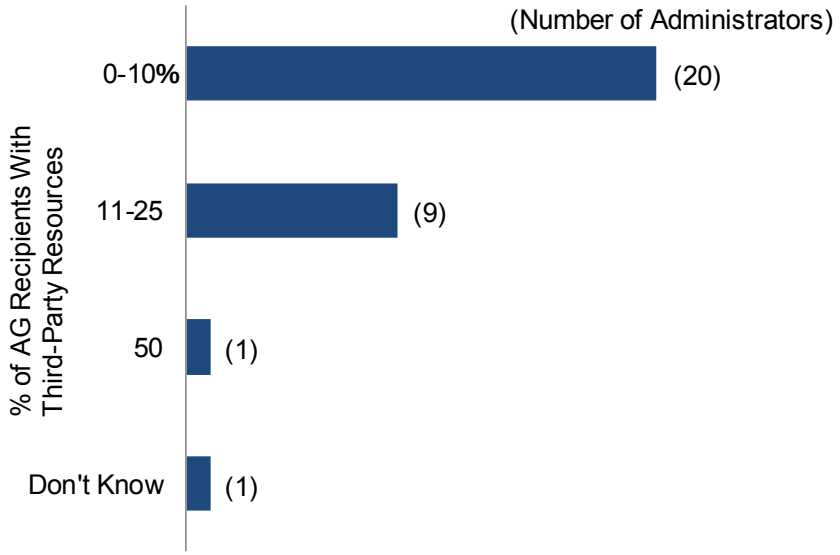
THIRD-PARTY PAYMENTS CAN COVER NEEDED SERVICES FOR A SMALL NUMBER OF AUXILIARY GRANT RECIPIENTS

The State may wish to consider other funding options for ALFs serving low-income individuals, especially since demand is expected to increase as Virginia's population grows and ages. Allowing third-party payments could be helpful but is likely to have only a limited impact because it appears that fewer than ten percent of AG recipients have such resources, as noted in the chart on the next page.

Virginia Department of Social Services (DSS) regulations currently prohibit ALFs from accepting third-party payments although a few facilities have accepted payments for services such as private room upgrades or podiatrist visits. Changing AG regulations to allow families or other third parties to provide additional financial sup-

port for some services is one option for supplementing the AG rate that would not require State funds.

Most Administrators Think Ten Percent or Fewer AG Recipients Have Third-Party Resources



Source: JLARC staff survey of administrators of ALFs serving AG recipients.

The report recommends that the General Assembly consider amending the *Code of Virginia* to allow ALFs to accept voluntary third-party payments on behalf of AG recipients for provision of goods and services other than food or shelter. These payments should be excluded from countable income. Third-party payments made pursuant to this recommendation would not affect individuals' eligibility for SSI, the AG, or Medicaid.

ALFs should also be required to provide specified, documented services beyond those required by the AG in exchange for third-party payments. The report recommends that DSS issue guidance clarifying what services facilities are required to provide for AG recipients. These recommendations would ensure that AG recipients receive additional services and would limit the incentive for ALFs to use an individual's access to third-party resources as a condition of admission or continued residence at the facility.

OTHER POSSIBLE REVENUE SOURCES REQUIRE ADDITIONAL STATE FUNDS

Other options to provide significant financial assistance for ALFs serving low-income Virginians will require additional State funding. The Department of Medical Assistance Services could consider

expanding Medicaid coverage of assisted living, which would leverage State dollars. However, proposed federal regulations and the prospect for significant changes in federal funding may constrain these options.

The State would have to mostly or fully fund other options, which include raising the AG rate from the current $1,112 per month or creating a new State program. If the AG caseload continues to decline, then a rate increase of as much as $37 per month could be funded by FY 2014 for the same FY 2012 AG appropriation. This small increase would not, however, address the larger issue of the inadequacy of the AG, which is currently about 30 percent of the typical cost of assisted living. A new State program structured without regard to most federal requirements would be the most costly approach.

Chapter 1

Availability of Assisted Living for Low-Income Virginians Is Limited

In Summary

With a 2011 capacity of 32,000, Virginia's 561 assisted living facilities (ALFs) provide assistance and care for persons with limited functional capabilities. The number of ALFs has declined during the past ten years, as has the number of beds: in 2011 there were 118 fewer facilities (17 percent fewer) and 2,600 (eight percent) fewer ALF beds than in 2001. Aged, blind, and disabled ALF residents who receive State funding through the auxiliary grant (AG) program are especially affected by the decline because they often have few alternative places to live. The number of ALFs that accept AG recipients also declined from 375 in 1997 to 312 in 2011. Although the AG, currently set by the General Assembly at $1,112 per month, is intended to cover the cost of room, board, and assistance with the activities of daily living, many ALFs that depend primarily on this funding struggle to comply with State standards. The impact of federal healthcare legislation on ALFs is unclear and depends on federal implementation decisions.

House Joint Resolution 580 from the 2011 General Assembly directs the Joint Legislative Audit and Review Commission (JLARC) to study Virginia's third-party payments for assisted living services. The resolution is provided in Appendix A. Specifically, the study resolution requests that JLARC staff

- identify revenue sources for assisted living facilities (ALFs),
- identify services that third-party payments can cover,
- determine how third-party supplemental payments affect eligibility for Supplemental Security Income (SSI) and State auxiliary grants (AGs), and
- recommend ways to encourage additional revenue for ALFs.

To address these issues, JLARC staff interviewed representatives of more than 200 ALFs, including the Virginia Assisted Living Association, the Virginia Association of Nonprofit Homes for the Aging, the Virginia Health Care Association, and the Southwest Virginia ALF Owners Association. JLARC staff also interviewed State and federal agency staff; visited several ALFs; conducted a telephone survey of 31 ALF administrators about capacity, revenue sources, and third-party payments; and analyzed relevant State agency data. More information about methods used in the study is provided in Appendix B.

JLARC has previously reviewed the licensing, funding, and operation of ALFs, beginning with the 1979 *Homes for Adults in Virginia.* A follow-up to that report was issued in 1990. A 1998 report focused on services for adult care residents with mental health disabilities. The 2007 *Final Report: Impact of Assisted Living Facility Regulations* and its associated interim and status reports assessed the impact of legislative changes in 2005 and agencies' regulatory responses. Unlike these prior reports, the current study focused on third-party payments and revenue sources rather than on the quality of care, licensing, or enforcement of State standards.

TREND IS TOWARD FEWER, LARGER ALFS AND RESIDENTS WITH DIVERSE NEEDS

Neither the definition of assisted living nor the regulations governing ALFs are consistent among the states. Virginia statutes define ALFs as non-medical residential settings that provide or coordinate personal and healthcare services, and provide 24-hour supervision and assistance for the care of four or more adults who are aged, infirm, or disabled. These facilities have been regulated in Virginia since 1954. The Department of Social Services (DSS) oversees assisted living through licensure and monitoring of the facilities. DSS also administers the auxiliary grant (AG) program, the State's financial assistance program for low-income ALF residents.

The number of ALFs in Virginia declined over the last decade while their average size, based on the number of beds, has increased (Table 1). The total number of ALFs peaked in 2001 with 679 licensed facilities with a total capacity of 34,696 beds. By 2011, the number of ALFs declined by 17 percent, and their total capacity declined by eight percent to 32,049 beds. The average facility size has also been increasing. The number of beds increased from an average of 51 in 2001 to 57 in 2011.

Table 1: Number of Assisted Living Facilities Peaked in 2001

Fiscal Year	Number of Facilities	Bed Capacity	Average Number of Beds
1979	314	10,420	33
1990	470	22,538	48
1997	612	27,537	45
1999	648	32,614	50
2001	679	34,696	51
2003	636	33,773	53
2005	603	33,460	55
2007	579	31,824	55
2009	561	31,545	56
2011	561	32,049	57

Source: Prior JLARC reports; Virginia Department of Social Services (DSS) 2010 and 2011 Annual Statistical Report; DSS licensing staff.

Activities of Daily Living (ADLs)

ADLs are seven basic activities of life: bathing, dressing, toileting, bowel function, bladder function, transferring, and eating/feeding. A person's degree of independence in performing these activities is a part of determining the appropriate level of care.

Uniform Assessment Instrument (UAI)

A written instrument, approved by DSS and DMAS, which provides basic descriptive and medical history information about an individual and documents an assessment of the individual's degree of independence in performing ADLs. A UAI is completed annually for each AG recipient and whenever there is a "change in condition" of the individual.

AG Recipients' Needs Are Diverse

ALFs serve a population with more diverse needs than nursing homes. Residents range in age from 18 to more than 100. Many residents have no mental health problems but need help with activities of daily living (ADLs). While persons who need such assistance are generally older, a significant number of younger and middle-aged residents with mental health diagnoses often require some help with daily activities that require a higher level of cognitive functioning and physical ability, such as meal preparation, housekeeping, and transportation.

Although there is no data available that describes all 32,000 ALF residents, the Uniform Assessment Instrument (UAI) provides data on the ALF population whose care is paid for through the AG program. UAI data from 1997 was used in the 1998 JLARC report, so trends over a longer period of time can be observed.

The data indicates that the median age of AG recipients has declined slightly since 1997, from 65 to 63 (Table 2). AG recipients

Table 2: AG Recipients in ALFs Are Younger and More Have Mental Health Diagnoses

	1997[a]	2011
Median Age	65	63
% Female	54%	51%
% Needing Help With ADLs		
Bathing	55	53
Dressing	33	31
Bladder	20	27
Toileting	18	19
Transferring	14	18
Bowel Function	12	12
Eating	9	8
% Dependent on Others for Medication Assistance	80	95
% With Mental Health Diagnosis		
Schizophrenia	17	19
Mental Retardation	11	10
Other	4	16
Bipolar/Personality Disorder	3	4
Dementia	3	6
Alzheimer's Disease	2	4
Epileptic/Other Neurological	1	5
Anxiety Disorders	1	3
Total With Mental Health Diagnosis	47%	49%
Total Number	**4,812**	**5,276**

[a]Data from Table 6 of the 1998 JLARC report *Services for Mentally Disabled Residents of Adult Care Residences.*

Source: JLARC staff analysis of Uniform Assessment Instrument data.

are more dependent on others for medication administration and are more likely to have a mental health diagnosis. Specific diagnoses such as Alzheimer's disease, dementia, and other neurological diagnoses show significant increases over the time period.

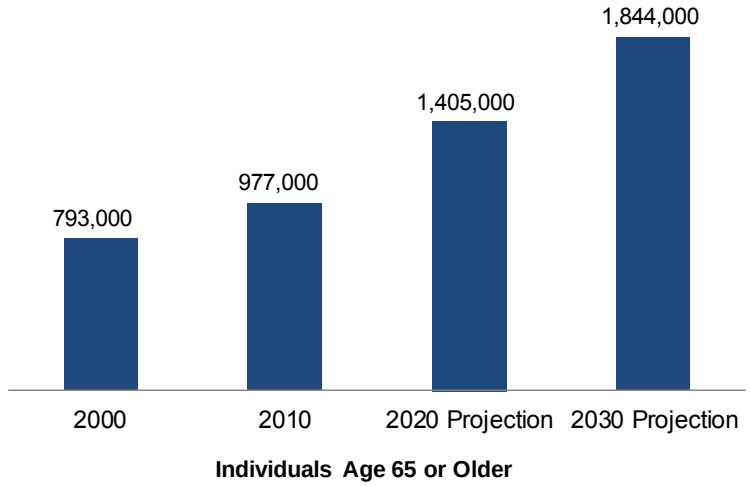
Growing Potential Population of ALF Residents

Demand for assisted living is expected to increase as Virginia's population grows and ages. In 2010, Virginia was the 12th fastest growing state, growing 13 percent to 8 million between 2000 and 2010, and its population is projected to increase 39 percent between 2000 and 2030.

Older Virginians represent one of the fastest growing segments of the population and are a key population served in assisted living. The number of Virginians 65 years or older is expected to grow from nearly 800,000 in 2000 to 1.8 million by 2030, representing an increase from 11 percent to 19 percent of the State's population (Figure 1). The proportion of Virginians over 85 years of age is expected to increase at an even faster pace, reaching 250,000 by 2030, according to projections recently noted by the Weldon Cooper Center.

The number of low-income adults in Virginia has also been increasing, suggesting a corresponding increase in demand for assistance of many kinds, including assisted living. According to the U.S. Census Bureau, the number of Virginians age 18 and older living in poverty increased 35 percent between 2000 and 2009, from approximately 409,000 to 550,000 individuals.

