Long-Term Care & Medicaid Reform Subcommittee

Draft Decision Matrix

November 8, 2007
Revised

Purpose of Document:

A. To review and discuss findings, public comments, and policy options regarding staff reports and other issues that came before the Commission and its Subcommittees in 2007.

B. To develop Commission recommendations to advance to the 2008 General Assembly.

Long-Term Care & Medicaid Reform Subcommittee
Decision Matrix

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Shortage of Geriatricians in Virginia

Jonathan M. Evans, Associate Professor/Chief of the Section of Geriatric Medicine
University of Virginia School of Medicine

*This document is a summary of Dr. Evan's presentation on October 17, 2007. Efforts were made to communicate the information presented clearly and accurately. The exact wording from the presentation was used when possible.

Background

A national shortage of certified geriatricians is projected to worsen over coming decades; 20,000 were needed nationwide in 2006 while there are only 7,100 certified geriatricians. Approximately, 350 geriatric physicians are in training each year nationwide.

In 2006, Virginia needed 500 geriatricians, but only 146 were in practice.

While the number of certified Geriatricians continues to fall, it is often claimed that financial disincentives pose the greatest barrier to entry into the field of geriatrics, but they do not. The greatest barriers in Virginia now are attitudinal and the scarcity of fellowship training positions. Regarding fellowship levels, one out of every 20 Medicare recipients nationwide lives in Virginia, which should translate into minimum of 18 training positions a year statewide at current levels, but the maximum number of physicians being trained to become geriatricians in Virginia is 9-10 per year.

The population of Virginians age 65 and older will double between 2000 and 2020. Currently, there is a lack of access to high quality, age-appropriate care for older Virginians that is expected to worsen over the next decade. The number of physicians willing to focus their practice on care of older Virginians is decreasing.

Care of Older Patients

Normal age-related changes in the body have major effects on response to drug prescribing, testing and treatment. Also, the ability to seek care, to care for oneself, and onset of age-related illness makes treating older patients different.

Geriatricians Training

There are few opportunities for geriatric training in Virginia colleges because:

- Not all 10 Medicare Approved Geriatric Fellowship training positions at 4 Sites/Schools are funded (For 2007-2008 - 7 geriatric trainees)
- Geriatric Medicine is not a high priority for Medical Schools, University Hospitals
- There is no widely held belief in need for change among University medical centers, faculty or among practicing physicians statewide.
- Medical culture and bureaucracy very much opposed to change, especially change imposed by others

How can the Virginia General Assembly impact the number of Geriatricians in Virginia?

- Allocate new funds for additional geriatric fellowship positions
- Tie current State funding for universities, teaching hospitals (i.e. Indigent Care funds) to geriatric training at all levels, including fellowship training
- Develop benchmark goals for teaching hospitals, Schools of Medicine re: geriatric education/training, number of Geriatricians statewide
- Complete funding of geriatric training experiences most likely to be effective, provided funds cannot be expropriated for other purposes

Options Created By JCHC Staff

Option 1: Take no action.

☑ **Option 2:** Request by letter of the Chairman that the Joint Commission study Virginia's pipeline for the education and specialization of medical doctors and compare the outputs to Virginia's medical needs. This would be a two-year study with an interim report JCHC in 2008 and a final report in 2009.

Staff Report:
States' Health Care Reform Initiatives

State Health Care Reform Themes
Many states are implementing health care reform initiatives and some of the themes throughout the states are:

- Offering insurance products with different premiums based on ability to pay
- Increasing Medicaid eligibility levels
- Managing chronic disease conditions
- Establishing incentives and penalties for employers providing health insurance coverage such as:
    - Tax credits for businesses providing health insurance (HI) coverage
    - Fees for larger employers that do not provide health insurance

Massachusetts
Massachusetts has initiated a health care reform that required all adults to purchase health insurance by July 1, 2007. Subsidies were to be provided for individuals below 300% the Federal Poverty Level (FPL). By October 2006, over 90,000 previously uninsured adults were enrolled in state-subsidized private health insurance coverage. The financing for this initiative is expected to come from additional state general funds, employer contributions, redistributing existing funding, Medicaid, and the Uncompensated Care pool.

- Total Cost for FY 2008 is expected to be $1.7 billion.

