



U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy

USING MEDICAID TO COVER SERVICES FOR ELDERLY PERSONS IN RESIDENTIAL CARE SETTINGS:

State Policy Maker and Stakeholder Views in Six States

December 2003

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Using Medicaid to Cover Services
for Elderly Persons in Residential
Care Settings: State Policy Maker
and Stakeholder Views in Six
States

Final Report

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Executive Summary

INTRODUCTION

The anticipated increase in the population aged 65 and older in the coming decades, particularly those aged 85 and older, will lead to an increase in the number of people who need long-term care services. Virtually all individuals who need long term care services prefer to receive them in their own homes. However, some people with long term care needs cannot live in their own homes, often because they live alone and need unscheduled assistance and protective oversight on a 24 hour basis.

Residential care settings have traditionally provided such assistance and oversight to persons with physical and mental impairments who cannot live at home alone but do not require a nursing home level of care. As such, residential care lies on the long term care continuum between home care and nursing home care.

Since the mid-seventies, states have had the option to use Medicaid to cover services in residential care settings under the personal care option, and since 1981, under the home and community-based services (HCBS) waiver program. Until the 1990s, most states used the waiver program to pay for services in residential care settings only for persons with mental retardation and other developmental disabilities, as an alternative to intermediate care facilities for persons with mental retardation. By 2002, however, 36 states had amended their Medicaid waiver programs to permit payment for services in residential care settings for elderly persons, and 13 states covered personal care in these settings under the state plan, together serving approximately 102,000 elderly Medicaid clients.

Historically, states have licensed two general types of residential care: (1) adult foster care, which typically serves five or fewer residents in a provider's home, and (2) congregate care, which typically serves six or more residents in a range of settings – from large residential homes to settings that look like commercial apartment buildings or nursing homes. These settings have been in existence for a long time. But with Medicaid funding, they are getting increased attention.

To date, there has been little research on how states use Medicaid to pay for services for elderly persons in these settings. This report is intended to fill that gap, by describing in depth how six states use their Medicaid programs to fund residential care services for elderly persons. These states are Florida, Minnesota, North Carolina, Oregon, Texas, and Wisconsin.

METHODS

Our findings are based on three sources: (1) an extensive review of published and unpublished information about the six states' long term care systems, with a focus on their residential care systems and Medicaid programs; (2) consultation with Medicaid program staff and policy makers and other key staff to obtain additional information and to clarify information obtained through the Internet and other sources; and (3) interviews with current and former state staff and policy makers, residential care providers, representatives of provider and consumer organizations, and academic experts and policy analysts. *Appendix A* contains additional information about the qualitative methodology we used to conduct this study.

FINDINGS

A primary purpose of the study was to gain an understanding of how state staff and policy makers and key stakeholders view Medicaid coverage of services in residential care for elderly persons.

Using Medicaid in Residential Care

All of the respondents we interviewed believed that their states' decision to use Medicaid to provide services in residential care settings was the right one. In states using the personal care option in their state plan, respondents felt that Medicaid had brought much needed revenues to a residential care sector that historically had been under-funded for Supplemental Security Income (SSI) recipients. In states using the waiver program, respondents felt that by providing an alternative to nursing homes for waiver clients who cannot be served at home, Medicaid funding had both afforded consumers additional long term care options and saved the states money.

Public Confusion about the Residential Care System

At the same time, the individuals interviewed for this report, who were typically quite candid in their comments, cited a range of concerns about the residential care system generally. With the exception of Oregon, stakeholders in each state said that public confusion about residential care options was a problem. The confusion is due primarily to the use of the term "assisted living" to market very different types of facilities, both in terms of the housing and the services offered.

Licensing and Regulatory Issues

Stakeholders also raised concerns about both overly prescriptive regulations and the lack of enforcement of existing regulations. Respondents in every state had concerns that providers were keeping residents longer and that regulatory changes were needed to

address the increased nursing needs and acuity levels of residents in residential care settings.

Whatever their views on specific regulations, nearly everyone interviewed believed that licensing and regulation were state functions and there should be no national regulations for residential care.

Staffing

Almost every person we interviewed had concerns about staffing levels in residential care settings, both the quality and quantity. Several noted that even with highly trained, competent staff, insufficient staffing would compromise the quality of care. All acknowledged that low pay, lack of benefits, lack of a career ladder, poor management and oversight, and, in some cases, an unpleasant work environment made it very difficult to recruit and retain staff and that general workforce shortages exacerbated the problems.

Admission and Retention Requirements

Most of those we interviewed felt that their state's admission and retention requirements were appropriate, but many expressed considerable concern about how these requirements worked in practice. While very few had concerns about admissions, nearly everyone we interviewed had concerns related to discharge and agreed that issues related to the ability to age in place were far from settled.

Barriers to Expanding Medicaid Coverage

Respondents in all states cited similar barriers to expanding Medicaid coverage of services in residential care settings, including a lack of funding for long term care programs generally and insufficient funding for waiver programs in particular. In the two states that do not limit the amount that providers can charge Medicaid clients for room and board, several noted that room and board charges were unaffordable for Medicaid clients.

Inadequate service rates were cited by some in every state as a disincentive for providers to serve Medicaid beneficiaries, particularly in states that restrict room and board payments to SSI levels. On the other hand, in states with relatively high rates, such as Wisconsin, some were concerned that providers are making too much of a profit. In states with relatively low rates, such as Florida and North Carolina, there are concerns about inadequate care.

Suggestions to Improve the Residential Care System

Those we interviewed had numerous suggestions for improving the Medicaid funded residential care system. The most frequent suggestion was increased funding for both the service component of residential care and the housing component. Several suggested that states allow long term care funding to "follow the person." Texas is using this approach by

allowing money from its nursing home budget to pay for waiver services for people transitioned to home and residential care settings.