Figure 1: Virginia's Population Age 65 or Older Is Projected to Increase



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

AG PROGRAM IS PRIMARY STATE FUNDING FOR ASSISTED LIVING

Most residents of Virginia's ALFs pay for their care from their own financial resources. These resources can include the resident's own income, which might consist of pensions, investments, long-term care insurance, Social Security, and/or veterans' benefits. Some residents may also receive funding from family members or other sources. Low-income individuals who are unable to pay for assisted living rely primarily on the State's AG program. However, these individuals have limited access to ALFs because many ALFs do not accept the AG.

AG Pays for Assisted Living for Low-Income Individuals

SSI

The federal Supplemental Security Income (SSI) program is administered by the Social Security Administration. It provides financial assistance to aged, blind, and disabled individuals with little or no income. A typical recipient received $674 monthly in 2011.

State funding available to ALFs in Virginia consists primarily of the AG, which is a combination of State and local funds paid to eligible aged, blind, or disabled individuals who reside in ALFs or adult foster care homes. The AG program was created in 1974 by the General Assembly, which continues to set the monthly AG rate in the Appropriation Act. The program is administered by DSS and is a State supplement to the federal SSI program.

Currently, about 15 percent of ALF residents are receiving the AG each month. The maximum monthly AG rate, which includes the maximum $674 SSI monthly payment, is currently set to $1,112 in most parts of the State and to $1,279 for parts of Northern Virginia (Table 3). The State funds 80 percent of the difference between the SSI payment and maximum monthly AG rate, or $350. Localities fund the remaining 20 percent of the difference, or $88. AG recipients also receive an $81 per month personal allowance, funded by the State and localities at the same 80/20 ratio.

Table 3: AG Includes Federal, State, and Local Funding

	Auxiliary Grant	Personal Allowance	Total
SSI	$674	--	$674[a]
State (80% of Total – SSI)	350	$65	416
Local (20% of Total – SSI)	88	16	104
Total AG Rate	$1,112	$81	$1,193

Note: Totals may not sum due to rounding.
[a]SSI amount shown is the maximum federal payment for an individual in 2011.

Source: Appropriation Act, DSS.

The Department of Planning and Budget recently approved a DSS request to increase the maximum monthly AG by $24 to $1,136, effective January 1, 2012. Since the federal government recently announced a $24 cost of living increase in the maximum SSI monthly payment, and the State pays the difference between the maximum

AG rate it sets and the federal SSI payment, this increase will require no additional State funds.

Virginia is one of 35 states that supplement SSI for assisted living, (Appendix C). Although the specific services funded by these supplements differ across the states, Virginia's monthly AG rate of $1,112 is in the middle of the range. Total monthly payments under these programs (SSI plus state supplements) range from $722 in Vermont for "assistive community care" to $1,501 in Indiana for care in a licensed residential facility and $1,561 in North Carolina for adult home special care units housing residents with Alzheimer's. These supplements are mostly intended to cover room and board, while Virginia's AG is intended to cover room and board as well as basic services. Nine states provide supplements to SSI but do not cover assisted living. Seven states provide no SSI supplement.

AG Recipients Have Limited Access to ALF Beds

The number of facilities accepting AG recipients has declined from 375 in 1997 to 312 in 2011.

Despite expectations of increasing demand for long-term care, both the number of facilities in Virginia accepting AGs and the average monthly AG caseload have declined over the last decade (Table 4). The 1997 JLARC report *Services for Mentally Disabled Residents of Adult Care Residences* reported that 375 (62 percent) facilities had at least one AG resident. As of August 2011, DSS staff reported that only 312 ALFs (56 percent) were accepting AG recipients. Similarly, the average number of monthly AG recipients has declined from 6,840 in 1997 to 4,910 in 2011, a 28 percent decline.

Three primary reasons for the decline in AG recipients were noted in a 2009 survey conducted by DSS of local social services departments:

- The AG rate is insufficient for ALF providers to cover the cost of required services; therefore, providers may not accept AG recipients.
- Individuals' care needs exceed the assisted living level of care, and thus they cannot be served by ALFs.
- Individuals are living at home and using home-based services, Medicaid waivers, or community services board (CSB) case management.

In addition to these three reasons, DSS staff note that another factor in the declining availability of AG beds for Virginians is the number of low-income Tennessee residents who move to a Virginia ALF, typically in Southwest Virginia, to take advantage of the AG

Table 4: Number of AG Recipients Has Declined

Fiscal Year	Average # of Recipients	Monthly Rate	Total Expenditures ($ in millions)
1979	2,281	$372	$ 4.4[a]
1990	5,761	602	15.5
1997	6,840	695	19.2
1999	6,725	775	21.7
2001	6,412	815	24.5
2003	5,994	854	23.5
2005	6,250	944	24.7
2007	5,497	1,048	28.7
2009	5,193	1,112	28.7
2011	4,910	1,112	27.8

[a]Appropriation.

Source: Prior JLARC reports; Virginia Department of Social Services (DSS) Adult Services Program SFY 2005 and 2010 Program Reports; DSS 2010 and 2011 Annual Statistical Reports; DSS licensing staff.

program (Tennessee does not have a state supplement to SSI). Proposed regulations establishing a 90-day Virginia residency requirement for the AG to address this issue were submitted by DSS in 2008 and are now under the Governor's review.

Community Services Boards (CSBs)

CSBs are local government agencies that are the point of entry into the publicly funded system of services for mental health, intellectual disabilities, and substance abuse. There are 40 CSBs statewide.

As a result of the declining availability of AG beds, case managers with CSBs have reported difficulty placing AG recipients. These case managers work with persons who have mental health disorders to find housing and services in the community. In a 2006 JLARC staff survey, 39 percent of case managers reported problems finding ALF beds for their AG clients, and 49 percent reported difficulty finding AG beds in ALFs that could meet clients' needs. The survey also found that 75 of the approximately 350 ALFs accepting AGs had at least one AG recipient on a waiting list.

The scarcity of ALF beds for AG recipients has persisted, according to a JLARC staff survey of ALF administrators serving AG recipients conducted for this study. Fifty-eight percent of those surveyed indicated that demand for AG beds exceeded their supply, and some of them said they keep waiting lists. These administrators are turning potential residents away due to lack of space and because applicants required a higher level of care than administrators felt they could provide for the AG rate.

In addition to a general decrease in their number, AG beds appear to be disproportionately concentrated in certain localities. As a result, some low-income individuals may have to move to different areas of the State to find available beds. A 2006 JLARC staff survey found that 41 localities had no AG beds and another 12 localities had between one and ten AG beds. These numbers appear to

have risen to approximately 48 and 16 localities, respectively, in FY 2010 based on self-reported estimates DSS collected from ALFs (Figure 2). In both 2006 and 2010, five localities accounted for approximately 32 percent of AG beds statewide.

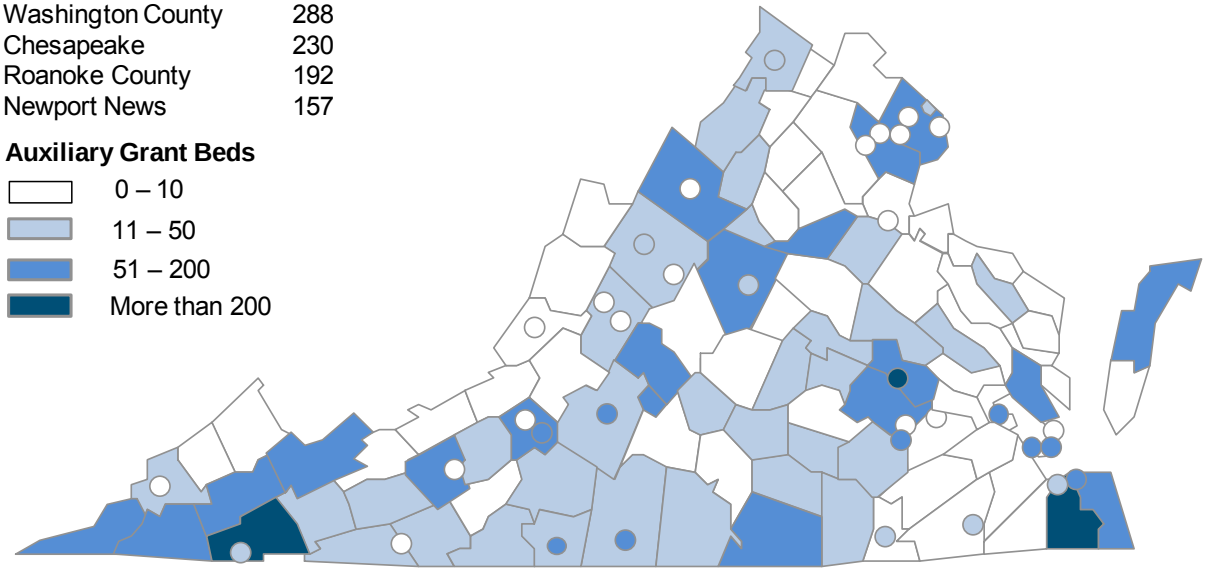
AG Rate Is About One-Third of Market Price

A key reason for the declining availability of AG beds is that the AG is widely considered to be insufficient to cover the cost of care. JLARC's 2007 report, *Impact of Assisted Living Facility Regulations,* found the AG rate was well below market prices for assisted living and likely not sufficient to ensure compliance with the State's minimum standards.

The AG rate is set in the Appropriation Act, and has been $1,112 ($1,279 for certain areas in northern Virginia) since 2009. This rate is approximately one-third of Virginia's market price for assisted living (Figure 3). A Genworth report found a median 2011 cost of $3,705 for a one bedroom/single occupancy, and MetLife reported an average base rate in 2010 of $3,743. The $1,136 AG rate effective January 1, 2012, for most areas of the state is still well below these market prices.

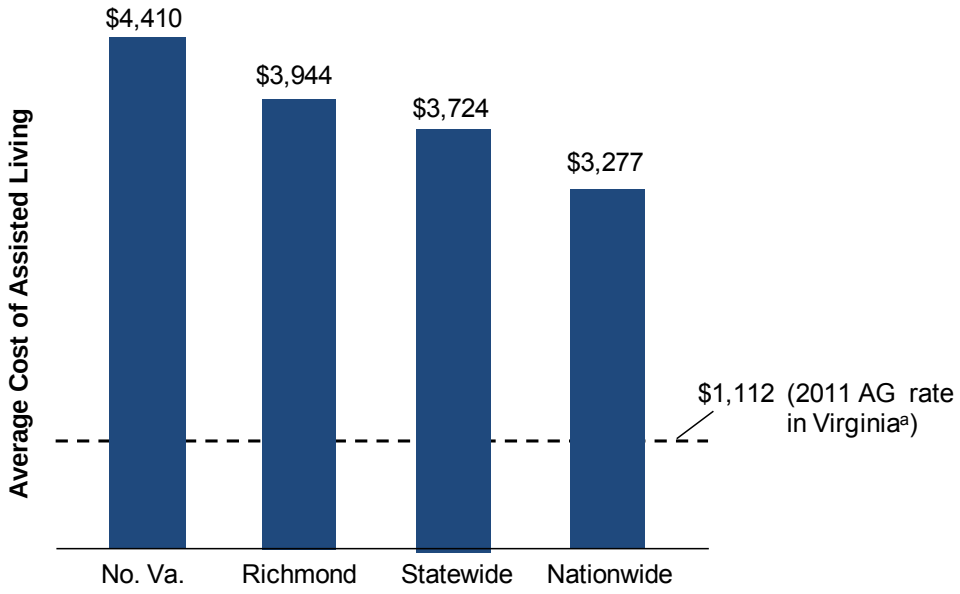
Figure 2: Over 60 Localities Have Ten or Fewer AG Beds

Top Five Localities	Auxiliary Grant Beds
Richmond City	749
Washington County	288
Chesapeake	230
Roanoke County	192
Newport News	157



Source: JLARC staff analysis of data from DSS Licensing staff.

Figure 3: AG Rate Is About One-Third of Market Price of Assisted Living



[a]2011 AG rate in Northern Virginia is $1,279.

Source: The MetLife Market Survey of Assisted Living Costs (October 2010); Genworth Financial Cost of Care Survey (April 2011).

