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Report to the Governor and the General Assembly of Virginia

Virginia's Assisted Living Facilities and In-Home Care Services for Older Adults

2026



COMMISSION DRAFT

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Summary: Virginia's Assisted Living Facilities and In-Home Care Services for Older Adults

WHAT WE FOUND

Virginia has 1.5 million older adults; at least one in eight has difficulty living independently

Virginia's population aged 65 and older represents 17 percent of the state's population. Many older Virginians have characteristics that can impede independent living: 31 percent report one or more disabilities, 19 percent have ambulatory difficulty, 12 percent have independent living difficulty, 7 percent have cognitive difficulty, and 7 percent have self-care difficulty. About one-quarter of older Virginians live alone, with no one else to assist them.

By 2050, Virginia's 65 and older population is projected to grow 40 percent, and the very old population (age 85+) is projected to more than double. By contrast, the under-65 population is projected to grow by just 15 percent, meaning there will be relatively fewer working-age adults to deliver care or provide services for older adults.

Rural regions have the highest proportions of older adults, and older adults in Southwest and Southside Virginia have the highest levels of measured service need across nearly every physical and cognitive indicator.

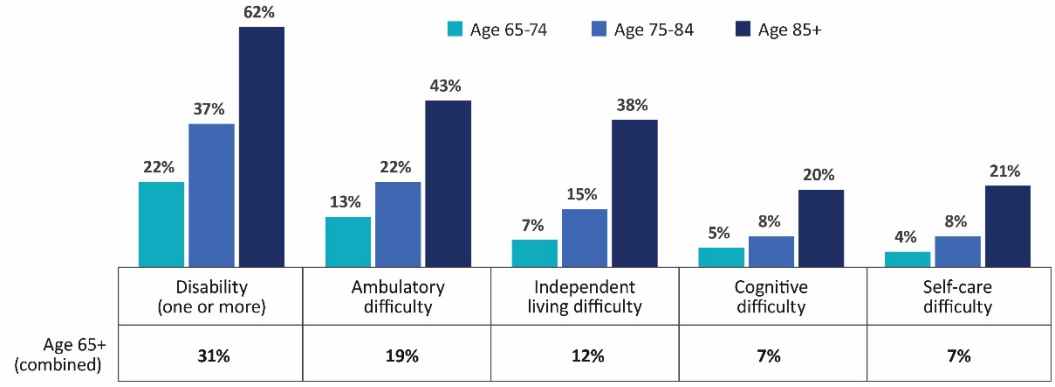
WHY WE DID THIS STUDY

In December 2025, the Commission directed staff to review the availability and quality of non-medical services and supports for aging Virginians, including in-home supports that allow individuals to age safely in their homes and congregate care housing for those who cannot.

ABOUT VIRGINIA'S ASSISTED LIVING AND IN-HOME CARE SERVICES

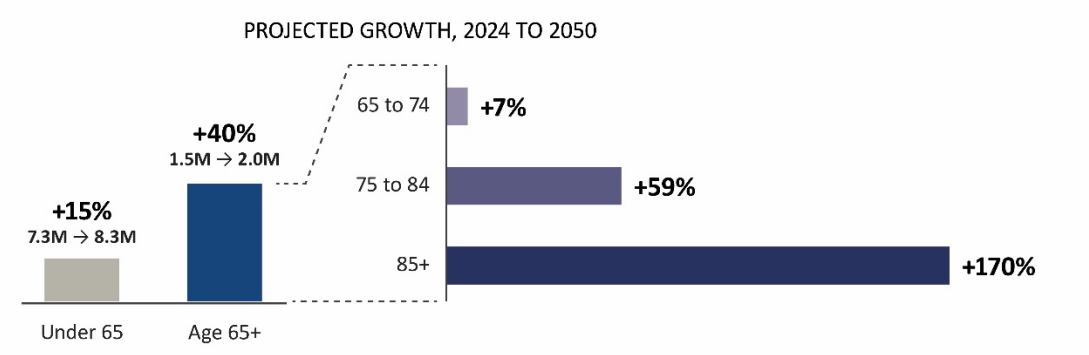
This study examines two core components of Virginia's aging services continuum: assisted living facilities, including memory care, and non-skilled, in-home personal care support with activities of daily living such as bathing, dressing, and mobility, as well as assistance with activities such as chores, meal preparation, and transportation. The study excludes other congregate care settings, most notably nursing facilities, as well as skilled or medical in-home care (e.g., home nursing services). Virginia has 580 assisted living facilities, ranging in size from four beds to 300 beds, about half of which offer memory care. Over 2,000 licensed home care organizations, with 38,000 direct-care staff, provide non-skilled, in-home care statewide.

Characteristics of older adults indicating potential need for services



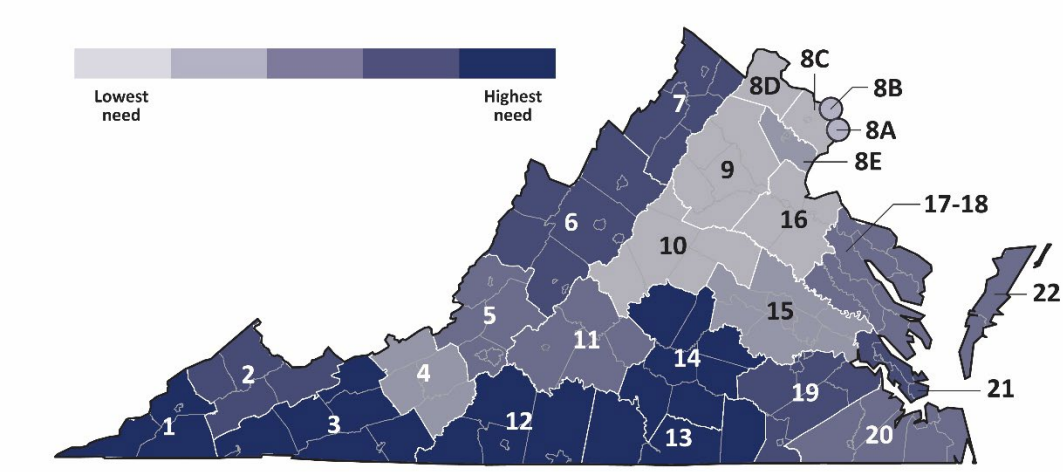
SOURCE: 2023 5-year American Community Survey data prepared for JLARC by Weldon Cooper Center at the University of Virginia. American Community Survey population estimates are subject to margins of error.

Virginia's older adult population is projected to grow 40 percent by 2050



SOURCE: 2024 American Community Survey 5-year population estimates and Virginia population projections from the Weldon Cooper Center at the University of Virginia Population Projections.

Older adults in Southwest and Southside regions have highest needs



SOURCE: 2023 5-year American Community Survey data prepared for JLARC by Weldon Cooper Center at the University of Virginia and 2024 American Community Survey 5-year estimates.

Assisted living and in-home care are typically least available in regions with the greatest needs

The supply of assisted living is uneven statewide even when accounting for differences in population and older adults' needs. The regions with the highest supply of assisted living have many more beds and facilities per older adult than the lowest-capacity regions. For example, Alexandria has more than 53 assisted living beds per 1,000 older adults compared with just 6.5 beds per 1,000 older adults in localities on the Eastern Shore, even though older adults on the Eastern Shore have a higher overall need for services and support. Likewise, rural regions in Southwest, Southside, and Eastern Virginia tend to have the highest proportions of adults with ambulatory, self-care, or independent living difficulty, but these regions have the fewest assisted living services.

The availability of memory care beds relative to potential need also varies significantly across the state. While Alexandria has 150 memory care beds per 1,000 older adults with cognitive difficulties, the three lowest-capacity regions in Southwest and Southside have about 10 or fewer beds per 1,000 older adults with cognitive difficulties. In far Southwest Virginia (Lee, Scott, Wise, and Dickenson counties and the City of Norton), there are no licensed memory care beds.

These trends are similar for in-home care services, and disparities are growing. Virginia regions with the lowest supply of in-home care services tend to be rural, and their older residents tend to have the greatest care needs. In-home services are most heavily concentrated in Northern Virginia and Hampton Roads and are least available in the state's Southwest, Southern, and Shenandoah regions. While new home care organization applications continue to increase statewide, so much so that the state cannot keep up with new licensure applications, new providers are disproportionately concentrated in regions that already have a lot of supply, especially Northern Virginia.

Most older Virginians do not have enough income to pay for assisted living or more than a few hours per week of in-home care

Access to assisted living and in-home care depends not only on their availability, but also on their affordability. Many older adults live on modest or fixed incomes that are insufficient to cover the high costs of long-term care but too high to qualify for public assistance. In addition, Medicare cannot be used to pay for assisted living or non-skilled, in-home care, and Medicaid cannot be used to pay for assisted living in Virginia.

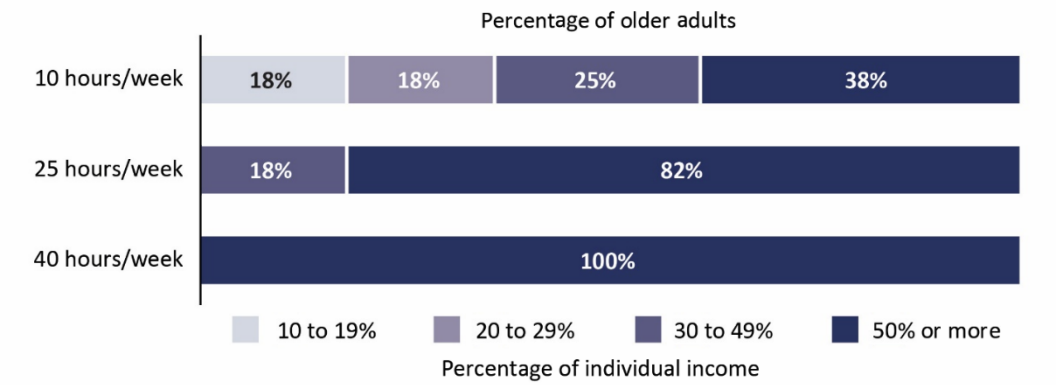
The average monthly cost of assisted living in Virginia was about $6,940 in 2025, according to the CareScout Cost of Care Survey, ranging from $5,734 to $8,725 monthly. The statewide average cost represents a 32 percent increase above the $5,250 figure in 2021 cited by the Joint Commission on Health Care's 2022 study, *Affordability of Assisted Living Facilities*. Just 18 percent of older Virginians have sufficient income to pay for average assisted living rates in their region. Assisted living ranges from being affordable for 33 percent of older adults in Alexandria to just 6 percent of older adults in Virginia's far Southwest region. Even when income from other family members is included, monthly assisted living costs range from about 62 percent to more than 100 percent of family median income across Virginia's regions.

The cost of memory care is estimated to be about 30 percent *higher* than typical assisted living facility costs, making memory care affordable to only 11 percent of older Virginians based on individual income. Even when income from other family members is included, the cost of memory care ranges from 81 percent to more than 100 percent of family median income across regions.

Affordability of assisted living is worse in regions where older adults have the greatest overall need, on average. In the eight regions with the highest levels of need among older adults (primarily Southwest and Southside), the proportion of older residents for whom assisted living is affordable is relatively small, compared with other regions.

Despite the relatively lower cost of in-home care, affording private pay in-home care is still difficult for many older adults. Like assisted living, in-home care is generally least affordable, relative to income, in regions where older adults have the highest overall need. The median statewide hourly private pay rate for in-home care was $35, ranging from $32 to $37 hourly by region. Eighty-two percent of older Virginians would have to spend at least half of their income to receive 25 hours of in-home care per week, and 63 percent of older Virginians can afford fewer than 10 hours per week of in-home care after paying for other essential expenses.

Just 10 hours of weekly in-home care costs 30 percent or more of the majority of older Virginians' income



SOURCE: JLARC analysis of 2023 5-year American Community Survey data prepared for JLARC by Weldon Cooper Center at the University of Virginia (adjusted to 2025 dollars) and CareScout Cost of Care Survey, 2026; https://www.carescout.com/cost-of-care.

Auxiliary grant program could be modified to help older or disabled adults pay for in-home care

Virginia's auxiliary grant is the only state government assistance program subsidizing assisted living costs, but it serves few older adults, and it has not kept up with the escalating cost of assisted living. Because the $2,130 monthly payment substantially lags the median private pay rate of $6,945 (in 2025), about two-thirds of facilities do not serve any auxiliary grant recipients. Just under 10 percent of total assisted living facility residents are auxiliary grant recipients, and fewer than half of these recipients are older adults. Raising the auxiliary grant to the rate that assisted living facility administrators say would be sufficient for them to accept auxiliary grant recipients would increase annual state and local spending by $38 million to $79 million. That estimate is based on current participation levels; if more facilities accepted the grant and more Virginians were able to use it, spending would increase even more.

Rather than tying auxiliary grant funds solely to expensive residential settings, Virginia could transition the grant into a more flexible cash assistance benefit. This change could allow eligible older, blind, or disabled adults to use the funds for in-home care

services, housing, utilities, or food. Virginia has already expanded the settings the auxiliary grant can be used for, adding supportive housing in 2016 to better serve individuals with severe mental illness, addiction, and substance abuse. To preserve the program's intent and target funds to individuals who are likely to need in-home support, eligibility could be based on the same functional criteria as the current auxiliary grant program.

New federal Medicaid rules in 2028 could create opportunities to reduce out-of-pocket assisted living costs for some Virginians

Unlike about half of all states, Virginia does not currently use Medicaid home- and community-based services (HCBS) waivers to pay for services in assisted living facilities but has done so in the past. Beginning in July 2028, new federal Medicaid waiver authority (under Section 1915(c)(11) of the Social Security Act) will allow states to apply to offer HCBS waivers to individuals not meeting a nursing facility level of care, which would be better aligned with the assisted living population, most of whom are not eligible for nursing home care. Using a Medicaid waiver for assisted living services would leverage federal matching funds, increasing facility payments more than an auxiliary grant increase would at the same state cost. More funding could incentivize additional facilities to accept lower-income, public-pay residents.

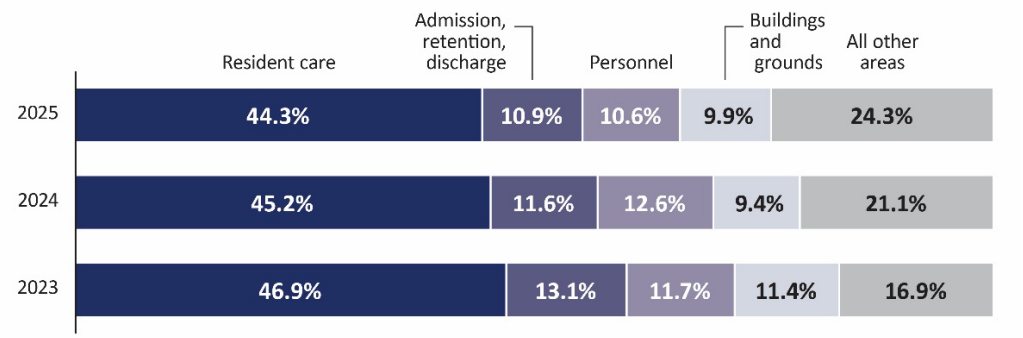
If Virginia applies for a Medicaid assisted living waiver in 2028, it could propose using the waiver to pay for general assisted living services, only memory care, or both. A waiver that targets or includes the Alzheimer's and dementia population would restore a Medicaid-supported option that Virginia has lacked since discontinuing its Alzheimer's Assisted Living waiver in 2018. Other states have Medicaid waiver programs that support individuals with dementia or Alzheimer's disease.

Quality of care is cause for concern in about 20 percent of assisted living facilities based on available information

Overall, Virginia Department of Social Services (VDSS) inspection results show the majority of assisted living facilities to be generally compliant with core health and safety requirements in 2025. When there are violations, they tend to be related to consequential resident care standards, including resident assessments and service planning, medication management, and personal care, rather than administrative requirements.

There does appear to be inconsistency in VDSS licensing inspectors' application of regulatory standards, however. Facility administrators and inspectors themselves raised concerns about inconsistent inspector practices, and JLARC's analysis of violations data supports these concerns.

Nearly half of violations each year cite resident care standards (2023–2025)



SOURCE: JLARC analysis of VDSS assisted living facility violation data, 2023–2025.
NOTE: Violations are categorized according to parts of the Standards for Licensed Assisted Living Facilities (22VAC40-73). Violations citing 22VAC40-80, 22VAC40-90, or the Code of Virginia are included in "all other areas." Percentages may not sum because of rounding.

Identifying concerns about the quality of care in these facilities requires reviewing operational data beyond basic licensing compliance. When including such information (e.g., adult protective services complaints and facility-specific observations by VDSS licensing inspectors, local department of social services, and area agency on aging staff), JLARC staff identified 122 assisted living facilities (21 percent) whose quality is cause for concern. On average, these facilities had significantly more total violations, serious violations, and substantiated incidents than all other assisted living facilities in 2025.

Area agency on aging and local department of social services staff, VDSS licensing inspectors, and facility administrators identified staffing and increasing resident acuity as the primary drivers of quality problems in assisted living facilities. These stakeholders described many specific incidents in which inadequate or ineffective staffing levels affected residents' care.

State's assisted living staffing standards are common but difficult to enforce, considered insufficient, and inconsistent with best practices

Virginia's assisted living facility staffing requirements are based on a "sufficiency" standard, broadly directing facilities to maintain enough staff to meet residents' care and safety needs. In addition, the regulation requires at least one direct care staff member to be awake and on duty in each building whenever residents are present. However, regulations do not specify any additional staffing minimums for assisted living care, regardless of resident census or most care needs.

Forty states use a general sufficiency model, and 24 also set a fixed minimum staffing floor like Virginia's "one awake staff" requirement. Other states require specific staffing levels, requiring either a fixed staff-to-resident ratio (Arkansas, Georgia, Maine, and South Carolina) or a minimum number of direct care hours per resident (Pennsylvania, Florida, and North Carolina).

National subject matter experts report that tying staffing requirements directly to residents' assessed care needs is the most effective approach to ensuring assisted living facilities are adequately staffed. Stakeholders suggest sufficiency standards, like Virginia's, give facilities too much discretion and do not ensure staffing is adequate to deliver quality care. The inadequacy of Virginia's staffing requirements is a longstanding challenge and has been identified as a deficiency in legislative reports dating back to 1979.

VDSS licensing inspectors and other licensing staff report that they frequently feel facilities are understaffed during inspections but cannot cite facilities because they meet the standard as long as they meet their own staffing plans.

Assisted living facility oversight is hindered by delays in complaint investigations, lack of additional monitoring for low-performing facilities, and outdated licensing system

VDSS also currently conducts a routine monitoring inspection once per year for most facilities, regardless of their compliance history. Therefore, the facilities most likely to have recurring or unaddressed problems receive the same level of routine oversight as better-performing ones.

The volume of complaints and self-reported incidents involving assisted living facilities has increased substantially in recent years, and reviewing and investigating these incidents now accounts for nearly half of inspectors' time. In JLARC's survey of VDSS licensing inspectors, only 19 percent reported being able to investigate complaints in a timely manner. Delays in investigating complaints and self-reported incidents can leave residents exposed to unsafe or harmful conditions. VDSS has kept pace with its required annual assisted living facility monitoring inspections and completed all required annual monitoring inspections on time in FY26.

VDSS's licensing software system is obsolete, does not meet operational and security standards, and lacks the functionality needed to help VDSS inspectors' efficiency or the agency's oversight of assisted living facilities. The system's mobile component was decommissioned in 2022, and VDSS staff report that inspection documentation now takes three times longer than it did with the mobile component. In addition, manual data collection and fragmented storage limit VDSS's ability to monitor trends in assisted living facility compliance. VDSS has further difficulty monitoring historical compliance trends because the system cannot generate reports on facilities' violation histories once the assigned inspector leaves the agency, leaving hundreds of facilities with incomplete violation records.

VDSS faces several barriers to holding assisted living facilities accountable for noncompliance

Despite regular use of enforcement actions, some poor-performing assisted living facilities are not held accountable. For example, of the 17 facilities identified by JLARC

staff as having the most significant quality concerns in 2025, only seven were subject to enforcement actions in FY25 or FY26. Statute caps the total civil penalties a facility can be assessed at $10,000 during a 12-month period, and the average civil penalty assessed between FY22 and FY25 was just $1,518. Licensing staff report that many facilities, especially larger ones, often treat these penalties simply as a cost of doing business.

A lengthy appeals process also allows some facilities to continue operating in noncompliance, and it is difficult for VDSS to intervene. The overall administrative process can take nine months or longer before an appeal even reaches judicial review. In addition, VDSS's internal procedures for enforcement actions are administratively burdensome and can discourage inspectors from pursuing them.

Weak state licensure of home care organizations allows ill-prepared organizations to operate, and many remain uninspected for years

The Virginia Department of Health's Office of Licensure and Certification (OLC) licenses and regulates home care organizations (HCOs). Many applicants for an HCO license are unprepared to complete the initial application or pass an on-site inspection. Initial applications are frequently of poor quality, contain basic errors, and lack required documentation, often requiring multiple rounds of revision with OLC staff. Furthermore, applicants regularly do not provide complete or accurate materials during initial on-site inspections.

Despite these deficiencies, OLC does not deny initial license applications. While the Code of Virginia implies that applications may be denied, neither state statute, administrative regulations, nor agency policy establishes explicit criteria for denial. As a result, OLC staff report they lack the clear authority needed to reject substandard applicants, allowing ill-prepared organizations to enter the market.

Most (about 90 percent) HCOs have not received a routine inspection within the required two-year time frame. OLC staff reported, and HCO providers confirmed, that some HCOs were last inspected more than a decade ago. OLC's home care division has substantial vacancies but could not conduct timely biennial inspections even if fully staffed, suggesting that OLC needs more inspector positions.

OLC inspections rarely include contact with HCO clients, either through interviews or in-home visits. Home visits were a required component of biennial inspections until 2012, when OLC leadership discontinued them. Without them, OLC inspectors have no first-hand information on the quality, appropriateness, or timeliness of the services HCO staff deliver. Inspectors instead review documentation that presents an insufficient picture of service delivery and HCO/client interactions.

The state also lacks sufficient enforcement authority and guidance to ensure HCOs comply with requirements. When an inspector identifies a deficiency, the public is not informed, OLC cannot impose a financial penalty, and there typically is no follow-through to ensure that the HCO has corrected the problem. HCOs face no

consequences if they do not follow through on plans of correction to correct deficiencies, and the Virginia Department of Health's (VDH) authority to suspend or revoke a license has not been used in the past three years. Enforcement mechanisms with financial or reputational consequences could help improve HCO compliance. Other states use a broader range of enforcement actions for HCOs, as do Virginia agencies that oversee other types of care settings, including financial penalties, restrictions on licensure or admissions, public disclosure of violations, and immediate ("summary") license suspension.

WHAT WE RECOMMEND

Legislative action

- Provide funding for Virginia's area agencies on aging to expand in-home services to eligible but unserved older adults.
- Replace the current assisted living facility staffing standard with enforceable minimum staffing requirements based on resident census and assessed care needs.
- Provide funding to VDSS for additional assisted living facility licensing inspectors.
- Require VDSS to conduct additional unannounced inspections each year of a randomly selected subset of assisted living facilities in each licensing region that demonstrate indicators of poor performance or high risk.
- Provide funding to replace the Division of Licensing Programs' IT system used to license and monitor assisted living facilities.
- Increase the dollar value of civil penalties that may be assessed against an assisted living facility.
- Grant VDH's OLC the explicit authority to deny a home care organization's application for licensure under specific circumstances.
- Grant VDH's OLC expanded authority to impose sanctions, graduated financial penalties, and license restrictions, and require inspection results to be posted publicly.
- Authorize the state health commissioner to summarily suspend the license of a home care organization when conditions or practices pose an immediate and substantial threat to the organization's clients.

Executive action

- VDSS to publish for each assisted living facility all regulatory standard violations and their severity ratings, state-imposed sanctions, and substantiated Adult Protective Services findings against facility staff on the assisted living facility search tool available on the VDSS website.

- VDSS to establish a special investigations unit within the Division of Licensing Programs, staffed by experienced inspectors, to exclusively investigate complaints and self-reported incidents involving the greatest risk of harm to assisted living facility residents.
- VDH to make in-home client visits and client interviews components of the biennial inspection for a sample of home care organizations.
- VDH to inspect a random sample of HCOs with overdue biennial inspections each year, develop a risk-based strategy for selecting HCOs for required biennial inspections, and prioritize HCOs serving the most clients for required biennial inspections.

Legislative Policy Options for Consideration

JLARC staff propose policy options for the General Assembly's consideration, rather than recommendations, when (1) the action proposed is a policy judgment best made by elected officials, (2) addressing a report finding is not necessarily required but doing so could be beneficial, (3) there are multiple ways to address a report finding, and there is insufficient evidence to support a single best way.

- Direct VDSS to plan for implementing an assisted living facility quality reporting system that includes measures of resident health outcomes, resident and family satisfaction, and facility staffing that would be available to the public through the VDSS website.
- Allow individuals who meet the functional criteria for the auxiliary grant to receive the grant as direct cash assistance even if they do not reside in an assisted living facility, adult foster care home, or supportive housing setting, while retaining the requirement that providers in those settings that accept the grant charge recipients no more than the established grant rate.
- Direct the Department of Medical Assistance Services (DMAS) to conduct the background research and administrative steps required to apply for a 1915(c)(11) Medicaid waiver, to be used to reimburse assisted living facilities for eligible residents' services, and to develop a timeline for applying for the waiver once the application window opens in 2028, and for the Department for Aging and Rehabilitative Services and the Virginia Department of Social Services to support DMAS as needed in this effort.

The complete list of recommendations is available on page xi.

Recommendations and Policy Options: Virginia's Assisted Living Facilities and In-Home Care Services for Older Adults

RECOMMENDATION 1

The General Assembly may wish to consider including funding in the Appropriation Act expressly for area agencies on aging to expand in-home care services to older adults who are eligible but are not currently served. (Chapter 2)

RECOMMENDATION 2

The General Assembly may wish to consider including language in the Appropriation Act directing the Department of Medical Assistance Services (DMAS) to conduct a comprehensive cost study of Medicaid reimbursement rates for agency-directed personal care services that should include (i) an assessment of the actual costs incurred by providers to deliver these services, including the costs necessary to provide competitive wages to direct care staff; (ii) a comparison of Virginia's reimbursement rates to those of other states; (iii) a determination of whether certain regulatory requirements could be modified to reduce providers' operating costs without compromising the quality and safety of care; (iv) a determination of the feasibility of publishing a list of approved electronic visit verification providers to reduce the administrative costs HCOs incur when selecting one; and (v) recommendations regarding the need for modifying the existing personal care rates, if justified. DMAS should submit a report of its findings to the House Appropriations and Senate Finance and Appropriations committees by December 1, 2027. (Chapter 2)

RECOMMENDATION 3

The Virginia Department of Social Services (VDSS) should publish on its public-facing assisted living facility search tool, by January 1, 2028: (i) additional facility characteristic information, including offered room types, typical charges and fees, admissions criteria, auxiliary grant participation, and whether the facility is part of a continuing care retirement community; (ii) the severity rating assigned to each standards violation; (iii) the number of, if any, substantiated APS investigations against facility employees within the last three years; and (iv) any sanctions imposed on the facility by VDSS for standards violations. This information should be regularly updated, and the search tool should specify the date of the last update. (Chapter 3)

RECOMMENDATION 4

The General Assembly may wish to consider amending § 63.2-1803 of the Code of Virginia to (i) replace the current "sufficiency standard" for assisted living facility direct care staffing with requirements that the number and types of direct care staff on duty at each facility be determined by resident census and the amount and types of assistance and care residents require and (ii) require the Board of Social Services to establish the explicit, detailed staffing standards that facilities must follow to meet the statutory requirements. (Chapter 4)

RECOMMENDATION 5

The Virginia Department of Social Services (VDSS) should (i) identify the causes of regional variation in assisted living facility violation citations; (ii) develop clear guidance articulating the agency's regulatory philosophy and expectations for inspection consistency; and (iii) provide additional training to inspectors on core inspection functions. (Chapter 5)

RECOMMENDATION 6

The General Assembly may wish to consider including funding in the Appropriation Act for additional full-time classified licensing inspector positions within the Division of Licensing Programs at the Virginia Department of Social Services. (Chapter 5)

RECOMMENDATION 7

The Virginia Department of Social Services should establish a special investigations unit within its Division of Licensing Programs, staffed by experienced licensing inspectors, to exclusively investigate complaints and self-reported incidents involving the greatest risk of harm to assisted living facility residents. (Chapter 5)

RECOMMENDATION 8

The General Assembly may wish to consider amending § 63.2-1706 of the Code of Virginia to require the Virginia Department of Social Services to conduct an additional unannounced inspection each year of a randomly selected subset of assisted living facilities in each licensing region that demonstrate indicators of poor performance or high risk. (Chapter 5)

RECOMMENDATION 9

The General Assembly may wish to consider including funding in the Appropriation Act for the Virginia Department of Social Services to replace the information technology system used to license and monitor assisted living facilities and other licensed settings under the purview of the Division of Licensing Programs. (Chapter 5)

RECOMMENDATION 10

The Virginia Department of Social Services should ensure that any new licensing system includes (i) a mobile component for inspectors to enter inspection data in real time; (ii) the ability to aggregate historical compliance records for a facility; (iii) centralized intake, triaging, and tracking of complaints and self-reported incidents; (iv) dashboard and analytic capabilities for historical and real-time trend analyses; and (v) capacity to collect and maintain comprehensive facility quality and performance metrics. (Chapter 5)

RECOMMENDATION 11

The General Assembly may wish to consider amending § 63.2-1709.2 of the Code of Virginia to increase the maximum civil penalties that may be assessed against an assisted living facility. (Chapter 5)

RECOMMENDATION 12

The General Assembly may wish to consider amending § 63.2-1709 of the Code of Virginia to require assisted living facilities to provide written notice of the intent of the Virginia Department of Social Services commissioner to revoke or deny renewal of the facility's license to all facility residents and their guardians, including when the commissioner's decision has been appealed by the facility. (Chapter 5)

RECOMMENDATION 13

The Virginia Department of Social Services (VDSS) should (i) establish criteria and a review process to determine whether a bona fide change in ownership and facility management has occurred when an assisted living facility applies for licensure under new ownership, and (ii) remove compliance history associated with a previous owner from the VDSS website only if the applicant demonstrates that a bona fide change in ownership and facility management has occurred. (Chapter 5)

RECOMMENDATION 14

The Virginia Department of Social Services should streamline its internal enforcement process for assisted living facilities by eliminating any unnecessary administrative burdens identified by inspectors, including unnecessary or overly burdensome documentation requirements. (Chapter 5)

RECOMMENDATION 15

The General Assembly may wish to consider amending the Code of Virginia to grant the Virginia Department of Health's Office of Licensure and Certification (OLC) express authority to deny applications for licensure when (i) an applicant submits a letter of readiness but lacks required policies, procedures, or documentation necessary to complete the initial inspection, (ii) the applicant's plan of correction is inadequate to address deficiencies identified during the initial inspection, or (iii) an applicant cannot demonstrate to OLC that it has addressed deficiencies identified during the initial inspection. (Chapter 6)

RECOMMENDATION 16

The General Assembly may wish to consider including language and funding in the Appropriation Act to establish a dedicated provider educator position within the Virginia Department of Health's Office of Licensure and Certification to assist applicants with their applications for home care organization licensure. (Chapter 6)

RECOMMENDATION 17

The Virginia Department of Health's Office of Licensure and Certification should develop and publish on its website (i) an available-on-demand webinar that explains the home care organization licensure process, the applicable regulations, and the most common reasons applications are returned, and (ii) a self-assessment checklist, tied to each regulatory requirement, that applicants can use to verify that their application is complete and that they have all required materials before they submit a letter of readiness. (Chapter 6)

RECOMMENDATION 18

The Virginia Department of Health's Office of Licensure and Certification (OLC) should immediately incorporate in-home client visits and client interviews into biennial inspections for a sample of home care organizations, using procedures that protect client confidentiality. (Chapter 6)

RECOMMENDATION 19

The Virginia Department of Health's Office of Licensure and Certification (OLC) should, until its inspection backlog is cleared, prioritize biennial inspections of home care organizations that are not subject to external oversight as Medicaid providers or as contractors for area agencies on aging. (Chapter 6)

RECOMMENDATION 20

The General Assembly may wish to consider including language in the Appropriation Act directing the Virginia Department of Health (VDH) to evaluate the cost-effectiveness of incentivizing third-party accreditation for non-skilled home care organizations (HCOs) to reduce the Office of Licensure and Certification's (OLC) inspection workload. VDH should (i) estimate state costs to incentivize accreditation versus current OLC inspection costs, both in the near term and long term, and (ii) submit a proposal for such incentives to the Office of the Governor, the House Appropriations Committee, and the Senate Finance and Appropriations Committee if VDH determines that providing such an incentive would be cost-effective. (Chapter 6)

RECOMMENDATION 21

The Virginia Department of Health should issue a Request for Information to assess the feasibility of using third-party organizations to supplement its home care organization inspection staff and, if feasible, procure third-party inspection services. (Chapter 6)

RECOMMENDATION 22

The Virginia Department of Health's Office of Licensure and Certification should implement a statewide regional approach for conducting its inspections of home care organizations, which should include defined regions and a plan to hire inspectors who live in those regions. (Chapter 6)

RECOMMENDATION 23

The General Assembly may wish to consider amending the Code of Virginia to authorize the Virginia Department of Health's Office of Licensure and Certification (OLC) to levy an administrative fine on a home care organization (HCO) when an inspector cannot conduct an unannounced inspection because (i) the HCO's office is closed during operating hours and its administrator or designee cannot be reached, or (ii) the HCO has moved without notifying OLC of its new address. (Chapter 6)

RECOMMENDATION 24

The Virginia Department of Health's Office of Licensure and Certification should maximize its oversight effectiveness with its existing inspection resources by (i) each year, selecting a random sample of home care organizations (HCOs) with overdue biennial inspections for inspection, rather than inspecting HCOs solely in order of their last inspection date, to reduce predictability, (ii) developing a risk-based strategy for selecting HCOs for biennial inspections, and (iii) prioritizing HCOs serving the most clients for biennial inspections. (Chapter 6)

RECOMMENDATION 25

The General Assembly may wish to consider amending the Code of Virginia to (i) grant the Virginia Department of Health's Office of Licensure and Certification (OLC) expanded authority to impose sanctions, graduated financial penalties, and license restrictions, and (ii) require that inspection results be posted on a public-facing website, which should be updated regularly and specify the date of the last update. (Chapter 6)

RECOMMENDATION 26

The General Assembly may wish to consider amending § 32.1-162.13 of the Code of Virginia to authorize the state health commissioner to summarily suspend the license of a home care organization, in conjunction with any proceeding for revocation, denial, or other action, when conditions or practices pose an immediate and substantial threat to the health, safety, and welfare of the organization's clients. (Chapter 6)

RECOMMENDATION 27

The General Assembly may wish to include language and funding in the Appropriation Act directing the Department for Aging and Rehabilitative Services to contract with a third-party expert to (i) collect and analyze data on the costs of operating assisted living facilities that serve auxiliary grant recipients, separating out costs associated with room and board from those associated with services and supports, (ii) estimate the auxiliary grant rate needed to adequately cover those costs, and (iii) report the results to the House Appropriations Committee and the Senate Finance and Appropriations Committee by November 30, 2027. (Chapter 8)

Policy Options to Consider

POLICY OPTION 1

The General Assembly could include language in the Appropriation Act directing the Virginia Department of Social Services to (i) submit to the House Appropriations and Senate Finance and Appropriations committees and the House Health and Human Services and Senate Rehabilitation and Social Services committees an implementation plan for a quality reporting system for licensed assisted living facilities that includes measures of resident health outcomes, resident and family satisfaction, and facility staffing; (ii) pilot test the system with a sample of facilities; and (iii) implement and make available on its website the comprehensive quality reporting system. The language could also direct the State Board of Social Services to promulgate regulations requiring all licensed assisted living facilities to report the measures included in the system as a condition of licensure. (Chapter 3)

POLICY OPTION 2

The General Assembly could (i) amend §§51.5-159 and 51.5-160 of the Code of Virginia to allow individuals who meet the functional criteria for auxiliary grant eligibility to receive the grant as direct cash assistance, even if they do not reside in an assisted living facility, adult foster care home, or supportive housing setting, while retaining the requirement that providers in those settings that accept the grant charge recipients no more than the established grant rate; (ii) include language in the Appropriation Act capping participation in the direct cash assistance option; (iii) include language in the Appropriation Act directing the Department for Aging and Rehabilitative Services (DARS) to amend 22VAC30-80 of the Virginia Administrative Code to establish financial eligibility requirements for the direct cash assistance option; and (iv) direct DARS to seek approval of the program changes from the Social Security Administration. (Chapter 8)

POLICY OPTION 3

The General Assembly could direct the Department of Medical Assistance Services to complete the background research and administrative steps required to apply for and implement a 1915(c)(11) assisted living waiver. This research would (i) determine the needs-based eligibility requirements, (ii) identify the services to be covered, (iii) estimate the number of potentially eligible individuals with and without a diagnosis of Alzheimer's or dementia, (iv) determine a rate adequate to meet cost-neutrality requirements and attract providers, (v) identify the number of potentially interested and eligible facility providers, (vi) produce a fiscal impact estimate, and (vii) present a timeline for applying for the waiver once the application window opens in 2028. The Department for Aging and Rehabilitative Services and Virginia Department of Social Services should be directed to support DMAS as needed in this effort. (Chapter 8)

1 Introduction

The Joint Legislative Audit and Review Commission approved a study resolution directing a review of non-medical support for aging Virginians, focusing on service quality and availability. The review covers non-skilled in-home care and congregate housing, including assisted living and memory care units. Additionally, the resolution directs JLARC to develop recommendations for expanding service access, including through a potential Medicaid waiver.

To complete this study, JLARC staff conducted structured and group interviews with state and local agency staff; industry groups; subject matter experts; assisted living and home care administrators; caregiver coordinators; and emergency medical service providers. JLARC staff also surveyed assisted living administrators, Virginia Department of Social Services (VDSS) licensing inspectors, area agencies on aging, and local departments of social services; and collected supplemental data directly from facilities where state data was incomplete. JLARC staff analyzed licensing, inspection, complaint, and enforcement data from VDSS; Medicaid data from the Virginia Department of Medical Assistance Services; and demographic data from the U.S. Census Bureau and the Weldon Cooper Center for Public Service at the University of Virginia. JLARC staff reviewed Virginia's laws, regulations, and agency policies and those of comparison states for assisted living and home care organization (HCO) oversight. Finally, JLARC observed VDSS staff conducting assisted living inspections and reviewed relevant research literature. (See Appendix B for more information on methods used for this study.)

Providers of **non-skilled in-home care** are trained caregivers, home health aides, and personal care attendants whose knowledge and skills are used to perform the demanding and essential work of providing the services and supports that older adults and adults with disabilities need to remain safe in their homes.

The term "non-skilled" is used strictly to differentiate from "skilled home health care," which is provided by licensed medical professionals (e.g., registered nurses, physical therapists) for specific conditions, often under a physician's order.

Assisted living and home care are key supports for older adults, a population that will grow rapidly

This study examines two aspects of Virginia's aging services landscape: assisted living facilities (ALFs), including memory care, and non-skilled in-home care. Non-skilled in-home care refers to personal care support with activities of daily living (ADLs) such as bathing, dressing, and mobility, as well as instrumental activities of daily living (IADLs), such as chore assistance, meal preparation, transportation, and companionship (sidebar). The study excludes other congregate care settings, most notably nursing facilities, as well as skilled or medical in-home care (e.g., home health nursing services).

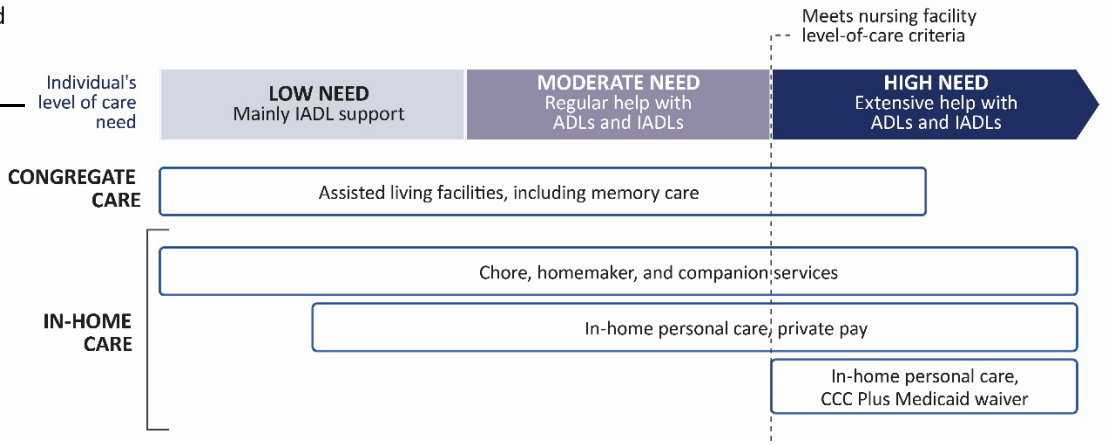
This report uses the term **older adults** to represent adults age 65 and older. The report uses specific age ranges when discussing subsets of the older adult population (e.g., age 85 and older or age 75 to 84).

ALFs and non-skilled home care are part of a broader continuum of services and support for older adults (Figure 1-1) (sidebar). ALFs generally serve individuals with low-to-moderate care needs (i.e., "acuity"), which are lower than the care needs of nursing home residents. Higher-acuity individuals are allowed to remain in assisted living under certain circumstances under Virginia law (Chapter 8). Non-skilled home

care, by contrast, is generally not bound by an acuity threshold and covers a range of in-home assistance that older adults can obtain through several arrangements. Individuals commonly hire and pay for non-skilled home care privately. Virginia's Commonwealth Coordinated Care (CCC) Plus Medicaid waiver also covers the cost of non-skilled in-home care, but only for Medicaid members whose needs qualify them for a nursing facility level of care. To a lesser extent, area agencies on aging (AAAs) (sidebar) or local departments of social services may arrange in-home care for people with varying care needs, often those with at least some financial need.

Area agencies on aging (AAAs) are local public or nonprofit entities designated under the federal Older Americans Act to plan, coordinate, and provide services to individuals aged 60 and older within a designated planning and service area (PSA). Virginia is served by 25 AAAs, which receive federal funding administered through the Virginia Department for Aging and Rehabilitative Services (DARS).

FIGURE 1-1
Assisted living facilities and non-skilled in-home care are part of a broader continuum of care and services for older adults



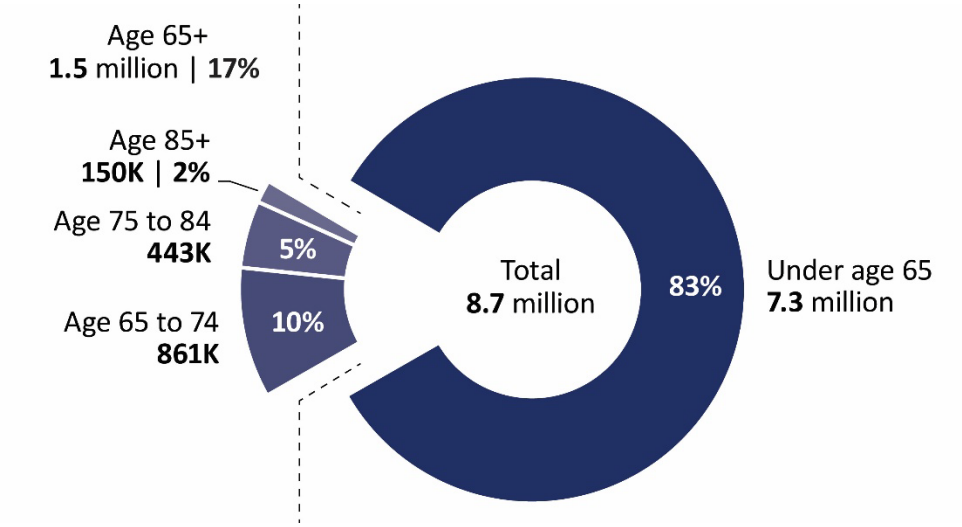
SOURCE: JLARC staff.

The **old-age dependency ratio** is the ratio of a state's 65 and older population relative to its working-age population (age 18 to 64). A higher ratio means there are more older adults relative to workers, which puts strain on pension systems, healthcare, and social programs.

Virginia has 1.5 million older adults; one in eight has difficulty living independently

Virginia has 1.5 million older adults, comprising about 17 percent of the population (Figure 1-2). Virginia's older adult population is smaller relative to its overall population than that of most states nationwide, ranking 40th among the 50 states and Washington, D.C. Virginia also has a comparatively low "old-age dependency ratio" of 27.1 older adults per 100 working-age adults, ranking 43rd among the 50 states and Washington, D.C. (sidebar).

FIGURE 1-2
1.5 million older adults comprise 17 percent of Virginia's population (2024)



SOURCE: 2024 American Community Survey 5-year estimates.
NOTE: American Community Survey population estimates are subject to margins of error.

The U.S. Census Bureau asks survey respondents about several demographic characteristics that can signify the potential need for aging-related services and support. Among Virginians age 65 and older, 31 percent report having one or more disabilities, 19 percent have ambulatory difficulty, 12 percent have independent living difficulty, 7 percent have cognitive difficulty, and 7 percent have self-care difficulty (Figure 1-3) (sidebar). These characteristics are much more common among the oldest adults: rates are three to five times higher among those aged 85 and older than among those aged 65 to 74, and roughly double the rates seen among those aged 75 to 84. Finally, 26 percent of older Virginians live alone, which is another indicator of potential need for support, since these individuals have no other household members available to assist them. Compared with other states, Virginia does not rank especially high in terms of the proportion of its older adults with these characteristics (Table 1-1).

The American Community Survey defines:

ambulatory difficulty as having serious difficulty walking or climbing stairs;

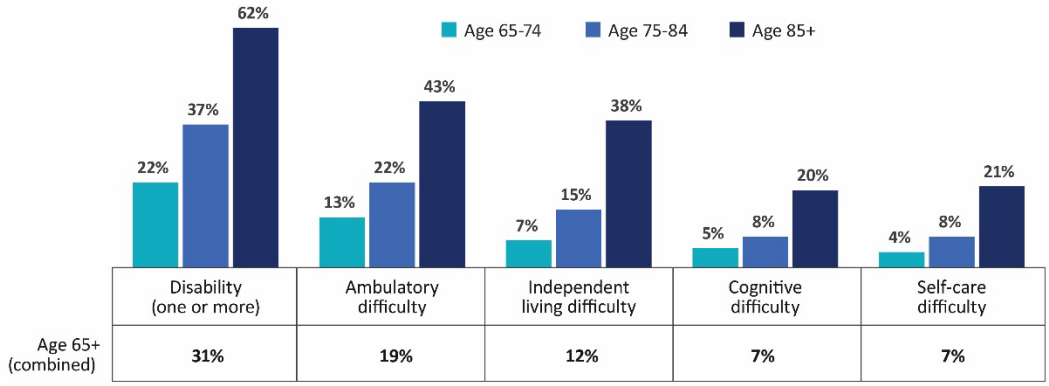
independent living difficulty as having difficulty doing errands alone—such as visiting a doctor's office or shopping—because of a physical, mental, or emotional problem;

cognitive difficulty as having serious difficulty remembering, concentrating, or making decisions because of a physical, mental, or emotional problem; and

self-care difficulty as having serious difficulty dressing or bathing.

Individuals often exhibit more than one of these characteristics, and the data is not unduplicated.

FIGURE 1-3
Older adults often have characteristics that indicate potential need for services and support



SOURCE: 2023 5-year American Community Survey data prepared for JLARC by Weldon Cooper Center at the University of Virginia.
NOTE: Percentages represent the proportion of individuals in an age group with the characteristic. Individuals may have more than one type of disability, so categories are not mutually exclusive. American Community Survey population estimates are subject to margins of error.

TABLE 1-1
Virginia ranks near middle of states for proportion of older adults with characteristics often needing support

	Disability	Ambulatory difficulty	Independent living difficulty	Cognitive difficulty	Self-care difficulty
Virginia (% of older adults)	31%	19%	12%	7%	7%
Nationwide (% of older adults)	33%	20%	13%	8%	7%
Rank (out of 51)	**37**	**29**	**25**	**29**	**24**

SOURCE: 2024 5-year American Community Survey data.
NOTE: Rank out of 50 states and Washington, D.C. Rank of 1 is equal to *highest* proportion of older adults with a characteristic (i.e., more people with disabilities or difficulties), rank 51 is the lowest proportion.

Characteristics of Virginia's older rural population indicate they may have a greater need for services and support

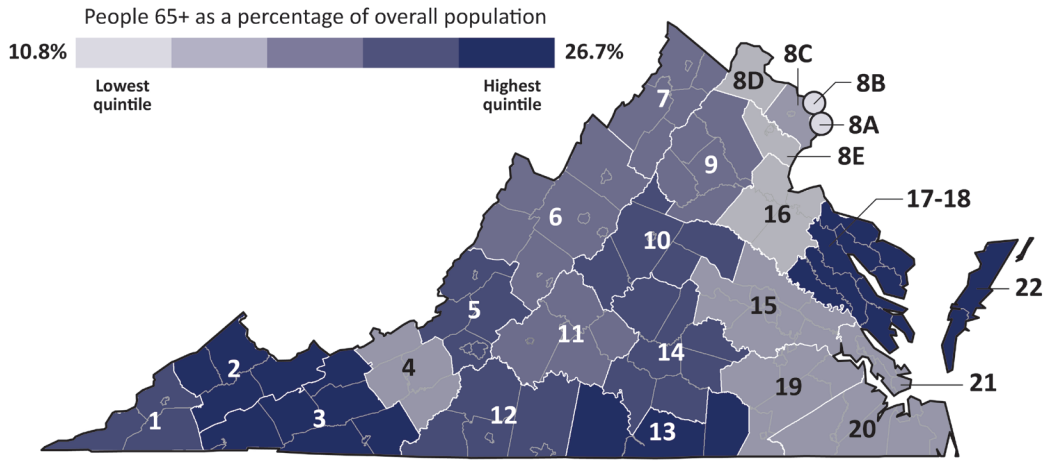
Statewide analysis of older adult demographics provides limited insight into the older adult population because population size and characteristics vary substantially by region. This report uses Planning and Service Areas (PSAs), which correspond to Virginia's 25 AAAs, to describe regional demographic variation (sidebar).

Virginia's rural regions have higher proportions of older adults (Figure 1-4). Older adults account for over one-quarter of the total population in PSA 22 Eastern Shore (26.7 percent), PSA 17/18 Northern Neck-Middle Peninsula (26.1 percent), and PSA 13 Southside (25.5 percent). (See Appendix D.) This is more than double the rate in

Planning and Service Areas (PSAs) for aging programs are established federally by the Older Americans Act. PSAs are officially identified only by number, and AAA names affiliated with PSA numbers follow varied conventions. As a result, **JLARC developed regional names** to make references to individual PSAs more intuitive throughout the report. These names are used for readability purposes only and are not official names.

the regions with the smallest proportions of older adults, which tend to be concentrated in Northern Virginia. By another measure, six rural regions of Virginia have a higher percentage of older adults than any U.S. state. (Maine has the highest statewide proportion in the nation at 22.4 percent.)

FIGURE 1-4
Southwest, Southside, and eastern portions of the state have the greatest proportions of older adults (Age 65+)



SOURCE: 2024 American Community Survey 5-year estimates.
NOTE: Regions are PSAs, which correspond to local area agencies on aging. See Appendix D for additional data about 65 and older population by PSA. American Community Survey population estimates are subject to margins of error.

Likewise, rural regions tend to have higher proportions of older adults with demographic characteristics that indicate potential need for aging-related services and support. For example, older adults residing in PSA 1 Far Southwest tend to most commonly exhibit these characteristics (Table 1-2). In addition, PSA 17/18 Northern Neck-Middle Peninsula has the highest percentage of very old adults (age 85+) as a proportion of its population. One outlier on this list is PSA 8A Alexandria, which has the highest percentage of older adults living alone. However, several rural regions also have high proportions of older adults living alone.

Quantifying an overall level of need among those older adults can provide greater insight into where demand for services and supports is most acute. To assess the overall need of older adults across Virginia's PSAs, JLARC created a composite ranking based on six key measures of need. These measures included the percentage of the population that is very old (age 85+) and the percentage of the population age 65 or older who were living alone or who had ambulatory difficulty, cognitive difficulty, self-care difficulty, or independent living difficulty.

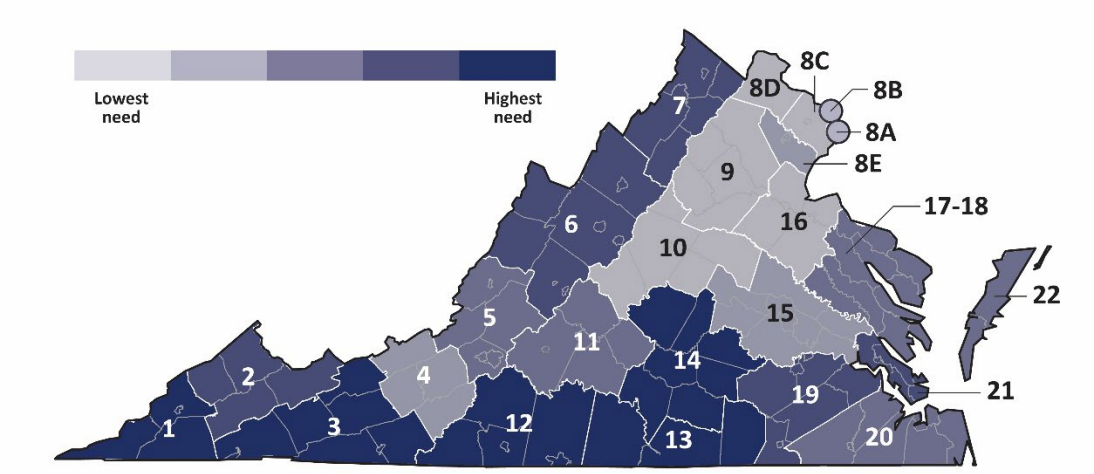
TABLE 1-2
Proportion of older adults with characteristics of need is more than twice as high in some regions as others

Characteristic	PSA with lowest proportion of adults 65+ with characteristic	PSA with highest proportion of adults 65+ with characteristic	Statewide proportion
Ambulatory difficulty	8A Alexandria (15%)	1 Far Southwest (34%)	19.2%
Independent living difficulty	9 Rappahannock-Rapidan (9%)	1 Far Southwest (20%)	12.4
Cognitive difficulty	8A Alexandria (5%)	1 Far Southwest (14%)	7.3
Self-care difficulty	22 Eastern Shore (4%)	1 Far Southwest (12%)	6.7
Living alone	8D Loudoun (18%)	8A Alexandria (40%)	26.4
Very old (% of pop. age 85+)	8E Prince William (1%)	17/18 Nor. Neck-Mid. Peninsula (3%)	1.7

SOURCE: 2023 5-year American Community Survey data prepared for JLARC by Weldon Cooper Center at the University of Virginia.
NOTE: See Appendix D for full list of PSAs by characteristic. PSA names are used for readability purposes only and do not reflect any official designations. American Community Survey population estimates are subject to margins of error.

Older adults in the rural regions of Southwest and Southside Virginia have the highest overall potential need for services and support, such as assisted living or in-home care, relative to other regions (Figure 1-5). The six PSAs that ranked highest statewide were all in these two areas: PSA 1 (Far Southwest), PSA 2 (Southwest Coalfields), PSA 3 (Bristol-Galax), PSA 12 (Martinsville-Danville), PSA 13 (Southside), and PSA 14 (Southern Piedmont).

FIGURE 1-5
Older adults in Southwest and Southside regions have highest needs

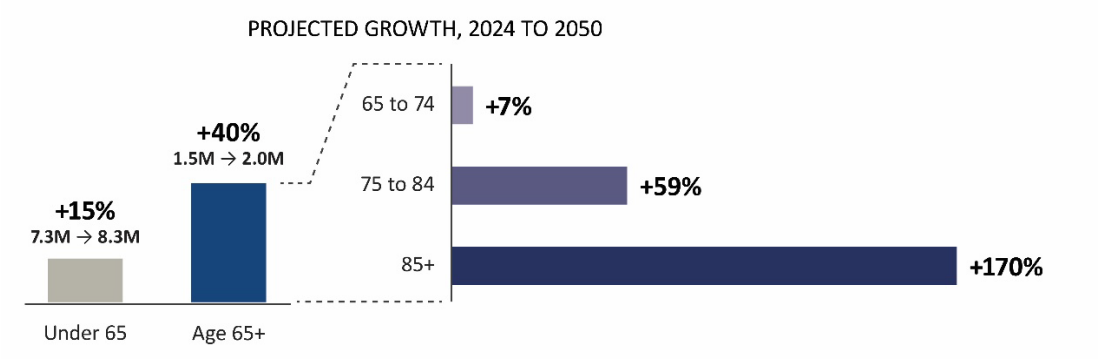


SOURCE: 2023 5-year American Community Survey data prepared for JLARC by Weldon Cooper Center at the University of Virginia and 2024 American Community Survey 5-year estimates.
NOTE: To calculate "overall need rank", each PSA's ranks on the six measures were averaged, and PSAs were then ranked by that average; see Appendix D for additional data about overall need by PSA. Regions are PSAs, which correspond to local area agencies on aging. American Community Survey population estimates are subject to margins of error.

Virginia's older adult population is projected to grow substantially, especially the very old

Virginia's population is aging, and the share of older adults, especially the very old, is expected to grow in the coming years. By 2050, Virginia's 65 and older population is projected to grow 40 percent from 1.5 million to just over 2 million (Figure 1-6). In addition, the very old population (age 85+) is projected to more than double by 2050, from 150,000 to 405,000 (+170 percent). By contrast, the under-65 population is projected to grow by just 15 percent, resulting in relatively fewer working-age adults to care for or provide services needed by older adults. These trends mirror nationwide projections.

FIGURE 1-6
Virginia's older adult population is projected to grow 40 percent by 2050



SOURCE: 2024 American Community Survey 5-year population estimates and Virginia population projections from the Weldon Cooper Center at the University of Virginia.

The older adult population is projected to grow fastest in Northern Virginia, at least doubling by 2050 in some Northern Virginia PSAs (Table 1-3), even though rural regions of the state will continue to have the highest proportion of older adults. Conversely, the older adult population is expected to decline in three southwest/southside regions by 2050; however, because the under-65 population will drop even faster, older adults will make up an increasing share of local residents. The three regions with the greatest current proportion of older adults are projected to remain the top three in 2050: PSA 22 Eastern Shore, PSA 17/18 Northern Neck-Middle Peninsula, and PSA 13 Southside.

TABLE 1-3
Northern Virginia regions projected to have highest relative growth in older adult population (2024 to 2050)

		Projected change (2024 to 2050)			
		Age 65+ population		Under age 65 population	
	PSA	% change	# change	% change	# change
	8D Loudoun	178%	83K	54%	207K
Highest	8E Prince William	114	70K	34	167K
	16 Fredericksburg	99	52K	31	105K
	Statewide	**40**	**580K**	**15**	**1.1M**
	13 Southside	-6	-1.2K	-27	-16K
Lowest	1 Far Southwest	-9	-1.6K	-31	-20K
	2 Southwest Coalfields	-22	-5.1K	-37	-28K

SOURCE: 2024 American Community Survey 5-year population estimates and Virginia population projections from the Weldon Cooper Center at the University of Virginia Population Projections.
NOTE: See Appendix D for full list of projected population change by PSA. PSA names are used for readability purposes only and do not reflect any official designations. American Community Survey population estimates are subject to margins of error.

About 30,000 Virginians live in assisted living facilities, most of whom are estimated to be 65 or older

As of 2026, approximately 30,000 adults reside in Virginia's assisted living facilities. Virginia-specific data on the age of assisted living residents is not available, but the National Center for Health Statistics (NCHS) reports that nationwide, 10 percent of assisted living residents are age 65–74, 31 percent are age 75–84, and 53 percent are age 85 or older; just 6 percent are younger than 65. NCHS also reports that 67 percent of assisted living facility residents are female and 33 percent are male.

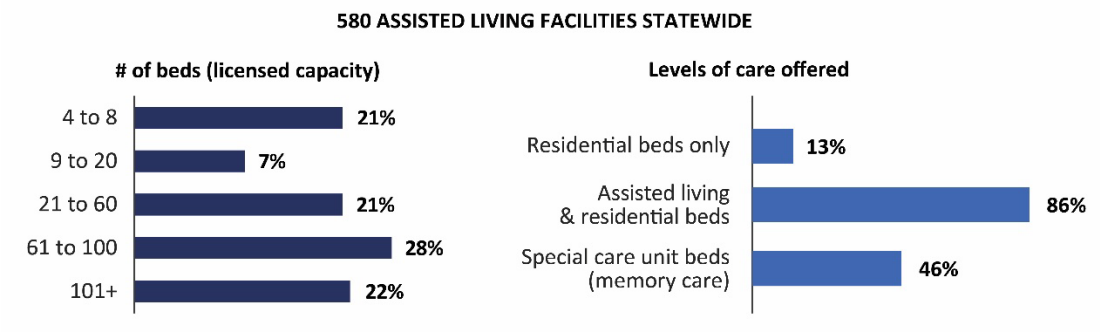
Virginia has 580 assisted living facilities, ranging in size from four beds to 300 beds. About half have 60 or fewer beds, and about 20 percent are very small with eight or fewer beds (Figure 1-7).

Virginia's assisted living facilities serve residents with differing care level needs. The levels of care are defined as:

- **Residential living care** is for residents requiring only minimal assistance with the activities of daily living, which includes individuals who are dependent on medication administration.
- **Assisted living care** is for residents requiring at least moderate assistance with activities of daily living.
- **Safe, secure environment (i.e., memory care)** is a self-contained special care unit for residents with serious cognitive impairments due to a primary diagnosis of dementia who cannot recognize danger or protect their own safety and welfare. This report refers to safe, secure environments as memory care.

State law requires that each facility be licensed to provide either residential living care only, or residential living care *and* assisted living care. Facilities licensed for both can also provide memory care for residents with dementia. Most of Virginia's ALFs are licensed to provide residential living care *and* assisted living care (494 facilities or 86 percent), with just 13 percent licensed for only residential level of care (73 facilities) (Figure 1-7). About half of facilities statewide (265 facilities or 46 percent) offer memory care.

FIGURE 1-7
Virginia's assisted living facilities range in size from four beds to over 100 beds; most facilities offer both assisted living and residential level of care

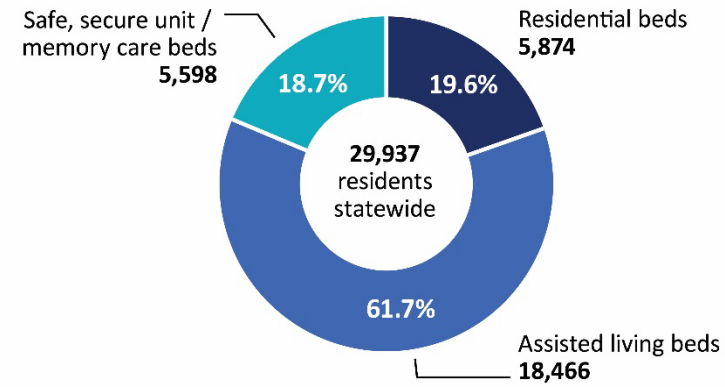


SOURCE: JLARC analysis of Virginia Department of Social Services licensing and active caseload data.