Pennsylvania
The Governor of Pennsylvania proposed "Cover All Pennsylvanians" (CAP) a small business and individual private insurance product to allow more citizens to become insured. Businesses that have fewer than 50 employees did not provide health insurance in the past 6 months and whose average employee salary is less than $40,000 are eligible for the CAP plan. Also, all individuals are eligible but those who are under 300% FPL can receive a subsidy toward the plan. The expected financing for this program is a 3% tax on businesses of their wages paid; however, credits will be available for businesses offering health insurance coverage to their employees.

Tennessee
Cover Tennessee is a combination of three health insurance programs recently enacted in Tennessee:

- AccessTN — comprehensive health insurance for the uninsurable
- CoverTN — basic individual health insurance for employees of qualified small businesses and the working uninsured
- CoverKids — comprehensive health insurance for children

Financing for these programs is through: premiums paid, Health Care Safety Net program, savings from Medicaid changes, state revenue, federal funding, and insurance industry assessments.

- The total cost $251 million for 3 years

Vermont

Vermont created a new state-supported individual insurance product for citizens that have been uninsured over 12 months and are not eligible for most existing state insurance programs. Financing for this program came from: individual premiums, new tobacco taxes, and employers.

Virginia

In 2005, Virginia had an estimated $1.45 billion in uncompensated medical care provided to the uninsured. This care was paid through health care provider donations, Medicaid Disproportionate Share Hospital (DSH), State and Local Hospitalization Fund, as well as other sources. In addition, insured patients are likely to pay more for their health care to cover providers' uncompensated care losses.

Virginia has undertaken several Medicaid reform initiatives, some of which include:

- Medicaid's major pharmacy initiatives to improve patient care and control costs
- Enhanced Smiles For Children
- FAMIS Mom's eligibility up to 166% FPL
- Revamped FAMIS Select
- Programs for All-Inclusive Care of the Elderly (PACE)
- Chronic Obstructive Pulmonary Disease (COPD) added to the Healthy Returns disease management program
- Long Term Care partnership
- Regional model for service integration
- Expansion of Medallion II (managed care) into Lynchburg region

The Governor convened a Health Care Reform Commission that has met since October of 2006. It is addressing health care reform in:

- Health Care Workforce
- Access to care
- Quality
- Transparency
- Prevention
- Long Term Care

The Commission's reform recommendations were presented to JCHC October 26th, 2007.

Update: Integration of Acute & Long-Term Care and Expansion of PACE

Cindi Jones, Chief Deputy Director
Department of Medical Assistance Services

*This document is a summary of Ms. Jones' presentation on August 16, 2007. Efforts were made to communicate the information presented clearly and accurately. The exact wording from the presentation was used when possible.

Overview of Long-Term Care Partnership Programs

Long-Term Care (LTC) partnerships are public-private ventures to address the financing responsibility of LTC and are designed to encourage individuals to purchase private LTC insurance in order to fund their LTC needs, rather than relying on Medicaid to do so.

The DRA lifted the moratorium on estate recovery disregards thereby encouraging new development of LTC partnerships as an option for state Medicaid programs. Under the DRA, states are now allowed to develop LTC partnerships using what is termed the "dollar-for-dollar" model. Dollar-for-dollar policies protect a specific amount of personal assets so that every dollar that a LTC Partnership insurance policy pays out in benefits, a dollar of assets can be protected during the Medicaid eligibility determination.

- The Virginia LTC Partnership launched in September 2007.

The Blueprint for the Integration of Acute and Long Term Care

The cost of serving the elderly and disabled is substantially greater than the cost of caring for children.

- Elderly and persons with disabilities represent 30 percent of Medicaid recipients, yet they account for 71 percent of program expenditures.

To decrease health care service fragmentation, capitated and coordinated care systems **c**ombine acute and long term care services (except for certain waiver programs) under one capitated rate.

DMAS has introduced two models for integration: community and regional.

The **Community Model** is the Program of All Inclusive Care for the Elderly or PACE which combines Medicaid and Medicare funding to provide all medical, social, and long term care services through an adult day health care center.

