



Progress and Potential in West Virginia's  
Community Long-Term Care System



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# **Progress and Potential in West Virginia's Community Long-Term Care System**

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## **Executive Summary**

### ***Purpose***

This report was prepared to provide West Virginia policy makers with an overview of the State's community long-term care system for elderly and physically disabled consumers, and to identify policy options to improve or enhance the system. The report focuses on community-based, long-term care services.

### ***Current Status of West Virginia's Long-Term Care System***

West Virginia has significantly increased the capacity of its community long-term care system in the past several years. West Virginia is now spending slightly more than the U.S. average on community-based care and falls in the middle of a group of comparison states. The recent increase in the Aged/Disabled Waiver program has enabled the State to eliminate the waiting list for that service, though West Virginia's rapidly aging population is certain to place increasing demands on the community system for the next 30 years.

### ***System Challenges***

West Virginia faces a number of challenges that should be considered by policy makers. These include the following:

- *Improvements are needed in how people enter West Virginia's long-term care system.* The current system creates conflicts of interest for providers, who complete the assessment form used to determine eligibility for services and then provide the services. It also limits the information that consumers receive, since the entry system for nursing homes is similar to but separate from the entry system for community services.
- *Policy toward non-medical residential care (including board and care homes and personal care homes) needs review, with explicit attention paid to the role of these homes in West Virginia's long-term care system.* Currently, non-medical residential care is almost entirely a private pay option. Medicaid beneficiaries who can not stay in their own homes and cannot afford this intermediate residential option may be entering nursing homes instead.
- *Among community providers, a number of "uneven playing field" issues threaten to undermine collaborative relationships.* These include the manner in which certificate of need requirements are applied and the "protected" status granted to certain providers.
- *Coordination of services is sometimes lacking in the system, despite significant resources dedicated to case management.* Case management tends to be tied to a particular service, so consumers receiving multiple services can have multiple case managers with little service coordination occurring among them.



- *Quality assurance relies heavily on traditional licensing and certification activities, which historically have focused on facilities and are not entirely appropriate or adequate for home-based care settings. In order to maintain quality services in the face of rapid growth, the State should make this an area of immediate focus.*
- *Although West Virginia is collecting considerable data, the State lacks strategic focus on analysis and use of data to inform long-term care policy choices and program management.*
- *Recruitment and retention of direct care workers (e.g., nurses' aides, homemakers, personal care attendants) is a widespread problem, but is more acute in some regions than in others.*

Each of these challenges is discussed in the report, and policy options are outlined to address them.

## **I. Introduction**

### ***Why was this report prepared?***

Based on the recent interest of the West Virginia Legislature in long-term care policy issues, West Virginia University and the West Virginia Health Care Authority asked us to prepare a report regarding West Virginia's long-term care system and to present our findings to the Legislature. Because public funding for long-term care comes primarily from Medicaid and State general appropriations, states are under increasing pressure to provide appropriate policy and financing in this area, and can expect even greater demands over the next 30 years as the population ages rapidly.

### ***What is the focus of this report?***

This report focuses on the array of community-based care for elderly and physically disabled people in the State, including services delivered in consumers' homes and in non-medical residential care facilities (commonly known as board and care homes in West Virginia). We offer our findings about West Virginia's community-based, long-term care system, compare West Virginia to four other states, and discuss policy options and their implications.

### ***Are nursing homes discussed in this report?***

Nursing homes are discussed only to the extent that they are part of overarching system issues. West Virginia is currently debating a number of issues related to free-standing and hospital-based nursing homes, including whether capacity should be allowed for ventilator-dependent patients, whether or not a separate Veteran's home should be built, and whether the supply of nursing home beds is adequate in general. These issues have been addressed in detail by others and are therefore not addressed in this report.<sup>1</sup>

### ***How was this report prepared?***

We visited West Virginia on October 16-18 and met with State officials, individual providers and provider association representatives, legislative staff, and a consumer advocacy organization. We visited offices and facilities in Charleston, Buckhannon and Parkersburg. Following our visit, we conducted telephone interviews with individuals who had been identified but not available during our visit. We also collected and reviewed a large number of West Virginia documents pertaining to long-term care. The list of persons interviewed is included as Appendix A, and the list of documents reviewed is included as Appendix B.

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<sup>1</sup> For a detailed discussion of the nursing home moratorium and related issues, see Barbara Manard's September, 2000, report to the Health Care Authority entitled "Nursing Facility Bed Supply and Need." For detailed information on nursing homes for Veterans, see "Veterans. Information Related to Veterans Skilled Beds from State and Federal Government Sources, Compiled Information and Surveys," prepared by the West Virginia Health Care Authority pursuant to West Virginia Code §29-22-9f.

## II. Description of West Virginia’s Community Long-Term Care System

*What kinds of community long-term care services are available in West Virginia?  
What does the State support with public financing?*

West Virginia has a range of community long-term care services, as described in Chart 1.

**Chart 1: Long-Term Care Services Provided in West Virginia**

Services	What is Provided?	Who is Eligible?	Medicaid Funding?	Other Funding?	Lead State Agency	Subject to CON?
<b>Older Americans Act Services</b>	Case management, homemaker, chore, personal care, nutrition	Anyone 60 years and older, but targeted to socially or economically needy	No	Federal Older Americans Act funds and consumer donations	Bureau of Senior Services	No, except for personal care services
<b>Community Care Services</b>	Personal care	People unable to perform 3-4 activities of daily living (ADLs)	Yes, as a State Medicaid Plan service	Limited State funds are available for those who are not Medicaid-eligible	Bureau of Senior Services administers; Bureau for Medical Svcs develops policy	Yes
<b>Aged/ Disabled Waiver Services</b>	Case management, homemaker, chore, nurse assessment	People who meet nursing home criteria (5 or more ADLs)	Yes, through the HCBS Waiver option.	No	Bureau of Senior Services administers; Bureau for Medical Svcs develops policy	No
<b>Home Health</b>	Skilled nursing, aides and therapies	People who have a skilled nursing need and meet other requirements	Yes, as a State Medicaid Plan service.	Federal Medicare funds for the Medicare eligible	Bureau for Medical Svcs develops Medicaid policy	Yes
<b>Non-medical Residential Care*</b>	Room, board, personal care services and nursing	Very few restrictions on persons served in these settings	No	Private pay and SSI; State funds for some <i>Hartley</i> <sup>#</sup> class members	Office of Health Facility Licensure and Certification	No

\*In West Virginia, this includes board and care homes, personal care homes, residential care communities (sometimes known as assisted living), and legally unlicensed health care homes.