About 62 percent of occupied beds in assisted living facilities are for assisted living level of care, accounting for over 18,000 residents statewide (Figure 1-8) (sidebar). Residential level of care beds and memory care beds account for about 5,900 residents (20 percent) and 5,600 residents (19 percent), respectively.

Counts of assisted living residents are estimates based on facilities' full licensed capacity and average occupancy rates reported by ALF administrators in response to a JLARC survey. (See Appendix B for more details).

FIGURE 1-8
More than half of occupied beds in Virginia are for assisted living level of care



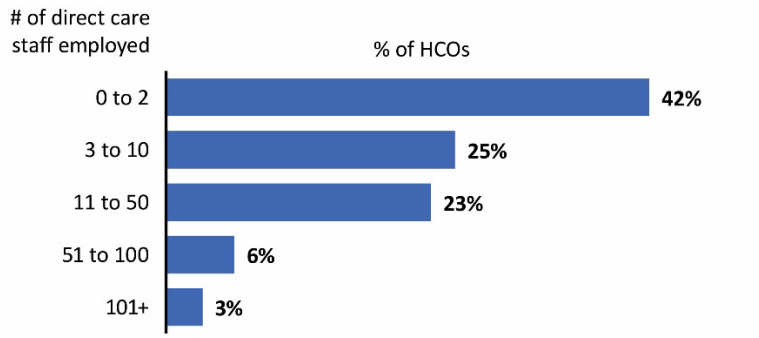
SOURCE: JLARC estimates based on analysis of Virginia Department of Social Services licensing and active caseload data and responses to JLARC survey of assisted living facility administrators (see Appendix B).

Over 2,000 HCOs with 38,000 direct care staff provide non-skilled in-home care services

Unlike for assisted living facilities, the total number of Virginians receiving non-skilled in-home care is unknown. Many older Virginians receive in-home personal care through private pay, but data is not collected to estimate the total number of recipients and their ages. However, the state does maintain data on the number of Medicaid recipients of CCC Plus waiver services, which is the largest public provider of non-skilled in-home care. In FY25, 32,943 Virginians 65 and older received in-home personal care services through CCC Plus, accounting for 57 percent of all the program's personal care recipients (the program also serves children and adults under age 65 with a disability). Separately, AAAs and local departments of social services provided publicly funded in-home care to an estimated 6,182 older adults statewide in FY25.

Over 2,000 HCOs with 38,000 direct care staff provide non-skilled in-home care statewide. The number of direct care staff employed by each HCO is the best available measure of their service capacity, similar to available beds in assisted living facilities (Figure 1-9). Individual HCOs employ anywhere from zero to over 1,000 direct care staff (zero direct care staff likely indicates an HCO where the administrator is also providing direct care services).

FIGURE 1-9
Majority of Virginia's home care organizations employ 10 or fewer direct care staff



SOURCE: JLARC analysis of Virginia Department of Health active licensing and self-reported staffing data.
NOTE: "Direct care staff" includes personal care aides and home health attendants and excludes registered nurses. Zero direct care staff likely indicates an HCO where the administrator is also providing direct care services.

State oversight of assisted living facilities and in-home care is shared across multiple agencies

Responsibility for the oversight of ALFs and non-skilled in-home care is distributed across three state agencies. The Virginia Department of Social Services (VDSS) licenses and inspects ALFs, while the Department of Health Professions (DHP)

separately licenses ALF administrators and certifies or registers certain ALF staff, including registered nurses, certified nurse aides, and medication aides. In-home personal care is overseen by the Virginia Department of Health (VDH), through its Office of Licensure and Certification (OLC), which licenses and inspects HCOs.

VDSS oversees assisted living facilities

VDSS's Division of Licensing Programs (DOLP) has primary responsibility for the state's oversight of ALFs. DOLP is charged broadly with protecting vulnerable adults in care settings such as adult day centers and assisted living facilities. Its licensing inspectors monitor facility compliance with applicable standards, regulations, and law.

DOLP primarily conducts oversight through facility inspection and enforcement. State law requires unannounced annual inspections for each facility. These inspections are carried out by DOLP inspectors based in five regional licensing offices, supported by DOLP's home office in Richmond. DOLP also investigates complaints about ALFs and self-reported incidents. When a facility is found out of compliance with state law or regulations, DOLP can impose several sanctions such as reducing a facility's licensed bed capacity, barring new admissions, requiring staff training at the facility's expense, or issuing civil penalties. For cases involving an immediate and substantial threat to resident health, safety, or welfare, DOLP can go further, issuing a summary suspension or revoking or denying the facility's license. Chapter 5 discusses the effectiveness of DOLP's inspection and enforcement actions.

Virginia Department of Health oversees home care organizations

The Virginia Department of Health is the state's lead agency for HCO oversight, which is carried out by its Office of Licensure and Certification (OLC) Home Care Division. OLC is charged with overseeing facilities providing health care and related services, including hospitals, nursing facilities, HCOs (both non-skilled in-home care and medical home health agencies), and hospice programs (sidebar).

OLC is expected to oversee facilities through issuing initial licenses, routine inspections, and investigation of complaints. State regulations require that HCOs receive at least one unannounced on-site inspection every two years. When inspections find an HCO is out of compliance, OLC's primary enforcement option is to require the HCO to develop a corrective action plan. However, state law allows the VDH commissioner to revoke or suspend an HCO's license because of non-compliance. Chapter 6 discusses the effectiveness of OLC's oversight of HCOs.

Approximately one-quarter of HCOs also provide **skilled home health care services,** such as home health and pharmaceutical services, which are out-of-scope for this review. Oversight of home health services falls under a different OLC division—the Home Care and Hospice Unit.

Three additional state agencies play an oversight role

Other state agencies play various oversight roles for assisted living and home care organizations.

DHP

DHP's Board of Long-Term Care Administrators licenses individuals who manage ALFs. State law requires ALFs licensed to provide assisted living level of care to operate under the supervision of a licensed administrator. In addition to establishing licensure and continuing education requirements, the board investigates complaints against administrators. If violations are found, the board can impose sanctions, ranging from probation, reprimands, and monetary penalties to license revocation, suspension, or nonrenewal. The board may also accept a voluntary settlement in lieu of formal disciplinary action.

Separately, DHP's Board of Nursing licenses or certifies any ALF staff working in positions that fall under the board's purview. These positions include registered and practical nurses, certified nurse aides, and medication aides. DHP may deny, revoke, or suspend a nurse aide's certificate if a violation is found.

DARS, Adult Protective Services, and long-term care ombudsman

The Department for Aging and Rehabilitative Services (DARS) houses several programs related to oversight of assisted living facilities and/or in-home care.

First, DARS oversees the state's 25 AAAs. AAAs are local public or private nonprofit organizations, designated by DARS under the federal Older Americans Act, that plan and deliver services for Virginians age 60 and older and their caregivers.

DARS also plays a role in in-home care offered by AAAs and local departments of social services. DARS sets service standards for in-home care, including personal care and homemaker services (i.e., practical assistance such as meal preparation), and distributes federal and state funds to AAAs. AAAs provide these services directly or through contracts with HCOs. Likewise, DARS sets the regulations and guidance for local departments of social services' provision of companion, chore, and homemaker services to eligible older adults and adults with disabilities and distributes the federal funding available for these services.

In addition, DARS houses Virginia's Adult Protective Services (APS) Division, which oversees APS activities carried out by the state's 120 local departments of social services. APS staff investigate reports of abuse, neglect, and exploitation. APS provides services to adults who are 60 years of age or older, or 18 years of age or older and incapacitated. APS investigates allegations in both congregate care (e.g., ALFs) and private residence settings. APS is required to initiate an investigation within 24 hours of receiving a complaint and must refer matters involving licensing or regulatory concerns to the appropriate agency for administrative action (e.g., VDSS for ALF licensing issues or VDH for issues with in-home care providers). APS is authorized to arrange

a range of health, housing, and legal services intended to stop or prevent further mistreatment and can also refer matters to law enforcement where necessary.

Furthermore, local long-term care ombudsman staff are housed at AAAs under the oversight of the Office of the State Long-Term Care Ombudsman at DARS. The Long-Term Care Ombudsman program advocates for individuals receiving long-term care services in ALFs, nursing homes, and several other settings (sidebar). Local staff investigate complaints, conduct facility visits, and work to resolve issues directly with residents, families, and facility staff. The program functions as an independent advocate rather than a regulator—ombudsmen are not inspectors and lack enforcement authority to compel a facility to make changes.

Finally, DARS administers the auxiliary grant program, which is a state and locally funded supplement that helps aged, blind, or disabled individuals cover the cost of care in a licensed ALF, an approved adult foster care home, or certain supportive housing settings. Chapter 8 describes the effectiveness of the auxiliary grant program in making assisted living more affordable.

The Code of Virginia (§ 51.5-182) extends the responsibility of the Long-Term Care Ombudsman beyond the minimum federal requirement to oversee congregate long-term care facilities (nursing facilities and ALFs) to include additional settings such as HCOs, adult day programs, hospice facilities, certain behavioral health providers, state hospitals operated by the Department of Behavioral Health and Developmental Services, and AAAs themselves.

In addition, a portion of the statewide team at the Office of the State Long-Term Care Ombudsman is dedicated to addressing complaints and concerns of Medicaid recipients.

DMAS

The Department of Medical Assistance Services (DMAS) and the five managed care organizations (MCOs) it contracts with share responsibility for overseeing HCOs that provide agency-directed personal care services through Medicaid. DMAS sets requirements and oversees the MCOs, and the MCOs authorize services, pay claims, and monitor and audit the HCOs in their networks. Together, they are responsible for ensuring that HCOs meet federal and state requirements for service delivery, including verifying that personal care aides are properly trained and supervised, members receive the services authorized in their care plans, and HCO reimbursements accurately reflect delivered service hours.

2 Supply of Assisted Living and In-Home Care

Whether the supply of assisted living and in-home care is sufficient is best assessed regionally. For assisted living facilities (ALFs), capacity in one part of the state does not necessarily serve older adults in another, because residents generally prefer to remain near family, existing caregivers, and their medical providers. Similarly, in-home care supply is determined by the number of home care organizations (HCOs) and direct care workers within reasonable traveling distance. Furthermore, regions' proportions of older adults and their needs vary significantly across Virginia, creating distinct levels of localized demand.

The state plays no role in determining the supply or geographic distribution of ALFs or HCOs. ALFs in Virginia are privately owned, and private owners decide facility locations, bed capacity, and offered care levels. HCOs are similarly private entities that determine their own service areas, populations they will serve, and client limits. Virginia has no certificate-of-public-need requirement or comparable regulatory mechanism for either industry, so the state cannot direct providers to locate in underserved areas, expand capacity where need is greatest, or maintain a minimum level of services in specific regions.

Assisted living capacity tends to be lowest in regions with higher proportions of older adults and care needs

The supply of assisted living facilities and bed capacity is not evenly distributed statewide (sidebar). Some regions have substantially more facilities and beds than others, even when accounting for differences in the population and level of need of older adults.

The count of assisted living facilities measures choice and proximity for residents. Assisted living bed counts measure total facility capacity.

When assisted living is not available, older adults face difficult options. They may be required to remain in a home that no longer meets their needs and rely more heavily on informal caregivers, like family and friends, who may already be under significant strain. Some adults could relocate to an ALF away from their community, but doing so separates them from family, friends, and their usual healthcare providers, such as their primary care physician. In some cases, older adults may wait to enter congregate care until their health further declines and they are eligible to enter a nursing facility, a typically more restrictive and expensive setting.

For this section, **supply of beds** represents the estimated number of occupied beds in assisted living facilities. Occupied beds are a proxy for total available supply because facilities report being filled to 96 percent of **staffed capacity**, on average, which is the number of residents an administrator believes can be safely cared for given the facility's current staffing levels.

Regions with the lowest supply of assisted living beds often have the highest levels of need among older adults

The regions with the highest supply of assisted living have more than three times the beds and facilities per older adult as the lowest-capacity regions (sidebar). Planning and service area (PSA) 8A Alexandria has the most beds, at over 53 per 1,000 older adults, compared with the region with the fewest beds, at just 6.5 per 1,000 in PSA 22 Eastern Shore. Facility counts show a similar gap: PSA 15 Richmond has nearly six assisted living facilities per 10,000 older adults, while PSA 22 Eastern Shore has fewer than one (Table 2-1). Appendix E reports bed and facility supply for all 25 PSAs.

Even regions with a higher supply of beds relative to the older adult population may not have enough available beds, overall or by type, to fully meet demand.

TABLE 2-1
Wide variation in assisted living facilities and beds across regions

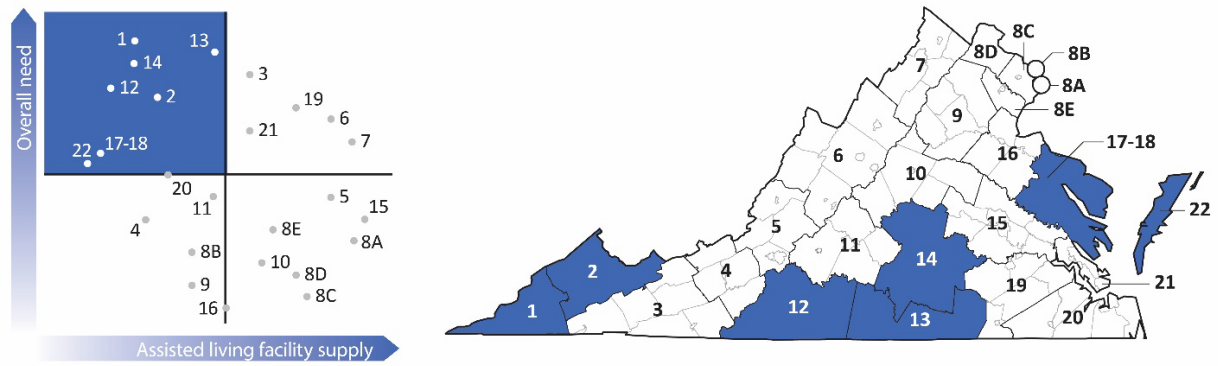
	PSA / AAA Region	Assisted living facilities per 10,000 age 65+ residents	PSA / AAA Region	Assisted living facility beds per 1,000 age 65+ residents
	15 Richmond	5.7	8A Alexandria	53.5
Highest	7 Northern Shenandoah	5.5	5 Roanoke Valley	31.2
	6 Central Shenandoah	5.3	15 Richmond	25.7
	Statewide	**4.1**	**Statewide**	**21.2**
	12 Martinsville-Danville	2.0	12 Martinsville-Danville	9.4
Lowest	17-18 Nor. Neck-Mid. Peninsula	1.9	17-18 Nor. Neck-Mid. Peninsula	9.2
	22 Eastern Shore	0.8	22 Eastern Shore	6.5

SOURCE: 2023 American Community Survey 5-year estimates from Weldon Cooper Center and Virginia Department of Social Services licensure data.
NOTE: Total assisted living beds is sum of occupied residential level of care, assisted living level of care, and memory care level of care beds (see Chapter 1 for definitions). Table shows ratios relative to older adults age 65+; this ranking does not significantly change when using 75–84 and 85+ age brackets. See Appendix E for full list of assisted living capacity by PSA. PSA names are used for readability purposes only and do not reflect any official designations. American Community Survey population estimates are subject to margins of error. Facilities are shown per 10,000 residents and beds per 1,000 residents so that both ratios can be expressed as numbers that are easier to interpret.

Overall need is a composite score for each PSA based on six key measures of need (Chapter 1 and Appendix D).

Age demographics alone are an imprecise indicator of potential demand for ALF beds because they omit key factors, such as ambulatory, self-care, or independent living difficulty. Accounting for these factors highlights even greater disparity in ALF supply versus need across the state. Seven regions that exhibit relatively high levels of older adult need (sidebar) fall below the statewide median for assisted living supply. Most notably, PSA 1 Far Southwest and PSA 14 Southern Piedmont are two of the three regions with highest older adult care needs in the state but are among the regions with the lowest assisted living supply (Figure 2-1). The three PSAs with the lowest supply (i.e., PSA 12 Martinsville-Danville, PSA 17-18 Northern Neck–Middle Peninsula, and PSA 22 Eastern Shore) each demonstrate older adult care needs above the statewide median.

FIGURE 2-1
Seven regions with lower assisted living facility capacity have higher levels of need among older adults



SOURCE: 2023 5-year American Community Survey data prepared for JLARC by Weldon Cooper Center at the University of Virginia and 2024 American Community Survey 5-year estimates.
NOTE: Regions are ranked based on average ranking across two measures of assisted living supply (beds per capita of older adults and facilities per capita of older adults) and across six individual measures of need; see Appendix D for additional data about overall need by PSA. Regions are planning and service areas (PSAs), which correspond to local area agencies on aging. American Community Survey population estimates are subject to margins of error. Analysis likely underestimates supply in some regions because it does not assume that residents of one region will use an ALF in a neighboring region, even if it is close by.

Most assisted living facilities are full relative to staffed capacity, and about half have waitlists

ALFs are generally filled to around 80 percent of their total licensed capacity (sidebar), according to results of JLARC's survey of assisted living administrators (sidebar). Overall, 30 percent of facilities statewide reported being filled to total licensed capacity.

Total licensed capacity is a facility's maximum number of residents allowed under its license.

Total licensed capacity often does not fully reflect how many residents a facility can serve. Staff shortages can prevent a facility from using all its licensed beds, or a facility may choose to serve fewer residents. (As described in Chapter 4, assisted living facilities experience significant staffing challenges because of low compensation and the nature of the work.) To capture a more accurate picture of available capacity, JLARC's survey of ALF administrators asked them to report on the staffed capacity of their facility, which was defined as the number of residents an administrator believes can be safely cared for at the facility's current staffing levels.

JLARC **surveyed assisted living facility administrators** statewide. The survey asked about facility capacity and census, the auxiliary grant program, resident acuity, state regulatory standards, the workforce, administrator licensing, facility quality, and Division of Licensing Programs oversight. JLARC received 160 responses.

The majority of ALFs responding to JLARC's survey are operating at or near their staffed capacity. Statewide, facility administrators reported that current residents occupy 96 percent of beds available under their current staffing, on average. Overall, 54 percent of facilities statewide reported operating at 100 percent of their staffed capacity.

Assisted living facilities that are full—either to total licensed capacity or to staffed capacity—may maintain a waitlist of individuals who are interested in living in the facility but for whom no bed is available. Forty-six percent of assisted living facilities

whose administrators responded to the JLARC survey maintain a waitlist. The 45 facilities that reported the size of their waitlist had a combined 802 individuals waiting for a bed, an average of 18 individuals per facility. Across these facilities, the number of individuals on waitlists was equal to about 20 percent of the total number of residents currently living in the facility (sidebar).

Waitlist counts may be an overcount of the true number of individuals waiting for an assisted living facility bed. Not everyone on a waitlist is still actively looking for a bed, and some people could be double counted because they are on a waitlist for multiple facilities.

Need for memory care beds is especially high in some regions; waitlists are more frequent and longer for these services

Substantial regional disparities exist in the availability of memory care beds relative to potential need (see Chapter 1). PSA 8A Alexandria has the highest memory care bed capacity relative to older adults with cognitive difficulty, with 150 memory care beds per 1,000 (Table 2-2). In contrast, the three PSAs with the lowest capacity (i.e., PSA 2 Southwest Coalfields, PSA 13 Southside, and PSA 1 Far Southwest) have about 10 or fewer memory care beds per 1,000 older adults with cognitive difficulties. In fact, PSA 1 Far Southwest does not have a memory care bed across its five localities (Wise, Lee, Scott, and Dickenson counties and the City of Norton).

TABLE 2-2
Top-served regions have much more ALF memory care capacity than the least-served regions (per 1,000 65+ adults with cognitive difficulty)

	PSA / area agency on aging region	Memory care beds per 1,000 65+ residents with cognitive difficulty
	8A Alexandria	150.7
Highest	10 Jefferson Area	86.3
	8C Fairfax	82.9
	Statewide	**54.7**
	2 Southwest Coalfields	10.6
Lowest	13 Southside	10.0
	1 Far Southwest	0.0

SOURCE: 2023 American Community Survey 5-year estimates from Weldon Cooper Center and Virginia Department of Social Services licensure data.
NOTE: Ratio comprises the number of safe, secure (memory care) level of care beds and American Community Survey estimate for adults age 65+ with cognitive difficulty per PSA. See Appendix E for full list of memory care bed capacity by PSA. PSA names are used for readability purposes only and do not reflect any official designations. American Community Survey population estimates are subject to margins of error.

Memory care beds also have waitlists. Of the ALF administrators responding to the JLARC survey whose facility has memory care beds, 53 percent reported maintaining a waitlist. The 33 facilities that reported the size of their memory care waitlist had a combined 214 individuals waiting for a bed, an average of six individuals per facility. Across these facilities, the number of people waiting for a memory care bed equaled about 24 percent of the number of residents currently in memory care beds.

Supply of in-home care does not align with where older adults need it most

In-home care is an important component of the continuum of care for older adults, alongside assisted living and other congregate care settings. In-home care is often preferable because it allows older adults to age in their own homes and is an essential alternative when assisted living is unavailable or unaffordable. In-home care can also be much less expensive than congregate care and is increasingly viewed as essential to controlling rising long-term care costs, particularly in public programs such as Medicaid. Meeting individuals' preferences and needs and avoiding expensive congregate care, however, depends on a sufficient supply of home care providers.

Similar to the state's supply of ALFs, the supply of non-skilled in-home care is distributed unevenly across the state. Some regions have a substantially larger supply of in-home care, even when accounting for regional differences in the population and care needs of older adults.

While the number of licensed HCOs and their direct care staff serve as proxies for HCO supply, precisely identifying where HCOs operate and areas that are underserved is challenging. Data from the Virginia Department of Health's Office of Licensure and Certification (OLC) shows where HCO main and branch offices are located and how many direct care staff they employ. To estimate regional HCO availability, JLARC assigned each HCO's coverage area to the PSA region that includes the locality where its offices are located. However, because HCO service areas can cross regional borders, this methodology likely understates some regions' HCO supply. Conversely, some geographically large regions' in-home care supply is likely overstated, particularly if they contain few HCOs with relatively small client capacity, as these providers cannot realistically serve an entire region.

Unlike assisted living, available data cannot be used to quantify the total number of Virginians receiving in-home care. HCOs are not licensed to serve a specific number of clients, and no data tracks clients paying with their own funds or private insurance policies. However, data captured by public programs that pay for in-home care (Medicaid) or fund and arrange it for clients (area agencies on aging [AAAs] and local departments of social services [LDSSs]) indicates that around 39,000 older Virginians received publicly funded non-skilled in-home care in FY25.

Regions with the lowest supply of in-home care tend to be rural and have the highest levels of need among older adults

Virginia's regions vary substantially in in-home care supply relative to their population of older adults. For example, PSA 8E Prince William, PSA 8C Fairfax, and PSA 20 Hampton Roads have more than 30 HCOs per 10,000 older adults, compared with just one HCO per 10,000 older adults in PSAs 1 Far Southwest, 4 New River Valley, and 14 Southern Piedmont. JLARC's analysis reveals similar disparities in the number of direct care workers employed by HCOs across regions, ranging from nearly 680 per

10,000 older adults in PSA 8C Fairfax to two per 10,000 in PSA 4 New River Valley (Table 2-3).

TABLE 2-3
HCOs tend to be in urban, high-population areas

	PSA / AAA Region	HCOs per 10,000 age 65+ residents	PSA / AAA Region	HCO direct care staff per 10,000 age 65+ residents
	8E – Prince William	40.0	8C – Fairfax	678.7
Highest	8C – Fairfax	32.9	8E – Prince William	574.6
	20 – Hampton Roads	30.8	20 – Hampton Roads	428.3
	Statewide	**14.8**	**Statewide**	**271.6**
	1 – Far Southwest	1.1	9 – Rappahannock-Rapidan	30.5
Lowest	4 – New River Valley	1.0	6 – Central Shenandoah	19.2
	14 – Southern Piedmont	1.0	4 – New River Valley	2.0

SOURCE: 2023 American Community Survey 5-year estimates from Weldon Cooper and HCO self-reported staffing data from VDH OLC (June 2026).
NOTE: Active HCOs only. Direct-care providers likely include a mix of personal care aides, certified nurse aides, and home health aides. Table shows ratios relative to older adults age 65+; this ranking does not significantly change when using 75–84 and 85+ age brackets. See Appendix E for full list of HCOs and direct care providers by PSA. PSA names are used for readability purposes only and do not reflect any official designations. American Community Survey population estimates are subject to margins of error.

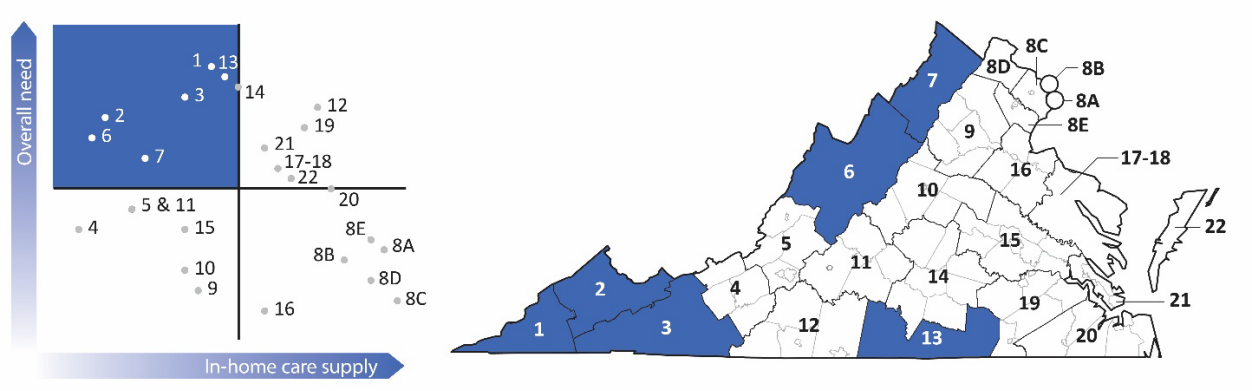
CCC Plus in-home care services are an entitlement available to all eligible recipients statewide (see later section of this chapter).

CCC Plus includes both agency-directed in-home care, which is provided by HCOs and reimbursed by Medicaid, and consumer-directed in-home care, in which members or their designated representative hire and manage an in-home care worker whom Medicaid pays an hourly rate.

The regions with the highest per capita rates of publicly funded in-home care vary by program. Commonwealth Coordinated Care Plus (CCC Plus) agency-directed care is most heavily used in large Northern Virginia urban regions (8A Alexandria, 8B Arlington, 8C Fairfax) (sidebar). CCC Plus consumer-directed care, by contrast, is most heavily used in rural areas, including PSA 12 Martinsville-Danville, PSA 17-18 Northern Neck–Middle Peninsula, and PSA 14 Southern Piedmont. AAAs and LDSSs provide the most publicly funded in-home care in PSA 1 Far Southwest, PSA 8C Fairfax, PSA 2 Southwest Coalfields, and PSA 3 Bristol-Galax (Appendix E).

Many underserved regions' older adults tend to have greater potential needs for long-term care services, like in-home care. Six regions rank below the statewide median for in-home care supply but above the median for older adult need. Most notably, PSA 1 Far Southwest and PSA 13 Southside have the highest levels of older adult need but rank 15th and 14th out of 25 for in-home care supply on a per capita basis (Figure 2-2). The PSAs with the second- and third-lowest supply, PSA 6 Central Shenandoah and PSA 2 Southwest Coalfields, each have older adult needs above the statewide median.

FIGURE 2-2
Six regions with lower in-home care capacity have higher levels of need among older adults



SOURCE: 2023 5-year American Community Survey data prepared for JLARC by Weldon Cooper Center at the University of Virginia and 2024 American Community Survey 5-year estimates.
NOTE: Regions are ranked based on average ranking across measures of in-home care supply per capita of older adults (HCO providers, in-home care direct care workers, CCC Plus agency-directed in-home care recipients, CCC Plus consumer-directed in-home care recipients, and recipients of in-home care from AAAs and LDSSs) and across six individual measures of need; see Appendix D for additional data about overall need by PSA. Regions are planning and service areas (PSAs), which correspond to local area agencies on aging. American Community Survey population estimates are subject to margins of error. Analysis likely underestimates supply in some regions because it does not assume that residents of one region will use an HCO in a neighboring region, even if it is close by.

The number of HCOs statewide has increased in recent years, but new supply is disproportionately concentrated in regions that already have the greatest supply. OLC staff report 374 initial license applications in FY24, 418 in FY25, and 581 in FY26. Seventy-six percent of new home care providers in the past three years (2023–2026) were in the 10 localities that already had the greatest number of HCOs; these 10 localities account for just 30 percent of the state's 65+ population. (Having the greatest number of HCOs does not mean that the need for in-home care in these localities is fully addressed.)

In-home care providers report workforce challenges can hinder their ability to meet demand

The supply of in-home care depends directly on the size of the direct care workforce. Because in-home care is typically provided one-on-one, the number of clients served and hours provided depend on worker availability. Workforce size and growth are therefore key to understanding in-home care supply.

Stakeholders report HCOs have systemic challenges hiring and retaining direct care workers (sidebar). As a result, HCOs must turn away new clients, offer fewer hours than consumers need or insurance authorizes, and experience staff "no shows." To maintain service delivery, HCOs also report having to rely on less experienced staff.

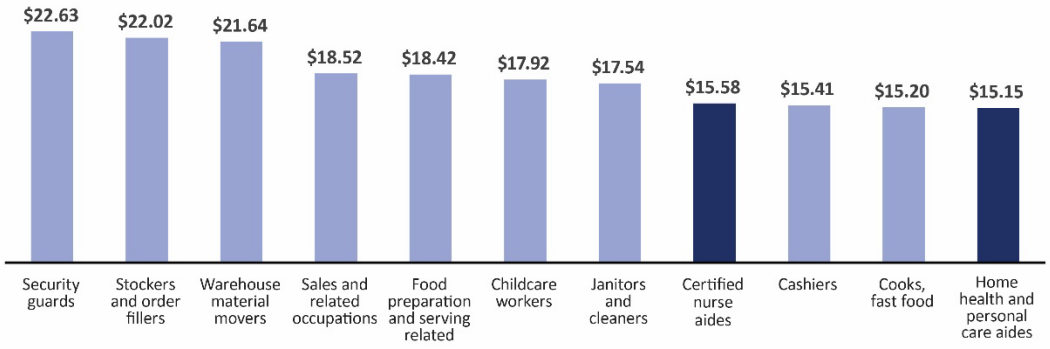
Low pay, demanding physical work, inconsistent scheduling, and time-consuming travel make it difficult for providers to maintain a sufficient direct care workforce,

HCOs typically employ three types of direct care service providers: personal care aides (PCAs), home health aides (HHAs), and certified nurse aides (CNAs). All three professions may provide in-home care services but are also employed elsewhere in the healthcare system (e.g., hospitals, rehabilitative centers, nursing homes, adult day programs, etc.). See Appendix F for more information.

according to HCO administrators. Compensation for PCAs, HHAs, and CNAs is relatively low, and the in-home care industry reportedly competes for staff with hospitality, retail, and fast-food employers (Appendix F).

Low compensation is reportedly a primary factor that hinders the development of a sufficiently large in-home care workforce. When compared to competing entry-level industries, the non-skilled in-home care sector struggles to attract and retain qualified workers. For example, home health and personal care aides earn an average of $15.15 per hour, and nurse aides earn $15.58 per hour, with both wage rates lagging the wages offered to food preparation and serving workers, childcare workers, and janitors (Figure 2-3).

FIGURE 2-3
In-home care industry lags competing industries in 2025 average hourly wages



SOURCE: JLARC analysis of VA Works data. All wage estimates are Virginia average hourly wages in 2025.

Few state workforce programs focus on the in-home care workforce. One example is FastForward, which funds training for certified nurse aides (CNAs) and therefore benefits HCOs that hire CNAs. HCOs also rely on HHAs and PCAs, but these occupations are not the target of workforce programs, which tend to prioritize higher-paying occupations.

Publicly funded in-home care serves narrow group of older adults and does not target underserved regions

CCC Plus in-home care eligibility criteria include functional and medical needs (applicants must be officially screened and be determined to require a nursing facility level of care) and financial requirements (applicants must meet income and asset limitations).

Some publicly funded programs help older adults pay for in-home care. The state's largest program to assist older Virginians with the cost of in-home care is the Medicaid CCC Plus waiver program. To receive in-home care through CCC Plus, Medicaid members must demonstrate that their care needs would make them eligible for a skilled nursing facility (sidebar). Medicaid's CCC Plus waiver is mostly available to older adults with the lowest income and higher care needs. AAAs and LDSSs also provide in-home care to a broader segment of older adults. Neither requires older adults to meet a nursing facility level of care, and they either have no income thresholds or the thresholds are more lenient than the Medicaid CCC Plus waiver. AAAs and LDSSs primarily

contract with HCOs to provide these services, although some employ care staff directly.

CCC Plus accounts for most publicly funded in-home care but serves only individuals with the lowest incomes and highest care needs

Medicaid's CCC Plus waiver for in-home care was provided to 32,943 adults in FY25, which included:

- 15,785 older adults (48 percent) through CCC Plus agency-directed care at a cost of $578.7 million ($36,664 per client annually) and
- 17,158 older adults (52 percent) in consumer-directed care at a cost of $260.3 million ($15,169 per client annually).

While most AAAs (88 percent) and LDSSs (76 percent) offer publicly funded in-home care services, they serve far fewer than the CCC Plus waiver program. Collectively, AAAs and LDSSs served 6,182 clients statewide in FY25 and spent approximately $18 million, or about $2,900 per client annually on in-home care (sidebar).

Furthermore, the state funds little of the in-home care services provided by LDSSs and AAAs. LDSSs have had no general fund allocation for home-based services since approximately 2010; their services are funded through federal and local funds (sidebar). In FY25, AAAs spent $10 million on in-home care services. State general funds accounted for $2.9 million of this spending, an average of $117,602 per AAA, and federal funds primarily accounted for the remainder.

The total individuals served by LDSSs includes both Adult Services and Adult Protective Services recipients. This figure includes a subset of adults who are under 65 but are physically or mentally incapacitated.

State Family Assistance Grants require a local match equal to 20 percent of the federal amount.

Additional funding for AAA in-home care would help serve a broader population of older adults and target regions with the greatest need

AAAs and LDSSs reported substantial waiting lists and unmet need for in-home care services in their regions and localities. AAAs estimated that approximately 3,200 to 5,500 older adults across their regions have unmet in-home care needs. (See Appendix B.) Seventeen AAAs reported having a waitlist for in-home services, and another two reported that they do not maintain a waitlist but have unmet demand for in-home care. AAAs had an average of about 34 people on their waitlists for in-home care. According to AAAs, about a third of people on their waitlists would wait six months or more for in-home services, and about 15 percent would remain on the waitlist "indefinitely" or are unlikely to receive services at all because the AAA lacked the resources. LDSS staff reported similar waitlists, wait times, and levels of unmet need.

AAA and LDSS staff generally indicated a willingness to provide additional in-home care services but cited funding and workforce challenges as barriers. In response to a JLARC survey, all AAAs (100 percent) and most LDSSs (74 percent) indicated that they wanted to expand home-based services. In addition, all AAAs and most LDSSs said that increased state funding for in-home services is what is most needed for them to expand these services for older adults. Staff at one AAA stated: "We have a massive waiting list now that is years long [for in-home services], which we may never

serve…The lack of funding for those services is the reason." Several other AAAs and LDSS shared similar sentiments.

Additional funding for in-home care delivered by AAAs or LDSS would have two policy benefits. First, it would expand publicly funded in-home care for older adults who cannot qualify for Medicaid's CCC Plus in-home services because of their incomes or care needs. Second, it could increase the availability of in-home care in regions with the fewest licensed home care organizations.

While AAAs and LDSSs currently provide in-home care and expressed a willingness to offer more with additional funding, the most prudent use of limited state funding would be to invest in expanding AAAs' in-home service capacity. Most AAAs already deliver these services and do so with direct care providers employed by the AAA, through a contract with HCOs that they oversee, or both. Unlike LDSSs, AAAs already have dedicated state funding for in-home care and other services that could be increased. Furthermore, their services are dedicated specifically to older adults (age 60 and over), rather than the broader adult population like LDSS services. However, any additional state funding dedicated to expanding local agencies' in-home services for older Virginians would be beneficial, including funding for LDSS services.

RECOMMENDATION 1

The General Assembly may wish to consider including funding in the Appropriation Act expressly for area agencies on aging to expand in-home care services to older adults who are eligible but are not currently served.

The amount of additional state funding needed would depend on the projected number of total older adults served. In FY25, AAAs provided or contracted for in-home care for 2,009 people at a cost of $10 million, including $2.9 million in general funds. Using AAAs' estimated range of unmet need (approximately 3,200 to 5,500 individuals) and current costs on a per-client basis (approximately $5,000 annually), addressing this unmet need would require $15.8 million to $27.6 million in additional state funding annually.

Although the 2026 Appropriation Act provided AAAs with an additional $2.5 million from the general fund for both FY27 and FY28 that *could* be used for in-home care, this funding will likely address only a small portion of the estimated unmet need. The appropriation was intended to offset rising service costs and increased demand for services that allow older Virginians to age in their homes. AAAs are not required to spend this additional funding solely on in-home care, and can use it for services such as transportation and nutrition, or to cover rising costs for services they already provide. Additional funding targeted specifically to in-home services, such as personal care, homemaker, and chore assistance, is necessary to ensure that AAAs can expand their capacity to deliver such services.

Additional funding could be distributed to AAAs using DARS's existing intrastate funding allocation formula, or it could be reserved for the regions that have demonstrated the greatest unmet need for in-home care services. While DARS's current formula reflects broad older adult demographics and includes a mid-year mechanism to redistribute unspent funds, it does not account for localized shortages specific to in-home services (sidebar). If the General Assembly wants to ensure that additional state funding for AAA-provided in-home care services is directed to regions with the greatest unmet need, it may wish to direct DARS to distribute the funding through a means other than its current funding formula for AAAs.

DARS uses an **intrastate funding formula** to allocate federal and state funds to area agencies on aging for several programs. The formula is based on each region's older adult population, with additional weight for older adults who are low-income, minority, or living in rural areas.

CCC Plus waiver is key to in-home care supply, which could decline as labor costs outpace recent rate increases

The Medicaid program is key to the sustainability of in-home care services and to low-income older Virginians' access to care. In FY25, nearly 16,000 older adults received Medicaid-funded in-home care (i.e., "personal care") from HCOs through agency-directed care under the CCC Plus waiver. To participate in the waiver, HCOs become certified by the Department of Medical Assistance Services (DMAS) and contract with one or more of the state's Medicaid managed care organizations (MCOs). HCOs are paid an hourly rate per member, and the General Assembly sets rate levels and increases through the Appropriation Act.

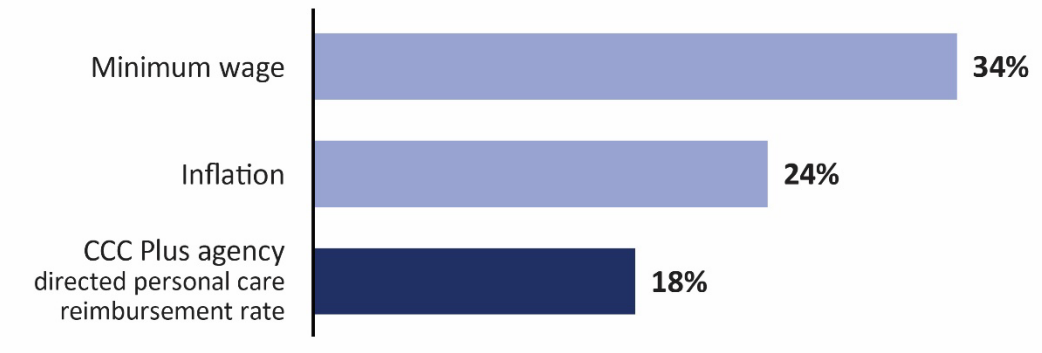
Despite state investments in higher Medicaid reimbursement rates for agency-directed personal care, state's rate remains comparatively low

The Medicaid reimbursement rate paid to HCOs for CCC Plus agency-directed personal care is a primary driver of service availability. Because personnel costs are the largest portion of HCO budgets, the reimbursement rate directly determines the wages HCOs can offer direct care staff. Providers decide whether to accept Medicaid clients, and to what extent, based on how well rates cover labor and operating costs. In addition, when reimbursement rates do not enable HCOs to pay competitive wages for direct care workers (and HCOs are unable to supplement those reimbursements with other revenue sources), HCOs will struggle to recruit and retain sufficient staff, restricting care access for eligible Medicaid beneficiaries.

While the General Assembly has increased reimbursement rates for CCC Plus agency-directed personal care, these increases have not kept up with minimum wage and inflation increases (Figure 2-4). For 2026, the reimbursement rate is $20.23 per hour in most of the state and $23.81 per hour in Northern Virginia. The rate has increased 18 percent since 2021, which includes small automatic cost-of-living adjustments as well as larger General Assembly-funded increases. However, both inflation and the state minimum wage have increased at faster rates over that time, 24 percent and 34 percent,

respectively. These increases have eroded the potential positive impacts of these legislative investments.

FIGURE 2-4
Medicaid reimbursement rate for in-home personal care has grown more slowly than minimum wage or inflation (2021 to 2026)



SOURCE: JLARC analysis of CCC Plus agency-directed reimbursement rates for personal care, Consumer Price Index, and Virginia minimum wage rates.

KFF's table ranks states' hourly payment rates for home care agencies in 2025. The survey asked states to report on their average hourly payment rates.

Virginia's hourly reimbursement rate for agency-directed personal care is low relative to other states. In 2025, before the most recent increases were enacted, Virginia's rate ranked 44th among the 47 states responding in a national survey, lower than all neighboring states and fourth lowest among all states (Table 2-4) (sidebar).

TABLE 2-4
Virginia's hourly reimbursement rate for in-home personal care lags neighboring states

State	Personal care agency hourly payment rate 2025	Rank (out of 47 states)
Virginia - rest of state	**$19.44**	**44**
Virginia - NOVA	**$22.88**	**39[a]**
North Carolina	$23.84	38
West Virginia	$25.44	30
Washington, D.C.	$25.52	28
Maryland	$25.58	27
Delaware	$25.90	26
Tennessee	$25.96	25
Median of all states	**$26.32**	**n.a.**

SOURCE: JLARC analysis of KFF Medicaid HCBS Survey 2025.
NOTE: [a] Northern Virginia rate is shown separately because the state pays a higher rate in the region. Ranked as if it were its own state, Northern Virginia would rank 39th out of 47. Includes Washington, D.C. Four states (Florida, Kentucky, Rhode Island, and Utah) did not respond to KFF survey and are excluded.

Despite the low reimbursement rates, the number of HCOs participating in Medicaid increased statewide over the past five years. JLARC counted an HCO as participating in Medicaid if the HCO was reimbursed during the state fiscal year for services provided through CCC Plus. In FY25, about 983 HCOs participated in Medicaid, which was a 30 percent increase since FY21. Over the same period, the number of participating HCOs remained the same or increased in 21 of the 25 PSAs (84 percent).

Upcoming rate increase may be too low to offset costs of new state labor policies, according to providers

Upcoming changes in state labor law could further increase HCOs' operating costs. Paid family leave (effective December 1, 2028), paid sick leave (effective January 1, 2029), and the minimum wage increase from $12.77 an hour in 2026, to $13.75 in 2027, and to $15 in 2028, could all raise the costs of employing full-time staff across the Commonwealth, including direct care workers (sidebar). HCOs interviewed for this study reported already operating on small profit margins, which could make absorbing these costs difficult without reducing operating costs.

Upcoming labor policy mandates include a **minimum wage increase** to $15 per hour (effective January 1, 2028), **paid family leave** providing up to 12 weeks of job-protected leave funded through payroll contributions (effective December 1, 2028), and **paid sick leave** allowing workers to accrue up to 40 hours annually at a rate of one hour per 30 hours worked (effective January 1, 2029).

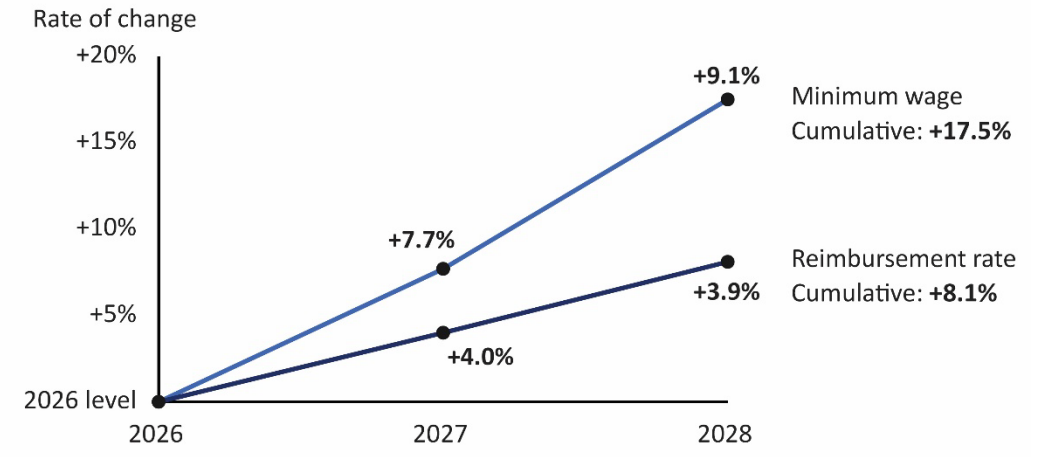
The minimum wage increase will likely raise wage costs for most HCOs. HCOs would need to raise the wages of their minimum wage employees. They may also face pressure to raise the wages of higher-paid employees to preserve pay differences between less and more experienced employees and to continue to offer wages that are competitive with other employers.

Funding in the Appropriation Act for future CCC Plus rate increases will not fully offset the impacts of upcoming labor costs, including minimum wage increases and required paid family and sick leave. The 2026 Appropriation Act increases the CCC Plus reimbursement rate for personal care services by 4 percent ($0.81 per hour statewide) effective January 1, 2027, and 3.9 percent ($0.82 per hour statewide) effective January 1, 2028, for a cumulative increase of 8.1 percent ($1.63 per hour statewide). However, the 17.5 percent increase in the minimum wage during the same timeframe outpaces the provider reimbursement rate increase (Figure 2-5). While the provider reimbursement rate will be higher than the minimum wage, the gap between the two will narrow. The amount by which the agency-directed reimbursement rate exceeds the minimum wage will decrease from $7.46 in 2026 (58.4 percent higher than minimum wage) to $6.86 in 2028 (45.7 percent higher) (sidebar). This analysis does not account for any added labor costs that could be realized because of paid sick and paid family leave requirements.

With the cost-of-living adjustment in Northern Virginia, the gap between the amount by which the agency-directed reimbursement rate exceeds the minimum wage will decrease from $11.04 in 2026 (86.5 percent higher) to $10.73 in 2028 (71.5 percent higher).

The smaller amount by which the reimbursement rate exceeds the minimum wage is significant because HCOs must use the reimbursement rate to cover more than direct care workers' wages. The rate also pays for administrative staff, employee benefits, the electronic visit verification (EVV) system, and registered nurse (RN) visits to evaluate clients, among other overhead costs. As the minimum wage rises faster than the reimbursement rate, a higher proportion of the reimbursement rate must be used to cover wages, leaving less available to cover these other costs.

FIGURE 2-5
Minimum wage is scheduled to rise 17.5 percent by 2028, more than double the 8.1 percent increase in the CCC Plus personal care reimbursement rate



SOURCE: Virginia Budget Language including § 40.1-28.10 and 2026 Special Session I Budget Amendment Item 291 #7c.
NOTE: Rates shown are agency-directed personal care rates for the rest of the state. Northern Virginia rates are higher but rise on the same percentage and date schedule, from $23.81 per hour in 2026 to $25.73 in 2028. All changes take effect on January 1 of the respective year.

While personal care costs are already a major driver of Medicaid spending, state should assess providers' true operating costs

HCO administrators indicate that increasing operating costs will likely require HCOs to rely more heavily on private-pay clients and could force some to close. According to administrators, HCOs use the higher profits they earn from private-pay clients to offset the cost of serving less profitable Medicaid clients. As costs rise, HCOs may need to shift to serving a larger share of private-pay clients, charge those clients higher rates, or both. Some HCOs report already making these shifts. Higher private-pay rates create affordability problems for older adults who do not qualify for Medicaid but lack sufficient resources to pay out of pocket (see Chapter 7). Finally, HCOs that serve primarily Medicaid clients report they may need to close if they are unable to attract enough private-pay clients to sustain their operations.

The state does not have a process for regularly benchmarking Medicaid personal care reimbursement rates against HCOs' costs of providing personal care. Increases to personal care reimbursement rates have instead been ad hoc and reactive to stakeholders' efforts to demonstrate the need for greater funding.

Any further increases to the state's Medicaid reimbursement rate for CCC Plus agency-directed personal care services would have substantial costs. Agency-directed personal care already accounts for the single largest service expenditure in Virginia's Medicaid program, and spending continues to rise rapidly. Inflation-adjusted spending for this service rose 21 percent between FY24 and FY25, with an estimated 12 percent growth

in FY26. Spending growth in agency-directed personal care has been driven by increased utilization, increased unit costs, and enrollment growth, including a 15 percent increase in service recipients between 2024 and 2025. The cumulative 8.1 percent increase for FY28 is projected to have a fiscal impact of $93.8 million, of which $44.3 million will come from the general fund.

HCOs identified two state requirements that could potentially be modified to lower certain costs of participating in Medicaid and help offset increasing labor costs. HCOs reported they incur administrative costs to select an electronic visit verification (EVV) provider, which DMAS could reduce by publishing a list of approved EVV providers. HCOs also suggested that DMAS allow licensed practical nurses (LPNs), rather than registered nurses (RNs), to conduct some additional types of supervisory visits to in-home clients without follow-up from an RN, which would cost HCOs less (sidebar).

LPNs are allowed to perform certain types of supervisory visits to in-home care recipients. However, an RN is still required to follow up on the LPN's supervisory visits and to perform the assessment to develop the plan of care.

DMAS should determine the feasibility of publishing a list of approved EVV providers to reduce the administrative costs HCOs incur when selecting one, and whether it is appropriate to allow LPNs to conduct certain clinical visits. Additionally, DMAS should explore whether there are other opportunities to adjust the regulatory requirements in ways that will reduce HCOs' operating costs without potentially compromising the health or safety of those being served through in-home care.

Additionally, DMAS should conduct a formal study comparing current personal care reimbursement rates to HCOs' actual operating costs. DMAS periodically evaluates the sufficiency of rates for other types of medical providers (e.g., the rebasing of reimbursement rates for skilled nursing and hospitals). A study of the personal care reimbursement rate would help the state assess industry claims of financial strain and quantify any gap between current rates and the true cost of care delivery.

RECOMMENDATION 2

The General Assembly may wish to consider including language in the Appropriation Act directing the Department of Medical Assistance Services (DMAS) to conduct a comprehensive cost study of Medicaid reimbursement rates for agency-directed personal care services that should include (i) an assessment of the actual costs incurred by providers to deliver these services, including the costs necessary to provide competitive wages to direct care staff; (ii) a comparison of Virginia's reimbursement rates to those of other states; (iii) a determination of whether certain regulatory requirements could be modified to reduce providers' operating costs without compromising the quality and safety of care; (iv) a determination of the feasibility of publishing a list of approved electronic visit verification providers to reduce the administrative costs HCOs incur when selecting one; and (v) recommendations regarding the need for modifying the existing personal care rates, if justified. DMAS should submit a report of its findings to the House Appropriations and Senate Finance and Appropriations committees by December 1, 2027.

3 Quality of Assisted Living Facilities

Assisted living facilities (ALFs) provide care to thousands of older Virginians, and the quality of that care is a central concern for residents and their families.

This chapter summarizes what is known about ALF quality in Virginia, drawing on available compliance and complaint data and stakeholder experiences and observations. While this analysis provides the most comprehensive statewide assessment of Virginia ALFs performed to date, this assessment does not include some especially informative indicators—such as resident health outcomes or resident and family satisfaction. Subject matter experts and research literature indicate that a comprehensive assessment of ALF quality should consider regulatory compliance alongside resident health outcomes, quality of life, resident and family satisfaction, and staffing. While many individual ALFs collect such information, the state has not yet begun collecting it for oversight or consumer information purposes and therefore it is not included in JLARC's assessment.

Majority of facilities were generally compliant with core health and safety requirements in 2025

Virginia's ALF oversight system collects information about facility compliance with state licensing requirements. The Virginia Department of Social Services (VDSS) Division of Licensing Programs (DOLP) collects and maintains this compliance information. Although compliance data does not comprehensively measure quality, it does indicate the extent to which ALFs are meeting core health and safety requirements.

The ALF inspection process records whether a facility met minimum licensing requirements on a given day, as determined by VDSS licensing inspectors. VDSS inspects ALFs when they first apply for licensure and at least once annually thereafter. Inspectors may also conduct ad hoc inspections in response to complaints or facility self-reported incidents (sidebar). When inspectors identify that a standard is not met, they issue a violation and record it in VDSS's licensing system.

By regulation, ALFs must report any major incident that negatively affects or threatens resident life, health, safety, or welfare to VDSS within 24 hours. By statute, these self-reported incidents are not considered complaints but may still be investigated by VDSS and result in violations and corrective action.

Despite limitations, VDSS compliance data remains useful for evaluating how well ALFs meet statutory and regulatory health and safety requirements. The historical compliance data maintained by VDSS is incomplete because of IT system limitations, preventing facility-level compliance analysis for years prior to 2025. Additionally, VDSS has limited report generation capabilities, which prevents staff from producing data on trends in ALF compliance across the state (sidebar). Still, 2025 data is useful for identifying facilities with compliance issues in the most recent year, and *aggregate*

More information on VDSS's technology limitations and their impact on oversight functions is included in Chapter 5.

statewide violation data from the past several years shows which standards ALFs violate most often.

The majority of ALFs were generally compliant with core health and safety requirements in 2025. The median facility was cited for four *total violations*, one of which was a *serious violation* (sidebar). Approximately 21 percent of facilities had no violations in 2025, and approximately 46 percent of ALFs were cited for no *serious violations* (Figure 3-1).

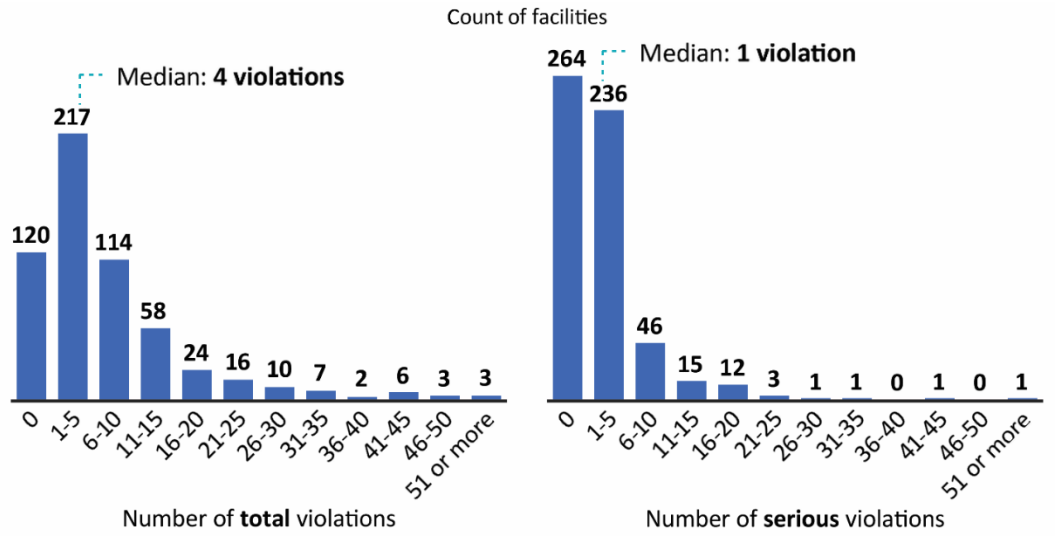
"Serious violations" refer to licensing violations in which at least serious harm is likely to occur, based on VDSS's Risk Assessment Matrix. VDSS uses this matrix to evaluate the violation circumstances across two dimensions:

Probability of harm (A=low/unlikely to occur, B=medium/likely to occur, C=high/harm is imminent or has occurred)

Severity of harm (1=moderate severity of harm, 2=serious severity, 3=extreme severity)

Serious violations include all B-2, B-3, C-2, and C-3 ranked violations.

FIGURE 3-1
Range of violations per facility in 2025



SOURCE: JLARC analysis of VDSS licensing violation data, 2025.
NOTE: N=580 for both figures. There were 580 licensed assisted living facilities in 2025.

Most facilities do not show evidence of major quality problems according to available information

While compliance data alone does not allow for a comprehensive assessment of quality, it can provide a useful indicator of quality-of-care problems. Facilities with an above-average number of violations of VDSS requirements are more likely to have such problems. However, facilities with few or no compliance violations cannot be assumed to be providing quality service because compliance data does not necessarily capture operational deficiencies that may adversely impact the quality of care. Moreover, compliance metrics do not capture meaningful quality differences between facilities with similar numbers of violations. Fully assessing whether there are quality-of-care concerns in these facilities requires reviewing operational data beyond basic licensure compliance.

To develop a more comprehensive picture of facilities' quality beyond VDSS's compliance data, JLARC collected available information from a variety of other

sources. Some potentially useful information, such as resident satisfaction, was not readily available. While this prevented JLARC staff from developing a *complete* picture of facilities' quality, the analysis summarized in this section is the most comprehensive statewide summary of facility quality made available to date.

Sources used by JLARC staff to supplement VDSS compliance data include:

- complaints filed against facilities and facilities' self-reported incidents, maintained by VDSS;
- data on Adult Protective Services (APS) complaints involving ALF staff, maintained by the Department for Aging and Rehabilitative Services;
- data on complaints regarding ALFs received by the Office of the State Long-Term Care Ombudsman (LTCO); and
- facility-specific observations by VDSS licensing inspectors, who have firsthand experience with ALFs through inspections, and local departments of social services (LDSS) and area agencies on aging (AAA) staff, who regularly interact with ALFs. (See Appendix B.)

Analysis of available information shows that about 20 percent of assisted living facilities have indicators of a quality problem

Using the information described above, JLARC staff identified five criteria as indicators of quality problems (Table 3-1).

TABLE 3-1
JLARC staff identified ALFs as having quality problems if they met at least one of five criteria

Criteria	Description
Total violations outlier	Facility had *total* violations above the high outlier threshold among similarly sized ALFs [a], or
Serious violations outlier	Facility had *serious* violations above the high outlier threshold among similarly sized ALFs, or
"Never event"/C-3 violation	Facility had at least one C-3 violation (most serious violation risk rating indicating harm of extreme severity occurred or was imminent), or
Substantiated incident outlier	Facility had total number of substantiated VDSS and APS complaints above high outlier threshold among similarly sized ALFs [b], or
Unanimous stakeholder concern	Survey respondents unanimously expressed concerns about the facility's quality.

SOURCE: JLARC staff analysis of assisted living facility quality information (2025) and stakeholder survey results (2026).
NOTE: [a] ALFs were compared with other facilities of similar size to control for variation related to facility size (e.g., larger facilities have more opportunity for violations). See Appendix B for description of outlier methodology. [b] Complaints received by the LTCO were excluded from this analysis because data on substantiated complaints was unavailable.

JLARC staff set a high threshold for each of the five criteria individually, but an ALF had to meet only one criterion to be identified as having a quality problem. In practice, this means that some ALFs that were not statistical outliers for violations or serious violations were still identified as having a quality problem if they met any one of the

other three criteria. However, this also means that any ALF with higher-than-average numbers of violations and serious violations is not included in the estimate if it did not meet any of the criteria. Although these facilities have exhibited some indication of quality concerns, their number of violations was not high enough to definitively conclude that they had quality problems.

JLARC staff identified 122 ALFs (21 percent of all ALFs) that met at least one of the five criteria indicating they have a quality problem (Table 3-2). Of these facilities, five met four of the criteria, 19 met three, 27 met two, and the remainder met one criterion. The remaining 458 licensed ALFs ("all other ALFs") did not meet any of the criteria. ALFs meeting these criteria were responsible for a disproportionate share of violations and substantiated incidents among Virginia's ALFs in 2025. Although they made up only 21 percent of all ALFs, they accounted for 51 percent of total violations, 65 percent of serious violations, and 75 percent of all substantiated incidents. On average, these facilities had significantly more total violations, serious violations, and substantiated incidents than all other ALFs (Table 3-3). Similarly, respondents to JLARC's surveys of VDSS licensing inspectors, AAA staff, and LDSS staff were much more likely to identify these facilities as having quality problems than all other facilities. (See Appendix B.)

TABLE 3-2
Facilities with quality problems were identified most frequently because of substantiated incidents and serious violations

	Total violations outlier	Serious violations outlier	Any C-3 violation	Substantiated incident outlier	Unanimous stakeholder concern	Total facilities with quality problem
ALFs meeting criterion	33	56	23	69	21	**122**

SOURCE: JLARC analysis of VDSS ALF violations data (2025); VDSS and APS complaint data (2025), and results of JLARC surveys of VDSS licensing inspectors, AAA staff, and LDSS staff.
NOTE: Facilities may be included in more than one category if they met multiple criteria. The total number is unduplicated.

TABLE 3-3
Facilities of concern performed much worse on available quality indicators

	Total violations (average)	Serious violations (average)	Substantiated incidents (average)	Percentage of stakeholders with concerns
Facilities of concern	17.6	8.1	3.5	45%
All other facilities	4.4	1.2	0.3	15%

SOURCE: JLARC analysis of VDSS ALF violations data (2025); VDSS and APS complaint data (2025), and results of JLARC surveys of VDSS licensing inspectors, AAA staff, and LDSS staff (i.e., "stakeholders with concerns").

Of the 122 facilities of concern, 17 facilities performed substantially worse than the rest. Though they make up just 3 percent of all facilities and all licensed beds statewide, these 17 facilities accounted for 17 percent of total violations, 26 percent of serious violations, 36 percent of all C-3 violations, and 20 percent of substantiated incidents. JLARC staff identified these as the "facilities of most concern"; Appendix G provides additional details on each.

Facility characteristics show no strong correlation with the likelihood of having quality problems. Although larger facilities tended to have more violations, they naturally present more opportunities for violations because they have more residents, staff, and physical space. To account for this, JLARC staff evaluated each facility against facilities of similar sizes (Appendix B) and did not identify a relationship between facility size and the likelihood of quality problems. Similarly, facilities with quality problems served auxiliary grant recipients and offered memory care at rates similar to other facilities.

VDSS organizes licensing field staff into five geographic regions: Central, Eastern & Peninsula, Fairfax, Northern & Valley, and Piedmont & Western. Each regional office covers an assigned set of localities and is responsible for the ALFs located within that territory.