DSS staff and ALF operators indicate that some ALFs have coped with the low AG rate by downgrading the level of care they provide. ALFs can hold either a license to provide assisted living or residential care. A facility licensed at the residential level of care need only provide "minimal" assistance with the activities of daily living (ADLs) instead of a "moderate" level of assistance. Residential ALFs can also use staff with less training. For example, a residential level ALF does not need to have a licensed assisted living administrator (required for the assisted living level), and staff are generally required to have less training.

The percentage of ALFs with a license for residential care has modestly increased from ten percent in 2006 to 13 percent in 2011. A higher percentage of ALFs certified to accept the AG, 19 percent, have licenses for residential care. While this data indicates only a modest increase, it does not reflect the fact that many facilities are licensed for assisted living but choose to accept only relatively high-functioning individuals.

DSS staff voiced concern that ALFs may be downgrading their level of care while the needs of their residents are not changing or may even be increasing. Forty-five percent of administrators JLARC staff interviewed said AG recipients increasingly need

higher levels of care, and 25 percent said AG residents are younger and have more mental health issues. Data supports this perception, although it also suggests the increase has been slight (Table 2).

The AG rate may be too low to ensure that care for all recipients consistently meets the State's minimum standards.

While this data indicates only a modest increase in AG recipients with a mental health diagnosis, several administrators interviewed by JLARC staff noted that they are starting to accept only relatively high-functioning individuals. Facilities are turning away individuals requiring higher levels of care because the AG rate is not enough to care for them, possibly explaining why the UAI data does not reflect the reported trend of more mental health issues among AG recipients.

As noted in the 2006 and 2007 JLARC reports, a major concern is that the AG rate may be too low to ensure that care for the recipients consistently meets the State's minimum standards. These reports found that 20 percent of all ALFs had a recent history of either compliance problems or an above-average number of verified complaints. These "ALFs of concern" were more likely to serve AG recipients.

The 2006 JLARC report noted that many ALFs serving mostly AG recipients coped with low AG rates through special circumstances. For example:

- ALF owners inherited the facility, thus reducing capital costs.
- The owner and/or family members were working at the facility and drawing below-market wages.
- ALF residents attended CSB-operated clubhouse activities, so the ALF where they reside could reduce staffing costs while residents were out of the facility.
- Some ALFs were subsidized by units of local government, CSBs, or other public entities.
- AG beds are provided because of a "sense of mission" felt by the owner or organization operating an ALF. These facilities may be partly funded by the owner, a religious organization, an endowment, or from higher charges to private-pay residents.

Medicaid Provides Limited Coverage of Assisted Living

Medicaid, administered by the Department of Medical Assistance Services (DMAS), provides medical care for low-income individuals and families and limited coverage of assisted living services. Medicaid covers the cost of certain medical services for its recipients not

living in nursing homes, including transportation to and from medical appointments, but does not cover room and board expenses. In 2010, DMAS spent approximately $83 million on AG recipients, or approximately $17,000 per person. The top five expenditure categories for these funds were

- mental health rehabilitation and related services,
- capitated care (per-person payments for medical care),
- Medicare premiums,
- mental health case management, and
- prescription drugs.

DMAS has also had an Alzheimer's Assisted Living (AAL) waiver program since 2005, on which DMAS spent approximately $477,000 in FY 2009. This waiver currently pays ALFs $47.50 per day (reduced from $50 in July 2011) to provide services including medication administration, skilled nursing services, and social activities for individuals with Alzheimer's. Recipients must meet Virginia's criteria for nursing facility placement, not have a serious mental illness, and be receiving the AG. ALFs must be approved by DMAS; provide a safe, secure environment; and foster individuals' independence.

While enrollment for the AAL waiver is limited to 200 individuals, only 45 persons benefited from this waiver in FY 2010. Few providers accept the waiver, possibly because the waiver regulations require higher levels of staffing and more activity hours than DSS licensing standards. Proposed changes to DMAS' regulations that are intended to address these differences are in the final stage of Virginia's regulatory process. DMAS staff are hopeful that the proposed changes will increase the provider pool.

Discontinuation of DMAS' Supplemental Funding for ALFs

Beginning in the 1990s, DMAS provided ALFs supplemental funding for regular assisted living residents through State funds ($90 per month) and for intensive assisted living residents through an Intensive Assisted Living (IAL) waiver ($180 per month). Regular assisted living residents were required to be dependent in at least two ADLs or in behavior, while intensive assisted living residents were required to be at risk of nursing facility placement. The Centers for Medicare and Medicaid Services (CMS) did not renew the IAL waiver in 2000. DMAS continued paying both supplement types for individuals who qualified before 2000 until the Appropriation Act terminated the payments in 2010.

STATE AND FEDERAL ACTIONS MAY IMPACT VIRGINIA'S ASSISTED LIVING INDUSTRY

The role of assisted living is changing, in part in response to a variety of governmental actions. For example, some state and federal efforts are aimed at moving persons with mental health disabilities away from institutional settings towards independent living in the community, with an unclear effect on ALFs. At the same time, federal healthcare reform includes some policies that may tend to increase the ALF population over the longer term.

States Are Shifting Resources From Institutions Toward Community-Based Settings

Demand for ALFs may increase as states shift resources from institutional care toward care in home- and community-based settings, sometimes including ALFs. As noted, Virginia created a Medicaid waiver for individuals with Alzheimer's to live in ALFs rather than nursing homes. According to the National Center for Assisted Living, nationwide Medicaid spending for personal care and waiver services rose 82 percent from 2001 to 2007 while nursing home spending increased only ten percent during that time.

Recent federal actions to shift resources to community settings will likely exclude ALFs, based on current guidance. As part of Virginia's *Olmstead* initiative (named after the 1999 Supreme Court decision that individuals with disabilities have a right to live in the least restrictive setting possible), Virginia joined 30 other states in 2008 in a five-year Money Follows the Person (MFP) demonstration project. Virginia's MFP, administered by DMAS, provides $28 million in federal Medicaid funds to enable individuals to transition from certain long-term care institutions into the community. Federal guidelines limit MFP participants to residences of four or fewer people, so it is likely that none of the 304 individuals served by Virginia's MFP (as of April 2011) resided in ALFs. The 2010 Patient Protection and Affordable Care Act extended MFP through 2016, providing an additional $2.25 billion for the program.

More recently, the U.S. Department of Justice determined in February 2011 that Virginia is in violation of the *Olmstead* decision. In response, the 2011 Virginia General Assembly created a $30 million trust fund to reduce the number of persons in State-run training centers which serve persons with intellectual disabilities. Staff at the Department of Behavioral Health and Developmental Services (DBHDS) are identifying community-based options. At this time, it is unclear whether ALFs will be among the options.

Impact of Federal Healthcare Reform on Assisted Living Is Unclear

Enacted in 2010, the Patient Protection and Affordable Care Act contains several provisions that may impact long-term care, including ALFs. The size and scope of the impact is currently unclear, especially since many provisions have yet to go into effect. Some provisions, such as the State Balancing Incentives Payment Program, reflect the federal government's desire to shift services and resources from institutions to community-based settings, as discussed in the previous section.

There are five provisions in the Affordable Care Act that may impact assisted living (Table 5). First, beginning in 2014, Medicaid

eligibility is expanded for all legal residents under age 65 to 133 percent of the federal poverty level, set at $10,890 for individuals without dependents in 2011. As a result, the Virginia Health Reform Initiative Advisory Council's November 2011 report *Recommendations for a Health Benefit Exchange* anticipates 420,000 additional enrollees. It is unclear how this will affect demand for assisted living. Some of these new enrollees may utilize assisted living services, while some may be incentivized to enter nursing homes or community settings if they cannot obtain funding for assisted living.

A second relevant provision of the act is the requirement for employers with at least 50 full-time employees to pay a penalty if at least one of their employees receives a premium tax credit to purchase health insurance. This penalty would be in the range of $2,000–$3,000 per employee receiving the credit. Some groups, such as the National Center for Assisted Living, are concerned that this may increase ALFs' labor costs as much as 25 percent. A

Table 5: Five Provisions in the 2010 Patient Protection and Affordable Care Act May Affect Assisted Living

Provision	Description	Effective Date
Medicaid Expansion	Expands Medicaid eligibility to include all legal residents under age 65 earning up to 133 percent of the federal poverty level. States will receive 100 percent federal funding for the first three years, reduced to 90 percent by 2020.	January 1, 2014
Employer-shared responsibility requirement for health care coverage	Employers with at least 50 full-time employees must pay a penalty if at least one of their employees receives a premium tax credit to purchase health insurance through a state-based American Health Benefit Exchange.	January 1, 2014
Community Living Assistance Services and Supports Program[a]	First national plan for long-term care insurance. It will be voluntarily open to all working adults with taxable income, regardless of health status.	January 1, 2011, although the Secretary of Health and Human Services has until October 1, 2012, to define the program
State Balancing Incentives Payment Program	Will provide qualifying states with an increased federal match for costs under Medicaid home- and community-based services programs.	October 1, 2011 through September 30, 2015
Community First Choice Option	Creates a new Medicaid state plan option to provide home- and community-based attendant support and services. States receive a six percentage point increase in the federal Medicaid match for these supports and services.	October 1, 2011

[a]The Secretary of Health and Human Services announced in October 2011 that implementation of this program has been stopped.

Source: JLARC staff analysis of the Patient Protection and Affordable Care Act and information from Centers for Medicare and Medicaid Services, Congressional Research Service, and Kaiser Family Foundation.

JLARC staff survey of administrators of ALFs with AG recipients found that 23 percent reported at least 50 full-time employees, with 86 percent of these facilities already offering health insurance. These facilities would not be affected by the penalties.

The Affordable Care Act also creates the Community Living Assistance Services and Supports (CLASS) program, which is the first national plan for long-term care insurance and is to take effect after October 2012. The program will be voluntarily open to all working adults with a taxable income, regardless of health status. Individuals who need help with two to three ADLs or need the equivalent amount of assistance because of cognitive impairment can receive benefits after paying premiums for at least five years, during three of which they must have been working. The act specifies a minimum benefit level of $50 per day.

CLASS's potential impact on assisted living is uncertain. The Secretary of Health and Human Services recently announced that the agency was halting implementation because of financing concerns. Currently, few individuals purchase long-term care insurance, often because they misjudge the resources that will be available to pay for assisted living or their risk of needing long-term care. Less than ten percent of persons over 60 years of age have a private long-term care insurance plan, and only four percent of long-term care expenditures are paid by private insurance. In the JLARC staff survey of ALFs serving AG recipients, 48 percent of administrators felt the CLASS program would not be a viable option for the AG population because these individuals often have no financial resources and are unable to work.

Federal Medical Assistance Percentage (FMAP)

FMAP is a percentage used to determine the federal government's share of the costs of certain joint federal-state programs, including Medicaid. FMAP varies by state and is determined by a formula set in statute. Virginia's FMAP has generally been about 50 percent, although federal stimulus funding increased it to 65 percent in 2010–2011.

The State Balancing Incentives Payment Program (SBIPP) will provide qualifying states with increased federal funding for expenditures on Medicaid home- and community-based services (HCBS) programs. The goal is to incentivize states to provide HCBS as an alternative to nursing home care. The program, which runs through September 2015, is available to states that spend less than 50 percent of their FY 2009 Medicaid long-term care spending on non-institutional care. Virginia, which spent at the 43 percent level in that year, is therefore eligible. If selected by the Secretary of Health and Human Services to participate, Virginia would receive a two percentage point increase in the federal medical assistance percentage (FMAP), and would be required to submit a plan for increasing Medicaid non-institutional spending to 50 percent by 2015.

Finally, the Community First Choice Option (CFCO) adds a new Medicaid state plan option to provide home and community-based attendant supports and services starting October 1, 2011. The goal is to expand and improve community services so that nursing

homes and institutional care are not the only option for individuals. This new program provides up to $3.7 billion for states to receive a six percentage point increase in FMAP for home and community-based attendant services and supports.

Although CFCO is designed for individuals who need help with ADLs such as bathing and eating, or who need help with health-related tasks through hands-on assistance or supervision, it is unclear whether this new program will cover assisted living. CMS is currently discussing the matter internally and will address the issue in its final rule. The proposed rule, issued February 2011, allows states to choose one or more models for service delivery. The two principal models are the "agency model," where services are provided by entities through contracts, and the "self-directed model," where individuals can self-direct services. The agency model would thus appear to include assisted living service providers, as long as CMS continues to consider assisted living a home- and community-based setting.