- Six communities actively pursuing PACE—6 were awarded start up grants ($250,000 each).
    - Hampton Roads (2)
    - Richmond (1)
    - Lynchburg (1)
    - Far Southwest (2)

The services provided by **Regional model** may vary and could range from a capitated payment system for Medicaid (potentially integrating Medicare funding) for acute care costs with care coordination for long term care services, to a fully capitated system for all acute and long term care services. Enrollment will be mandatory with opt-out provisions. Certain services are carved out of this model, including:

- Behavioral Health Services (state plan option only)
- Certain waiver programs (MR, DS, DD, Technology Assisted, Alzheimer's Assisted Living)

Phase I (September 1, 2007) expands managed care for primary and acute care needs only to the Aged, Blind and Disabled with no Medicare, but who have long term care needs. LTC services remain fee for service. This will impact about 500 Medicaid only clients who are receiving managed care first and now need long term care services.

Phase II (2008-2010): Fully integrates acute and long term care services and combines Medicaid and Medicare funding, but excludes certain home and community-based care waiver program services (MR, DS, DD, Tech, Assisted Living).

Update: Medicaid Reform and Long-Term Care Partnership

Steve Ford, Director of Policy and Research
Department of Medical Assistance Services

*This document is a summary of Mr. Ford's presentation on August 16, 2007. Efforts were made to communicate the information presented clearly and accurately. The exact wording from the presentation was used when possible.

Update on Agency Efforts in Response to Citizenship and Identity Provisions of the DRA

Section 6036 of the Deficit Reduction Act of 2005 (DRA) mandates a new provision, effective July 1, 2006, that requires individuals claiming U.S. citizenship to provide satisfactory documentary evidence of citizenship and identity when initially applying for Medicaid, or at the first re-determination of eligibility completed on or after July 1, 2006. Prior to this change, self-attestation of citizenship was acceptable.

The requirements have already had a significant impact on the enrollment statistics for the Medicaid program including a net decrease in Medicaid enrollment of children of approximately 9,500 since the new requirements were implemented (through June, 2007).

DMAS continues to look for ways to streamline the Medicaid eligibility process with our partner agencies through:

- DSS and VDH Vital Records are developing an on-line batch process to further streamline Virginia birth verifications
- DMAS and DMV are exploring the feasibility of data matches to properly establish identity of applicants/recipients
- DMAS and DSS continue facilitating the sharing of birth record data between states
- DMAS and its partner agencies continue to participate in national discussions of the unintended consequences of the requirements, in hopes that additional modifications to the provisions can occur.

Update on Recommendations of the Medicaid Revitalization Committee

The mission of the Medicaid Revitalization Committee (MRC) is to consider potential revisions and make recommendations regarding the future structure of Virginia's Medicaid program.

In response to recommendations by the MRC, a variety of resulting initiatives undertaken are described below.

The 2007 Appropriation Act provided authority and funding for DMAS to add Chronic Obstructive Pulmonary Disease (COPD) to the *Healthy Returns*^{SM} disease management program.

Pursuant to legislation, DMAS is currently developing Enhanced Benefit Accounts incentive models for Medicaid recipients in the *Healthy Returns*^{SM} program, which will be considered during the upcoming Executive Budget development process.

DMAS Medicaid managed care program, Medallion II, began operation in the Lynchburg region beginning October, 2007. Three managed care organizations will cover approximately 14,000 eligible enrollees there.

DMAS conducted a study of buy-in options under the FAMIS Program last year (House Document 48, 2006), which identified several competing factors that would influence the take-up rate and cost of a buy-in option.

Update: "No Wrong Door" System and Departmental Actions Due to HB 2032

Debbie Burcham, Chief Deputy Commissioner
Virginia Department for the Aging

*This document is a summary of Ms. Burcham's presentation on August 16, 2007. Efforts were made to communicate the information presented clearly and accurately. The exact wording from the presentation was used when possible.

Background

HB 2032 was passed in 2007 and amended Section 2.2-701 of the *Code* to:

- Promote self-care and independent living
- Expand long-term care services to include:
  - Educational Services
  - Housing Services
  - Transportation Services

The *Code*'s description of long-term care now matches the direction that Virginia's long-term care system has taken as state agencies actively work to transform the system and parallels the direction of the federal Older Americans Act which guides Virginia's 25 local AAAs

- Virginia Department for the Aging engaging is a variety of educational, housing, and transportation service activities.