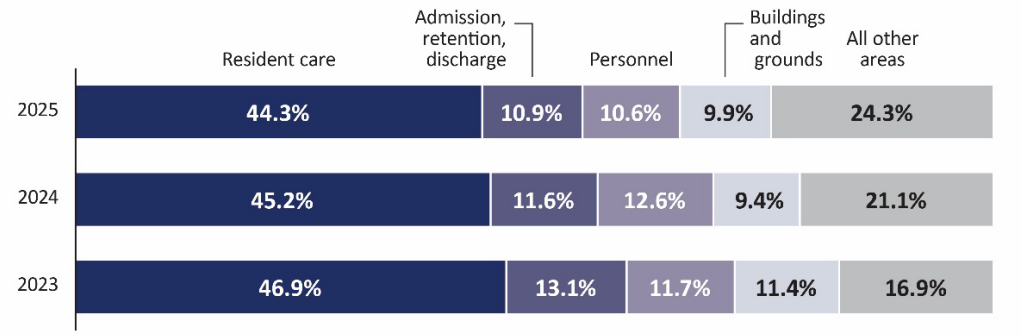
In contrast, a facility's location *does* correlate with the likelihood of quality problems. Thirty percent of facilities with quality problems were in the Piedmont & Western licensing region (sidebar), although only 17 percent of all facilities are in this region. In comparison, the Central region had only 15 percent of facilities with quality problems, despite having 27 percent of all facilities. This regional variation likely is at least partially attributable to true quality differences among the facilities in these regions; however, inconsistent inspector practices across regions likely also play a role. More information on these inconsistencies is in Chapter 5.

Compliance data indicates that violations in recent years are concentrated in categories related to resident care

Compliance data shows that licensing violations are concentrated in direct resident care, which accounts for nearly half of all cited infractions. Analysis of VDSS compliance data between 2023 and 2025 (sidebar) indicates that four categories account for approximately 79 percent of all violations, led by the resident care and related services category at 45 percent. This category includes resident assessments, service planning, medication management and administration, personal care, and food service, among other aspects of care. Violations related to admission, retention, and discharge of residents (12 percent), personnel (12 percent), and building and grounds (10 percent) accounted for most of the remainder (Figure 3-2).

While historical facility-level violation data is incomplete, VDSS staff report that the *relative* share of total violations is representative from 2023 to 2025.

FIGURE 3-2
Nearly half of violations each year cite resident care standards (2023–2025)

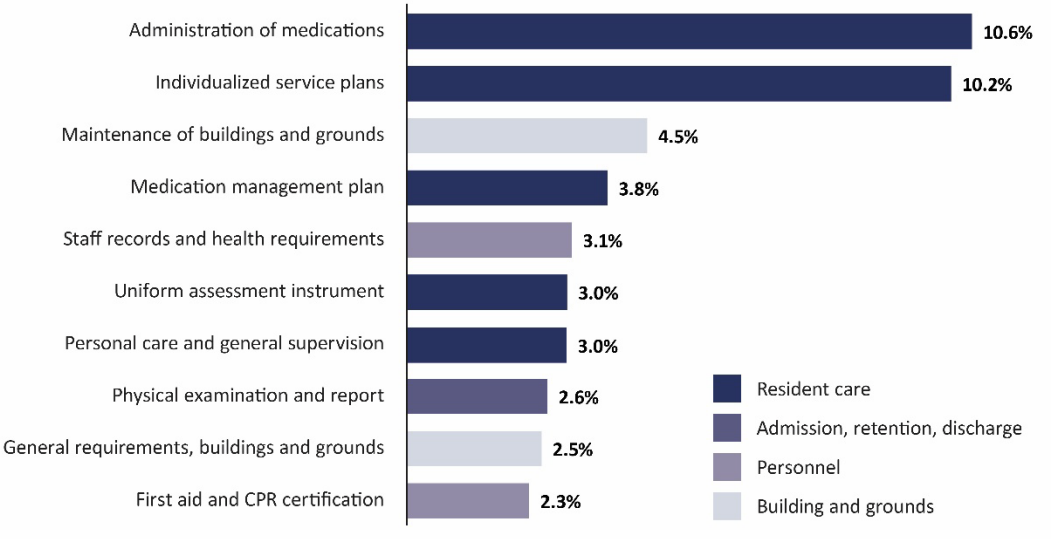


SOURCE: JLARC analysis of VDSS ALF violation data, 2023–2025.
NOTE: Violations are categorized according to parts of the Standards for Licensed Assisted Living Facilities (22VAC40-73). Violations citing 22VAC40-80, 22VAC40-90, or the Code of Virginia are included in "all other areas." Percentages may not sum because of rounding.

Previous legislative studies have identified medication administration and service planning as significant compliance issues. Specifically, a 2018 Joint Commission on Health Care study identified service planning and medication administration as the most cited violations among not-for-profit ALFs, and at least five JLARC reports dating back to 1979 highlighted medication administration as a quality-of-care concern.

Violations were most concentrated in a small number of standards directly impacting resident health and safety. ALFs may be cited for more than 700 unique regulatory standards; however, two standards alone accounted for more than one-fifth of all violations: administration of medications (11 percent) and individualized service plans (10 percent). Between 2023 and 2025, approximately 65 percent of licensed ALFs were cited under these two standards. Eight other standards accounted for 25 percent of violations, including those related to medication management and resident assessment (Figure 3-3). Previous legislative reports (sidebar) have repeatedly found that compliance deficiencies were concentrated in these same regulatory areas, suggesting there are widespread and longstanding compliance issues among Virginia ALFs in these areas of resident care.

FIGURE 3-3
Ten standards account for nearly half of all violations (2023–2025)



SOURCE: JLARC analysis of Virginia Department of Social Services ALF violation data, 2023–2025.

The most cited standards remained consistent throughout the three years JLARC staff examined for this study. Six licensing standards, mostly dealing with medication administration and service planning, ranked in the top 10 violations across all three years (Table 3-4).

TABLE 3-4
Six standards were among the top 10 most cited violations between 2023 and 2025

Standard	Description
22VAC40-73-(6)-680-D	Administration of medications in accordance with prescribers' orders
22VAC40-73-(6)-640-A	Maintaining medication management plan and reference materials
22VAC40-73-(6)-450-C	Individualized service plans – initial completion
22VAC40-73-(6)-450-F	Individualized service plans – review and updates
22VAC40-73-(8)-870-A	Maintenance of building and grounds – good repair requirements
22VAC40-73-(6)-680-I	Administration of medications and related provisions – medication administration record keeping

SOURCE: JLARC analysis of VDSS Division of Licensing Programs ALF violation data, 2023—2025.

Available information is insufficient for the public to evaluate and compare ALFs

Providing easy-to-understand, facility-level information to the public can help aging Virginians and their families make informed care decisions. Publishing information about ALFs' characteristics (e.g., facility size, service availability, costs) and compliance

history can help the public identify ALFs that meet their needs. Collecting and publishing additional quality information could allow the public to better differentiate among facilities offering similar services and could promote accountability by drawing attention to facilities' licensing and quality deficiencies. The state is best positioned to collect and publish this additional quality information because it can require facilities to report these measures under its licensing authority. In addition, the state already publishes some compliance information for all facilities.

VDSS publishes some ALF information online, but omits available information that would help the public navigate care

VDSS publishes limited information about ALFs' characteristics and compliance history through an online search tool. On VDSS's website, members of the public can use the Assisted Living Facility Search function to find ALFs in their area. Users can filter by locality, zip code, and whether the facility is licensed for non-ambulatory care, assisted living level of care, or memory care. Each facility's profile (Figure 3-4) contains basic information about the facility's license type, expiration, capacity, and administrator contact information. Additionally, the profile lists inspection results, including whether the inspection stemmed from a complaint and if any violations were cited. Users can click on the inspection date to see the areas reviewed during the inspection, the inspector's comments, and any standards that were violated.

FIGURE 3-4
VDSS's ALF search tool provides limited facility and compliance information

Facility Name

Facility street address
Phone number

Facility Type:	Assisted Living Facility
License Type:	2YR
Expiration Date:	Month, Date, Year
Qualification:	Assisted Living Non-Ambulatory Special Care Un
Administrator:	Administrator name
Business Hours:	12:00 AM - 11:59 PM, Sunday-Saturday
Capacity:	##
Inspector:	Inspector name and phone number

Inspection Date	Complaint Related	Violations
Date	NO	Yes
Date	NO	Yes
Date	NO	Yes

SOURCE: Assisted Living Facility Search tool on the Virginia Department of Social Services website, 2026.
NOTE: Clicking on the hyperlinked "Yes" in the "Violations" column displays additional detail about the inspection, including the regulatory areas reviewed, the specific standards that were violated and evidence for those violations, inspectors' comments about the inspection process, and any corrective actions taken by the facility.

While VDSS's online ALF search tool can be helpful, it omits some available information that would be useful to the public in choosing a facility, including room

types offered (e.g., private, shared), typical charges, whether the facility accepts the auxiliary grant (sidebar), and whether it is part of a continuing care community.

More importantly, the search tool omits information about the seriousness and consequences of violations. Inspection records do not include the severity of violations or whether the facility was subject to sanctions. Regulations require ALFs to post the results of inspections in their facilities, but the posted information does not have to include the severity of violations, and VDSS does not post sanction or violation severity information online.

VDSS should update its ALF search tool to include additional information about facilities' characteristics, compliance records, and APS investigations. This should include the number of substantiated APS investigations involving instances of abuse, neglect, or exploitation committed by facility employees within the last three years (sidebar). Publishing this information would require no new data collection, because VDSS already receives most of it through licensing applications, facility disclosure statements, and interagency data sharing with APS; however, it may require additional manual aggregation and temporary workarounds in VDSS's existing IT system and reporting tools.

DARS currently maintains a list of ALFs that participate in the auxiliary grant program. However, even though a facility participates in the auxiliary grant program, it may not currently have a bed available. The availability of auxiliary grant beds is not currently collected in real time.

§63.2-104 of the Code of Virginia allows VDSS to disclose statistical information regarding APS records to any person with a legitimate interest. Specific information, such as the names of individuals involved, date of the incident, and specific circumstances of the investigation may not be disclosed.

RECOMMENDATION 3

The Virginia Department of Social Services (VDSS) should publish on its public-facing assisted living facility search tool, by January 1, 2028: (i) additional facility characteristic information, including offered room types, typical charges and fees, admissions criteria, auxiliary grant participation, and whether the facility is part of a continuing care retirement community; (ii) the severity rating assigned to each standards violation; (iii) the number of, if any, substantiated APS investigations against facility employees within the last three years; and (iv) any sanctions imposed on the facility by VDSS for standards violations. This information should be regularly updated, and the search tool should specify the date of the last update.

Assisted living facility inspectors assess compliance with core requirements, which do not fully reflect quality of care provided

While compliance is one component of ALF quality, subject matter experts and research literature indicate that residents' quality of life, satisfaction, safety, and health outcomes and facility staffing are other key indicators of ALF quality care. However, VDSS is not required to, and does not, collect information needed to assess and compare ALFs across these areas. Table 3-5 contrasts the traditional compliance measures used in Virginia's ALF inspection process with broader quality performance measures that would provide more information about quality.

TABLE 3-5
ALF inspectors do not collect performance data on key quality measures

Measurement area	Compliance indicators Did the facility do what was required?	Quality measures How well did the facility perform?
Resident quality of life and satisfaction	• Services provided as outlined in care plan • Meals provided at required times • Activity schedules are posted • Visiting hours are not restricted	• Resident and family satisfaction surveys • Quality of life surveys
Resident safety	• Facility meets building security requirements • Facility reported major incidents impacting safety to VDSS as required • Facility maintains emergency preparedness plans	• Trends in safety-related violations over time • Substantiated APS complaints • Frequency of elopements • Frequency of resident-to-resident altercations • Frequency of use of physical restraints or anti-psychotic medications
Resident health outcomes	• Facility secured medical attention for health care needs • Facility notified VDSS of incidents affecting resident health as required	• Fall rates • Emergency department visits and hospital admissions per resident • Medication error rates • Pressure ulcer prevalence • Infection and outbreak rates • Unintended weight loss rates
Staffing	• Staffing plan is on file • Staff records show that qualification and training requirements were met	• Direct-care staff turnover and retention rates • Staffing hours per resident • Vacancy rates • Use of temporary or agency staffing

SOURCE: JLARC review of VDSS licensing requirements and quality measures in other states and research literature.

Virginia could collect and publish more information on ALF quality than it does now, similar to other states

About half of states collect more ALF quality information than Virginia. At least 24 states have established quality measurement, data collection, or management requirements beyond minimum regulatory compliance, and at least 10 require ALFs to collect resident or family satisfaction information. Minnesota, Ohio, and Oregon are among a handful of states that publish ALF quality information in an accessible and understandable format for the public. Each of these states publishes different products that aggregate facility-level characteristics, compliance, and quality performance information.

- **Minnesota** operates the *Assisted Living Report Card* website, which uses a five-star rating system to assess resident quality of life, family satisfaction, and resident health, safety, and staffing. This information is collected through annual surveys and inspection findings that are updated quarterly. The report card also displays basic facility characteristics, including location, license type, and capacity.

- **Ohio** operates the *Long-Term Care Quality Navigator* website covering the state's nursing homes and ALFs. The website displays resident and family satisfaction scores from biennial surveys, licensing inspection deficiencies, and information on facility capacity, rates, ownership type, staffing, policies, amenities, and payment types accepted. The website is refreshed regularly as facilities submit information through a state-operated portal.
- **Oregon** operates the *Quality Measurement Program* for ALFs and publishes an annual report on facility-level performance across six metrics: direct care staff retention, staff training compliance, falls resulting in injury, nonstandard use of antipsychotic medications, administrator tenure, and results of a resident satisfaction survey. ALFs submit data for all non-survey measures annually through a state-operated data collection tool. Oregon also operates a separate *Long-Term Care Settings Search* tool, which displays facility characteristics (e.g., location, capacity, whether the facility accepts Medicaid or offers memory care) as well as licensing violations, sanction information, and abuse violations.

Implementing a public-facing ALF quality reporting system in Virginia could further improve facility accountability and would help Virginia families make better-informed care decisions. While Recommendation 3 would expand access to ALF compliance information already collected by VDSS, older Virginians and their families would still have little access to information on residents' outcomes and quality of life or family satisfaction across facilities. That information gap matters because ALF care decisions are often made quickly and under stress (e.g., after a hospitalization or the death of a caregiver) when families have the least capacity to gather and verify information themselves. Many of Virginia's ALFs already track data such as resident falls and medication errors and collect feedback from residents and their caregivers. This information could be collected uniformly and made available to the public.

Establishing an ALF quality reporting system would require significant upfront time and resources and ongoing funding and staffing. Furthermore, while the transparency accompanying such a system would facilitate assisted living facility placement decisions and possibly improve facilities' quality over time, a quality reporting system is not the only means for improving transparency and quality, and most states have not developed something this extensive. Whether or not to develop an assisted living facility quality reporting system for Virginia is therefore ultimately a policy decision for the General Assembly. Minnesota took five years to publish its *Assisted Living Report Card* after the initial 2019 appropriation, a period during which the state (1) contracted with a university to conduct a national literature review, (2) convened expert panels, (3) surveyed statewide stakeholders, and (4) completed multiple rounds of testing of resident and family surveys prior to launch. Oregon took about four years to develop its program, while Ohio was able to launch in just under two years because of pre-existing state data-sharing infrastructure. All three states dedicate at least one staff position to the program and contract with outside partners for some analytic work,

including survey administration and data processing. Minnesota dedicates approximately $2 million per year to these types of contracts.

ALFs would need to report performance on standardized quality measures as a condition of licensure for the quality reporting system to be fully effective. Although many ALFs already collect data on some quality measures on their own (sidebar), these measures are not consistently defined or tracked, nor are they required to be reported to the state.

Many of Virginia's ALFs already collect data on some quality measures. Among respondents to JLARC's survey of ALF administrators,

91% track resident falls,

80% track medication errors,

64% track hospital admissions,

62% track emergency room visits,

63% conduct resident satisfaction surveys, and

52% conduct family satisfaction surveys.

If the General Assembly chooses to implement a statewide ALF quality reporting system, Virginia could expedite its development and implementation by drawing on other states' experiences. An expedited process would likely require at least two years for system development and full implementation. Staff in Minnesota, Ohio, and Oregon report that states should take several steps to ensure successful quality reporting system development and implementation, including:

- soliciting feedback from the public and the assisted living industry on measurement selection, definitions, data collection methods, and display design;
- establishing technology and data-sharing agreements among relevant state agencies;
- developing or purchasing the technology needed to collect, manage, and publish new quality metrics;
- partnering with university research entities or private contractors to gather and process data and administer surveys; and
- testing the data collection, processing, and publication components of the system and educating providers on how to collect and report the required data elements.

To facilitate successful implementation of an ALF quality reporting system, VDSS could first develop a detailed plan addressing key decisions. These include deciding which measures to include; how they should be defined; how data should be collected, validated, and presented; the resources and partnerships needed for implementation; estimated one-time and ongoing project costs; and an estimated implementation timeline. Key stakeholders, including VDSS licensing staff, ALF operators and administrators, representatives of the Office of the State LTCO, and resident representatives, could participate in the plan's development. VDSS would need to ensure that the specific measures included in the system assess resident health outcomes, resident and family satisfaction, and ALF staffing. VDSS could pilot test the quality reporting system with a sample of ALFs and use the results to correct any deficiencies in the data collection, processing, and publishing processes prior to statewide implementation of the system.

POLICY OPTION 1

The General Assembly could include language in the Appropriation Act directing the Virginia Department of Social Services to (i) submit to the House Appropriations and Senate Finance and Appropriations committees and the House Health and Human Services and Senate Rehabilitation and Social Services committees an implementation plan for a quality reporting system for licensed assisted living facilities that includes measures of resident health outcomes, resident and family satisfaction, and facility staffing; (ii) pilot test the system with a sample of facilities; and (iii) implement and make available on its website the comprehensive quality reporting system. The language could also direct the State Board of Social Services to promulgate regulations requiring all licensed assisted living facilities to report the measures included in the system as a condition of licensure.

JLARC staff propose policy options for the General Assembly's consideration, rather than recommendations, when (1) the action proposed is a policy judgment best made by elected officials, (2) addressing a report finding is not necessarily required but doing so could be beneficial, or (3) there are multiple ways to address a report finding, and there is insufficient evidence to support a single best way.

Recommendation 3 and Policy Option 1 would improve the information VDSS collects and publicly reports about ALFs' quality and performance, as well as other information that would help Virginians and their caregivers choose a facility. The recommendation and policy option, if both implemented, are intended to result in a single, public-facing, up-to-date, searchable web-based tool. The tool would need to be developed in phases. The first phase should be implementation of Recommendation 3 because the new information to be reported is readily available, indicates safety concerns, or both.

4 Assisted Living Facility Staffing

Direct care staff provide daily assistance and care that assisted living facility (ALF) residents rely on, including bathing, dressing, and feeding; medication administration; and monitoring for changes in health or behavior. Various types of staff can fulfill these responsibilities, including personal care aides (PCAs), certified nurse aides (CNAs), registered medication aides, and licensed nurses. The number, qualifications, and mix of these staff strongly influence the quality and safety of residents' care.

Virginia does not mandate staffing ratios or positions for ALFs, allowing each facility to establish its own staffing levels. Stakeholders throughout Virginia's assisted living system identified insufficient direct care staffing as the greatest threat to quality of care, particularly because ALF residents' needs have become more complex. Virginia broadly mandates that ALFs have sufficient staff to meet residents' needs and requires facilities to have one direct care staff member awake and on duty in each building with residents present (sidebar). However, these standards are too general to ensure facilities are adequately staffed or to hold ALFs accountable when they are understaffed.

Virginia has more prescriptive **staffing requirements for memory care units**, described later in this chapter.

Insufficient staffing and increasing resident care needs are main contributors to care quality issues

ALFs serve residents with a wide range of physical, mental, and psychosocial needs. The Code of Virginia and associated regulations bar ALFs from admitting individuals with certain conditions but otherwise let each facility judge whether it can meet the needs of a prospective or current resident (sidebar). Meeting the needs of residents requires ALFs to regularly and accurately assess the care needs of each resident and to have the appropriate number and mix of staff to meet those needs.

Under **Virginia law**, assisted living facilities may not admit or retain a resident with conditions across 12 specific categories, including, but not limited to, ventilator dependency, feeding tubes, or a need for continuous nursing care.

Stakeholders and research literature identify adequate, qualified direct care staffing as the best predictor of facility quality

Stakeholders who regularly interact with ALFs in Virginia report that direct care staffing has the greatest impact on the quality of care provided by facilities. In response to JLARC surveys, ALF administrators, Virginia Department of Social Services (VDSS) licensing inspectors, area agencies on aging (AAA) staff, and local departments of social services (LDSS) staff consistently highlighted staffing-related factors as the most impactful on overall ALF quality (Table 4-1). (See Appendix B.) These stakeholders emphasized that ALFs must maintain both sufficient *levels* of direct care staff and sufficiently *competent* direct care staff. Stakeholders also frequently cited resident care needs that exceed a facility's capabilities as a primary driver of quality concerns. This

challenge is closely tied to staffing, as residents with extensive or complex care needs require significantly more staff time and resources.

TABLE 4-1
Stakeholder ranking of factors affecting ALF quality

Factor	VDSS licensing inspectors [a]	AAAs	LDSSs	ALF administrators [b]
Insufficient direct care staffing levels	1st	1st	1st	3rd
Inadequate experience, qualifications, or training of direct care staff	4th	3rd (tied)	2nd	2nd
Residents require a level of medical or behavioral care that exceeds what the facility is equipped to handle	2nd (tied)	2nd	3rd	4th

SOURCE: JLARC surveys of VDSS licensing inspectors, AAA staff, local departments of social services staff, and licensed assisted living facility administrators.
NOTE: [a] The other number two factor cited by VDSS licensing inspectors was "Ineffective management/leadership style and practices." [b] The number one factor cited by ALF administrators was "low staff morale." ALF administrators were asked about the staffing of facilities in general rather than their own. Other factors survey respondents could choose include ineffective facility management, unsatisfactory food service and nutrition, insufficient resident enrichment/activity/engagement activities, unsatisfactory physical condition of the facility, unsatisfactory sanitation and cleanliness of the facility, inadequate state regulation and/or oversight through licensing and inspection, inadequate experience and tenure of management, and inadequate education and training of management.

ALF administrators, VDSS licensing inspectors, AAA staff, and LDSS staff described many specific incidents in which inadequate or ineffective staffing levels affected residents' care. The quotes below depict several examples of incidents observed by stakeholders. These are only a few examples stakeholders described.

> "There are prolonged periods without toileting, unanswered medical needs, pressure sores, and inadequate feeding assistance. Medications not received on time or [not] being re-ordered. Residents needing assistance with bathing/showering are not receiving it consistently. Residents that are incontinent are being left unattended in wet pads and clothing for long periods of time." – *VDSS licensing inspector*

> "Residents pay their entire life savings to these facilities for bare minimum care or no care at all due to the lack of staff available to tend to residents in a timely manner. Falls are more frequent for residents due to them trying to care for themselves when assistance is needed, but unavailable." – *AAA staff*

> "The residents are often unkempt with outdated, soiled clothing and body odor. There is a lack of attention to residents' individual needs...No one maintains their hair and they are not assisted with showers." – *VDSS licensing inspector*

Research literature reinforces stakeholders' perspectives, identifying adequate staffing as a key driver of resident outcomes and care quality in ALFs. For example, one national study found that when states replaced general staffing requirements with more specific requirements for direct care workers, ALF residents' monthly risk of hospitalization decreased. Another study of 2,700 ALFs in one state found that facilities with

only part-time or no nurse availability were more than twice as likely to have severe deficiencies as facilities with a nurse available 24 hours a day. Broader long-term care research, conducted mostly in nursing homes, has also found that better staffing is associated with fewer hospitalizations and other adverse health outcomes, such as pressure ulcers, as well as fewer regulatory deficiencies.

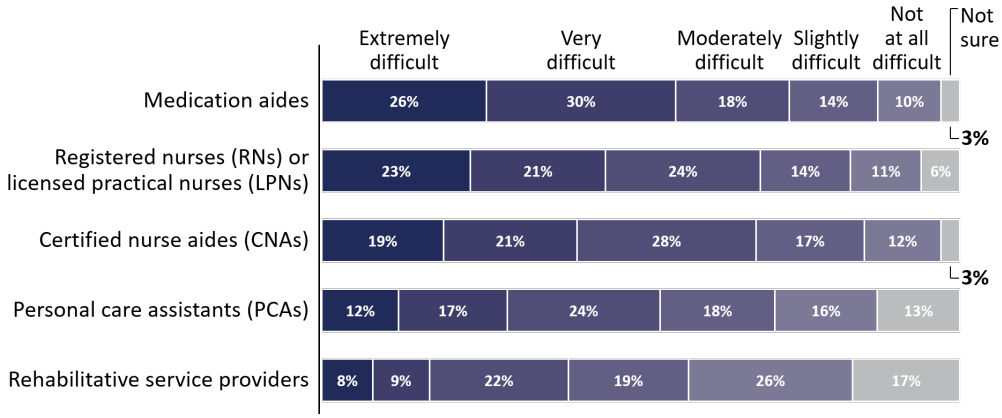
Adequate staffing is even more important for ALF residents with dementia. The same national study of staffing standards found that more specific staffing requirements were associated with a reduction in hospitalization risk among residents with dementia. Another study across four states found that the benefits of licensed nurse staffing on reducing hospitalizations became increasingly significant as a facility's population of residents with dementia grew.

Facilities report challenges recruiting and retaining key direct care staff, which can negatively affect quality

ALF administrators frequently cited difficulty maintaining adequate direct care staffing, especially for certain positions. In response to a JLARC survey, administrators cited medication aide as the most difficult position to keep filled, followed by registered nurse (RN) or licensed practical nurse (LPN), CNA, PCA, and rehabilitative service providers (Figure 4-1). When asked in which positions worker shortages pose the greatest risk to safety and quality, administrators identified the positions with the greatest shortages, citing medication aides as most impactful on quality, followed by CNAs, PCAs, and RNs or LPNs. These direct care staff provide hands-on daily care and administer medications. When facilities face shortages in these positions, residents face higher risks of medication errors, unattended care needs, and adverse health outcomes.

Administrators of ALFs that offer memory care units reported significant difficulty maintaining enough qualified staff in those units. Approximately 92 percent of these administrators reported difficulty maintaining memory care staff, with one-third of those characterizing it as "very" or "extremely" difficult.

FIGURE 4-1
Administrators report most difficulty keeping medication aides and nurse positions filled



SOURCE: JLARC analysis of results of survey of licensed ALF administrators in Virginia.
NOTE: For this survey question, administrators were asked about difficulty maintaining these staff positions at assisted living facilities, in general, and not by specific shift, care level (residential, assisted living), or unit (memory care).

Low pay, competition from other employers, and a shortage of qualified applicants leave many ALFs unable to maintain adequate direct care staffing. When asked to characterize their current staffing situation, 38 percent of ALF administrators reported being unable to hire because of a lack of qualified applicants, and 14 percent reported needing more staff but being unable to hire because of costs. More than half (58 percent) of ALF administrators responding to JLARC's survey cited low pay as the factor that contributes most to difficulty maintaining enough qualified staff, and 46 percent cited competition with other long-term care and health care employers in the area as a contributing factor. Other factors reported by administrators include the nature or difficulty of the work being unappealing (34 percent) and competition with other types of non-long-term care or non-health care employers (e.g., hospitality, retail) (32 percent).

The demanding nature and difficulty of memory care create a distinct challenge for maintaining sufficient staffing in these units. Like other administrators, administrators of facilities that reported difficulty maintaining memory care unit staff cited low pay (57 percent) and competition (54 percent) as the most significant barriers to maintaining enough qualified memory care staff. However, 48 percent cited the nature or difficulty of memory care work compared with only 34 percent of general ALF staff.

Facility staffing levels and practices vary among a sample of Virginia facilities

In a separate staffing survey, 60 ALF administrators statewide reported the total direct care staff hours they scheduled on the Monday of the most recent week. (see Appendix B.)

ALFs develop their own staffing policies, and because they do not share them with the state, there is no readily available information on staffing levels and practices across facilities. A small percentage of ALFs reported staffing information to JLARC through a survey (sidebar).

Direct care staffing levels vary across the sample of Virginia assisted living facilities that responded to JLARC's survey. On average, these facilities scheduled approximately 0.9 direct care hours per resident day for residents in residential and assisted living levels of care. However, staffing levels varied widely across facilities, ranging from approximately 0.6 hours per resident day at facilities in the quartile with the lowest staffing to approximately 1.1 hours per resident day at facilities in the quartile with the highest staffing.

Responding facilities also reported how they access licensed nurses for their facility. Sixty-two percent of facilities reported directly employing an LPN; 35 percent of facilities reported directly employing an RN; and 15 percent reported accessing an RN through their parent organization or under contract. Seventeen percent of facilities reported having no arrangement with an RN, and many facilities had RNs available on call. (Because facilities could report more than one arrangement, these percentages are not mutually exclusive.) Among facilities with an RN on staff or under contract, an RN was physically present in the facility for an average of 25 weekday hours and four weekend hours.

Facilities reported using different approaches to determine direct care staffing hours. The most frequently used approach was a fixed staff-to-resident ratio, reported by 40 percent of facilities. Twenty-seven percent of facilities reported using a fixed staffing schedule that does not vary by daily census or other factors; 27 percent reported that staffing was left to the judgment of the day-to-day administrator or designated scheduler; and 23 percent of facilities reported using an acuity-based staffing tool that determined staffing needs based on residents' care needs. (Because facilities could report more than one approach, these percentages are not mutually exclusive.)

ALF administrators report that resident care needs have increased, which can further strain staff's ability to meet their needs

Overall resident care needs have increased in recent years, according to JLARC staff's interviews with and surveys of assisted living staff and stakeholders. For example, 70 percent of ALF administrators who responded to JLARC's survey reported that residents' care needs at their facility have increased in the last three years. Specifically, administrators reported that needs have increased most in relation to high-dependency ADLs and incontinence care (sidebar), physical mobility and fall management, medication management, and mental and behavioral health.

High-dependency activities of daily living (ADLs) are self-care tasks that require significant physical or cognitive assistance from a caregiver. Examples of these ADLs include bathing, dressing, toileting, feeding, and transferring (e.g., from bed to a chair or wheelchair).

Subject matter experts, ALF administrators, and other stakeholders attribute rising resident care needs to a growing preference among older adults to "age in place" in their own homes, which means that their needs tend to be greater if they eventually move to congregate care. Stakeholders also noted that some residents whose conditions worsen to nursing-home-level care choose to remain in ALFs because the cost is less than nursing facilities.

Resident care needs that exceed staff capabilities contribute to safety and quality issues and staff dissatisfaction. As shown in Table 4-1, Virginia stakeholders identified residents requiring care that exceeds a facility's capabilities as one of the top factors affecting the quality of ALF care. When residents' needs exceed staff capabilities, these needs can go unmet and contribute to negative health outcomes, including falls, medication errors, and avoidable hospitalizations. Research literature and subject matter experts also indicate that serving higher-need residents is associated with lower direct care worker satisfaction and higher burnout, which contributes to difficulty maintaining adequate staff.

Virginia's ALF staffing rules match most states, but stronger standards would better ensure care quality

Virginia's ALF staffing requirements are based on a "sufficiency" standard, under which state regulation broadly directs ALFs to maintain enough staff to meet residents' care and safety needs. In addition, the regulation requires at least one direct care staff member to be awake and on duty in each building whenever residents are present. However, regulations do not specify any additional staffing minimums for assisted living care, regardless of resident census or care needs.

Virginia's requirements are more prescriptive for memory care. In memory care units, regulation requires a minimum of two direct care staff members to be present and awake in each building with residents present, with the required number of staff increasing as resident census in the unit increases. However, just one in five assisted living facility residents in Virginia are in memory care, so these stricter staffing requirements do not apply to most of the ALF population.

Virginia's approach to ALF staffing standards is common but does not follow best practice

Virginia's reliance on a general sufficiency standard is common among states. Of the 50 states, 40 primarily use a "sufficient staff" model like Virginia's for ALFs. Of those states, 24 also set a fixed minimum staffing floor like Virginia's "one awake staff" requirement.

Other states require specific staffing levels, mandating either a minimum number of direct care hours per resident or a fixed staff-to-resident ratio. For example, Pennsylvania, Florida, and North Carolina require a minimum number of direct care hours measured per shift, per day, or per week. Arkansas, Georgia, Maine, and South Carolina require fixed staff-to-resident ratios.

National subject matter experts report that tying staffing requirements directly to residents' assessed care needs, rather than to a general sufficiency standard or a flat ratio, is the most effective approach to ensuring assisted living facilities are adequately staffed. In interviews and survey responses, VDSS central office licensing staff and inspectors, multi-state ALF operators, and ALF administrators expressed similar

views. For example, several administrators reported that "staffing requirements should be adjusted to resident acuity" and that "staffing should be based on acuity levels related to specific diagnoses."

Oregon ties minimum staffing numbers directly to resident care needs. In 2021, Oregon's legislature mandated that all ALFs use a state-approved acuity-based tool to calculate required staffing. The tool converts residents' assessed care needs across 22 elements into the amount of staff time required. Oregon requires facilities to use these results to develop per-shift and per-unit staffing plans, which must be posted in the facility. Oregon fully implemented its requirement in 2024, and interviews with Oregon officials indicate that there have been positive early impacts on facility staffing. For example, more facilities regularly and accurately update residents' care plans and make staffing decisions based on those plans.

Virginia's ALF staffing requirements are widely recognized as insufficient

"Sufficiency-based" staffing requirements are intended to ensure facilities have the right mix and number of staff to meet residents' needs, but VDSS licensing staff, AAA staff, and LDSS staff reported that Virginia's overly general and minimal sufficiency-based staffing requirements do not ensure that facilities are appropriately staffed. These stakeholders noted that current requirements are not specific enough and give individual ALFs too much discretion. The inadequacy of Virginia's staffing requirements is a longstanding challenge and has been identified as a deficiency in legislative reports dating back to 1979 (sidebar).

Previous JLARC reports, including reports in 1979, 1990, and 2005–2007, as well as a 2018 Joint Commission on Health Care study, highlighted the inadequacy of Virginia's sufficiency-based ALF staffing requirements.

> "[We need] a more objective view of staffing requirements. Just stating the facility needs to staff to meet the needs of the residents does not give a clear statement of how many staff should be present at any given time." – *AAA staff*

VDSS licensing inspectors also report that Virginia's overly general ALF staffing requirements make it difficult to hold ALFs accountable for problems arising from insufficient staffing. Inspectors and other licensing staff report that they frequently feel that facilities are understaffed during inspections but cannot cite facilities because they meet the staffing standards set out in their own staffing plans.

> "For all my facilities, staffing should be increased. Since there are no mandatory ratios for the assisted living facilities, the facilities staff to the bare minimum." – *VDSS licensing inspector*

> "Often there are residents who require two-person assist, and the facility does not schedule or have enough staff to meet the acuity level needs of the residents. This is always a gray area when looking at this regulation to cite because the standard does not specify a staff-to-resident ratio for assisted living residents." – *VDSS licensing inspector*

Key stakeholders support stronger ALF staffing requirements. For example, some multi-state assisted living providers favored more specific requirements that account

for residents' care needs. In interviews, all five VDSS regional licensing administrators supported strengthening Virginia's staffing regulations, either by establishing minimum staffing ratios or enhancing acuity-based requirements. In response to JLARC surveys, a majority (55 percent) of VDSS licensing inspectors reported that Virginia's ALF staffing regulations were too lenient, and staff from AAAs and LDSSs also indicated a need for staffing ratios. Several ALF administrators reported that additional regulatory clarity, through minimum staffing requirements or more specific acuity-based requirements, would improve their ability to staff appropriately.

> "Staffing plans [should] be directly related to actual resident acuity levels and individualized care needs. It is very difficult to justify to the corporate level the acuity needs and level of care for residents." – *ALF administrator*

Improved ALF staffing standards would promote better care quality and state oversight

Implementing stronger staffing standards would improve ALF care quality and enable more effective state oversight, putting Virginia among the group of states with more specific and rigorous staffing rules. To be most effective, direct care staffing standards must be measurable and adjusted based on resident care needs. The standards should establish specific staffing requirements, relying less on facilities' own judgment, and should require facilities to increase staffing when their number of residents and/or residents' care needs increase. Establishing clear, measurable standards would set explicit staffing expectations for providers and strengthen VDSS staff's ability to evaluate and enforce compliance.

RECOMMENDATION 4

The General Assembly may wish to consider amending § 63.2-1803 of the Code of Virginia to (i) replace the current "sufficiency standard" for assisted living facility direct care staffing with requirements that the number and types of direct care staff on duty at each facility be determined by resident census and the amount and types of assistance and care residents require and (ii) require the Board of Social Services to establish the explicit, detailed staffing standards that facilities must follow to meet the statutory requirements.

JLARC staff calculated **ALF operating costs from annual working budgets submitted to VDSS and data collected from a sample of ALFs** via a data collection instrument administered by JLARC.

New ALF staffing standards would require substantial planning and resources, including a meaningful increase in VDSS licensing staff to effectively develop, implement, and monitor compliance with new requirements. More stringent staffing requirements could increase some facilities' operating costs if they add staff to meet the new standards, and those costs would likely be passed on to residents. Personnel costs account for 62 percent of ALFs' operating costs, according to facility budgets and expenditures (sidebar). However, while ALF costs are also affected by factors other than staffing (e.g., real estate costs and cost of living), available cost data does not indicate that residents in states with more stringent staffing requirements pay more than residents in Virginia (Table 4-2).

TABLE 4-2
ALF costs in states with more stringent staffing requirements are similar to Virginia's

	Median monthly cost of care in an ALF
Virginia	**$6,945**
Florida	$5,610
Pennsylvania	$6,480
North Carolina	$6,496
Oregon	$6,875

SOURCE: JLARC analysis of CareScout Cost of Care Survey, 2026; https://www.carescout.com/cost-of-care.

Virginia could strengthen staffing standards using one of two approaches that differ in their responsiveness to resident care needs and implementation difficulty.

Option 1: Base staffing on a state-approved, acuity-based staffing tool. The state could require facilities to use a staffing tool that converts each resident's assessed care needs (e.g., ADLs and other care tasks and services) into the amount of direct care staff hours required to meet these needs. The number of staff hours required would translate to the number and types of staff (e.g., nurses, medication aides, direct care aides) needed on-site for each shift. Under this approach, the state would develop or adopt an existing acuity-based staffing tool and make it available to ALFs at no cost. Facilities could also use proprietary tools, provided they meet state regulatory requirements. About one-quarter of Virginia ALFs responding to JLARC's staffing survey reported that they already use proprietary acuity-based staffing tools to set their staffing levels (sidebar).

VDSS previously published a model acuity-based staffing tool on its website for ALF operators to use. Some operators reported they found this tool helpful, but VDSS recently removed it from its website because it was outdated and created confusion over whether facilities were expected or required to follow the tool's staffing guidance.

If the state pursues this option, the General Assembly will need to codify the requirement in statute, and the Board of Social Services will need to amend state regulations to make state licensure contingent on ALFs' use of an acuity-based staffing tool. As a starting point, Oregon's staffing tool potentially could be modified to meet Virginia's needs. Oregon's implementation process involved substantial stakeholder engagement to develop the tool, several rounds of pilot testing, and additional staff positions at the state level to oversee the tool's development and implementation. After implementation, Oregon, which has about the same number of ALFs as Virginia, also needed to significantly increase the number of licensing inspectors to effectively monitor ALFs' implementation and use of the tool, from nine inspectors and a manager to 30 inspectors and three supervisory staff.

Furthermore, if Virginia requires use of an acuity-based staffing tool, the Board of Social Services may need to strengthen resident assessment requirements. Virginia requires ALFs to complete a reassessment of residents' care needs only annually or when their condition changes, which is likely too infrequent to guide ongoing staffing decisions. By contrast, Oregon requires facilities to reassess new residents at 30, 60, and 90 days, and quarterly thereafter, or whenever a resident's condition changes. Oregon

also requires ALFs to update residents' service plans and staffing levels when assessments occur.

Option 2: Base staffing on state-prescribed minimum direct care hours. The state could prescribe a minimum number of direct care staff hours that assisted living residents should receive. These would be scaled by facility census and broad categories of resident needs (e.g., number of residents requiring mobility assistance) rather than the specific care needs of each resident.

This approach would be similar to practices in Florida, North Carolina, and Pennsylvania. Florida requires a minimum number of direct care hours *per resident per week*, and requirements vary by a facility's census. Pennsylvania requires minimum care hours *per day per resident*, with more care required for residents with mobility needs, and North Carolina prescribes the minimum number of direct care staff hours *per shift* for facilities with 21 or more residents, scaled by the facility's census.

If Virginia pursues this option, the state will need to make several implementation decisions, including:

- selecting the unit (e.g., total facility hours, hours per resident) and compliance period (e.g., per shift, per day, average per week);
- setting the minimum number of care hours;
- determining the staff categories that count toward the minimum (e.g., direct care hours only, administrator/supervisory hours);
- identifying which factors necessitate additional care hours, like facility census or need categories (e.g., number of non-ambulatory residents, number of residents requiring two-person assistance); and
- establishing how facilities would document and verify their staffing hours.

Minimum direct care hour requirements are less responsive to resident care needs than an acuity-based staffing tool requirement but offer a more concrete, rigorous, and enforceable standard than Virginia's current requirements. Depending on its structure, minimum direct care hours can also give facilities more flexibility than a fixed staff-to-resident ratio, allowing facilities to schedule staff around peak care hours, use varying staff mixes, and scale coverage as census changes. However, flexibility is dependent on the compliance period determined by the state. For example, mandating minimum hours per shift requirements is more rigid but better ensures adequate staffing levels, whereas daily or weekly averages give facilities greater discretion while risking understaffing during certain times.

While an acuity tool (Option 1) is more responsive to residents' specific care needs, fixed direct care service hour minimums (Option 2) are simpler for facilities and the state to implement and enforce. The state could combine approaches by initially requiring that facilities provide a minimum number of direct care hours per resident while it undertakes the development of an acuity-based tool. This approach would

allow the state to strengthen staffing standards sooner while developing a long-term model that better reflects resident acuity.

Additionally, VDSS has proposed changing its licensing of ALFs to be based on tiered service levels (residential living care, assisted living care, enhanced assisted living care, or secure specialized care), each with progressively more rigorous licensing standards. If VDSS's proposed ALF licensure structure is implemented, the state will still need more rigorous staffing requirements, and VDSS should incorporate one or both staffing standard options described in this chapter.

5 Oversight of Assisted Living Facilities

States are responsible for regulating and overseeing assisted living facilities (ALFs). Unlike nursing homes, ALFs are not governed by a federal framework that serves as the basis for ALF regulation across states. Each state must establish a regulatory framework that sets health and safety requirements for ALFs and defines the oversight and enforcement mechanisms used to ensure compliance.

The Virginia Department of Social Services (VDSS) is the primary state entity responsible for oversight of ALFs in Virginia. This chapter assesses the effectiveness of VDSS's oversight of ALFs. Within VDSS, the Division of Licensing Programs (DOLP) licenses and monitors ALFs. The DOLP field operations unit issues ALF licenses and conducts inspections. The unit comprises 31 licensing inspectors and five licensing administrators organized into five geographic licensing regions.

Stakeholders generally view VDSS oversight positively, but there are concerns about consistency

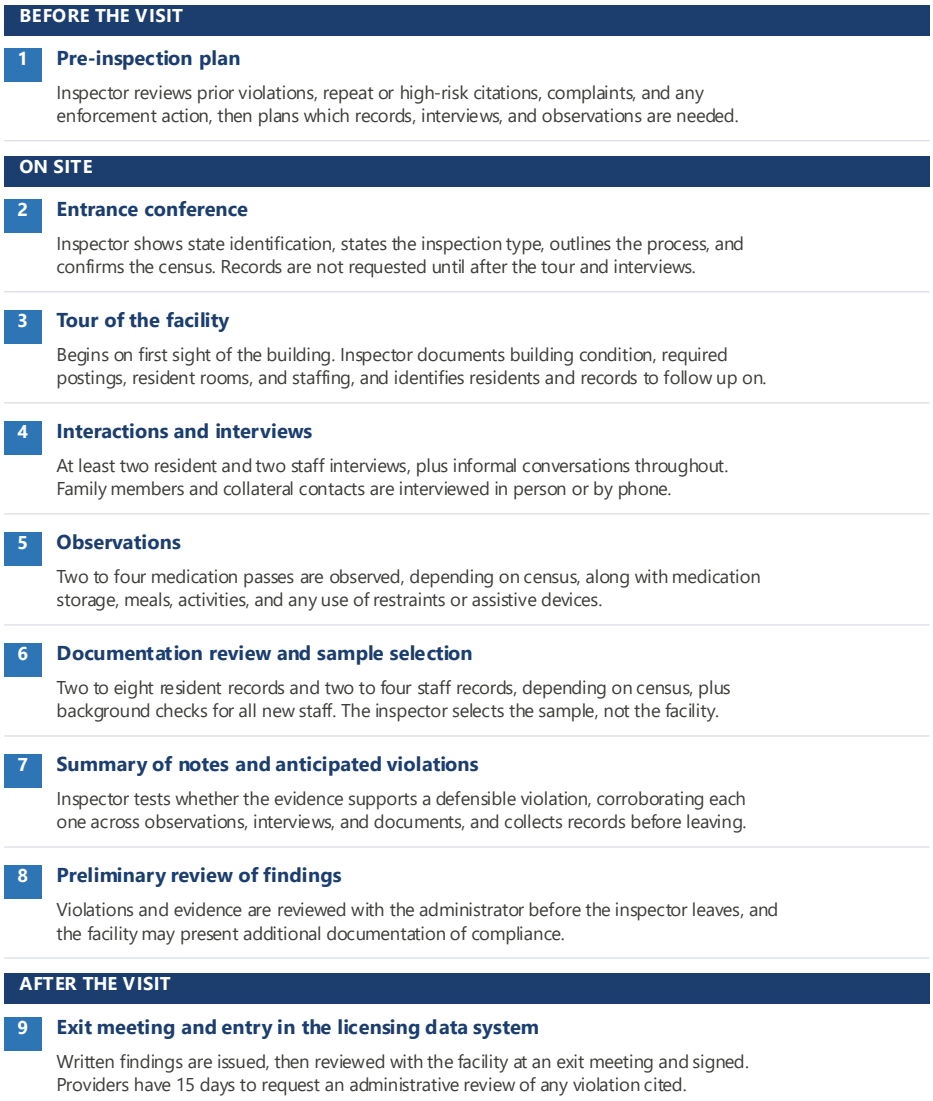
DOLP licensing inspectors conduct several types of inspections required by statute ("mandated inspections"), including initial licensing inspections for new applicants, renewal inspections for existing providers, and at least one annual monitoring inspection of all facilities. Initial licensing inspections are *announced* on-site inspections that occur before a facility begins admitting residents to evaluate whether the facility is move-in ready, while license renewal and annual monitoring inspections are *unannounced* on-site inspections that evaluate compliance with all applicable laws and regulations.

Mandated monitoring inspections consist of nine components, including a tour of the facility, interviews with residents and staff, and a document review (Figure 5-1). One inspector typically conducts an on-site inspection in a single day, although some inspections may require multiple inspectors over several days depending on facility size and the level of care offered (e.g., memory care units require additional review).

DOLP also conducts inspections in response to public complaints and self-reported incidents (self-reports) submitted by ALFs (sidebar). Because statute grants VDSS discretion over whether an on-site inspection is necessary, complaint and self-report inspections are not considered mandated inspections. DOLP triages each complaint and self-report to determine whether to conduct an on-site inspection. Unlike routine monitoring inspections, these inspections focus on the specific incidents alleged in the complaint or reported by the ALF. However, inspectors can concurrently investigate additional areas of concern identified during the inspection.

ALFs must report to VDSS within 24 hours any major incident that has negatively affected or that threatens the life, health, safety, or welfare of any resident. By statute, these self-reported incidents are not considered official complaints but may still be investigated and can result in violations and corrective action.

FIGURE 5-1
ALF monitoring inspections involve nine components

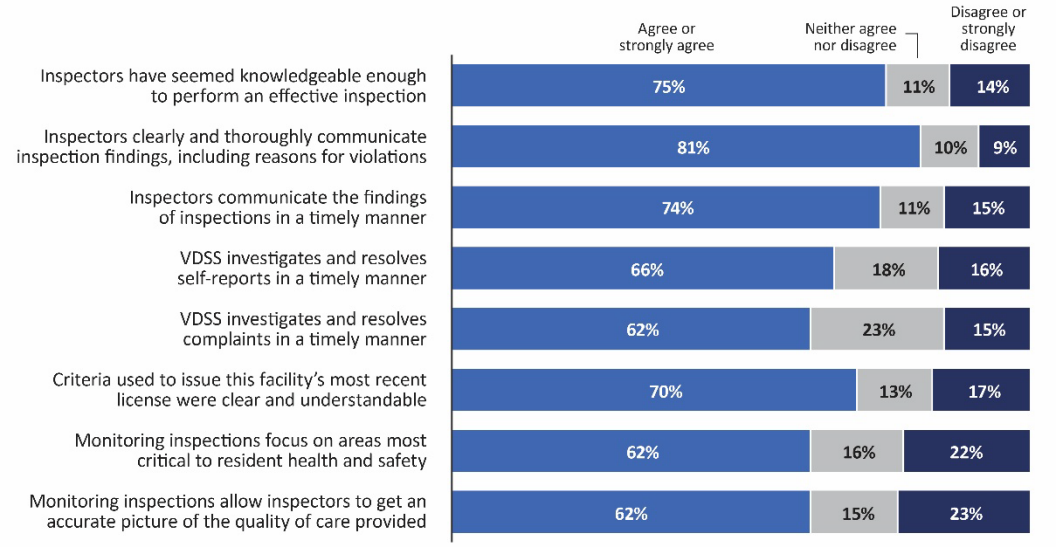


SOURCE: JLARC review of VDSS licensing guidance documents.

VDSS's process, inspectors, and timeliness for ALF oversight were viewed positively, but stakeholders had concerns about inconsistency

ALF administrators were generally positive in their feedback about VDSS's oversight of ALFs. In JLARC's survey of licensed ALF administrators in Virginia, most administrators reported that VDSS uses reasonable oversight processes and procedures, and that VDSS inspectors are knowledgeable and investigate and communicate in a timely and clear manner (Figure 5-2).

FIGURE 5-2
ALF administrators shared positive perspectives on VDSS's oversight of ALFs



SOURCE: JLARC survey of licensed ALF administrators.
NOTE: The number of respondents ranged from 138 to 141, depending on the statement. "Not sure" responses are combined with "neither agree nor disagree." Percentages may not sum to 100 because of rounding.

Area agencies on aging (AAA) and local departments of social services (LDSS) staff also indicated that VDSS generally performs its oversight role well. In response to JLARC surveys, 80 percent of AAA staff reported that VDSS oversees ALFs either somewhat well (45 percent) or very well (35 percent). LDSS staff responded similarly, with 70 percent saying VDSS oversees ALFs somewhat well (36 percent) or very well (34 percent).

Although stakeholders were generally positive about VDSS's ALF oversight, licensing inspectors and ALF administrators both expressed concerns about inconsistent application of regulations across facilities and licensing regions. In response to JLARC's survey, fewer than half (45 percent) of licensing inspectors agreed that inspectors are consistent in determining violations, and nearly three-quarters (74 percent) said they would benefit from additional training on core inspection functions, such as identifying violations, gathering evidence, and assigning risk levels to violations. In interviews, ALF operators with multiple facilities in Virginia described similar consistency concerns, reporting that inspectors' expectations differ across licensing regions. Similarly, in open-ended survey responses, ALF administrators reported that some inspectors are stricter or more punitive than others, and that inspectors have applied similar regulations differently over time, without clear explanations for the change.

> *"Consistency in the interpretation and enforcement of regulations across inspectors and regions needs improving. Communities often experience variations in how requirements are applied, with similar situations receiving different responses depending on the inspector conducting the review."*
>
> **– ALF administrator**

Violations data supports inspectors' and administrators' concerns regarding inconsistency. JLARC analysis of 2025 ALF violation data found substantial variation in average violations per facility across licensing regions (Table 5-1). Facilities in the Piedmont & Western licensing region averaged nearly five times as many violations as facilities in the Central licensing region, and the pattern holds within every facility size

category. While some of this variation could reflect differences in facility quality and compliance across licensing regions, differences of this magnitude are consistent with inspectors' and administrators' reports of variation in inspector practices.

TABLE 5-1
Average violations vary substantially across VDSS licensing regions (2025)

Facility size	Central	Eastern & Peninsula	Fairfax	Northern & Valley	Piedmont & Western
Group 1 (20 or fewer)	2.3 avg violations	4.2	7.1	1.9	11.7
Group 2 (21–50)	3.3	7.1	3.8	9.0	10.6
Group 3 (51–100)	2.6	7.0	7.1	6.6	10.2
Group 4 (101+)	3.6	10.7	12.8	6.1	20.6
All facilities	**2.7**	**7.4**	**8.6**	**6.6**	**13.0**

SOURCE: JLARC analysis of Virginia Department of Social Services violation data, 2025.

VDSS leadership acknowledges that maintaining consistency across inspectors and licensing regions remains an ongoing challenge. To address this, VDSS hired a field operations manager in 2024 to oversee regional licensing offices and standardize licensing operations. Staff report that this position has helped improve consistency, but challenges persist. VDSS should further investigate factors driving inconsistency across inspectors and licensing regions and address them through additional guidance and training. More consistent inspector practices, including improved identification of violations and assignment of risk levels, would also improve the reliability of the compliance information VDSS posts on its public ALF search tool, including the information that would be added under Recommendation 3 (e.g., standards violations and severity).

RECOMMENDATION 5
The Virginia Department of Social Services (VDSS) should (i) identify the causes of regional variation in assisted living facility violation citations; (ii) develop clear guidance articulating the agency's regulatory philosophy and expectations for inspection consistency; and (iii) provide additional training to inspectors on core inspection functions.

VDSS typically processes licensure applications within a few months and completes annual inspections within the required time frame

VDSS generally processes initial ALF licensure applications within a reasonable timeframe. Between FY24 and FY26, VDSS received an average of 50 initial applications per year, and the statewide median time from application receipt to facility opening was 64 business days, although regional medians ranged from 37 (Eastern and Peninsula region) to 74 (Northern and Valley region) business days. The state does not require that applications be processed within a certain timeframe.

VDSS does not have a backlog of annual ALF monitoring inspections. In FY26, VDSS completed all required annual monitoring inspections on time.

Investigations of complaints are often not timely, and inspection approach needs to be more strategic

Although most stakeholders report that VDSS does a good job of overseeing ALFs, VDSS's oversight could be strengthened. Processing licensure applications and completing mandated inspections on time is important, but VDSS also needs to respond promptly to reported incidents that affect residents' welfare. VDSS staff report delays in initiating and completing investigations, with some complaints remaining unaddressed for months. Additionally, VDSS needs to focus more on facilities with chronic noncompliance or poor performance and inspect them more regularly.

Growing workload has slowed responsiveness to complaints and self-reported incidents

Delays in investigating complaints and self-reports can leave residents exposed to unsafe or harmful conditions. Inspectors must prioritize mandated inspections (annual monitoring and renewal inspections) to comply with statutory requirements, which leaves limited time to investigate complaints and self-reports. However, complaints and self-reports often involve incidents or conditions that pose a threat to the health, safety, or welfare of ALF residents. VDSS should investigate these incidents as soon as possible to ensure residents do not face any ongoing harm (sidebar).

There are no statutory or regulatory timeliness standards for complaint investigations, but VDSS has established internal protocols that complaint and self-report investigations should typically be initiated within 30 days and completed within 60 days. Under this protocol, investigations of complaints involving abuse, neglect, or substantial health and safety risks should be initiated within seven days.

The volume of complaints and self-reports involving ALFs has increased substantially in recent years, and reviewing and investigating these incidents now accounts for nearly half of inspectors' time. Between FY25 and FY26, the total number of self-reports increased 13 percent, and the total number of complaints increased 21 percent, across all facilities overseen by DOLP. VDSS staff estimate that 80 percent of these self-reports and complaints involved an ALF as opposed to other types of facilities overseen by DOLP (e.g., adult day centers, children's residential facilities). Long-term trends cannot be measured because VDSS did not centrally collect or track complaint and self-report data before FY25. However, staff report anecdotally that the volume has risen sharply over the past five years. In FY25, 43 percent of VDSS licensing inspectors' time went to reviewing (25 percent) and investigating (18 percent) self-reports and complaints.

The current volume of complaints and self-reports already exceeds inspector capacity. In JLARC's survey of VDSS licensing inspectors, only 19 percent reported being able to investigate complaints in a timely manner, and only 32 percent said the same for self-reported incidents. Furthermore, VDSS staff report that they currently investigate about 8 percent of self-reports but believe at least 25 percent should be investigated to appropriately evaluate risks and identify patterns of harm and systemic issues.

Additional licensing inspectors would allow VDSS to initiate investigations more quickly, review a larger share of complaints and self-reports, and reduce the workload of existing inspectors. In its most recent budget request for the 2026–2028 biennium, VDSS estimated that it needed at least eight additional licensing inspectors and an additional licensing administrator to meet the growing inspection and investigation workload demand, driven by increases in complaints and self-reported incidents. VDSS estimates that these positions will cost approximately $1.1 million per year.

RECOMMENDATION 6

The General Assembly may wish to consider including funding in the Appropriation Act for additional full-time classified licensing inspector positions within the Division of Licensing Programs at the Virginia Department of Social Services.

VDSS should use at least a portion of any additional inspector capacity allocated to the agency to prioritize investigating incidents posing the highest risk to ALF residents' health and safety. Currently, complaints and self-reports are assigned to each facility's designated inspector, who is also responsible for processing licensing applications and conducting mandated annual monitoring inspections across facilities on their caseload. VDSS should instead dedicate some inspectors to a special unit that investigates complaints and self-reports that involve the greatest risk of harm to residents, a practice used by the Virginia Department of Behavioral Health and Developmental Services and the Virginia Department of Health. This structure would help ensure rapid responses to the most serious allegations while leaving other inspectors free to complete mandated inspections.

RECOMMENDATION 7

The Virginia Department of Social Services should establish a special investigations unit within its Division of Licensing Programs, staffed by experienced licensing inspectors, to exclusively investigate complaints and self-reported incidents involving the greatest risk of harm to assisted living facility residents.

VDSS could improve its ALF oversight by inspecting facilities with weaker compliance histories more frequently

VDSS currently inspects most ALFs once per year, regardless of their compliance history. In the past, facilities with shorter-term licenses, which generally reflect greater compliance concerns, were inspected more frequently (sidebar). The General Assembly eliminated this tiered inspection approach in 2010 and now requires one unannounced inspection annually for all licensed ALFs. Therefore, the facilities most likely to have recurring or unaddressed problems receive the same level of oversight as better-performing ones. (Adult day centers, which VDSS also oversees, continue to be inspected up to three times per year depending on license length.)

By regulation, facilities that **substantially exceed minimum standards receive a three-year license**, facilities that **routinely meet compliance standards** and exceed them in some areas **receive a two-year license**, and facilities with **an inconsistent level of compliance receive a one-year license**.

DOLP also issues six-month conditional licenses to new facilities and provisional licenses when a facility temporarily cannot demonstrate substantial compliance.

Some licensing inspectors reported that one inspection per year is insufficient and indicated they would prefer to inspect *all* ALFs more frequently. In response to JLARC's survey, about one-third (32 percent) of licensing inspectors indicated that the frequency of mandated inspections is insufficient to determine if ALFs consistently meet regulatory requirements. Similarly, all five regional licensing administrators felt ALFs should be inspected more than once per year. Additionally, inspectors and licensing administrators reported that ALF administrators are often able to anticipate and prepare for their annual inspection as the annual deadline approaches, reducing the effectiveness of the unannounced nature of inspections.

Increasing the frequency of unannounced inspections could improve VDSS's insight into ALFs' compliance with minimum standards; however, inspecting all ALFs more than once per year is not feasible with DOLP's current resources. Additionally, Virginia already inspects ALFs more frequently than some comparison states (sidebar). Across these 10 states, only three (Maryland, North Carolina, Pennsylvania) require annual inspections, and the other seven require inspections every 15 (Delaware, Ohio, Washington) to 24 months (Florida, Minnesota, Oregon, Wisconsin). None of these states require inspections more frequently than once per year.

For this review, JLARC staff identified **10 states for comparison** across a variety of domains related to aging services: **DE, FL, MD, MN, NC, OH, OR, PA, WA, and WI**. More information on why these states were selected is in Appendix B.

Virginia could improve its oversight of poor-performing ALFs by requiring additional random inspections of a subset of facilities that demonstrate high risk or poor past compliance. Going forward, DOLP should randomly select each year a percentage (e.g., 25 percent) of poor-performing facilities in each licensing region for an additional unannounced inspection. VDSS could establish a pool of facilities eligible for these random inspections using criteria such as having a history of higher-than-average total violations compared with other similarly sized facilities in the region, having a higher rate of serious violations, receiving an unusually high number of complaints, or receiving a one-year license because of compliance issues. Additional staffing resources allocated to DOLP in accordance with Recommendation 6 could help address the additional workload associated with these inspections.

RECOMMENDATION 8

The General Assembly may wish to consider amending § 63.2-1706 of the Code of Virginia to require the Virginia Department of Social Services to conduct an additional unannounced inspection each year of a randomly selected subset of assisted living facilities in each licensing region that demonstrate indicators of poor performance or high risk.

VDSS's outdated licensing software system hinders ALF oversight

An effective licensing software system should support consistent, efficient collection, maintenance, and analysis of inspection data. VDSS's licensing software system, the Division of Licensing Programs Help and Information Network (DOLPHIN), is

obsolete and lacks the functionality needed to meet operational and security standards. The system was first implemented in 2003 and has exceeded its useful life by several years. Because of its age, DOLPHIN is no longer supported by the original vendor or by VDSS's internal IT staff, which creates maintenance, security, and reliability problems. DOLPHIN also does not comply with current Virginia Information Technologies Agency (VITA) requirements because it does not operate on an approved cloud-based platform and uses an obsolete programming language.

DOLPHIN's limitations substantially reduce the efficiency of VDSS licensing staff. Most significantly, the system's mobile component was decommissioned in 2022 because it no longer met VITA security standards. Without it, inspectors record inspection information by hand on-site, type their findings into a word processing document, and then copy that information into DOLPHIN. VDSS staff report that inspection documentation now takes triple the time it did with the mobile component. As a result, ALF operators report that it now takes longer to receive inspection results, which can hinder their ability to address issues that were identified in the inspection that impact resident health and safety.

DOLPHIN also lacks a central system for receiving and tracking complaints, self-reports, and allegations of illegal operation. Instead, VDSS receives this information through several channels: the online complaint portal; email, phone, or fax to the central office or directly to inspectors; and mail. Staff then enter each incident and track its investigation status manually in spreadsheets, a labor-intensive process.

Manual data collection and fragmented storage limit VDSS's ability to monitor trends in ALF compliance. Because inspectors record inspection information by hand, the format and level of detail captured vary across inspections, facilities, and inspectors, and each step creates opportunities for error, such as omitted evidence and misidentified violations. Compliance information for a single facility is stored across multiple systems, spreadsheets, and documents rather than in a central database, leaving VDSS little ability to report on compliance trends, emerging problems across facilities, or the timeliness of oversight activities. VDSS has further difficulty monitoring historical compliance trends because DOLPHIN cannot generate reports on facilities' violation histories once the assigned inspector leaves the agency, leaving hundreds of facilities with incomplete violation records.

VDSS is working to improve its technology capabilities but cannot replace the DOLPHIN system within its current budget (sidebar). VDSS worked with a vendor to develop a new mobile licensing application for inspectors, which was originally intended to interface with DOLPHIN. However, during development, VDSS determined that the interfacing was not feasible, and the application cannot launch until the underlying licensing system is replaced. VDSS reports that it does not have the necessary funds to replace DOLPHIN but has submitted a request for approximately $3.2 million for the project.