USE OF THIRD-PARTY FUNDING FOR AG RECIPIENTS

Third Party

Someone who is indirectly involved but is not a principal party in an arrangement or contract. For this study, a third party is typically a member of an ALF resident's family.

A key concern is whether families or other third parties can supplement the AG without affecting the recipient's continued eligibility for both SSI and the AG. As a resident ages and needs additional help, family members may want to contribute funding to help the resident receive needed assistance and stay in place rather than having to move to a more costly nursing home (the $1,112 AG rate provides $36.55 per day, compared to the Medicaid nursing home rate, which averaged $157 per day in FY 2011).

This report focuses on identifying flexibility in the SSI and AG programs. Federal SSI rules preclude use of such third-party funding to provide basic food or shelter, but allow funds to be used to upgrade services to ALF residents such as providing additional help with incontinence. The Commonwealth therefore may be able to alter the AG program to allow third-party supplementation for certain services.

Chapter 2

Third-Party Payments Can Cover Needed Services for Some Auxiliary Grant Recipients

In Summary

Virginia's auxiliary grant (AG) regulations currently prohibit third-party payments, which are payments that typically would be made by a family member to an assisted living facility (ALF) on behalf of an AG recipient. Third-party payments may provide some limited revenue to ALFs serving AG recipients to help provide a number of personal, medical, and recreational items that AG recipients need or want but that may not be affordable under the current AG rate. Such third-party payments would only have a limited impact because fewer than ten percent of AG recipients appear to have access to such resources. Program requirements can address concerns about whether Supplemental Security Income eligibility would be retained and how facilities would use the additional funds. Third-party payments should be limited to the provision of items other than food or shelter, and ALFs should be required to provide additional services beyond those specified by the AG program. Changing policy through the legislative process may effect more rapid change than through the regulatory process.

As noted in Chapter 1, JLARC was directed to identify services for which assisted living facilities (ALFs) can accept third-party payments on behalf of auxiliary grant (AG) recipients and to determine how third-party payments would affect eligibility for Supplemental Security Income (SSI) and the AG. In this case, the term "third party" refers to anyone other than the AG recipient or the ALF, typically family or community members.

Virginia's current AG regulations prohibit third-party payments, but family or community contributions may help ALFs provide services that AG recipients need or want at no cost to the State. The *Virginia Administrative Code* Section 22 VAC 40-25-20 prohibits "the collection or receipt of money, gift, donation, or other consideration from or on behalf of a [AG] recipient for any services provided" because the AG was originally intended to cover most or all care-related expenses. Changing Virginia's regulations to allow third-party payments is one option for funding additional goods and services for AG recipients without requiring State funds, although it is unlikely to increase the availability of ALF beds for AG recipients.

THIRD-PARTY PAYMENTS MAY HELP FACILITIES PROVIDE SERVICES AG RECIPIENTS NEED OR WANT

Third-party payments can potentially help facilities provide goods or services that AG recipients need or want. Although the AG pro-

gram was originally intended to cover most care-related expenses, the majority of administrators reported in a JLARC staff survey that the AG rate is insufficient to cover many personal, medical, and recreational items that third parties like family or community members could supplement.

Virginia's AG regulations establish a basic standard of living, requiring ALFs to provide many goods and services in exchange for the monthly AG rate (Table 6). These requirements include services related to room and board as well as maintenance and care. AG recipients receive a personal allowance, currently $81 per month, intended to cover other basic living needs. For instance, recipients can choose to use the personal allowance for clothing, laundry, hair care services, and entertainment. AG recipients also receive limited Medicaid coverage of certain medical goods and services including dental services, eyeglasses, and physical therapy.

In a JLARC staff survey, 84 percent of administrators of ALFs serving AG recipients reported that the current AG rate is not sufficient to cover many needed or desired goods and services, including a number of medical, personal, and recreational items. Consequently, many AG recipients may be unable to access them. Table 6 lists the goods and services that administrators identified as being not covered or not covered adequately, many of which are items that the AG, personal allowance, or Medicaid are explicitly intended to cover.

A few of the goods and services that administrators identified are explicitly covered by the AG but administrators report that they often have to go beyond these requirements. For instance, the requirement that facilities secure transportation for medical treatment also necessitates paying a transportation service and providing accompanying staff. Medicaid provides transportation for individuals to medical appointments. However, administrators report that this service does not serve all areas and is unreliable, often arriving late and causing individuals to miss their appointments. Additionally, the service does not provide staff to stay with individuals during the appointment, but many AG recipients with mental health diagnoses need supervision. As a result, facilities often have to provide their own transportation and a staff member to accompany the resident.

Under current standards, facilities are also expected to provide "minimal" assistance with bladder or bowel incontinence needs. Administrators report that some AG recipients need more than "minimal" assistance, such as requiring a high number of incontinence products.

Table 6: The AG, Personal Allowance, and Medicaid Cover Certain Goods and Services for AG Recipients While Others Are Not Covered or May Not Be Covered Adequately

Good or Service	Covered by AG	Covered by Personal Allowance	Covered by Medicaid[a]	Not Covered or Not Covered Adequately[b]
Room and Board				
Furnished room	✓			
Housekeeping services	✓			
Meals and snacks	✓			
Clean bed linens and towels	✓			
Maintenance and Care				
Minimal assistance with personal hygiene, including needs associated with occasional bladder or bowel incontinence	✓			✓
Securing health care and transportation for medical treatment	✓			✓
Medication administration	✓			
Generic toiletries	✓			
Minimal assistance with care of personal possessions, care of funds if requested, arranging transportation, obtaining personal items, making and keeping appointments	✓			
Providing social and recreational activities	✓			
General supervision for safety	✓			
Other Living Costs				
Other needs such as postage stamps, dry cleaning, laundry, personal transportation		✓		
Personal telephone, TV, or radio		✓		
Clothing		✓		✓
Personal toiletries beyond required generic ones		✓		✓
Personal items such as tobacco products, sodas, and snacks		✓		✓
Hair care services		✓		✓
Over-the-counter medication, medical copayments and deductibles, insurance premiums		✓		✓
Social events and entertainment beyond required activities program		✓		✓
Dental services			✓	✓
Physical therapy			✓	✓
Podiatrist services			✓	✓
Wheelchairs			✓	✓
Cable TV				✓
Eyeglasses				✓
Hearing aids				✓
Internet				✓
Private Room				✓

[a] Medicaid coverage of these items for adults is limited (see Table 7).
[b] Third-party payments could potentially cover or augment coverage of these goods and services.

Source: JLARC staff analysis of *Virginia Administrative Code* Sections 22.40-25-30 and 22.40-25-40; information from DMAS staff; JLARC staff survey of administrators of ALFs serving AG recipients.

Many goods and services that administrators identified are explicitly intended to be covered by the $81 personal allowance. A significant portion of the personal allowance is often required to cover medical copayments alone. As a result, AG recipients often have little or no funds left to cover other items. Some administrators said they are hesitant to offer outings to movies, restaurants, or shops because they know many of their AG residents do not have enough funds from their personal allowance to participate. Consequently, some administrators indicate they either refrain from offering outings or use their own personal funds to pay for the residents. Additionally, some AG recipients are reportedly in debt to their facility for items such as clothing and cigarettes.

Other services identified by administrators are not explicitly covered by the AG or personal allowance but would be extremely beneficial for AG recipients, according to administrators surveyed by JLARC staff. Medicaid provides limited coverage of the medical needs listed in Table 7 such as dental services, hearing aids, and physical therapy. However, some administrators reported that Medicaid coverage of these goods and services is insufficient for some AG recipients. Thirty-five percent of administrators surveyed

Table 7: Medicaid Provides Limited Coverage of Certain Medical Needs

Service	Under 21 Years Old	21 Years or Older
Dental services	Covered. Can receive medically necessary dental care including preventive care, fillings, extractions, crowns, and prosthetics with various time limits for each service. Dentures require pre-authorization.	Most dental services, including dentures, are not covered. Medically necessary oral surgery and associated diagnostic services may be allowed with pre-authorization.
Eyeglasses	Covered, once every 24 months. More frequent coverage may be provided if a statement of medical need is submitted.	Not covered
Hearing aids	Covered, generally every 60 months with two repairs or modifications per year	Not covered
Physical therapy	Covered. Physician must certify that outpatient services are medically necessary for improving or restoring impaired or lost functions. Individuals can receive intensive rehabilitation services if they meet stricter criteria regarding needs, stability, and ability to participate in therapy.	Covered, same as for under 21
Podiatrist services	Covered, for reasonably and necessary diagnostic, medical, or surgical treatment of disease, injury, or defects of the foot	Covered, same as for under 21
Wheelchairs	Covered, generally every 60 months with various time limits for specific part replacements	Covered, same as for under 21

Note: ALFs may serve individuals aged 18 and above.

Source: JLARC staff analysis of DMAS provider manuals and information provided by DMAS staff.

stated that paying for dental services is a significant problem. Residents with mental health diagnoses especially need dental care because their psychiatric medications often affect their teeth. Many residents end up getting teeth pulled rather than fixed because that is all they can afford. The following case studies illustrate other needed goods or services for which Medicaid coverage may be insufficient:

Case Studies

One administrator said one of her residents had been discharged from a state hospital and received physical therapy for the first few months. After the time frame specified on the initial medical evaluation passed, the resident was no longer able to receive the therapy. The administrator believes that the resident could significantly benefit from weekly outpatient services to improve his mobility, but the individual does not meet Medicaid criteria for coverage.

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One administrator said that an AG recipient with cerebral palsy had a wheelchair that was deteriorating and breaking down frequently after three years. Medicaid replaces wheelchairs once every five years, unless justification for a replacement is requested and approved sooner, so the resident may not have been able to get a replacement until next year. The facility owner recently donated a wheelchair to the resident so that he would not have to wait.

Residents may also want amenities that are not covered by the AG or personal allowance, such as Internet access, cable TV, and a private room rather than the typical semi-private room. Approximately ten percent of the administrators interviewed by JLARC staff said that families have asked whether they could supplement the AG so that their family member could have a private room.

THIRD-PARTY PAYMENTS WILL HELP A LIMITED NUMBER OF AG RECIPIENTS

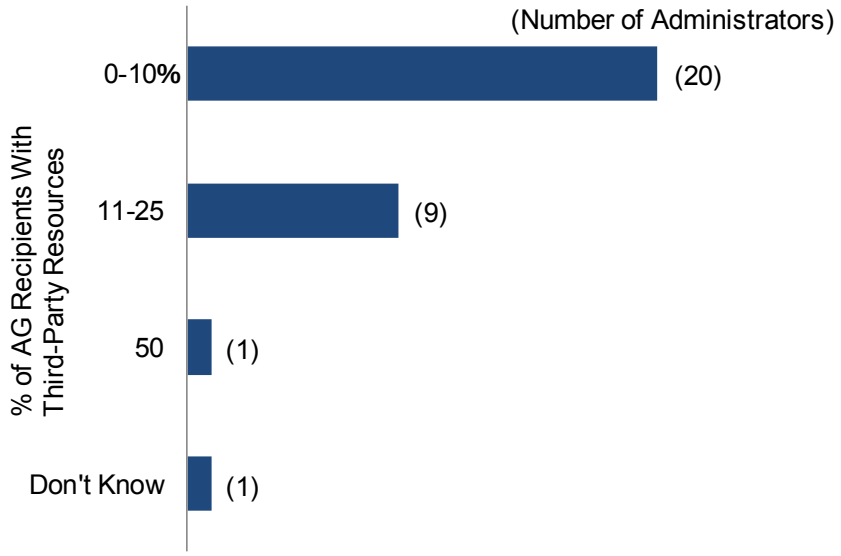
While third-party payments may help ALFs provide a number of services that AG recipients want or need, allowing third-party payments would help only a relatively small number of AG recipients who have access to third-party resources. Furthermore, some facilities have already been accepting third-party payments despite regulations prohibiting the practice.

Fewer Than Ten Percent of AG Recipients Have Access to Third-Party Resources

DSS staff, interest groups, facility administrators, and other stakeholders in the assisted living industry estimate that fewer than ten percent of AG recipients have access to third-party resources. Allowing third-party payments will thus have a limited impact, although it could be important to the individuals affected.