<sup>#</sup>*Hartley* refers to a court settlement in which the State agreed to provide certain services for a specified class of people represented by the suit.

West Virginia offers a range of publicly-funded, in-home services comparable to many other states. Major components include:

- **Older Americans Act** services, which may be provided to anyone who is at least 60 years of age. These services, which include information and referral, chore and nutrition, are often provided to people who can live independently, but need limited assistance to do so. These services are federally funded, but each state's allotment is capped, so services are targeted to those with the greatest need who do not qualify for other programs;
- The **Community Care** program, which provides Medicaid-funded personal care services to people who need assistance with 3 to 4 Activities of Daily Living (ADLs), such as bathing, dressing, transferring and toileting. These are individuals whose needs are significant but do not yet rise to the level of nursing home certification; and
- The **Aged/Disabled Waiver** program, which provides Medicaid-funded home-based services to people with a high degree of functional impairment, who meet the criteria for nursing home care (needing assistance in 5 or more ADLs). These are people who, but for the provision of waiver services, are at high risk of nursing home admission. Recent increases in funding for the Aged/Disabled Waiver Program have eliminated the waiting lists that previously existed for this service.

Noticeably absent in West Virginia is any significant State support for non-medical residential care options, known in the State as **board and care homes, personal care homes, legally unlicensed health care homes and residential care communities**. These are important intermediate options for people who cannot be served at home for one reason or another, and who are likely to go to nursing homes if an intermediate residential option is not available. In West Virginia, these options are available in the private-pay market, but the State does not currently provide public funding for them, except for a limited number of people who qualify for funding under the *Hartley* court settlement.

***How do West Virginians enter the publicly-funded long-term care system? How are their health and functional needs determined?***

Currently, West Virginia has two similar but largely separate processes for entry into publicly-funded long-term care: the nursing home system and the home care system. Entry into either the nursing home or home care system requires the same basic steps:

- A Pre-admission Screen (PAS) is completed by a provider and sent to the consumer's physician;
- The physician reviews and signs the form;
- The form is sent (usually by fax) to the West Virginia Medical Institute (WVMI), the State's contractor for PAS review. Nurses at WVMI review the information and determine whether the consumer meets the medical criteria for Medicaid-funded services; and
- The consumer and provider who submitted the form are notified as to whether the consumer meets the medical eligibility criteria.

In theory, the consumer has been counseled about the range of West Virginia's long-term care services prior to the PAS being submitted. By most accounts, however, consumers

rarely hear about the full range of options, because the system is divided into two sectors (nursing home and home care), and a consumer is likely to hear only about the sector he or she has entered. The following hypothetical examples illustrate the process:

### **Nursing Home Example**

Frank and his wife, Mary, live in their home. Frank needs extensive help with Activities of Daily Living (ADLs) and until recently, Mary has provided all of his care at home. On a recent visit from Ohio, Mary and Frank's daughter, Jill, became very concerned that her mother's health was declining rapidly and would worsen if she had to continue providing care to Frank. Mary quickly arranged a meeting with the local nursing home, and the home's nurse assessor came to the house to complete a Pre-admission Screen (PAS). The nurse explained that if Frank passed the screen and qualified financially for Medicaid, he could enter the nursing home and Medicaid would pay the balance of the bill after Frank contributed his Social Security check. Having lived in Ohio for several years, Jill was not aware that Medicaid could also pay for home-based services that would help Mary care for Frank at home. This option was not discussed with Jill, and the family proceeded with the nursing home application.

### **Home Care Example**

Liddy and her husband, Bob, are both in their eighties. The Senior Center has been helping them with chores around the house, and they've been getting meals delivered, but staff have become concerned that Liddy's ability to function is declining significantly, and she needs much more help than Bob or they can provide with their current Older Americans Act funding. Staff explain to Liddy and Bob that, if Liddy will allow them to complete a Pre-admission Screen (PAS), Medicaid might pay for personal care or homemaker services, allowing the Center to increase the level of services it has been providing. Liddy agrees, qualifies for the Aged/Disabled Waiver program, and begin receiving intensive home-based services. Although Liddy's care needs qualify her for nursing home care, that option is not discussed with her.

As these examples illustrate, the type of information a consumer receives in West Virginia depends largely on how the consumer enters the system, and information often comes from a provider who is impacted by the decisions made by consumers. We could not identify a point in the West Virginia system where consumers receive comprehensive, objective information regarding all of their choices, including the range of home care, residential care (e.g., board and care homes) and nursing homes.

### ***What is the West Virginia Senior and Disabled Assessment Pilot Project?***

The West Virginia Senior and Disabled Assessment Pilot Project is testing the feasibility of using a standardized, electronic instrument to assess consumer needs across West Virginia's long-term care providers.<sup>2</sup> The pilot project grew out of the work of the Interagency Long-Term Care Panel's Universal Assessment Task Force and is led by the Health Care Authority. The tool is currently being piloted in twelve sites representing three types of providers: county senior programs, home health providers and case management agencies.

Goals of the project include standardization of assessments, referral of consumers to the most appropriate care setting regardless of how they enter the system, and development of a data base for policy and program development, with quality and reimbursement thought to be areas of particular potential.

The pilot project holds out promise as a tool to facilitate standardization of data and assessment processes throughout West Virginia's long-term care system, but it is too early to make any judgements about its success. An interim evaluation of the project is expected in the Spring of 2001. It is also important to note that the tool's effectiveness will depend on how it is implemented. For example, the tool could be used to create a uniform assessment process that includes both nursing homes and community services, but it could also be used in exactly the same way that the paper Pre-admission Screening forms are used now, with separate but parallel processes for nursing homes and community services. In other words, the tool alone will not transform West Virginia's long-term care system. It must be accompanied by changes in policy and procedure.