JLARC's 2026 report *Governance and Oversight of Artificial Intelligence in Virginia* recommends that the Virginia Information Technologies Agency (VITA) establish an expedited review and approval process for AI coding assistance tools proposed by state agencies for modernizing existing IT systems. VDSS could explore whether and how AI coding could be used to develop a modernized licensing system.

Replacing DOLPHIN would improve inspectors' efficiency and data quality for ongoing ALF oversight. A modernized system would enhance data collection and analysis while providing the infrastructure needed to track ALF quality metrics (in conjunction with the quality reporting system discussed in Chapter 3). VDSS staff estimate that procuring and implementing a replacement system would take at least a year after appropriation.

RECOMMENDATION 9

The General Assembly may wish to consider including funding in the Appropriation Act for the Virginia Department of Social Services to replace the information technology system used to license and monitor assisted living facilities and other licensed settings under the purview of the Division of Licensing Programs.

A modernized licensing system should include several capabilities that DOLPHIN lacks. Specifically, the modernized system should include:

- a mobile licensing component that allows for real-time data entry;
- a case management system that integrates all available compliance data at the facility level;
- a centralized complaint and self-reported incident intake, triage, and tracking system;
- dashboard and analytic capabilities to allow for historical and real-time trend analysis; and
- capability and capacity to collect and maintain additional ALF quality information, as proposed in a policy option in Chapter 3.

RECOMMENDATION 10

The Virginia Department of Social Services should ensure that any new licensing system includes (i) a mobile component for inspectors to enter inspection data in real time; (ii) the ability to aggregate historical compliance records for a facility; (iii) centralized intake, triaging, and tracking of complaints and self-reported incidents; (iv) dashboard and analytic capabilities for historical and real-time trend analyses; and (v) capacity to collect and maintain comprehensive facility quality and performance metrics.

VDSS faces several barriers to holding ALFs accountable for noncompliance

The Code of Virginia authorizes the commissioner of VDSS to impose administrative sanctions on ALFs to ensure prompt correction of violations that adversely affect residents' health, safety, or welfare.

Available sanctions include:

- Revoking a license prior to expiration
- Denying renewal of a license
- Suspending a license
- Prohibiting new admissions
- Reducing facility capacity
- Requiring an interim administrator
- Placing a facility on probation
- Petitioning a court to appoint a receiver
- Assessing civil penalties against the licensee
- Mandating staff training
- Requiring facilities to contact guardians or other responsible persons for all residents

DOLP regularly pursues enforcement against facilities with serious compliance issues. VDSS considers sanctions for any serious violation, which includes any licensing violation with at least a medium probability of serious harm (sidebar). Between FY22 and FY25, VDSS pursued 76 enforcement cases, 70 of which culminated in sanctions against a facility. Of these 70 cases, three involved the death of an ALF resident, 29 involved serious injuries, and 16 involved resident elopements.

VDSS assigns a risk rating to each violation using a risk assessment matrix that evaluates the circumstances of violation across two dimensions:

Probability of harm (A=low/unlikely to occur, B=medium/likely to occur, C=high/harm is imminent or has occurred)

Severity of harm (1=moderate severity of harm, 2=serious severity, 3=extreme severity)

Serious violations include all B-2, B-3, C-2, and C-3 ranked violations.

Despite DOLP's regular use of enforcement actions, some poor-performing ALFs do not face sanctions. For example, of the 17 ALFs identified in Chapter 3 as having the most significant quality concerns in 2025, only seven were subject to enforcement actions in FY25 or FY26. Further, facilities subject to enforcement actions often exhibit persistent noncompliance. DOLP staff report that certain administrative barriers and policies hinder their oversight, including restrictions on the use of certain sanctions, lengthy appeals and administrative loopholes that delay or minimize enforcement impact, and burdensome internal processes that discourage some inspectors from pursuing enforcement cases.

Civil penalties may not motivate compliance, particularly at larger facilities

The Code of Virginia allows the VDSS commissioner to fine ALFs that are out of compliance with state standards. These civil penalties can be assessed for each day a facility is out of compliance and residents' health, safety, or welfare is at risk. As directed by statute, the Board of Social Services has set criteria for when a civil penalty should be assessed and how amounts are determined, based on the severity, pervasiveness, duration, and degree of noncompliance risk. However, statute caps the total civil penalties a facility can be assessed at $10,000 during a 12-month period.

> *"The fines are a drop in the bucket to many large facilities. A $10,000 fine is basically one resident's monthly fee for these large facilities."*
>
> **– VDSS licensing staff**

Although civil penalties are VDSS's most frequently used sanction, licensing staff report that fines are often too small to deter noncompliance or incentivize lasting operational improvements. The average civil penalty assessed between FY22 and FY25 was just $1,518, less than a quarter of the median monthly cost for a single ALF resident in 2025 ($6,945). Licensing staff report that many facilities, especially larger ones, are not affected much by these penalties and often treat them as a cost of doing business.

Several comparison states offer examples of substantially higher civil penalties against ALFs, which make the penalties more impactful. Of the 10 comparison states JLARC reviewed (see Appendix B), nine had no aggregate cap on civil penalties, instead setting only a maximum per violation. Delaware and Florida, for example, allow fines up to $20,000 and $10,000, respectively, *per violation*. Pennsylvania sets per-resident, per-day amounts that vary by the violation's severity, with no aggregate cap. Oregon was the only comparison state with an aggregate cap but sets it much higher than Virginia's $10,000 annual cap. Oregon's cap is $40,000 for abuse-related violations and $20,000 for all other violations *per 90-day period*.

Increasing civil penalties would make financial sanctions a more effective tool for driving ALFs' compliance. Penalties could be scaled by facility size to account for differences in their revenues. Funds collected from civil penalties could support additional technical assistance to ALFs related to the quality monitoring efforts recommended in Chapter 3 (sidebar).

By statute, funds from civil penalties are allocated to the **Assisted Living Facility Education, Training, and Technical Assistance Fund**. This fund provides education and training for staff and technical assistance to improve the quality of care in such facilities.

RECOMMENDATION 11

The General Assembly may wish to consider amending § 63.2-1709.2 of the Code of Virginia to increase the maximum civil penalties that may be assessed against an assisted living facility.

Lengthy appeals processes allow some ALFs to continue operating in noncompliance, and it is difficult for VDSS to intervene

ALFs may challenge both violation findings and resulting sanctions (Figure 5-3). Facilities can first seek an informal VDSS review of a cited violation. If VDSS imposes a sanction, the facility may pursue additional administrative appeals and ultimately seek judicial review in circuit court.

FIGURE 5-3
Facilities may dispute violations and appeal sanctions



SOURCE: JLARC analysis of assisted living facility sanction and appeals process.

The appeal process outlined in the second part of Figure 5-3 is governed by Virginia's Administrative Process Act (APA). Each step of this process has its own timeline (sidebar, next page), but the overall administrative process can take nine months (or longer depending on scheduling delays and continuances) before an appeal even reaches judicial review. The judicial review stage can take from several months to years before a final decision is issued by the court.

APA appeal timelines:

- Facility appeal of notice of intent: *15 days*
- VDSS decision after informal conference: *90 days*
- Hearing officer recommendation after administrative hearing: *90 days*
- Commissioner's case decision after recommendation: *30 days*
- Facility appeal of case decision to circuit court: *30 days*

While the APA process affords important due process to facilities, extended appeal timelines can inhibit the effectiveness of sanctions and delay accountability for some noncompliant facilities. For example, in January 2025, VDSS imposed a civil penalty on a facility and required it to provide written notice of the violations to residents and guardians following multiple resident care and staff training standards violations identified during inspections between May and September 2024. While all facilities are required to post the results of their most recent inspection on the premises, written notification to residents and guardians is required only if ordered by the commissioner through a sanction. The facility appealed these sanctions through each step of the appeal process up to the circuit court, which ultimately upheld the sanctions against the facility in September 2026. During the two-year appeal process, the facility did not pay the assessed penalty, and written notification of the violations to residents and guardians was delayed until the appeal was resolved, diminishing the usefulness of the enforcement action.

Additionally, some facilities continue operating in noncompliance during the lengthy appeals process, even when facing possible license revocation or renewal denial, which could place residents at risk. For example, VDSS recommended denying a facility's license renewal after it had accrued 25 licensing violations between 2022 and 2023, many of which were related to resident care. The facility appealed the decision and, during the appeal process, accrued 80 additional licensing violations through 2025. Through a consent agreement, the facility retained its license provisionally but has since accrued additional serious violations, leading VDSS to once again recommend denying its license renewal in March 2026. The facility appealed this decision and continued operating for several months before ultimately deciding to voluntarily close in October 2026.

VDSS also has authority to protect residents at noncompliant ALFs by **restricting admissions, reducing capacity, requiring an ALF to appoint an interim administrator, or petitioning the court to appoint a receiver for an ALF**. However, these are intended to be **intermediate sanctions** that are imposed prior to revoking or denying renewal of a license.

VDSS has statutory authority to suspend ALF operations to protect residents during the appeals process but rarely uses it because of legal and logistical challenges. State law allows the VDSS commissioner to summarily suspend an ALF's license when conditions pose an immediate and substantial threat to residents' health, safety, or welfare (sidebar). All summary orders of suspension are subject to a hearing before a hearing officer, whose decision can be appealed to the circuit court. VDSS staff report that this process requires significant resources and rarely succeeds. In addition, suspensions force emergency resident relocations, disrupting care and living arrangements. Because of these challenges, the commissioner has initiated only two summary suspensions in the last five years.

ALF residents and their guardians could be better informed of ongoing sanction proceedings against their facilities. Currently, ALFs are required by statute only to post notice of the commissioner's intent to revoke or deny renewal of a license at public entrances. While these postings reach mobile residents and facility visitors, they do not ensure that all residents and guardians are informed of ongoing proceedings. Directly notifying residents and guardians about the commissioner's intent to revoke or deny

renewal of the facility license would allow them to make informed decisions about whether to remain in the facility.

RECOMMENDATION 12

The General Assembly may wish to consider amending § 63.2-1709 of the Code of Virginia to require assisted living facilities to provide written notice of the intent of the Virginia Department of Social Services commissioner to revoke or deny renewal of the facility's license to all facility residents and their guardians, including when the commissioner's decision has been appealed by the facility.

Change of ownership process allows some ALFs to avoid public consequences of noncompliance

ALFs can avoid some of the public consequences of noncompliance sanctions by completing a change of ownership. VDSS staff report that ownership changes are frequently just technical changes, with ownership moving from one limited liability company to another, but with facility management, staff, and name remaining the same. VDSS staff report that some ALF operators pursue an ownership change to remove their history of noncompliance from the VDSS website rather than for legitimate business reasons. When a facility completes an ownership change, all compliance information associated with that facility under the previous owner is removed from VDSS's ALF search page.

VDSS should preserve facilities' compliance history on its ALF search page following a change of ownership, unless the facility's new owners demonstrate that a bona fide transfer of ownership occurred. To qualify as a bona fide change in ownership, the sale should represent an arm's-length transaction between unrelated parties in which no prior owner or affiliated entity retains an ownership interest in the facility. The change should also include a new entity or individual responsible for the facility's day-to-day operation (e.g., a new licensed administrator or new management company). If a new owner successfully demonstrates a bona fide transfer, VDSS should remove the compliance history associated with the previous owners from its ALF search page.

RECOMMENDATION 13

The Virginia Department of Social Services (VDSS) should (i) establish criteria and a review process to determine whether a bona fide change in ownership and facility management has occurred when an assisted living facility applies for licensure under new ownership, and (ii) remove compliance history associated with a previous owner from the VDSS website only if the applicant demonstrates that a bona fide change in ownership and facility management has occurred.

Inefficient internal procedures can discourage inspectors from pursuing enforcement

Issuing enforcement actions against ALFs requires a multi-tiered review process. Licensing inspectors initiate the enforcement process against ALFs that are on their caseload. Inspectors who identify serious violations consult with their regional licensing administrator before submitting a sanction recommendation to an enforcement committee, made up of staff from DOLP's central office team. As part of the sanction recommendation, the inspector must prepare an enforcement package that contains a significant amount of documentation, such as a description of the recommended sanction, investigation notes, correspondence with the facility operator, and any previous corrective action plans. The DOLP enforcement committee reviews the enforcement package to decide whether sanctions should proceed. If approved by the committee, the sanction recommendation then goes to the DOLP director for approval and ultimately to the VDSS commissioner to issue the sanction.

> *"Every enforcement action that is taken requires more and more work in the field on the licensing inspector and administrator. A lot of people shy away from that because they are already overwhelmed and overworked. Recommending enforcement is just one more thing, and it's challenging."*
>
> **– VDSS licensing inspector**

This internal process for enforcement actions is administratively burdensome for licensing inspectors, and some report that it discourages them from pursuing sanctions against ALFs. The documentation requirements for preparing the enforcement package require substantial time and effort from inspectors. Once the package is submitted to central office, the process typically takes at least two months after an inspection to issue a sanction but can take much longer if the facility appeals. Inspectors report that this process is difficult to manage given their ongoing inspection workload demands.

VDSS inspectors and central office staff report that the outdated IT system causes much of the initial administrative burden associated with preparing enforcement cases, including consolidating facility and inspection information. Plans for the modernized licensing IT system include components that should reduce this burden. However, VDSS should solicit inspector feedback to identify additional opportunities to streamline the enforcement process, including specific documentation requirements that could be reduced without affecting the integrity of the process.

RECOMMENDATION 14

The Virginia Department of Social Services should streamline its internal enforcement process for assisted living facilities by eliminating any unnecessary administrative burdens identified by inspectors, including unnecessary or overly burdensome documentation requirements.

6 State Oversight of Home Care Organizations

State oversight of home care organizations (HCOs) in Virginia should help protect the health, safety, and welfare of home care recipients, who are commonly elderly, disabled, or chronically ill. Employees of HCOs provide unsupervised care for these individuals in their homes, making recipients especially vulnerable. Care recipients may live alone or be alone when HCO staff visit, and HCO staff are usually not supervised or accompanied by other colleagues when providing care. Effective oversight of HCOs should ensure these organizations are hiring qualified and vetted direct care staff and that staff are properly developing and following individualized plans of care that meet their clients' needs.

This chapter assesses the effectiveness of VDH OLC's monitoring of HCO compliance with Virginia's regulations governing quality and safety. It is not an evaluation of the quality of services provided on an individual recipient basis.

The Code of Virginia and state regulations establish expectations for HCO operations and direct the Virginia Department of Health (VDH) to oversee Virginia's HCOs through its Office of Licensure and Certification (OLC) (sidebar). OLC is responsible for ensuring providers comply with state regulations by processing initial applications for licensure and conducting biennial inspections of HCOs.

State regulations are applicable to all personal care providers (those who assist with activities of daily living, administer normally self-administered drugs, take vital signs, etc.). Organizations that provide *only* housekeeping, chore or beautician services are exempt from the regulations.

This chapter identifies several shortcomings in OLC's oversight of HCOs, which VDH and OLC leadership acknowledge and indicate they are taking steps to address. VDH's plan for its HCO program includes four priorities: (1) reducing the backlog of overdue biennial inspections by assigning inspectors to regions and monitoring their performance; (2) streamlining and improving the licensure application review process; (3) verifying that HCOs correct identified deficiencies and applying existing enforcement authority more consistently; and (4) recruiting and retaining enough staff while modernizing data systems to manage the office's workload. These efforts are still in development.

OLC's weak licensure process lets unprepared HCOs enter the market and creates significant backlogs

A robust licensure process is essential for protecting the public by ensuring ill-prepared health care organizations do not enter the market. OLC's review of initial applications is especially important because the initial review includes the only inspection an HCO receives for a long period of time, often many years.

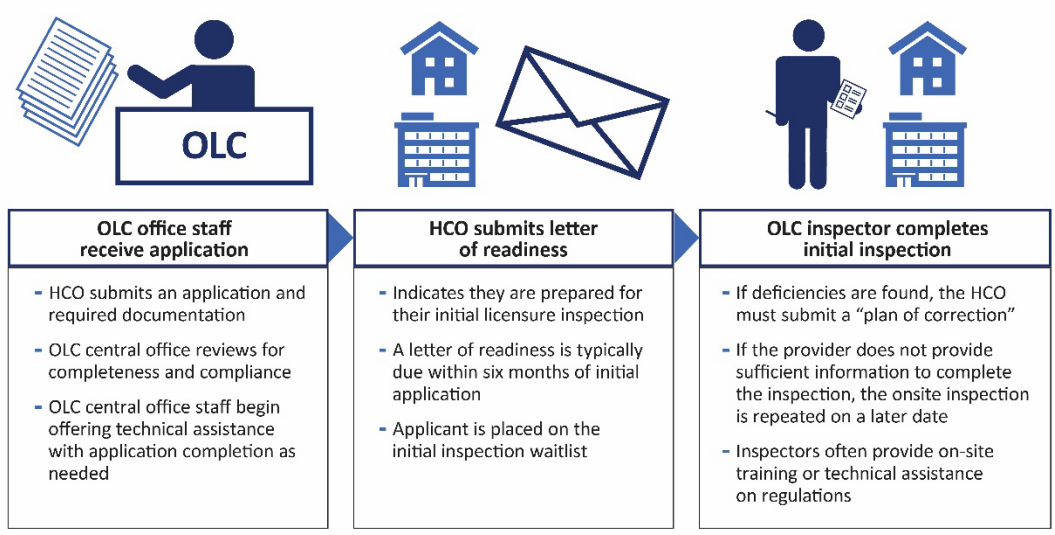
Virginia's requirements for new HCOs to qualify for an operator's license are generally comparable to those in other states. Requirements for new HCOs vary among states, but Virginia's are not substantially more or less stringent than other states. Because Virginia's requirements are broadly in line with other states, the review did not evaluate

The initial application requires HCO applicants to submit basic information including the agency's legal name and information about the owner, administrator, nursing manager, and financial manager. (See Appendix F for additional description of application requirements.)

the adequacy of the requirements themselves. Instead, it examined the process OLC uses to determine whether new applicants meet those requirements.

OLC reviews each licensure application and conducts an initial inspection of each prospective HCO's main office to determine whether the HCO applicant complies with relevant state laws and regulations before granting it an operator's license (Figure 6-1) (sidebar). OLC office staff first receive and review an application to determine whether it is complete and meets regulatory requirements. If it is determined to be complete and compliant, an OLC inspector conducts an on-site inspection of the HCO. During the inspection, an HCO is expected to provide copies of its policies and procedures, emergency operation plans, employee orientation materials, governing body meeting minutes, and other required documents.

FIGURE 6-1
Initial licensure process includes application and inspection components



SOURCE: VA Administrative Code Chapter 381 and JLARC staff interviews with OLC inspectors.
NOTE: According to OLC staff, the office has not enforced its rule that HCOs submit their letter of readiness within six months of submitting their initial application because of initial application processing backlogs.

OLC does not deny initial HCO license applications, which allows ill-prepared providers to enter the market

According to OLC staff, many HCO applicants are unprepared to successfully complete the initial application or to pass an on-site inspection. Staff reported that applications are often of poor quality, and OLC returns many to applicants for revision at least once, and often multiple times, because they are missing documents or contain basic errors. At the on-site inspection, applicants often do not have all required materials available, or the materials are incomplete or inaccurate. As OLC staff explained, "People are working full-time jobs and trying to start an HCO; they don't really have a handle on what they are getting into… This is a serious business."

OLC provides extensive technical assistance to HCO applicants until they meet licensure requirements, based on staff's interpretation that the regulations obligate them to provide such assistance (sidebar). In practice, this means that OLC works with applicants to fix deficiencies through application resubmissions, multiple on-site inspections, plans of correction, and additional consultation. This assistance continues even when applicants show no evidence of improvement or do not demonstrate an understanding of state regulations or the gravity of the work they will be undertaking.

State regulations specify that OLC should provide prelicensure consultation and technical assistance regarding the licensure process (12VAC5-381-40).

OLC's practice of giving applicants extensive technical assistance and repeated opportunities to correct deficiencies contributes to ill-prepared HCOs entering the market. OLC staff interviewed by JLARC reported that the process eventually allows HCOs to receive a license, even though they are ultimately unprepared for operations. As OLC staff described, "[If I had the power, I would want to deny initial licenses to some providers.] I've gone to some initial inspections where they did not meet one single benchmark. We've gone through a plan of correction for two months now with that one provider. They don't have a good grasp on what is needed."

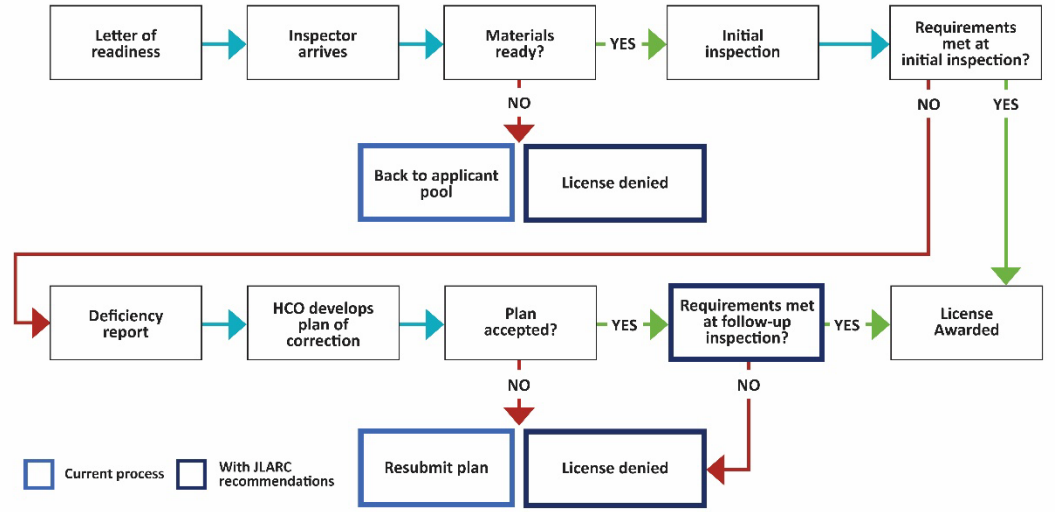
The Code of Virginia and regulations outline when an HCO license should be approved and imply that applications for licensure may be denied. However, because neither the statute nor regulations contain explicit criteria for when one should be denied, and OLC has no formal policy for when staff should deny a license, some OLC staff report they feel that they lack the ability to deny applications. As one staff member noted, "We don't deny licenses at [the initial application]. We just work with them to get it."

To reduce the number of ill-prepared HCOs entering the market, the state should establish clear criteria for when OLC staff should deny an initial HCO license. Under these criteria, OLC could deny a license when an applicant is unable to meet state requirements without substantial technical assistance and repeated opportunities to correct deficiencies. Denial could occur at several points in the licensure process, such as during application review, at the on-site inspection, or after an unsuccessful plan of correction (Figure 6-2). Specifically:

- OLC could be directed to deny a license when an applicant submits a letter of readiness—indicating it is prepared to be inspected—but OLC finds that the required policies, procedures, and documentation are not sufficiently available to allow a full inspection.
- OLC could be directed to deny a license when an applicant's plan of correction is inadequate to address the deficiencies found at an initial inspection, which would reduce use of staff resources to assist with repeated submissions and help to prevent unprepared providers from being awarded a license.
- OLC could strengthen the initial application process by verifying that applicants correct identified deficiencies before receiving a license. Currently, OLC awards a license to an applicant who submits a plan of correction without

consistently verifying that deficiencies were addressed. OLC could prioritize the most serious deficiencies for follow-up inspections to alleviate some of the additional workload associated with this new responsibility.

FIGURE 6-2
Initial licensure process could allow application denial at certain points



SOURCE: VA Administrative Code Chapter 381 and JLARC staff interviews with OLC Medical Facility Inspectors.

RECOMMENDATION 15

The General Assembly may wish to consider amending the Code of Virginia to grant the Virginia Department of Health's Office of Licensure and Certification (OLC) express authority to deny applications for licensure when (i) an applicant submits a letter of readiness but lacks required policies, procedures, or documentation necessary to complete the initial inspection, (ii) the applicant's plan of correction is inadequate to address deficiencies identified during the initial inspection, or (iii) an applicant cannot demonstrate to OLC that it has addressed deficiencies identified during the initial inspection.

OLC's extensive technical assistance to HCO applicants contributes to inspector workload and a substantial licensure backlog

OLC's practice of essentially providing unlimited technical assistance to fix deficiencies rather than deny a license contributes to an inefficient initial HCO licensure process. Regulations state that OLC should provide technical assistance and prelicensure consultation. In practice, OLC central office and HCO licensing staff provide extensive assistance that includes repeatedly reviewing revised submissions, conducting multiple on-site inspections, and accepting multiple plans of correction.

Increased workload from repeated submissions and inspections for new applicants, along with a growing number of applicants and insufficient inspector staffing (discussed later in the chapter), has produced a substantial backlog. As of July 1, 2026,

OLC reported 477 pending initial license applications, and staff estimated that HCOs wait about 10 to 11 months after applying to receive an initial license. HCO applicants reported that this delay raises their startup costs because they must lease space and retain staff while awaiting approval.

OLC could reduce the substantial technical assistance burden on its inspectors and office staff by dedicating one or more positions to supporting applicants. Provider readiness shortcomings currently result in inspectors spending significant time providing technical assistance and training during or following inspections, adding to their workload. To relieve this burden, OLC should dedicate one or more staff positions to guiding applicants through the licensure process, fielding technical assistance calls, and helping applicants understand the applicable requirements, regulations, and steps. OLC could also task this position with developing guidance or training materials to help prospective HCOs understand the responsibilities and requirements of operating a home care organization.

RECOMMENDATION 16

The General Assembly may wish to consider including language and funding in the Appropriation Act to establish a dedicated provider educator position within the Virginia Department of Health's Office of Licensure and Certification to assist applicants with their applications for home care organization licensure.

Furthermore, VDH likely could help reduce inspectors' backlog by developing tools to help applicants determine their preparedness to submit a letter of readiness and pass inspection. To avoid some of the common problems described by OLC staff, such as missing documents, basic errors, and incomplete materials at inspection, VDH should create an available-on-demand webinar explaining the licensure process, applicable regulations, and common reasons applications are returned. VDH could also create a self-assessment checklist that includes each regulatory requirement. Requiring applicants to verify they have completed the webinar and checklist may lead to fewer revisions, repeat inspections, and plans of correction. The provider educator position in Recommendation 16 could develop and maintain these materials.

RECOMMENDATION 17

The Virginia Department of Health's Office of Licensure and Certification should develop and publish on its website (i) an available-on-demand webinar that explains the home care organization licensure process, the applicable regulations, and the most common reasons applications are returned, and (ii) a self-assessment checklist, tied to each regulatory requirement, that applicants can use to verify that their application is complete and that they have all required materials before they submit a letter of readiness.

General Assembly considered placing a temporary moratorium on issuing new licenses until OLC clears its inspection backlog

Initial applications exceed OLC's capacity to process them, contributing to a backlog in both initial and biennial inspections. Because of these backlogs, the 2026 General Assembly considered, but ultimately did not enact, legislation to place a temporary moratorium on issuing new licenses.

If a moratorium is reconsidered, the General Assembly could limit it to regions that have the highest supply of HCO capacity in terms of the most HCOs per older adult. For example, five planning and service areas (8C Fairfax, 20 Hampton Roads, 8E Prince William, 15 Richmond, and 8D Loudoun) account for 77 percent of all HCOs statewide (and only 45 percent of the state's older adult population). Temporarily pausing the process for new entrants in these heavily served regions could allow OLC to process outstanding applications without exacerbating shortages in significantly underserved areas.

Alternatively, rather than pausing new licensing altogether, OLC could prioritize the review and inspection of applications from less-served regions. Prioritizing these applications would allow providers in those regions to enter the market more quickly while OLC works through its overall backlog of new applications.

Another consideration is whether a moratorium would apply only to new initial applications, meaning no new applications would be accepted, or to the award of new licenses altogether. A moratorium on awarding new licenses altogether would have a broader impact by including HCOs that have already submitted applications and are waiting for an initial licensing inspection.

State HCO oversight is weak with rare in-home visits and a large inspection backlog

State regulations require OLC inspectors to conduct unannounced on-site inspections of HCOs at least once every two years. Biennial inspections take place at the HCO's main office or branch office(s) and include a file review to verify compliance with Virginia regulations and state laws (e.g., background checks, staff training, adherence to care plans).

Nearly all (96 percent) biennial inspections conducted between FY24–26 identified noncompliance with state law or regulations ("deficiencies"). Staff report that they commonly cite violations related to minimum staffing requirements, background checks, and client care plans.

If any inspection finds deficiencies, the HCO is required to submit a plan of correction to OLC within 15 working days of receiving the letter of deficiency from the OLC inspector. The plan must describe how the HCO expects to correct the deficiency and prevent its recurrence. Regulations require all corrective actions to be completed within 45 working days of receiving the letter of deficiency.

OLC biennial inspections rarely include contact with HCO clients, either through interviews or in-home visits

In nearly all cases, OLC's determinations of HCO compliance during a biennial inspection are based entirely on record reviews that occur in an HCO's office, because inspectors are no longer required by OLC policy to conduct home visits or interview clients. Regulations give inspectors the authority to conduct home visits and client interviews as part of *any* inspection, but inspectors reported that they almost never interview clients or conduct observational home visits. Instead, OLC staff routinely inspect HCOs' written policies, insurance documents, leadership resumes, personnel files, and a sample of patient care plans that are maintained in the HCO's office (Table 6-1). Home visits were a required component of biennial inspections until 2012, when OLC leadership at the time discontinued them.

The lack of client interviews and home visits during biennial inspections is a major shortcoming that limits the effectiveness of OLC's oversight of HCOs. Without them, OLC inspectors have no firsthand information on the quality, appropriateness, or timeliness of the services HCO staff deliver. Inspectors instead review documentation that presents an insufficient picture of service delivery and HCO/client interactions.

TABLE 6-1
Regulatory requirements vary based on type of inspection

Inspection component	Inspection type
Written administrative/operational policies (e.g., client rights, infection control, emergency services, mandated reporting, communicable diseases, handling complaints)	Initial and biennial
Financial viability and policies (e.g., verification of services delivered, billing methods, admission agreements)	Initial and biennial
Liability insurance	Initial and biennial
Resumes and job descriptions for all roles (administrative and direct care staff)	Initial and biennial
Proof of Quality Improvement Committee	Initial and biennial
Personnel files and policies (e.g., criminal background checks, training and certification)	Biennial only
Sample of individualized care plans and service records	Biennial only
Interviews with direct care staff or patients	(As needed during biennial)
Home visits	(As needed during biennial)

SOURCE: VA Administrative Code Chapter 381 and JLARC staff interviews with OLC inspectors.
NOTE: See Appendix F for more information on regulatory requirements of each OLC interaction. In practice, interviews of clients and in-home visits are rarely done by OLC inspectors as part of biennial inspections.

Even within current resource constraints, OLC should require inspectors to conduct client interviews and in-home visits during routine inspections of HCOs. To keep workload manageable, inspectors could be required to conduct these activities for a

sample of HCOs, selecting them randomly so they would not be able to prepare for the inspections. The possibility that their clients could be interviewed or visited at home would give HCOs an incentive to further ensure the quality, appropriateness, and timeliness of the services their staff deliver. To support this effort, OLC should issue formal guidance for inspectors detailing standardized interview questions and specific regulatory requirements to verify during these visits.

RECOMMENDATION 18

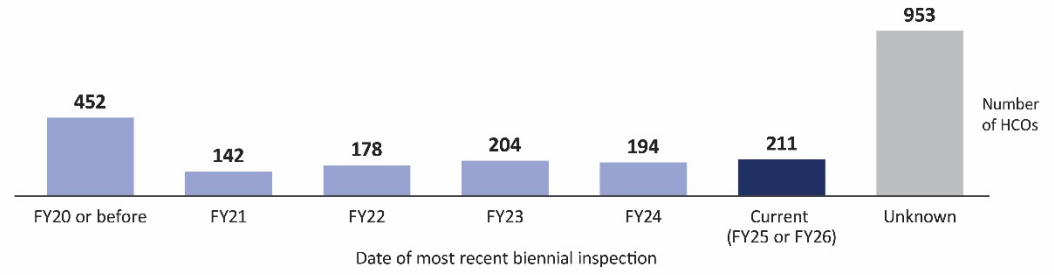
The Virginia Department of Health's Office of Licensure and Certification (OLC) should immediately incorporate in-home client visits and client interviews into biennial inspections for a sample of home care organizations, using procedures that protect client confidentiality.

Most licensed HCOs have not been inspected by the state as required

Timely biennial inspections are necessary to ensure HCOs' ongoing compliance with safety and quality requirements, but most (about 90 percent) HCOs have not been inspected within the two-year timeframe (Figure 6-3). In addition, OLC staff do not know the last inspection date for approximately 40 percent of HCOs because of data limitations. OLC staff reported, and HCO providers confirmed, that some HCOs were last inspected more than a decade ago.

FIGURE 6-3

Approximately 90 percent of HCOs have not received timely biennial inspections



SOURCE: VDH OLC staff analysis.

NOTE: The "Unknown" column depicts active home care providers that lack a recorded prior inspection date because the data is stored in a discontinued legacy IT system or in paper files and was never manually migrated into OLC's updated IT system (updated in mid-2023). OLC staff reported that 2,123 out of 2,334 currently active HCOs have not been inspected within the last two years.

Both inspectors and HCO staff emphasized the importance of routine inspections for ensuring quality care and protecting vulnerable populations. One OLC inspector reported receiving increasingly serious complaints of recipients having "falls, hospital trips, and mistreatment events" as well as unnecessary emergency room visits, stemming from insufficient service delivery. HCO staff also expressed concerns, noting that without on-site verification through biennial inspections, noncompliant providers can operate with impunity, potentially providing unsafe or inadequate services.

OLC's home care division has substantial vacancies but could not conduct timely biennial inspections even if fully staffed

Substantial staffing vacancies contribute to the home care division's inability to complete required biennial inspections on time. OLC's home care division (sidebar) currently has one supervisor and four experienced inspectors (Table 6-2). In addition to biennial HCO inspections, these inspectors are also responsible for conducting initial licensure inspections of HCOs. If fully staffed, the home care division would have 12 staff, 10 of whom are inspectors. Funding for three positions is exclusively federal and expires in 2027.

OLC is a large office within VDH with multiple divisions including Acute Care (hospitals, HCOs, home health/hospice) and Long-Term Care (nursing facilities). There are 133 total classified positions allocated (107 filled) across the entire office.

TABLE 6-2
OLC's home care division is operating well below maximum staffed capacity

Job title	Current staffing level	Maximum staffing level
Supervisors	1	2
Full-time classified inspectors	4	7
Full-time temporary inspectors	0	3
Total	**5**	**12**

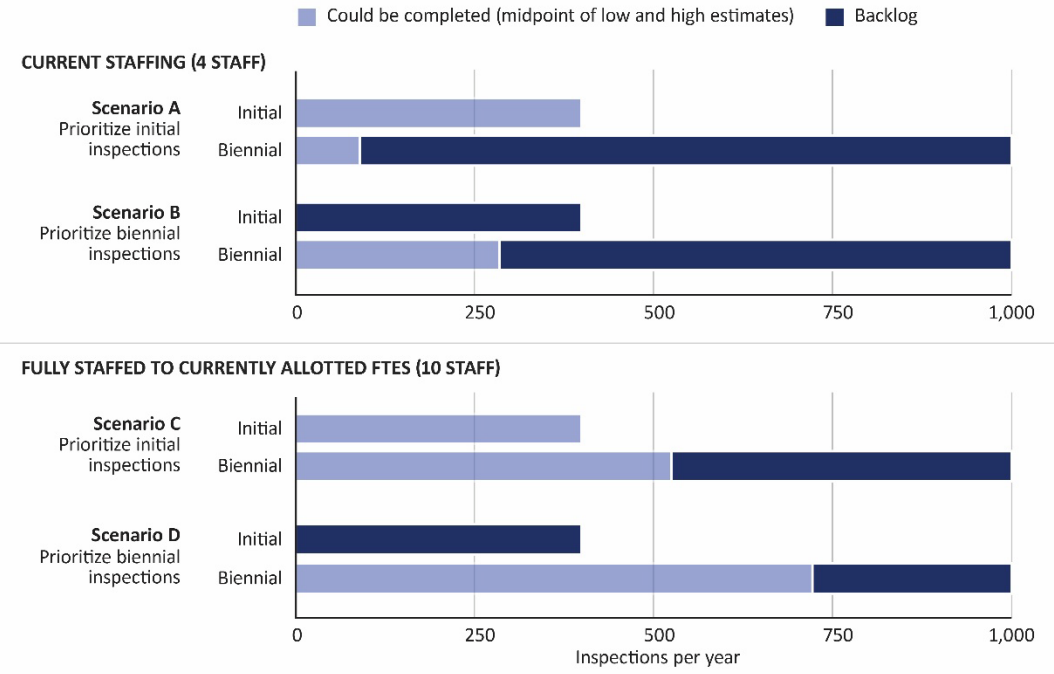
SOURCE: VDH Office of Licensure and Certification organizational chart.
NOTE: Public Health Infrastructure Grant funding expires in late 2027. OLC also has one part-time wage position, not included in this table, that is also vacant.

OLC's home care division has struggled to hire and retain inspectors, and the shortage is most acute in Northern Virginia. The largest proportion of HCOs are based in Northern Virginia (approximately 1,000, nearly half), and while OLC has dedicated Northern Virginia inspector positions, these have consistently remained vacant. (OLC anticipates a Northern Virginia supervisor position being filled in fall 2026.) Three grant-funded inspectors hired in early 2026 left within months. OLC leadership reported that the office has tried several strategies to improve recruitment and retention of inspectors, including sign-on bonuses and "front-loading" leave, which provides new inspectors additional leave time from their date of employment.

Filling vacancies alone will not allow OLC to meet the state's biennial inspection requirement. At current staffing levels, OLC completes only about 150 of the approximately 1,000 biennial inspections that come due each year (sidebar). If OLC devoted all current staff time to biennial inspections and stopped conducting initial licensure inspections altogether, it could complete an estimated 285 biennial inspections. Even fully staffed at 10 full-time inspectors (excluding two supervisors), the home care division could not keep up with the total number of initial and biennial inspections required each year, let alone clear the backlog of overdue inspections (Figure 6-4).

The timeline for completing an initial or biennial inspection includes traveling, conducting the inspection (e.g., file review, staff interviews), writing findings, and issuing a plan of correction (when necessary).

FIGURE 6-4
Illustrative examples: OLC's staff capacity is insufficient to meet inspection workload at both current staffing levels and if all positions were filled



SOURCE: JLARC analysis of OLC staff capacity based on VDH OLC workload estimates.
NOTE: "Prioritize" describes how the office can deploy inspector staff (prioritizing completion of all initial inspections each year, or maximizing biennial inspections). Workload calculations presented are the midpoint of estimates provided by OLC HCO division leadership and staff.

OLC needs substantially more inspectors to handle its full workload, and it plans to request additional positions in the upcoming budget cycle. JLARC estimates that OLC needs about 10 additional full-time inspectors to complete its existing inspection workload (initial and biennial inspections), based on the range of workload estimates provided by OLC leadership and staff (inspectors and supervisors). VDH leadership indicated that they plan to request funding for 14 additional full-time inspectors.

Even with additional staffing, OLC would be unlikely to resolve its inspection workload quickly. OLC has struggled to fill even its current vacant positions. Furthermore, OLC staff estimate that new hires will need three months of training before they can conduct inspections on their own. It could therefore take several years for OLC to clear its backlog and conduct timely inspections.

OLC could supplement its inspection capacity with other entities' oversight of HCOs, at least temporarily

In addition to adding new positions and working to recruit and retain qualified inspectors, OLC should be more strategic in its prioritization of HCOs for inspection and should leverage outside resources to supplement its oversight duties.

OLC could temporarily prioritize inspecting home care organizations that receive no other state or local oversight

Until its backlog is resolved, OLC could prioritize inspections of HCOs that are not already subject to oversight from another state or local entity. Two groups of HCOs must meet certain administrative, financial, and quality requirements: those that accept Medicaid and those that contract with area agencies on aging (AAAs) to provide care to AAA clients (Table 6-3). HCOs that accept Medicaid must be registered with the Department of Medical Assistance Services (DMAS) and meet the contracting requirements of the managed care organizations (MCOs) that pay them. MCO reviews primarily focus on financial audits and verification of service provision. About half of all HCOs statewide billed Medicaid for services provided to clients in FY25 (and a potentially larger proportion are *enrolled* as a Medicaid provider). AAAs that contract with HCOs verify licensure, staff training requirements, client records, care plans, and the completion of service reassessments (sidebar).

Accredited HCOs that have been exempted from OLC licensure (discussed in the next section) are not inspected by OLC and so are not part of this approach.

Relying on reviews by DMAS, MCOs, and AAAs should be only a temporary strategy to help reduce OLC's inspection backlog. These reviews involve examination of some aspects of HCO operations, but they are more limited and narrow in scope, covering only some components of an OLC inspection. For example, MCO audits focus more narrowly on whether HCOs accurately bill for the hours of care they provide and whether those hours meet the client's needs as described in their individualized care plan. Ultimately, OLC will still need to regularly inspect all HCOs to verify full regulatory compliance.

TABLE 6-3
Oversight by other entities covers only some components of an OLC inspection

Inspection Component	OLC inspection	DMAS/ MCO audit	AAA contract
Written administrative/operational policies (e.g., client rights, infection control, emergency services, mandated reporting, communicable diseases, handling complaints)	✓		
Verification of provider license			✓
Service agreement completed between client and service provider			✓
Financial viability and policies (e.g., verification of services delivered, billing methods, admission agreements)	✓	✓	✓
Liability insurance	✓		
Resumes and job descriptions for all roles (admin and direct care staff)	✓		✓
Proof of Quality Improvement Committee	✓		
Personnel files and policies (e.g., job descriptions, criminal background checks, training and certification)	✓		✓ [a]
Client care plans & service records	✓	✓	✓ [b]

SOURCE: JLARC staff analysis of VA Administrative Code Chapter 381, JLARC interviews with DMAS staff, and DARS service standards for personal care

NOTE: [a] Criminal background checks are strongly recommended but not required by AAAs. [b] AAAs develop the care plan the HCO must follow. AAA contract column reflects the standards in AAA personal care service contracts.

HCOs must submit **license renewals** once every three years.

OLC does not currently collect the information needed to identify which HCOs are subject to these alternative forms of oversight. OLC could collect this information uniformly through the licensure renewal process (sidebar), because the process already requires every licensed HCO to submit materials to OLC on a recurring basis. As part of renewal, OLC should require each HCO to submit any active contracts with AAAs or MCOs and/or documentation of any DMAS certification. OLC leadership also reported that the office is developing a process to collect and maintain each HCO's National Provider Identifier (NPI). With NPIs on file, VDH licensing data could be matched to DMAS data to identify which HCOs are Medicaid providers.

RECOMMENDATION 19

The Virginia Department of Health's Office of Licensure and Certification (OLC) should, until its inspection backlog is cleared, prioritize biennial inspections of home care organizations that are not subject to external oversight as Medicaid providers or as contractors for area agencies on aging.

Third-party accreditation is a potential strategy to reduce OLC's inspection workload

OLC could potentially rely on third-party accreditation as the mechanism to oversee some HCOs, which would reduce its biennial inspection workload and backlog. Under state law, an HCO may request an exemption from OLC licensure if it is accredited by a Centers for Medicare & Medicaid Services (CMS)-recognized organization, such as The Joint Commission, the Community Health Accreditation Partner (CHAP), or the Center for Improvement in Healthcare Quality. Accredited HCOs would receive regular inspections by their accrediting organization. In the near term, this could reduce the number of inspections OLC must complete and help it address its backlog, and over the long term, it could reduce OLC's ongoing inspection workload and the staff resources needed to carry it out.

For accreditation to meaningfully reduce OLC's inspection workload, the state would need to incentivize HCOs to accredit their non-skilled home care services. Providers currently have a stronger incentive to accredit their skilled service businesses, such as private duty and home health, because accreditation by a CMS-approved organization confers Medicare "deemed status," which substitutes for the standard federal certification survey and reduces the number of state and federal reviews. No comparable federal benefit exists for non-skilled home care because Medicare does not cover personal care services. Accreditation is also expensive, typically costing a health care provider $3,000 to $8,000 before annual maintenance fees, plus indirect costs, such as staff time for survey preparation. Any state-funded incentive large enough to meaningfully offset these costs would likely require a substantial state appropriation.

RECOMMENDATION 20

The General Assembly may wish to consider including language in the Appropriation Act directing the Virginia Department of Health (VDH) to evaluate the cost-effectiveness of incentivizing third-party accreditation for non-skilled home care organizations (HCOs) to reduce the Office of Licensure and Certification's (OLC) inspection workload. VDH should (i) estimate state costs to incentivize accreditation versus current OLC inspection costs, both in the near term and long term, and (ii) submit a proposal for such incentives to the Office of the Governor, the House Appropriations Committee, and the Senate Finance and Appropriations Committee if VDH determines that providing such an incentive would be cost-effective.

VDH could consider contracting with third parties to perform biennial inspections

VDH could also consider contracting with one or more third parties to conduct biennial inspections on OLC's behalf. The inspections would continue to be based on current standards, and OLC would retain responsibility for licensure decisions and enforcement actions. VDH currently uses a third-party contractor to supplement staff for nursing home inspections.

National accrediting organizations such as The Joint Commission and CHAP already employ inspectors with expertise in evaluating personal care service providers (non-skilled in-home care); other organizations may be options as well. VDH should develop a request for information to explore available third-party resources for these inspections. If expedited, third parties could provide additional inspection resources before VDH is able to hire and train additional inspectors.

RECOMMENDATION 21

The Virginia Department of Health should issue a Request for Information to assess the feasibility of using third-party organizations to supplement its home care organization inspection staff and, if feasible, procure third-party inspection services.

OLC could complete more inspections by addressing several operational inefficiencies

In addition to a lack of staff, OLC does not structure its inspection function efficiently, which contributes to its growing backlog.

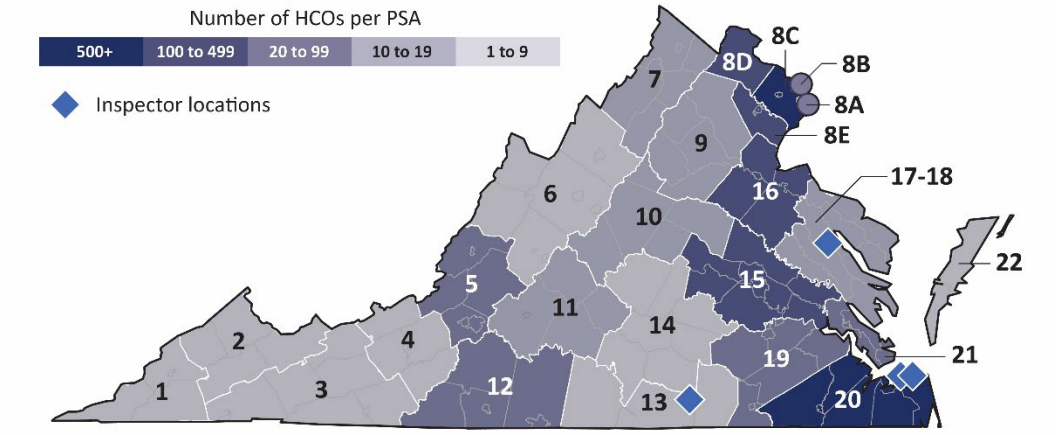
OLC should regionalize its inspection operations

OLC inspectors spend a substantial portion of their work week traveling because OLC has not assigned inspectors to defined regions. Biennial and complaint inspections must be conducted on-site at an HCO's office, and because inspectors work remotely, their travel originates from their homes. Two inspectors live in Hampton Roads, but none live in Northern Virginia or the western half of the state, even though many HCOs are based in these areas. OLC's HCO inspection supervisor has recently begun assigning inspectors to HCOs based on geographic proximity. Even so, inspectors

report traveling five to 10 hours in a typical week and up to half their time in others (Figure 6-5).

FIGURE 6-5

No inspectors live within or near some regions with many HCOs, resulting in extensive inspector travel time



SOURCE: JLARC staff analysis of VDH OLC licensure data.

RECOMMENDATION 22

The Virginia Department of Health's Office of Licensure and Certification should implement a statewide regional approach for conducting its inspections of home care organizations, which should include defined regions and a plan to hire inspectors who live in those regions.

HCOs should be penalized if they are unavailable during an inspector visit

OLC's standard practice when inspectors arrive at an office that is not open during business hours is to call the agency's posted phone number and allow one hour for the administrator's arrival.

OLC inspectors reported that unannounced inspections are frequently unsuccessful because the HCO cannot be reached or located during posted business hours. In these cases, inspectors arrive to find that the office is closed, the administrator or designee is unreachable, or that the HCO has moved without updating its address (sidebar). OLC's use of unannounced inspections follows best practice, but each unsuccessful visit wastes inspector time that could be spent completing other inspections. This is particularly problematic because OLC has limited inspection staff and a substantial inspection backlog. Regulations require HCOs to have an administrator or designee available or reachable during operating hours and to notify OLC of any change of address. However, OLC's only tool to enforce these requirements is a plan of correction, which inspectors characterize as ineffective. Granting OLC the authority to levy financial penalties may more effectively encourage compliance.

RECOMMENDATION 23

The General Assembly may wish to consider amending the Code of Virginia to authorize the Virginia Department of Health's Office of Licensure and Certification (OLC) to levy an administrative fine on a home care organization (HCO) when an inspector cannot conduct an unannounced inspection because (i) the HCO's office is closed during operating hours and its administrator or designee cannot be reached, or (ii) the HCO has moved without notifying OLC of its new address.

OLC should adopt a more strategic inspection approach

OLC has not optimized its limited inspection staff to address the current backlog. OLC currently prioritizes overdue inspections solely by how much time has elapsed since the last inspection, even though state law gives the office flexibility to prioritize based on other factors (sidebar). OLC could more strategically utilize its limited staff capacity in the following ways:

Statutory language (§ 32.1-162.10) directs OLC staff to inspect all HCOs before conducting repeat inspections but grants broad flexibility to adjust inspection schedules for necessary follow-ups, complaint investigations, or other priorities determined by the commissioner or their designee.

- **Conduct biennial inspections based on a random sample of HCOs each year.** Rather than conducting inspections in the order dictated by their last inspection date, OLC could begin conducting random inspections of HCOs from the pool of overdue inspections. Under the current system, HCOs that have a more recent overdue biennial inspection and are aware of the substantial backlog can deduce that they will not receive another inspection for a long period of time, potentially years. Random inspections would maintain a "threat" of inspection and help ensure that OLC's well-known backlog does not contribute to poor-quality operations by some HCOs.
- **Prioritize HCOs that pose greater risk of noncompliance.** OLC could develop a risk-based strategy to identify specific HCOs, or HCOs with certain characteristics, that are more likely to have compliance problems. OLC could use the provider's history of compliance or an analysis of inspection results to identify patterns of noncompliance among certain types of providers (large vs. small, new vs. established, region of the state).
- **Prioritize inspections of HCOs with larger caseloads.** Because HCOs with larger caseloads serve the most individuals, prioritizing their inspections would help ensure that compliance is achieved for the greatest number of individuals served. The risk-based approach described above could account for caseload size when identifying higher-risk HCOs.

RECOMMENDATION 24

The Virginia Department of Health's Office of Licensure and Certification should maximize its oversight effectiveness with its existing inspection resources by (i) each year, selecting a random sample of home care organizations (HCOs) with overdue biennial inspections for inspection, rather than inspecting HCOs solely in order of their last inspection date, to reduce predictability, (ii) developing a risk-based strategy for selecting HCOs for biennial inspections, and (iii) prioritizing HCOs serving the most clients for biennial inspections.

State lacks sufficient enforcement authority and guidance to ensure HCOs comply with requirements

An effective state oversight program requires the authority to (i) incentivize ongoing compliance, (ii) compel noncompliant providers to fix deficiencies, and (iii) take corrective actions against providers for repeated or unresolved violations.

OLC has two primary mechanisms to enforce compliance with regulatory requirements. OLC can issue a deficiency report summarizing all deficiencies identified during an on-site inspection. Upon receipt of a deficiency report, an administrator has 15 working days to submit an acceptable plan of correction detailing how the facility will fix the issues and prevent them from recurring. The other mechanism is for the commissioner of health to suspend or revoke an HCO's license if it fails to comply with statutory provisions or with state regulations.

However, neither of these has been a useful or effective enforcement tool. HCOs face no consequences if they do not follow through on plans of correction to correct deficiencies, and in practice, the authority to suspend or revoke a license is not used. When an inspector identifies a deficiency, the public is not informed, OLC cannot impose a financial penalty, and there typically is no follow through to ensure that the HCO has corrected the problem. The authority to suspend or revoke an HCO license has not been used in the past three years.

Inspectors expressed concern about the lack of enforcement authority:

> "We have providers saying 'why should I care?' about the plan of correction, and there's nothing you can do about it. The plan of correction has no teeth at all, which is disheartening. As an [inspector], you take all that time to write something up, and nothing comes of it." – OLC staff

> "We can look at their plan of correction from their last visit and see if they have followed it, but we don't do any follow-up visits to see if they are implementing the plan of correction." – OLC staff

Although OLC generally has not completed routine biennial inspections on time, inspectors in some cases visit the same HCO multiple times within a relatively short period to investigate complaints against it.

Without consequences, some HCOs repeatedly violate requirements, and OLC cannot hold them accountable. Multiple inspectors report finding the same violations across several visits to the same HCO (sidebar), including serious violations such as hiring individuals with barrier crimes. These inspectors report issuing multiple plans of

correction over years of inspections with no change in provider behavior. Inspectors cited this inability to hold noncompliant HCOs accountable as a primary source of frustration in their role.

> "I wish we had more of an ability to [suspend or revoke licenses]. We can't enforce anything… What is the point of my job?" – OLC staff

Enforcement mechanisms with financial or reputational consequences could help improve HCO compliance. Other states use a broader range of enforcement actions for HCOs, as do Virginia agencies that oversee other types of care settings:

- **Financial penalties.** Several states, including Florida, Minnesota, Oregon, and Washington, give their oversight entities broader authority to levy fines or fees on HCOs with documented violations. Some states grade penalties by the severity of the violation or the type of care provided to clients. The Virginia Department of Social Services (VDSS) may fine assisted living facilities up to $10,000 per year, and VDH may petition a court to impose civil penalties in long-term care settings.
- **Restrictions on licensure or admissions.** Some states impose interim sanctions on an HCO licensee before suspending or revoking its license. Delaware can place a noncompliant HCO on a provisional license for up to one year, and Minnesota and Washington can modify, restrict, or condition HCO licenses. In Virginia, the VDH commissioner may prohibit new admissions to a nursing home, and VDSS may ban new admissions to an assisted living facility.
- **Public disclosure of violations.** In Virginia, VDSS may require assisted living facilities to publicly post their violations, and VDSS also posts the results of its assisted living facility inspections online. OLC has no such authority for HCOs.

OLC should have intermediate enforcement authority between the plan of correction and license revocation, which would require the General Assembly to amend statute. The authority could include financial penalties, mandatory client notification of deficiencies, and public posting of inspection results. These capabilities would make OLC's enforcement authority more consistent with comparable states and other state oversight bodies in Virginia.

RECOMMENDATION 25

The General Assembly may wish to consider amending the Code of Virginia to (i) grant the Virginia Department of Health's Office of Licensure and Certification (OLC) expanded authority to impose sanctions, graduated financial penalties, and license restrictions, and (ii) require that inspection results be posted on a public-facing website, which should be updated regularly and specify the date of the last update.

If the General Assembly amends state law to expand OLC's enforcement authority, OLC should also establish guidance for its staff on when to apply sanctions. The guidance should direct staff to base sanctions and penalties on (i) the nature of the violation and (ii) whether the violation is an initial one or part of repeated or continued noncompliance. Minnesota law, for example, specifies 14 grounds on which the state may take disciplinary action against a home care provider, including harming clients, falsifying a license application, failing to pay fees, and repeatedly assigning staff to work beyond their competency.

The General Assembly could also strengthen OLC's sanction authority by allowing the commissioner to summarily suspend an HCO's license when conditions pose an immediate threat to client health and safety. State law authorizes VDH to revoke or suspend an HCO's license but does not provide for summary suspension, so an HCO with serious quality and safety problems can continue to operate throughout the Administrative Process Act appeals process (which can take months or years). In contrast, the Department of Behavioral Health and Developmental Services has summary suspension authority for group homes and residential facilities when conditions pose an immediate and substantial threat to residents' health, safety, and welfare. The Department of Health Professions' health regulatory boards may suspend a license without first holding a hearing if they find a substantial danger to public health or safety. Summary suspension could be easier to carry out for an HCO than for a congregate care facility because clients would not need to move, and finding another in-home care provider may be easier. HCOs would maintain the right to appeal but could not operate while the appeal is pending.

RECOMMENDATION 26

The General Assembly may wish to consider amending § 32.1-162.13 of the Code of Virginia to authorize the state health commissioner to summarily suspend the license of a home care organization, in conjunction with any proceeding for revocation, denial, or other action, when conditions or practices pose an immediate and substantial threat to the health, safety, and welfare of the organization's clients.

7 Assisted Living and In-Home Care Affordability

Access to assisted living and in-home care services depends not only on their availability (Chapter 2), but also on their affordability. Many older adults live on modest or fixed incomes that are insufficient to cover the high costs of long-term care but too high to qualify for public assistance.

This chapter assesses the affordability of assisted living and in-home care primarily using individual income and family income. Individual income is the most direct measure of an older Virginian's ability to pay for assisted living and in-home care. Family (i.e., household) income is another reasonable benchmark because many older adults live with a spouse or other relatives whose income could be used to help cover the cost of care. Still, comparing assisted living costs to individual income is the more conservative measure of affordability.

In addition to income, older adults' assets, such as savings, home equity, and retirement funds, are a key factor in determining the type of care they can afford and for how long. Many older adults would likely draw on these assets to pay for in-home care or assisted living. However, few reliable data sources describe the assets of older Virginians specifically, so this chapter bases most affordability estimates solely on income. As a result, these estimates are conservative and likely understate some individuals' ability to pay for care.

Most older Virginians do not have the income to pay for assisted living or more than a few hours per week of in-home care

Most Virginians do not receive assistance from public programs to pay for assisted living or in-home care. This is true for 90 percent of assisted living residents and likely a substantial share of in-home care recipients. Private health insurance and long-term care insurance can pay for these services in some cases, but Virginians mostly rely on their own financial resources (sidebar).

Long-term care insurance can be purchased and used to help pay for the cost of aging services and support. Just 4 percent of Virginia adults (241,000) had a long-term care insurance policy as of 2024.

Just 18 percent of older Virginians have the income to pay for average assisted living rates in their region

The average monthly cost of assisted living in Virginia was about $6,940 in 2025, according to the CareScout Cost of Care Survey (Table 7-1). Cost varies by region, ranging from $5,734 monthly in PSA 7 (Northern Shenandoah) to $8,725 in Northern Virginia PSAs. (See Appendix H.) The statewide average cost represents a 32 percent increase compared with the $5,250 figure in 2021 cited by the Joint Commission on

Health Care's 2022 study, *Affordability of Assisted Living Facilities*. Facility charges and fees are based mostly on facility operations costs, which are driven primarily by personnel and building expenses (sidebar).

Two categories account for most assisted living facility operating costs:

Personnel expenses (62 percent) include wages and benefits paid to staff, including administration, direct care staff, and other support staff.

Building and plant expenses (29 percent) include rent or mortgage payments; facility maintenance and upkeep; equipment; and motor vehicles.

TABLE 7-1
Average assisted living costs vary by 50 percent across regions (2025)

	PSA / AAA Region	Average Assisted Living Cost (Monthly)
	8B - Arlington	$8,725
Highest	8A - Alexandria	"
	8C - Fairfax	"
	Statewide	**6,940**
	1 - Far Southwest	5,825
	2 - Southwest Coalfields	"
	3 - Bristol-Galax	"
Lowest	13 - Southside	"
	22 - Eastern Shore	"
	7 - Northern Shenandoah	5,734

SOURCE: JLARC analysis of CareScout Cost of Care Survey, 2026; https://www.carescout.com/cost-of-care.
NOTE: See Appendix H for average assisted living costs for all PSAs. PSA names are used for readability purposes only and do not reflect any official designations.

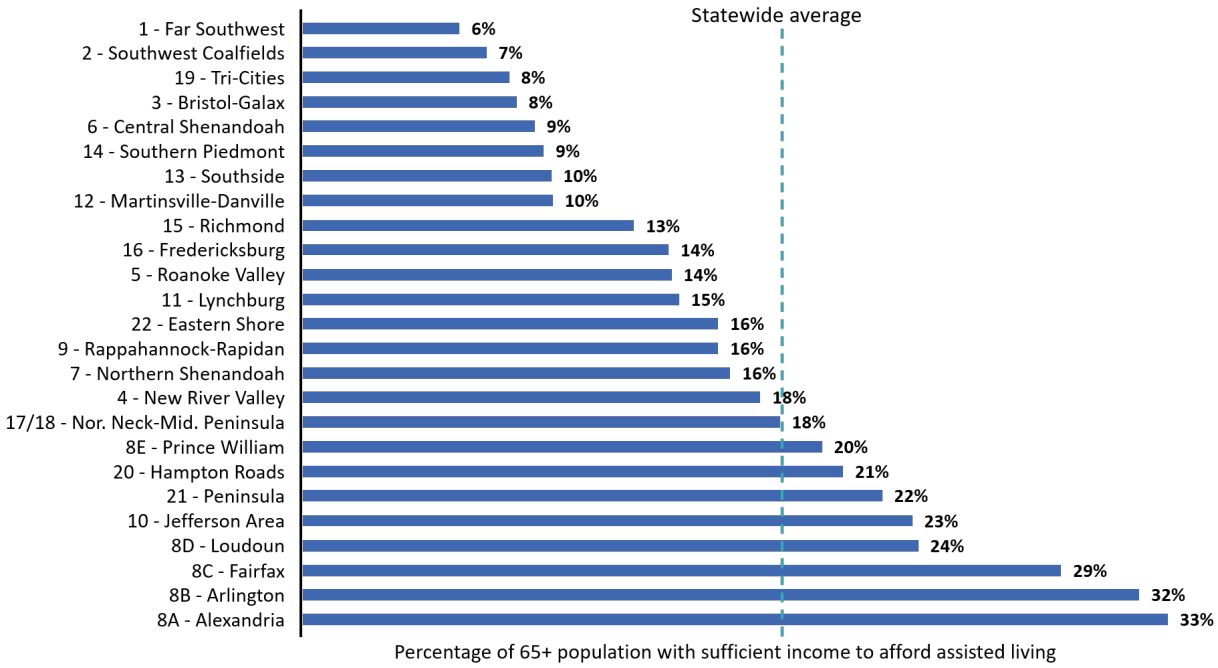
The **personal needs allowance (PNA)** is the amount of money a recipient of publicly funded assisted living benefits (i.e., Virginia's auxiliary grant) keeps each month for personal items and services. Virginia's auxiliary grant PNA is $87, about 4 percent of the total program rate.

JLARC staff determined assisted living is affordable if it takes up no more than 90 percent of an older adult's monthly income. Because assisted living facilities (ALFs) provide housing, utilities, and food, residents are expected to cover other expenses (e.g., doctor visits, personal items, recreational activities) through the remaining 10 percent of monthly income. The 90/10 split aligns with the upper threshold for "personal needs allowances" used by state-subsidized assisted living programs (e.g., Virginia's auxiliary grant program) (sidebar).

According to the 90 percent benchmark, only 18 percent of older Virginians have enough income to afford assisted living, without considering the value of their assets (Figure 7-1). The proportion of older adults for whom assisted living is affordable varies widely by region, from 33 percent of older adults in PSA 8A (Alexandria) to just 6 percent of older adults in PSA 1 (Far Southwest).