The majority of administrators interviewed by JLARC staff said that few, if any, of their current AG residents had access to family or community members who would be willing to contribute money for additional services (Figure 4). Of those surveyed, 55 percent said none of their residents have third-party resources, while another ten percent said that ten percent or fewer of their AG residents have third-party resources. The rest of the administrators thought that between 11 and 50 percent of their residents, or approximately three AG residents at each of these facilities, may have access to third-party resources.

Figure 4: Most Administrators Think Ten Percent or Fewer AG Recipients Have Third-Party Resources



Source: JLARC staff survey of administrators of ALFs serving AG recipients.

These percentages are low because AG recipients typically have no family contact, or their families are unwilling or unable to provide financial support. Following is a sample of comments from administrators interviewed by JLARC staff:

Case Studies

The administrator of a facility serving over 75 AG recipients expressed amusement when asked whether any of her AG recipients have family or other-third party resources available. She said family members won't buy a bar of soap for the residents, much less visit them. She does not even know who the family members of her AG recipients are.

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The administrator of a facility with approximately 20 beds cited one AG recipient at his facility whose sister, a doctor, did not want to contribute any money. Instead, she wanted to use the resident's personal allowance when eating at a restaurant.

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The administrator of a facility exclusively serving AG recipients said one of his approximately 15 residents had a family member who would do the resident's laundry every week. This was the most assistance any family member provided for any of his AG residents.

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The administrator of a facility serving approximately 30 AG recipients said approximately four of her AG recipients receive weekly family support. This support typically is in the form of two or three dollars sent in the mail.

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A 107-year old ALF resident had exhausted his savings paying for assisted living, and his facility did not accept AGs because the rate was too low. The individual wanted to stay rather than move to a nursing home in order to receive Medicaid funding. The community where the ALF was located, made aware of the situation through a newspaper article, raised funds in 2007 to pay for his costs at the facility. However, this money counted as income under SSI rules, making the individual ineligible for SSI and the AG. Furthermore, the community-raised funds could not have been used to supplement the AG under current regulations, so the community funds ran out sooner than otherwise would have occurred. Nonetheless, the community was able to fully fund three years of assisted living at his preferred facility until the individual's death in 2010.

These case studies illustrate that while some AG recipients do have family or community resources, access is rare and third-party resources, especially family resources, are often minimal.

Although most ALF administrators report that fewer than ten percent of their AG recipients have access to third-party resources, 71 percent of administrators also believe allowing third-party payments would be beneficial.

Although most AG recipients do not have access to third-party resources, third-party payments may be beneficial for those who do. Seventy-one percent of administrators, including many who said none of their current AG recipients have these resources, thought allowing third-party payments would be beneficial. They noted that third-party payments may be a more viable option for future AG recipients. Some administrators think family members of future AG recipients may be more affluent and more willing to provide financial support. This belief, however, depends partly on the state of the economy.

Some Facilities Have Already Accepted Third-Party Payments

Administrators at some ALFs reported in a JLARC staff survey that they have already accepted third-party payments, although current regulations prohibit this practice. Changing the regulations to allow third-party payments will benefit AG recipients in facilities following current regulations. The following case studies are examples of facilities that have accepted or currently accept third-party payments for private room upgrades and podiatrist services:

Case Studies

One facility allows families of two or three of the facility's seven AG recipients to pay for a private room upgrade. The families pay the difference between the private room rate ($1,715) and the AG rate, or $603 per month. The facility's administrator said she was unaware that current AG regulations prohibit an ALF from accepting third-party payments.

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An administrator of a facility with over 100 beds said that his facility used to allow several families to pay for a private room upgrade on behalf of their family member. These families paid the difference between the private studio rate and the AG rate, or $750 per month at the time. The facility stopped accepting the payments in 2003 when DSS issued clarification about the regulations.

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A facility serving ten AG recipients has a podiatrist visit the facility every three months to cut diabetic residents' toe nails. The facility bills the $30 charge to families of resi-

dents who choose to participate since Medicaid does not cover this service.

As these case studies illustrate, ALF administrators may not understand current regulations and it is difficult to enforce regulations prohibiting third-party payments. One reason enforcement may be difficult is that there is no dedicated funding for administering and monitoring the AG program under current terms of the DSS appropriation. Furthermore, DSS has no way of knowing whether a facility is accepting third-party payments unless the facility reports it or DSS inspectors discover the practice. Consequently, facilities may already be accepting third-party payments for private room upgrades and possibly other services, unbeknownst to State agencies.

PROGRAM REQUIREMENTS CAN ADDRESS CONCERNS ABOUT BENEFIT ELIGIBILITY AND USE OF THIRD-PARTY PAYMENTS

Third-party payments on behalf of AG recipients should be allowed, and regulations or statutes allowing them should address concerns about whether individuals would retain their eligibility for SSI and how ALFs would use the additional funds. These regulations or statutes should also ensure that ALFs are providing additional services in exchange for third-party payments and are not using the availability of third-party resources as a condition of admittance or retention.

Third-Party Payments Should Only Be Allowed for Goods and Services ALFs Provide Other Than Food or Shelter

A key concern for the State should be to ensure that third-party payments do not affect an AG recipient's SSI eligibility. Individuals' eligibility for the AG depends primarily on their eligibility for SSI, and AG recipients are automatically eligible for Medicaid. Therefore, retaining SSI eligibility is important for retaining both AG and Medicaid eligibility.

Third-party payments made directly to ALFs for anything they provide other than food or shelter would not affect an individual's eligibility for SSI, the AG, or Medicaid.

Third-party payments made directly to ALFs for the provision of anything other than food or shelter would not affect an individual's SSI eligibility. The *Code of Federal Regulations* states, "Some things you receive are not income because you cannot use them as food or shelter, or use them to obtain food or shelter….Payment of your bills by someone else directly to the supplier is not income." For example, in the aforementioned case study involving a podiatrist, the ALF billed the third party for the service and therefore their payment would not be considered income.

With the exception of items listed under Room and Board, private rooms appear to be the only item listed in Table 6 for which third-party payments could affect SSI eligibility. According to an SSI

program expert, there may be rare cases when payments for a private room upgrade would not count as shelter—if, for example, the additional cost for a private room over a shared room is solely for additional services. The most likely case, however, is that payment for a private room would be construed as payment for shelter rather than services and would thus affect the SSI benefit amount.

In the case where third-party payments for a private room upgrade count as shelter, these payments would reduce the SSI benefit or completely eliminate it. These payments would lower the monthly SSI benefit amount dollar-for-dollar, after excluding the first $20 of income per month, up to $245. An individual would lose the SSI benefit completely if the value of the third-party payment combined with the individual's other countable monthly income reduces the maximum SSI benefit amount (currently $674) to zero. If an individual loses the SSI benefit, he or she is at risk of also losing the AG, depending on the amount of the third-party payment and the individual's other income.

Third-Party Payments in North Carolina

Since 2005, North Carolina has allowed third-party payments, limited to private room upgrades, on behalf of individuals receiving its SSI state supplement. These individuals' SSI benefits are reduced or terminated, although the state may be providing a higher state supplement amount to offset this SSI reduction. To date, state records indicate that only nine individuals have received these third-party payments.

Based on the average ALF rates, individuals receiving family supplementation for a private room (as in the two case studies above) would have their SSI benefit amounts significantly reduced or even eliminated. The average rate that AG-dependent ALFs in JLARC staff's survey charged for a semi-private room was $1,817. This rate would require a third-party payment of $705 above the AG rate, thereby reducing the SSI benefit amount by the maximum $245. Private rooms would likely cost even more considering the typical monthly charge for assisted living in the State was $3,700 in 2010-2011, as reported in the two insurance company surveys noted in Chapter 1.

ALFs Should Provide Additional, Specified Services in Exchange for Third-Party Payments

Stakeholders, including DSS staff, have identified two other concerns, both of which relate to facilities' use of third-party payments. First, third-party payments should fund additional services, not just increase provider revenues. Second, some AG-dependent ALFs may be tempted to use an individual's ability to access third-party resources as a condition of admittance or retention. Both of these concerns can be addressed by requiring documented provision of additional, specified services for each third-party payment.

Stakeholders express skepticism about whether ALFs would use additional funding to improve living conditions for AG recipients. These same stakeholders also express concern that ALFs serving a predominantly AG population struggle to meet State standards. However, requiring any additional funding, especially if it is not

public funding, to be used to improve the quality of already-required services seems impractical and unenforceable.

A better approach is to require ALFs accepting third-party payments to provide specific, additional services beyond those already required by AG standards. Families and other third parties should be able to pay for items covered by the personal allowance, however, since ALFs are not required to provide them if an AG recipient does not have sufficient personal allowance.

DSS should clarify the specific services ALFs are required to provide for AG recipients. As noted previously, two items listed in Table 6 that would be beneficial for AG recipients are explicitly covered by the AG but may have limits. For instance, some administrators believe they are providing more than the required "minimal assistance" with "occasional" incontinence needs for residents who need a relatively high number of incontinence products. Third-party payments may help these individuals stay longer at ALFs rather than transfer to more costly nursing facilities.

Some administrators also feel that having to pay for or provide transportation as well as staff members to accompany AG recipients to medical appointments is beyond the requirement to "secure health care and transportation." While it is reasonable to expect that these activities are included in the requirement to "secure transportation" since all AG recipients should have transportation to medical treatment, regardless of their access to third-party resources, DSS should clarify this requirement.

DSS staff and others have also expressed a related concern about equity because third-party payments could create two groups of AG recipients—those with and those without third-party resources. Several interest groups noted that third-party payments would be problematic if there are not enough AG beds to house everyone. In that case, the concern is that ALFs could choose to admit only those AG recipients with third-party resources. Current AG regulations already state that "the provider shall not require an auxiliary grant recipient or his personal representative to request any item or service as a condition of admission or continued stay." In addition, ALFs will have less incentive to distinguish between AG recipients based on third-party resources if they are required to provide additional goods or services in exchange for the payments.

LEGISLATION MAY EFFECT MORE RAPID CHANGE THAN REGULATORY CHANGES

Virginia can allow third-party payments for AG recipients either by amending the AG regulations or by passing legislation through

the Virginia General Assembly during its annual session. The legislative process may be faster than the regulatory process.

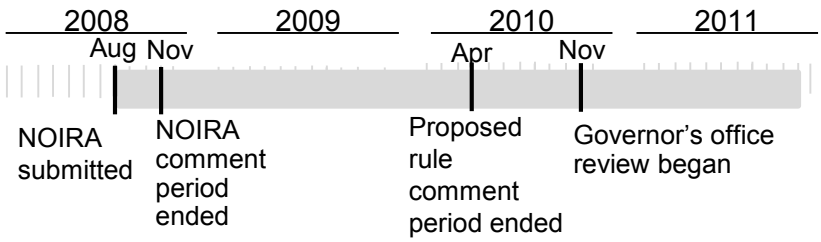
The typical regulatory process takes 18 to 25 months and has three main steps: a Notice of Intended Regulatory Action (NOIRA), a proposed regulation, and a final regulation. As discussed in JLARC's 2009 report *Review of Exemptions to the Virginia Administrative Process Act*, recent executive orders have required the Governor's approval before publication of final regulations, an executive branch review power that is not contained in the Virginia Administrative Process Act (VAPA). These executive orders do not limit the time frame within which the Governor's office has to complete its review.

Virginia Administrative Process Act (VAPA)

VAPA governs the way in which State agencies propose and promulgate regulations, which have the force of law. The act also specifies procedures for public notification and comment as well as the external review functions of certain entities in the executive and legislative branches.

In some cases, the time for executive review of final regulation packages has been exceptionally long. For instance, DSS submitted a NOIRA in August 2008 to establish a 90-day Virginia residency requirement for its AG program, as noted in Chapter 1. These regulations remained in the final stage as of November 2011, having been under the Governor's review since November 2010 (Figure 5). Therefore, successful legislation may have a more immediate impact than amending DSS' AG regulations.

Figure 5: Regulatory Process for Changes to Certain AG Regulations Has Taken Over Three Years



Source: JLARC staff analysis of Virginia Regulatory Town Hall information.

Recommendation (1). The General Assembly may wish to amend the *Code of Virginia* to allow assisted living facilities (ALFs) to accept voluntary third-party payments on behalf of auxiliary grant (AG) recipients for the provision of goods and services other than food or shelter. These third-party payments should be excluded from countable income. In exchange for third-party payments, ALFs should be required to provide specific, documented services beyond those required by AG regulations.