### ***What roles do State agencies play in the community long-term care system?***

Several State agencies are involved in West Virginia's long-term care system:

- The ***Bureau for Medical Services*** (within DHHR) develops policy and provides financing for Medicaid-funded long-term care, including the Community Care and Aged/Disabled Waiver programs, Medicaid home health and nursing home care;
- The ***Bureau of Senior Services*** administers community-based long-term care programs, including those funded by the federal Older Americans Act, Medicaid and State funds. It administers the Medicaid-funded Community Care and Aged/Disabled Waiver programs in collaboration with the Bureau for Medical Services;
- The ***Office of Health Facility Licensure and Certification*** (within DHHR) licenses or certifies most long-term care providers. Its traditional focus has been on facility-based care provided in nursing homes and non-medical residential care;
- The ***Health Care Authority*** has several interests in the State's long-term care system. Its formal responsibilities include administration of West Virginia's Certificate of Need program, described in greater detail below. The Health Care Authority is also charged with being the State's health data repository. In addition to these statutory responsibilities, the Health Care Authority has supported several collaborative efforts

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<sup>2</sup> For a detailed report on the project, see Cathy Chadwell's report entitled West Virginia Senior and Disabled Assessment Pilot Project State Innovations: The Role of Technology in State Long-Term Care Reform.

in recent years, including the Interagency Long-Term Care Panel. It has also been the lead agency for the Senior and Disabled Assessment Pilot Project.

***Who is responsible for quality assurance?***

The ***Office of Health Facility Licensure and Certification*** (OHFLAC) performs the traditional licensing and certification function, with a particular emphasis on facility-based care. This includes compliance with life safety codes and with multiple structure and process standards, including staffing qualifications and levels, maintenance of resident records, and assurance that facility residents have been made aware of their rights.

As the administering agency, the ***Bureau of Senior Services*** monitors the Community Care and Aged/Disabled Waiver programs. It monitors compliance with State and federal program rules. Monitoring includes unannounced visits to provider agencies, where records may be inspected.

***What is the State's current certificate-of-need policy regarding long-term care?***

The Health Care Authority administers the certificate of need (CON) process for West Virginia. The CON process requires certain health providers to obtain approval from the State before developing new capacity. The State's CON law specifies what must be reviewed and establishes the review criteria.

Long-term care services ***subject to CON review*** include:

- Personal care services;
- Home health services (skilled nursing, aides, therapies); and
- Nursing homes, which are currently subject to a moratorium on new beds.<sup>3</sup>

Long-term care services ***not subject to CON review*** include:

- Most services provided under the federal Older Americans Act, including homemaker, chore and nutrition services;
- Medicaid Aged/Disabled Waiver services, which include case management, homemaker and chore services;
- Non-medical residential care, which includes personal care homes, board and care homes and legally unlicensed health care homes; and
- Conversion of hospital beds to Medicare-only Skilled Nursing Facility beds.

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<sup>3</sup> The moratorium and related issues affecting nursing homes has been addressed extensively by others and will not be addressed here. See Barbara Manard's September, 2000 report to the Health Care Authority entitled "Nursing Facility Bed Supply and Need," and the Health Care Authority's recent report entitled "Veterans. Information Related to Veterans Skilled Beds from State and Federal Government Sources, Compiled Information and Surveys."

### III. West Virginia Comparison to Arkansas, Maine, North Dakota and South Carolina

For purposes of comparing West Virginia to other states, we chose four states, all of which are similar to West Virginia in some, but not all, respects. Chart 2 provides a general profile of the states.

**Chart 2: General Profile of Comparison States**

	W. Virginia	Arkansas	Maine	N. Dakota	S. Carolina	U.S.
<b>1999 Population</b>	1,806,928	2,551,373	1,253,040	633,666	3,885,736	
<b>1999 Pop 85 and over (percent of total)</b>	31,922 (1.77%)	44,499 (1.74%)	22,181 (1.77%)	14,761 (2.33%)	46,726 (1.20%)	
<b>Percent of People in Poverty. 3-year average, 1997-99.</b>	16.7%	16.4%	10.4%	13.9%	12.8%	12.6%
<b>Median Household Income: 3-Year Average, 1997-99</b>	\$28,420	\$28,393	\$36,459	\$32,238	\$35,376	\$39,657
<b>Home-ownership rate, 1990</b>	74.1%	69.6%	70.5%	65.6%	69.8%	67.8%

Source: U.S. Census

All of the states in the comparison group are small in terms of population. West Virginia falls in the middle of the group, with a population of nearly 2 million people. The need for long-term care services increases with age, with the 85 and older group considered at greatest risk. West Virginia's percentage of "very old" residents (85 and older) is at the high end of the comparison states, with only one state (North Dakota) having a higher percentage.

West Virginia is a national leader in home ownership, and has the highest percentage among the comparison states on that measure. Finally, median household income and the percent of West Virginian's living below the Federal Poverty Level indicate that West Virginians are poor relative to the country as a whole and to all but one of our comparison states (Arkansas).

Chart 3 compares the number of West Virginia Medicaid beneficiaries by eligibility group to those of the comparison states. Together, elderly, blind and disabled beneficiaries comprise less than a third (29.8%) of the total Medicaid population in West Virginia. This is slightly higher than the U.S. average (26.1%), very close to South Carolina (29.4%), and lower than the other comparison states (ranging from 31.1% to 35%). In all of the states, elderly, blind and disabled beneficiaries are relatively small groups when compared to children, the largest group of beneficiaries.



**Chart 3: 1998 Medicaid Beneficiaries by Eligibility Group**

	W. Virginia	Arkansas	Maine	N. Dakota	S. Carolina	U.S
<b>Total Beneficiaries*</b>	342,668	424,727	170,456	62,280	594,962	
<b>Age 65 and Older (% of Beneficiaries)</b>	29,157 (8.5%)	50,746 (11.9%)	22,669 (13.3%)	10,376 (16.7%)	72,074 (12.1%)	(9.8%)
<b>Blind or Disabled (% of Beneficiaries)</b>	73,037 (21.3%)	96,507 (22.7%)	37,064 (21.7%)	8,953 (14.4%)	102,904 (17.3%)	(16.3)
<b>Other Adults (% of Beneficiaries)</b>	56,682 (16.5%)	85,023 (20.0%)	30,487 (17.9%)	11,398 (18.3%)	121,013 (20.3%)	(19.5)
<b>Children (% of Beneficiaries)</b>	153,021 (44.7%)	179,405 (42.2%)	74,213 (43.5%)	27,779 (44.6%)	269,751 (45.3%)	(45.0)
<b>Foster Care Children (% of Beneficiaries)</b>	5,065 (1.5%)	4,994 (1.2%)	2,160 (1.3%)	1,481 (2.4%)	6,412 (1.1%)	(1.6%)

Source: Health Care Financing Administration, Center for Medicaid and State Operations, HCFA 2082 Report.