No Wrong Door

"No Wrong Door" enables individuals to understand all of their options for services regardless of where they originally seek help. Aging and disabled individuals within a geographic region are served, regardless of income. Implementation sites for this program include:

- Valley Programs for Aging Services
- Senior Connections, The Capitol Area Agency on Aging
- Peninsula Agency on Aging
- Bay Aging

Additional sites expected to be trained and implemented by October, 2007 are:

- Mountain Empire for Older Citizens
- Rappahannock-Rapidan CSB/AAA

Virginia Department for the Aging's next steps for No Wrong Door are:

- Developing an electronic Medicaid application in collaboration between VDA, VDSS, and DMAS.
- Integrating 2-1-1 Virginia and No Wrong Door into a complementary solution
- Developing the No Wrong Door portal
- Establishing processes to allow secure sharing of confidential client information

2007 Report of the Virginia Alzheimer's Disease and Related Disorders Commission

Russell H. Swerdlow, MD
Chair, Alzheimer's Disease and Related Disorders Commission

*This document is a summary of Dr. Swerdlow's presentation on August 16, 2007. Efforts were made to communicate the information presented clearly and accurately. The exact wording from the presentation was used when possible.

2007 Short Term Recommendations

- Respite care is any service or set of services that allows a caregiver of a demented individual to temporarily escape from the caregiver role
- Takes on different forms:
  - Adult day care
  - In home respite care
  - Institutional respite care

Scope of the Problem

- 7 of 10 people with AD live at home
- 75 percent of their care is provided by family and friends
- On average each care recipient receives $23,436 worth of informal care
- In 2005, Virginia had almost 250,000 caregivers with an equivalent of 215,563,228 hours of unpaid care per that year valued at over $2.1 billion

Benefits to the Commonwealth

- Respite care resources allow caregivers to continue within the taxable workforce, which increases the tax base and in turn helps pay for increased respite program investment
- Increasing investment in respite care can create jobs, and can therefore benefit local economies
- Respite care can delay time to nursing home placement, which can reduce dependence on Medicaid subsidization of long term care and result in substantial savings to the Commonwealth
  - Can delay nursing home placement by a year
- Respite helps preserve both the mental and physical status of caregivers, which keeps them productive in their communities and in the workforce

- Although the number of Alzheimer's patients in the Commonwealth has markedly increased in the past 20 years, the amount of funding by the Virginia General Assembly for its Respite Care Initiative has not increased in 20 years

Virginia Alzheimer's Commission AlzPossible Initiative (VACAPI)

- Education, Outreach, and Information Core
- Services Core
- Research Core
- Administrative Core

Recommendations

- Increase funding for the Virginia General Assembly's Respite Care Initiative to achieve more complete statewide coverage (expand coverage to locales currently not served by the program)
- Encourage local level planning for increased delivery of resources (local agencies will decide how to organize service improvements, by either providing services to more people, or else providing more services to those already participating in respite programs)
- Strive to reduce the length of respite care wait lists and the time to receive services once services are applied for (a reduction in wait lists and wait times should be used as outcome measures)
- Create a mechanism for receiving feedback from caregivers on the state of respite care services (it is further recommended this mechanism be provided through the Virginia Alzheimer's Commission AlzPossible Initiative website).

Options

Option 1: Take no action.

Option 2: Introduce a budget amendment to provide funding (amount to be determined) to allow for additional funding for the Respite Care Initiative.

JLARC Final Report: Impact of Assisted Living Regulations

Walt Smiley, Team Leader
Joint Legislative Audit and Review Commission

*This document is a summary of Mr. Smiley's presentation on October 17, 2007. Efforts were made to communicate the information presented clearly and accurately. The exact wording from the presentation was used when possible.

Study Mandate

Item 21E of the Appropriation Act directed JLARC to report on impact of new regulations for assisted living facilities

Assisted Living at a Glance

What is assisted living?

- Non-medical residential settings provide personal and health care services and 24-hour supervision

Who oversees Virginia's ALFs?

- Licensed by Department of Social Services if 4 or more residents
- Other regulations by Department of Health and Department of Health Professions

What are key characteristics of ALFs in Virginia?