There was consensus among those we interviewed that states need to pay more attention to quality of care issues generally, and staffing issues specifically. To increase the recruitment and retention of direct care staff, many respondents noted a need for better pay and benefits, more training, career ladders, improved management, and better work environments.

In light of the older ages, higher levels of impairment, and chronic health conditions characteristic of residential care residents, several noted the need to increase both the quantity and quality of health and nursing services provided in residential care settings.

There was agreement among state staff, providers, and consumer advocates that service rates must reflect actual costs and that reimbursement systems need to better match payment rates to residents' needs.

Finally, at least one person in each state felt that the state needed to help consumers better understand the long term care system generally and the differences between different services options. Several said that consumers and their families needed some method to help them compare residential care options and choose those that were best suited to their needs and preferences.

CONCLUDING REMARKS

In each of the six states, there is very strong interest in developing affordable residential alternatives to nursing homes that will provide quality care. The individuals interviewed for this report were typically quite candid in their comments, which frequently reflected their frustration in coping with the challenges of developing affordable residential care. State staff, in particular, find themselves grappling with a number of issues that require the reconciliation of what appear to be inherently contradictory goals. These issues are:

- finding ways to cover the actual costs of serving frail older individuals with chronic care needs in residential care settings, when Medicaid is not permitted to pay for room and board and the payment sources available to cover room and board are insufficient;
- finding ways to meet expectations for privacy, amenities, and quality services that have been set by the private pay dominated model of “assisted living” when Medicaid cannot afford to pay private pay rates;
- finding ways to make it possible for individuals to “age in place” without making residential care settings into de facto nursing homes by virtue of having to meet the needs of ever older and more impaired residents;

- finding ways to give consumers a sense of what they should reasonably be able to expect from a setting that calls itself “assisted living” or “adult foster care” or some other name, without imposing uniform definitions through state regulation; and
- finding ways to assure a minimally acceptable quality of care without imposing rules that stifle improvements and without the regulated “floor” becoming the “ceiling.”

The appropriate balance point between these goals will vary depending on the unique characteristics of each state’s long term care system and residential care systems. While the states may face the same challenges, the tradeoffs in attempting to reach the balance will also differ based on the states’ characteristics. However, states can gain valuable insights by examining the experiences of other states as they work to develop affordable residential care alternatives to nursing homes for low income and Medicaid-eligible elderly persons.

Introduction

The anticipated increase in the population aged 65 and older in the coming decades, particularly those aged 85 and older, will lead to an increase in the number of people who need long term care services. Virtually all individuals who need long term care services prefer to receive them in their own homes. However, some people with long term care needs cannot live in their own homes, often because they live alone and need unscheduled assistance and protective oversight on a 24 hour basis.

Residential care settings have traditionally provided such assistance and oversight to persons with physical and mental impairments who do not require a nursing home level of care. As such, they are often viewed as the midpoint of the long term care continuum between home care and nursing home care. These settings are licensed, regulated, and monitored at the state level, and serve both private pay and publicly subsidized residents. The public subsidy is typically through the Supplemental Security Income (SSI) program and, in many states, a state funded SSI supplement. SSI and state supplement recipients can use the payments to pay for room and board and custodial care.

Every state's long term care system includes two major types of out-of-home residential care:

- adult foster care in private or corporate-owned homes that serve a small number of residents (typically five or fewer), and
- congregate care settings with bed sizes greater than foster care, which vary from 6 to 200 or more.

Congregate care settings traditionally have been known by a variety of names, which vary by state. The more common names are domiciliary care homes, board and care homes, adult care homes, and rest homes.

In the U.S., between 800,000 and 1,000,000 aged persons live in licensed residential care settings. An equal number are thought to live in unlicensed boarding homes.ⁱ

In the late 1980s, a new model of residential care for elderly persons was introduced in Oregon and spread rapidly across the country.ⁱⁱ This model, called assisted living, differed from the other two types of residential care in that it was based on a philosophy that emphasized privacy and a homelike environment; services and oversight available 24 hours a day to meet both scheduled and unscheduled needs; services provided or arranged to promote independence; and an emphasis on consumer dignity, autonomy, and choice.ⁱⁱⁱ In the assisted living model, privacy and a homelike environment is assured by providing residents with, at a minimum, a private room and bath with a lockable door. The original model as piloted in Oregon provided a full apartment with separate living space for sleeping

and a full kitchen or kitchenette. Assisted living potentially combines ordinary accessible housing with services so that people who need long term care services can receive them without the lifestyle sacrifices required by nursing home admission.^{iv}

A national survey of residential care facilities in 1998 found that while basic rates ranged from \$16,000 to \$26,000 per year, persons seeking high privacy and high service levels can expect to pay about 30 percent more.^v Considering these rates, assisted living serves a predominantly private pay clientele. The popularity of the assisted living residential care model in the private pay market has led to increased interest among aging services providers, consumer advocates, and states in developing affordable versions of the model for low income and Medicaid-eligible persons.

States in particular are interested in the potential of this model of residential care to serve as an alternative to nursing home care for some Medicaid waiver clients who cannot safely be served in their own homes but do not need the skilled care provided in nursing homes. Unlike Medicaid coverage of nursing home care, which includes payment for all services and room and board, Medicaid does not cover room and board in residential care settings. However, states have the option to use Medicaid to cover services in these settings. Paying only for services in a residential care setting and not for room and board can potentially reduce state spending for nursing home eligible individuals.

From the inception of the waiver program, states have used waivers to pay for services in residential care settings as an alternative to intermediate care facilities for persons with mental retardation (ICF-MRs). Apart from Oregon, few states used waivers to pay for residential care services for the elderly population until the 1990s. By 2002, however, 36 states had amended their Medicaid waiver programs to permit payment for services in out-of-home residential care settings, and 13 states covered personal care under the state plan in these settings. However, relatively few persons in these settings receive services through the waiver program compared to the number receiving personal care services through the state Medicaid plan.