\*Individual categories do not add to total because a miscellaneous category (“Unknown”) was omitted.

Although elderly, blind and disabled beneficiaries are relatively few in number, they account for more than half of all Medicaid expenditures in every state. In 1998, West Virginia spent 67% of its Medicaid budget on elderly, blind and disabled beneficiaries, placing the State at the low end of the comparison group, with only South Carolina spending a lower percentage (61.4%).

**Chart 4: 1998 Medicaid Expenditures by Eligibility Group (in thousands of \$\$)**

	W. Virginia	Arkansas	Maine	N. Dakota	S. Carolina	U.S
<b>Total Expenditures* in thousands</b>	\$1,243,151	\$1,375,797	\$747,028	\$341,015	\$2,018,620	
<b>Age 65 and Older (% of Total Expend.)</b>	\$359,268 (28.9%)	\$430,018 (31.3%)	\$239,293 (32.0%)	\$131,362 (38.5%)	\$477,951 (23.7%)	(28.5)
<b>Blind or Disabled (% of Total Expend.)</b>	\$473,515 (38.1%)	\$791,183 (57.5%)	\$329,089 (44.1%)	\$140,167 (41.1%)	\$762,313 (37.8%)	(42.4)
<b>Other Adults (% of Total Expend.)</b>	\$101,664 (8.2%)	\$99,325 (7.2%)	\$43,740 (5.9%)	\$22,900 (6.7%)	\$162,109 (8.0%)	(10.4)
<b>Children (% of Total Expend.)</b>	\$153,582 (12.4%)	\$262,323 (19.1%)	\$96,498 (12.9%)	\$33,676 (9.9%)	\$305,303 (15.1%)	(14.4)
<b>Foster Care Children (% of Total Expend.)</b>	\$32,283 (2.6%)	\$28,863 (2.1%)	\$26,400 (3.5%)	\$10,113 (3.0%)	\$259,713 (12.9%)	(1.6%)

Source: Health Care Financing Administration, Center for Medicaid and State Operations, HCFA 2082 Report.

\*Individual categories do not add to total because a miscellaneous category (“Unknown”) was omitted.

Summarizing this phenomenon, Chart 5 illustrates that elderly, blind and disabled beneficiaries comprise just under a third of all Medicaid beneficiaries, but account for just over two-thirds of the Medicaid program's expenditures. This is consistent with the experience in the comparison states, and with the national average.

**Chart 5: Elderly, Blind and Disabled Beneficiaries in West Virginia Medicaid**

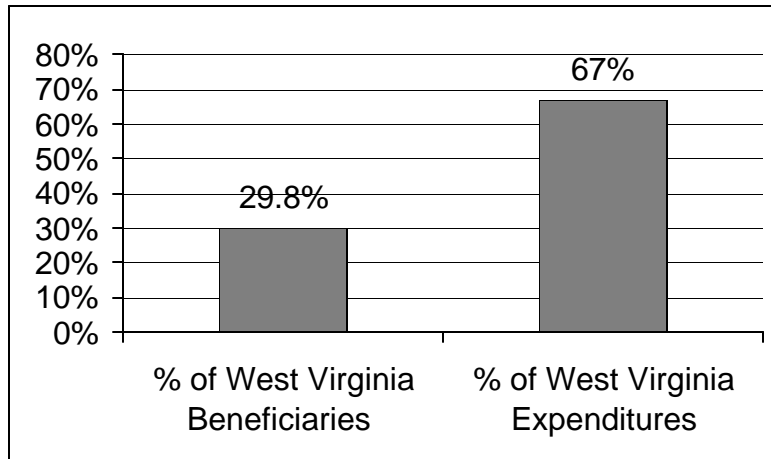


Chart 6 compares Medicaid expenditures per beneficiary for each of the eligibility groups, confirming that elderly, blind and disabled beneficiaries have the highest per person costs. All of the states spend considerably more per elderly and disabled beneficiary than they do per child or adult who is not disabled, reflecting the high cost of long-term care.

**Chart 6: 1998 Medicaid Expenditures Per Beneficiary, by Eligibility Group**

	W. Virginia	Arkansas	Maine	N. Dakota	S. Carolina
All Groups	\$3,628	\$3,239	\$4,383	\$5,476	\$3,393
Age 65 and Older	\$12,322	\$8,474	\$10,556	\$12,660	\$6,631
Blind or Disabled	\$6,483	\$8,198	\$8,879	\$15,656	\$7,408
Other Adults	\$1,794	\$1,168	\$1,435	\$2,009	\$1,340
Children	\$1,004	\$1,462	\$1,300	\$1,212	\$1,132
Foster Care Children	\$6,374	\$5,779	\$12,222	\$6,829	\$7,990

Source: Derived from Health Care Financing Administration, Center for Medicaid and State Operations, HCFA 2082 Report.

Nursing homes represent the single largest long-term care cost in most states, and West Virginia is no exception. Chart 7 shows 1999 Medicaid nursing home and community long-term care expenditures as a percentage of total Medicaid spending for the year. With 20.1% of expenditures on nursing homes, West Virginia is very close to the national average (20.2%), considerably lower than North Dakota (32.7%), and higher than the other comparison states (ranging from 13.5% to 19.9%).

Chart 7 also shows home care expenditures as a percentage of nursing home expenditures, a simple measure of a state's balance between nursing home and home care expenditures. Only Maine has more balanced expenditures among the comparison states, reflecting West Virginia's strong support for home- and community-based care programs in recent years.