Family financial support may make assisted living affordable for more older Virginians, but affordability likely remains a challenge for most. Monthly assisted living costs range from about 62 percent to more than 100 percent of family median income across Virginia's regions (Table 7-2). In eight of Virginia's 25 PSAs, the average monthly cost of assisted living exceeds family median income. As with individual income, assisted living was least affordable relative to family median income in the Southwest regions and Southside.

FIGURE 7-1
Just 18 percent of older adults statewide, on average, have sufficient individual income to afford assisted living



SOURCE: JLARC analysis of 2023 Weldon Cooper Center individual income data 65+ years of age (adjusted to 2025 dollars) and CareScout Cost of Care Survey, 2026; https://www.carescout.com/cost-of-care.
NOTE: Affordability is defined as the proportion of individuals in a PSA for whom the average assisted living monthly charge is less than 90 percent of individual income. Affordability estimates do not account for the value of individuals' assets, such as home equity. PSA names are used for readability purposes only and do not reflect any official designations. American Community Survey population and income estimates are subject to margins of error.

TABLE 7-2
Assisted living costs exceed 90 percent of family median income in 14 of 25 PSAs

	PSA / AAA Region	Average assisted living cost (Monthly)	Family median income (Monthly)	Percentage of family median income
More affordable relative to family median income	8B - Arlington	$8,725	$14,034	62%
	8A - Alexandria	8,725	13,674	64
	8C - Fairfax	8,725	13,313	66
	Statewide	**6,940**	**8,554**	**81**
Less affordable relative to family median income	12 - Martinsville-Danville	5,972	5,222	114
	1 - Far Southwest	5,825	4,465	130
	2 - Southwest Coalfields	5,825	4,463	131

SOURCE: JLARC analysis of 2023 Weldon Cooper Center family median income data 65+ years of age (adjusted for 2025 inflation) and CareScout Cost of Care Survey, 2026; https://www.carescout.com/cost-of-care.
NOTE: Affordability estimates do not account for the value of individuals' assets, such as home equity. See Appendix H for average assisted living costs for all PSAs. PSA names are used for readability purposes only and do not reflect any official designations. American Community Survey population and income estimates are subject to margins of error.

JLARC estimates that **memory care is 30 percent more expensive than** average assisted living care based on a review of peer-reviewed research and industry estimates.

Residing in a memory care unit at an ALF is even less affordable for older Virginians. The cost of memory care is estimated to be about 30 percent *higher* than typical ALF costs (sidebar) and therefore affordable to only about 11 percent of older Virginians based on individual income. Even when income from other family members is included, the cost of memory care ranges from 81 percent to more than 100 percent of family median income across PSAs. (See Appendix H for more information about the cost of memory care relative to individual and family median income.)

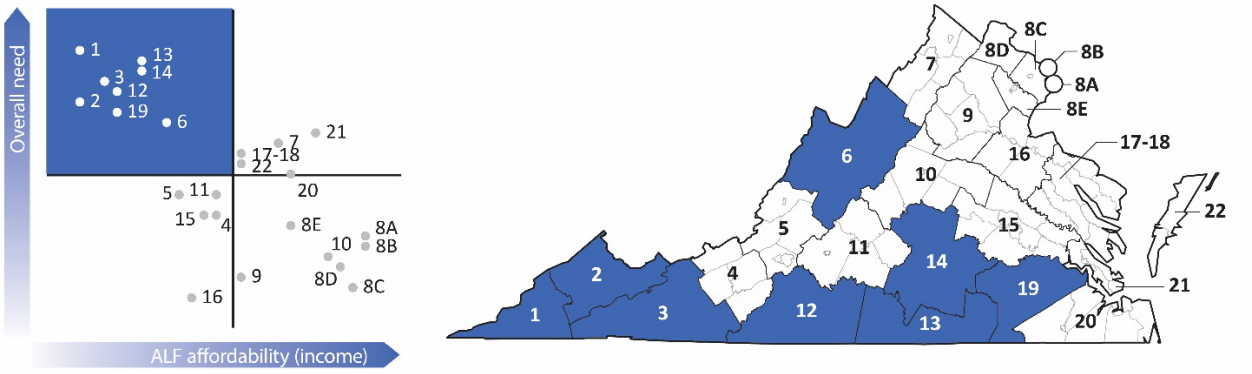
Medicare can be used to cover the skilled nursing services associated with short-term rehabilitation in a nursing facility.

While ALFs are unaffordable to most Virginians, they cost less than private pay nursing facilities. According to CareScout data, the median cost of a private pay nursing facility is $11,680 per month, about 68 percent higher than assisted living. Older adults are heavily reliant on Medicare and Medicaid to cover nursing facility costs, but neither can be used to pay for assisted living in Virginia (sidebar).

Regions where assisted living is least affordable have the highest levels of need among older adults

Affordability of assisted living is worse in regions where older adults have the greatest overall need, on average. In the eight regions with the highest levels of need among older adults, assisted living affordability is below the statewide median, and nearly all are in the southwest and southern portions of the state (Figure 7-2). PSA 1 Far Southwest has both the least affordable assisted living and the greatest overall need among its older adult population.

FIGURE 7-2
Eight regions with lowest ALF affordability have highest level of need among older adults

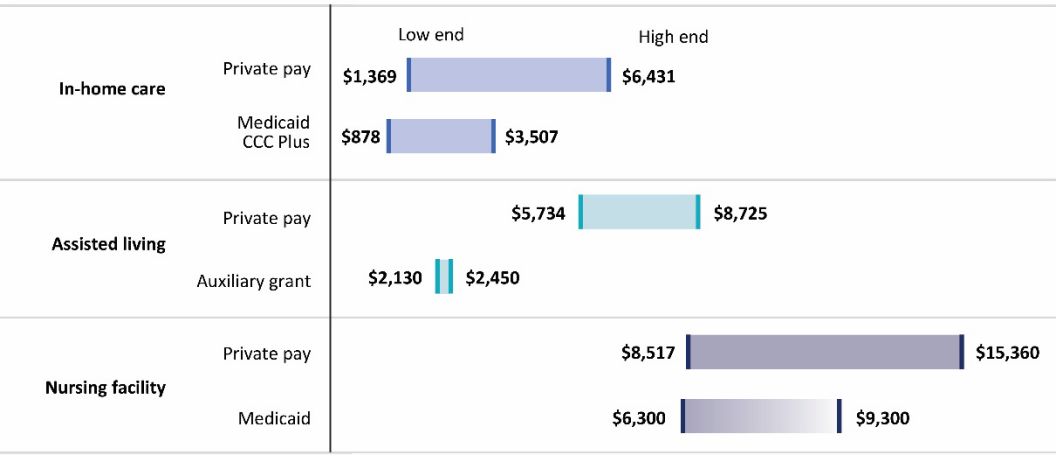


SOURCE: 2023 5-year American Community Survey data prepared for JLARC by Weldon Cooper Center at the University of Virginia and 2024 American Community Survey 5-year estimates.
NOTE: Regions are ranked based on average ranking across two measures of assisted living affordability (90 percent of older adult monthly income benchmark and average assisted living cost as a proportion of family median income) and across six measures of need; see Appendix D for additional data about overall need by PSA. Regions are PSAs, which correspond to local area agencies on aging. American Community Survey population estimates are subject to margins of error.

In-home care generally costs less than other long-term care options and is relatively similar across regions

In-home care tends to be more affordable than assisted living or skilled nursing facilities because individuals can purchase only the hours of care they need rather than full-time care. In contrast, ALF residents pay fixed costs for room, board, and other fees regardless of how much care they need. Family members of individuals receiving in-home care may also provide some care, further reducing the number of paid hours of care needed. In-home care costs 26 to 76 percent less than private pay assisted living, on average, depending on the number of weekly hours provided (Figure 7-3). However, in-home care recipients must continue to pay for and maintain their own homes, whereas these expenses are included in ALF room and board fees.

FIGURE 7-3
In-home care generally costs less than assisted living or skilled nursing facilities



SOURCE: CareScout Cost of Care Survey, 2026; https://www.carescout.com/cost-of-care; Medicaid Commonwealth Coordinated Care Plus waiver program personal assistance hourly rate; Virginia auxiliary grant rate; and Virginia Medicaid nursing facility monthly capitated rate.
NOTE: Private pay in-home care, assisted living, and nursing facility costs are based on 2026 CareScout Cost of Care Survey. Monthly in-home care cost ranges for public and private pay are calculated using a low-volume assumption of 10 hours per week and a high-volume assumption of 40 hours per week. Medicaid nursing facility reimbursement rate is for FY25. Auxiliary grant presented is the rate paid to facilities excluding the $87 personal needs allowance.

The hourly cost of private pay in-home care is relatively similar across regions (Table 7-3). The median statewide hourly private pay rate for in-home care was $35, ranging from $32 hourly to $37 hourly by region. As a result, the average monthly cost of 25 hours per week of in-home care ranged from $3,422 in PSA 6 Central Shenandoah to $4,019 in PSA 10 Jefferson Area (sidebar).

JLARC staff used a benchmark of **25 hours weekly** as being a "typical" amount of in-home care received. This benchmark was based on input from home care organizations (HCOs) about the hours they typically provide and on an analysis of the average weekly hours received by CCC Plus recipients.

TABLE 7-3
Regional differences in the monthly cost of in-home care

	PSA / Area agency on aging region	10 hours per week	25 hours per week	40 hours per week
	10 - Jefferson Area	$1,608	$4,019	$6,431
Highest	8A - Alexandria	1,564	3,911	6,257
	8B - Arlington	"	"	"
	Statewide	**1,521**	**3,802**	**6,083**
	1 - Far Southwest	1,390	3,476	5,562
	2 - Southwest Coalfields	"	"	"
	3 - Bristol-Galax	"	"	"
Lowest	13 - Southside	"	"	"
	22 - Eastern Shore	"	"	"
	6 - Central Shenandoah	1,369	3,422	5,475

SOURCE: JLARC analysis of in-home care data from CareScout Cost of Care Survey, 2026; https://www.ca-rescout.com/cost-of-care.

NOTE: See Appendix H for a full list of in-home care costs by PSA. PSA names are used for readability purposes only and do not reflect any official designations. American Community Survey population estimates are subject to margins of error.

Cost burden thresholds reflect affordability benchmarks used for other major household expenses:

Childcare (7 to 10 percent) – The Department of Health and Human Services (HHS) set 7 percent as the affordability benchmark in 2016, after historically using 10 percent.

Healthcare (20 percent) – The Commonwealth Fund sets spending more than 20 percent of income (premiums plus medical spending) as a cost burden.

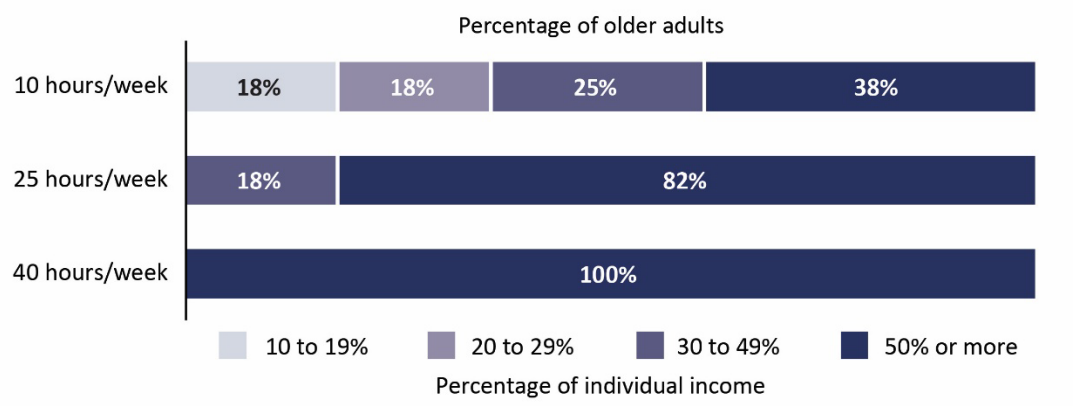
Housing (30 to 50 percent) – The Department of Housing and Urban Development (HUD) considers households spending over 30 percent of income on housing cost-burdened, and over 50 percent severely cost-burdened. See Appendix B for more information.

Despite relatively lower costs, affording private pay in-home care is difficult for many older adults

In-home care affordability can be evaluated by looking at its "cost burden" to the individual. Like childcare, health care, and housing, in-home care is a large, recurring expense in addition to daily living costs. Standard benchmarks for other living expenses define the share of income above which these expenses strain a budget (sidebar). For example, a widely accepted metric for housing affordability is the federal government's use of 30 percent of income for housing costs; households are considered "cost-burdened" when their housing costs are 30 percent or more of their income. There is not a similar benchmark for in-home care. However, most older Virginians would have to spend a substantial share of their income to purchase even a modest amount of in-home care (Figure 7-4). At 10 hours of care per week, 63 percent of older adults would have to spend 30 percent or more of their income. The burden increases sharply with more hours of care. At 25 hours per week, 82 percent would have to spend at least half of their income; only those with annual incomes over $100,000 would spend less. At 40 hours per week, essentially all older Virginians would have to spend at least half of their income.

Even when evaluated against total family income, affording in-home care remains challenging in most PSAs (Table 7-4). The cost of 25 hours of in-home care exceeds 30 percent of family median income in 22 of 25 PSAs. Even a low level of in-home care (10 hours) would be considered unaffordable if the federal government's childcare affordability benchmark were used, costing over 10 percent of family median income in every PSA. (See Appendix H.)

FIGURE 7-4
Just 10 hours of weekly in-home care costs 30 percent or more of the majority of older Virginians' income



SOURCE: JLARC analysis of 2023 5-year American Community Survey data prepared for JLARC by Weldon Cooper Center at the University of Virginia (adjusted to 2025 dollars) and CareScout Cost of Care Survey, 2026; https://www.carescout.com/cost-of-care.
NOTE: About 15 percent of the 65-plus population earns $100,000 or more per year, but the American Community Survey does not specify exact incomes above that threshold. This analysis sets income at $100,000 for that entire group, which leads to an underestimate of the hours of care high-income individuals in that group could afford. See Appendix H for a full list of the cost burden of in-home care by PSA. American Community Survey population and income estimates are subject to margins of error.

TABLE 7-4
Twenty-five hours of weekly in-home care is close to or above 30 percent of family median income in nearly all regions

		Monthly family median income (FMI)	Cost of 25 hours of in-home care per week as percentage of FMI
Less affordable relative to family median income	2 - Southwest Coalfields	$4,463	78%
	1 - Far Southwest	$4,465	78
	12 - Martinsville-Danville	$5,222	68
	Statewide	**$8,554**	**44**
More affordable relative to family median income	8C - Fairfax	$13,313	29
	8A - Alexandria	$13,674	29
	8B - Arlington	$14,034	28

SOURCE: JLARC analysis of 2023 5-year American Community Survey data prepared for JLARC by Weldon Cooper Center at the University of Virginia (adjusted to 2025 dollars) and CareScout Cost of Care Survey, 2026; https://www.carescout.com/cost-of-care.
NOTE: See Appendix H for a full list of in-home care costs relative to family median income by PSA. PSA names are used for readability purposes only and do not reflect any official designations. American Community Survey population and income estimates are subject to margins of error.

Thirty-eight percent of older adults cannot afford to pay for any in-home care

JLARC staff used the Elder Index—a measure of the income older adults need to cover basic living expenses—to estimate the amount of excess funds older adults may have available to pay for in-home care.

Staff calculated the excess funds available for in-home care as the net income remaining after subtracting expenses (Elder Index) from monthly income.

See Appendix B for more information.

Another way to measure the affordability of in-home care is to determine the maximum number of hours an individual could afford after covering basic living expenses (sidebar). Across a sample of 12 PSAs, older adults with annual incomes below $25,000 would not have any funds available for in-home care after other living expenses (although some may be eligible to receive in-home care through Medicaid), while those with higher incomes can afford progressively more hours. Statewide, the majority of older adults (63 percent) can afford fewer than 10 hours of care per week after paying for essential expenses (Figure 7-5).

FIGURE 7-5
Thirty-eight percent of older adults have no excess income to afford any in-home care

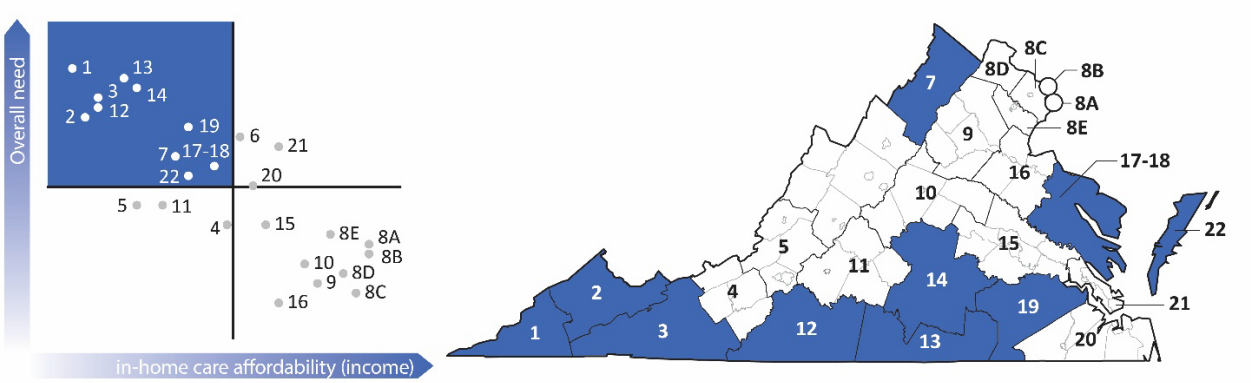


SOURCE: JLARC analysis of CareScout Cost of Care Survey, 2026; https://www.carescout.com/cost-of-care in-home care data, 2023 5-year American Community Survey data prepared for JLARC by Weldon Cooper Center at the University of Virginia, and Elder Index Data from the Gerontology Institute at the University of Massachusetts Boston.
NOTE: Ranges represent hours of in-home care that could be afforded, by PSA, using all individual income exceeding basic living expenses according to the Elder Index. Below $25,000 category includes older adults with no income (3 percent) and those with incomes from $1 to $24,999 (35 percent). Elder Index values used for analysis assume that an individual is single, owns his or her own home and has no mortgage, and is in poor health. The Elder Index factors in regional cost differences by locality and does not take government subsidies (e.g., LIHEAP, SNAP) into account.

In-home care is least affordable in most of the regions where older adults have the highest care needs

In-home care is generally least affordable in regions where older adults have the highest overall need. Ten of the 12 regions with the highest levels of need among older adults have in-home care affordability below the statewide median, all of which are in rural areas (Figure 7-6). PSA 1 Far Southwest has the least affordable in-home care and the greatest overall need among its older adult population.

FIGURE 7-6
In-home care is less affordable in regions with greater overall need among older adults



SOURCE: 2023 5-year American Community Survey data prepared for JLARC by Weldon Cooper Center at the University of Virginia and 2024 American Community Survey 5-year estimates.
NOTE: Regions are ranked based on average ranking across two measures of in-home care affordability (proportion of older adults with a 30 percent or greater burden as proportion of individual income at 10 hours of in-home care per week and the cost of 25 hours of in-home care relative to family median income) and across six individual measures of need; see Appendix D for additional data about overall need by PSA. PSAs correspond to local area agencies on aging. American Community Survey population estimates are subject to margins of error.

Factoring in assets makes at least some care affordable for most older adults

Nearly all older Virginians have assets in addition to their income that could be used to help pay for care. These assets include savings, home equity, and retirement funds. Home equity is one of the largest assets held by older Virginians. About 80 percent of Virginians age 65 and older own their homes, and 55 percent have no mortgage or other loan on their home. Nationally, home equity accounts for approximately half of net worth for older adults.

Estimates suggest that when considering assets, a majority of older adult households could cover several years of assisted living or in-home care services. For example, nearly half of older adult households have an estimated $500,000 or more in assets, which could cover roughly six years in assisted living or roughly 11 years of receiving 25 hours of in-home care per week, if costs stay flat over that period.

However, some Virginia households age 65 and older have sufficient assets to pay only for a relatively short period of assisted living or in-home personal care. Older adult households with less than $25,000 in assets (17 percent) could afford, at most, four months of assisted living at median statewide costs and seven months of in-home care (25 hours per week) at median statewide costs, prior to depletion of their assets (Table 7-5) (sidebar).

Assets are finite, however, and older adults using assets to pay for goods and services beyond care may exhaust their resources more quickly. Some assets, such as investment

This analysis assumes that services are paid for entirely with assets and likely understates the duration of affordability for many households, because most older adults would likely use both their income and their assets to pay for care.

However, estimates of older Virginians' assets and income come from two different data sources: U.S. Census Bureau's Survey of Income and Program Participation and 5-year American Community Survey. Because the two sources draw on different samples of people, the data cannot be linked to show the assets and income of any individual older adult.

accounts, also generate income, so drawing down these assets reduces the income they provide. Additionally, not all assets are available to draw upon, such as a home that is occupied by other family members or savings that a spouse uses for expenses.

TABLE 7-5

Seventeen percent of households have insufficient assets to cover assisted living or in-home care for more than a few months

	$0 or negative	$1 to $24,999	$25,000 to $99,999	$100,000 to $499,999	$500,000+
Proportion of age 65+ households in Virginia	**4%**	**13**	**5**	**29**	**49**
Duration in months that assets could be used to pay for…					
Median assisted living cost	0	0 to 4	4 to 14	14 to 72	72+
Median in-home care cost (10 hours weekly)	0	0 to 16	16 to 66	66 to 329	329+
Median in-home care cost (25 hours weekly)	0	0 to 7	7 to 26	26 to 132	132+
Median in-home care cost (40 hours weekly)	0	0 to 4	4 to 16	16 to 82	82+

SOURCE: U.S. Census Bureau 2025 Survey of Income and Program Participation: State-Level Wealth, Asset Ownership & Debt of Households Detailed Tables (2024); Wealth, Asset Ownership, & Debt of Households Detailed Tables (2024).

NOTE: Durations calculated by using minimum and maximum asset level for each category. Proportion of age 65+ households in Virginia is calculated by applying nationwide distribution of household net assets by age group to Virginia statewide distribution of household net assets for all ages combined.

8 Improving Affordability of Assisted Living and In-Home Care

States can improve the affordability of assisted living and in-home care through direct and indirect policy tools. Direct subsidies can expand access to care by helping individuals cover the costs of assisted living or in-home care. States' less direct policy options include tax incentives to help reduce assisted living facility rates, municipal authority to negotiate for a certain number of affordable units in new assisted living developments, and state-sponsored long-term care insurance. JLARC did not identify a state that offers such a tax credit, and Washington is the only state JLARC identified with a state-sponsored long-term care insurance program. Appendix I includes additional existing and potential strategies for improving affordability and access to assisted living and in-home care that are not discussed in this chapter.

Virginia's auxiliary grant is the state's only program for improving assisted living affordability. The program provides an income supplement to low-income Virginians who are aged, blind, or disabled and reside in a licensed assisted living facility (sidebar). Eligible individuals include Supplemental Security Income (SSI) recipients as well as adults who meet SSI criteria but have income that slightly exceeds federal limits. To meet the auxiliary grant's functional eligibility criteria, an individual must be assessed as needing residential or assisted living level of care and must not have needs that meet nursing facility level-of-care criteria (Chapter 1). A qualified assessor makes this determination using Virginia's Uniform Assessment Instrument (sidebar). At minimum, an individual must need help with one daily living activity (e.g., bathing or dressing), one household activity (e.g., meal preparation or managing money), or medication administration. Recipients must use the grant to pay for assisted living costs, and participating assisted living facilities cannot charge these residents more than the maximum auxiliary grant rate.

The CCC Plus Waiver, a Medicaid home- and community-based waiver, is the state's primary mechanism for enhancing the affordability of in-home care. CCC Plus requires applicants to meet both a financial eligibility standard tied to Medicaid, and a screening showing the person meets nursing facility level-of-care criteria.

The auxiliary grant is also available to pay for housing in **two other settings**: adult foster care homes and supportive housing.

In FY25, just 75 of the 2,898 total auxiliary grant recipients (3 percent) lived in an adult foster care home or supportive housing setting.

Virginia's **Uniform Assessment Instrument** is the state's standard form for assessing whether, and how much, an adult needs long-term care, based on their physical and mental health, social and functional abilities, and medical or nursing needs.

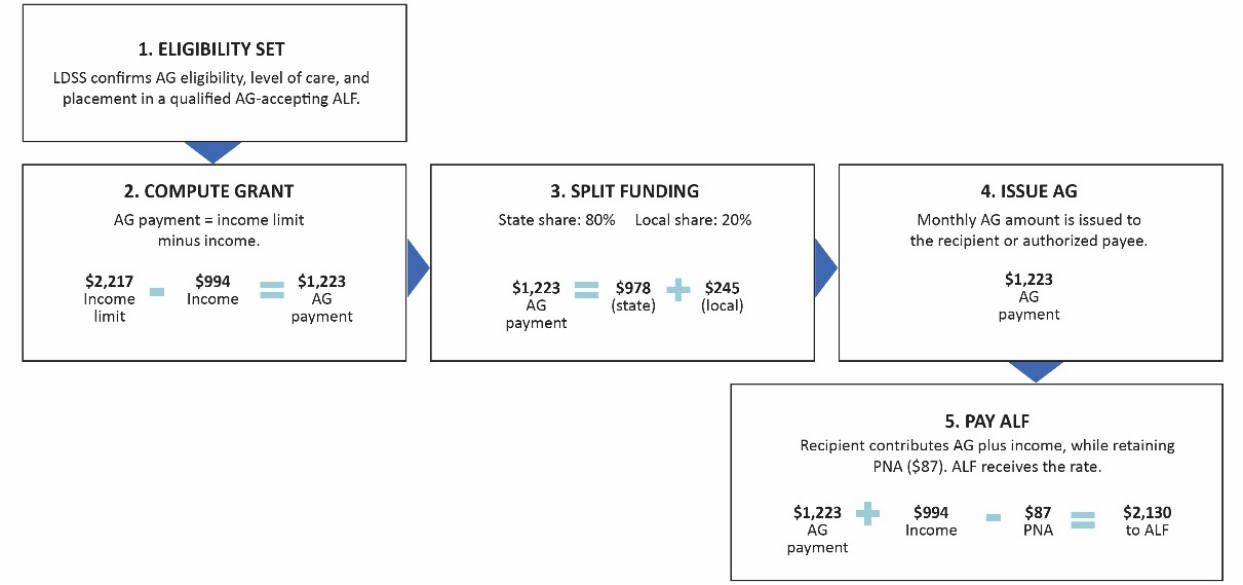
State's auxiliary grant serves few older adults and has not kept pace with assisted living cost growth

The auxiliary grant is Virginia's Optional State Supplement (OSS) program. States can elect to offer an OSS program to supplement the income of federal SSI recipients who are lower-income aged, blind, or disabled individuals. Virginia chose to establish its OSS program in the 1970s to comply with federal SSI requirements. States implement OSS programs with state funds, and OSS programs must conform to certain eligibility

and benefit level parameters set by the Social Security Administration. States may choose to tie these cash supplements to residence in an assisted living facility or other congregate settings and require recipients to be assessed as needing that level of care; Virginia is one of 16 states that follow this approach.

The auxiliary grant rate is the maximum monthly payment a facility can receive for a grant recipient, which is $2,450 in Northern Virginia and $2,130 for the rest of the state. To qualify, an individual's monthly income must be below the auxiliary grant rate (plus an $87 personal needs allowance), and the individual's countable resources, such as cash, bank accounts, and investments, must be below $2,000 ($3,000 for a couple), the same resource limit used for SSI. Grant payments are made directly to the individual or a designated payee. The recipient uses the auxiliary grant payment and all but $87 of their monthly income to pay the applicable facility rate—$2,130 or $2,450 (Figure 8-1).

FIGURE 8-1
Example auxiliary grant payment process for an individual with $994 monthly income

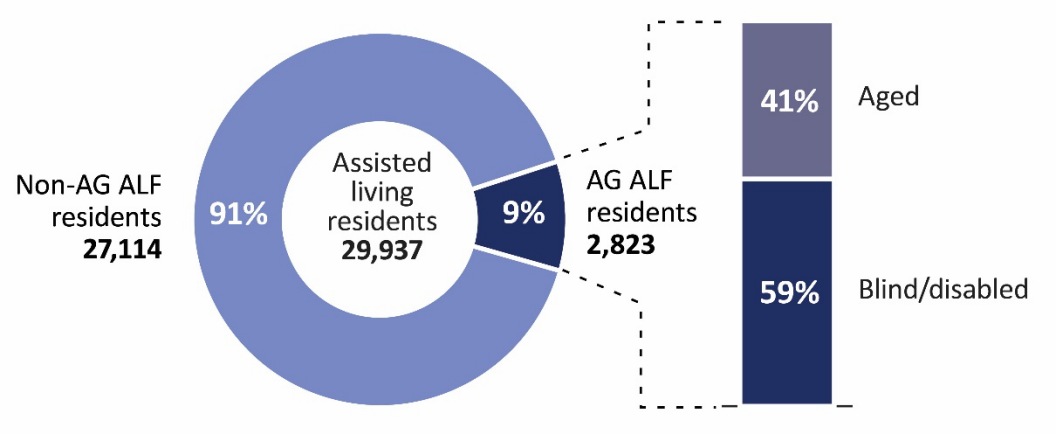


SOURCE: JLARC example of auxiliary grant reimbursement rate.
NOTE: An income of $994 is used to represent a person with *only* full Supplemental Security Income benefits as monthly income.
"PNA" = Personal Needs Allowance.

Auxiliary grant improves affordability for just a small share of assisted living residents, a minority of whom are older adults

Just under 10 percent of total assisted living facility residents are auxiliary grant recipients, and fewer than half of these recipients are older adults (Figure 8-2).

FIGURE 8-2
Older adults are a minority of auxiliary grant recipients



SOURCE: JLARC analysis of Department for Aging and Rehabilitative Services auxiliary grant certification report data FY21–25.
NOTE: "Aged ALF residents" are adults 65 and older who participated in the auxiliary grant program and lived in an assisted living facility.

Approximately two-thirds of facilities statewide do not currently have an auxiliary grant recipient, and the number of auxiliary grant recipients varies greatly by region. During FY25, seven of eight facilities in PSA 2 Southwest Coalfields averaged at least one auxiliary grant recipient each month. In contrast, three PSAs had no facilities with auxiliary grant recipients (PSA 8D Loudoun, PSA 17-18 Northern Neck – Middle Peninsula, and PSA 22 Eastern Shore). The proportion of beds within facilities that are occupied by auxiliary grant recipients also varies across PSAs. On average, auxiliary grant recipients occupied 74 percent of beds in PSA 1 Far Southwest and 42 percent in PSA 2 Southwest Coalfields each month in FY25. In contrast, there were no beds occupied by auxiliary grant recipients in PSA 8D Loudoun, PSA 17-18 Northern Neck–Middle Peninsula, and PSA 22 Eastern Shore during FY25. (See Appendix E.)

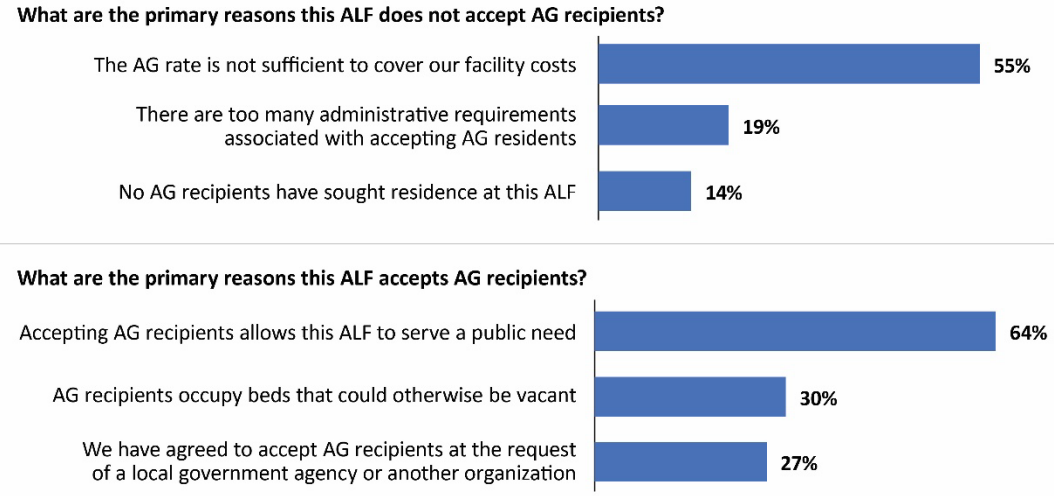
While two-thirds of assisted living facilities (ALFs) do not participate in the auxiliary grant program, expanding access is not merely a matter of recruiting non-participating facilities. Even facilities that currently house auxiliary grant recipients may be unable or unwilling to accept additional auxiliary grant recipients.

The limited availability of auxiliary grant beds can mean that eligible older adults need to relocate far from family and health-care providers or delay care until they need a nursing facility. Area agencies on aging, local departments of social services, and state agency staff report that eligible older adults frequently cannot find a nearby facility with an available auxiliary grant bed. In these cases, individuals may have to relocate far from their family, friends, and health-care providers. While some seek in-home care to avoid moving, in-home services may not always be available or affordable. Some older grant-eligible adults who cannot find an auxiliary grant facility or cannot find or

pay for in-home care may forgo care altogether until their health deteriorates to the point of requiring nursing facility care, which is more restrictive and expensive.

The low auxiliary grant reimbursement rate is the primary reason facilities are reluctant to accept these residents, a longstanding concern highlighted in numerous studies, including multiple JLARC reports. The $2,130 monthly payment is substantially less than the median private pay rate of $6,945 (in 2025). In JLARC's survey of facility administrators, 90 percent of facilities that accept the auxiliary grant, and three-quarters of those that do not, disagreed or strongly disagreed that the monthly rate is enough to meet their operating costs. Administrators at non-participating facilities cited the rate as a deterrent almost three times as often as they cited the next most common factor (Figure 8-3). Administrators at facilities that accept auxiliary grant recipients said they did so to serve a public need, to fill vacant beds, or at the request of local government agencies or other organizations.

FIGURE 8-3
Top reasons ALFs did and did not participate in the auxiliary grant program



SOURCE: JLARC analysis of ALF administrator survey responses.
NOTE: Data represents the percentage of assisted living facilities that responded affirmatively to the statement. Seventy-four assisted living facility respondents did not accept auxiliary grant recipients and 66 did. The second-highest reason ALFs were reported to not accept auxiliary grant recipients, "I don't know, this decision was made by someone else in the company," was cited by approximately 36 percent of administrators.

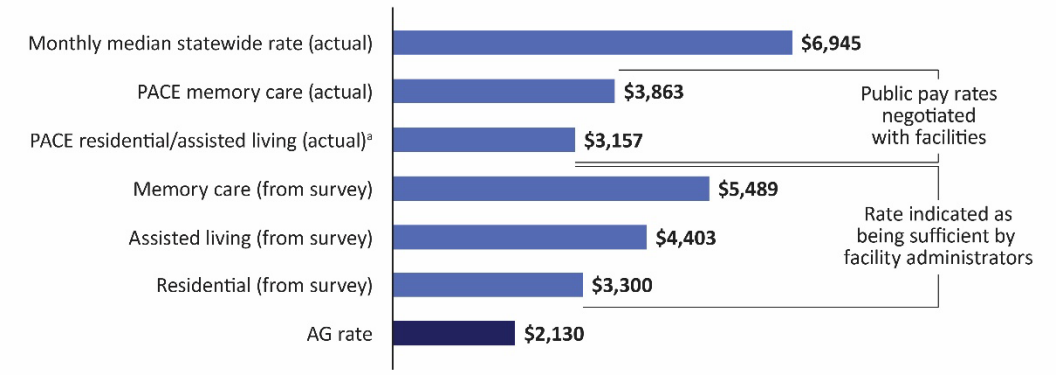
Approximately $9 million in appropriated auxiliary grant funding was unspent and reverted to the general fund between FY22 and FY25. More funding was allocated than could be used. This is largely because some eligible individuals were unable to find a participating facility or an available bed. However, according to DARS staff, some of the unspent funding also reflects the state's budgeting for potential additional use of the program and for cost-of-living adjustments to the auxiliary grant rate.

An auxiliary grant rate that facility administrators consider sufficient would increase state and local spending by up to $79 million annually

Assisted living facility administrators indicate that the auxiliary grant rate would have to be substantially higher, and ideally vary by level of care, to accept new or additional program participants (Figure 8-4). JLARC's survey of assisted living facility administrators asked respondents to estimate a sufficient auxiliary grant rate to accept recipients across three different levels of care need (e.g., bed type). Facility administrators cited average monthly rates well above the current rate: $3,300 for residential level of care, $4,403 for assisted living level of care, and $5,489 for memory care. Based on these administrators' estimates, increasing the auxiliary grant rate to adequately cover the cost of residential and assisted living levels of care is estimated to cost between $76 million and $117 million in state and local funds annually, a $38 million to $79 million increase compared to current program costs (sidebar). This estimate uses current participation levels and therefore underestimates new costs, as a higher rate would likely lead to increased program participation.

Auxiliary grant funding is split 80/20 between the state and localities. The state is responsible for 80 percent of program costs, and localities contribute a 20 percent match.

FIGURE 8-4
Auxiliary grant rate falls well short of PACE payments to facilities and amount administrators say is sufficient



SOURCE: JLARC analysis of ALF administrator survey responses and PACE contract rates with ALFs; CareScout Cost of Care Survey, 2026; https://www.carescout.com/cost-of-care.
NOTE: Rates represent the average minimum rate that would be sufficient to cover costs, according to administrators in facilities that currently have one or more auxiliary grant residents. PACE contracts are the average contracted rate PACE facilities pay to house participants at ALFs within their service area.
[a] Average agreed-upon rate by PACE for residential or assisted living level of care patients. Patients contribute available income toward the agreed-upon rate using a calculation similar to the auxiliary grant (Figure 8-1), and PACE covers the remainder.

Evidence indicates that assisted living facilities would accept an auxiliary grant rate that is lower than these higher rates cited by administrators. Virginia's Programs of All-Inclusive Care for the Elderly (PACE) helps participants secure housing through contracts with assisted living facilities. The average amount paid by PACE programs to facilities is $3,157 per month (sidebar), providing an example of a negotiated public pay rate that facilities are willing to accept. A comparable increase would raise costs by

A **Program of All-Inclusive Care for the Elderly (PACE)** is a Virginia Medicaid program administered by the Department of Medical Assistance Services (DMAS) that helps adults 55+ with chronic healthcare needs or disabilities receive community-based healthcare services and supports.

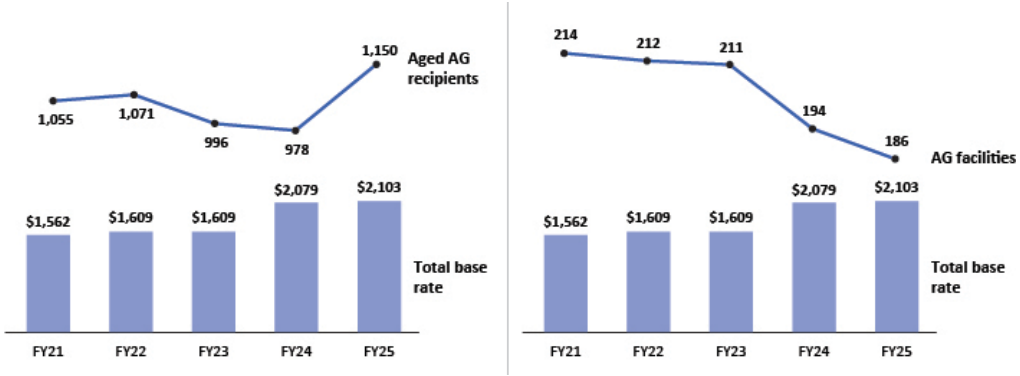
$35.7 million in state and local funds annually. (This estimate also used current participation levels.)

The personal needs allowance is not required to increase with cost-of-living adjustments. The General Assembly determines the personal needs allowance amount and most recently authorized an increase from $82 to $87 effective January 1, 2024.

The General Assembly's last meaningful auxiliary grant rate increase did not ultimately increase the number of facilities willing to accept it. In 2023, the General Assembly appropriated $7 million to increase the auxiliary grant rate 29 percent effective January 1, 2024, with the goal of increasing the number of facilities accepting the grant (sidebar). While program participation increased overall, the number of participating facilities continued to decline (Figure 8-5). As a result, grant recipients were consolidated into fewer assisted living facilities.

Consolidation of auxiliary grant participants into fewer facilities means that fewer low-income older Virginians live near a facility with affordable units. This concentration could also further challenge those facilities' ability to provide quality care in a safe environment. Facilities with many auxiliary grant participants are more likely to have difficulty covering their operating costs, including maintaining qualified staff and properly maintaining their buildings. Some facilities with a large concentration of grant recipients already reduce their daytime operating costs by requiring all residents to leave the facility during the day to attend adult day programs, even if that is not the individuals' preference, which saves on daytime staff and meal expenses.

FIGURE 8-5
After the auxiliary grant rate increased in 2024, program participation grew, but the number of participating assisted living facilities declined (2021–2025)



SOURCE: JLARC analysis of DARS auxiliary grant certification report data FY21–25.
NOTE: The General Assembly authorized an auxiliary grant increase effective January 1, 2024 (halfway through FY24). "Aged AG recipients" are adults 65 and older who participated in the auxiliary grant program and lived in an assisted living facility. "Total base rate" is the amount paid to assisted living facilities by an auxiliary grant resident across the majority of state; Northern Virginia has a higher rate.

Despite the decline in facility participation following the 2024 rate increase, DARS staff reported that rate increases can still help maintain *existing* facility participation or slow further decline, which is important for preserving access to the program.

Auxiliary grant program structure makes it difficult to increase grant rate as assisted living costs grow

Concerns about the auxiliary grant program have persisted since its creation, despite significant funding from the General Assembly and local governments. The grant is the only program that attempts to improve the affordability of assisted living; nearly 3,000 Virginians depend on it to pay for their care. In addition, many ALFs have agreed to participate despite the difference between their reported operating costs and the grant rate.

The structure of Virginia's auxiliary grant program makes it difficult to increase the grant amount in response to rapidly rising assisted living facility costs. The primary challenge is that the grant operates as a federal OSS program, and such programs are more typically are for the purpose of providing a modest supplement to low-income individuals rather than to pay for a high-cost service such as assisted living. While other states limit OSS payments to modest amounts ranging from $674 to $1,719 per month, Virginia's maximum auxiliary grant payment ($2,130 statewide) is the highest in the nation. Out of the 16 states that allow OSS recipients to live in congregate settings, Virginia is one of only 12 states that use their OSS primarily for the purpose of closing the gap between the cost of assisted living and the amount low-income residents can pay.

Relying on the federal OSS program to offset the cost of assisted living has two major fiscal downsides:

- **Rate increases automatically expand eligibility**: Under federal regulations, the maximum auxiliary grant rate also serves as the monthly income eligibility threshold. Therefore, raising the rate paid to facilities simultaneously expands eligibility because individuals with incomes up to the new rate become eligible. State and local costs for the program increase because of higher payments per participant and a greater number of participants.
- **Maintenance of effort:** Federal maintenance-of-effort rules for OSS programs require Virginia to maintain its year-over-year expenditure on individuals enrolled in the program. Compliance is a condition of the state's federal Medicaid funding, meaning the state has limited flexibility to reduce the auxiliary grant rate after an increase.

The fiscal impact of federal OSS rules is further magnified by a state-level policy decision: Virginia chooses to give auxiliary grant recipients automatic eligibility for Medicaid. A rate increase also increases the number of people eligible for the grant because the grant rate is also the maximum income eligibility threshold, and those additional eligible people become newly eligible for Medicaid. The 2024 rate increase carried an estimated $2 million in additional Medicaid costs. Automatic Medicaid eligibility is not

a federal requirement but a Virginia policy decision. Virginia provides automatic eligibility to auxiliary grant recipients through its state Medicaid plan.

Allowing direct cash assistance and expanding auxiliary grant's use to in-home care could serve more adults

The weakness of using the auxiliary grant solely for assisted living is that assisted living facilities are inherently expensive and their costs rapidly increase. Eliminating the requirement that the grant must be spent in specific settings could give older adults (and blind and disabled program participants) greater choice for how they spend their benefit, broadening the types of care and housing that the grant helps make more affordable.

Virginia could change the auxiliary grant program to direct cash assistance, allowing eligible older, blind, or disabled adults to use the funds for in-home care services, housing, food, clothing, or other expenses. Virginia has already expanded the settings the auxiliary grant can be used for, adding supportive housing in 2016 to better serve individuals with severe mental illness, addiction, and substance abuse. To preserve the program's intent and target funds to individuals who are likely to need in-home support, eligibility could be based on the same functional criteria as the current auxiliary grant program. Under these criteria, individuals must have residential or assisted living level of care needs, which means they need help with at least one daily living activity, one or more household activities, or taking medications, but not require nursing home level of care, as determined through Virginia's Uniform Assessment Instrument.

National and state survey data indicate that older adults and individuals with disabilities prefer to receive care at home. A 2024 AARP national survey found that three-quarters of older adults want to remain in their current homes and communities as they age, and area agency on aging staff report the same preference among Virginia's older adults. State agency staff reported that the disability community, which comprises about 60 percent of auxiliary grant participants, has consistently advocated for in-home care options.

Several states offer OSS programs that fund both direct cash assistance for living expenses and subsidies for congregate care. For example, North Carolina's OSS program offers two options: its State and County Special Assistance for In-Home Residents provides participants with a monthly cash supplement that can be used for living expenses such as housing, care, food, clothing, and other daily necessities, and the State and County Special Assistance for Adult Care Home Residents program helps older adults pay for congregate care (similar to the auxiliary grant). Other states offering both cash and congregate care models for their OSS program include Wisconsin, California, Washington, Indiana, and Minnesota.

Two bills proposed during the 2023 General Assembly session (HB 1906 and SB 1269) would have allowed auxiliary grant recipients to live in independent community living settings (sidebar). The bills resulted from a Joint Commission on Health Care (JCHC)

HB 1906 and SB 1269 had an estimated fiscal impact of $3.3 million ($2.5 million in general funds) for the state share of auxiliary grant payments for 200 individuals in independent community living, Medicaid coverage for recipients expected to become newly eligible through the grant, and one new DARS position to oversee the program.

policy option that JCHC members unanimously recommended following the commission's 2022 study, *Affordability of Assisted Living Facilities*. Neither bill passed.

State addition of a cash assistance program would need to consider provider price controls and rate structure

Converting the auxiliary grant to *only* direct cash assistance could inadvertently make assisted living and other relevant housing options less affordable for program recipients. To preserve affordability and maintain provider price controls, Virginia should consider preserving the requirement that any assisted living facility, adult foster care home, or supportive housing provider accepting auxiliary grant funds cannot charge recipients more than the established grant amount.

Virginia would also need to decide whether to change or maintain its auxiliary grant reimbursement rate. A lower rate could be considered because in-home care costs less than congregate care. However, because of federal eligibility requirements, a lower rate would decrease the income eligibility threshold, and fewer Virginians would benefit. In addition, lower rates may not allow recipients to purchase sufficient in-home care. For example, 10 hours per week of in-home care costs about $1,500 per month at the statewide median rate (Chapter 7), before any spending on housing, food, clothing, or other expenses. Keeping the same rate across all settings (assisted living, supportive housing, adult foster care, etc.) would also minimize additional administrative complexity (sidebar).

North Carolina, for example, uses the same rate of $1,397 for both its assisted living and direct cash assistance programs.

Direct cash assistance would not meet the needs of all eligible older adults, particularly those with high care needs

A direct cash assistance program may not be well suited to all older adults who meet the eligibility requirements, particularly those with high care needs. For example, the monthly grant payment at the current rate would be insufficient to pay for moderate to high weekly hours of in-home care. Older adults with higher levels of need, or who do not have access to a suitable living arrangement, would likely be better served in an assisted living facility.

Direct cash assistance program could escalate state costs without a cap

Because a direct cash assistance program would not be limited by the number of available ALF beds, participation and costs could increase substantially. JLARC staff estimate that 35,000 to 105,000 older Virginians meet the auxiliary grant's income and functional criteria and could qualify for a direct cash assistance program, compared with about 2,800 participants in the current program (sidebar). (Participation is constrained under the current program by the limited number of facilities accepting the grant.) This estimate does not include people who are blind or disabled, who currently make up the majority of program participants, so the number of potential participants would be even higher.

JLARC staff estimated the **number of older adults who could meet the auxiliary grant's income and functional criteria** by using older adults' individual income levels and the proportion of older adults who report self-care, independent living, or ambulatory difficulty, according to the U.S. Census Bureau. This analysis does not include the grant's $2,000 resource limit, so the number of older adults who would qualify for a direct cash option could be lower.

To manage state expenses, Virginia could cap direct cash assistance enrollment, which is allowed under federal rules for OSS programs. The auxiliary grant currently does not limit the number of assisted living recipients but caps supportive housing at 120 participants.

Direct cash assistance would remove oversight of recipients' living settings, so state would need to explore options for safeguards

A direct cash assistance option would also remove a safeguard of the current auxiliary grant program. Recipients currently must live in a setting that is regulated and overseen by a state or local entity: an assisted living facility licensed by the Virginia Department of Social Services (VDSS), supportive housing overseen by the Department of Behavioral Health and Developmental Services (DBHDS), or an adult foster care home approved by a local department of social services (LDSS). Under a direct cash option, recipients without access to a private residence with family or a close friend could end up in unregulated congregate settings, such as unlicensed group homes or boarding houses. While there are no estimates of the number of these unregulated congregate settings, state and local agency staff have expressed some concern about their proliferation. If any auxiliary grant recipients were to reside in one of these settings, state funds could be used to subsidize these arrangements without any oversight of the quality of care or safety of the living environment.

Defining which community settings qualify for payments could help prevent recipients from using state funds to live in unregulated congregate settings. Kentucky's optional state supplement allows individuals who are aged, blind, or disabled and need personal care services to receive payments while living in a private residence. Kentucky sets parameters for what is considered a private residence to prevent state funds from being used in settings of concern, such as boarding houses and group homes.

Implementing a direct cash assistance program would require SSA approval

Adding a direct cash assistance program to the auxiliary grant would require approval from the Social Security Administration. DARS staff expressed concern about how long SSA approval for a new setting could take, because there is currently no SSA contact person, and the federal government made significant changes to the SSA workforce. DARS staff report that their inquiries about changes or technical aspects of the auxiliary grant program have taken a long time to receive a response or have gone unanswered entirely in recent years.

POLICY OPTION 2

The General Assembly could (i) amend §§51.5-159 and 51.5-160 of the Code of Virginia to allow individuals who meet the functional criteria for auxiliary grant eligibility to receive the grant as direct cash assistance, even if they do not reside in an assisted living facility, adult foster care home, or supportive housing setting, while retaining the requirement that providers in those settings that accept the grant charge recipients no more than the established grant rate; (ii) include language in the Appropriation Act capping participation in the direct cash assistance option; (iii) include language in the Appropriation Act directing the Department for Aging and Rehabilitative Services (DARS) to amend 22VAC30-80 of the Virginia Administrative Code to establish financial eligibility requirements for the direct cash assistance option; and (iv) direct DARS to seek approval of the program changes from the Social Security Administration.

Adding a direct cash assistance option to the auxiliary grant would require additional state appropriations to fund the grant and could require additional DARS staff resources to implement the expanded program. The cash assistance option would also increase Medicaid costs because participants would be automatically eligible for coverage under Virginia's current state Medicaid plan.

Regardless of whether the General Assembly modifies the auxiliary grant program's structure, it could consider periodic rate increases to ensure that assisted living facilities participate and that low-income Virginians in need of assisted living can use the benefit. Setting the amount of any future increase involves tradeoffs. A relatively modest increase (for example, less than $500 per month) would be less costly to the state but may not be enough to encourage additional facility participation. A larger increase to about $3,300 per month, which is approximately comparable to PACE contract rates and the low end of what facility administrators indicate is sufficient, would increase state and local costs by about $38 million in the first year based only on current participation levels.

The potential auxiliary grant rates discussed in this chapter were largely based on information reported by assisted living facilities, and the state currently has limited insight into the actual costs of providing assisted living to auxiliary grant recipients. Before deciding on a rate increase, Virginia should commission a formal cost study of housing and caring for auxiliary grant recipients in assisted living facilities and use those findings to set an appropriate rate.

RECOMMENDATION 27

The General Assembly may wish to include language and funding in the Appropriation Act directing the Department for Aging and Rehabilitative Services to contract with a third-party expert to (i) collect and analyze data on the costs of operating assisted living facilities that serve auxiliary grant recipients, separating out costs associated with room and board from those associated with services and supports, (ii) estimate the auxiliary grant rate needed to adequately cover those costs, and (iii) report the results to the House Appropriations Committee and the Senate Finance and Appropriations Committee by November 30, 2027.

In Virginia, **a person with nursing facility level-of-care needs** (i) has limited functional capacity along with medical or nursing needs and is at risk of nursing facility admission within 30 days, or (ii) is semi-dependent in some functional capacity and requires daily direct services or supervision of a licensed nurse.

A private pay resident with nursing facility level-of-care needs may continue living in an ALF if (i) they are receiving hospice care, or (ii) their independent physician provides approval to continue living in an ALF with skilled nursing services provided by an outside licensed medical professional (doctor, nurse), home care organization, or facility staff under supervision of a registered nurse.

Medicaid HCBS waivers, also known as 1915(c) waivers, allow states to provide specific services in community settings (e.g., private residence, assisted living) by waiving certain Medicaid state plan requirements.

Medicaid could be used to improve assisted living affordability when federal rules change in 2028

Medicaid home and community-based services (HCBS) waivers can be used to pay for *services* provided in assisted living facilities, which can greatly improve assisted living affordability for low-income older adults. Nearly all states, including Virginia, have at least one HCBS waiver program (sidebar). A 2026 Government Accountability Office (GAO) report found that 28 of the 41 states with HCBS waiver programs use them to pay for assisted living services for adults 65 and older.

Virginia does not currently use HCBS waivers for assisted living services although it has in the past. Current federal eligibility regulations restrict the population who might qualify for waiver-covered assisted living services to a small subset of assisted living residents. Federal rules require that waiver recipients meet nursing facility level of care criteria. In Virginia, individuals qualifying for nursing facility care are generally disqualified by statute from living in an assisted living facility, with some narrow exceptions (sidebar). In addition, federal law bars Medicaid payment for room and board at assisted living facilities, meaning that waivers can only be used to cover the cost of services and supports provided to assisted living residents.

Federal law will soon allow HCBS waiver programs for individuals below nursing facility level of care

Beginning in July 2028, new federal Medicaid waiver authority (under Section 1915(c)(11) of the Social Security Act) will allow states to apply to offer HCBS waivers to individuals not meeting a nursing facility level of care. This would be better aligned with the assisted living population than current 1915(c) waivers, which require nursing facility level of care to be eligible, and could be used to pay for the service component of assisted living costs. States will have flexibility to define needs-based qualification criteria, subject to approval by the U.S. Secretary of Health and Human Services.

Currently, Tennessee is the only state that uses a Medicaid waiver to serve individuals below a nursing facility level of care. Tennessee does so through a Section 1115 demonstration waiver. The Tennessee program appears to have served as a model for the new Section 1915(c)(11) authority that becomes available in 2028.

Waiver would allow Virginia to leverage federal funds to reduce assisted living costs

Using a Medicaid waiver to pay for assisted living services would be more cost-effective than increasing the auxiliary grant rate because the federal match on Medicaid spending would allow Virginia to increase payments to facilities by a larger amount for the same cost. Higher payments could make facilities more willing to accept lower-income, public-pay residents. For example, Virginia could spend an additional $1,000 per auxiliary grant recipient (split 80/20 between the state and localities) and increase the auxiliary grant rate paid to facilities to $3,130 (sidebar). Alternatively, the state could spend $1,000 per qualifying resident on assisted living facility services and receive a federal match of $1,000, resulting in facilities receiving $4,130 (assuming waiver recipients also receive the auxiliary grant). Further, if the waiver rate were set *higher* than the auxiliary grant rate, a facility could receive more revenue for a waiver recipient than for an auxiliary grant recipient, even if the waiver recipient did not also receive the grant.

Virginia's **Federal Medical Assistance Percentage** (FMAP) indicates that the federal Medicaid match rate is approximately 50 percent, meaning half of new assisted living waiver costs would be federally funded.

A new assisted living waiver could cover assisted living generally or be narrowed to just memory care

If Virginia applies for a Medicaid assisted living waiver in 2028, it could propose using the waiver to pay for general assisted living services, only memory care, or both. A waiver that targets or includes the Alzheimer's and dementia population would restore a Medicaid-supported option that Virginia has lacked since discontinuing its Alzheimer's Assisted Living waiver in 2018. Memory care tends to be the most expensive tier of assisted living. Other states have Medicaid waiver programs that support individuals with dementia or Alzheimer's disease. For example, Ohio, Illinois, and California all operate ALF waivers that have provisions and/or rates specific to the dementia population and memory care services.

Virginia would need to address shortcomings that ended previous assisted living waivers

Virginia has twice used a Medicaid waiver to serve older adults in assisted living facilities. However, both programs were discontinued because of federal quality concerns, noncompliance with federal requirements, and low participation.

From 1996 to 2000, Virginia operated an Assisted Living Waiver program that provided services to individuals who were older adults, blind, or disabled, which paid for assisted living facilities to provide services for residents participating in the auxiliary grant program (the grant only supplemented room and board payments, which Medicaid cannot pay for). The program had two levels of care: (i) regular assisted living for individuals with an assisted living level of care financed solely with state funds, and (ii) intensive assisted living for individuals needing a nursing facility level of care financed with state and federal Medicaid funds. The federal government denied renewal of the waiver in March 2000 because of concerns about the quality of services being provided to participants and noncompliance with federal requirements.

Virginia operated the Alzheimer's Assisted Living waiver from 2006 to 2018 for low-income individuals 55 and older who had a diagnosis of Alzheimer's disease or related dementia. To qualify, individuals had to meet nursing facility level-of-care criteria, receive an auxiliary grant, and live in an approved ALF memory care setting. Outside Northern Virginia, participating facilities received a Medicaid payment of approximately $1,485 per month for covered services, which was in addition to the auxiliary grant for room and board.

Virginia discontinued the Alzheimer's Assisted Living waiver in 2018 after determining that the program could not be brought into compliance with the federal HCBS "settings" requirements that disallowed many of the freedom of movement and other restrictions characteristic of safe and secure memory care units. The federal government also continued to have concerns with the quality of care that was being delivered, similar to the previous, broader waiver.

When discontinued, the Alzheimer's Assisted Living waiver served only 59 individuals across 12 facilities. Low participation was primarily driven by low monthly payments (about $2,700 including Medicaid and the auxiliary grant rate at the time), eligibility being restricted to individuals requiring nursing facility level of care, and the mandatory use of the auxiliary grant program.

A new waiver would need to ensure quality of care without deterring assisted living facility participation

A new waiver must set provider requirements that ensure adequate quality of care without deterring assisted living facilities from participating, a balance neither of the state's previous waivers achieved. Under the original Assisted Living Waiver (1996 to 2000), the quality of care provided by facilities to waiver recipients was a major concern. State agency staff and Centers for Medicare and Medicaid Services (CMS) documentation from that period describe insufficient assisted living facility staffing levels and staff training, as well as state licensing standards too weak to ensure the quality of care CMS requires for waiver services. The 2006 Alzheimer's Assisted Living waiver required participating facilities to *exceed* Virginia's base assisted living licensing standards in several areas, including staffing. State agency staff reported that these additional requirements deterred most facilities from participating.

To avoid this problem, before introducing a new waiver Virginia should assess whether assisted living regulations and the state's enforcement of them have been strengthened enough in recent years to meet CMS's standards. Many of CMS's past quality concerns could be addressed through the recommendations regarding assisted living facility quality in Chapters 3, 4, and 5 of this report.

A new waiver would need to meet HCBS settings rules

Noncompliance with HCBS settings rules was a key factor that led to the discontinuation of the Alzheimer's Assisted Living waiver. Federal HCBS settings rules

introduced in 2014 required that waiver recipients have a choice among waiver setting options and providers, are integrated into the broader community, have autonomy and independence (i.e., no locked doors, ability to freely admit guests), and have privacy and freedom from coercion. However, other states have successfully used HCBS waivers to cover assisted living services, and federal guidance on locked doors and federal guidance on locked doors and egress has since been modified in ways that may make compliance easier.

Waiver recipients would need choice of service providers

A new waiver would need to give participants a choice of service providers, which the state's previous Alzheimer's Assisted Living waiver did not. The federal HCBS settings rule requires that waiver participants have a choice of the services they receive while in an assisted living facility and service providers. The Department of Medical Assistance Services' (DMAS) 2016 assessments found that assisted living facility staff or facility-selected contractors provided nearly all waiver services and that participants were not offered a choice of provider. This noncompliance was one of the main reasons the waiver was discontinued. A new waiver would need to allow residents to choose between qualified facility staff and outside providers, whether it served assisted living residents generally or only those in memory care.

There is no federal guidance for how states should operationalize service provider requirements. DMAS would need to consult CMS and peer states such as Ohio, Illinois, and California, when developing waiver language and requirements for participating facilities.

For a memory care waiver, controlled egress would need to be based on each resident's needs rather than applying uniformly to all residents

Virginia's Alzheimer's Assisted Living waiver required every participant to live in a safe and secure unit with controlled egress (i.e., locked doors), regardless of the individual's risk of wandering or elopement (sidebar). After assessing 12 participating ALFs in 2016, Virginia and CMS determined that bringing the waiver into compliance with the settings rule was not feasible. This was another key reason the waiver was discontinued.

CMS subsequently issued guidance that memory care settings with controlled egress can comply with the settings rule if restrictions are based on each resident's individual needs and documented in residents' care plans (sidebar). Virginia would likely need to revise its regulations for safe and secure units (i.e., memory care), at least for ALFs participating in the waiver.

Other HCBS settings rules and additional CMS oversight would apply to facilities accepting waiver recipients

To qualify for HCBS funding, assisted living facilities will have to meet other CMS settings requirements, including lockable doors to personal living quarters at the

CMS guidance from 2016 says that controlled egress must be addressed as a modification of the rules defining HCBS settings, with the state ensuring that the provider complies with various federal rules. Additionally, any provider setting with controlled egress must assess a wandering individual, and document needed safety measures and community engagement plans in his or her person-centered care plan.

There are two types of egress locking systems.

Delayed egress locks allow a person to exit a short amount of time after a first attempt (e.g., 15 seconds).

Controlled egress locks require manual opening by another individual.

In both cases, systems can be fitted to automatically unlock in case of emergency (e.g., a fire).

discretion of the resident, choice of roommate or a private unit, a lease, and freedom to have visitors.

A new waiver would need to ensure timely reassessments

Federal rules require states to reevaluate waiver participants at least annually to confirm they still qualify for services, but DMAS found that providers in the state's previous Assisted Living Waiver did not consistently meet this deadline. A new waiver should clearly establish reassessment responsibilities and deadlines in the waiver application, regulations, and provider agreements, and it should include a process for monitoring compliance.

Medicaid reimbursement rates would need to be sufficient to encourage facility participation, but also be lower than comparable institutional settings

To ensure that enough ALFs participate in the waiver, Medicaid would need to pay a reimbursement rate that sufficiently covers the cost of providing services. As with the auxiliary grant, providers could decline to accept Medicaid residents or cap the number of Medicaid beds if reimbursement rates are set too far below the cost of providing services, or too far below private-pay rates. DMAS reported concerns from the industry that the reimbursement rate for the 1996 Assisted Living Waiver was too low, a concern also commonly reported in other states interviewed by JLARC staff.