- 583 licensed facilities: 4 to 500 beds (average: 55)
- 32,000 statewide capacity
- 81% private pay

ALF Population & Facility Size Increasing

Capacity grew 207% from 1979 to 2007 – from 10,420 to 31,964

- Outpaced State population growth by 43%

Number of Virginians 85 and older expected to double between 2000 and 2030

Auxiliary grant beds not available in 41 localities

2005 Legislation Required 3 Sets of Regulations

Board of Social Services (DSS) licensing authority enhanced

- Increased maximum fine to $10,000
- Streamlined license suspension
- Required DSS to issue emergency regulations

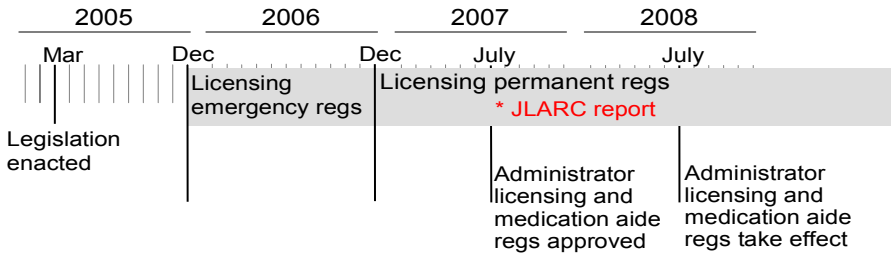
Board of Nursing (BON) to register medication aides

- Aides must pass State exam and register by July, 2008
- ALFs must develop medication management plans

Board of Long-Term Care Administrators (BLTCA) to license ALF administrators

- Draft licensure regulations developed, not yet finalized

Regulations Phase In Over Time



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ALF Administrator Licensing Delayed

Governor questioned Board of Long-Term Care Administrators draft regulations

- Need for both national and State exam
- Required amount of administrator-in-training hours
- Sufficiency of candidate pool

The Board met July 10, 2007 and adopted changes

- Dropped test on State law
- Changed initial licensure requirements, lowering required time as Administrator-in-Training
- Altered 'preceptor' requirements

Draft regulations now in Governor's Office

Finding

114 ALFs (20%) had significant compliance problems and/or verified complaints

"Quality" Not Defined in Statute or Regulation

To identify ALFs of concern, JLARC used data on compliance with standards and verified complaints

DSS staff monitor ALFs for compliance

Complaints investigated by

Long-Term Care Ombudsman in Area Agencies on Aging

- DSS Adult Protective Services
- DSS Division of Licensing Programs

1 in 8 ALFs Had 5 or More Verified Complaints in 2006

1 in 9 ALFs Had a Recent History of Problems Meeting Standards

- Provisional license

- Adverse enforcement action
- Enforcement watch
- Above-average number of high-risk health and safety violations (5 or more)

25 ALFs Had Both Verified Complaints and Compliance Problems in 2006

Characteristics of ALFs of Concern

Larger: capacity of 20 or more

More prevalent in 4 of 8 DSS regions: Western, Fairfax, Piedmont, Verona

Serve more auxiliary grant recipients

- 23 per ALF (compared to 11 for all ALFs)
- 40% of capacity (compared to 31% for all ALFs)

One Year Later: ALFs Of Concern as Identified in JLARC *2006 Status Report*

Status	Number	Percent
Improved; No Longer "Of Concern"	56	41%
Closed	12	9%
Closed & Reopened Under New Ownership	10	7%
Remain "Of Concern"	59	43%
Total	137	100%

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Finding

Quality of key services continues to be a problem

- Medication administration
- Staffing
- Access to mental health services

Medication Administration Still of Concern

18% of verified licensing complaints were medication-related (22% last year)

8 of 10 most frequently cited high-risk health and safety violations were medication-related (same as last year)

Most frequent problems (same as last year)

- Failure to follow physicians' prescriptions and orders
- Inadequate documentation
- Inadequate staff training

Registration of medication aides required by 2005 law takes effect in July

Adequacy of Staffing and Training Still of Concern
Second-most frequent licensing complaint
More than 400 complaints of resident abuse or neglect verified in 168 ALFs
Staffing a factor in three-fourths of adverse enforcement actions issued

Finding
New law and regulations will require new fees and increase costs

Fees and Training Costs Increasing
ALF administrator licensing draft standards

- High school or GED, exam, annual fee, training and education requirements (some exceptions)