**Chart 7: 1999 Medicaid Expenditures for Long-Term Care**

	W. Virginia	Arkansas	Maine	N. Dakota	S. Carolina	U.S.
Nursing Homes, as % of Total Medicaid	20.1%	19.9%	16.1%	32.7%	13.5%	20.2%
Home Care*, as % of Total Medicaid	11.5	9.5%	12.4%	12.3%	6.8%	9.0%
Home Care*, as % of Nursing Homes	57.2%	47.9%	76.8%	37.6%	50.4%	44.4%

Source: Burwell, B. Medicaid Long-Term Care Expenditures in FY 1999. The MEDSTAT Group, Cambridge, MA, April 2000.

\*Home Care is defined as the total Medicaid expenditures for HCBS Waiver, State Plan Personal Care and Home Health.

#### **IV. Findings and Policy Options**

Our general impressions of West Virginia's long-term care system are favorable. Considerable progress has been made toward developing a balanced system with an increasing emphasis on community-based care. Significant increases in the Medicaid Aged/Disabled Waiver program have eliminated the waiting lists for that home-based care option, and the system appears to have absorbed the rapid growth without significant implementation problems. The Senior and Disabled Assessment Pilot Project, if accompanied by critical policy change, could foster further streamlining of the system, and provide timely information to inform policy and program decisions. These and other strengths of the system are summarized in Chart 8.

As a demographically old State, however, West Virginia cannot afford to rest in the development of its long-term care system. Demand for long-term care services will rise continuously over the next 30 years, challenging the State to expand services in the most cost-effective manner possible. An important part of this challenge is the need to allocate resources with increasing precision according to individual needs. On an individual consumer level, this includes making the best use of standardized and meaningful assessment data across service settings, and referring consumers to the most integrated and effective services possible. On a system level, it includes compiling and analyzing information to develop more precise payment methods, ensure high quality services and focus program development activity where it is most needed. We have identified a number of challenges in this area, summarized on Chart 8. The remainder of this report focuses on those challenges and discusses some policy options to address them.

## **Chart 8. Strengths and Challenges of West Virginia's Long-Term Care System**

### ***Strengths***

- Strong commitment to home- and community-based services (HCBS), as demonstrated by large budget increases in recent years.
- Easy access to the system through virtually any provider.
- Strong commitment to making the consumer assessment process uniform and to standardizing data collection, as demonstrated by the Senior and Disabled Assessment Pilot Project.
- Remarkably rapid deployment of increased community-based care resources through a strong network of community-based agencies.
- State agencies that work well together, despite some fragmentation of long-term care policy responsibility, and the obvious potential for turf battles.
- An entrepreneurial and creative spirit among providers, with notable deployment of local resources to stretch State dollars.
- Significant collection of data, with potential to inform policy making.

### ***Challenges***

- Entry to the system is very diffuse. The nursing homes and community long-term care entry systems are similar but largely separate. Despite efforts to ensure consumer choice of service provider, the information received by consumers regarding choices appears to be dependent on where they enter the system.
- Non-medical residential care (including board and care homes, personal care homes, and legally unlicensed health care homes) remains largely outside the public long-term care system, with no apparent vision for its role in West Virginia's long-term care system.
- Provider tensions appear to be rising around a number of "uneven playing field" issues, including the application of certificate of need and "protected" status granted to certain providers.
- Coordination of services is sometimes lacking in the system, despite significant resources dedicated to case management.
- Quality assurance relies heavily on traditional licensing and certification activities, which historically have focused on facilities and are not entirely appropriate or adequate for home-based care settings.
- Although West Virginia is collecting considerable data, the State lacks strategic focus on analysis and use of data to inform long-term care policy choices and program management.
- Recruitment and retention of direct care workers (e.g., nurses' aides, homemakers, personal care attendants) is a widespread problem, but is more acute in some regions than in others.

## ***1. Entry to the System***

*Finding: Entry to West Virginia's long-term care system is extremely diffuse and, while significant effort has been made to promote consumer choice of provider, consumer information appears to depend on where one enters the system.*

Virtually any provider can complete a pre-admission screen (PAS) and submit it for approval on behalf of a consumer. While this has the advantage of promoting easy access for consumers, it may be undermining the integrity of the PAS system, since providers have an obvious interest in helping consumers qualify for services. Many West Virginia providers play dual roles that may be in conflict ("agent of the State" in administering the PAS and "provider of services" triggered by the PAS). Despite this potential for conflict-of-interest, the State does not currently have a system for checking the validity of assessments submitted.

Ironically, allowing multiple providers to complete the PAS may actually be constraining consumer choice. Nursing home or hospital workers generally conduct the PAS for nursing home admission, while community agency staff generally conduct the PAS for home-based services. During either of these assessment processes, consumers are supposed to receive information about the range of options for which they may qualify, but it seems unlikely that nursing home staff are advising applicants about community care options, or that community agency staff are advising them about nursing home options. The diffuse nature of the PAS process may be limiting the information that actually goes to consumers and their families.

***Policy Option:*** *Entry to the long-term care system should be strengthened by unifying the nursing home and community care entry systems, clarifying provider roles, and maximizing consumer choice.*

Currently, the entry systems for nursing homes and community-based care are similar but largely separate. The State should consider unifying them to ensure that all West Virginians who seek publicly funded long-term care services receive all relevant information regarding the range of services available to them.

The State should clarify and distinguish between two significant roles played by providers in the State's long-term care system. The first is "agent of the State," in which the State has delegated a function to a provider. In West Virginia, this includes conducting the pre-admission screen (PAS) and submitting it to West Virginia Medical Institute for approval. It also includes counseling applicants as to their choice of services. The second is "provider of services," in which an organization is responsible for the delivery of services. In the current system, these roles often overlap within a single agency, creating an obvious conflict-of-interest.

There are at least two different approaches the State could consider to address this situation:

- ***Separate the “agent of the State” function from the “provider of services” function and allow vendors to perform one or the other, but not both.*** The State’s agent would have no financial interest in the outcome of an assessment, and would provide objective information to consumers and their families regarding the full range of options available to them. The agent could be a statewide vendor or a regional vendor, but the State would not select more than one vendor per defined geographic area. If more than one assessor is available, consumers and the providers who refer them might be encouraged to “shop” for an assessor, creating a perverse incentive among assessors to ensure favorable assessments or risk losing business; or
- ***Develop quality assurance mechanisms to monitor the pre-admission screen (PAS) and choice counseling processes.*** One advantage of West Virginia’s diffuse entry system is that it promotes access. Consumers and their families can enter the system through virtually any provider they choose. If the State decides to maintain the current system in the interest of unfettered access, it should address the inherent conflicts-of-interest by developing quality assurance mechanisms. These could include random and targeted PAS reviews. It could also include surveys, interviews or focus groups with consumers and family members to learn about their experiences with the system. What options were discussed with them? Did they understand their choices?