To date, there has been little research on how states use Medicaid to pay for services for elderly persons in residential care settings.^{vi} A recent publication on Medicaid home and community services briefly discussed options for Medicaid coverage of assisted living and the factors states need to consider when deciding whether and how to cover services in assisted living (see *Appendix H* for this information.)^{vii} This report builds on that discussion by examining in depth how six states are using Medicaid to pay for services for elderly persons in residential care settings. The states are Florida, Minnesota, North Carolina, Oregon, Texas, and Wisconsin.^{viii}

A primary purpose of the study was to gain an understanding of how state staff and policy makers and stakeholders view Medicaid coverage of services in residential care for elderly persons. As stated earlier, the names used to describe residential care settings have historically varied, both within and among states. In the past several years, many states

have begun to use the term “assisted living” generically to cover all three types of residential care: adult foster care, congregate care, and the new assisted living model. Minnesota defines assisted living as a program and not a place. At the same time, some consumers, providers, and states view assisted living as a distinct model of care. Therefore, to prevent confusion about which type of residential care is being referred to, this report uses the generic term “residential care setting” to include all types of residential care, including adult foster homes, small board and care homes, large domiciliary care homes, and private assisted living apartments. We will use different terms only when needed to distinguish between the three specific residential care models and when describing specific settings in a given state.

Our findings are based on three sources: (1) an extensive review of published and unpublished information about the six states’ long term care systems, with a focus on their residential care systems and Medicaid programs; (2) consultation with Medicaid program staff and policy makers and other key staff to obtain additional information and to clarify information obtained through the Internet and other sources; and (3) interviews with current and former state staff and policy makers, residential care providers, and representatives of provider and consumer organizations. These interviews occurred between June 2002 and February 2003.

This report is organized as follows. The next section provides information on the two Medicaid options for covering services in residential care settings and a brief description of the six states’ reasons for using specific options. The following two sections present the views of state staff and policy makers and key stakeholders about Medicaid coverage of services in residential care settings and their suggestions for improving the Medicaid-funded residential care system. The final section presents concluding remarks.

Appendix A contains a discussion of the qualitative methodology we used to conduct this study. Appendices B through G contain a description of each state’s long term care system focused on its Medicaid program and residential care system. The state descriptions provide background and technical information, as well as summaries of the views of those we interviewed. Appendix H provides technical information about factors for states to consider when choosing to cover Medicaid services in residential care settings.

1. Medicaid Options for Providing Services in Residential Care Settings

States have the option of paying for custodial care – including personal care – in residential care settings through state funded supplemental payments to SSI recipients. The disadvantage for the states in using this option is that the supplement is not matched by federal funds. States also have the option to pay for personal care and other long term care services in residential care settings through the Medicaid state plan personal care option and the home and community-based services (HCBS) waiver program. This section describes these options and the six states' reasons for choosing particular options.^{ix}

PERSONAL CARE OPTION

Since the mid-1970s, states have had the option to offer personal care services under the Medicaid state plan in individuals' place of residence, whether in their own home or in a residential care setting. Until 1993, the Medicaid personal care option had a medical orientation: services had to be prescribed by a physician, supervised by a nurse, and delivered in accordance with a care plan. In 1993, Congress amended Medicaid law to allow states to use means other than physician prescription to authorize personal care services and other than nurse supervision to oversee the provision of care. States may impose reasonable medical necessity criteria for receiving personal care services, but may not restrict it to persons who require a nursing home level of care.

Because personal care is an optional Medicaid service, states have considerable discretion in its provision. While optional services must be offered statewide, states can set additional eligibility criteria for the receipt of services. For example, Florida restricts eligibility for personal care services to residents of group living arrangements, and, prior to 1995, North Carolina restricted eligibility to people in their own homes.

An advantage of using the personal care option to cover services in residential care settings is that the state can provide services to a less severely impaired population than those eligible for nursing home care. From the perspective of individuals who need personal care, a disadvantage of the personal care option is that it lacks the higher income eligibility standard that states may use for waiver programs. From the state's perspective, however, this limitation may be seen as an advantage because it enables the state to limit costs by restricting the benefit to those who meet the lower income eligibility standard.

As of 2003, 36 states have the personal care option in their state Medicaid plan, but only 13 use the option to cover services in residential care settings.^x

HOME AND COMMUNITY-BASED SERVICES WAIVER OPTION

States have had the option of covering services in residential care settings through the HCBS waiver program since 1981 when Congress first established the waiver authority. This option is limited only by a state's ability to serve residents who meet the state's nursing home level-of-care criteria under current licensing and regulatory provisions for residential care settings. States can either amend an existing waiver to add services provided in residential care settings, or they can apply for a new separate waiver to cover services in residential care settings.

Adding to an existing waiver program is simple and minimizes reporting and tracking requirements. However, advocates for home and community services may perceive the addition of services in residential care settings as increased competition for a limited number of slots available for home services more generally.

The option to use the waiver program to cover services in residential care settings was rarely used until the late eighties and early nineties, when the introduction and popularity of the private pay model of assisted living led to increased state interest in providing this option for waiver clients who could not be safely cared for at home. In response to this increased interest, the Centers for Medicaid & Medicare Services (CMS)^{xi} added *assisted living* to the standardized waiver format as one of two types of service under the heading of *Adult Residential Care*. It is defined as:

Assisted living: Personal care and services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under state law), therapeutic social and recreational programming, provided in a home-like environment in a licensed (where applicable) community care facility, in conjunction with residing in the facility. This service includes 24 hours on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. Other individuals or agencies may also furnish care directly, or under arrangement with the community care facility, but the care provided by these other entities supplements that provided by the community care facility and does not supplant it.