Virginia's waiver would have to demonstrate "cost neutrality," meaning that per-member spending could not exceed spending for comparable institutional services, like nursing facility care. Other states with assisted living waivers have successfully demonstrated cost neutrality because of the significant difference between the cost of assisted living and more costly skilled nursing facilities. Still, the cost neutrality requirement will constrain the level of Medicaid reimbursement that can be provided to assisted living facilities.

Under a new waiver, participants would still be responsible for the room and board portion of assisted living costs

Under federal law, waiver recipients remain responsible for their own room and board costs. Using rates from other states with a Medicaid waiver, room-and-board costs in assisted living average about $2,100 per month, accounting for about one-third of the median *total* assisted living facility cost (with remaining costs being for services and supports provided to residents at the facility) (sidebar).

Ohio **caps room and board charges** for assisted living waiver participants to enhance affordability.

While auxiliary grant recipients can use grant funds to pay for room and board, Virginia should not limit waiver eligibility to auxiliary grant recipients. Doing so would exclude low-income seniors who need waiver support but exceed grant income thresholds. Medicaid waivers can cover individuals with income up to 300 percent of the SSI federal benefit rate (about $3,000 per month). In contrast, the auxiliary grant is limited

to individuals whose income is below the General Assembly-set auxiliary grant income limit ($2,217 per month). Individuals with modest pensions or Social Security income who cannot afford private pay assisted living, but whose income is too high for the grant, would therefore be excluded if only auxiliary grant recipients were eligible for a new waiver. These individuals currently receive no public assistance for assisted living costs.

Significant preparation and agency coordination are needed to administer a new Medicaid waiver

Substantial work must be completed before Virginia could successfully apply for and administer a new assisted living waiver under 1915(c)(11) authority in 2028. DMAS and VDSS would need to evaluate current assisted living licensing requirements and regulations to bring them in line with CMS rules. DMAS must also develop a waiver application, establish a state "needs-based" eligibility threshold, conduct a rate-setting study, propose a rate that will meet cost-neutrality requirements and ensure sufficient ALF participation, and estimate participation levels and state and federal costs. As part of these steps, DMAS would need to consult with DARS to determine how the auxiliary grant would complement the waiver, such as by covering residents' room and board. In addition, DMAS would need to produce a fiscal impact estimate and a timeline for applying for the new waiver once the application window opens in 2028. If a waiver were eventually implemented, DMAS would also need to evaluate interested providers to ensure compliance with the HCBS Settings Rule.

The General Assembly will ultimately decide the waiver's eligible population, based on the information and research DMAS provides through the application development process. The waiver could apply to all assisted living residents who meet the needs-based criteria defined by DMAS, individuals with a diagnosis of Alzheimer's or dementia, or both.

A 1915(c)(11) waiver would increase state Medicaid spending regardless of the eligible population, but the waiver would give the state more control than if it added the benefit to the state Medicaid plan. The General Assembly could cap participation in the waiver to control program costs and maintain some budget flexibility. A program added to the general state Medicaid plan through a state plan amendment could not be capped (sidebar).

A 1915(i) State plan HCBS option allows states to provide HCBS services, including assisted living services, to one or more specific populations under state-defined needs-based criteria and eligibility groups. However, 1915(i) waiver option participation cannot be capped, must be applied statewide, and must follow all other federal requirements of state plan programs.

POLICY OPTION 3

The General Assembly could direct the Department of Medical Assistance Services to complete the background research and administrative steps required to apply for and implement a 1915(c)(11) assisted living waiver. This research would (i) determine the needs-based eligibility requirements, (ii) identify the services to be covered, (iii) estimate the number of potentially eligible individuals with and without a diagnosis of Alzheimer's or dementia, (iv) determine a rate adequate to meet cost-neutrality requirements and attract providers, (v) identify the number of potentially interested and eligible facility providers, (vi) produce a fiscal impact estimate, and (vii) present a timeline for applying for the waiver once the application window opens in 2028. The Department for Aging and Rehabilitative Services and Virginia Department of Social Services should be directed to support DMAS as needed in this effort.

Appendix A: Study resolution

In-home and residential congregate care services for aging Virginians
Authorized by the Commission on December 16, 2025

WHEREAS, Virginia's population will continue aging, with more than 600,000 Virginians projected to be 80 years old or older by 2040; and

WHEREAS, localities in each of Virginia's economic development regions are projected to experience large increases in the age 80-plus population by 2040; and

WHEREAS, about one-quarter of the population in each region is age 60 or older and living alone, and an even higher proportion is age 60 or older and disabled; and

WHEREAS, many of the state's aging residents will be unable to remain in their homes without external services and supports or will need congregate care residential living options, such as assisted living and memory care units, to ensure their safety and well-being; and

WHEREAS, no data exists about whether existing home- and community-based services and supports, and congregate care residential living options, will be sufficient to meet the demands of aging Virginians; and

WHEREAS, state government is responsible for establishing operation regulations for these services, ensuring their quality and, in some cases funding them; now, therefore, be it

RESOLVED by the Joint Legislative Audit and Review Commission that staff be directed to review the availability and quality of non-medical services and supports available for aging Virginians. These services and supports include those designed to allow individuals to age safely in their own homes and congregate care housing, such as assisted living and memory care units, for those who cannot remain in their homes. In conducting its review, staff shall: (i) determine the current number of service providers, their services, and their existing capacity, by region and by whether they accept public funding; (ii) estimate existing and future service shortages, by service type and by region, and determine the reasons for these shortages; (iii) summarize what is known about the quality of these services, by service type and by region, and determine the primary contributors to poor quality; (iv) evaluate the effectiveness of the state's quality assurance mechanisms, especially its facility inspections and available sanctions/incentives; and (v) develop options for expanding the availability of services for aging Virginians, including through a potential Medicaid waiver.

JLARC shall make recommendations as necessary and review other issues as warranted.

All agencies of the Commonwealth, including the Department for Aging and Rehabilitative Services, the Department of Social Services, the Department of Medical Assistance Services, and the secretary of health and human resources, shall provide assistance, information, and data to JLARC for this study, upon request. JLARC staff shall have access to all information in the possession of agencies pursuant to § 30-59 and § 30-69 of the Code of Virginia. No provision of the Code of Virginia shall be interpreted as limiting or restricting the access of JLARC staff to information pursuant to its statutory authority.

Appendix B: Research activities and methods

Key research activities JLARC performed for this study include:

- structured and group interviews with staff of state agencies, area agencies on aging (AAAs), assisted living and home care providers, stakeholder associations, subject-matter experts, and aging services agencies and offices in other states;
- surveys of assisted living facility administrators, licensing inspectors, and local department of social services and area agency on aging staff;
- analysis of data and information collected from assisted living facilities, local departments of social services, area agencies on aging, the Department of Social Services, Department of Health, Department for Aging and Rehabilitative Services, Department of Medical Assistance Services, and the Department of Health Professions;
- analysis of U.S. Census Bureau demographic data and other publicly available federal data;
- site visits to assisted living facilities and observations of facility inspections;
- reviews of assisted living and in-home care regulation in other states; and
- reviews of documents, research literature, and Virginia laws, regulations, and policies relevant to assisted living facilities and home care organizations.

Structured interviews

Structured interviews were a key research method for this report. JLARC conducted over 100 individual interviews and 15 group interviews. Key interviewees included staff of the state agencies that license and oversee assisted living facilities and home care organizations, staff of AAAs, assisted living and home care providers, local and community organizations, stakeholder associations, subject-matter experts, emergency medical service providers, and staff of aging services agencies in other states.

Virginia Department of Social Services

At the outset of the study, JLARC met with the commissioner of the Virginia Department of Social Services (VDSS), the deputy commissioner for state programs, and the director of the Division of Licensing Programs (DOLP), which licenses and oversees assisted living facilities. JLARC conducted 14 additional interviews with DOLP staff, including the division director, the field operations manager, the enforcement team, and the licensing administrators for all five DOLP regions.

Central office interviews covered the inspection and enforcement processes, the operating budget requirement for new facility applicants under § 63.2-1702 of the Code of Virginia, new involuntary discharge regulations, as well as data availability and the limitations of the systems DOLP uses to track licensure and oversight activity. Interviews with regional licensing administrators covered the composition of the assisted living market in each region, including the prevalence of memory care units and of facilities that accept the auxiliary grant; the licensing and monitoring inspection process; and the adequacy of Virginia's assisted living standards.

Virginia Department of Health

JLARC interviewed three medical facility inspectors and a supervisor from the home care division of the Virginia Department of Health (VDH) Office of Licensure and Certification (OLC), which licenses and oversees home care organizations, as well as the deputy commissioner for governmental and regulatory affairs and the office's director and deputy director. Topics included inspector workload and travel, the initial licensure and biennial survey process, complaint investigations, demand for new home care organization licenses, and recent changes to the license renewal cycle.

Other state agencies

JLARC interviewed staff of the Department for Aging and Rehabilitative Services (DARS), including the auxiliary grant program manager, the deputy commissioners for community living and aging services, the director of Adult Protective Services, and the State Long-Term Care Ombudsman. Topics included auxiliary grant eligibility and payment rates and options for modifying the program; aging services programs, including the Caregiver Coalition and the Lifespan Respite Voucher program; Adult Protective Services' role in overseeing assisted living facilities and home care; and the ombudsman's role in advocating for residents.

JLARC interviewed Department of Medical Assistance Services (DMAS) staff regarding the Commonwealth Coordinated Care Plus waiver, agency- and consumer-directed in-home care services, quality management review measures, and network adequacy requirements for managed care organizations.

JLARC also interviewed the Department of Health Professions (DHP) Board of Long-Term Care Administrators regarding the licensing of facility administrators, and Joint Commission on Health Care staff regarding staffing standards.

Area agencies on aging and local organizations

JLARC interviewed leadership of the Virginia Association of Area Agencies on Aging and directors of three individual area agencies on aging regarding the in-home services agencies provide to older Virginians, the unmet need for those services, and the supply and quality of assisted living in their regions.

JLARC also interviewed members of the VDH emergency medical services regional council and the Virginia League of Social Services Executives regarding local staff's experience with assisted living facilities in their areas.

Assisted living and home care providers

JLARC interviewed representatives of three assisted living providers who operate multiple facilities in Virginia and other states regarding how Virginia's regulatory framework, staffing standards, and oversight practices compare to those of other states.

JLARC also interviewed staff of a statewide home care organization and a home care organization operating in multiple states regarding the supply, quality, and affordability of in-home care. Responses were not attributed to a specific individual or organization.

JLARC interviewed representatives of five Programs of All-Inclusive Care for the Elderly (PACE) operating in Virginia and of the National PACE Association. Topics included PACE catchment areas and enrollment, whether participants reside in assisted living facilities, the rates PACE organizations pay for facilities to house participants, the services provided in participants' homes, and the role of PACE in other states.

Stakeholder associations

JLARC interviewed representatives of the following organizations:

- ADvancing States;
- Alzheimer's Association, Greater Richmond Chapter;
- Argentum;
- LeadingAge Virginia;
- Virginia Assisted Living Association and its provider members;
- Virginia Association for Home and Hospice Care;
- Virginia Association of Area Agencies on Aging;
- Virginia Association of In-home Care Providers;
- Virginia Health Care Association–Virginia Center for Assisted Living;
- Virginia League of Social Services Executives; and
- Virginia Villages Collective.

Interviews covered these organizations' and their members' perspectives on the supply, affordability, and quality of assisted living and in-home care in Virginia, Virginia's regulatory standards and oversight practices, and opportunities to improve services for aging Virginians. Several of these interviews were conducted early in the study to inform its scope.

Subject-matter experts

JLARC interviewed faculty of the Virginia Center on Aging at Virginia Commonwealth University, the director of the Virginia Tech Center for Gerontology, and a caregiving researcher at the Martha W. Goodson Center at Riverside Health System regarding caregiving in Virginia and research on services for older adults. JLARC also interviewed representatives of Genworth CareScout regarding its Cost of Care Survey and the rates and fees charged by assisted living facilities and home care organizations.

Aging services agencies in other states

JLARC conducted 10 interviews with staff of aging services agencies in other states. Interviews covered three topics: optional state supplement programs comparable to Virginia's auxiliary grant, in Maryland, North Carolina, and Ohio; Medicaid waivers that cover assisted living services, in Ohio and Tennessee; and state programs for measuring and reporting assisted living quality and for setting staffing requirements, in Minnesota, Ohio, and Oregon.

Group interviews

JLARC conducted 15 group interviews with staff who work directly with older Virginians receiving assisted living or in-home care. Participants were recruited by email and registered through an online form. Group interviews were conducted with:

- long-term services and supports screeners at local health departments and local departments of social services, including adult services and Adult Protective Services social workers and public health nurses;
- area agency on aging caregiver support staff;
- emergency medical services providers;
- home care organization administrators;
- home care organization scheduling coordinators; and
- home care organization care coordinators and direct care staff.

Topics varied by group but generally covered the supply, quality, and affordability of assisted living and in-home care in participants' areas; the challenges participants encounter in their work; and opportunities to improve services for aging Virginians. Screeners were also asked about the screening process and the options available to individuals who screen as eligible for long-term services and supports.

Surveys

Five surveys were conducted for this study: (1) a survey of assisted living facility administrators, (2) a follow-up survey of assisted living facility administrators on staffing levels and affordability, (3) a survey of VDSS licensing inspectors, (4) a survey of local department of social services and area agency on aging staff, and (5) a survey of Virginia's AAAs to determine whether they utilize a care registry or similar tool. The two surveys of facility administrators were conducted several months apart.

Survey of assisted living facility administrators

JLARC electronically administered a survey to administrators of all licensed assisted living facilities in Virginia for which VDSS caseload data included accurate contact information (approximately 460). The Virginia Assisted Living Association also shared the survey with the entirety of its membership. Administrators responsible for more than one facility were asked to respond on behalf of a single facility of their choosing and were informed that their responses would not be attributed to them or their facility.

JLARC received 160 responses from assisted living facility administrators; 149 of the responses were full and another 11 were partial but had answered a sufficient number of questions to be used for at least portions of the analysis.

Survey topics included facility capacity and census, including licensed capacity, staffed capacity, occupancy by level of care, and waitlists; the auxiliary grant program, including whether the facility accepts recipients, the reasons for that decision, and whether the rate covers facility costs; resident acuity; whether Virginia's regulatory standards related to staffing, standards unrelated to staffing, and stand-

ards for safe, secure environments need to change; the workforce, including the difficulty of maintaining qualified staff by position type and the use of contract staff; the administrator licensing process; facility quality, including quality measures tracked internally and third-party accreditation; and oversight by DOLP, including monitoring inspections, complaint and self-report investigations, and inspector communication.

Follow-up survey of assisted living facility administrators on staffing and affordability

JLARC electronically administered a follow-up survey focused on assisted living facility (ALF) staffing and affordability to administrators of all licensed assisted living facilities in Virginia for which VDSS caseload data included accurate contact information (approximately 460). The Virginia Assisted Living Association also shared the follow-up survey with the entirety of its membership. JLARC received 60 responses.

The follow-up survey collected the number of residents at each level of care and asked administrators to report direct care staffing hours scheduled for the overnight, day, and evening shifts on the Monday of the most recent week, by staff type. It also asked what arrangements the facility has for registered nurse and licensed practical nurse coverage, how the facility determines how many direct care staff hours to schedule, and whether it can meet its targeted staffing levels.

The survey further asked whether the facility offers financial aid to residents and which of several potential state actions would be most likely to lead the facility to accept more auxiliary grant recipients or to offer lower monthly charges to lower-income residents. Options included a higher auxiliary grant rate, rates that vary by level of care, a Medicaid waiver covering care but not room and board, simplified paperwork and faster payment, grants or low-interest loans for facility repairs, tax relief, and wage supplements for direct care staff.

Survey of VDSS licensing inspectors

JLARC electronically administered a survey to all VDSS licensing inspectors who inspect ALFs. Inspectors were presented with a list of each facility on their caseload as of March 31, 2026, and asked to indicate their level of concern about the overall quality of each facility, which factors contribute most to those concerns, whether facility ownership type is related to quality, and what accounts for quality at facilities they considered to be high performing.

Additional survey topics included whether Virginia's regulatory standards need to change and which are of greatest concern; whether staff-related requirements are too lenient or too strict; inspector workload and caseload size; inspectors' ability to conduct mandated monitoring inspections and investigate self-reports and complaints in a timely manner; sufficiency of regional office staffing and agency support; the effect of licensing software systems on inspectors' work; the adequacy of policies, guidance, and training; and consistency across inspectors. JLARC received responses from all 31 licensing inspectors that inspect ALFs (100 percent response rate).

Survey of local department of social services and area agency on aging staff

JLARC electronically administered a survey to staff of local departments of social services (LDSS) and area agencies on aging (AAA), directed to the staff member at each agency most familiar with the

quality of ALFs in the agency's service area. Respondents were permitted to consult other staff but asked to submit a single response for the agency, and included long-term care ombudsmen, AAA directors, LDSS directors, Adult Protective Services workers, care coordinators, and social workers.

Respondents were presented with a list of the assisted living facilities in their service area and asked to indicate their level of concern about the overall quality of each. The survey also asked about the factors that influence assisted living facility quality, how effectively state and local entities ensure facility quality and what is needed to improve the process for submitting, investigating, and resolving complaints. JLARC received responses from 75 of the 120 local departments of social services (63 percent) and 23 of the 25 area agencies on aging (92 percent).

Care registry questionnaire to AAAs

JLARC administered a survey to all 25 area agencies on aging in Virginia to determine whether any AAAs maintain a care registry or similar tool. A care registry is a list of screened, independent (non-agency) caregivers that an AAA maintains and makes available to older adults and adults with disabilities who are looking for in-home help.

The survey asked whether each AAA currently maintains a care registry and, for AAAs that previously maintained one but discontinued it, why it was discontinued. AAAs that maintain a registry were asked approximately how many individual care providers are listed on it. AAAs that do not maintain a registry were asked whether they offer any other tool, resource, or program to help consumers locate or connect with in-home care providers; which forms of support would be most helpful if the state were to encourage AAAs to establish a registry; and whether there are barriers beyond resources that would make it difficult to establish or maintain one. JLARC received responses from 13 of the 25 AAAs (52 percent).

Information collection instruments

JLARC administered two information collection instruments.

Local department of social services and area agency on aging home-based services

The data collection instrument for local department of social services (LDSS) and area agency on aging (AAA) staff was administered electronically. JLARC received responses from 84 out of 120 LDSSs (70 percent) and 22 out of 25 AAAs (88 percent). JLARC requested that the staff member at each agency most familiar with their respective in-home services complete the survey. Respondents were permitted to consult other staff but were asked to submit a single response for the agency.

Respondents were asked to report information about the types of services provided by their organization (e.g., homemaker, companion, and/or chore services), hourly rates of pay to providers, and the level of unmet need for in-home services in their service areas. Unmet need was defined as the number of adults who are eligible for, but not receiving, in-home services from AAAs and/or LDSSs.

Home care organization licensure and oversight data

JLARC sent a structured information request to the home care division staff within VDH's Office of Licensure and Certification (OLC), which asked for the best available operational data by fiscal year and instructed staff to provide a reasonable estimate where exact figures were unavailable.

The request collected data on initial license inspections and biennial surveys, including the number of organizations on each backlog, and the longest time an organization had been waiting; the status of recent complaint investigations; history of enforcement actions taken against HCO licenses; and the proportion of investigations and surveys resulting in a corrective action plan. To support an analysis of office workload and staffing, the request also collected a roster of active medical facilities inspectors, vacant inspector positions, workload estimates of how many inspections an inspector could complete monthly by inspection type, and license renewals due in each month from July 2026 through June 2029. JLARC also requested inspector training and quality control materials, as well as available analysis of the office's staffing needs.

Assisted living facility charges & fees and operating costs data collection

JLARC sent two data collection instruments to a random sample of assisted living facility administrators, selected to be representative of facilities statewide. The first instrument collected each facility's current monthly charges and fees by room type, and the second instrument collected monthly operating expenses. Administrators completed each instrument as a spreadsheet and returned it by email. Because the information requested is proprietary, responses were kept confidential and were not attributed to a specific facility or operator.

Data collection and analysis

JLARC collected data from VDSS, VDH, DARS, DMAS, and DHP to analyze for this study. JLARC also analyzed publicly available data from the U.S. Census Bureau and other federal and national sources and contracted for a demographic analysis of Virginia's older adult population.

Partnership with Weldon Cooper Center at the University of Virginia (throughout report)

JLARC contracted with the University of Virginia's Weldon Cooper Center for Public Service to prepare a custom dataset of demographic, economic, and health indicators for Virginia's older adult population, aggregated primarily to the state's 25 Planning and Service Areas (PSAs) (with certain housing cost indicators provided at the county level).

The Weldon Cooper Center's Demographics Research Group compiled the dataset from the American Community Survey (ACS) Special Tabulations on Aging (2019–2023) published by the Administration for Community Living and from the ACS 5-Year Estimates (2019–2023) published by the U.S. Census Bureau. Variables covered population by age, sex, and race; family and living arrangement; poverty status; individual and family income; housing tenure, mortgage status, and housing cost burden; disability status and type; and health insurance coverage. Most variables were provided for the 65-and-older population overall and for three 10-year age groups (65–74, 75–84, and 85+). Estimates in the dataset are based on the ACS sample and are subject to sampling error; the Weldon Cooper Center reported a standard error alongside each estimate and suppressed values for geographic areas or subpopulations with insufficient sample sizes.

JLARC used a dataset provided by the University of Virginia's Weldon Cooper Center for Public Service to analyze the demographics of Virginia's older adult population. This analysis described older adults' physical characteristics and economic status, including individual income and family median income, and identified the overall level of need in each region of the state. JLARC also used the data to compare the supply and cost of assisted living and in-home care in each region with older adults' potential demand for these services and their ability to pay for them (more information in sections below).

Analysis of Virginia's aging population demographics (Chapter 1)

The size, characteristics, and projected growth of Virginia's older adult population statewide and in each of the state's 25 Planning and Service Areas (PSAs) were analyzed. Analyses included population totals by age, sex, and race; the proportion of older adults living alone; and the proportion of older adults with an ambulatory difficulty, a cognitive difficulty, a self-care difficulty, or an independent living difficulty. This analysis was largely based on datasets provided by the Weldon Cooper Center (see previous section).

In addition, JLARC calculated a combined ranking of "overall" need in each PSA, based on that PSA's average rank across six measures: the proportion of the population age 85 and older, the proportion of older adults living alone, and the four physical characteristic measures above. Estimates were drawn from the Weldon Cooper Center dataset described above and the U.S. Census Bureau 2024 ACS 5-year estimates.

JLARC compared Virginia's aging population to all 49 other states and D.C. on several measures using 2024 ACS 5-year estimates.

Population projections through 2050 were drawn from the Weldon Cooper Center's Virginia Population Projections. JLARC used population projections published in July 2025 by the Demographics Research Group at the University of Virginia's Weldon Cooper Center for Public Service to estimate how Virginia's aging population will change through 2050.

Analysis of assisted living facility supply and demand (Chapter 2)

JLARC used VDSS licensing and active caseload data and responses from JLARC's survey of assisted living facility administrators to analyze facility occupancy, staffed capacity, and waitlists. JLARC calculated average facility census as a percentage of total licensed capacity and as a percentage of staffed capacity, for each of five facility size groupings, as weighted averages. Staffed capacity — the maximum number of residents a facility could safely care for given its current staffing levels — was reported by facility administrators through JLARC's survey. JLARC also calculated the percentage of facilities maintaining a waitlist, overall and by level of care; the average size of facility waitlists as a percentage of occupied beds; and the extrapolated statewide total of individuals on assisted living waitlists, for all assisted living beds and for memory care beds specifically.

JLARC used VDSS licensure data on assisted living facilities and their licensed bed capacity, adjusted using census data reported by facilities in JLARC's survey of assisted living administrators, to estimate the statewide and regional distribution of occupied assisted living beds and facilities across Virginia. To adjust for the difference between licensed capacity and typical use, JLARC grouped all licensed

facilities into five size tiers based on licensed capacity. For each tier, JLARC calculated the average facility census as a percentage of licensed capacity using responses from JLARC's administrator survey. JLARC then applied each tier's average utilization rate to the licensed capacity of all facilities in the corresponding tier to produce an estimated statewide bed supply. JLARC aggregated adjusted bed counts and facility counts by planning and service area (PSA), Virginia's 25 regional planning areas that correspond to area agencies on aging. Total assisted living beds were calculated as the sum of residential level of care, assisted living level of care, and safe, secure (memory care) level of care beds. JLARC used 2023 ACS 5-year population estimates, prepared for JLARC by the Weldon Cooper Center, to calculate beds per 1,000 adults age 65 and older and facilities per 10,000 adults age 65 and older, by PSA.

Using the same size-tier census adjustment described above, JLARC calculated an estimated statewide supply of safe, secure (memory care) level of care beds from VDSS licensure data. JLARC used 2023 ACS 5-year estimates of adults age 65 and older with a cognitive difficulty, prepared for JLARC by the Weldon Cooper Center, to calculate memory care beds per 1,000 older adults with cognitive difficulty, by PSA.

To compare assisted living supply to older adult need by region, JLARC staff ranked Virginia's 25 PSAs on both supply and need and compared the two rankings. JLARC staff ranked each PSA by its average ranking across two per capita measures of assisted living supply—beds per capita older adults and facilities per capita older adults—and by its average ranking across six individual measures of older adult need (Chapter 1). Supply measures were calculated from adjusted VDSS licensure data and 2023 ACS 5-year estimates prepared for JLARC by the Weldon Cooper Center. Need measures were calculated from 2024 ACS 5-year estimates. JLARC staff identified PSAs that rank below the statewide median for supply but above the statewide median for need.

Analysis of in-home care supply and demand (Chapter 2)

JLARC used home care organization (HCO) data from the Virginia Department of Health's Office of Licensure and Certification (OLC) to analyze the statewide and regional distribution of the supply of non-skilled in-home care. OLC data identified the locations of HCO main and branch offices and the number of direct care staff (self-reported number of "CNAs and home attendants") reported by each active HCO, as of June 2026. Because an HCO's service area can extend beyond the locality of its office, JLARC staff assigned each HCO's supply to the planning and service area (PSA)—Virginia's 25 regional planning areas that correspond to area agencies on aging—in which its main and branch offices are located. This approach likely overstates supply in PSAs served by small, single-locality HCOs and understates it in PSAs served by HCOs based elsewhere. JLARC aggregated active HCO counts and reported direct care staff counts by PSA and calculated HCOs per 10,000 adults age 65 and older and direct care workers per 10,000 adults age 65 and older, using 2023 ACS 5-year population estimates prepared for JLARC by the Weldon Cooper Center.

Because data on private-pay in-home care is not available, JLARC staff used data on publicly funded in-home care programs as additional measures of supply. JLARC staff used Department of Medical Assistance Services (DMAS) data on recipients of Medicaid agency-directed and consumer-directed in-home care through Commonwealth Coordinated Care Plus (CCC Plus), and DARS data on in-home care provided through area agencies on aging (AAAs) and local departments of social services

(LDSSs) in FY25. JLARC staff calculated recipients per 1,000 adults age 65 and older for each program by PSA, using the same ACS population estimates.

In addition, JLARC used OLC data on initial home care license applications for FY23 through FY26 to analyze recent growth in the number of HCOs and the geographic distribution of that growth. JLARC staff calculated the share of new HCOs located in the localities that already had the largest numbers of HCOs, and the share of the statewide older adult population in those localities.

To compare in-home care supply to older adult need by region, JLARC staff ranked Virginia's 25 PSAs on both supply and need and compared the two rankings. JLARC staff ranked each PSA by its average ranking across five per capita measures of in-home care supply—HCO providers, HCO direct care workers, CCC Plus agency-directed recipients, CCC Plus consumer-directed recipients, and AAA or LDSS recipients—and by its average ranking across six individual measures of older adult need (Chapter 1). Supply measures were calculated from VDH OLC home care organization data, DMAS Commonwealth Coordinated Care Plus data, AAA and LDSS in-home care data, and 2023 ACS 5-year estimates prepared for JLARC by the Weldon Cooper Center. Need measures were calculated from 2024 ACS 5-year estimates. JLARC staff identified PSAs that rank below the statewide median for supply but above the statewide median for need.

Analysis of CCC Plus data

JLARC analyzed Department of Medical Assistance Services (DMAS) claims data for personal care and respite care delivered through the Commonwealth Coordinated Care (CCC) Plus program, focusing on recipients age 65 and older. The data covered state fiscal years 2021 through 2025, based on claim paid date, and excluding Medicare crossover claims. Staff used the data to describe the number of recipients by service type (agency-directed and consumer-directed personal care, and agency-directed and consumer-directed respite care), total spending by service type, and recipient age and locality. Staff also analyzed weekly hours of agency-directed personal assistance and the duration of care by PSA, the number of provider organizations serving recipients age 65 and older by fiscal year, and the distribution of reimbursed hours and payments across providers.

Analysis of the in-home care workforce (Chapter 2)

JLARC analyzed Virginia Works (Department of Workforce Development and Advancement) data on personal care/home health aides and certified nurse aides to identify workforce trends over the past 10 years, and benchmarked wages against those in comparable industries. Staff also used federal Bureau of Labor Statistics data to compare the rate of growth and pay scale for direct care providers against national benchmarks.

Analysis of Medicaid in-home care reimbursement rates (Chapter 2)

JLARC analyzed the Medicaid reimbursement rate for CCC Plus agency-directed personal care and its relationship to the supply of participating HCOs. JLARC used DMAS data on the number of older adults receiving agency-directed in-home care and associated spending for SFY25, and on the number and share of HCOs paid for personal care services through CCC Plus by PSA for FY21 through FY25. JLARC staff compared the CCC Plus agency-directed reimbursement rate from 2021 through 2026 against growth in the Consumer Price Index and the Virginia minimum wage and compared the

scheduled reimbursement rate and minimum wage increases through 2028 as established by the Appropriation Act. JLARC staff used the 2025 KFF Medicaid Home and Community-Based Services Survey to compare Virginia's hourly reimbursement rate for agency-directed personal care to those of other states. JLARC staff also analyzed DMAS spending on agency-directed personal care for FY24 through FY26 and the projected fiscal impact of the scheduled 2028 rate increase.

Analysis of assisted living facility quality and compliance (Chapter 3 and Chapter 5)

JLARC staff compiled a facility-level dataset to assess the quality of Virginia's licensed assisted living facilities. The dataset combined Virginia Department of Social Services (VDSS) facility characteristics and facility-level licensing violation data for 2025, VDSS enforcement records, and VDSS complaint and self-reported incident data, together with Adult Protective Services (APS) complaint data maintained by the Department for Aging and Rehabilitative Services for 2023 through 2025 and complaint data from the Office of the State Long-Term Care Ombudsman. JLARC also used results from its surveys of VDSS licensing inspectors, area agencies on aging staff, and local department of social services staff.

JLARC staff used this dataset to identify facilities with potential quality concerns. Specifically, JLARC staff assessed each facility across five potential quality indicators: total violations, serious violations, having been cited for C-3 violations (the highest risk level on VDSS's risk assessment scale), substantiated incidents (based on VDSS and founded APS complaints), and stakeholder concern. For the total violations, serious violations, and substantiated incident criteria, JLARC staff identified facilities that were outliers by comparing each facility to other facilities of similar size and flagging values more than 1.5 times the interquartile range above the third quartile. Facilities were further flagged if they had any C-3 violations or if survey respondents unanimously identified the facility as having quality concerns. This methodology identified 122 ALFs as having quality concerns. JLARC staff then identified the share of total violations, serious violations, and substantiated violations these facilities accounted for in 2025.

Stakeholder concerns about facility quality aligned with VDSS licensing violations. Facilities that AAA staff, LDSS staff, or VDSS licensing inspectors identified as having quality problems on JLARC's surveys were cited for 4.6 more violations, on average, in 2025 than facilities not identified by any group. Facilities identified by two or more groups were cited for 8.1 more violations, on average.

JLARC staff then assessed whether facility characteristics (licensing region, licensed capacity, whether the facility accepts the auxiliary grant, and whether it offers memory care) were related to the likelihood of having quality concerns. When analyzing quality by facility characteristics, JLARC staff evaluated each facility against facilities of similar size. Staff grouped facilities into four categories by licensed capacity: 20 or fewer residents, 21 to 50 residents, 51 to 100 residents, and 101 or more residents. These categories align with the classifications VDSS uses to determine the number of resident records to review during inspections. JLARC staff did not identify a relationship between facility size and the likelihood of quality problems. JLARC staff did identify a relationship between licensing region and average number of violations per facility, which also informed findings in Chapter 5.

JLARC staff then identified the worst performers within each size category of facilities with quality concerns and manually reviewed the 17 facilities (2.9 percent of all facilities) that performed substantially worse than the rest, including their inspection records, complaints filed against the facility, and any state sanctions. All facilities were ranked across various quality indicators from 2025, including LTCO complaints, C-3 violations, total VDSS violations, serious violations (B-2, B-3, C-2, C-3), and verified incidents (VDSS complaints resulting in a violation and verified APS complaints). The 17 facilities identified ranked either within the top 10 (having most violations) across all 580 of Virginia's ALFs, or within the top three among facilities of a similar size based on licensed capacity (20 or fewer residents, 21 to 50 residents, 51 to 100 residents, and 101 or more residents). Like with the 122 facilities of concern, JLARC staff then identified the share of total violations, serious violations, and substantiated violations these 17 facilities accounted for in 2025.

JLARC also analyzed statewide licensing violation data from 2023 to 2025 to identify trends in ALF compliance. Specifically, JLARC staff used this data to identify which regulatory categories and specific standards were cited most often across all facilities and how violation concentration changed over time. Staff also used violation data from 2025 to analyze the distribution of total and severe violations across all ALFs, as well as the average and median of total and severe violations. Previous years of violation data were not used for this same purpose because facility-level records were incomplete.

Analysis of staffing information from follow-up survey of ALF administrators (Chapter 4)

JLARC staff analyzed responses from the follow-up survey of ALF administrators to identify direct care staffing levels and practices at a sample of 60 Virginia facilities. Staff calculated direct care hours per resident day for each responding facility by dividing the total direct care staff hours the facility reported scheduling across the overnight, day, and evening shifts on the Monday of the most recent week by the number of residents reported in the residential and assisted living levels of care, and grouped facilities into quartiles to describe the range of staffing levels across the sample. Staff also calculated the percentage of facilities reporting each type of registered nurse (RN) and licensed practical nurse (LPN) arrangement, the average weekly hours an RN was physically present among facilities with an RN on staff or under contract, and the percentage reporting each approach to setting staffing hours; because facilities could report more than one nurse arrangement or staffing approach, these percentages are not mutually exclusive.

Analysis of state oversight of assisted living facilities (Chapter 5)

JLARC reviewed VDSS licensing reports to determine whether initial applications are processed in a timely manner and whether mandated inspections were completed on time. JLARC staff analyzed regional licensing application data from FY24 through FY26 to identify the median application processing time by region. JLARC staff also reviewed regional inspection records for FY26 to determine the percentage of mandated inspections completed within the fiscal year.

JLARC staff also analyzed VDSS licensing complaint and self-reported incident data to assess trends in volume between FY25 and FY26. JLARC staff attempted to use this data to evaluate the timeliness of complaint investigations and resolutions, but data quality issues prevented staff from drawing conclusions.

JLARC staff also reviewed data from the Long-Term Care Ombudsman and Adult Protective Services on complaints involving assisted living facilities for calendar year 2021 through 2025. JLARC staff analyzed overall trends in the volume of complaints received and substantiated, as well as trends in facility-level complaints.

Analysis of enforcement actions (Chapter 5)

JLARC analyzed VDSS enforcement cases against facilities to determine how frequently each sanction is used, how frequently enforcement cases involved serious harm (e.g., injury or death) or resident elopements, and whether facilities subject to enforcement were cited for the same or similar violations in later years. JLARC used VDSS enforcement data for FY22 through FY25, which included 76 enforcement cases related to serious violations, and analyzed the frequency and average amount of civil penalties and the use of the mandated training sanction over that period. JLARC staff also reviewed data on ongoing enforcement cases as of FY26. JLARC staff also analyzed enforcement records to assess the time between inspection and sanction implementation, particularly for cases involving appeals.

Analysis of state oversight of home care organizations (Chapter 6)

JLARC collected staff perspectives from VDH OLC to determine the typical time required for a home care organization to move from initial application to active provider status and to renew a license. VDH OLC staff submitted a data collection instrument with their best estimates of key metrics, including the extent of backlogs in initial license inspections and biennial surveys, the office's inspection workload relative to staffing levels, and the prevalence of survey deficiencies and corrective action plans.

Partnership with and analysis of Genworth CareScout Cost of Care Survey data (Chapter 7)

For estimates of the cost of assisted living communities, in-home care, and other types of care described in the report, JLARC staff relied partially on data collected as part of the 2026 national CareScout Cost of Care Survey. The most recent CareScout Cost of Care methodology can be found here: https://www.carescout.com/cost-of-care.

JLARC staff used data from the 2026 CareScout Cost of Care Survey to estimate the cost of assisted living communities, in-home care, and other types of care in Virginia. CareScout, LLC, collected the data through a national survey of care providers and reported median private-pay rates by care category. Under a data license agreement, CareScout provided JLARC staff with Virginia-specific rates, including hourly rates for non-medical in-home care and monthly rates for assisted living communities, at the state and metropolitan statistical area (MSA) levels for 2025. JLARC staff used these rates to estimate the cost of assisted living and in-home care in Virginia and to compare Virginia's costs with national and regional figures.

Analysis of assisted living facility charges and operating costs (Chapter 7)

JLARC analyzed the operating costs and profit margins of Virginia's assisted living facilities using two data sources: (1) annual working budgets that facilities submit to the Virginia Department of Social Services (VDSS) when applying for initial licensure or a change of ownership (as required by §63.2-

1702 of the Code of Virginia), and (2) an operating costs data collection instrument that JLARC administered directly to facilities.

JLARC analyzed operating costs for 64 facilities to assess cost drivers, categorizing costs as personnel expenses, building and plant expenses, administrative expenses, employee training and travel, marketing, and other contractual costs. For the subset of 54 facilities with both operating costs and revenue data, JLARC calculated the net profit or loss margin as the percentage of net income (after accounting for all expenses, interest, and taxes) over revenue.

Analysis of older Virginians' income and assets (Chapter 7)

JLARC analyzed data from the U.S. Census Bureau's Survey of Income and Program Participation (SIPP) to estimate the assets available to older Virginians to pay for care, because income alone does not indicate whether an individual can afford it. JLARC used two sets of SIPP wealth tables reflecting data year 2024: state-level estimates of household assets by type, and national estimates of the same measures by age of the householder. JLARC analyzed net worth both including and excluding home equity, because home equity is generally not available to pay for ongoing care while an individual continues to live in the home. Because the Census Bureau does not publish household net worth for Virginians age 65 and older, JLARC applied the national estimates for households headed by an individual age 65 and older to Virginia's state-level asset data; estimates produced this way should be treated as approximate.

Analysis of assisted living affordability (Chapter 7)

JLARC assessed the affordability of assisted living in each of Virginia's 25 Planning and Service Areas (PSAs) using two measures.

The first measure compared the average monthly cost of assisted living in each PSA to individual monthly income for adults age 65 and older. Assisted living was considered affordable if the average monthly cost was less than 90 percent of an individual's monthly income. JLARC selected the 90 percent threshold because assisted living covers housing, utilities, food, and other costs that would otherwise consume most of a resident's monthly budget, and because it is at the upper end of the range of personal needs allowances used by states that fund assisted living subsidy programs.

The second measure calculated the average monthly cost of assisted living as a proportion of family median income for adults age 65 and older in each PSA. JLARC also estimated affordability for memory care in each PSA by adding 30 percent to the average assisted living cost, based on a review of peer-reviewed research and industry estimates. JLARC used 2025 assisted living cost data from the 2026 CareScout Cost of Care Survey and 2023 individual and family median income data for adults age 65 and older prepared for JLARC by the Weldon Cooper Center at the University of Virginia (adjusted to 2025 dollars).

To compare assisted living affordability to older adult need by region, JLARC staff ranked Virginia's 25 PSAs on both affordability and need and compared the two rankings. JLARC staff ranked each PSA by its average ranking across two measures of assisted living affordability—the share of older adults who can afford average assisted living costs at 90 percent of individual income, and average assisted living cost as a proportion of family median income—and by its average ranking across six

individual measures of older adult need (Chapter 1). Affordability measures were calculated from the 2026 CareScout Cost of Care Survey and 2023 individual and family median income estimates for adults age 65 and older prepared for JLARC by the Weldon Cooper Center (adjusted to 2025 dollars). Need measures were calculated from 2024 ACS 5-year estimates. JLARC staff identified PSAs that rank below the statewide median for affordability but above the statewide median for need.

Analysis of in-home care affordability (Chapter 7)

JLARC assessed the affordability of private pay in-home care in each of Virginia's 25 PSAs using three measures, at service levels of 10, 25, and 40 hours per week.

The first measure calculated the monthly cost of in-home care as a share of individual monthly income for adults age 65 and older and sorted the results into five cost-burden levels based on federal affordability benchmarks for childcare, health care, and housing. Because the American Community Survey does not specify exact incomes above $100,000, JLARC set income at $100,000 for all individuals with incomes above that threshold, which likely understates income for those individuals.

The second measure calculated the monthly cost of in-home care as a proportion of family median income for adults age 65 and older in each PSA.

The third measure estimated the maximum weekly hours of in-home care an older adult could afford after meeting basic living expenses. For this measure, JLARC subtracted expenses in the Elder Index, which is a measure of the income older adults need to cover basic living expenses, developed by the Gerontology Institute at the University of Massachusetts Boston, from individual monthly income to calculate excess funds available for in-home care. For the purposes of this analysis, Elder Index values assume an individual is single, owns a home with no mortgage, and is in poor health. This calculation was performed for a sample of 12 PSAs. JLARC used 2025 in-home care cost data from the 2026 CareScout Cost of Care Survey and 2023 individual and family income data for adults age 65 and older prepared for JLARC by the Weldon Cooper Center at the University of Virginia (adjusted to 2025 dollars).

To compare in-home care affordability to older adult need by region, JLARC staff ranked Virginia's 25 PSAs on both affordability and need and compared the two rankings. JLARC staff ranked each PSA by its average ranking across two measures of in-home care affordability—the share of older adults facing a cost burden of 30 percent or more of individual income for 10 hours of care per week, and the cost of 25 hours of care per week as a proportion of family median income—and by its average ranking across six individual measures of older adult need (Chapter 1). Affordability measures were calculated from the 2026 CareScout Cost of Care Survey and 2023 individual and family median income estimates for adults age 65 and older prepared for JLARC by the Weldon Cooper Center (adjusted to 2025 dollars). Need measures were calculated from 2024 ACS 5-year estimates. JLARC staff identified PSAs that rank below the statewide median for affordability but above the statewide median for need.

Analysis of the auxiliary grant program (Chapter 8)

JLARC analyzed auxiliary grant rates and recipient utilization from state fiscal years 2021 to 2025 to identify participation trends. JLARC compared the monthly auxiliary grant rate to the median monthly

operating costs and private-pay charges of assisted living facilities, and to the rates PACE programs pay facilities, to determine the extent to which the rate covers facility costs. JLARC also analyzed whether recent rate increases led to more facilities accepting auxiliary grant recipients or led participating facilities to add beds.

Review of Medicaid waiver options (Chapter 8)

JLARC reviewed federal requirements for section 1915(c) home and community-based services waivers and section 1115 demonstration waivers to identify options for modifying Virginia's existing waivers or applying for a new waiver to support assisted living or in-home care. JLARC reviewed 28 approved waiver applications (27 states plus Washington D.C.) through the Medicaid.gov State Waivers List to identify 1915(c) home and community-based waiver programs that support assisted living affordability. JLARC also reviewed the U.S. Government Accountability Office's 2026 report on federal spending and Medicaid coverage of assisted living services (GAO-26-107884), which found that 41 states' Medicaid programs covered assisted living services through a home- and community-based waiver as of March 2025.

Observations of facility inspections

JLARC observed three VDSS inspections of ALFs across the state to assess how licensing inspectors apply the state's safety and quality criteria and the extent to which written inspection policies and procedures are implemented in practice. JLARC staff accompanied licensing inspectors on facility tours, observed inspector interactions with ALF residents and staff, and participated in staff and resident file reviews. These observations allowed JLARC staff to evaluate the adequacy of the inspection process, to observe the operational challenges experienced by licensing inspectors, and to better understand the day-to-day operations of ALFs.

Review of assisted living and in-home care regulation in other states

JLARC compared Virginia's assisted living and in-home care statutes and regulations, oversight processes, and public assistance and affordability programs to those of other states. JLARC conducted high-level 50-state reviews for several specific topics (e.g., ALF staffing regulations, quality measurement systems), which were informed by third-party aggregations of other states' ALF regulations and practices, including the National Center for Assisted Living's (NCAL) Assisted Living State Regulatory Review. However, comparing every state's system across many domains of ALF and in-home care regulation was not feasible, so JLARC selected a sample of states for more detailed comparison. The criteria for selecting the sample were (i) whether the state is a neighbor or is in the mid-Atlantic region; (ii) whether the state has aging demographics similar to Virginia's; and (iii) whether the state has been cited by experts as a leader in the availability, affordability, or quality of assisted living or in-home care (Table B-1). JLARC compared Virginia to additional states for specific programs identified as promising practices.

TABLE B-1
Comparison states

State	Neighboring or regional state	Similar aging demographics	Cited by experts as a good example	Comparison for a specific purpose
DE	✓			
FL				✓ (large aging population)
MD	✓			
MN			✓	
NC	✓			
OH			✓	
OR			✓	
PA	✓			
WA		✓	✓	
WI			✓	

SOURCE: JLARC.

Review of documents and literature

JLARC also reviewed numerous other documents and literature, such as:

- Virginia laws, regulations, and policies relating to assisted living facilities and home care organizations, including the *Standards for Licensed Assisted Living Facilities*;
- VDSS and VDH licensing, inspection, and complaint investigation policies, procedures, manuals, and checklists;
- DARS service manuals for in-home care activities (chore, companion, and homemaker) and auxiliary grant annual reports;
- research literature on long-term care affordability and workforce retention, including reports from the Harvard Joint Center for Housing Studies and the Joint Commission on Health Care on rising costs and their effect on middle-income older adults;
- research literature on measuring quality in assisted living and other long-term care settings and factors influencing quality care;
- publications from national organizations specializing in assisted living and home care, including accreditation entities (e.g., The Joint Commission, CARF International), national industry associations (e.g., Argentum, ADvancing States, National PACE Association), and groups of subject-matter experts (e.g., Center for Excellence in Assisted Living at the University of North Carolina, The Assisted Living Workgroup, and the Long-Term Care Community Coalition); and
- other states' laws, regulations, policies, and processes related to assisted living facilities and in-home care, including those related to licensure, staffing, quality measurement, and public assistance programs.

Appendix C: Agency responses

As part of an extensive validation process, the state agencies and other entities that are subject to a JLARC assessment are given the opportunity to comment on an exposure draft of the report. JLARC staff sent an exposure draft of this report to the secretary of health and human resources, the Virginia Department of Social Services (VDSS), the Virginia Department of Health (VDH), the Virginia Department for Aging and Rehabilitative Services (DARS), and the Department of Medical Assistance Services (DMAS).

Appropriate corrections resulting from technical and substantive comments are incorporated in this version of the report. This appendix includes a response letter from VDSS, DARS, VDH, and the secretary of health and human resources.

COMMONWEALTH of VIRGINIA
DEPARTMENT OF SOCIAL SERVICES
Office of the Commissioner

S. Duke Storen
Commissioner

October 30, 2026

Dr. Hal E. Greer, Director
Joint Legislative Audit and Review Commission (JLARC)
919 E. Main Street, Ste. 2101
Richmond, VA 23219

Dear Director Greer:

Virginia Department of Social Services (VDSS) appreciates the opportunity to review and provide feedback on the exposure draft of the JLARC report, *Assisted Living and Non-skilled In-Home Care Services in Virginia*. VDSS applauds JLARC's collaborative approach and thorough review. VDSS agrees and concurs with the recommendations from JLARC and wishes to highlight several key areas.

Staffing Standards for Assisted Living Facilities (ALF)

Adding staffing requirements such as ratios or staffing patterns based on resident acuity would significantly improve the quality of care for residents in assisted living facilities (Recommendation 4). As noted in the report, there was consensus with stakeholder feedback and national research that quality and quantity of direct care staff significantly impact resident outcomes and the overall quality of care in assisted living facilities. VDSS has identified the need for additional levels of care to be described on the ALF license; an acuity-based staffing model would complement this change and allow accountability when staffing is insufficient.

Information Technology System Replacement

VDSS strongly supports Recommendations 9 and 10 which highlight the request for funding the replacement of the Division of Licensing Programs' (DOLP) current information technology system used to monitor and license assisted living facilities. The existing licensing system is outdated and no longer meets the operational needs of DOLP. The mobile inspection component is retired, there is no clear process to track complaints and self-reported incidents,

inspections are entered using manual data entry, all of which undermines the efficiency, consistency, and accuracy of VDSS' oversight and ability to track and analyze data. The requirements outlined in Recommendation 10 align with DOLP's previously identified system needs, and replacing the licensing system would substantially improve the workload of DOLP staff, freeing up inspectors to focus more on health and safety inspections. Without a modernized system, adding additional quality elements to the ALF website (Recommendations 3 and 13, Quality Policy Option 1) would be challenging and administratively burdensome. VDSS likely would need a later implementation date for the ALF website search page revisions unless significant financial resources are appropriated.

Licensing Inspection Consistency and Training

VDSS agrees with the need for greater consistency in licensing inspections and enhanced training for licensing staff (Recommendation 5). DOLP acknowledges that inspector turnover in the post-pandemic period contributed to variability in inspection practices and documentation. To strengthen consistency and support staff development across regions, DOLP created a clinical training team in 2025 and began structured new inspector training to be completed in the first year of orientation. DOLP held an internal training conference in October 2026 focused on standardizing inspection procedures, regulatory interpretation, and documentation practices. DOLP will host a follow-up training conference in 2027 to reinforce expectations, address evolving operational needs, and ensure sustained alignment with regulatory requirements and best practices.

Implementation Considerations and Fiscal Impact

VDSS notes that several recommendations, including ALF staffing ratios, additional licensing staff, establishing a special investigations unit, increasing mandatory inspections, replacing the outdated information system with the identified requirements, and displaying compliance and change of ownership history (Recommendations 3, 6, 7, 8, 9, 10, and 13) have significant fiscal impacts and will require robust increases in budgetary resources for VDSS. Successful implementation of these recommendations is contingent upon the availability of adequate resources and appropriations. VDSS decision packages for additional staff and funding the replacement of the licensing system are under consideration for the 2027 General Assembly session.

Thank you again for your thoughtful analysis and continued partnership in strengthening licensing, accountability, and the quality of care in assisted living facilities in Virginia.

Sincerely,

S. Duke Storen

S. Duke Storen

COMMONWEALTH of VIRGINIA

Department of Health
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State Health Commissioner

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October 30, 2026

Hal E. Greer, Director
Joint Legislative Audit and Review Commission (JLARC)
919 East Main Street
Richmond, VA 23219

Dear Mr. Greer:

Thank you for providing the Virginia Department of Health (VDH) with the opportunity to review the draft report, *Assisted Living and Non-Skilled In Home Care Services in Virginia*. I appreciate the thoroughness of the review and the opportunity to discuss its findings with your team.

VDH recognizes that lengthy delays in inspections and initial licensure, staffing and capacity constraints, and gaps in enforcement have weakened oversight of home care organizations (HCOs). These conditions require a sustained response. We agree with the report's central finding that the current system requires substantial improvement, and many of JLARC's recommendations align with VDH's own assessment and the direction of work already underway.

As we discussed during our recent meeting, VDH has begun work to strengthen this program. Our approach is organized around four connected strategies: restoring timely oversight, modernizing initial licensure, strengthening enforcement and accountability, and building sustainable operating capacity.

Restore timely oversight. VDH is pursuing a regional approach to HCO inspections, with provider caseloads assigned under two supervisors: one for Northern Virginia and one for the remainder of the Commonwealth. This approach is intended to reduce unnecessary travel, improve supervisory oversight, and make more efficient use of available inspection capacity. We are also establishing consistent inspection expectations and supervisory review while protecting capacity to respond to urgent health and safety concerns.

VDH is validating the overdue inspection inventory and assessing available staff capacity to establish monthly production targets and a projected backlog recovery horizon. We will review progress regularly and adjust our approach as capacity changes. We will also evaluate how client interviews and, where appropriate, home visits can be incorporated into inspections, including the staffing, privacy, and operational considerations needed to conduct them effectively.

Modernize initial licensure. VDH is working to separate application review and applicant communication from field inspection responsibilities so that inspectors can focus more of their time on inspections. We are also reviewing pending applications by stage and age to better manage the initial inspection queue.

Additional work in development includes standardized readiness checks and handoff materials, improved application status tracking, and clear instructions to help applicants understand licensure requirements and prepare for inspection. These changes are intended to reduce avoidable delays, support applicants in meeting requirements, and make more effective use of staff time.

Strengthen enforcement and accountability. VDH is working to improve the consistency of deficiency findings and follow-through on corrective action. This includes clearer responsibility for tracking correction plans, deadlines, verification, and unresolved cases.

We are also developing an HCO enforcement protocol that will establish review triggers, standard notices, legal review, and consistent documentation of decisions. As part of this work, VDH will review its existing enforcement authorities and identify any additional statutory or regulatory tools needed to support timely correction and appropriate escalation.

Build sustainable operating capacity. VDH is pursuing a request for 18 additional positions, including 14 medical facility inspectors, two supervisors, and two licensing or program-support positions. Additional staffing is necessary, but it must be accompanied by a stronger operating model and the training and systems needed to support staff.

VDH is working to improve inspector efficiency through licensing support, standard field guides, preceptors, and competency review. We are also developing improved workload measurement, tracking, and dashboards to support decisions about staffing and the deployment of resources as additional capacity becomes available.

VDH will continue to evaluate JLARC's recommendations, including their operational, legal, and resource implications, as we advance this work. We appreciate the report's contribution to identifying both the immediate actions and longer-term investments needed to strengthen oversight and protect Virginians who receive care in their homes.

Thank you again for the opportunity to review and respond to the draft report.

Sincerely,

Dr. Cameron Webb
State Health Commissioner

VDH VIRGINIA DEPARTMENT OF HEALTH

COMMONWEALTH OF VIRGINIA
DEPARTMENT FOR AGING AND REHABILITATIVE SERVICES

DR. NEDRA MONCRIEF-CRAIG
Commissioner

5620 Cox Road
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Toll free (800) 552-5019
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October 30, 2026

Mr. Hal E. Greer
Director
Joint Legislative Audit and Review Commission
919 East Main Street, Suite 2101
Richmond, VA 23219

Dear Mr. Greer:

Thank you for the opportunity to review and provide feedback on the Joint Legislative Audit and Review Commission's (JLARC) report on "Assisted Living and Non-skilled In-home Care Services in Virginia". These services are critical for many of the individuals the Department for Aging and Rehabilitative Services (DARS) serves.

We appreciate the time, attention, and hard work JLARC staff have taken to review these services that support individuals with disabilities and older Virginians. We commend you and your staff for the breadth and depth of the study but would like to provide some additional information, context, and clarity around several issues which center on Adult Protective Services (APS) and adult services; Area Agencies on Aging; the Auxiliary Grant; and the Long-Term Care Ombudsman.

Recommendation 1 - Expand In-Home Care Services to Older Adults who are Eligible but Not Currently Served

DARS partners with Area Agencies on Aging (AAAs) and local departments of social services (LDSS) to serve local communities. AAAs focus on older adults, while LDSS, through APS and adult services programs, serve both older adults and younger adults with an impairment or incapacity. The report mentions both AAAs and LDSS but primarily focuses on AAAs as referenced in Recommendation 1.

DARS appreciates the recognition of the crucial role AAAs play in helping older adults remain in their homes and communities. It is important to consider several points and to carefully draft a proposal for additional funding for in-home care services should that move forward. Currently, AAA funding is distributed based upon an intrastate funding formula (IFF) that was created in collaboration with the AAAs and approved by the Administration for Community Living (ACL). Consideration would need to be given as to how any additional funding would be allocated to the 25 AAAs. DARS recommends that the IFF be used for the distribution of any additional dollars that may be appropriated for in-home services through the AAAs. In addition, general fund dollars used to support community services for AAAs may go to other services outside of the non-skilled in-home care services reviewed by the report. These services are no less critical in supporting older adults in their homes and communities.

LDSS currently operates home-based services programs but also experiences some of the same funding limitations as AAAs. Adults who access these services through LDSS are able to remain at home and delay admission to more costly residential programs. However, DARS is concerned that the discussion of providing additional funding for in-home care at the local level only references AAAs and not LDSS. It is important to acknowledge that LDSS home-based care programs fill a critical gap outside of the AAA service population for many Virginians with limited resources.

Recommendation 3 – Publication of additional information on the Department of Social Services' (DSS) public-facing ALF search tool

Transparency can be a powerful tool in helping citizens make informed decisions. However, information can be misleading if it is inaccurate, out-of-date, or is one dimensional. Equipping individuals and families with better information regarding ALFs would be a valuable way to help them assess potential providers or monitor current providers. However, there are some important points to consider before adding information about auxiliary grant (AG) participating providers and substantiated APS investigations against facility employees to the search tool. First, there would need to be a mechanism by which to update AG participating providers. Listing a provider as participating in the AG program does not mean that the provider has an available AG bed. Some ALFs may only become AG providers after long-term residents deplete all of their resources, or they may only have one or two AG beds within the facility. In addition, listing substantiated APS investigations against facility employees may set up a pseudo-APS perpetrator registry, which creates questions around due process and legal ramifications.

Policy Option 2 – Change the Code of Virginia to allow for a direct cash assistance AG option

The AG program is governed by complex, often non-intuitive Social Security Administration (SSA) rules. One of the most common misconceptions about AG is that the full rate is the amount that the adult receives. In fact, the AG payment is a supplement amount added to the adult's countable income to bring them up to the $2130 rate. If a direct cash assistance program were authorized for the AG Program to support adults in their homes, the AG payment may not be adequate to fully meet the cost of home care in addition to housing, utilities, food, and other necessities.

Any proposals to develop another AG payment setting would need to be carefully crafted as well as funded. An additional setting would entail additional programmatic and administrative costs.

Thank you for the considerable time, effort, and expertise which the JLARC staff have dedicated to this thorough study. The collaborative nature in which staff engaged to understand programs and their nuances is greatly appreciated. DARS stands ready to respond to any additional questions or concerns.

Sincerely,

Dr. Nedra Moncrief-Craig

COMMONWEALTH of VIRGINIA
Office of the Governor

Marvin B. Figueroa
Secretary of Health and Human Resources

Dr. Hal E. Greer, Director
Joint Legislative Audit and Review Commission (JLARC)
919 E. Main Street, Ste. 2101
Richmond, VA 23219

Dear Mr. Greer:

Thank you for providing the Office of the Secretary of Health and Human Resources and our agencies with the opportunity to review and provide feedback on the Joint Legislative Audit Review Commission's (JLARC's) report, *Assisted Living and Non-skilled In Home Care Services in Virginia*. I appreciate your team's time, collaboration, and engagement in identifying the needs and opportunities for improvement within the Commonwealth's assisted living facilities (ALFs) and home care organizations (HCOs).

I believe strongly that our health and human resources system must be responsive to Virginians with long-term care needs, such as our seniors or individuals with conditions requiring complex care, to ensure they receive safe, appropriate, and high-quality care regardless of where that care is provided. At the foundation of our work is the belief that older Virginians deserve the opportunity to age with dignity and that any Virginian who has long-term care needs can choose a care setting that is right for them. Our systems, policies, and oversight practices must reflect these principles.

I agree with the report's central findings that our current system is not operating as intended and that we have work to do to ensure these principles are reflected in practice. The concerns raised in the report deserve serious consideration, and we recognize that improvements are necessary to strengthen the quality, consistency and accountability of services within these care settings.

The findings in the report align with the work that my office and our agencies have already begun to advance. We recognize that meaningful and lasting improvements require continued attention, collaboration, and accountability. Our agencies have provided dual responses, which I have included below, that outline some of the initiatives and actions underway for continued improvement.

In addition to these efforts, my office is giving significant attention to program integrity and where we can work together across our agencies to improve accountability, responsiveness, and oversight of our systems. We have made great strides within our nursing home system. Since taking office, we have increased timely nursing home inspections from 20% to 40%, published new sanctions guidance for

nursing home inspections, established interagency agreements across our agencies, and have established a road map to improve nursing home inspection backlogs by July 2027. Going forward, we will take the success of this work to address similar needs within other care settings.

My office remains committed to building on the progress already underway, addressing the challenges identified in the report, and strengthening our systems that support older Virginians, Virginians with complex care needs and their families.

Thank you again for your engagement and continued partnership in this important work.

Sincerely,

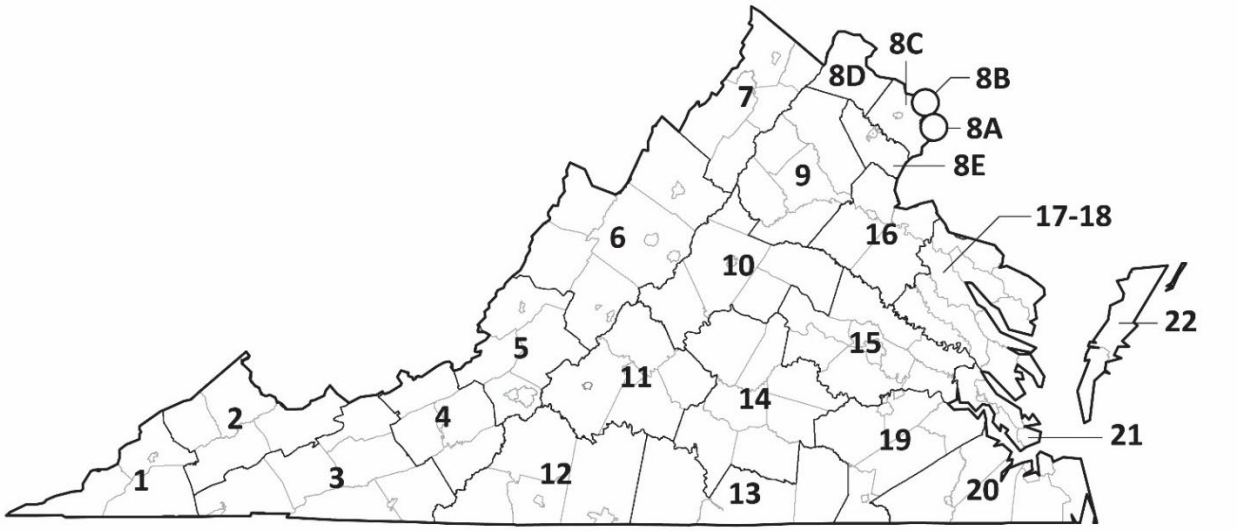


Marvin B. Figueroa
Secretary of Health and Human Services

Appendix D: Demographics of Older Virginians

This report primarily analyzes the demographics of older adults, along with the supply and affordability of assisted living and in-home care, at the planning and service area (PSA) level. Planning and service areas (PSAs) for aging programs are established federally by the Older Americans Act (42 U.S.C. § 3001 et seq.). As a result, PSAs are the geographic unit corresponding to Virginia's network of 25 area agencies on aging (AAAs). Because PSAs are officially identified only by number, and AAA names follow varied conventions, some geographic, others historical, organizational, or otherwise not descriptive of the area served, JLARC developed regional names to make references to individual PSAs more intuitive throughout the report. These names are used for readability purposes only and do not reflect any official designations.