Recommendation (2). The Department of Social Services should issue guidance that clarifies the specific services assisted living facilities are required to provide for auxiliary grant recipients. This guidance should include definitions of the terms "minimal assistance," "occasional," and "securing health care and transportation," as used in 22 VAC 40-25-30.

Chapter 3

Other Possible Revenue Sources for Assisted Living Facilities Require Additional State Funds

In Summary

The options most likely to provide significant financial assistance to ALFs serving low-income individuals will require State funding. The Department of Medical Assistance Services could consider expanding Medicaid coverage of assisted living, for which the federal government would share some of the costs, but proposed federal regulations and the prospect for significant changes in federal funding may constrain available methods. The State could also consider increasing the AG rate. One approach would be to maintain the FY 2012 AG appropriation, which would result in a modest rate increase of $37 per month by 2014, assuming the AG caseload continues to decline. Finally, a new State program could be structured without regard to most federal requirements, although it would be fully State-funded and would thus be the most costly option.

JLARC was directed to identify revenue sources for assisted living facilities (ALFs) and ways to encourage the development of additional revenue for ALFs, as noted in Chapter 1. As discussed in previous chapters, the auxiliary grant (AG) provides the primary State support for low-income ALF residents. Allowing third parties to supplement the AG may help address the concern that the AG rate is inadequate, but as noted in Chapter 2, will have a quite limited impact.

Other, limited options are available to the State to provide funding for ALFs serving low-income individuals. Additional funding could potentially improve the quality of care ALFs provide low-income residents and increase the availability of ALF beds for AG recipients. These options include expanding Medicaid coverage of assisted living, raising the AG rate, and creating a new State program. Each of these options would require additional State funding.

AG FACILITIES PRIMARILY RELY ON PRIVATE-PAY RESIDENTS AND THE AG

Identifying how ALFs with AG residents are currently funded can help determine whether additional revenue sources are needed and how to capitalize on existing or new sources. While a variety of private and public funds are available, ALFs serving AG recipients rely almost exclusively on private-pay individuals and the AG.

ALFs receive funds directly from residents as well as from several public sources, chief of which is the AG (Table 8). It is important to note that many private-pay ALF residents rely on state and federal programs such as Social Security or veterans' benefits to help

pay for their care. Because these funds are paid to the individual recipients, who then choose to use part or all of the funds to pay their assisted living costs, these public benefit programs are considered part of the private-pay residents' personal funds. By contrast, other programs such as the AG and the Medicaid Alzheimer's assisted living (AAL) waiver, are not considered part of private-pay residents' personal funds because they offer funding or services on the condition that the person reside in an ALF.

Table 8: Assisted Living Facilities Have a Variety of Private and Public Revenue Sources

Revenue Source	Description
Private Sources	
Personal funds	Individuals often use their personal funds from savings, pensions, investments, or other sources to pay for assisted living.
Family or community contributions	Individuals may receive financial support from family or community members.
Long-term care insurance	Nationally, approximately ten percent of individuals age 60 and over have private long-term care insurance.
Private grants	Some organizations offer grants that can be used for assisted living, like the American Health Assistance Foundation's Alzheimer's grant.
State or Local Funding	
Auxiliary Grant	The auxiliary grant program augments Supplemental Security Income (SSI) for certain individuals in ALFs.
Discharge Assistance Project	The Department of Behavioral Health and Developmental Services' Discharge Assistance Project (DAP) has an annual budget of $18.9 million and serves over 600 individuals, 135 of whom live in ALFs. With DAP funds, local community services boards provide supports, typically short-term, for individuals being discharged from State mental health facilities. These supports include case management services, clinical services, and rehabilitative services.
Local funding	An estimated five ALFs receive funding from local governments or other local agencies, according to DSS staff.
Federal Funding	
Supplemental Security Income (SSI)	SSI supports aged, blind, and disabled individuals with little or no income.
Social Security retirement funds	Social Security primarily provides benefits for retirement, disability, survivorship, and death.
Veterans Administration Aid and Attendance Benefit	The Veterans Administration offers an Aid and Attendance benefit to low-income veterans who (1) need regular assistance with activities like eating, bathing, dressing, and taking medication; (2) are bedridden; (3) reside in a nursing home due to mental or physical disabilities; or (4) are blind. The benefit provides a maximum monthly amount of $1,644, or $54 per day, for veterans without dependents.
Black Lung Compensation	The Department of Labor provides Black Lung Compensation, currently $625 per month for beneficiaries without dependents, for coal miners who are completely disabled from black lung disease as a result of working in or around coal mines.
Joint Federal and State Funding	
Medicaid	Administered by the Department of Medical Assistance Services, Medicaid provides medical care to low-income individuals and families. Currently, Virginia's Medicaid funds certain services for AG recipients, including 45 Alzheimer's residents in assisted living through the Alzheimer's Assisted Living waiver.

Source: JLARC staff analysis and interviews with State agencies, various interest groups; JLARC staff survey of administrators of ALFs serving AG recipients.

It is difficult to know how much the average ALF in Virginia relies on each revenue source. Forty-four percent of ALFs do not accept AG recipients, and a JLARC staff survey found as few as two or three AG recipients in some ALFs. By contrast, some ALFs exclusively serve AG recipients. Financial data is not available on all ALFs because DSS no longer collects financial reports from facilities. Finally, a JLARC staff survey found that many ALF administrators can identify the number of AG recipients in their facilities, but they generally do not know how their private-pay residents obtain their funds.

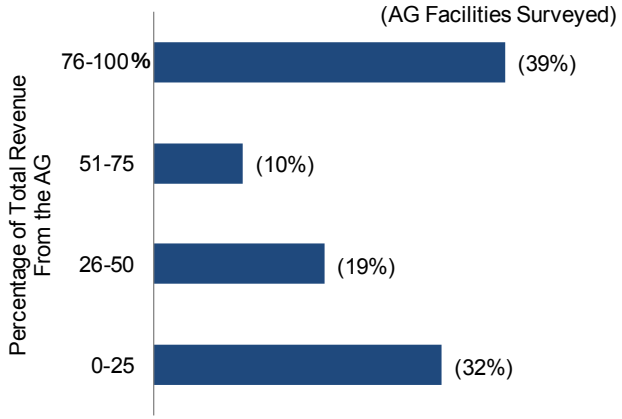
For facilities serving AG recipients, an average of 53 percent of their total revenue comes from the AG combined with SSI and 43 percent comes from private-pay individuals.

According to the ALF administrator survey, facilities with AG recipients rely almost exclusively on the resources of private-pay individuals and the AG. Survey respondents indicated that, on average, 53 percent of a facility's revenue came from the AG and 43 percent came from private-pay individuals. Few facilities received other available revenue sources. In the JLARC staff survey, six percent of facilities reported receiving funding from the Department of Behavioral Health and Developmental Services' discharge assistance project, six percent reported receiving the Medicaid AAL waiver, and three percent reported receiving local government funding. Cost reports DSS collected for FY 2005 had similar findings, indicating that, on average, 46 percent of an AG facility's revenue came from the AG and 45 percent came from private-pay individuals in that year.

Facilities serving AG recipients depend on the AG to varying extents (Figure 6). More than one-third of these facilities relied on the AG for more than 75 percent of their total revenue, while approximately one-third of the facilities relied on the AG for 25 percent or less of their total revenue. Thus, a significant percentage of facilities depend heavily on the AG and may be affected considerably by any changes to the AG program.

Given that the facilities that serve low-income residents rely heavily on the AG and private-pay residents as sources of revenue, additional revenue sources may be needed to ensure that these facilities can fully meet the needs of the potential growing population of ALF residents in Virginia, as discussed in Chapter 1. JLARC staff identified three options for funding ALFs that serve low-income persons.

Figure 6: Over One-Third of AG Facilities Rely Heavily on the AG



Source: JLARC staff survey of administrators of ALFs serving AG recipients.

OPTION 1: EXPAND MEDICAID COVERAGE OF ASSISTED LIVING SERVICES

One option for funding ALFs serving low-income individuals is to expand Virginia's currently limited Medicaid coverage of assisted living services. Although Medicaid cannot cover room and board in assisted living, the program can cover certain services. Medicaid typically covers nursing home care, although studies have consistently found that assisted living is less expensive. Medicaid currently pays an average $157 per day for nursing homes in Virginia (the State's share of which is approximately 50 percent, or $79 per day), compared to the State's $14 average daily AG payment. Some ALF administrators estimate that, if additional funding were available, as many as one-third of ALF residents who transfer to nursing homes could receive the care they need in an ALF. Increasing Medicaid coverage of assisted living services could potentially allow some of these residents to stay longer in the less-costly ALFs.

Since Medicaid is jointly funded by the State and federal governments, Virginia would only have to pay approximately half of the full cost of Medicaid-covered assisted living. A recent national trend has been to shift Medicaid spending from institutional settings to home- and community-based settings, possibly including assisted living, as noted in Chapter 1. Two provisions in the Patient Protection and Affordable Care Act encourage such shifts by increasing federal funding for home- and community-based services (HCBS) programs.

Four Methods for Covering Assisted Living Through Medicaid

States use four methods for covering assisted living through Medicaid, the most common of which is the §1915(c) waiver program used in 37 states, including Virginia, as of 2009 (Table 9). The second most popular method is the personal care State Plan option used in 13 states. Several states cover services using more than one source of funding. For instance, six states covered services through both §1915(c) waivers and the personal care State Plan option in 2009.

Table 9: Section 1915(c) Waivers Are Most Widely Used Method for Covering Assisted Living Through Medicaid (2009)

Method	Number of States
§1915(c) waiver	37
Personal care State Plan option	13
§1915(i) HCBS State Plan option	4 [a]
§1115 demonstration project	4

Note: Some states use more than one method.
[a] As of June 2010.

Source: American Health Care Association; Kaiser Family Foundation.

Nursing Facility Level-of-Care Criteria

Individuals must have a medical condition which requires ongoing medical or nursing management and must meet functional capacity requirements. Functional capacity requirements specify various combinations of dependencies in activities of daily living (ADLs), behavior pattern and orientation, joint motion, medication administration, and mobility.

The first three methods vary most importantly with respect to entitlement (Table 10). The two State Plan options must be available to all eligible individuals statewide, whereas states can limit the number of individuals and types of groups served through §1915(c) waivers. According to DMAS staff, the State Plan options would require larger financial commitments than waivers since the State could not limit the number of individuals who would be served. The least costly option would be to expand the waivers.

Options also vary with respect to other features, including benefit availability and functional eligibility criteria. For instance, services provided through a personal care State Plan cannot be limited to assisted living settings. The §1915(i) HCBS State Plan option, however, can offer different service packages to targeted groups like assisted living, and §1915(c) waivers can be limited to certain recipients in assisted living settings. Additionally, individuals receiving a §1915(c) waiver must meet a state's nursing facility level-of-care criteria, whereas the two State Plan options can have less strict level-of-care criteria and thus serve more individuals.

Table 10: Methods for Covering Assisted Living Through Medicaid Vary With Respect to a Number of Features

Feature	§1915(c) Waiver	Personal Care State Plan Option	§1915(i) HCBS State Plan Option[a]
Entitlement	States may limit the number of individuals served and restrict services to specific groups.	States must provide services to all beneficiaries who qualify for Medicaid.	States must provide services to all beneficiaries who meet financial and functional eligibility requirements.
Benefit Availability	May limit amount, scope, and duration to specific geographic areas or beneficiary groups	Must be available in the same amount, scope, and duration to all beneficiaries across the state	Must be available to all eligible beneficiaries across the state, although states can design different service packages for specific, targeted populations
Financial Eligibility	State may set eligibility up to 300% of the monthly federal SSI federal benefit rate if also used for nursing home eligibility.	Must be SSI eligible or meet the state's community-based income eligibility standard	Must have incomes below 150 percent of federal poverty line. States can serve those with incomes up to 300 percent of the SSI federal benefit rate, for whom states may use institutional eligibility criteria.
Functional Eligibility	Must meet the state's nursing home level-of-care criteria	Must meet State Plan criteria for services	Must meet state-specified, needs-based criteria that are less stringent than the state's institutional level-of-care criteria
Scope of Services	States may cover • case management, • homemaker/home health aide services, • personal care, • adult day health, • habilitation, • respite care, • partial hospitalization services for individuals with chronic mental illness, • psychosocial rehabilitation services for individuals with chronic mental illness, • clinical services for individuals with chronic mental illness, and • other services as approved by the Secretary.	Services authorized by a physician in accordance with a treatment plan or state-approved service plan. Personal care services may include assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs).	States may cover • case management, • homemaker/home health aide services, • personal care, • adult day health, • habilitation, • respite care, • partial hospitalization services for individuals with chronic mental illness, • psychosocial rehabilitation services for individuals with chronic mental illness, • clinical services for individuals with chronic mental illness, and • other services as approved by the Secretary.
Approval Period	Initial waivers approved for three years; renewals for five years	Not time-limited	Not time-limited. States targeting specific populations must renew every 5 years.