Personalized care is furnished to individuals who reside in their own living units (which may include dually occupied units when both occupants consent to the arrangement, which may or may not include a kitchenette and/or living room, and which contain bedrooms and toilet facilities. The consumer has a right to privacy. Living units may be locked at the discretion of the consumer, except when a physician or mental health professional has certified in writing that the consumer is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. (This requirement does not apply where it conflicts with a fire code.)

Each living unit is separate and distinct from each other. The facility must have a central dining room, living room or parlor, and common activity center(s) (which may also serve as living rooms or dining rooms). The consumer retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk. Care must be furnished in a way which fosters the independence of each consumer to facilitate aging in place. Routines of care provision and service delivery must be consumer-driven to the maximum extent possible, and treat each person with dignity and respect.

This definition incorporates the central tenets of the assisted living philosophy – privacy, autonomy, and choice – but states have the option to use a different definition. Medicaid will pay for services provided in adult residential care settings as long as a "homelike environment" is preserved; thus, it will not pay for services in a facility that is located in the wing of a nursing home.

If states do not currently license residential care settings to provide services to persons with a nursing home level of need, they have two options. They can amend licensing and regulatory requirements for existing residential care settings to allow them to serve a more highly impaired and chronically ill population, or they can create a new category of residential care settings that is licensed to cover this population.

REASONS FOR USING SPECIFIC OPTIONS IN SIX STATES^{xii}

As shown in Table 1, four of the six states use both the personal care option and the waiver program to pay for services in residential care settings, while one uses only the personal care option and another uses only the waiver option. The reasons for choosing the options – as described by those we interviewed – are unique to each state's long term care system, philosophy, and goals.

Table 1. Use of Medicaid Options to Pay for Services in Residential Care Settings

Medicaid Option	State
Pays for services through Personal Care Option	North Carolina
Pays for services through Personal Care Option and HCBS Waiver Program	Florida Minnesota Wisconsin
Pays for services through HCBS Waiver Program	Oregon Texas

However, there was consensus among the respondents that states' primary goals in using Medicaid to pay for services in residential care settings are (1) to provide an alternative to nursing homes for people who cannot live at home, thereby providing consumers with more choice; (2) to reduce nursing home utilization; and (3) to save money.

Nearly all respondents felt that their state's decision to use Medicaid to fund services in residential care settings was a positive development. The following comments are illustrative of their views.^{xiii}

- *The most important feature of Medicaid paying for services in residential care facilities is that it provides the flexibility to provide services based on people's needs. If consumers can't live at home, it gives them a choice other than the nursing home. Some people choose to live in a residential care setting and it's also a safety net for people who wind up there because they have no other choice.*
- *The use of Medicaid to support older persons with dementia in a residential care setting has been highly successful. A good residential care setting is highly preferable to a nursing home.*
- *People were becoming more frail and needing more services, but not qualifying for a nursing home, and couldn't afford a private assisted living facility. Under the personal care option, they can now get some services.*
- *The waiver program has achieved the primary goals of cost saving, reduction in the nursing home bed base, and more humane long term care alternatives. Each dollar spent on the waiver would have cost \$2.70 in the nursing home.*
- *Including personal care in the state plan was key to the state's efforts to provide additional revenues to assisted living facilities. It has been instrumental in attracting providers who were reluctant to take state supplement recipients in the past and provides Medicaid funding for frail elders who are not as impaired as waiver clients.*

The state wanted to get to the point where nursing homes were not a high priced alternative to community care. Using Medicaid to pay for assisted living fit a niche.

The following descriptions illustrate both the commonalities among the six states in their reasons for choosing specific options and the unique features of their long term care systems influencing their choice of options.

Florida

Florida uses both the personal care option and the waiver program to cover services in residential care settings. Since 1975, Florida licensed a type of residential care setting called Adult Congregate Living Facility (ACLF), which provided room and board, assistance with one Activity of Daily Living (ADL), social services, and supervision of self-administered

medication.^{xiv} ACLFs served a predominantly private pay clientele, but also some individuals who received SSI and an SSI supplement through the state's Optional State Supplementation program. The state did not have a residential care setting that was licensed to serve state supplement recipients who needed substantial levels of personal or home health care but not the level of skilled nursing care provided in nursing homes. Consequently, individuals with this level of impairment had to either enter a nursing home, at a much greater expense to the state, or find an unlicensed facility that would accept them.

To address this gap, in 1992 the state developed a new licensing category of ACLF called Extended Congregate Care that could serve residents with higher levels of need. However, at that time, Florida's waiver program served only individuals who lived in their own homes. In 1995, Florida initiated a pilot program called the Assisted Living for the Elderly waiver, which was designed to serve only individuals who reside in assisted living facilities. In 1997, the state expanded the waiver to statewide status.

In 2001, Florida amended its state plan to include personal care services, which are provided through a program called Assistive Care Services. Elderly persons who live in their own homes are not eligible to receive these services; only those who live in licensed adult family care homes and licensed assisted living facilities are eligible.^{xv}

Prior to the addition of personal care services to the state's Medicaid plan, Florida paid for some personal care in residential care settings through its Optional State Supplementation (OSS) program, which is funded by general revenues. The state supplement is not provided to individuals who live in their own homes. Once personal care was added to the Medicaid program, the state reduced the OSS payment and used the money saved to provide the state match for Medicaid personal care services.

Minnesota

Minnesota uses both the personal care option and the waiver program to cover services in residential care settings. In 1983, to reduce nursing home utilization, the state instituted a moratorium on new nursing home beds, and in 1988, implemented an Elderly Waiver program that provides services in a person's home and in residential care settings. At the same time, the state expanded the services in the Medicaid state plan to include personal care services. The state sought by these actions to maximize the number of supportive service options available to persons at risk of institutionalization. Personal care services – called Personal Care Attendant (PCA) services – are available to eligible persons in their homes, apartments, registered housing with services, and adult foster care settings.