FIGURE D-1
Virginia's planning and service areas (PSAs)



SOURCE: Planning and Service Areas (PSAs) for aging programs are established federally by the Older Americans Act (42 U.S.C. § 3001 et seq.).

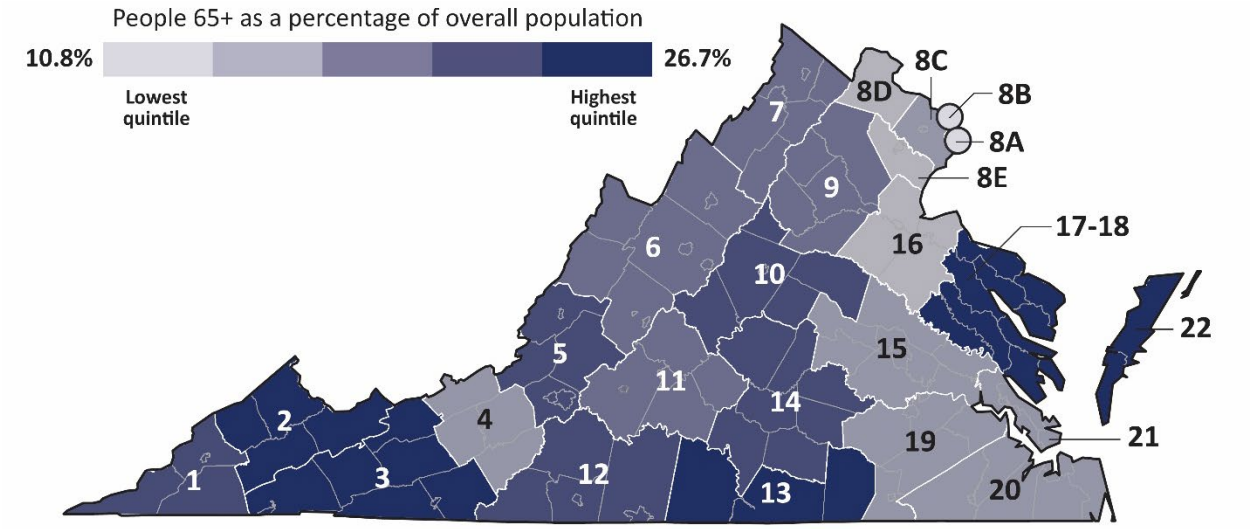
TABLE D-1
Total population age 65 and older by 10-year age bracket (2024)

PSA	Age 65 to 74 population	Age 75 to 84 population	Age 85+ population	Total age 65+ population
1 Far Southwest	10,841	5,568	1,893	18,302
2 Southwest Coalfields	13,752	7,647	2,055	23,454
3 Bristol-Galax	25,780	14,216	4,932	44,928
4 New River Valley	18,171	9,812	2,675	30,658
5 Roanoke Valley	33,375	17,175	7,617	58,167
6 Central Shenandoah	34,728	18,697	7,013	60,438
7 Northern Shenandoah	28,207	14,999	5,327	48,533
8A Alexandria	12,210	6,198	1,940	20,348
8B Arlington	16,672	8,315	3,136	28,123
8C Fairfax	104,270	54,880	18,568	177,718
8D Loudoun	27,091	14,848	4,955	46,894
8E Prince William	38,130	18,392	5,040	61,562
9 Rappahannock-Rapidan	20,346	11,288	3,247	34,881
10 Jefferson Area	31,499	15,176	5,899	52,574
11 Lynchburg	30,090	16,480	5,780	52,350
12 Martinsville-Danville	32,669	18,389	5,647	56,705
13 Southside	11,658	6,409	2,314	20,381
14 Southern Piedmont	12,177	6,330	2,412	20,919
15 Richmond	116,463	55,409	19,103	190,975
16 Fredericksburg	33,181	16,202	4,128	53,511
17/18 Nor. Neck-Mid. Peninsula	22,114	11,507	4,406	38,027
19 Tri-Cities	17,647	9,175	3,334	30,156
20 Hampton Roads	111,826	53,786	17,797	183,409
21 Peninsula	51,104	28,113	9,401	88,618
22 Eastern Shore	7,271	3,675	1,166	12,112
Total	**861,272**	**442,686**	**149,785**	**1,453,743**

SOURCE: U.S. Census Bureau 2024 American Community Survey 5-year estimates prepared for JLARC by Weldon Cooper Center at the University of Virginia.
NOTE: Regions are planning and service areas (PSAs), which correspond to local area agencies on aging. Names are used for readability purposes only and do not reflect any official designations. American Community Survey population estimates are subject to margins of error.

FIGURE D-2: Proportion of PSA population that is age 65+ (2024)

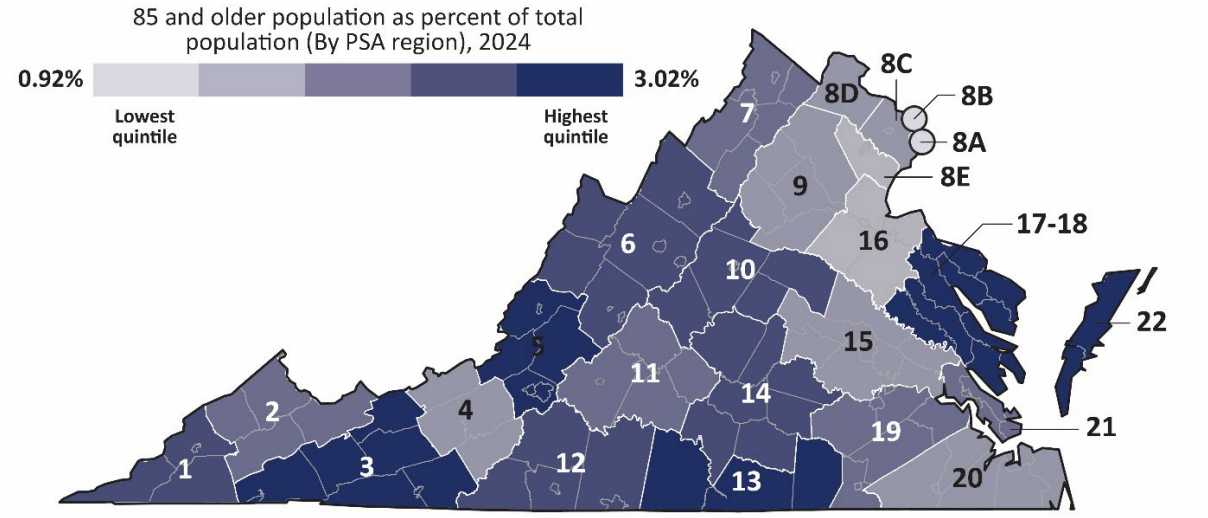
PSA	65+ population	Total population	65+ as a % of total population	Rank
1 Far Southwest	18,302	82,404	22.2%	7
2 Southwest Coalfields	23,454	98,310	23.9	5
3 Bristol-Galax	44,928	185,752	24.2	4
4 New River Valley	30,658	181,664	16.9	16
5 Roanoke Valley	58,167	280,395	20.7	8
6 Central Shenandoah	60,438	306,859	19.7	12
7 Northern Shenandoah	48,533	248,320	19.5	13
8A Alexandria	20,348	156,976	13.0	22
8B Arlington	28,123	236,254	11.9	23
8C Fairfax	177,718	1,187,573	15.0	20
8D Loudoun	46,894	432,998	10.8	25
8E Prince William	61,562	548,654	11.2	24
9 Rappahannock-Rapidan	34,881	188,267	18.5	14
10 Jefferson Area	52,574	264,315	19.9	10
11 Lynchburg	52,350	263,798	19.8	11
12 Martinsville-Danville	56,705	238,350	23.8	6
13 Southside	20,381	79,996	25.5	3
14 Southern Piedmont	20,919	101,287	20.7	9
15 Richmond	190,975	1,145,548	16.7	18
16 Fredericksburg	53,511	398,936	13.4	21
17/18 Nor. Neck-Mid. Peninsula	38,027	145,869	26.1	2
19 Tri-Cities	30,156	180,321	16.7	17
20 Hampton Roads	183,409	1,204,702	15.2	19
21 Peninsula	88,618	502,228	17.6	15
22 Eastern Shore	12,112	45,394	26.7	1
Total	**1,453,743**	**8,705,170**	**16.7**	



SOURCE: U.S. Census Bureau 2024 American Community Survey 5-year estimates.
NOTE: Regions correspond to planning and service areas (PSAs), which align with local area agencies on aging. Names are for readability only and carry no official designation. American Community Survey population estimates are subject to margins of error.

FIGURE D-3: Proportion of PSA population that is age 85+ (2024)

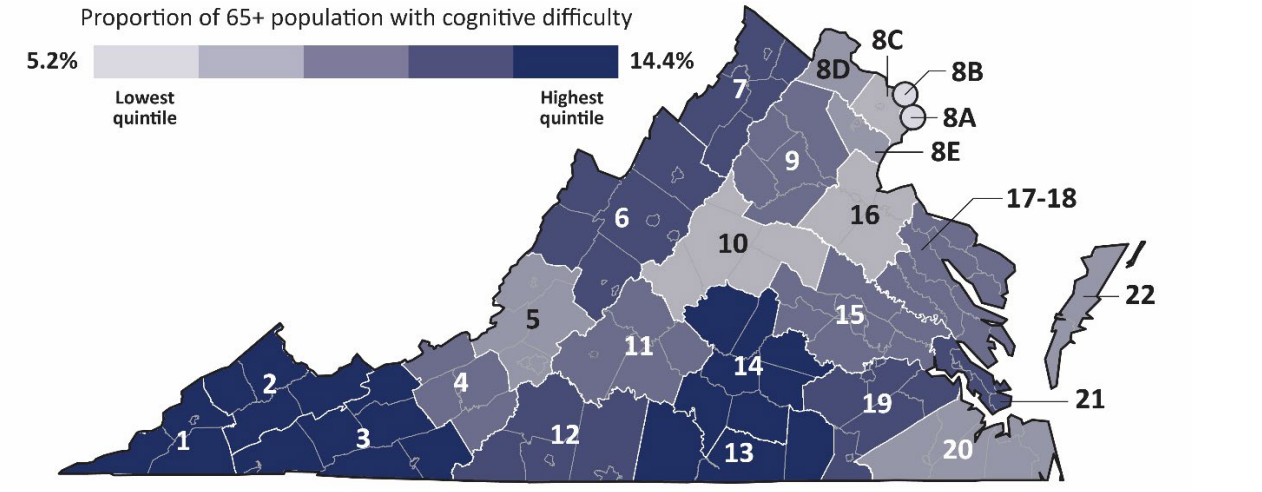
PSA	85+ population	Total population	85+ as a % of total population	Rank
1 Far Southwest	1,893	82,404	2.3%	8
2 Southwest Coalfields	2,055	98,310	2.1	13
3 Bristol-Galax	4,932	185,752	2.7	4
4 New River Valley	2,675	181,664	1.5	20
5 Roanoke Valley	7,617	280,395	2.7	3
6 Central Shenandoah	7,013	306,859	2.3	9
7 Northern Shenandoah	5,327	248,320	2.1	12
8A Alexandria	1,940	156,976	1.2	22
8B Arlington	3,136	236,254	1.3	21
8C Fairfax	18,568	1,187,573	1.6	18
8D Loudoun	4,955	432,998	1.1	23
8E Prince William	5,040	548,654	0.9	25
9 Rappahannock-Rapidan	3,247	188,267	1.7	16
10 Jefferson Area	5,899	264,315	2.2	10
11 Lynchburg	5,780	263,798	2.2	11
12 Martinsville-Danville	5,647	238,350	2.4	7
13 Southside	2,314	79,996	2.9	2
14 Southern Piedmont	2,412	101,287	2.4	6
15 Richmond	19,103	1,145,548	1.7	17
16 Fredericksburg	4,128	398,936	1.0	24
17/18 Nor. Neck-Mid. Peninsula	4,406	145,869	3.0	1
19 Tri-Cities	3,334	180,321	1.8	15
20 Hampton Roads	17,797	1,204,702	1.5	19
21 Peninsula	9,401	502,228	1.9	14
22 Eastern Shore	1,166	45,394	2.6	5
Total	**149,785**	**8,705,170**	**1.7**	



SOURCE: U.S. Census Bureau 2024 American Community Survey 5-year estimates.
NOTE: Regions correspond to planning and service areas (PSAs), which align with local area agencies on aging. Names are for readability only and carry no official designation. American Community Survey population estimates are subject to margins of error.

FIGURE D-4: Proportion of age 65+ population with cognitive difficulty by PSA (2023)

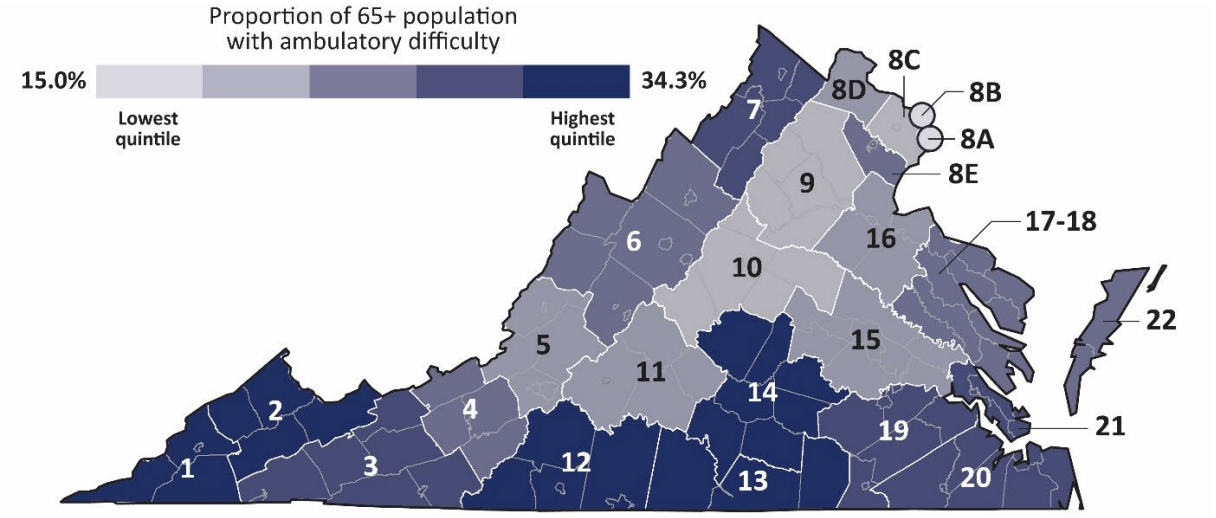
PSA	65+ population	65+ population with cognitive difficulty	With cognitive difficulty as a % of 65+ population	Rank
1 Far Southwest	18,260	2,625	14.4%	1
2 Southwest Coalfields	23,215	2,810	12.1	3
3 Bristol-Galax	44,225	4,015	9.1	5
4 New River Valley	30,155	2,125	7.0	14
5 Roanoke Valley	57,200	3,660	6.4	18
6 Central Shenandoah	58,900	4,785	8.1	8
7 Northern Shenandoah	46,895	3,710	7.9	9
8A Alexandria	19,720	1,035	5.2	25
8B Arlington	27,325	1,550	5.7	24
8C Fairfax	171,940	10,050	5.8	23
8D Loudoun	44,290	2,790	6.3	20
8E Prince William	58,735	4,010	6.8	16
9 Rappahannock-Rapidan	33,800	2,555	7.6	11
10 Jefferson Area	50,560	2,975	5.9	22
11 Lynchburg	51,065	3,700	7.2	12
12 Martinsville-Danville	55,995	4,745	8.5	7
13 Southside	20,110	1,845	9.2	4
14 Southern Piedmont	20,310	2,510	12.4	2
15 Richmond	184,080	13,120	7.1	13
16 Fredericksburg	51,315	3,185	6.2	21
17/18 Nor. Neck-Mid. Peninsula	37,100	2,565	6.9	15
19 Tri-Cities	29,765	2,635	8.9	6
20 Hampton Roads	177,590	12,005	6.8	17
21 Peninsula	85,775	6,625	7.7	10
22 Eastern Shore	11,825	745	6.3	19
Total	**1,410,150**	**102,375**	**7.3**	



SOURCE: U.S. Census Bureau 2023 American Community Survey 5-year estimates prepared for JLARC by Weldon Cooper Center at UVA.
NOTE: According to the U.S. Census Bureau, cognitive difficulty refers to serious difficulty remembering, concentrating, or making decisions because of a physical, mental, or emotional condition. Regions correspond to planning and service areas (PSAs), which align with local area agencies on aging. Names are for readability only and carry no official designation. American Community Survey population estimates are subject to margins of error.

FIGURE D-5: Proportion of age 65+ population with ambulatory difficulty by PSA (2023)

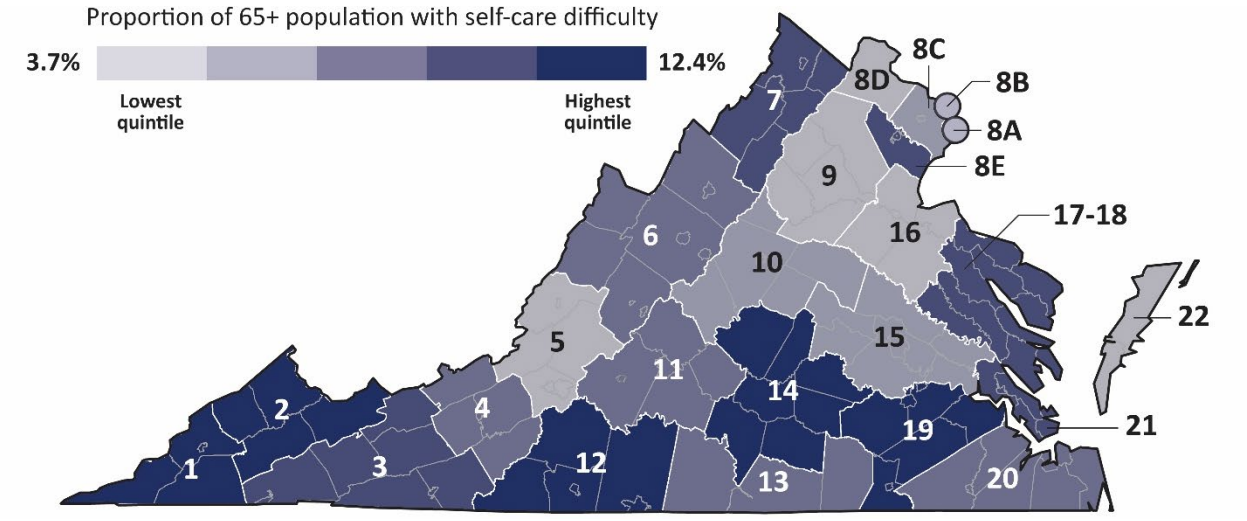
PSA	65+ population	65+ population with ambulatory difficulty	With ambulatory difficulty as a % of 65+ population	Rank
1 Far Southwest	18,260	6,255	34.3%	1
2 Southwest Coalfields	23,215	7,105	30.6	2
3 Bristol-Galax	44,225	10,075	22.8	6
4 New River Valley	30,155	5,775	19.2	13
5 Roanoke Valley	57,200	10,185	17.8	18
6 Central Shenandoah	58,900	11,615	19.7	11
7 Northern Shenandoah	46,895	9,760	20.8	9
8A Alexandria	19,720	2,960	15.0	25
8B Arlington	27,325	4,250	15.6	23
8C Fairfax	171,940	25,965	15.1	24
8D Loudoun	44,290	7,265	16.4	20
8E Prince William	58,735	10,835	18.4	15
9 Rappahannock-Rapidan	33,800	5,330	15.8	22
10 Jefferson Area	50,560	8,100	16.0	21
11 Lynchburg	51,065	9,140	17.9	17
12 Martinsville-Danville	55,995	13,105	23.4	5
13 Southside	20,110	4,810	23.9	4
14 Southern Piedmont	20,310	5,040	24.8	3
15 Richmond	184,080	33,850	18.4	16
16 Fredericksburg	51,315	8,845	17.2	19
17/18 Nor. Neck-Mid. Peninsula	37,100	6,850	18.5	14
19 Tri-Cities	29,765	6,585	22.1	7
20 Hampton Roads	177,590	36,020	20.3	10
21 Peninsula	85,775	18,125	21.1	8
22 Eastern Shore	11,825	2,330	19.7	12
Total	**1,410,150**	**270,175**	**19.2**	



SOURCE: U.S. Census Bureau 2023 American Community Survey 5-year estimates prepared for JLARC by Weldon Cooper Center at UVA.
NOTE: According to the U.S. Census Bureau, ambulatory difficulty refers to serious difficulty walking or climbing stairs. Regions correspond to planning and service areas (PSAs), which align with local area agencies on aging. Names are for readability only and carry no official designation. American Community Survey population estimates are subject to margins of error.

FIGURE D-6: Proportion of age 65+ population with self-care difficulty by PSA (2023)

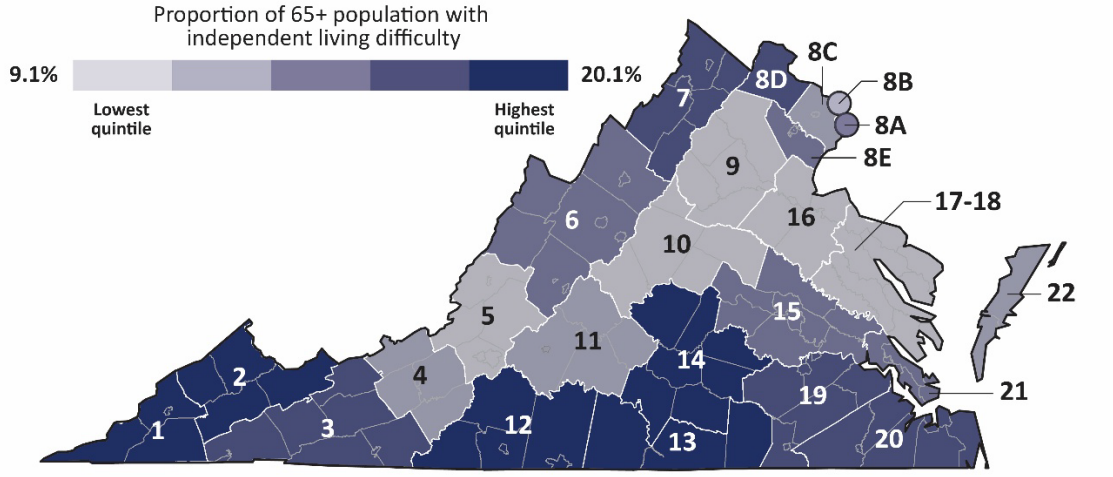
PSA	65+ population	65+ population with self-care difficulty	With self-care difficulty as a % of 65+ population	Rank
1 Far Southwest	18,260	2,270	12.4%	1
2 Southwest Coalfields	23,215	1,860	8.0	5
3 Bristol-Galax	44,225	3,505	7.9	6
4 New River Valley	30,155	1,980	6.6	14
5 Roanoke Valley	57,200	3,325	5.8	21
6 Central Shenandoah	58,900	3,860	6.6	15
7 Northern Shenandoah	46,895	3,220	6.9	10
8A Alexandria	19,720	1,230	6.2	18
8B Arlington	27,325	1,745	6.4	17
8C Fairfax	171,940	10,525	6.1	19
8D Loudoun	44,290	2,400	5.4	23
8E Prince William	58,735	4,395	7.5	7
9 Rappahannock-Rapidan	33,800	1,630	4.8	24
10 Jefferson Area	50,560	3,065	6.1	20
11 Lynchburg	51,065	3,460	6.8	13
12 Martinsville-Danville	55,995	4,545	8.1	3
13 Southside	20,110	1,370	6.8	11
14 Southern Piedmont	20,310	1,865	9.2	2
15 Richmond	184,080	11,795	6.4	16
16 Fredericksburg	51,315	2,895	5.6	22
17/18 Nor. Neck-Mid. Peninsula	37,100	2,595	7.0	9
19 Tri-Cities	29,765	2,405	8.1	4
20 Hampton Roads	177,590	12,055	6.8	12
21 Peninsula	85,775	6,190	7.2	8
22 Eastern Shore	11,825	435	3.7	25
Total	**1,410,150**	**94,620**	**6.7**	



SOURCE: U.S. Census Bureau 2023 American Community Survey 5-year estimates prepared for JLARC by Weldon Cooper Center at UVA.
NOTE: According to the U.S. Census Bureau, self-care difficulty refers to difficulty bathing or dressing. Regions correspond to planning and service areas (PSAs), which align with local area agencies on aging. Names are for readability only and carry no official designation. American Community Survey population estimates are subject to margins of error.

FIGURE D-7: Proportion of age 65+ population with independent living difficulty by PSA (2023)

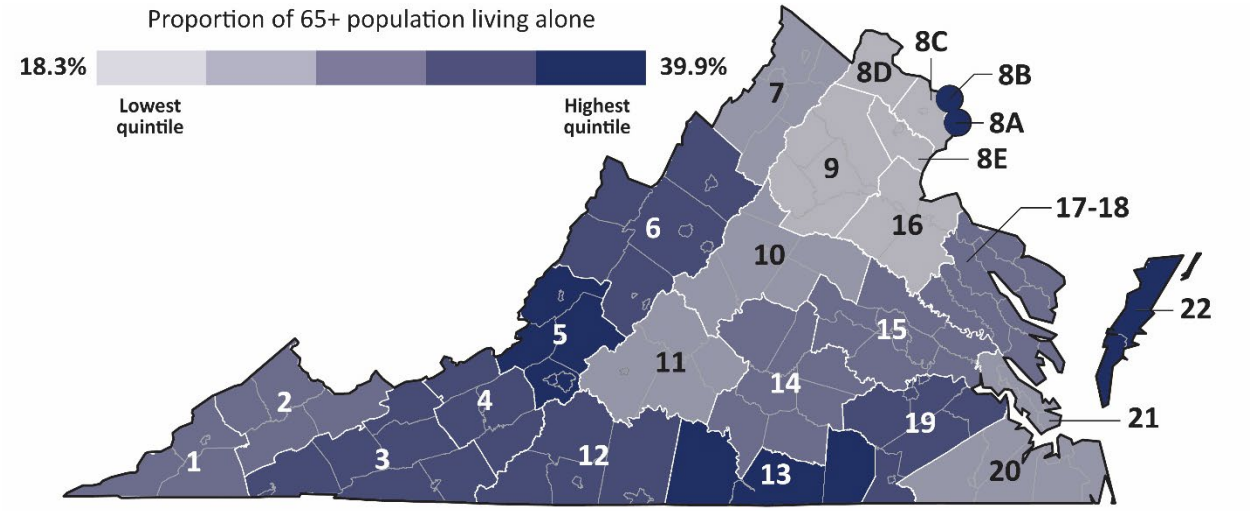
PSA	65+ population	65+ population with ind. living difficulty	With ind. living difficulty as a % of 65+ population	Rank
1 Far Southwest	18,260	3,675	20.1%	1
2 Southwest Coalfields	23,215	4,295	18.5	2
3 Bristol-Galax	44,225	6,270	14.2	7
4 New River Valley	30,155	3,420	11.3	20
5 Roanoke Valley	57,200	6,355	11.1	22
6 Central Shenandoah	58,900	7,385	12.5	12
7 Northern Shenandoah	46,895	6,320	13.5	8
8A Alexandria	19,720	2,435	12.3	13
8B Arlington	27,325	3,105	11.4	19
8C Fairfax	171,940	19,585	11.4	18
8D Loudoun	44,290	5,775	13.0	9
8E Prince William	58,735	7,250	12.3	14
9 Rappahannock-Rapidan	33,800	3,080	9.1	25
10 Jefferson Area	50,560	5,115	10.1	24
11 Lynchburg	51,065	6,060	11.9	16
12 Martinsville-Danville	55,995	8,355	14.9	5
13 Southside	20,110	3,020	15.0	4
14 Southern Piedmont	20,310	3,305	16.3	3
15 Richmond	184,080	21,975	11.9	15
16 Fredericksburg	51,315	5,810	11.3	21
17/18 Nor. Neck-Mid. Peninsula	37,100	4,050	10.9	23
19 Tri-Cities	29,765	4,230	14.2	6
20 Hampton Roads	177,590	22,515	12.7	10
21 Peninsula	85,775	10,770	12.6	11
22 Eastern Shore	11,825	1,360	11.5	17
Total	**1,410,150**	**175,515**	**12.4**	



SOURCE: U.S. Census Bureau 2023 American Community Survey 5-year estimates prepared for JLARC by Weldon Cooper Center at UVA.
NOTE: According to the U.S. Census Bureau, independent living difficulty refers to difficulty performing errands alone, such as visiting a doctor's office or shopping, because of a physical, mental, or emotional condition. Regions correspond to planning and service areas (PSAs), which align with local area agencies on aging. Names are for readability only and carry no official designation. American Community Survey population estimates are subject to margins of error.

FIGURE D-8: Proportion of age 65+ population living alone by PSA (2023)

PSA	65+ population	65+ population living alone	Living alone as a % of 65+ population	Rank
1 Far Southwest	18,260	5,105	28.0%	12
2 Southwest Coalfields	23,215	6,395	27.5	13
3 Bristol-Galax	44,225	13,335	30.2	6
4 New River Valley	30,155	9,035	30.0	7
5 Roanoke Valley	57,200	17,655	30.9	5
6 Central Shenandoah	58,900	16,740	28.4	10
7 Northern Shenandoah	46,895	11,690	24.9	20
8A Alexandria	19,720	7,860	39.9	1
8B Arlington	27,325	9,230	33.8	3
8C Fairfax	171,940	37,685	21.9	21
8D Loudoun	44,290	8,090	18.3	25
8E Prince William	58,735	11,295	19.2	24
9 Rappahannock-Rapidan	33,800	6,725	19.9	23
10 Jefferson Area	50,560	13,300	26.3	19
11 Lynchburg	51,065	13,445	26.3	18
12 Martinsville-Danville	55,995	16,670	29.8	8
13 Southside	20,110	6,975	34.7	2
14 Southern Piedmont	20,310	5,580	27.5	14
15 Richmond	184,080	51,725	28.1	11
16 Fredericksburg	51,315	10,880	21.2	22
17/18 Nor. Neck-Mid. Peninsula	37,100	10,065	27.1	15
19 Tri-Cities	29,765	8,685	29.2	9
20 Hampton Roads	177,590	47,885	27.0	17
21 Peninsula	85,775	23,165	27.0	16
22 Eastern Shore	11,825	3,745	31.7	4
Total	**1,410,150**	**372,960**	**26.4**	



SOURCE: U.S. Census Bureau 2023 American Community Survey 5-year estimates prepared for JLARC by Weldon Cooper Center at UVA.
NOTE: Regions correspond to planning and service areas (PSAs), which align with local area agencies on aging. Names are for readability only and carry no official designation. American Community Survey population estimates are subject to margins of error.

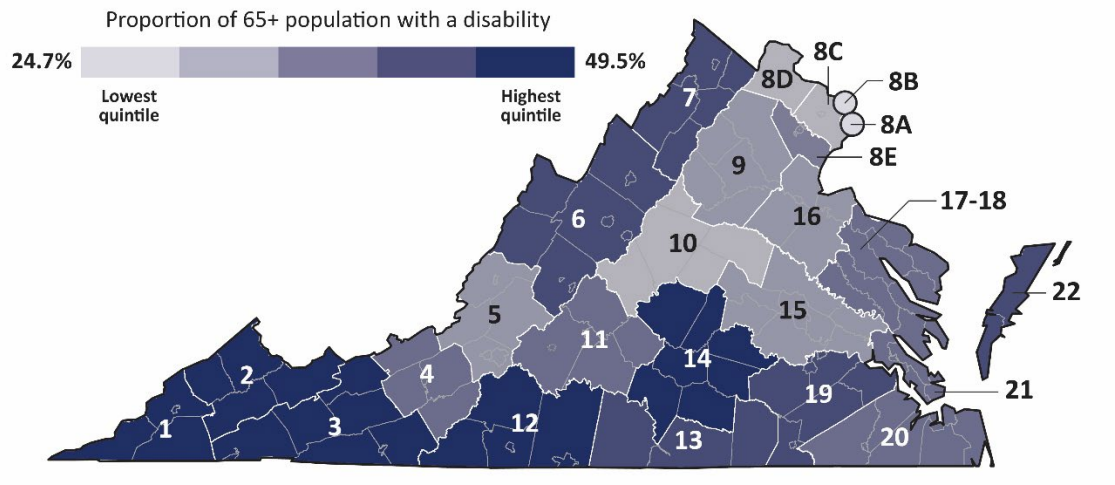
TABLE D-2: Overall need of older adults by PSA (2023)

PSA	Age 85+ rank Fig. D-3	Cognitive difficulty rank Fig. D-4	Ambula-tory difficulty rank Fig. D-5	Self-care difficulty rank Fig. D-6	Ind. living difficulty rank Fig. D-7	Living alone rank Fig. D-8	Overall need rank
1 Far Southwest	8	1	1	1	1	12	1
2 Southwest Coalfields	13	3	2	5	2	13	6
3 Bristol-Galax	4	5	6	6	7	6	4
4 New River Valley	20	14	13	14	20	7	16
5 Roanoke Valley	3	18	18	21	22	5	14
6 Central Shenandoah	9	8	11	15	12	10	8
7 Northern Shenandoah	12	9	9	10	8	20	10
8A Alexandria	22	25	25	18	13	1	19
8B Arlington	21	24	23	17	19	3	20
8C Fairfax	18	23	24	19	18	21	24
8D Loudoun	23	20	20	23	9	25	22
8E Prince William	25	16	15	7	14	24	18
9 Rappahannock-Rapidan	16	11	22	24	25	23	23
10 Jefferson Area	10	22	21	20	24	19	21
11 Lynchburg	11	12	17	13	16	18	14
12 Martinsville-Danville	7	7	5	3	5	8	5
13 Southside	2	4	4	11	4	2	2
14 Southern Piedmont	6	2	3	2	3	14	3
15 Richmond	17	13	16	16	15	11	16
16 Fredericksburg	24	21	19	22	21	22	25
17/18 Nor. Neck-Mid. Peninsula	1	15	14	9	23	15	11
19 Tri-Cities	15	6	7	4	6	9	7
20 Hampton Roads	19	17	10	12	10	17	13
21 Peninsula	14	10	8	8	11	16	9
22 Eastern Shore	5	19	12	25	17	4	12

SOURCE: U.S. Census Bureau 2023 American Community Survey 5-year estimates prepared for JLARC by Weldon Cooper Center at UVA.
NOTE: To calculate "overall need rank," each PSA's ranks on the six measures (figures D-3 through D-8) were averaged and PSAs were then ranked by that average. The "Age 85+ rank" column uses data from 2024, whereas all others use 2023 data. See Chapter 1 for a map depicting overall need by region. Regions correspond to planning and service areas (PSAs), which align with local area agencies on aging. Names are for readability only and carry no official designation. American Community Survey population estimates are subject to margins of error.

FIGURE D-9: Proportion of age 65+ population with a disability by PSA (2023)

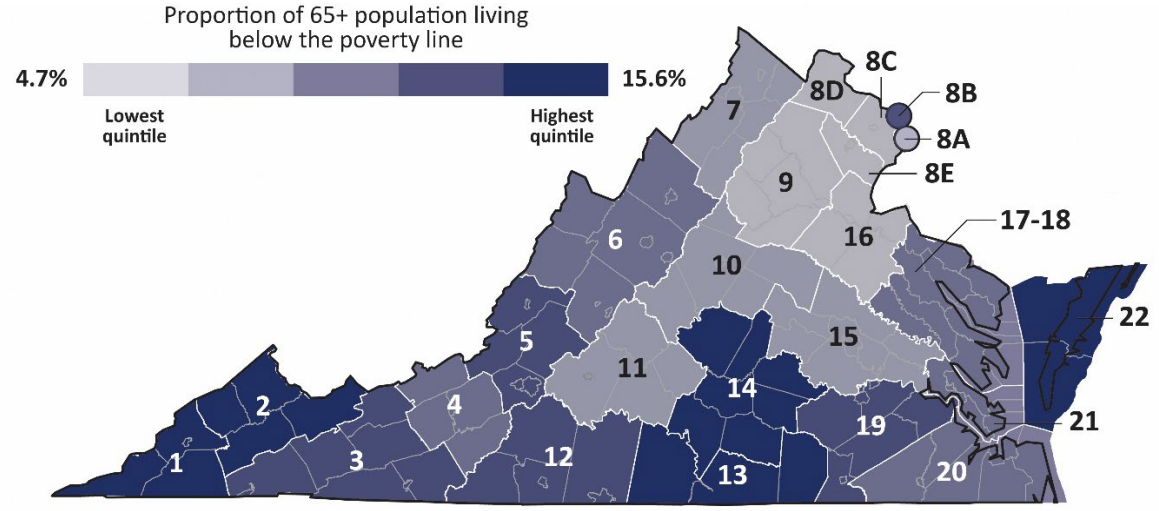
PSA	65+ population	65+ population with a disability	With a disability as a % of 65+ population	Rank
1 Far Southwest	18,260	9,045	49.5%	1
2 Southwest Coalfields	23,215	10,895	46.9	2
3 Bristol-Galax	44,225	16,200	36.6	4
4 New River Valley	30,155	9,395	31.2	13
5 Roanoke Valley	57,200	16,070	28.1	20
6 Central Shenandoah	58,900	19,600	33.3	9
7 Northern Shenandoah	46,895	15,600	33.3	10
8A Alexandria	19,720	5,050	25.6	23
8B Arlington	27,325	6,760	24.7	25
8C Fairfax	171,940	42,585	24.8	24
8D Loudoun	44,290	12,355	27.9	21
8E Prince William	58,735	17,180	29.3	16
9 Rappahannock-Rapidan	33,800	9,545	28.2	19
10 Jefferson Area	50,560	13,465	26.6	22
11 Lynchburg	51,065	15,570	30.5	15
12 Martinsville-Danville	55,995	20,305	36.3	5
13 Southside	20,110	6,985	34.7	7
14 Southern Piedmont	20,310	7,665	37.7	3
15 Richmond	184,080	53,215	28.9	17
16 Fredericksburg	51,315	14,730	28.7	18
17/18 Nor. Neck-Mid. Peninsula	37,100	11,485	31.0	14
19 Tri-Cities	29,765	10,550	35.4	6
20 Hampton Roads	177,590	55,770	31.4	12
21 Peninsula	85,775	27,810	32.4	11
22 Eastern Shore	11,825	4,100	34.7	8
Total	**1,410,150**	**431,930**	**30.6**	



SOURCE: U.S. Census Bureau 2023 American Community Survey 5-year estimates prepared for JLARC by Weldon Cooper Center at UVA.
NOTE: ACS definitions cover six functional domains: hearing, vision, cognitive, ambulatory, self-care, and independent living. Regions correspond to planning and service areas (PSAs), which align with local area agencies on aging. Names are for readability only and carry no official designation. American Community Survey population estimates are subject to margins of error.

FIGURE D-10: Proportion of age 65+ population below the poverty line by PSA (2023)

PSA	65+ population	65+ population below the poverty line	Below the poverty line as a % of 65+ population	Rank
1 Far Southwest	18,260	2,847	15.6%	1
2 Southwest Coalfields	23,215	3,083	13.3	5
3 Bristol-Galax	44,225	4,883	11.0	7
4 New River Valley	30,155	2,490	8.3	14
5 Roanoke Valley	57,200	5,604	9.8	9
6 Central Shenandoah	58,900	4,588	7.8	15
7 Northern Shenandoah	46,895	3,598	7.7	17
8A Alexandria	19,720	1,425	7.2	19
8B Arlington	27,325	2,835	10.4	8
8C Fairfax	171,940	8,880	5.2	24
8D Loudoun	44,290	2,074	4.7	25
8E Prince William	58,735	3,258	5.5	23
9 Rappahannock-Rapidan	33,800	2,006	5.9	22
10 Jefferson Area	50,560	3,515	7.0	20
11 Lynchburg	51,065	3,954	7.7	16
12 Martinsville-Danville	55,995	6,719	12.0	6
13 Southside	20,110	2,725	13.6	4
14 Southern Piedmont	20,310	2,899	14.3	2
15 Richmond	184,080	13,985	7.6	18
16 Fredericksburg	51,315	3,130	6.1	21
17/18 Nor. Neck-Mid. Peninsula	37,100	3,094	8.3	12
19 Tri-Cities	29,765	2,814	9.5	10
20 Hampton Roads	177,590	14,969	8.4	11
21 Peninsula	85,775	7,140	8.3	13
22 Eastern Shore	11,825	1,623	13.7	3
Total	**1,410,150**	**114,138**	**8.1**	



SOURCE: U.S. Census Bureau 2023 American Community Survey 5-year estimates prepared for JLARC by Weldon Cooper Center at UVA.
NOTE: The American Community Survey uses the U.S. Census Bureau's official poverty thresholds, which are inflation-adjusted annually. Status is determined using gross pre-tax income. Regions are planning and service areas (PSAs) which correspond to local area agencies on aging. Names are used for readability purposes only and do not reflect any official designations. American Community Survey population estimates are subject to margins of error.

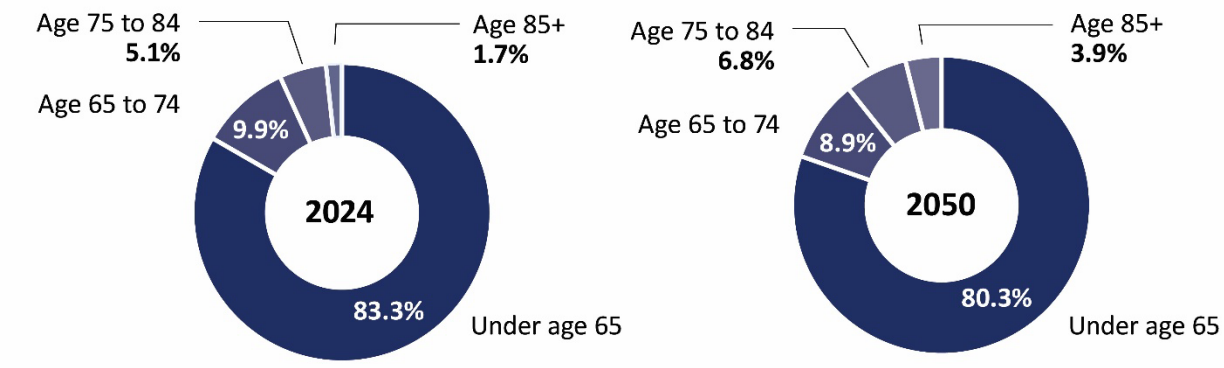
TABLE D-3
Age 65+ population as proportion of total population by state (2024)

State	Proportion of population 65+	Rank	State	Proportion of population 65+	Rank
Maine	22.4%	1	Kentucky	17.3%	27
Vermont	21.4	2	Minnesota	17.3	28
Florida	21.3	3	North Carolina	17.2	29
West Virginia	21.0	4	New Jersey	17.2	30
Delaware	20.6	5	Mississippi	17.2	31
Hawaii	20.5	6	Tennessee	17.1	32
New Hampshire	20.1	7	Idaho	17.0	33
Montana	20.1	8	Illinois	17.0	34
Pennsylvania	19.5	9	Nevada	17.0	35
New Mexico	19.3	10	Kansas	17.0	36
Oregon	19.1	11	Indiana	16.8	37
Arizona	18.9	12	Louisiana	16.7	38
South Carolina	18.9	13	Nebraska	16.7	39
Rhode Island	18.7	14	**Virginia**	**16.7**	**40**
Michigan	18.6	15	Maryland	16.7	41
Wisconsin	18.5	16	Washington	16.6	42
Wyoming	18.5	17	North Dakota	16.5	43
Connecticut	18.5	18	Oklahoma	16.3	44
Ohio	18.3	19	California	15.7	45
Iowa	18.1	20	Colorado	15.6	46
South Dakota	18.0	21	Georgia	15.0	47
New York	17.9	22	Alaska	13.8	48
Missouri	17.9	23	Texas	13.4	49
Massachusetts	17.9	24	District of Columbia	12.8	50
Alabama	17.8	25	Utah	11.9	51
Arkansas	17.6	26	**Nationwide**	**17.2**	

SOURCE: U.S. Census Bureau 2024 American Community Survey 5-year estimates.
NOTE: American Community Survey population estimates are subject to margins of error.

FIGURE D-11: Projected growth of population age 65+ by PSA (2024–2050)

PSA	2024 pop.	2030 projected pop.	2024-2030 projected growth (%)	2040 projected pop.	2024-2040 projected growth (%)	2050 projected pop.	2024-2050 projected growth (%)
1 Far Southwest	18,302	18,757	2%	17,536	-4%	16,650	-9%
2 Southwest Coalfields	23,454	23,820	2	21,040	-10	18,335	-22
3 Bristol-Galax	44,928	48,365	8	48,463	8	45,621	2
4 New River Valley	30,658	34,118	11	35,533	16	35,221	15
5 Roanoke Valley	58,167	69,591	20	69,249	19	65,316	12
6 Central Shenandoah	60,438	72,038	19	73,815	22	73,848	22
7 Northern Shenandoah	48,533	62,558	29	70,125	44	73,926	52
8A Alexandria	20,348	23,477	15	23,093	13	21,838	7
8B Arlington	28,123	31,175	11	30,197	7	28,909	3
8C Fairfax	177,718	209,112	18	219,724	24	226,766	28
8D Loudoun	46,894	77,656	66	107,393	129	130,283	178
8E Prince William	61,562	90,308	47	113,225	84	131,568	114
9 Rappahannock-Rapidan	34,881	45,746	31	49,870	43	52,217	50
10 Jefferson Area	52,574	64,202	22	69,724	33	74,587	42
11 Lynchburg	52,350	63,912	22	65,369	25	62,872	20
12 Martinsville-Danville	56,705	64,545	14	62,925	11	57,558	2
13 Southside	20,381	22,224	9	20,916	3	19,162	-6
14 Southern Piedmont	20,919	24,812	19	24,923	19	25,043	20
15 Richmond	190,975	249,173	30	279,855	47	297,968	56
16 Fredericksburg	53,511	77,656	45	94,321	76	106,330	99
17/18 Nor. Neck-Mid. Peninsula	38,027	44,246	16	45,009	18	44,179	16
19 Tri-Cities	30,156	38,839	29	38,311	27	35,906	19
20 Hampton Roads	183,409	242,561	32	256,134	40	260,201	42
21 Peninsula	88,618	113,159	28	116,411	31	116,443	31
22 Eastern Shore	12,112	14,014	16	13,927	15	12,736	5
Total	**1,453,743**	**1,826,064**	**26**	**1,967,090**	**35**	**2,033,485**	**40**

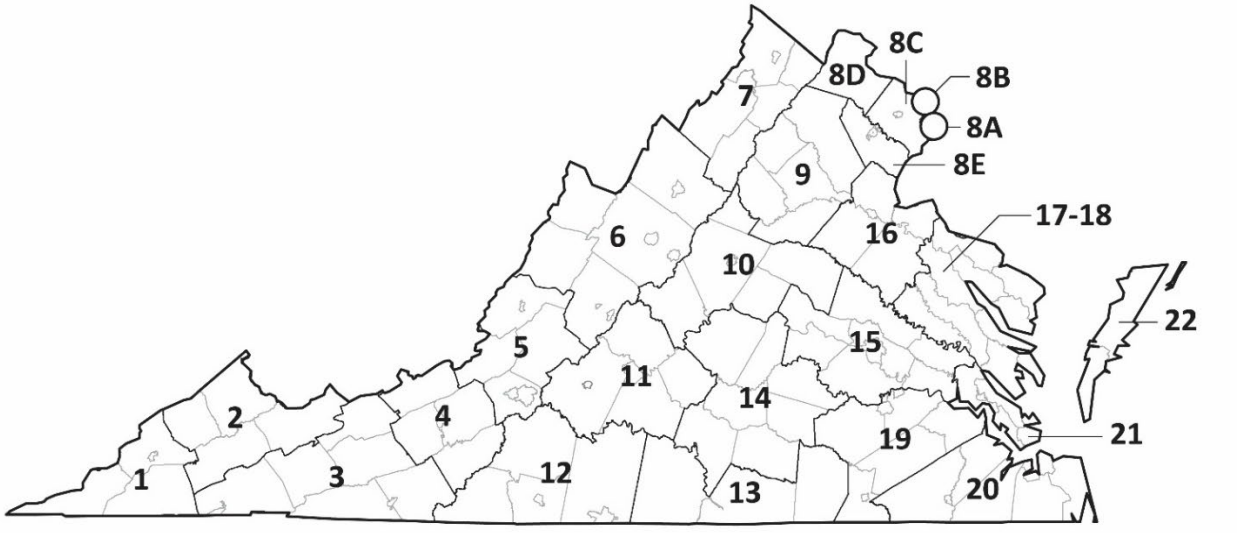


SOURCE: U.S. Census Bureau 2024 American Community Survey 5-year estimates and Virginia population projections from the Weldon Cooper Center at the University of Virginia.

Appendix E: Assisted living and in-home care supply

This report primarily analyzes the supply of assisted living and in-home care at the planning and service area (PSA) level. Planning and service areas (PSAs) for aging programs are established federally by the Older Americans Act (42 U.S.C. § 3001 et seq.). As a result, PSAs are the geographic unit corresponding to Virginia's network of 25 area agencies on aging (AAAs). Because PSAs are officially identified only by number, and AAA names follow varied conventions—some geographic, others historical, organizational, or otherwise not descriptive of the area served—JLARC developed regional names to make references to individual PSAs more intuitive throughout the report. These names are used for readability purposes only and do not reflect any official designations.

FIGURE E-1
Virginia's planning and service areas (PSAs)



SOURCE: Planning and service areas (PSAs) for aging programs are established federally by the Older Americans Act (42 U.S.C. § 3001 et seq.).

TABLE E-1
Count of assisted living beds by level of care (by PSA)

PSA	Residential living level of care beds	Assisted living level of care beds	Safe, secure environment / memory care beds	Total beds	Rank
1 Far Southwest	58	155	0	213	22
2 Southwest Coalfields	73	159	30	262	21
3 Bristol-Galax	306	440	129	875	14
4 New River Valley	85	291	68	444	19
5 Roanoke Valley	375	1,189	221	1,785	5
6 Central Shenandoah	373	841	290	1,504	6
7 Northern Shenandoah	250	741	209	1,200	8
8A Alexandria	204	695	156	1,055	13
8B Arlington	79	323	117	519	17
8C Fairfax	682	2,610	833	4,125	2
8D Loudoun	193	707	216	1,115	10
8E Prince William	157	757	331	1,245	7
9 Rappahannock-Rapidan	89	319	86	494	18
10 Jefferson Area	172	683	257	1,112	11
11 Lynchburg	197	682	255	1,133	9
12 Martinsville-Danville	105	350	73	528	15
13 Southside	60	125	18	204	23
14 Southern Piedmont	49	109	40	199	24
15 Richmond	1,024	2,796	904	4,723	1
16 Fredericksburg	183	683	204	1,070	12
17/18 Nor. Neck-Mid. Peninsula	58	218	66	342	20
19 Tri-Cities	172	285	65	522	16
20 Hampton Roads	599	2,030	643	3,273	3
21 Peninsula	322	1,231	368	1,920	4
22 Eastern Shore	10	47	21	77	25
Total	**5,874**	**18,466**	**5,598**	**29,937**	

SOURCE: VDSS licensure data and JLARC survey of assisted living facility administrators.
NOTE: Values represent estimated occupied beds across 580 assisted living facilities as of March 2026. Estimates calculated using facilities' full licensed capacity multiplied by the average reported census, by facility size, among facilities responding to JLARC's survey of assisted living facility administrators. Regions are planning and service areas (PSAs) which correspond to local area agencies on aging. Names are used for readability purposes only and do not reflect any official designations. Rank is according to total number of beds.

TABLE E-2
Assisted living beds per 1,000 age 65+ residents (by PSA)

PSA	Beds per 1,000 age 65+ residents: Residential living level of care	Assisted living level of care	Safe, secure environment / memory care	Total	Rank
1 Far Southwest	3.2	8.5	0.0	11.7	19
2 Southwest Coalfields	3.2	6.8	1.3	11.3	20
3 Bristol-Galax	6.9	10.0	2.9	19.8	13
4 New River Valley	2.8	9.7	2.3	14.7	17
5 Roanoke Valley	6.6	20.8	3.9	31.2	2
6 Central Shenandoah	6.3	14.3	4.9	25.5	5
7 Northern Shenandoah	5.3	15.8	4.5	25.6	4
8A Alexandria	10.4	35.2	7.9	53.5	1
8B Arlington	2.9	11.8	4.3	19.0	14
8C Fairfax	4.0	15.2	4.8	24.0	7
8D Loudoun	4.4	16.0	4.9	25.2	6
8E Prince William	2.7	12.9	5.6	21.2	11
9 Rappahannock-Rapidan	2.6	9.4	2.6	14.6	18
10 Jefferson Area	3.4	13.5	5.1	22.0	10
11 Lynchburg	3.8	13.4	5.0	22.2	9
12 Martinsville-Danville	1.9	6.3	1.3	9.4	23
13 Southside	3.0	6.2	0.9	10.1	21
14 Southern Piedmont	2.4	5.4	2.0	9.8	22
15 Richmond	5.6	15.2	4.9	25.7	3
16 Fredericksburg	3.6	13.3	4.0	20.8	12
17/18 Nor. Neck-Mid. Peninsula	1.6	5.9	1.8	9.2	24
19 Tri-Cities	5.8	9.6	2.2	17.5	16
20 Hampton Roads	3.4	11.4	3.6	18.4	15
21 Peninsula	3.7	14.3	4.3	22.4	8
22 Eastern Shore	0.9	3.9	1.7	6.5	25
Total	**4.2**	**13.1**	**4.0**	**21.2**	

SOURCE: 2023 American Community Survey 5-year estimates from Weldon Cooper Center and VDSS licensure data and JLARC survey of assisted living facility administrators.
NOTE: Values represent estimated occupied beds across 580 assisted living facilities as of March 2026. Estimates calculated using facilities' full licensed capacity multiplied by the average reported census, by facility size, among facilities responding to JLARC's survey of assisted living facility administrators. Regions are planning and service areas (PSAs), which correspond to local area agencies on aging. Names are used for readability purposes only and do not reflect any official designations. American Community Survey population estimates are subject to margins of error. Rank is according to total number of beds.

TABLE E-3
Assisted living facilities (by PSA)

PSA	Total number of assisted living facilities	Assisted living facilities per 10,000 age 65+ residents	Rank
1 Far Southwest	4	2.2	22
2 Southwest Coalfields	8	3.4	16
3 Bristol-Galax	17	3.8	10
4 New River Valley	7	2.3	21
5 Roanoke Valley	29	5.1	7
6 Central Shenandoah	31	5.3	4
7 Northern Shenandoah	26	5.5	3
8A Alexandria	10	5.1	6
8B Arlington	9	3.3	17
8C Fairfax	90	5.2	5
8D Loudoun	16	3.6	11
8E Prince William	23	3.9	9
9 Rappahannock-Rapidan	12	3.6	13
10 Jefferson Area	18	3.6	12
11 Lynchburg	15	2.9	20
12 Martinsville-Danville	11	2.0	23
13 Southside	9	4.5	8
14 Southern Piedmont	6	3.0	19
15 Richmond	105	5.7	2
16 Fredericksburg	18	3.5	14
17/18 Nor. Neck-Mid. Peninsula	7	1.9	24
19 Tri-Cities	20	6.7	1
20 Hampton Roads	58	3.3	18
21 Peninsula	30	3.5	15
22 Eastern Shore	1	0.8	25
Total	**580**	**4.1**	

SOURCE: 2023 American Community Survey 5-year estimates from Weldon Cooper Center and VDSS licensure data and JLARC survey of assisted living facility administrators.
NOTE: Regions are planning and service areas (PSAs), which correspond to local area agencies on aging. Names are used for readability purposes only and do not reflect any official designations. American Community Survey population estimates are subject to margins of error.

TABLE E-4

Safe, secure beds / memory care beds per 1,000 age 65+ residents with cognitive difficulty (by PSA)

PSA	Age 65+ pop. with cognitive difficulty	Safe, secure environment / memory care beds	Safe, secure environment / memory care beds per 1,000 age 65+ residents with cognitive difficulty	Rank
1 Far Southwest	2,625	0	0.0	25
2 Southwest Coalfields	2,810	30	10.6	23
3 Bristol-Galax	4,015	129	32.1	16
4 New River Valley	2,125	68	32.0	17
5 Roanoke Valley	3,660	221	60.3	11
6 Central Shenandoah	4,785	290	60.6	10
7 Northern Shenandoah	3,710	209	56.4	12
8A Alexandria	1,035	156	150.7	1
8B Arlington	1,550	117	75.2	6
8C Fairfax	10,050	833	82.9	3
8D Loudoun	2,790	216	77.4	5
8E Prince William	4,010	331	82.6	4
9 Rappahannock-Rapidan	2,555	86	33.7	15
10 Jefferson Area	2,975	257	86.3	2
11 Lynchburg	3,700	255	68.8	8
12 Martinsville-Danville	4,745	73	15.3	22
13 Southside	1,845	18	10.0	24
14 Southern Piedmont	2,510	40	16.1	21
15 Richmond	13,120	904	68.9	7
16 Fredericksburg	3,185	204	64.0	9
17/18 Nor. Neck-Mid. Peninsula	2,565	66	25.6	19
19 Tri-Cities	2,635	65	24.7	20
20 Hampton Roads	12,005	643	53.6	14
21 Peninsula	6,625	368	55.5	13
22 Eastern Shore	745	21	27.6	18
Total	**102,375**	**5,598**	**54.7**	

SOURCE: 2023 American Community Survey 5-year estimates from Weldon Cooper Center and VDSS licensure data and JLARC survey of assisted living facility administrators.

NOTE: Ratio comprises the number of safe, secure (memory care) level of care beds and American Community Survey estimate for adults age 65+ with cognitive difficulty per PSA. Regions are planning and service areas (PSAs), which correspond to local area agencies on aging. Names are used for readability purposes only and do not reflect any official designations. American Community Survey population estimates are subject to margins of error.

TABLE E-5
Auxiliary grant participation by assisted living facility, FY25 (by PSA)

PSA	Total # of assisted living facilities	Facilities with ≥1 AG recipient	% of facilities with ≥1 AG recipient	Total number of assisted living beds	AG recipients (monthly avg.)	AG recipients as % of total beds
1 Far Southwest	4	3	75.0%	213	158	74.2%
2 Southwest Coalfields	8	7	87.5	262	109	41.7
3 Bristol-Galax	17	12	70.6	875	296	33.8
4 New River Valley	7	5	71.4	444	50	11.3
5 Roanoke Valley	29	11	37.9	1,785	230	12.9
6 Central Shenandoah	31	9	29.0	1,504	138	9.2
7 Northern Shenandoah	26	7	26.9	1,200	53	4.4
8A Alexandria	10	1	10.0	1,055	1	0.1
8B Arlington	9	4	44.4	519	50	9.6
8C Fairfax	90	20	22.2	4,125	111	2.7
8D Loudoun	16	0	0.0	1,115	0	0.0
8E Prince William	23	4	17.4	1,245	18	1.4
9 Rappahannock-Rapidan	12	1	8.3	494	2	0.4
10 Jefferson Area	18	2	11.1	1,112	45	4.0
11 Lynchburg	15	3	20.0	1,133	49	4.3
12 Martinsville-Danville	11	7	63.6	528	114	21.6
13 Southside	9	6	66.7	204	63	30.9
14 Southern Piedmont	6	6	100.0	199	63	31.6
15 Richmond	105	34	32.4	4,723	443	9.4
16 Fredericksburg	18	3	16.7	1,070	18	1.7
17/18 Nor. Neck-Mid. Peninsula	7	0	0.0	342	0	0.0
19 Tri-Cities	20	12	60.0	522	120	23.0
20 Hampton Roads	58	14	24.1	3,273	315	9.6
21 Peninsula	30	6	20.0	1,920	170	8.9
22 Eastern Shore	1	0	0.0	77	0	0.0
Virginia	**580**	**177**	**30.5**	**29,937**	**2,616**	**8.7**

SOURCE: VDSS licensure data and JLARC survey of assisted living facility administrators and DARS auxiliary grant data (FY25).
NOTE: Auxiliary grant recipients represent average monthly number of recipients for FY25 as reported to DARS. The number of facilities with one or more auxiliary grant recipients and the number of auxiliary grant recipients in this table differ from the numbers cited in Chapter 8 (n=186 and n=2,823) because data limitations required JLARC to manually match recipients to facilities by facility name, and a match could not be identified for all recipients. Assisted living facility and beds estimates represent occupied beds across 580 assisted living facilities as of March 2026. Estimates calculated using facilities' full licensed capacity multiplied by the average reported census, by facility size, among facilities responding to JLARC's survey of assisted living facility administrators. Regions are planning and service areas (PSAs), which correspond to local area agencies on aging. Names are used for readability purposes only and do not reflect any official designations.

TABLE E-6
Number of assisted living facilities by share of residents receiving the auxiliary grant, by PSA (FY25)

PSA	Total # of assisted living facilities	Total # of facilities with 0% AG residents	> 0% to < 25% AG residents	25% to < 50% AG residents	50% to <75% AG residents	≥ 75% AG residents
1 Far Southwest	4	1	0	0	2	1
2 Southwest Coalfields	8	1	2	1	2	2
3 Bristol-Galax	17	5	2	0	3	7
4 New River Valley	7	2	4	0	1	0
5 Roanoke Valley	29	18	5	2	4	0
6 Central Shenandoah	31	22	4	0	1	4
7 Northern Shenandoah	26	19	5	1	0	1
8A Alexandria	10	9	1	0	0	0
8B Arlington	9	5	1	0	2	1
8C Fairfax	90	70	18	0	2	0
8D Loudoun	16	16	0	0	0	0
8E Prince William	23	19	4	0	0	0
9 Rappahannock-Rapidan	12	11	1	0	0	0
10 Jefferson Area	18	16	0	0	2	0
11 Lynchburg	15	12	2	1	0	0
12 Martinsville-Danville	11	4	2	1	3	1
13 Southside	9	3	0	1	2	3
14 Southern Piedmont	6	0	2	1	0	3
15 Richmond	105	71	7	3	5	19
16 Fredericksburg	18	15	2	1	0	0
17/18 Nor. Neck-Mid. Peninsula	7	7	0	0	0	0
19 Tri-Cities	20	8	2	1	3	6
20 Hampton Roads	58	44	5	1	4	4
21 Peninsula	30	24	1	1	0	4
22 Eastern Shore	1	1	0	0	0	0
Virginia	**580**	**403 (69%)**	**70 (12%)**	**15 (3%)**	**36 (6%)**	**56 (10%)**

SOURCE: VDSS licensure data and JLARC survey of assisted living facility administrators and DARS auxiliary grant data (FY25).
NOTE: Auxiliary grant recipients represent average monthly number of recipients for FY25 as reported to DARS. The number of facilities with one or more auxiliary grant recipients in this table differs from the numbers cited in Chapter 8 (n=186) because data limitations required JLARC to manually match recipients to facilities by facility name, and a match could not be identified for all recipients. Names are used for readability purposes only and do not reflect any official designations.