[a]Reflects amendments to §1915(i) by the Patient Protection and Affordable Care Act.

Source: Department of Medical Assistance Services; Centers for Medicare and Medicaid Services; National Academy for State Health Policy; Congressional Research Service.

Section 1115 demonstration projects have significantly more flexibility than the three options in Table 10 and are intended to test new approaches. Under §1115, states are allowed to make broad changes to Medicaid statutes and regulations, including availability, eligibility, and service delivery. These projects require approval by the Secretary of Health and Human Services and are limited to five years with the option for renewal.

Proposed Federal Regulations May Constrain Least Costly Method, and Potential Funding Decreases May Limit Other Methods

According to DMAS staff and a nationally-recognized Medicaid policy expert, creating a new §1915(c) waiver or expanding Virginia's current §1915(c) AAL waiver to include individuals who do not have Alzheimer's would be the least costly method for expanding the State's Medicaid coverage of assisted living services. However, DMAS staff and some ALF interest groups anticipate that a waiver would affect no more than ten to 15 percent of ALF residents since recipients must meet strict nursing facility level-of-care criteria.

While a §1915(c) waiver may be the least costly method, a rule proposed by the Centers for Medicare and Medicaid Services (CMS) may limit its use for ALFs. The proposed rule defines home- and community-based settings for the first time, stating that they must be integrated in the community:

> A setting is not integrated in the community if it is: (A) Located in a building that is also a publicly or privately operated facility which provides inpatient institutional treatment or custodial care; in a building on the grounds of, or immediately adjacent to, a public institution or disability-specific housing complex, designed expressly around an individual's diagnosis or disability, as determined by the Secretary; or (B) Has qualities of an institutional setting, as determined by the Secretary.

Health policy experts and a number of organizations, including the National Center for Assisted Living and the National Association of Area Agencies on Aging, are concerned that this definition will prevent individuals from using 1915(c) waivers in some, if not most, ALFs. Over 1,600 comments were submitted before the comment period closed in June 2011, and there is no timeline for the release of CMS' final rule.

Uncertainties about the definition of home- and community-based settings constrain Virginia's options for expanding Medicaid. DMAS should not consider changes to its Medicaid coverage of as-

sisted living until it is clear that CMS will continue to consider assisted living a home- and community-based setting.

In addition to the unknown impact of federal regulations, potential funding uncertainties may constrain the other, more costly methods for expanding Medicaid. Increased federal matching funds for Medicaid terminated in 2011, and 12 states cut Medicaid funding in 2011, according to the National Association of State Budget Officers. The federal government may also decrease Medicaid funding to lower the U.S. deficit.

OPTION 2: INCREASE THE MONTHLY AG RATE

The State could also consider increasing the monthly AG rate. The AG program's monthly rate of $1,112 is widely considered inadequate to provide all of the required services, as discussed in Chapter 1. At $37 per day, the AG rate is expected to cover meals, assistance with the activities of daily living, medication administration, and other costs. Many ALF administrators interviewed for this study cited goods and services the AG rate was insufficient to cover, including clothing and various medical needs, as noted in Chapter 2.

A $24 per month cost of living adjustment to SSI will take effect January 1, 2012, increasing the AG rate to $1,136. No additional State funding is required.

While the current rate is considered inadequate, there is no agreement as to what the proper rate should be. The typical market price for assisted living in Virginia was about $3,700 per month, or $121 per day, in two recent studies noted in Chapter 1. A 2007 JLARC study, which analyzed unaudited cost reports ALFs voluntarily submitted to DSS, found an average monthly cost per bed of $1,827 and a median monthly cost per bed of $1,384. The average monthly charge for a semi-private room in the 31 ALFs contacted for the current study was $1,817.

Modest Increase in AG Rate Would Not Require Additional State Funds

If the AG caseload continues to decline, then the FY 2012 appropriation could fund a $37 per month increase in the AG by FY 2014.

The State could consider increasing the AG rate by maintaining the FY 2012 AG appropriation level. Assuming the AG caseload continues to decline (as discussed in Chapter 1), the State could use the resulting unspent funds from the FY 2012 AG appropriation of $22,639,804 to increase the AG rate. By FY 2014, the monthly rate could be increased by approximately $37 under this approach, assuming the caseload continues to decline approximately five percent per year. However, if the caseload begins to increase, this funding option would not be available.

As with the recently announced $24 federal cost of living adjustment, this $37 adjustment would not change the overall inadequacy of the AG rate. While this $37 monthly increase could potentially help some facilities, particularly those serving primarily AG recipients, provide additional goods or services, the resulting monthly rate of $1,173 (which includes the recently announced $24 increase mentioned above) would still be far below the typical market rate for assisted living.

Increasing AG Rate Further Would Require Additional State Funds

Alternatively, the State could provide additional appropriations to increase the AG rate. Each $10 per month increase would require an additional State funding of approximately $471,000, assuming the 2011 monthly caseload average of 4,910 recipients. A $50 per month increase would require an additional $2.4 million in State funding.

This approach would better address the inadequacy of the AG rate than the approach of passing on the SSI increase or maintaining the FY 2012 AG appropriation level. Any AG rate increases that are substantial enough to significantly improve care and possibly increase the availability of AG beds would require additional State funds.

OPTION 3: CREATE A NEW STATE PROGRAM

According to DSS and Social Security Administration staff, another way to address the inadequacies of the AG program could be to start a separate State program, not tied to the SSI program. A new program could be structured in any fashion and would avoid certain constraining federal requirements. For example, a federal "maintenance of effort" provision requires Virginia to maintain either the same total expenditure level or the same payment levels for the AG program as the previous year. Consequently, the State may be hesitant to increase funding for the AG program since funding could generally not be reduced in the future if needed.

While there would be no such federal constraints on a new State program unconnected to SSI, the new program would probably be more costly than increasing the AG rate because it would be fully funded by the State. For example, if the new State program set an ALF residential rate of $1,500 per month ($18,000 per year), then the 100 residents would cost $1.8 million per year. Under the current AG program, however, the State would only pay $871,000 per year for 100 residents at this rate since local governments and the federal SSI program would share the cost.

SUMMARY OF OPTIONS

Table 11 summarizes the State's options for funding ALFs serving low-income individuals. The table includes comments on each option, based on the discussion above, and whether additional State funds would be required.

Table 11: Summary of State Options for Funding ALFs Serving Low-Income Individuals

	Comments	Additional State Funds Needed?
Expand Medicaid Coverage of Assisted Living Services		
§1915(c) waiver [a]	Could provide support for up to ten to 15 percent of ALF residents. However, proposed federal rules may limit the use of this option in ALFs.	Yes. Would be least costly method for expanding Medicaid.
Personal care State Plan option [a]	Could provide support by covering personal care services for a larger portion of ALF residents than a §1915(c) waiver could cover.	Yes
§1915(i) HCBS State Plan option [a]	Could provide support for a larger portion of ALF residents than a §1915(c) waiver could cover.	Yes
§1115 demonstration project [a]	Could be structured to provide any level of support.	Yes
Increase the Monthly Auxiliary Grant Rate		
Increase AG rate by approximately $37 by FY 2014 to maintain FY 2012 total appropriation	Would provide a modest level of support for ALFs serving AG recipients.	No, as long as AG caseload continues to decline.
Increase AG rate using additional State appropriations	Would provide a more meaningful level of support for ALFs serving AG recipients.	Yes, $471,000 per $10 monthly increase for current average caseload.
Create New State Program [a]		
	Could be structured to provide any level of support.	Yes, may be the most costly option.

[a] Impact and amount of additional state funds required would depend on the program's structure and payment levels.

Source: JLARC staff analysis and 2011 AG caseload data provided by DSS.

JLARC Recommendations:

Funding Options for Low-Income Residents of Assisted Living Facilities

1. The General Assembly may wish to amend the *Code of Virginia* to allow assisted living facilities (ALFs) to accept voluntary third-party payments on behalf of auxiliary grant (AG) recipients for the provision of goods and services other than food or shelter. These third-party payments should be excluded from countable income. In exchange for third-party payments, ALFs should be required to provide specific, documented services beyond those required by AG regulations. (p. 28)

2. The Department of Social Services should issue guidance that clarifies the specific services assisted living facilities are required to provide for auxiliary grant recipients. This guidance should include definitions of the terms "minimal assistance," "occasional," and "securing health care and transportation," as used in 22 VAC 40-25-30. (p. 29)

Appendix A

Study Mandate

HOUSE JOINT RESOLUTION NO. 580

Directing the Joint Legislative Audit and Review Commission to study third-party payments for assisted living services. Report.

Agreed to by the House of Delegates, February 4, 2011
Agreed to by the Senate, February 22, 2011

WHEREAS, the number of elderly and disabled Virginians is increasing rapidly, making it crucial to have resources and facilities that will protect their quality of life while providing assistance with their daily needs in place; and

WHEREAS, assisted living, a relatively new concept 25 years ago, is now the most preferred and fastest growing long-term care option for seniors; and

WHEREAS, according to the Virginia Assisted Living Association, there are currently 561 licensed assisted living communities in Virginia serving approximately 34,500 seniors and disabled persons; and

WHEREAS, auxiliary grants supplement the resources available to individuals who receive Supplemental Security Income (SSI) and other financial assistance for aged, blind, or disabled persons residing in assisted living facilities or adult foster care homes; and

WHEREAS, 80 percent of the funding for the auxiliary grant program comes from state general funds and 20 percent of the funding for the auxiliary grant program comes from local funds, and the rate that an assisted living facility may charge to provide services for an individual with an auxiliary grant is determined by the General Assembly and is administered by the Department of Social Services; and

WHEREAS, the growing demand for assisted living facilities and resources coupled with continuing cuts in state funding have increased the need for auxiliary grants to supplement the financial resources available to individuals in dire financial situations and to ensure such individuals are able to maintain a standard of living that meets a basic level of care; and

WHEREAS, just over 300 licensed assisted living facilities accepted individuals receiving auxiliary grants in 2009; and

WHEREAS, increased demand for services and the increased cost of care highlight the need for unique and innovative solutions to address the necessity for additional resources, including resources made available through the auxiliary grant program, for persons requiring assisted living care; 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 Virginia's third-party payments for assisted living services. Such study shall include review of basic contractual services provided by assisted living service providers, sources of payments for assisted living services including federal, state, and local benefits for residents and third-party payments for services provided to residents, and the potential impact of third-party payments for assisted living services on assisted living facility residents' eligibility for state auxiliary grants.

In conducting its study, the Joint Legislative Audit and Review Commission shall (i) identify sources of revenue for assisted living facilities providing care for residents, including federal and state benefits and third-party payments for services for residents, and other sources of revenue; (ii) identify those services for which assisted living facilities or assisted living service providers may accept third-party supplemental payments; (iii) determine the relationship between third-party supplemental payments for assisted living services and eligibility for Supplemental Security Income (SSI) and state auxiliary grants, and whether third-party supplemental payments could be accepted by a provider without affecting a resident's eligibility for SSI or auxiliary grant benefits; and (iv) recommend measures to encourage development of additional sources of revenue, including third-party payments, for providers of assisted living services.

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, 2011, and for the second year by November 30, 2012, 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 to the General Assembly and the Governor a report of its findings and recommendations for publication as a House or Senate document. The executive summaries and reports 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

Research Activities and Methods

Research activities for this study included

- interviews of State and federal agency staff, representatives of the ALF industry, health care experts, and other stakeholder groups;
- a phone survey of administrators of assisted living facilities (ALFs) serving auxiliary grant (AG) recipients;
- site visits;
- reviews of State and federal statutes and regulations, as well as research literature on Medicaid and the Patient Protection and Affordable Care Act (PPACA); and
- an analysis of data from the Departments of Medical Assistance Services (DMAS) and Social Services (DSS).