Minnesota uses a managed care model in its Medicaid program called the Pre-paid Medical Assistance Program (PMAP). Persons eligible for Medicaid are enrolled in PMAP and a capitated fee is paid to the PMAP managed care provider, who then becomes responsible for the delivery of all Medicaid state plan services, including PCA services. The PMAP covers PCA services in a person's place of residence, wherever that may be.

Technically, PCA services are available to an Elderly Waiver client in a residential care setting. However, because the residential care setting typically provides personal care to waiver clients under its own contract with the resident, PCA services from outside the setting (through the state Medicaid plan) are not used. PCA services under the Medicaid state plan are typically used in residential care settings such as adult foster care by persons with disabilities under age 65 who are not eligible for the Elderly Waiver program.

North Carolina

North Carolina uses only the Medicaid state plan personal care option to cover services in adult care homes. Prior to 1995, North Carolina provided Medicaid personal care only to individuals in their own homes. The state funded a small amount of personal care in adult care homes through a relatively generous state supplement called Special Assistance (SA), which is available only to residents of adult care homes.^{xvi} The combined SSI+SA payment is set each year by the state as the rate for adult care homes to provide room, board, and custodial care. In 2003, the SA supplement for an SSI recipient is \$560.

In the late 1980s to mid 1990s, advocates for the elderly lobbied the state to address perceived quality of care problems in adult care homes. In particular, there were concerns that persons requiring a nursing home level of care were residing in these homes and were not receiving appropriate or adequate services.^{xvii} In response, North Carolina commissioned a study, whose findings confirmed these concerns. The study found that adult care home residents in North Carolina had significant levels of impairment.^{xviii} It also found that compared to persons in residential care settings in ten other states, North Carolina residents had much higher levels of incontinence, ADL impairments, and cognitive impairment, with nearly two-thirds having moderate to severe cognitive impairment.

These findings led to pressure from advocates to increase the amount of care provided to residents of adult care homes and pressure from providers for higher payments. In response, the state decided to expand the Medicaid personal care program to cover services provided in adult care homes. The expansion was budget neutral because the state reduced the state supplement and used the savings as the state match for the federal funds.

According to one respondent, another factor influencing North Carolina's decision to expand its personal care program to cover services in residential care settings was congressional consideration of a proposal to block grant Medicaid. At the time Congress was discussing the proposal, many in the state felt it would be advantageous to draw as much Medicaid funding as possible before the program was block granted. Even so, the state was concerned about the cost of the new benefit, and so it established three fixed reimbursement levels for personal care in adult care homes – basic, and two enhanced levels – to be determined by a case manager. In addition to paying for one hour of personal care per day, the Medicaid program also provides case management to oversee residents with heavy care needs.

North Carolina has chosen not to use the waiver program to cover services in adult care homes because these homes are licensed to provide only custodial care and some personal care. State licensing rules specifically prohibit adult care homes from serving persons who need a nursing home level of care. Thus, residents of adult care homes are not eligible for waiver services even if their condition deteriorates. Residents who need skilled nursing services or skilled therapies receive them through the Medicaid or Medicare Home Health benefit. If North Carolina wanted to serve waiver clients in residential care settings, it would have to either amend adult care home licensing requirements or create a new type of residential care setting with appropriate licensing and regulatory standards.

Oregon

Oregon uses only the waiver program to fund services in residential care settings. Although the Medicaid state plan includes the personal care option, Oregon decided to use the waiver program alone because its specific goal was to reduce nursing home utilization, and persons who meet a nursing home level of care typically need more than personal care.

The state expanded its community long term care infrastructure by focusing initially on the development of adult foster care, and later on assisted living facilities and other non-medical residential settings. Residents in all residential care settings can receive Medicaid waiver services as long as the facilities meet the regulatory requirements for providing these services.

Texas

Texas uses only the waiver program to cover services in residential care settings. In the early 1990s, Texas became interested in supporting residential care alternatives to nursing homes for individuals who met a nursing home level of care but could not be safely cared for at home. In 1994, Texas implemented an HCBS waiver program – called Community Based Alternatives – to provide services in private homes, in adult foster care homes, and in assisted living/residential care facilities. The state’s primary goal in creating the Community Based Alternatives waiver program was to offer both home and community alternatives to institutional care and to provide an opportunity for persons in institutions to transition to the community.

Wisconsin

Wisconsin uses both the personal care option and the waiver program to cover services in residential care settings. In 1981, to decrease nursing home utilization, the state instituted a moratorium for nursing facilities and shortly after implemented an HCBS waiver program to provide services to persons residing in their own homes, supported apartments, and all types of residential care settings. The state’s primary goal in using the Medicaid waiver to pay for services in residential care settings is to provide an alternative to nursing homes for people who cannot live in their own homes.

In 1988, Wisconsin amended its state Medicaid plan to provide coverage of personal care. The rationale for adding personal care to the state plan was that the Medicaid home health benefit, which paid for home health aides to perform nurse delegated tasks such as wound care, was not able to meet the personal care needs of many persons with disabilities. When personal care was added to the state plan, it was initially covered only in private homes.

In the 1990s, the state realized that there was inadequate funding to support the care of residents in Community Based Residential Facilities (CBRFs). At this time, personal care services provided in CBRFs was paid through the waiver program, the state's general revenue funded Community Options program, county funding, and federal social services block grant funding. However, these funding sources were not sufficient to meet the need, and people who were eligible for waiver services often faced long waiting lists. Therefore, the state decided to expand its personal care program to cover persons in CBRFs. Coverage in these settings was viewed as cost efficient because the state does not pay for room and board in CBRFs, as it does in nursing homes.