It is worth noting that the Senior and Disabled Assessment Pilot Project offers potential as a tool for standardizing the PAS process across providers. However, statewide implementation of a uniform and automated assessment tool will not ensure that consumers are accurately assessed and referred to the most appropriate settings of care. An excellent assessment tool can not, by itself, prevent assessor bias. In mixing the “agent of the State” and “provider of services” roles, West Virginia’s current long-term care system routinely creates conflict-of-interest situations.

## ***2. Non-medical Residential Care***

***Finding:*** *Non-medical residential care (including board and care homes, personal care homes, and legally unlicensed health care homes) remain largely outside the State’s public long-term care system, with no clear vision for its role in West Virginia’s long-term care system.*

Currently, very little public funding is available to West Virginians who do not need nursing home care, but can not be served at home and can not afford non-medical residential care homes. In West Virginia, non-medical residential care homes are available almost exclusively to private payers.<sup>4</sup>

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<sup>4</sup> Some *Hartley* class members receive public funding for non-medical residential care, but in general, fees to these homes are paid privately.

Many other states have opted to fund non-medical residential care as an intermediate option (between home care and nursing homes) but, to date, West Virginia has not. We were consistently told that many residents of these homes receive federal Supplemental Security Income (SSI) cash assistance, which they use to pay the homes' operators, but that the SSI check is generally not sufficient. In 2001, maximum federal SSI benefits are \$530 per month for an eligible individual and \$796 for an eligible individual with an eligible spouse. We were told by both State officials and providers that monthly fees for non-medical residential care in West Virginia typically fall between \$1,500 and \$2,000 per month. The difference is presumably made up by family members.

West Virginia does not have an SSI State Supplement program to enhance payments to these homes. West Virginia is unusual in this regard. In 2000, 45 states had SSI State Supplement programs.<sup>5</sup> These included three of the comparison states discussed earlier (Maine, North Dakota and South Dakota). Without an SSI State Supplement program, poor West Virginians who can not afford the difference between their SSI checks and monthly fees may be going to nursing homes instead, where the State Medicaid program pays the difference between income and fees.

West Virginia also does not permit Aged/Disabled Waiver nor other Medicaid-funded services to be delivered in non-medical residential care homes. It is unclear whether this decision was made by the Medicaid program or the health facilities licensing agency. As a result, it may be foregoing Medicaid match for Hartley class members who are otherwise being supported with unmatched State dollars.

***Policy Option:*** *The State should carefully review the potential of non-medical residential care options (including board and care homes, personal care homes, and legally unlicensed health care homes) to fill a gap in the State's publicly-funded long-term care system.*

In most states, development of a comprehensive range of long-term care services has included support for the development and operation of non-medical residential care options. These can include boarding homes, personal care homes, affordable assisted living, etc., but they all offer an intermediate level of assistance that is greater than available in consumers' homes but less than available in nursing homes. Public funding generally comes from a combination of special development funds, SSI State Supplement payments and Medicaid funding for services. West Virginia currently does not provide funding through these mechanisms.

An important question is whether public funding for non-medical residential care would be cost effective. In order to be cost-effective, the State must be able to carefully target the service to consumers who are currently receiving services funded with all State dollars (e.g., Hartley class members), or who would otherwise be served in nursing homes at a higher cost (e.g., people who can no longer be served at home, but are going to nursing homes because they can not afford residential care rates). This would involve

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<sup>5</sup> Social Security Administration. 2000 SSI Annual Report. May 30, 2000.

strengthening the PAS process (as described in Finding 1, above) and establishing clear policy regarding who should be served in the non-medical residential care setting.

Another important issue is the degree and type of regulation applied to such homes, beyond the current licensing requirements. Presumably, in return for State funding, the homes would need to enhance their services to successfully serve people who would otherwise go to nursing homes. However, the State should resist applying nursing home-like requirements, which would not only drive up costs over time, but would make it difficult to maintain a home-like atmosphere for consumers.

### ***3. Uneven Playing Field***

***Finding:*** *There is widespread concern about an “uneven playing field” among providers.*

We heard many complaints from providers regarding uneven application of certain public policies in West Virginia, including certificate-of-need (CON) requirements, provider taxes, and “protected” roles for certain providers:

- ***Certificate-of-Need (CON)*** requirements apply to some but not all providers in the long-term care system. The State appears to have based the CON requirement on the medical nature of the service. Thus, nursing homes are subject to CON, but non-medical residential care homes are not. Similarly, personal care services provided through the Community Care program and skilled services provided through home health agencies are subject to CON, but the homemaker services provided through the Aged/Disabled Waiver program are not. An important caveat to this general rule is that current CON policy does not allow any additional personal care services to be approved if Medicaid expenditures would increase. Therefore, no applications have been approved and the program has been effectively closed to new providers;
- ***Provider taxes are tied to CON*** (if an agency’s services are reviewable under CON, the agency is subject to tax), so to the extent that CON is unevenly applied, the same is true of provider taxes; and
- ***Protected provider status*** occurs to some extent in the present system. The State’s CON policy on personal care is cited by potential competitors as evidence. The Senior Centers were the traditional vendors for the Community Care program and, as such, have been grandfathered into that role, while CON policy keeps new players out. Under the Community Care program, Senior Centers are allowed to perform multiple functions, including assessment, case management and delivery of personal care services. By contrast, services provided in the Aged/Disabled Waiver program are generally not subject to CON, permitting competitors to enter the field, but in that program, providers must choose to offer either case management or homemaker services, but may not offer both.



***Policy Option:*** Review certificate-of-need (CON) policy to ensure that it advances the State’s goals for the long-term care system.