INTERVIEWS

JLARC staff conducted several interviews with State and federal agency staff as well as other stakeholder groups. Generally, the purpose of the interviews was to collect information about trends in the assisted living industry, understand current regulations for Supplemental Security Income (SSI) and the AG program, hear opinions about allowing third-party payments on behalf of AG recipients, and learn about other issues relevant to the study resolution.

In total, JLARC staff conducted 25 interviews, including

- State and federal officials at DSS, DMAS, the Department of Behavioral Health and Developmental Services, the Department of Rehabilitative Services, North Carolina's Department of Health and Human Services, and the Social Security Administration;
- ALF interest groups such as the Virginia Assisted Living Association, the Virginia Association of Nonprofit Homes for the Aging, the Virginia Health Care Association, and the Southwestern Virginia ALF Association;
- Healthcare experts from the National Academy for State Health Care Policy (NASHP) and George Washington University's Center for Health Policy Research; and

- Other stakeholder groups such as the Virginia Municipal League, the Virginia Association of Counties, the Virginia League of Social Services Executives, the National Alliance on Mental Illness, and the Virginia Board for People with Disabilities.

SURVEY OF ADMINISTRATORS OF ALFs SERVING AG RECIPIENTS

JLARC staff conducted a semi-structured phone survey of 31 administrators of AG-dependent ALFs throughout the State. Some of these administrators were also owners of their facilities. Using a DSS list of ALFs certified to accept the AG, JLARC staff selected a ten percent random sample that was representative of these ALFs' geographic distribution throughout the eight DSS licensing regions. There was no significant difference between the sample and all AG-dependent ALFs with respect to their licensed capacity.

The survey was designed to supplement the information obtained in interviews and site visits. Survey topics included

- facilities' capacity and occupancy, private-pay rates, and revenue sources;
- AG recipients' ability to access and need for third-party resources;
- how facilities were impacted by recent regulatory and funding changes; and
- opinions on other relevant issues such as the impact of federal healthcare reform and expanding Medicaid funding for assisted living.

JLARC staff used the survey to understand current trends in assisted living, identify AG-dependent ALFs' revenue sources and the general extent to which ALFs use each source, determine the need for and potential impact of allowing third-party payments for AG recipients, and understand administrators' perspectives on a variety of issues affecting AG-dependent ALFs.

SITE VISITS

JLARC staff conducted site visits to four ALFs. DSS licensing staff and JLARC staff selected these ALFs for their geographic proximity and diversity. The purpose of these site visits was to familiarize JLARC staff with the assisted living industry. During these visits, JLARC staff interviewed facility owners or administrators and toured each facility.

DOCUMENT REVIEWS

JLARC staff reviewed SSI and AG statutes and regulations to determine the State's ability to allow third-party payments for AG recipients. JLARC staff also reviewed information from the Department of Health and Human Services, Centers for Medicare and Medicaid Services, the Congressional Research Service (CRS), the Kaiser Family Foundation, and other organizations to identify provisions in the PPACA that may affect assisted living. Additionally, JLARC staff reviewed federal statutes as well as documents from DMAS, NASHP, CRS, the National Center for Assisted Living, and other organizations to identify options for expanding Virginia's Medicaid coverage of assisted living.

DATA ANALYSIS

JLARC staff analyzed Uniform Assessment Instrument (UAI) data from DMAS to review the care needs and medical diagnoses of AG recipients in assisted living. While slightly more than 6,100 individuals received the AG at some point during FY 2011 according to DSS and DMAS staff, DMAS only received assessments from screening teams for 5,276 individuals. The data JLARC staff obtained covered these 5,276 AG recipients who were screened and authorized for assisted living in FY 2011, including both initial assessments for those first entering an ALF as well as reassessments for continuing ALF residents.

JLARC staff also analyzed estimates of each facility's average monthly number of AG recipients to approximate the availability of AG beds throughout the State. DSS collected these self-reported estimates for FY 2010 from ALFs certified to accept the AG. These estimates only approximate the number because ALFs do not always keep accurate census records and may have based their responses on the number of AG recipients they had at the time rather than the average monthly number of AG recipients they had during the preceding year. Therefore, JLARC staff only used these numbers to identify trends in the availability of AG beds since previous JLARC reports.

Appendix C

Assisted Living Payments, Including SSI and State/Local Supplements, 2010

State	Living Arrangement	Monthly Amount[a]	Number of Recipients
Alabama	Personal care home	$730-$734	199
Alaska	Assisted living home	$774	1,172
California	Nonmedical out-of-home care	$1,086	53,237
Colorado	Adult foster care home	$1,250	13
Delaware	Adult residential care facility	$814	651
District of Columbia	Adult foster care home	$1,159 (1-50 beds) $1,269 (51+ beds)	699 (1-50 beds) 11 (51+ beds)
Florida	Assisted living facility	$752	7,871
Hawaii	Domiciliary care facility	$1434 (6+ beds)	37
Idaho	Assisted living facility	$1,013-$1,147	58
Illinois	Residential facility	N/A: Based on individual needs	442
Indiana	Licensed residential facility	$1,501	1,737
Iowa	Residential care	$965	1,783
Kentucky	Personal care facility	$1,194	3,073
Maine	Boarding home	$891-$908	1,081
Maryland	Assisted living facility	$858	3,306
Massachusetts	Assisted living facility Licensed rest home	$1,128 $823-$967	1,164 1,500
Michigan	Domiciliary care Personal care facility Home for the aged	$761 $832 $853	29 11,906 369
Minnesota	Nonmedical, group residential facility	$915	$9,116
Missouri	Licensed residential care facility	$830-966	Unknown
Montana	Assisted living facility	$768	106
Nebraska	Assisted living facility	$1,112	962
Nevada	Domiciliary care	$1,065	389
New Hampshire	Residential care facility for adults	$895	85
New Jersey	Congregate care facility	$824	4,675
New Mexico	Licensed adult residential care home	$774	69
New York	Congregate care facility	$902-$1,109	29,561
North Carolina	Adult care home Special care unit	$1,228 $1,561	21,480 1,938
Ohio	Residential care facility	$1,180-$1,280	409
Pennsylvania	Adult domiciliary care facility Personal care boarding home	$1,108 $1,113	1,174 12,152
Rhode Island	Adult residential care or assisted living facility	$1,212	563
South Carolina	Community residential care facility	$1,157	3,928
South Dakota	Adult foster care Assisted living facility	$1,002 $1,379	9 68
Vermont	Assistive community care Residential care home	$722 $898	263 141
Virginia	Assisted living facility	$1,193	5,167
Wisconsin	Private nonmedical group home or natural residential setting	$854	22,640

[a]Does not include amounts paid by Medicaid.

Note: Arizona, Arkansas, Mississippi, North Dakota, Oregon, Tennessee, and West Virginia do not offer optional SSI state supplementation. Connecticut, Georgia, Kansas, Louisiana, Oklahoma, Texas, Utah, Washington, and Wyoming offer optional SSI state supplementation but their supplements do not cover assisted living, as defined by Virginia. Residents in these states received only the federal SSI amount, which was $674 in 2010.

Source: JLARC staff analysis of the Social Security Administration's *State Assistance Programs for SSI Recipients*, January 2010; review of state agency websites; and information provided by selected states.

Appendix D

Agency Response

As part of an extensive validation process, State agencies and other entities involved in a JLARC assessment are given the opportunity to comment on an exposure draft of the report. JLARC staff provided an exposure draft of this report to the Department of Social Services, Department of Medical Assistance Services, and the Secretary of Health and Human Resources. Appropriate technical corrections resulting from the comments received have been made in this version of the report. This appendix includes the written response letter received from the Department of Social Services.

COMMONWEALTH of VIRGINIA

DEPARTMENT OF SOCIAL SERVICES

Office of the Commissioner

Martin D. Brown
COMMISSIONER

December 5, 2011

Mr. Glen S. Tittermary, Director
Joint Legislative Audit and Review Commission
Suite 1100, General Assembly Building, Capitol Square
Richmond, Virginia 23210

Dear Mr. Tittermary:

Thank you for the opportunity to review and comment on JLARC's exposure draft, "Funding Options for Low-income Residents of Assisted Living Facilities." We commend the JLARC team for its work on this project. Their research is a significant addition to information about the Auxiliary Grant (AG) Program.

In general, we found the report to be thorough and reflective of the challenges and opportunities facing the AG Program. We concur with the findings that "the availability of assisted living for low-income Virginians is declining," and that "A key reason for the declining availability of AG beds is that the AG rate is widely considered inadequate."

After careful review of the draft report, I have enclosed comments that the Department requests that JLARC staff consider as they complete the final draft and recommendations to the Commission.

Should you have questions regarding our comments, please do not hesitate to contact me.

Sincerely,

Martin D. Brown

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VDSS RESPONSE TO THE EXPOSURE DRAFT:
FUNDING OPTIONS FOR LOW-INCOME RESIDENTS OF ASSISTED LIVING FACILITIES

KEY FINDINGS:
VDSS concurs with the findings that "the availability of assisted living for low-income Virginians is declining," and that "a key reason for the declining availability of AG beds is that the AG rate is widely considered inadequate."

It should be noted that one factor in the declining availability of Auxiliary Grant (AG) beds for low-income Virginians is the number of indigent Tennessee residents who move to a Virginia ALF, usually in Southwest Virginia, to take advantage of the AG program. (Tennessee does not have a state supplement to SSI.) Among proposed changes to the AG regulation, 22 VAC 40-25, pending in the Governor's Office, is establishment of a 90-day Virginia residency requirement for the AG. The purpose is reduce the use of Virginia taxpayer funds by Tennessee residents, especially the double burden for Southwest Virginia localities that also pay the 20 percent local AG match, and to free up AG beds for low-income Virginia residents.

DRAFT RECOMMENDATIONS:
Funding Options for Low-Income Residents of Assisted Living Facilities

1. *The General Assembly may wish to amend the Code of Virginia to allow assisted living facilities (ALFs) to accept voluntary third-party payments on behalf of auxiliary grant (AG) recipients for the provision of goods and services other than food or shelter. These third-party payments should be excluded from countable income under AG regulations. In exchange for third-party payments, ALFs should be required to provide specified, documented services beyond those required by the AG.*

VDSS accepts JLARC's conclusion that voluntary third-party payments to ALFs for goods and services they provide other than food or shelter would not affect an individual's eligibility for Social Security Income (SSI), the AG or Medicaid, with the exclusion of payments for a private room upgrade. We agree that any third-party payments should be restricted to funding documented, specific additional services beyond those required by AG standards. In fact, VDSS has for some time interpreted AG regulations to permit third-party payments for services unrelated to room, board and other requirements of the AG standards.

However, if, as the report indicates, only 10 percent or fewer AG recipients would have access to third-party payments, it is a fair question whether it is good public policy to institute a change that benefits only a few but has unknown consequences for others, for good or for ill. As the draft report notes, VDSS has significant concerns about creating inequities among AG participants that in effect would use public funds to establish two classes of people in the same

public program and often in the same ALF. We also share concerns that this practice may encourage providers to "cherry-pick" residents with access to third-party resources. Therefore, VDSS requests that the report's discussion of these concerns be strengthened to reflect these significant public policy issues.

It also is important to note that the Auxiliary Grant is a direct payment to the client, not the provider, and that the AG appropriation includes no funds to administer or monitor the program. As the draft report states, some ALFs reported that they already accept third-party payments from family members for private room upgrades in violation of SSI and AG regulations, and that "DSS has no way of knowing" whether a facility is doing so "unless the facility reports it or DSS [Licensing] inspectors discover the practice."

The report correctly states that "a key concern for the State would be to ensure that third-party payments do not affect an AG recipient's SSI eligibility." It also points out that to avoid the temptation for providers "to use an individual's ability to access third-party resources as a condition of admittance or retention...documented provision of additional, specified services for each third-party payment" should be required. Activities necessary to monitor these requirements would require administrative funding not available under the current terms of the appropriation. Therefore, VDSS requests that the lack of funding for administration and monitoring of the AG Program be recognized in the final report and recommendations to the Commission.

2. *The Department of Social Services should issue guidance that clarifies the specific services assisted living facilities are required to provide for auxiliary grant recipients.*

VDSS accepts the recommendation that AG guidance be clarified to include definitions of such terms as "minimal assistance," "occasional," and "securing health care and transportation" as used in 22 VAC 40-25-30.

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