Initially, both waiver services and personal care under the state plan were provided only to residents of CBRFs with no more than eight beds. The state used small bed size as a proxy for "home-like" and did not want to encourage the payment of public money to quasi-institutional residential care facilities, i.e., those with more than eight beds. The bed restriction was recently increased to 20 beds, in part because some residents were being forced to leave their residence and move to one with eight or fewer beds in order to receive Medicaid services.

2. How Medicaid is Working in Residential Care Settings: State and Stakeholder Views

INTRODUCTION

In addition to providing a technical description of how states use Medicaid to cover services in residential care settings, we wanted to gain an understanding of how the states and key stakeholders viewed this coverage. To ensure a cross section of views, in addition to interviewing state staff and program administrators we interviewed both providers and their representatives as well as consumer advocates.

We were interested in their views generally, such as whether they saw Medicaid coverage as a positive development in their long term care systems. We were also interested in knowing if they had any general or specific concerns about how the residential care system in their state was working for Medicaid clients. Specifically, we asked for their views on a range of issues, including barriers to the provision of Medicaid coverage of services in residential care settings, and licensing and regulatory requirements – particularly those related to admission and discharge – that affect the ability to age in place.

Although the purpose of our interviews was to gain a better understanding of Medicaid's coverage of services in residential care settings, nearly everyone we interviewed provided their views on issues related to the state's residential care system regardless of whom it serves: private pay, Medicaid-eligible residents, or a combination of both. Consequently, many of the respondents' views regarding the state's residential care system did not differentiate between Medicaid and private pay residents. For example, concerns expressed about discharge policies apply to both private pay and Medicaid clients. Nonetheless, respondents also had views about issues specific to Medicaid's coverage of services in residential care settings.

Respondents' views are categorized into six major headings:

1. General Comments on the Residential Care System
2. General Comments on Medicaid's Role in Residential Care Settings
3. Licensing and Regulatory Requirements
4. Staffing Issues

5. Barriers to Expanding Medicaid Coverage of Services in Residential Care Settings

6. Future Plans

The content of this section is based solely on the views of those we interviewed, all of whom were quite candid in their discussions with us. For an in-depth description of each state's Medicaid program and residential care system, and specific issues related to Medicaid coverage of services in residential care settings, please see the descriptions of each state in *Appendices B through G*.

GENERAL COMMENTS ON THE RESIDENTIAL CARE SYSTEM

Comments about the residential care system generally were, for the most part, unique to each state and are summarized first, followed by a summary of comments about one issue raised by respondents in all six states.

Florida. The increase in the cost of liability insurance was cited by most respondents as the biggest problem facing the assisted living industry in Florida, and a major barrier to assuring the availability of residential care options for older persons who do not want to live in a nursing home. Recently, assisted living facilities (ALFs) with Extended Congregate Care (ECC) or Limited Nursing Services (LNS) licenses have been notified by insurers that they will be charged the same liability insurance rates as nursing homes. The rate increase is based on insurers' views that these facilities are equally at risk for lawsuits because they are licensed to serve waiver clients who meet the state's nursing home level-of-care criteria.

One provider stated that her annual liability insurance premium had increased from \$7,000 three years ago to \$55,000 this year. One respondent stated that since January 2002, ALFs with ECC and LNS licenses could not obtain liability insurance at all. Although the legislature authorized a state insurance program that can provide insurance for up to 800 ALFs, two respondents felt that this program would not solve the liability insurance crisis in the absence of tort reform. Most respondents recommended tort reforms that would set a limit on compensatory and punitive damages.

Minnesota. Minnesota's assisted living program is a service model that can be provided in virtually any type of housing, and respondents mentioned a number of issues related to this model. Because admission and discharge decisions in Minnesota's system are solely within the housing providers' discretion, two respondents felt that a resident's bill of rights and an appeals process were needed, particularly to address involuntary discharges. Another felt that a minimum level of care should be required of all settings.

North Carolina. Two respondents felt that the state's Certificate of Need (CON) program for ALFs needed to be better targeted. One noted that the current CON program has a cap by county, but there is a shortage of beds for people who are difficult to place, such as those

with AIDS and behavior problems. Another noted that a county could have only two very old facilities with physical plants that no one wants to live in, but if someone wanted to build a better adult care home in that county, the permit would be denied as long as there were vacancies in the existing facilities.

Others criticized the state's nursing home moratorium and CON program, stating that they had a negative impact on consumers because they led to an insufficient supply of beds. Consequently, "people who should be in nursing homes wind up in adult care homes."

Oregon. The only major concern, expressed by all respondents, was the effect of budget cuts on the state's residential care system. Nearly all agreed that proposed budget cuts to the waiver program, if enacted, would cause some providers to go out of business, particularly those that serve a high proportion of Medicaid residents.

Texas. The only major concern, expressed by a few respondents, was that the state could be facing a liability insurance crisis in the near future. One noted that an error in the regulations had led to increased liability for providers, and another noted that the 2003 legislative session was going to address tort reform. However, Texas does not currently require ALFs to have liability insurance.

Two respondents mentioned that the federal SSI payment was too low to cover provider costs for room and board and that a state supplement was needed. However, both acknowledged that it was unlikely the state would provide a state supplement given current budget shortfalls.

Wisconsin. A consensus existed that the state was not adequately enforcing its residential care regulations and the primary reason was lack of funding to do so. One respondent felt that the state needed more adult family care homes, i.e., adult foster care homes.

Confusion About the Various Types of Residential Care

As noted in the beginning of this report, the term "assisted living" originated as a distinct type of residential care model for the private pay market as an alternative to nursing homes and traditional residential care settings such as board and care homes. The model was developed to provide what was perceived to be lacking in these other settings: a private room and bath or full apartment, autonomy, and the ability to tailor service packages as long term care needs increased or decreased, temporarily or permanently.