When they were created nationally in the 1970s, CON programs were intended primarily to control the supply of expensive, facility-based health care services. Premised on the theory that “if you build it, they will come,” CON was an effort to rationalize and control the supply of health services by making approval contingent on a demonstrated shortage or need. As technological change and expanding Medicaid coverage have made home-based services more feasible, many states have opted to encourage community expansion as a matter of policy by not applying CON to new community services. West Virginia is somewhat unique in that it applies CON policy to some community services but not others. Current policy appears to turn on whether or not the services are medical in nature, but it is not clear what policy goal the rationale advances. The State may want to review its application of CON to ensure that it supports the State’s overall vision for the long-term care system and, like many other states, loosen CON requirements for community-based services while maintaining them for institutional services. Some states with excess institutional supply have developed special incentives within the CON law to encourage institutional providers to convert excess capacity to less intensive forms of care. That has included, for example, conversion of nursing home beds to assisted living units.

#### ***4. Case Management***

***Finding:*** The care planning and management system is not integrated across providers, resulting in poor coordination among home health, waiver and community care providers.

Case management is occurring on a program-by-program basis in West Virginia’s long-term care system. While this may work well for consumers who interact with only one program or provider type, it is reportedly not working well for those who use more than one type of service. For example, a consumer in the Aged/Disabled Waiver program receives case management from an agency designated specifically to provide case management for that program. The same consumer may be receiving home health services, which are case managed directly by the home health agency. We were consistently told (by both home health and Aged/Disabled Waiver case management agencies) that coordination is often lacking in these situations. We heard anecdotes about home health nurses entering a home and being surprised that a homemaker or personal care attendant was in the home. Because these systems run independently, coordination is entirely dependent on informal relationships across agencies and is not systematically occurring.

Related specifically to the Aged/Disabled Waiver program, case management was described by some parties as unnecessarily expensive, given that the Waiver program contains only one service (homemaker). Case management reportedly consumes 23 to 27% of the Aged/Disabled Waiver program’s resources.

***Policy Option:*** *The State should review the way case management is conducted in the long-term care system and how it intersects with Medicare home health.*

In the Medicaid-funded long-term care system, the State could consider consolidating all case management activities in agencies designated to perform that function across service providers. (The State does have designated case management agencies, but their responsibilities are related specifically to the Adult/Disabled Waiver program.) This might improve service coordination and case management efficiency when only Medicaid-funded services are involved, but it is not likely to improve coordination for dually eligible beneficiaries (those eligible for both Medicaid and Medicare) when a consumer is receiving both Medicare home health and Medicaid home care. The State could choose to designate Medicare home health agencies as the case management agencies for Medicaid home care, but that would raise significant concerns about the “medicalization” of long-term care services. It would also introduce extremely contentious politics among providers, since the case managers are the gatekeepers of their respective services.

The State may want to consider working with all providers to develop inter-provider protocols for coordination of care when consumers receive services from multiple agencies. In developing the protocols, special attention will need to be paid to confidentiality concerns.

Finally, the State should review whether some consumers are receiving ongoing case management when they do not need or want it. The extent of case management being provided in the Aged/Disabled Waiver program was of particular concern to several people we interviewed. It may be possible to reduce case management costs in that program and reapply savings to expanded services.

## ***5. Quality Management and Improvement***

***Finding:*** *Quality assurance relies heavily on the traditional licensing and certification processes. The State lacks a vision for a comprehensive Quality Management and Improvement system appropriate to the rapidly expanding community long-term care system.*

As is true in many states, West Virginia relies heavily on its licensing and certification process to assure quality in long-term care, despite the fact that traditional facility-based quality assurance activities are often difficult to apply or inappropriate for community-based care. While there are some pockets of quality activity in the community long-term care system, the State has not articulated a vision for quality that is relevant and appropriate to community-based care.

**Policy Option:** *Among the State program agencies involved in community long-term care, one should be given responsibility for leading the development of a comprehensive quality management and improvement system for community-based long-term care. Quality assurance in community long-term care is challenging relative to facility-based care, because it not associated with a physical structure that can be visited and reviewed. All states are struggling with this challenge, and West Virginia is no exception. The State should focus attention on this, particularly in light of the rapid growth of its community services. A few examples of specific quality issues needing attention include:*

- *Consumer satisfaction.* Establishment of regular consumer feedback mechanisms to determine whether people are satisfied and whether they are receiving information and services according to procedures;
- *Consumer outcomes.* In addition to satisfaction, how well are consumers doing in terms of health, function and quality of life measures?
- *Consumer information.* How can the State develop and promote the use of comparative information across providers to help consumers make informed decisions?
- *System response times.* How long does it take for home services to be delivered once an application has been made? Are people being hospitalized or admitted to nursing homes while awaiting community services?
- *Accuracy of pre-admission screens (PAS).* How accurately are assessments performed? Does accuracy vary by agency?
- *Care plan compliance.* Are consumers actually receiving the services indicated in their care plans? Does billing to Medicaid reflect services authorized in the care plan?

## **6. Collection and Use of Data**

**Finding:** *West Virginia has considerable long-term care data and will be accumulating more if the Senior and Disabled Assessment Pilot Project is implemented more broadly. However, the data that are collected are often not aggregated or analyzed to inform policy choices and program management.*

West Virginia has articulated a clear and convincing vision for the collection of standardized long-term care data and has taken an important step toward that vision with the Senior and Disabled Assessment Pilot Project. Less clear is how the State intends to use its data as it wrestles with policy and program issues.

**Policy Option:** *The State should begin exploiting the long-term care data it has to inform policy development and program management.*

Through the Senior and Disabled Assessment Pilot Project, the State has appropriately devoted resources to collecting standardized long-term care data. Related to this, more

attention should be paid to exploiting the rich data sources available in the State and strategically developing them for policy development and program management.

In part, this will involve clarifying the roles of several State agencies. For example, the Health Care Authority sees data collection as a primary responsibility, and it has provided leadership on development of the Senior and Disabled Assessment Pilot Project. The data gathered through the Pilot will enable the Health Care Authority to incorporate far more detailed information regarding the health and functional status of West Virginians in future State Health Plans. Unclear at this point, however, is how the relevant State program agencies (in particular, the Bureau of Senior Services and the Bureau for Medical Services) will access and analyze the data for policy development and program management. It is in those agencies that the data could be applied directly to policy and program.