Medication aide registration standards

- Annual fee, training, exam

DSS standards

- On-site quarterly reviews of special diets by dietitian or nutritionist

Facility Costs Increasing
Air conditioning by June 2007 for "largest common area used by residents"

- Estimates exceed $10,000 for older ALFs
- Air conditioning in all areas used by residents in 2012
- Many, but not all ALFs already air conditioned

Connection to temporary electrical power required in July, 2007

Typical Costs Imposed by New Law and Regulations

	Cost per "Average" ALF
Administrator Licensing	$200 + training
Medication Aide Registration	$120 + training
Dietitian Review of Special Diets	$120-1,200/year
Temporary Electrical Power	0-$6,000 +
Air Conditioning	0-$10,000 +
Total Potential Costs	**$440-17,520 +**

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Finding
Auxiliary grant increases have not accounted for cost of new requirements; the rate remains below market prices

Auxiliary Grant Has Increased
More than 50% of ALFs are partly or totally dependent on State auxiliary grant funding.

- Majority of residents receive auxiliary grant funding in at least 208 ALFs; another 100 ALFs have at least one auxiliary grant recipient

As of July, the auxiliary grant rate is $1,061 per month, with $75 personal allowance.

SSI	$ 623
State	$ 350
Local	$ 88
Total	$1,061

Rate is not tied to cost or quality of care.
Auxiliary grant rate is well below market prices.
Auxiliary Grant May Not Be Sufficient for Compliance.
ALFs of concern serve more auxiliary grant recipients.
ALFs serving auxiliary grant recipients have less revenue available.

Key Findings
As new law and regulations phase in, some ALFs continue to experience problems.

- Medication administration, staffing, mental health services

Auxiliary grant beds may not be available in the areas they are needed

- 41 localities have none

New law and regulations impose added costs on ALFs and ALF staff, but adjustments to auxiliary grant rate have not been adequate – the rate remains well below the market.

JLARC Study: Impact of an Aging Population on State Agency Services

Ashley S. Colvin, Team Leader
Joint Legislative Audit and Review Commission

*This document is a summary of Mr. Colvin's presentation on October 17, 2007. Efforts were made to communicate the information presented clearly and accurately. The exact wording from the presentation was used when possible.

Scope and Content of the Study

Certain factors may affect extent of demand

- Disability rates, availability of federal funds for caregivers, ability of retirees to pay for long-term care and other costs.

Future Trends in Overall Disability Rates Are Not Well Understood

Certain factors, particularly those reported among baby boomers, may increase future disability rates

- Number of Virginians with Alzheimer's Disease is expected to increase, which may impact spending
- Obesity is reported to persist into later life and increase health care costs. More baby boomers are obese than today's older Virginians

Trends Suggest Some Retirees May Not Be Able To Pay for Health Care

Trends that may affect ability of persons to pay for health care and other services include:

- Decreasing availability of private-sector pensions and retiree health care benefits
- Some baby boomers may have less income in retirement than today's retirees

If these trends continue, State and local agencies may face increased service demands. However, projected decreases in poverty rates suggest that eligibility rates for Medicaid may decrease

Future Availability of Caregivers Could Affect Extent of Impact on Agencies

Informal, unpaid caregivers provide most of the care to older persons, and may mitigate need for publicly funded services

Future availability may be affected by trends in workforce participation and family structure

State support could increase future caregiver availability, but there is unmet demand for current State-supported services

- State funding for Caregivers Grant has been inconsistent
- Statewide capacity for adult day care centers is 2,406
    - Adult day care is not available statewide

Projections Indicate Shortage of Nurses and Other Health Care Workers
State Council of Higher Education for Virginia reports shortage of 22,600 registered nurses in Virginia by 2020

- Difficulty recruiting and retaining nursing faculty
- Limited number of clinical sites
- Inadequate student aid

PriceWaterhouseCoopers reports current shortage of 2,763 health care workers in northern Virginia.