Respondents in several states noted that due to the popularity of the new model, many residential care settings were using the term "assisted living" in their marketing materials, even though some did not provide private rooms or the ability to age in place. Some states now use the term as an umbrella category for quite different types of residential care settings; some have amended regulations to rename traditional domiciliary care homes as assisted living. Minnesota uses the term to describe a package of services that can be

delivered in a wide range of housing settings, some of which market themselves as assisted living.

Respondents in several states noted that use of the term “assisted living” for different types of residential care settings has led to considerable confusion among consumers. Several respondents noted that the residential care system was so confusing that it was difficult for consumers (and their families) to figure out what type of residential care setting would be able to meet their needs.

Oregon is the only state of the six that limits the use of the term to residential care settings that provide individual apartments. There was a consensus among the Oregon respondents that the state was right to limit the use of the term in this way. In marked contrast with other states, no one in Oregon mentioned public confusion about the different types of residential care as an issue.

Minnesota. In Minnesota, assisted living is viewed not as an architectural model but as a service package that can be provided in a wide variety of housing types. One respondent noted that families are surprised to learn that the assisted living model in Minnesota is licensed as a home care provider, that 24-hour supervision is not available in many settings, and that although a residence is licensed, it is not regulated.

North Carolina. According to several respondents, when North Carolina amended its statutory provisions governing domiciliary care, the industry lobbied the legislature to redefine adult care homes as assisted living, because it wanted to be able to market adult care homes as assisted living to compete with the newer, private-pay, high end facilities.

The state’s new statutory definition of assisted living includes adult foster care, adult care homes, and a new category of senior housing that provides meals and housekeeping and social services only. Many respondents – providers, consumer advocates, and state staff – said that the generic use of the term “assisted living” in North Carolina’s residential care system was confusing for the public. They noted that the public does not understand the differences between nursing homes, adult care homes, and assisted living.

Several noted that the situation is particularly confusing when adult care homes with few if any of the features of market rate private-pay assisted living facilities market themselves as such. To add to the confusion, facilities licensed under the same standards offer substantially different levels of care. Some facilities accept only those with few needs, while others accept those with multiple needs.

One respondent said that another source of confusion was the use of the term “assisted living” by adult care homes that did not serve a predominantly elderly population. In North Carolina, adult care homes are permitted to serve persons of varying ages with substantially different service needs in the same facility: young adults with serious mental illness or developmental disabilities and frail elderly persons. Several felt that this caused even more

confusion for the public, which generally associates the term “assisted living” with the care of elderly persons.

One person noted that she has received calls from families looking for residential care, who were upset after visiting some of these homes, saying that they could not put their frail mother in an assisted living facility that also served young adults with serious mental illness. They were particularly concerned because these homes did not have private units with lockable doors.

Several respondents, both consumer advocates and providers, said it was impossible to assure that the service needs of different groups – the seriously mentally ill, developmentally disabled, and frail elderly – could be met using the same set of licensing and regulatory provisions.

Wisconsin. Wisconsin has a similar situation as North Carolina, having only one licensing standard for all community based residential facilities (CBRFs), which can serve a diverse population, including elderly persons, persons with serious mental illness, traumatic brain injuries, developmental disabilities, veterans, unwed mothers, and even corrections clients.^{xix} As in North Carolina, a few respondents – both consumer advocates and providers – said it was not possible to assure that the service needs of such different populations could be met using the same licensing and regulatory provisions.

When Wisconsin created a new licensure category called assisted living and required facilities licensed under this name to provide private apartments, the residential care industry lobbied the state to permit CBRFs (which provide private and shared bedrooms and mostly shared baths) to also market themselves as assisted living. Wisconsin revised the statute to allow this, and due to concerns that the public would be confused if the new apartment model and CBRFs were both called assisted living, it renamed the licensing category of the apartment model from assisted living to Residential Care Apartment Complex (RCAC).

Consequently, the model that matches the assisted living philosophy is not called assisted living. According to several respondents, this has created considerable confusion among the public. Several respondents said that just about any type of setting could call itself assisted living, and that the operative condition in the state when looking for a residential care placement is “buyer beware.”

One noted that the state had a website that did an excellent job explaining the differences between RCACs and CBRFs and adult foster care, but that access to the web is an issue. The average age of entry into residential care is the early to mid-eighties, and many older persons and their families do not have computers; those that have computers do not always know how to use them to get information. This same respondent noted that another issue is that many, if not most, residential care placements are made in a crisis situation, after a

hospitalization or a nursing home stay, and under these conditions, decisions are often made based on what is convenient and available rather than what is needed and preferred.

Another source of confusion for the public is that while RCACs must provide services up to 28 hours a week, they are permitted to choose which services to offer above the minimum required personal, supportive, and nursing services. One RCAC could limit nursing services to health monitoring, medication management, and administration (i.e., the minimum), and another could offer additional nursing services. Several respondents stated that differences in the services offered made it difficult for people to identify a facility that would best meet their needs over time.

In sum, with the exception of Oregon, respondents in all states agreed that the term “assisted living” has become a generic term that is not helpful to consumers, and that some standard nomenclature is needed to help the public understand the residential care system. A few respondents (all providers) stated that they opposed limiting the term “assisted living” to a specific model. The remainder felt that the term should be used to define a distinct model, because its current generic usage to cover many different types of residential care settings is confusing to the public.

GENERAL COMMENTS ON MEDICAID’S ROLE IN RESIDENTIAL CARE SETTINGS

In all the states, while some respondents had concerns about specific Medicaid-related issues, there was unanimous agreement that Medicaid payment for services in residential care settings was overall a positive development. Medicaid payment was universally viewed as a way to reduce nursing home utilization, and in so doing, both save money and increase community alternatives to nursing homes, thereby providing consumers with more choice. A respondent in Oregon stated that the public has many more options because Medicaid participates in the funding of residential care services.