All of the State agencies we visited appeared to lack the resources needed to make use of current data. Clarifying agency roles and interests in the data would allow a strategic division of responsibilities. The State may be able to leverage a reasonable investment in data analysis by identifying appropriate research partners who share an interest in the data and can help attract external funding for targeted analyses. Much of the analyses will involve Medicaid services, making federal matching dollars available at the administrative rate of 50% federal/50% state. Absent a strategic focus on beefing up analytic capacity, however, the State will not be able to use the data it already has, much less new data planned for the future.

A few examples of untapped data potential include:

- The Health Care Authority recently conducted surveys of home health, nursing home and hospice providers, but has not been able to analyze the results. The surveys may contain important data about the current status of West Virginia's long-term care workforce;
- It was suggested to us that the Aged/Disabled Waiver program is not truly cost effective, because the people in that program are less impaired than people in nursing homes. The data exists in West Virginia to answer this question. Preadmission screens are completed on all applicants for both programs and submitted to the West Virginia Medical Institute for review. WVMi enters assessment information into a database. The data could be used to compare the level of impairment among applicants to the two programs; and
- West Virginia's licensing regulations for non-medical residential care (board and care homes and personal care homes) require that all residents receive a functional needs assessment within 30 days of admission, and homes use the State's pre-admission screening (PAS) form for this purpose. If compiled and analyzed, these forms could provide a valuable snapshot of the needs of West Virginians living in the homes, and could be compared to the needs of nursing home residents and Aged/Disabled Waiver participants. Analysis of this type would be invaluable in determining whether West Virginia should develop public reimbursement for the homes and if so, who should be served in the homes and at what rate.

## **7. Supply of Direct Care Workers**

**Finding:** *Consistent with the national experience, West Virginia is experiencing a shortage of direct care workers in its long-term care system.*

We heard from several providers that recruiting and retaining direct care workers is increasingly challenging, particularly in some areas of the State. (Charleston and the Eastern Panhandle were cited frequently as areas of acute shortage.) However, the tight labor market does not appear to have prevented the rapid expansion of community services to date. Nursing homes appear to be experiencing particular challenges in this area and may be losing staff to the community system. Provider surveys conducted by the Health Care Authority may have important data to provide on this issue and should be analyzed.

It is important to note that this problem is likely to get worse, given the demographics of the State and most parts of the Country. Over the next 30 years, not only will the number of elderly people expand greatly, but the number of working age adults will actually shrink. This means that labor shortages are likely to affect many sectors of the economy. As a profession that tends to have low wages and benefits for direct care workers, the long-term care sector will find it increasingly difficult to compete for labor.

**Policy Option:** *The State could promote a public-private partnership among State agencies, professional regulation boards, providers, educational institutions and foundations to development a long-term strategy to improve recruitment and retention of long-term care workers.*

In many states, wages of direct care workers have been singled out as a major factor in the long-term care worker shortage. While improvement of wages and benefits is certainly an important short-term strategy, many states have recognized that their ability to impact this problem through increased reimbursement alone is very limited. In the long run, the profession must become more attractive, workers must feel less isolated, and existing workers must become more effective through the use of technology and acquisition of new skills. These steps require the active participation of provider agencies, nursing boards, technical colleges and other groups that may not be engaged in this issue. The State could facilitate discussion among these groups through the creation of a visible commission charged with development of a long-term strategy for West Virginia.

## **V. Conclusion**

West Virginia has made considerable progress in the development of its community long-term care system, but it has many important challenges ahead. These challenges do not need to be addressed all at once, nor do changes need to be implemented immediately statewide. The State should consider prioritizing system improvements and piloting changes on a regional basis. Given the considerable differences between West Virginia's cities and its rural areas, system changes will need sufficient flexibility to accommodate regional variation.

## **Appendix A. Persons Interviewed for Report**

P. John Alfano, West Virginia Health Care Association  
Mike Anderson, West Virginia Health Care Association  
Joan G. Armbruster, West Virginia Dept. of Health & Human Resources, Bureau for  
Medical Services, Office of Behavioral & Alternative Health Care  
Robert P. Brauner, R.Ph., West Virginia Dept. of Health and Human Resources, Office of  
Health Facility Licensure & Certification  
Cathy J. Chadwell, R.N., West Virginia Health Care Authority  
Charles F. Conroy, Jr. , West Virginia Bureau of Senior Services  
William C. Davis, AARP Southeast Region Office  
Laura Friend, West Virginia Council of Home Care Agencies  
Pam Garrett, RN, West Virginia Department. of Health and Human Resources, Office of  
Health Facility Licensure & Certification  
Robert E. Graham, Council on Aging/All Care Home & Community Services  
John Grey, West Virginia Health Care Authority  
Mike Hay, West Virginia Health Care Association  
Sallie H. Hunt, West Virginia Health Care Authority  
Earl F. Jarvis, Kanawha Valley Senior Services, Inc.  
Heather Johnson-Lamarche, PKC Corporation  
Matthew C. Keefer, NHA, West Virginia Department of Health and Human Resources,  
Office of Health Facility Licensure & Certification  
Karen Leachman, Wood County Senior Citizens Association  
Kenna Levendosky, West Virginia Health Care Authority, Planning & Policy  
Development Division  
William E. Lytton, Jr., West Virginia Bureau of Senior Services  
Barbara Manard, Manard Company  
Scott McClanahan, Kanawha Valley Senior Services, Inc.  
Jill McDaniel, West Virginia Hospital Association  
Gaylene A. Miller, West Virginia Bureau of Senior Services  
Marsha K. Morris, Esq., West Virginia House of Delegates, House Finance Committee  
Stephen W. Mullins, West Virginia Department of Health and Human Resources, Bureau  
for Medical Services, Office of Behavioral & Alternative Health Care  
Gloria Pauley, West Virginia Department of Health and Human Resources, Office of  
Health Facility Licensure & Certification  
Evelyn Post, Central West Virginia Aging Services, Inc.  
James M. Schock, West Virginia Bureau of Senior Services  
Linda S. Sovine, West Virginia Health Care Authority  
Dayle D. Stepp, West Virginia Health Care Authority  
Ann Stottlemyer, West Virginia Medical Institute  
Steven J. Summer, West Virginia Hospital Association

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**(Appendix B continued)**

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