TABLE E-7
In-home care HCOs and direct care provider staff per 10,000 65+ residents (by PSA)

PSA	HCO providers per 10,000 65+ residents	Rank	Direct care staff per 10,000 65+ residents	Rank
1 Far Southwest	1.1	23	35.6	22
2 Southwest Coalfields	2.2	20	39.6	21
3 Bristol-Galax	1.8	21	78.9	18
4 New River Valley	1.0	24	2.0	25
5 Roanoke Valley	4.4	12	138.6	13
6 Central Shenandoah	1.4	22	19.2	24
7 Northern Shenandoah	3.6	16	110.0	14
8A Alexandria	28.9	4	242.9	6
8B Arlington	11.3	7	143.5	12
8C Fairfax	32.9	2	678.7	1
8D Loudoun	26.2	5	415.2	4
8E Prince William	40.0	1	574.6	2
9 Rappahannock-Rapidan	3.3	18	30.5	23
10 Jefferson Area	3.8	15	238.9	7
11 Lynchburg	2.7	19	49.0	20
12 Martinsville-Danville	4.6	11	108.2	15
13 Southside	3.5	17	71.6	19
14 Southern Piedmont	1.0	25	79.8	17
15 Richmond	8.3	9	205.7	9
16 Fredericksburg	21.0	6	235.0	8
17/18 Nor. Neck-Mid. Peninsula	4.3	13	186.0	11
19 Tri-Cities	7.4	10	193.9	10
20 Hampton Roads	30.8	3	428.3	3
21 Peninsula	9.8	8	252.8	5
22 Eastern Shore	4.2	14	85.4	16

SOURCE: 2023 American Community Survey 5-year estimates from Weldon Cooper Center and VDH licensure data (2023-2026), including self-reported staffing totals.

NOTE: Ratio comprises the total number of HCO providers and direct care staff (both directly hired by HCO and on contract) and American Community Survey estimate for adults age 65+ with independent living difficulty, self-care difficulty, and ambulatory difficulty per PSA. Regions are planning and service areas (PSAs) that correspond to local area agencies on aging. Names are used for readability purposes only and do not reflect any official designations. American Community Survey population estimates are subject to margins of error.

TABLE E-8
Recipients of publicly funded in-home care per capita (by PSA)

PSA	CCC+ agency direct recipients per 1,000 65+	Rank	CCC+ consumer direct recipients per 1,000 65+	Rank	AAA+LDSS recipients per 1,000 65+	Rank
1 Far Southwest	5.53	17	9.64	16	19.11	1
2 Southwest Coalfields	2.76	24	7.11	22	11.42	3
3 Bristol-Galax	3.50	22	9.43	18	11.01	4
4 New River Valley	2.42	25	6.77	25	0.99	24
5 Roanoke Valley	4.27	20	6.99	23	1.87	21
6 Central Shenandoah	5.70	16	8.52	19	2.94	11
7 Northern Shenandoah	5.44	18	7.27	21	2.03	19
8A Alexandria	27.23	1	18.76	5	7.05	6
8B Arlington	24.56	2	18.01	6	5.45	7
8C Fairfax	22.30	3	16.13	9	11.42	2
8D Loudoun	19.71	6	14.90	10	9.46	5
8E Prince William	21.03	5	17.09	7	2.33	15
9 Rappahannock-Rapidan	6.63	15	11.80	13	2.75	13
10 Jefferson Area	2.99	23	9.95	15	1.15	23
11 Lynchburg	4.33	19	9.54	17	2.70	14
12 Martinsville-Danville	10.59	10	22.86	1	2.82	12
13 Southside	10.29	11	16.61	8	2.04	18
14 Southern Piedmont	7.53	14	22.06	3	4.92	8
15 Richmond	3.80	21	6.81	24	1.90	20
16 Fredericksburg	10.00	12	13.41	12	0.84	25
17/18 Nor. Neck-Mid. Peninsula	13.99	8	22.40	2	1.21	22
19 Tri-Cities	11.29	9	14.08	11	2.99	10
20 Hampton Roads	15.39	7	11.67	14	3.00	9
21 Peninsula	9.25	13	7.93	20	2.10	17
22 Eastern Shore	22.16	4	21.40	4	2.28	16

SOURCE: 2023 American Community Survey 5-year estimates from Weldon Cooper Center, FY25 DARS datasets on AAA in-home services (personal care, companion, and chore) and LDSS in-home services (chore, homemaker, and companion), and FY25 DMAS CCC+ expenditure and service data.

NOTE: Ratio comprises the total number of public recipients of in-home care services (CCC+ agency directed, CCC+ consumer directed, and AAA/LDSS) and American Community Survey estimate for adults age 65+ per PSA. Regions are planning and service areas (PSAs) that correspond to local area agencies on aging. Names are used for readability purposes only and do not reflect any official designations. American Community Survey population estimates are subject to margins of error.

Appendix F: Staffing roles and regulatory requirements for HCOs

Virginia's in-home care industry relies primarily on three types of direct care providers: personal care aides (PCAs), home health aides (HHAs), and certified nurse aides (CNAs). While these roles require varying levels of clinical training and certification, all are assigned to work under the supervision of a skilled professional and assist with personal care and with ordinarily self-administered medication. Average annual pay remains uniformly low across all three roles, hovering between $31,510 and $32,400 (Table F-1).

TABLE F-1
In-home care roles, requirements, and pay

Type of Direct Care Provider	Training requirements	Job duties	Virginia pay rate
Personal care aide (PCA)	40 documented hours of initial training provided by their employer and 12 documented hours of employer-provided training annually.	Assigned to work under the supervision and direction (care plan) of a skilled professional (RN, physician, etc.). Job duties include providing personal care services and assisting with medications ordinarily self-administered.	$15.15/hour ($31,510 annually)
Home health aide (HHA)	75-hour training program (including at least 16 hours of practical clinical experience).		
Certified nurse aide (CNA)	State-approved training program with supervised clinical training totaling at least 120 hours (approximately 6–12 weeks). Must pass the Virginia Nurse Aide Competency Exam and be registered in the Virginia Nurse Aide Registry.	Assigned to work under the supervision and direction (care plan) of a skilled professional (RN, physician, etc.). Job duties include providing personal care services and assisting with medications ordinarily self-administered, as well as basic nursing skills (e.g., taking and recording vital signs, recognizing changes in bodily function, caring for patients who are near death).	$15.58/hour ($32,400 annually)

SOURCE: Administrative Code of Virginia (12VAC5-381-10). Hourly and annual payment rates from Virginia Works, based on NAICS Industry code 6216 (home health services).

The Office of Licensure and Certification (OLC) conducts various types of inspections and regulatory interactions to ensure home care organizations (HCOs) comply with state standards. Table F-2 details the required components for each inspection type, including specific materials, policies, and procedural evidence HCOs must provide during these reviews.

TABLE F-2
Required regulatory components by inspection type

Type of OLC interaction	Required components
Initial licensure application	Facility details (name, address, contact information)
	Ownership and operator information
	Administrative personnel (administrator, alternate administrator, nursing manager, financial manager)
	Hours of operation
	Service information (geographic service areas, branch offices, drop sites, services to be provided, number and type of service personnel)
	Medicaid enrollment information
	Small business information
	Required attachments (business plan/working budget, administrator job description and resume, nursing director job description and resume, insurance coverage, evidence of office occupancy, bill of sale, letter of readiness)
	Certification and submission
	$1,500 licensure fee paid
Initial licensure inspection	Agency policies and procedures reflecting 12VAC5-381
	Criminal record checks obtained within 30 days of employment
	Management and administration: (1) Posted business information on door, (2) Emergency operation plan, (3) Procedure for encouraging and facilitating the availability of flu shots for staff and clients
	Governing body meeting minutes (signed and dated by those in attendance; evidence of review of agency policies/procedures and appointment of administrator)
	Financial controls (proposed working budget, including projected revenue and expenses, balance sheets, and credit availability)
	Evidence of indemnity coverage (malpractice insurance, general liability insurance, third-party crime or blanket fidelity bond of $50,000)
	Complaint log form
	Personnel files (date of hire, sworn disclosure statement, criminal record check, evidence of meeting minimum qualifications for position, applicable licenses/certifications, evidence of orientation, verified reference checks, job descriptions)
	Employee orientation packet (including objective/philosophy of the organization, confidentiality, client rights, mandated reporting, emergency preparedness, infection control practices, cultural awareness, and other applicable policies or procedures)
	Client admission packet forms (service agreement, client rights, complaint procedure)
	Contracts
Biennial inspection	Lists spanning the past year for active clients, discharged clients, active employees, and terminated employees
	Governing body and Annual Quality Improvement Committee meeting minutes from the last three years
	A 5 percent sample of active client records, including service agreements, RN assessments, RN plans of care, and PCA documentation notes

	Personnel files featuring applications, sworn statements, State Police criminal record checks, two professional reference checks, and 12-hour in-service records
	Client admission packet, client handbook, and complaint logs
	Evidence of required insurance coverage
	Agency policy and procedure manual
Application renewal	Application submitted to VDH OLC
	Pay $1,500 renewal fee

SOURCE: VA Administrative Code Chapter 381, JLARC staff interviews with OLC Medical Facility Inspectors, and JLARC staff review of OLC inspection checklists used for initial and biennial inspections.
NOTE: This list may not be all-inclusive. Inspectors may require additional information to substantiate deficiencies or complaint investigations (e.g., home visits).

Appendix G: Assisted living facilities of most concern

This report highlights the overall trends and quality associated with assisted living facilities in Virginia. Within overall trends, some facilities were identified as outliers for poor compliance, quality, and safety. This appendix outlines 17 facilities identified as being most concerning, based on a definition established by JLARC.

Each of Virginia's 580 ALFs was ranked on each of the five complaint and violation variables for which raw totals are shown in the table, and those five rankings were averaged to produce the value in the "Statewide rank" column. The "Rank within size tier" column shows each facility's rank relative to other facilities in its size tier. A facility was identified as being of most concern if it ranked in the top three within its size tier or in the top 10 statewide, including ties.

These 17 facilities represent 2.9 percent of Virginia's 580 ALFs, but account for 35.7 percent of all C-3 violations, 17.4 percent of all violations, 26.1 percent of all serious violations, 19.7 percent of all verified incidents, and 9.3 percent of all LTCO complaints in 2025.

TABLE G-1
Virginia assisted living facilities of most concern, 2025

Facility	LTCO complaints	Total VDSS violations	Serious VDSS violations	C-3 violations	Verified incidents	Statewide rank	Rank within size tier	Size group	Region
A	1	80	60	11	19	1	1 (tie)	4	Piedmont & Western
B	12	46	18	0	11	2	1 (tie)	4	Fairfax
C		66	42	1	1	3	2	1	Fairfax
D	3	62	26	0	6	4	1	1	Piedmont & Western
E		43	16	2	8	5	3	4	Eastern & Peninsula
F	6	43	19	0	8	6	4	4	Fairfax
G	1	46	35	0	4	7 (tie)	8	4	Piedmont & Western
H	5	42	23	0	6	7 (tie)	5 (tie)	4	Piedmont & Western
I	11	42	14	0	7	9	5 (tie)	4	Piedmont & Western
J		42	22	0	2	10 (tie)	1	3	Piedmont & Western
K		35	25	0	3	10 (tie)	1	2	Northern & Valley
L		34	17	0	4	13	2	3	Eastern & Peninsula
M		25	19	1	13	14	3	2	Northern & Valley
N		30	13	0	6	18	3 (tie)	3	Piedmont & Western
O		44	14	0	2	19	3	1	Piedmont & Western
P	4	25	20	0	3	21	2	2	Northern & Valley
Q		22	14	0	10	23	3 (tie)	3	Piedmont & Western
Total	**43**	**727**	**397**	**15**	**113**				

SOURCE: JLARC analysis of VDSS ALF violations data, 2025.

NOTE: "Rank" is based on the average ranking of each facility for each violation/complaint metric across all 580 assisted living facilities. Facility names have been replaced with letters to preserve anonymity. Verified incidents involve the 2025 sum of all complaint-related inspections resulting in a "yes" violation and all substantiated Adult Protective Services complaints. Rank within size tier indicates the facility's average rank (on the same criteria listed in the table) within size tiers: Group 1 (20 or fewer), Group 2 (21-50), Group 3 (51-100), Group 4 (101 or more). Blank cells in the LTCO complaints column are paired with facilities for which no LTCO complaint data could be reliably matched or located, and the average rank for facilities with missing LTCO data was calculated using only the four other rankings.

TABLE G-2
Notable incidents from Virginia's facilities of most concern, 2024–2025

Facility	Incident summary	Incident severity
E	Resident #1 fell while being assisted to the toilet by staff and later reported "I pulled myself up on the bar and I went to sit on the toilet and I slipped and slid down and she tried to pick me up three times and I bent my legs back and that's how I broke it." The resident was hospitalized and died a week later; the death certificate lists the cause of death as a complication of a right femur fracture.	C-3
A	Resident #1 was admitted to the facility's safe, secure unit despite documentation indicating a history of sexually inappropriate behavior, including entering others' rooms and requiring redirection. Staff found Resident #1 naked in bed with Resident #2, who was partially unclothed, prompting police notification and Resident #2's transfer to the hospital for evaluation. Evidence showed Resident #1 had previously been warned not to enter female residents' rooms, but Resident#1 continued doing so, and a psychiatric evaluator concluded Resident #1 was not safe to remain in a memory care setting with vulnerable residents. Hospital records characterized the incident as a confirmed sexual assault, and Resident #1 was subsequently arrested and charged with aggravated sexual battery.	C-3
B	The facility substantiated allegations of physical abuse after reviewing video footage showing multiple staff members physically mistreating Resident #1. Video evidence showed Staff #1 repeatedly forcing the resident into a bathroom, holding the door shut against the resident's attempts to leave, roughly handling the resident despite repeated protests, and dropping the resident from a wheelchair while the resident cried out in pain and asked staff to stop. Additional footage documented Staff #1 pulling the resident by the arms, forcibly placing the resident in bed, disregarding complaints of breathing difficulty, and continuing physical interventions after the resident refused contact. The facility's investigation also found that Staff #3 and Staff #4 pushed and struck the resident, and that Staff #4 threatened to kill the resident if the resident moved from the bed.	C-2
C	During medication administration, Staff #3 entered a restroom while Resident #5 was using the toilet despite being asked not to and attempted to administer medication while the resident repeatedly refused. Staff #3 disregarded Resident #5's objections and proceeded with medication administration while the resident was seated on the commode. Later that day, Staff #3 attempted to administer nine medications at once to Resident #9, ignoring multiple requests to delay the medication or receive the pills one at a time with applesauce. Licensing staff observed that Staff #3 failed to respect both residents' choices, dignity, and right to refuse medication, resulting in treatment that lacked courtesy, respect, and consideration.	C-2
K	Resident #1 attempted to put his hands down Resident #2's shirt, and facility records showed prior inappropriate interactions, including an earlier incident in which Resident #1 was found kissing Resident #2. Staff acknowledged that Resident #2 was particularly vulnerable, with Staff #1 stating that Resident #2 was unable to describe what happened because of dementia and was unable to independently move a wheelchair, while Staff #2 stated Resident #2 was verbal but "doesn't make sense." Although the facility documented notification of Resident #1's power of attorney (POA) and implemented interventions such as one-to-one supervision, boundary-setting, and frequent safety checks, there was no documentation that Resident #2's POA had been notified despite Staff #1's statement that a phone call was made. Staff #1 further confirmed that the facility failed to immediately report the incident as suspected abuse to Adult Protective Services as required.	C-2

B	The facility received and investigated allegations that Staff #4 verbally and physically mistreated multiple residents. A staff witness observed Staff #4 cursing at residents, calling one resident lazy, berating another resident for urinating during care, and speaking harshly to a bedbound resident. The facility's investigation substantiated that Staff #4 yelled at residents, argued with a resident who resisted care, and handled a bedbound resident roughly while assisting with dressing. Facility management concluded that Staff #4's actions violated residents' dignity, right to self-expression, and expectation of respectful and appropriate care.	B-2
F	Staff #1 was informed by a collateral contact that Resident #1 had unexplained red marks on the arms and a possible injury or incident involving the pelvic area, raising a suspicion of abuse. During an interview with the licensing inspector, Staff #1 acknowledged receiving this information and recognized the concern. However, Staff #1 confirmed that the suspected abuse was not reported to Adult Protective Services. The facility failed to ensure that a report of suspected abuse was made to the appropriate protective authority.	B-2
A	The facility reported that Resident #1 was involved in a resident-to-resident altercation in which another resident grabbed Resident #1 by the throat. Law enforcement, EMS, and emergency responders were contacted, and Resident #1 was transported to the hospital for evaluation and treatment. Although the incident was reported to the licensing inspector, the report did not identify Resident #2 as the alleged aggressor. The on-site inspection revealed the facility had still not provided the licensing inspector with the identity of the other resident involved in the altercation.	A-2

SOURCE: VDSS ALF violations narrative data, 2024–2025.

Appendix H: Assisted living and in-home care affordability measures

TABLE H-1
Proportion of 65+ individuals within each individual income range, by PSA (2023)

PSA	No Income	<$25,000	$25K - $49.9K	$50K - $74.9K	$75K - $99.9K	>=$100,000
1 - Far Southwest	400 (2%)	9,625 (54%)	4,870 (28%)	1,710 (10%)	450 (3%)	625 (4%)
2 - Southwest Coalfields	490 (2%)	11,575 (51%)	6,860 (30%)	2,015 (9%)	795 (4%)	810 (4%)
3 - Bristol-Galax	795 (2%)	21,045 (49%)	12,510 (29%)	5,140 (12%)	1,735 (4%)	1,825 (4%)
4 - New River Valley	610 (2%)	10,924 (37%)	8,595 (29%)	4,010 (14%)	2,100 (7%)	3,080 (11%)
5 - Roanoke Valley	1,200 (2%)	22,370 (41%)	15,725 (29%)	7,420 (14%)	3,075 (6%)	4,685 (9%)
6 - Central Shenandoah	1,350 (2%)	20,910 (37%)	17,755 (31%)	7,885 (14%)	4,255 (7%)	5,125 (9%)
7 - Northern Shenandoah	1,000 (2%)	17,885 (39%)	13,255 (29%)	6,120 (13%)	3,000 (7%)	4,555 (10%)
8A - Alexandria	705 (4%)	4,550 (24%)	3,370 (17%)	2,380 (12%)	1,870 (10%)	6,430 (33%)
8B - Arlington	1,095 (4%)	6,585 (25%)	4,300 (16%)	3,250 (12%)	2,865 (11%)	8,590 (32%)
8C - Fairfax	8,180 (5%)	42,315 (25%)	30,070 (18%)	21,985 (13%)	17,600 (10%)	49,490 (29%)
8D - Loudoun	2,770 (6%)	12,330 (28%)	8,855 (20%)	5,210 (12%)	4,215 (10%)	10,355 (24%)
8E - Prince William	3,165 (5%)	17,215 (30%)	11,480 (20%)	8,505 (15%)	6,120 (11%)	11,645 (20%)
9 - Rappahannock-Rapidan	910 (3%)	10,245 (31%)	8,900 (27%)	4,780 (14%)	2,915 (9%)	5,300 (16%)
10 - Jefferson Area	1,275 (3%)	14,745 (30%)	13,310 (27%)	8,565 (17%)	4,005 (8%)	7,630 (15%)
11 - Lynchburg	795 (2%)	19,760 (40%)	14,730 (30%)	6,845 (14%)	2,940 (6%)	4,230 (9%)
12 - Martinsville-Danville	1,250 (2%)	27,365 (50%)	14,575 (27%)	5,845 (11%)	2,435 (4%)	2,805 (5%)
13 - Southside	530 (3%)	9,445 (49%)	5,155 (27%)	2,160 (11%)	970 (5%)	870 (5%)
14 - Southern Piedmont	430 (2%)	9,325 (48%)	5,445 (28%)	2,460 (13%)	660 (3%)	1,155 (6%)
15 - Richmond	5,465 (3%)	58,700 (32%)	49,010 (27%)	29,660 (16%)	14,635 (8%)	23,165 (13%)
16 - Fredericksburg	1,660 (3%)	17,690 (35%)	11,740 (23%)	7,535 (15%)	4,910 (10%)	7,150 (14%)
17-18 - Nor. Neck-Mid. Peninsula	630 (2%)	12,895 (36%)	10,800 (30%)	5,225 (14%)	2,285 (6%)	4,385 (12%)
19 - Tri-Cities	815 (3%)	10,825 (38%)	8,490 (30%)	4,280 (15%)	1,950 (7%)	2,290 (8%)
20 - Hampton Roads	5,155 (3%)	58,770 (34%)	47,200 (27%)	26,510 (15%)	14,015 (8%)	22,180 (13%)
21 - Peninsula	1,990 (2%)	29,105 (35%)	20,870 (25%)	13,495 (16%)	7,390 (9%)	11,435 (14%)
22 - Eastern Shore	290 (3%)	4,819 (42%)	3,235 (28%)	1,384 (12%)	670 (6%)	1,185 (10%)
State Total	**42,955 (3%)**	**481,018 (35%)**	**351,105 (25%)**	**194,374 (14%)**	**107,860 (8%)**	**200,995 (15%)**

SOURCE: ACS 5-year 2023 Weldon Cooper Center data. Count represents the number of individuals 65 years of age or older who declared individual income within the range.

TABLE H-2
Family median income by 5-year age band, by PSA (2025 dollars)

PSA	Monthly family median income (2025 dollars)
1 - Far Southwest	
65-69	$4,581
70-74	$4,531
75-79	$4,200
80-84	$4,601
85 and older	$4,132
2 - Southwest Coalfields	
65-69	$4,630
70-74	$4,553
75-79	$4,578
80-84	$4,487
85 and older	$3,336
3 - Bristol-Galax	
65-69	$5,880
70-74	$5,416
75-79	$5,023
80-84	$4,334
85 and older	$4,622
4 - New River Valley	
65-69	$7,306
70-74	$6,708
75-79	$8,052
80-84	$6,261
85 and older	$4,514
5 - Roanoke Valley	
65-69	$7,319
70-74	$6,397
75-79	$6,287
80-84	$5,581
85 and older	$5,050
6 - Central Shenandoah	
65-69	$7,303
70-74	$7,523
75-79	$7,904
80-84	$6,239
85 and older	$5,233
7 - Northern Shenandoah	
65-69	$7,618
70-74	$6,829
75-79	$6,636
80-84	$5,670
85 and older	$6,503
8A - Alexandria	

PSA	Monthly family median income (2025 dollars)
65-69	$15,192
70-74	$13,998
75-79	$13,636
80-84	$14,188
85 and older	$7,549
8B - Arlington	
65-69	$14,764
70-74	$17,596
75-79	$11,914
80-84	$11,104
85 and older	$8,843
8C - Fairfax	
65-69	$14,040
70-74	$14,566
75-79	$13,269
80-84	$11,630
85 and older	$10,097
8D - Loudoun	
65-69	$14,726
70-74	$11,514
75-79	$11,529
80-84	$8,755
85 and older	$9,949
8E - Prince William	
65-69	$12,052
70-74	$11,699
75-79	$10,760
80-84	$9,055
85 and older	$8,122
9 - Rappahannock-Rapidan	
65-69	$9,863
70-74	$9,274
75-79	$9,694
80-84	$8,267
85 and older	$5,814
10 - Jefferson Area	
65-69	$10,189
70-74	$8,681
75-79	$9,553
80-84	$7,382
85 and older	$6,835
11 - Lynchburg	
65-69	$7,499
70-74	$6,945
75-79	$6,377
80-84	$5,270

PSA	Monthly family median income (2025 dollars)
85 and older	$5,261
12 - Martinsville-Danville	
65-69	$6,140
70-74	$5,254
75-79	$4,779
80-84	$4,709
85 and older	$4,054
13 - Southside	
65-69	$6,230
70-74	$5,856
75-79	$5,877
80-84	$4,130
85 and older	$4,609
14 - Southern Piedmont	
65-69	$6,970
70-74	$5,921
75-79	$5,610
80-84	$5,419
85 and older	$3,853
15 - Richmond	
65-69	$9,094
70-74	$8,646
75-79	$7,822
80-84	$6,951
85 and older	$5,917
16 - Fredericksburg	
65-69	$9,469
70-74	$8,958
75-79	$7,571
80-84	$7,424
85 and older	$7,816
17/18 - Nor. Neck-Mid. Peninsula	
65-69	$7,753
70-74	$6,537
75-79	$8,013
80-84	$5,134
85 and older	$4,747
19 - Tri-Cities	
65-69	$7,573
70-74	$7,466
75-79	$8,379
80-84	$5,331
85 and older	$5,746
20 - Hampton Roads	
65-69	$9,005
70-74	$8,381

PSA	Monthly family median income (2025 dollars)
75-79	$7,062
80-84	$7,014
85 and older	$5,466
21 - Peninsula	
65-69	$9,131
70-74	$9,372
75-79	$8,330
80-84	$7,954
85 and older	$6,131
22 - Eastern Shore	
65-69	$6,878
70-74	$6,716
75-79	$6,916
80-84	$7,750
85 and older	$3,620

SOURCE: ACS 5-year 2023 Weldon Cooper Center data. Adjusted for 2025 inflation using federal COLA.

TABLE H-3
Virginians age 65 and older by household income as a percentage of the federal poverty level (FPL), by PSA (2023)

PSA	<100% FPL	100-149% FPL	150-199% FPL	200-249% FPL	250-299% FPL	>=300% FPL
1 - Far Southwest	2,850	2,275	2,575	2,135	2,090	5,755
2 - Southwest Coalfields	3,080	2,920	3,530	2,905	2,065	8,035
3 - Bristol-Galax	4,885	5,650	6,050	4,310	4,215	17,950
4 - New River Valley	2,485	2,300	2,625	2,890	2,325	16,680
5 - Roanoke Valley	5,600	4,665	5,755	5,030	4,825	28,575
6 - Central Shenandoah	4,575	5,185	5,390	5,500	5,130	31,495
7 - Northern Shenandoah	3,600	4,220	3,905	2,970	3,860	27,260
8A - Alexandria	1,425	1,030	785	700	955	14,410
8B - Arlington	2,830	1,259	1,180	790	905	19,715
8C - Fairfax	8,870	5,705	6,390	6,180	6,735	135,750
8D - Loudoun	2,075	1,530	1,780	1,835	1,785	34,760
8E - Prince William	3,260	2,470	2,910	2,830	2,660	44,005
9 - Rappahannock-Rapidan	2,015	1,815	1,635	2,270	2,550	22,785
10 - Jefferson Area	3,515	2,765	3,615	2,735	3,760	33,155
11 - Lynchburg	3,950	4,245	4,635	4,550	4,675	27,250
12 - Martinsville-Danville	6,725	7,255	6,635	5,780	4,895	23,010
13 - Southside	2,725	2,535	2,695	1,530	1,550	8,100
14 - Southern Piedmont	2,900	2,100	2,235	2,140	1,735	8,370
15 - Richmond	13,980	11,800	13,955	12,380	11,840	116,675
16 - Fredericksburg	3,135	2,940	2,900	3,585	3,285	34,820
17-18 - Nor. Neck-Mid. Peninsula	3,095	2,675	2,870	3,640	2,895	21,025
19 - Tri-Cities	2,820	2,610	2,255	2,110	2,830	16,030
20 - Hampton Roads	14,975	11,620	12,915	12,805	13,310	108,215
21 - Peninsula	7,140	5,990	6,030	5,320	5,620	54,195
22 - Eastern Shore	1,615	1,045	1,070	1,035	1,055	5,745
State Total	**114,125**	**98,604**	**106,320**	**97,955**	**97,550**	**863,765**

SOURCE: ACS 5-year 2023 Weldon Cooper Center data. Count represents the number of individuals 65 years of age or older whose household income falls within the federal poverty line category.

TABLE H-4
Average monthly cost of assisted living by PSA (2025)

PSA	Average monthly cost
1 - Far Southwest	$5,825
2 - Southwest Coalfields	5,825
3 - Bristol-Galax	5,825
4 - New River Valley	6,765
5 - Roanoke Valley	6,391
6 - Central Shenandoah	6,984
7 - Northern Shenandoah	5,734
8A - Alexandria	8,725
8B - Arlington	8,725
8C - Fairfax	8,725
8D - Loudoun	8,725
8E - Prince William	8,725
9 - Rappahannock-Rapidan	8,087
10 - Jefferson Area	6,591
11 - Lynchburg	5,973
12 - Martinsville-Danville	5,972
13 - Southside	5,825
14 - Southern Piedmont	6,051
15 - Richmond	7,482
16 - Fredericksburg	8,217
17-18 - Nor. Neck-Mid. Peninsula	6,232
19 - Tri-Cities	7,232
20 - Hampton Roads	6,525
21 - Peninsula	6,525
22 - Eastern Shore	5,825
State Average	**6,940**

SOURCE: JLARC analysis of CareScout Cost of Care Survey, 2026; https://www.carescout.com/cost-of-care. See Appendix B for calculation methodology.

TABLE H-5
Ratio of monthly assisted living cost to median income for families age 65 and older, by PSA (2025)

PSA	Family Median Income	ALF Cost	Affordability Ratio	Meets 0.9 benchmark
1 - Far Southwest	$4,465	$5,825	1.30	✗
2 - Southwest Coalfields	4,463	5,825	1.31	✗
3 - Bristol-Galax	5,233	5,825	1.11	✗
4 - New River Valley	6,813	6,765	0.99	✗
5 - Roanoke Valley	6,354	6,391	1.01	✗
6 - Central Shenandoah	7,031	6,984	0.99	✗
7 - Northern Shenandoah	6,816	5,734	0.84	✓
8A - Alexandria	13,674	8,725	0.64	✓
8B - Arlington	14,034	8,725	0.62	✓
8C - Fairfax	13,313	8,725	0.66	✓
8D - Loudoun	11,863	8,725	0.74	✓
8E - Prince William	11,000	8,725	0.79	✓
9 - Rappahannock-Rapidan	9,011	8,087	0.90 [a]	✓
10 - Jefferson Area	8,879	6,591	0.74	✓
11 - Lynchburg	6,567	5,973	0.91	✗
12 - Martinsville-Danville	5,222	5,972	1.14	✗
13 - Southside	5,557	5,825	1.05	✗
14 - Southern Piedmont	5,842	6,051	1.04	✗
15 - Richmond	8,151	7,482	0.92	✗
16 - Fredericksburg	8,595	8,217	0.96	✗
17-18 - Nor. Neck-Mid. Peninsula	6,698	6,232	0.93	✗
19 - Tri-Cities	7,131	7,232	1.01	✗
20 - Hampton Roads	7,897	6,525	0.83	✓
21 - Peninsula	8,560	6,525	0.76	✓
22 - Eastern Shore	6,626	5,825	0.88	✓
State Average	**8,554**	**6,940**	**0.81**	✓

SOURCE: JLARC analysis of CareScout Cost of Care Survey, 2026; https://www.carescout.com/cost-of-care assisted living data. See Appendix B for calculation methodology.
a) The ratio for PSA 9 - Rappahannock-Rapidan is 0.897.

TABLE H-6
Ratio of monthly memory care cost to median family income for families age 65 and older, by PSA (2025)

PSA	Family Median Income	Memory Care Cost	Affordability Ratio	Meets 0.9 benchmark
1 - Far Southwest	$4,465	$7,573	1.70	✗
2 - Southwest Coalfields	4,463	7,573	1.70	✗
3 - Bristol-Galax	5,233	7,573	1.45	✗
4 - New River Valley	6,813	8,795	1.29	✗
5 - Roanoke Valley	6,354	8,309	1.31	✗
6 - Central Shenandoah	7,031	9,079	1.29	✗
7 - Northern Shenandoah	6,816	7,455	1.09	✗
8A - Alexandria	13,674	11,343	0.83	✓
8B - Arlington	14,034	11,343	0.81	✓
8C - Fairfax	13,313	11,343	0.85	✓
8D - Loudoun	11,863	11,343	0.96	✗
8E - Prince William	11,000	11,343	1.03	✗
9 - Rappahannock-Rapidan	9,011	10,513	1.17	✗
10 - Jefferson Area	8,879	8,568	0.96	✗
11 - Lynchburg	6,567	7,765	1.18	✗
12 - Martinsville-Danville	5,222	7,764	1.49	✗
13 - Southside	5,557	7,573	1.36	✗
14 - Southern Piedmont	5,842	7,867	1.35	✗
15 - Richmond	8,151	9,727	1.19	✗
16 - Fredericksburg	8,595	10,682	1.24	✗
17-18 - Nor. Neck-Mid. Peninsula	6,698	8,102	1.21	✗
19 - Tri-Cities	7,131	9,402	1.32	✗
20 - Hampton Roads	7,897	8,483	1.07	✗
21 - Peninsula	8,560	8,483	0.99	✗
22 - Eastern Shore	6,626	7,573	1.14	✗
State Average	**8,554**	**9,022**	**1.05**	✗

SOURCE: JLARC analysis of JLARC analysis of CareScout Cost of Care Survey, 2026; https://www.carescout.com/cost-of-care assisted living data. See Appendix B for calculation methodology.

TABLE H-7
Average cost of in-home care by PSA (2025)

PSA	Cost per hour	Monthly Cost 10hrs/week	Monthly Cost 25hrs/week	Monthly Cost 40hrs/week
1 - Far Southwest	$32	$1,390	$3,476	$5,562
2 - Southwest Coalfields	32	1,390	3,476	5,562
3 - Bristol-Galax	32	1,390	3,476	5,562
4 - New River Valley	33	1,425	3,563	5,701
5 - Roanoke Valley	36	1,546	3,864	6,183
6 - Central Shenandoah	32	1,369	3,422	5,475
7 - Northern Shenandoah	34	1,492	3,730	5,967
8A - Alexandria	36	1,564	3,911	6,257
8B - Arlington	36	1,564	3,911	6,257
8C - Fairfax	36	1,564	3,911	6,257
8D - Loudoun	36	1,564	3,911	6,257
8E - Prince William	36	1,564	3,911	6,257
9 - Rappahannock-Rapidan	35	1,530	3,824	6,118
10 - Jefferson Area	37	1,608	4,019	6,431
11 - Lynchburg	34	1,477	3,693	5,909
12 - Martinsville-Danville	33	1,427	3,567	5,707
13 - Southside	32	1,390	3,476	5,562
14 - Southern Piedmont	33	1,415	3,538	5,661
15 - Richmond	36	1,564	3,911	6,257
16 - Fredericksburg	34	1,495	3,737	5,979
17-18 - Nor. Neck-Mid. Peninsula	33	1,451	3,628	5,805
19 - Tri-Cities	35	1,506	3,766	6,025
20 - Hampton Roads	35	1,521	3,802	6,083
21 - Peninsula	35	1,521	3,802	6,083
22 - Eastern Shore	32	1,390	3,476	5,562
State Average	**35**	**1,521**	**3,802**	**6,083**

SOURCE: JLARC analysis of in-home care data from CareScout Cost of Care Survey, 2026; https://www.carescout.com/cost-of-care. See Appendix B for calculation methodology.

TABLE H-8

Ratio of monthly in-home care cost to monthly family median income for individuals age 65 and older, by PSA (2025 dollars)

PSA	Family median income (monthly)	10 hrs. weekly	25 hrs. weekly	40 hrs. weekly
1 - Far Southwest	$4,465	0.31	0.78	1.25
2 - Southwest Coalfields	4,463	0.31	0.78	1.25
3 - Bristol-Galax	5,233	0.27	0.66	1.06
4 - New River Valley	6,813	0.21	0.52	0.84
5 - Roanoke Valley	6,354	0.24	0.61	0.97
6 - Central Shenandoah	7,031	0.19	0.49	0.78
7 - Northern Shenandoah	6,816	0.22	0.55	0.88
8A - Alexandria	13,674	0.11	0.29	0.46
8B - Arlington	14,034	0.11	0.28	0.45
8C - Fairfax	13,313	0.12	0.29	0.47
8D - Loudoun	11,863	0.13	0.33	0.53
8E - Prince William	11,000	0.14	0.36	0.57
9 - Rappahannock-Rapidan	9,011	0.17	0.42	0.68
10 - Jefferson Area	8,879	0.18	0.45	0.72
11 - Lynchburg	6,567	0.22	0.56	0.90
12 - Martinsville-Danville	5,222	0.27	0.68	1.09
13 - Southside	5,557	0.25	0.63	1.00
14 - Southern Piedmont	5,842	0.24	0.61	0.97
15 - Richmond	8,151	0.19	0.48	0.77
16 - Fredericksburg	8,595	0.17	0.43	0.70
17/18 - Nor. Neck-Mid. Peninsula	6,698	0.22	0.54	0.87
19 - Tri-Cities	7,131	0.21	0.53	0.84
20 - Hampton Roads	7,897	0.19	0.48	0.77
21 - Peninsula	8,560	0.18	0.44	0.71
22 - Eastern Shore	6,626	0.21	0.52	0.84
Statewide	**8,554**	**0.18**	**0.44**	**0.71**

SOURCE: JLARC analysis of Weldon Cooper Center family median income data 65+ years of age 2023, adjusted for 2025 inflation using federal COLA, and in-home care data from CareScout Cost of Care Survey, 2026; https://www.carescout.com/cost-of-care.
NOTE: In-home care costs used for each PSA according to average rates from the CareScout Cost of Care Survey.

TABLE H-9
Monthly in-home care burden by PSA based on individual income (2025 dollars)

PSA / Burden level	10 hours/week	25 hours/week	40 hours/week
1 - Far Southwest			
less than 10 percent	0%	0%	0%
10 to 19 percent	6%	0%	0%
20 to 29 percent	10%	0%	0%
30 to 49 percent	28%	6%	0%
50+ percent	57%	94%	100%
2 - Southwest Coalfields			
less than 10 percent	0%	0%	0%
10 to 19 percent	7%	0%	0%
20 to 29 percent	9%	0%	0%
30 to 49 percent	30%	7%	0%
50+ percent	54%	93%	100%
3 - Bristol-Galax			
less than 10 percent	0%	0%	0%
10 to 19 percent	8%	0%	0%
20 to 29 percent	12%	0%	0%
30 to 49 percent	29%	8%	0%
50+ percent	51%	92%	100%
4 - New River Valley			
less than 10 percent	0%	0%	0%
10 to 19 percent	18%	0%	0%
20 to 29 percent	14%	0%	0%
30 to 49 percent	29%	18%	0%
50+ percent	39%	82%	100%
5 - Roanoke Valley			
less than 10 percent	0%	0%	0%
10 to 19 percent	9%	0%	0%
20 to 29 percent	19%	0%	0%
30 to 49 percent	29%	9%	0%
50+ percent	43%	91%	100%
6 - Central Shenandoah			
less than 10 percent	0%	0%	0%
10 to 19 percent	16%	0%	0%
20 to 29 percent	14%	0%	0%
30 to 49 percent	31%	16%	0%
50+ percent	39%	84%	100%
7 - Northern Shenandoah			
less than 10 percent	0%	0%	0%
10 to 19 percent	16%	0%	0%
20 to 29 percent	13%	0%	0%
30 to 49 percent	29%	16%	0%
50+ percent	41%	84%	100%
8A - Alexandria			

PSA / Burden level	10 hours/week	25 hours/week	40 hours/week
less than 10 percent	0%	0%	0%
10 to 19 percent	33%	0%	0%
20 to 29 percent	22%	0%	0%
30 to 49 percent	17%	33%	0%
50+ percent	27%	67%	100%
8B - Arlington			
less than 10 percent	0%	0%	0%
10 to 19 percent	32%	0%	0%
20 to 29 percent	23%	0%	0%
30 to 49 percent	16%	32%	0%
50+ percent	29%	68%	100%
8C - Fairfax			
less than 10 percent	0%	0%	0%
10 to 19 percent	29%	0%	0%
20 to 29 percent	23%	0%	0%
30 to 49 percent	18%	29%	0%
50+ percent	30%	71%	100%
8D - Loudoun			
less than 10 percent	0%	0%	0%
10 to 19 percent	24%	0%	0%
20 to 29 percent	22%	0%	0%
30 to 49 percent	20%	24%	0%
50+ percent	35%	76%	100%
8E - Prince William			
less than 10 percent	0%	0%	0%
10 to 19 percent	20%	0%	0%
20 to 29 percent	25%	0%	0%
30 to 49 percent	20%	20%	0%
50+ percent	35%	80%	100%
9 - Rappahannock-Rapidan			
less than 10 percent	0%	0%	0%
10 to 19 percent	25%	0%	0%
20 to 29 percent	14%	0%	0%
30 to 49 percent	27%	25%	0%
50+ percent	34%	75%	100%
10 - Jefferson Area			
less than 10 percent	0%	0%	0%
10 to 19 percent	15%	0%	0%
20 to 29 percent	25%	0%	0%
30 to 49 percent	27%	15%	0%
50+ percent	32%	85%	100%
11 - Lynchburg			
less than 10 percent	0%	0%	0%
10 to 19 percent	15%	0%	0%
20 to 29 percent	14%	0%	0%
30 to 49 percent	30%	15%	0%

PSA / Burden level	10 hours/week	25 hours/week	40 hours/week
50+ percent	42%	85%	100%
12 - Martinsville-Danville			
less than 10 percent	0%	0%	0%
10 to 19 percent	10%	0%	0%
20 to 29 percent	11%	0%	0%
30 to 49 percent	27%	10%	0%
50+ percent	53%	90%	100%
13 - Southside			
less than 10 percent	0%	0%	0%
10 to 19 percent	10%	0%	0%
20 to 29 percent	11%	0%	0%
30 to 49 percent	27%	10%	0%
50+ percent	52%	90%	100%
14 - Southern Piedmont			
less than 10 percent	0%	0%	0%
10 to 19 percent	9%	0%	0%
20 to 29 percent	13%	0%	0%
30 to 49 percent	28%	9%	0%
50+ percent	50%	91%	100%
15 - Richmond			
less than 10 percent	0%	0%	0%
10 to 19 percent	13%	0%	0%
20 to 29 percent	25%	0%	0%
30 to 49 percent	27%	13%	0%
50+ percent	36%	87%	100%
16 - Fredericksburg			
less than 10 percent	0%	0%	0%
10 to 19 percent	24%	0%	0%
20 to 29 percent	15%	0%	0%
30 to 49 percent	23%	24%	0%
50+ percent	38%	76%	100%
17/18 - Nor. Neck-Mid. Peninsula			
less than 10 percent	0%	0%	0%
10 to 19 percent	18%	0%	0%
20 to 29 percent	14%	0%	0%
30 to 49 percent	30%	18%	0%
50+ percent	37%	82%	100%
19 - Tri-Cities			
less than 10 percent	0%	0%	0%
10 to 19 percent	15%	0%	0%
20 to 29 percent	15%	0%	0%
30 to 49 percent	30%	15%	0%
50+ percent	41%	85%	100%
20 - Hampton Roads			
less than 10 percent	0%	0%	0%
10 to 19 percent	21%	0%	0%

PSA / Burden level	10 hours/week	25 hours/week	40 hours/week
20 to 29 percent	15%	0%	0%
30 to 49 percent	27%	21%	0%
50+ percent	37%	79%	100%
21 - Peninsula			
less than 10 percent	0%	0%	0%
10 to 19 percent	22%	0%	0%
20 to 29 percent	16%	0%	0%
30 to 49 percent	25%	22%	0%
50+ percent	37%	78%	100%
22 - Eastern Shore			
less than 10 percent	0%	0%	0%
10 to 19 percent	16%	0%	0%
20 to 29 percent	12%	0%	0%
30 to 49 percent	28%	16%	0%
50+ percent	44%	84%	100%

SOURCE: JLARC analysis of 5-year American Community Survey data prepared for JLARC by Weldon Cooper Center at the University of Virginia (adjusted to 2025 dollars) and in-home care data from CareScout Cost of Care Survey, 2026; https://www.carescout.com/cost-of-care.

NOTE: About 15 percent of the 65-plus population earns $100,000 or more per year, but the American Community Survey does not specify exact incomes above that threshold. This analysis sets income at $100,000 for that entire group, likely an understatement for most individuals within it. American Community Survey population and income estimates are subject to margins of error.

Appendix I: Other approaches for enhancing supply and affordability of services and support for older adults

This appendix includes information about other approaches for addressing supply and affordability of services and support for older adults. These include:

- Care registries
- Adult foster care
- Villages
- Structured family caregiving
- Respite care
- Program of All-Inclusive Care for the Elderly (PACE)
- Local ability to negotiate affordable assisted living units in new developments

Care registries

A care registry is a list of screened, independent caregivers that older adults and adults with disabilities can use to find and directly hire in-home help. Registry caregivers are not employed by a home care agency, and they offer services such as companionship, light housekeeping, meal preparation, personal care, and medication reminders. The organization that maintains the registry typically screens caregivers before listing them, but the consumer and the caregiver negotiate the type and amount of care and the fee.

Only five of the 13 area agencies on aging (AAAs) that responded to a JLARC survey maintain a care registry. Three of those registries list 25 or fewer caregivers, and the other two list between 51 and 100.

AAAs without a care registry cited concerns regarding liability, the lack of a standardized quality of care, appearing biased toward certain providers, workforce issues, and keeping a registry up to date as barriers that make it difficult for them to establish or maintain a care registry. Two AAAs that discontinued their registries cited an inability to properly vet the caregivers, as well as liability and safety concerns.

Nearly all AAAs without a care registry offer consumers another way to find in-home care providers. Out of the eight AAAs that do not currently maintain a care registry, seven reported that their AAA offers another tool, resource, or program specifically designed to help consumers locate or connect with in-home care providers. Those included arranging care for grant recipient clients, referrals to service finders, community referrals, offering in-home care services directly, and referring clients to home-based care vendors at a discounted rate.

AAAs without a care registry most often identified ongoing operational funding as the state support that would help them establish and maintain one. Seven of the eight AAAs that responded to the survey and do not have a care registry identified ongoing operational funding as a top need. Six identified a statewide model template for establishing a registry, and four identified startup funding.

Adult foster care

Adult foster care is a small, locally approved residential option for adults who cannot live independently. A provider offers room, board, supervision, and special services in a home to no more than three adults. Serving a fourth adult requires an assisted living facility license from the Virginia Department of Social Services. Residents can pay with the auxiliary grant (AG), a state- and locally funded income supplement for low-income adults who are aged, blind, or disabled. The AG maximum rate is the same for adult foster care as for assisted living: $2,130 per month as of January 2026.

DARS describes adult foster care as serving adults with physical, intellectual, or mental health disabilities, which can include older adults. However, adult foster care may not suit those with substantial care needs. Providers are not required to be licensed or to help with daily activities such as bathing and dressing. The Joint Commission on Health Care concluded that the setting may best serve adults who need only a residential level of care.

Adult foster care is a local option with limited state involvement. Local boards decide whether to offer the program. Local departments approve each home, authorize each placement, and may set their own eligibility criteria. The Department for Aging and Rehabilitative Services (DARS) writes regulations and guidance, trains local staff, and monitors local performance. However, no state agency licenses adult foster care homes, and DARS directs people seeking a home to their local department rather than to a provider list.

Adult foster care is available in few localities and serves few people. The number of local departments offering it fell from 17 in FY14 to seven in FY25. The remaining seven are Chesapeake, Fairfax, Fauquier, Montgomery, Norfolk, Prince William, and Virginia Beach. There were just 46 individuals in adult foster care in FY25; available data does not indicate how many are older adults.

Similarly, Virginia's behavioral health and developmental disability systems have their own small-home settings, including licensed group homes of eight or fewer residents. Medicaid's Community Living waiver also allows approved adult foster care providers to deliver group home services.

Washington and Oregon have much larger small-home systems. Their programs differ from Virginia's in who licenses homes, how many residents a home serves, and how care is paid for, which may help explain their higher use. Washington's Department of Social and Health Services licenses adult family homes for up to six residents, or eight with approval, and the state's provider association reports nearly 2,800 homes. In Oregon, adult foster care homes for older adults and adults with physical disabilities are licensed by the Oregon Department of Human Services (ODHS) and can serve up to five people. Oregon reported 1,430 licensed adult foster homes in 2023. Both states use Medicaid to pay for care in these homes. In Washington, more than 7,200 adult family home residents received Medicaid in FY13, and Oregon Medicaid has covered adult foster care since 1981.

Virginia Villages Collective

Virginia's neighborhood Villages are community-based organizations that help older adults age in place by providing non-medical services and fostering social connection. Operating on a volunteer-driven, neighbor-helping-neighbor model, Villages offer practical assistance with everyday tasks such

as transportation, minor home repairs, technology support, and errands, as well as social, educational, and wellness programming. Villages address needs at the lower end of the continuum of care for older adults who do not require professional or skilled assistance to remain at home, complementing the in-home supports offered through AAAs and Commonwealth Coordinated Care Plus (CCC Plus) that serve more vulnerable populations. A central goal of the Village model is to reduce social isolation among older adults by providing practical, non-medical supports before more costly professional interventions become necessary.

As of 2025, Virginia had 14 Villages, with the majority concentrated in Northern Virginia and the remainder spread across the eastern, central, and west-central regions of the state. In a survey of 11 of these Villages, leaders reported a combined membership of approximately 2,900 individuals served by roughly 1,200 non-member volunteers who delivered nearly 52,000 hours of assistance, valued at approximately $1.9 million. Volunteers provided more than 30,000 trips to health care appointments and drove over 191,000 miles for member activities such as grocery shopping and errands.

In FY26, the General Assembly appropriated $400,000 for the Aging Well with Virginia Villages program. The funding supported several activities, including capacity-building grants ranging from $7,100 to $10,000 to 11 existing Villages, an outreach and education campaign to promote the Village model across the state, development of startup guides and training materials for new Villages, an independent third-party program evaluation of program effectiveness, and program management and administration.

Structured family caregiving

Structured family caregiving (SFC) is a Medicaid service in which a live-in family member or other trusted individual provides a member's daily care with support from a provider agency. Medicaid pays the agency a fixed daily rate rather than an hourly rate. The agency screens the caregiver, assigns professional staff, such as nurses and social workers, to coach and oversee the caregiver, and passes part of the rate to the caregiver as a stipend. Participants generally must meet the functional criteria for nursing facility care.

At least 13 states offer SFC, though Virginia does not. According to KFF's 2025 survey of state Medicaid officials, 11 states offer SFC through Medicaid home care waivers, most often to older adults and people with physical disabilities, and Massachusetts and Nevada offer it outside these waivers. The state Medicaid agency, or Medicaid health plans in states that use managed care, pays the daily rate. As of July 2025, daily rates in nine states ranged from about $43 to $135, according to rate data compiled by an SFC provider. Six of these states specify how much of the payment must go to the caregiver, either as a share of the daily rate (50 to 60 percent) or as a set dollar amount.

Advocates contend that SFC helps members stay at home by giving caregivers consistent professional support. Caregivers are typically assigned a coach or care team that stays with the family over time and tailors training to the member's conditions, such as dementia or fall risk. Coaches also review caregivers' regular notes and alert the member's care coordinator or health plan to problems such as declining health or caregiver burnout.

Advocates also contend that SFC benefits states by reducing demand for direct care workers, making spending more predictable, and delaying nursing facility placements. A 2017 report by Indiana's Family

and Social Services Administration found that SFC participants had greater functional needs than other waiver participants but lower State Plan spending: $591 per member per month, compared with $1,609 for waiver participants overall. Most of the difference was in State Plan home health services. A 2024 analysis commissioned by an SFC provider found that participants had a 21 percent lower probability of visiting an emergency department and a 45 percent lower probability of injury from falling than a comparison group.

SFC is less suited to families that rely on caregiving as a main source of income. The service is available only to members who live with a willing caregiver, and the caregiver may need to limit work outside the home to meet the member's needs. According to SFC provider staff, the stipend is less than consumer-directed attendants typically earn and is not a living wage. As a result, families that mainly need income tend to choose consumer direction, and some switch from SFC for that reason. Provider staff said that families caring for members with high needs, such as dementia, Parkinson's disease, or ALS, are more likely to choose SFC for the added support.

DARS respite care voucher and CCC Plus respite care

Additional publicly funded in-home care is provided through respite care programs. Respite care is short-term care that gives an unpaid family caregiver a break from caregiving. Two state-administered programs pay for respite. The Department of Medical Assistance Services (DMAS) administers respite through the CCC Plus Medicaid waiver, and DARS administers the Virginia Lifespan Respite Voucher Program. AAAs also offer respite through federal Older Americans Act funding.

CCC Plus respite care is a Medicaid waiver service that provides up to 480 hours per year of short-term substitute care for members. The service is available only to people enrolled in the waiver, who must be eligible for Medicaid and meet the criteria for nursing facility care. Members can receive respite through a home care agency, which employs a trained aide supervised by a nurse. They can also use consumer direction, in which the member or a representative hires and manages the attendant. The 480-hour limit equals about nine hours of respite per week over a full year.

At least 13,000 older CCC Plus members received respite in FY25, most through consumer direction. According to JLARC analysis of DMAS claims data, 13,213 members age 65 and older received consumer-directed respite and 2,575 received agency-directed respite; some received both. From FY21 to FY25, consumer-directed respite use grew by 28 percent, while agency-directed respite use fell by 38 percent. DMAS spent about $71 million on respite for older members in FY25.

The DARS voucher program reimburses family caregivers for up to $595 per household per year in respite costs. The program is not limited to Medicaid members or older adults. Caregivers qualify if they live in Virginia, live with the care recipient at least part time, and document the recipient's disability or medical condition. According to DARS staff, about half of caregivers in the program care for a spouse or parent with dementia or a similar condition, and others care for children with autism or developmental disabilities. Caregivers choose their own respite provider, such as a home care agency, adult day center, or neighbor, and DARS reimburses them after they submit proof of payment.

The voucher program depends on federal grant funding, which is expected to decline. The program is funded through discretionary grants from the federal Administration for Community Living. The most recent grant provided about $1.2 million over five years, and DARS staff expect the next grant

to be about half that amount. In the most recent program year, the program reimbursed $260,819 to 424 caregivers.

PACE

The Program of All-Inclusive Care for the Elderly (PACE) is a Medicare and Medicaid program in which a single organization provides or arranges all a participant's medical care and long-term services and supports. Each PACE organization operates a center where an interdisciplinary team of physicians, nurses, therapists, social workers, and aides provides primary care, therapy, meals, and social activities. The organization also provides transportation to the center and arranges specialists, hospital, nursing facility, and in-home care services. PACE serves adults 55 and older who live in a PACE service area, meet nursing facility level of care criteria, and can live safely in the community with PACE services.

PACE organizations receive a fixed monthly payment for each participant and are financially responsible for a participant's care. Medicare pays a monthly amount for each Medicare-enrolled participant based on the participant's diagnoses and acuity, and Medicaid pays a separate capitated rate. Federal rules require Medicaid PACE rates to be lower than what the state would otherwise spend on the same population. DMAS set FY26 rates about 13 percent below that amount, for a statewide average of about $6,240 per participant per month. Participants typically pay no deductibles or copayments. Medicaid participants, however, must contribute income above a monthly personal allowance toward their care, and DMAS reduces its payment by that amount. PACE staff put the allowance at about $1,600. Individuals who do not qualify for Medicaid may pay privately, but PACE staff reported that the private-pay rate is about $10,000 per month, so most participants are enrolled in Medicaid.

PACE has expanded in Virginia since 2007, but much of the state remains outside any service area. Eight organizations now operate 14 sites, which together served more than 2,000 participants as of 2024. Sites are in Alexandria, Big Stone Gap, Cedar Bluff, Charlottesville, Farmville, Gretna, Lynchburg, Marion, Newport News, Norfolk, Portsmouth, Richmond, Salem, and Winchester. The Winchester program is the newest and opened in September 2024. DMAS assigns each organization a defined set of ZIP codes. Based on those assignments, 45 of Virginia's 133 counties and cities have no area served by PACE, and several others are only partially covered. Unserved localities are concentrated in Prince William County and the Fredericksburg area, the central Shenandoah Valley and Alleghany Highlands, Southside, the Middle Peninsula and Northern Neck, and the Eastern Shore.

PACE organizations can use their capitated payments to help some participants pay for assisted living and in-home care. Medicaid cannot pay for room and board in assisted living facilities. According to National PACE Association staff, however, a PACE organization may cover housing costs within its capitated payment when a participant's care team determines housing is needed. Several Virginia PACE programs contract with assisted living facilities for participants who can no longer live safely at home, and two programs each had 50 or more participants in contracted facilities. The participant pays the facility all income except a small personal allowance, and the PACE program pays the rest of the contracted rate, much like the auxiliary grant (Chapter 8). PACE programs pay assisted living facilities an average of $3,157 per month for residential or assisted living care. That is nearly 50 percent more than the $2,130 auxiliary grant rate but less than half the $6,945 statewide median private-pay rate (Chapter 7). Rates are negotiated with each facility and vary by level of care. One program reported

rates ranging from $2,300 to $4,500 per month, with the highest for memory care. PACE programs provide in-home personal care mostly through their own aides and use contracted agencies to fill gaps. Because PACE organizations must ensure participants receive every hour of care in their plans, one program pays agencies 104 percent of the Medicaid personal care rate and employs its own backup aides to ensure hours are met.

The 2026 Appropriation Act directs DMAS to issue a request for proposals for a PACE program in the Augusta/Rockingham/Harrisonburg area and allows, but does not require, DMAS to make an award (Item 295 UU). No PACE organization currently serves this area, which is in a region where assisted living is among the least affordable in the state (Chapter 7). The language does not set a deadline or appropriate funds. State regulations give DMAS sole discretion over when and where PACE expands. According to PACE staff, new programs can take years to open even after an award, because an organization must build and fully staff its center before it can enroll participants. The Winchester program, for example, received its award in May 2022 and began enrolling participants in September 2024. PACE staff also reported that awarded service areas sometimes go unused. One organization held an area for 13 years without serving it before giving it up.

Local authority to secure affordable assisted living units in new assisted living developments

Virginia statute expressly authorizes localities to adopt certain affordable housing zoning policies, but none of the statutory provisions specifically mention affordable assisted living units. Under current state law (§ 15.2-2304), authority to enact affordable dwelling unit ordinances is restricted to jurisdictions under the county executive and county manager forms of government, which include Albemarle, Arlington, Fairfax, and Loudoun counties, and the cities of Alexandria, Charlottesville, Fairfax, and Falls Church. Effective July 1, 2027, legislation enacted in 2026 (SB 74 and HB 867) will expand this authority statewide, allowing any Virginia locality to establish an affordable housing dwelling unit program and broadening available implementation tools. Another state law (§ 15.2-2305) authorizes comparable programs in other localities through a different statutory framework.

However, because assisted living facilities are not expressly mentioned, local governments face legal uncertainty about whether they can require or negotiate affordable assisted living beds. Virginia is a Dillon Rule state, meaning localities generally may only exercise powers specifically granted by the state.

House Bill 1021 (2026) would have authorized localities with existing affordable housing programs to *require* affordable residential units as a condition of receiving a special zoning exception or special use permit for an assisted living facility. The bill would have provided localities the *option* to impose such a requirement; it would not have established a statewide affordable assisted living unit mandate. HB 1021 was continued to the next legislative session. A 2025 version of the bill would have allowed localities to *negotiate* with assisted living developers for affordable units, rather than requiring developers to include them.

Other states have adopted related housing and long-term care policies, although they are not all equivalent to an assisted living-specific local zoning set-aside. For example, Massachusetts allows qualifying affordable housing developments—including certain assisted living developments—to bypass local zoning restrictions if a certain percentage of units are considered affordable. In New Jersey, local zoning boards can negotiate affordable unit set-asides for low- and moderate-income seniors in assisted living developments. Rhode Island expressly includes qualifying assisted living housing in its statutory definition of affordable housing and authorizes local inclusionary zoning requirements for assisted living supported by density bonuses.

Industry representatives have expressed concerns that a mandatory set-aside could inadvertently halt development of new assisted living facilities in localities that choose to use the authority. However, the mandate's effect would depend on the percentage of affordable units to be set aside, the affordability threshold, available development incentives, and the profitability of the overall project. Changing the bill to expressly authorize localities to negotiate and accept voluntary affordable-unit commitments as part of the special exception or special use permit process, rather than require them, could address some stakeholders' concerns.

Fairfax County's experience demonstrates that some developers are willing to make such commitments. The county's Health Care Advisory Board has historically recommended that applicants reserve 4 percent of assisted living or memory care beds for low-income residents. Some developments have accepted this condition, including one approved in 2016 that required at least 4 percent of beds to be

maintained for auxiliary grant-eligible residents. This demonstrates that localities can successfully obtain affordable-unit commitments through negotiated zoning conditions.

In addition to allowing localities to *negotiate* the inclusion of affordable assisted living facility units with developers, other changes could be considered. For example, the bill does not specify the eligible residents, the share of affordable units, the affordability standard, enforcement mechanisms, or applicability of the new authority (i.e., only new developments).

The legislation could be strengthened in several ways:

- Define the target population: The legislation should specify that units are restricted to individuals qualified for assisted living level of care. The bill does not identify who could occupy the affordable units, and one stakeholder group expressed concern that it could be interpreted as requiring assisted living facilities to set aside units for a broader population.

- Give localities flexibility to determine the share of affordable units and the affordability standard: To maximize the clarity of local authority, the bill could expressly grant localities flexibility in how "affordability" is defined in development agreements and in determining the number or proportion of units that must meet the definition. The bill is currently silent on those issues.

- Allow localities flexibility to define the cost components of assisted living that must meet the affordability definition: An assisted living facility generally charges for both room and board and personal care or other services, so restricting affordability only to room and board could leave the combined cost unaffordable. To ensure that affordable units provide meaningful financial assistance, the legislation could expressly authorize localities to establish affordability standards based on the combined cost of housing and required services, or to distinguish the components subject to the affordability requirement.

- Require local agreements to include enforcement mechanisms: To ensure that affordable units remain available to eligible residents over time, the bill could require local ordinances to establish compliance and enforcement mechanisms. These could include a specified affordability period, periodic reporting of occupancy and charges, and appropriate procedures for addressing noncompliance.

- Specify whether the authority applies to new developments or modifications to existing assisted living facilities: An existing facility could apply for a special zoning exception or special use permit, and the legislation is unclear about whether the locality's authority would extend to those circumstances. The bill could be amended to restrict authority to future new assisted living facility developments or clarify that it applies to all instances of assisted living facilities applying for zoning approvals, or it could clarify that existing facilities applying for an exception or permit related to a modification or renovation could also be included.

Finally, because the bill references state laws governing affordable dwelling units (ADUs) (§ 15.2-2304, 2305, 2305.1), it could be modified to amend those sections of statute so that assisted living units qualify for affordability initiatives under local ADU programs.

The financial feasibility of setting aside affordable units in new assisted living developments will depend on requirements in a local ALF affordability program and a developer's ability to offset lower revenues with revenue from market-rate units or subsidized financing. Currently, the Department of Housing and Community Development (DHCD) excludes assisted living facilities from eligibility under its Affordable and Special Needs Housing (ASNH) program, which administers resources from the Virginia Housing Trust Fund and certain federal housing programs. Policymakers could consider whether state and local housing trust funds or other housing assistance programs could be used to support affordable assisted living development, which could reduce development costs and improve the feasibility of affordable-unit commitments in assisted living facilities.

Additionally, stakeholders acknowledged that state law could be clearer about whether assisted living facilities should be considered "housing" for certain purposes, including eligibility for special financing and local zoning authorities. While statute (§ 36-55.26, § 36-141) expressly treats medical and related facilities providing residence and care for older adults as dwelling accommodations for purposes of Virginia Housing's statutory authority, the provision does not automatically establish eligibility under the Virginia Housing Trust Fund or federal housing programs. The General Assembly could direct DHCD and Virginia Housing to evaluate whether these administrative restrictions should be adjusted to allow qualifying assisted living developments to compete for low-interest financing.



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