Local Agency Staff Report Shortages of Medicaid-Funded Nursing Home Beds
Seventy-nine percent of Medicaid nursing home expenditures are for persons age 65 and older

Projections indicate total Medicaid nursing home expenditures will increase
Certain factors may impede access

- Nursing homes are reportedly unwilling to accept clients with behavioral problems or complex needs
- Nursing homes reportedly prefer higher-paying clients

Shortage of Auxiliary Grant Beds in Assisted Living Is Reported
Assisted living facilities that accept the auxiliary grant agree to charge no more than the auxiliary grant rate

- About 44 percent of auxiliary grant recipients are age 65 and older, and expenditures in FY 2004 were about $8 million
- Some areas lack auxiliary grant beds

Mental Health, Mental Retardation, and Substance Abuse Services
Community services boards (CSB) report that their reliance on Medicaid results in restrictions on who is served

Nursing homes report that Medicaid rate limits hiring of staff needed for residents with behavioral problems

State mental health hospitals, and mental retardation training centers, are affected by a lack of private & community-based services

Lack of community providers of MH, MR, and SA services with geriatric training

Mental health (MH): Persons with behavioral problems due to dementia are typically not eligible to receive publicly funded MH services. Other public services are not designed to meet their needs

Mental retardation (MR): The lifespan of persons with MR is increasing. Lack of appropriate supportive services in the community may result in institutionalization

Substance abuse (SA): Medicaid just began to pay for some SA services, but the number of older Virginians who need SA services may increase

Medicaid projections do not account for likely impact of increasing life expectancy among persons with MR, or the aging of their informal caregivers

Extent of existing unmet need for MH, MR, and SA services may be greater for today's older Virginians because of self-reliance and stigma

- Baby boomers may be more willing to demand services

Services for Vulnerable Older Virginians Are Limited

Long-Term Care Ombudsman program responds to complaints about quality of long-term care services

- Current staffing level is below 1:2,000 level established in statute
- Very few calls are from non-institutional clients, but increasing demand for home and community-based services could increase demand for this service as well

No Policy Options Presented

Virginia Quality Improvement Program (QIP)

Terry Smith; Division Director
Division of Long-Term Care
Department of Medical Assistance Services

*This document is a summary of Ms. Smith's presentation on October 17, 2007. Efforts were made to communicate the information presented clearly and accurately. The exact wording from the presentation was used when possible.

Background

House Bill 2290 of the Virginia General Assembly required the Director of DMAS to:

- Establish a Nursing Facility (NF) Quality Improvement Program; and,
- Provide a strategic plan and progress report to the Governor, Chairmen of the House Committees on Health, Welfare and Institutions, and Appropriations; the Senate Committees on Education and Health, and Finance; and the Joint Commission on Health Care by October 1, 2007.

Civil Money Penalty (CMP) Funds

Federal and State law dictate certain quality standards for NFs that are enforced through periodic surveys conducted by the Virginia Department of Health and the Centers for Medicare and Medicaid Services (CMS).

- Several remedies exist to address quality issues raised during the survey process including imposition of civil money penalties for NFs out of compliance.
- CMS gives states broad latitude in using CMP funds.
- Nationally, states use CMP funds for:
    - survey and certification activities, such as temporary management, relocation, or consulting; and
    - special projects.
- CMP funds are collected when quality deficiencies are discovered during periodic on-site surveys.

VDH conducts the on-site surveys and assesses the fines.

- The amount of a fine assessed depends upon three deficiency categories.
    - Category 1 Deficiency - typically remedied by a plan of correction, state monitoring, and/or directed in-service training.
    - Category 2 Deficiency – resolution includes denial of payment by CMS for new admissions for all residents, and/or CMPs of $50 to $3,000 per day; or, a single instance of $1,000 to $10,000
    - Category 3 Deficiencies (most serious)
        - Deficiencies in Category 3 directly affect resident behavior, nursing practices, quality of life, and quality of care. Remedies involve temporary management or termination of the provider agreement.

QIP Advisory Committee
The Alzheimer's Association; State Long-Term Care Ombudsman; Virginia Association for Home Care and Hospice; Virginia Coalition for the Aging; Virginia Health Care Association; Virginia Association of Non-Profit Homes for the Aging; State Agencies (VDA, VDH, DMHMRSAS, VDSS, Health Professions, DMAS); Other advocates and stakeholders

Committee Discussions
QIP programs were researched in other states and considered for replication in Virginia

- For the foreseeable future, the need to attract and retain an adequate and stable number of well-qualified and motivated direct care workers will continue to be a shared concern of employers, employees, consumers, families, and public payors.
- Based upon discussions and review of existing QIPs, the committee endorsed building on voluntary models that would refocus facility culture, operations, and outcomes without increasing costs.

A Culture of Caring
North Carolina's Program, *Better Jobs Better Care*, builds a culture of caring within nursing facilities. It is a proven model for quality care and seems to best match the committee's vision for enhancing the lives of Virginia's nursing facility residents.

- Better Jobs Better Care began as a pilot program limited to 60 providers.
    - North Carolina expanded the successful pilot program statewide with the intent of making it a meaningful and voluntary "raise-the-bar" program pertaining to nurse recruitment and retention in long-term care.
    - Program's 4 Domains:
        - Supportive Workplaces (peer monitoring, coaching supervision, supportive management)
        - Balanced Workloads
        - Training
        - Career Opportunities
- Participating NFs:
    - Attend an orientation meeting
    - Work toward implementing the program requirements with the expectation of submitting an application to become a designated facility, which will be publicized as a positive achievement for the NF
    - Provide feedback as requested to program administration

A key component is a special two year licensure designation, "New Organization Vision Aware" (NOVA), using a statewide, uniform set of criteria and

expectations. Providers voluntarily submit evidence for consideration - On-site visits and desk reviews are conducted. Eligibility for enhanced funding or reimbursement may follow NOVA designation.

The Strategic Plan:

The Mission
The Virginia Quality Improvement Program Advisory Committee seeks to ensure an adequate supply of nursing staff in Virginia's NFs through innovative recruitment and retention practices to meet the current and future need for care of one of the Commonwealth's most vulnerable populations.

Goal One
Promote culture change in NFs by encouraging NFs to adopt proven operational practices and innovative strategies that strengthen the performance of nursing staff and improve the quality of care based on the "Better Jobs Better Care" demonstration project.

- **Goal One, Objective One**

  Improve the quality of Virginia's NFs by examining the potential use of CMP funds to develop a voluntary incentive-driven program to promote "culture change."
- **Goal One, Objective Two**

  Develop and maintain online resources offering technical assistance to NFs on nursing recruitment and retention efforts. Include information on staff career advancement, mentoring, and trends.

Goal Two
Using the "Better Jobs Better Care" model, direct a portion of CMP funds specifically toward recruitment and retention efforts of nursing staff in NFs, particularly of nursing assistants, that would provide positive inducements for NFs to voluntarily implement practices to improve workforce stability and care quality.

- **Goal Two, Objective One**

  Develop, pilot, and implement a uniform set of criteria and expectations for statewide use, on a voluntary basis, for NFs that address factors affecting the recruitment, retention, and job satisfaction of direct care staff. Consideration should be given to the reason why nursing staff leave their jobs as demonstrated in long-term care research.
- **Goal Two, Objective Two**

  Consider the "raise-the-bar" program pertaining to direct care staff recruitment and retention based on job practices known to contribute the high turnover and, by extension, workplace cultures where there is low turnover and high job satisfaction (supportive workplaces, balanced workloads, training, and career opportunities).

- **Goal Two, Objective Three**

Outline eligibility requirements for participation as a pilot site and criteria for attaining a special designation indicating that the NF is a participating facility. The program should allow for creative, innovative, and cost-effective approaches to achievement of identified measurable objectives based on sound culture change principles.

The Strategic Plan: Funding

DMAS could use existing CMP funds to begin the development and implementation of the QIP project. The Advisory Committee may consider setting aside a base funding amount of $500,000 to offset costs of relocation of residents, maintenance of operation of a NF pending correction of deficiencies or closure.

- **Funding Suggestion**

While the Advisory Committee did not discuss the Pay-for-Performance (P4P) initiative, the QIP should be a complementary program. It may be appropriate to use a small portion of the CMP funds to "jump start" the P4P project. Funding could be continued on a yearly basis in an amount determined by the Advisory Committee.

Conclusion: Next Steps

- DMAS will reconvene an advisory committee to develop program criteria and implement the QIP strategic plan.
- Advisory committee decisions will include developing parameters for a pilot QIP, recommending a funding amount, defining measurable outcomes and marketing strategies.
- Meetings will be quarterly.
- The Virginia QIP Advisory Committee examined many programs and identified the best-practice model for the basis of quality improvement program in the Commonwealth.
- Involvement of all of our long-term care partners is critical to successful development of Virginia's future QIP.