Respondents in Florida noted that prior to the use of the personal care option in residential care settings, many people needed services but did not meet the nursing home level of care criteria and could not afford to pay privately for residential care. Adding personal care under the Medicaid plan was key to the state’s efforts to provide additional revenue to residential care settings that previously received only SSI and a state supplement as full payment for room and board and services. Medicaid coverage of personal care in residential care settings has attracted providers who, in the past, were reluctant to take state supplement recipients.

Florida respondents also noted that covering services in residential care settings through the waiver program was responsible for major cost savings. One stated that each dollar spent on the waiver would cost \$2.70 in the nursing home. Minnesota respondents expressed

satisfaction with Medicaid coverage because it enabled many people to be served in settings outside the nursing home.

North Carolina respondents felt that Medicaid coverage of personal care in residential care settings had improved the quality of care and had saved the state money by shifting some of the cost of personal care to the federal government. However, some felt that the adult care home population is becoming more and more impaired, and that the homes are not able to provide the level of care that many residents need. One respondent felt that the state is using limited resources inefficiently by providing nursing care to large numbers of people in residential care settings through the Medicaid Home Health benefit. Another noted that even though occupancy rates in some adult care homes were low, some facilities did not want to accept Medicaid residents because they would have to submit cost reports.

Single Occupancy vs. Double Occupancy Rooms

Of the six states, only Oregon requires assisted living facilities to provide private apartments to Medicaid clients.^{xx} In the other states, Medicaid contracting rules may encourage, but do not require, private bedrooms and bathrooms. Yet, in every state, nearly all respondents who commented on the issue of single vs. double occupancy rooms felt strongly that Medicaid clients should have private rooms and baths in residential care settings, noting that most older people highly value their privacy and want private rooms.

Many were highly critical that the term “assisted living” was used to describe facilities that had two and as many as four people in a room (in Florida). One respondent criticized Florida’s Extended Congregate Care regulations for defining privacy as “encompassing dual-occupancy with a choice or roommate where possible.” However, some noted that the low room and board rates mandated for Medicaid clients could make it difficult for some providers to offer private rooms.^{xxi}

In North Carolina, dual occupancy is the standard for Medicaid-eligible residents. Several North Carolina respondents felt that many facilities that called themselves assisted living were similar to institutional care. In Wisconsin, whether a waiver client is served in a single room depends on the availability of these rooms in the area they live in, and whether the facility will accept the low amount that waiver clients typically have to pay for room and board.

Oregon respondents felt that success of the state’s assisted living program lay in its offering Medicaid waiver clients the same residential care options available to the private pay market. As one said, “if the private pay market gets privacy and independence, then so should the Medicaid client.” Another noted that while giving Medicaid clients private rooms in assisted living had been very successful, the downside was that the state has not invested in the physical upgrading of nursing homes, which are viewed as being “stuck in the 50s and 60s.”

One Oregon respondent noted that the assisted living physical plant requirements had generated a greater degree of accessible housing for persons under age 65 with disabilities, noting that ALFs offer a housing option for the younger disabled who need some oversight and services but want privacy and independence.

LICENSING AND REGULATION

States have the authority to license and regulate all types of residential care. There are no applicable federal statutes, other than the Keys Amendment to the Social Security Act, which is applicable to board and care facilities in which a "substantial number of SSI recipients" are likely to reside.^{xxii} State rules vary widely, and thus, respondents' views on licensing and regulatory issues are state specific.

In order to use Medicaid to cover services in residential care settings, the state must assure that its licensing and regulatory provisions match the needs of the individuals who will receive services in these settings. Licensing and regulatory provisions cover many areas, including construction and physical plant standards, health and safety standards, admission and retention standards, and staffing. A number of these areas are key for states serving a Medicaid population in residential care settings, particularly those who meet the state's nursing home level-of-care criteria.

Federal HCBS waiver regulations require facilities in which waiver services are furnished to meet applicable state standards, so state standards set the minimum requirements for Medicaid providers. However, the state's Medicaid program may set additional or more stringent standards for settings that serve waiver clients. For example, a state may permit residential care settings to offer rooms shared by two, three, or more residents, but a state's assisted living waiver program may choose to contract only with facilities that offer private occupancy unless the resident chooses to share a room or unit.

Residential care settings providing waiver services must meet the standards for service provision that are set forth in the approved waiver documents. Medicaid contracting requirements may also specify additional training and other requirements if state licensing rules do not have sufficient requirements for facilities serving people with dementia.

State licensing and regulatory requirements address many areas, and an overview of these requirements for all fifty states can be found in other published sources.^{xxiii} *Appendices B through G* of this report describe key licensing and regulatory provisions for residential care settings in the six study states.

All of the respondents we interviewed had strong views about a number of licensing and regulatory provisions issues. Their responses fell into seven categories, each of which is discussed in turn:

- National Standards
- Prescriptive Regulations
- Staffing
- Nursing Services
- Admission and Retention Requirements
- Negotiated Risk Agreements
- Enforcement

National Standards

In all of the states, nearly everyone interviewed believed that licensing and regulation were state functions and that there should be no national regulations for residential care. There was general agreement that major differences in the states' residential care systems and the heterogeneity of the population served in residential care necessitated different licensing and regulatory provisions. Some felt that federal regulations might stifle state creativity.

In Wisconsin, respondents felt that the licensing and regulatory provisions were good but needed fine tuning. Some stated that the Medicaid waiver program provided quite enough federal oversight. Even in states where considerable dissatisfaction was expressed about certain licensing and regulatory provisions, respondents did not see federal regulation as appropriate or needed.

On the other hand, model standards were viewed as both potentially helpful for informing state licensing and regulatory provisions and also as potentially problematic if they became minimum standards. Some respondents were concerned that model standards would lead to a nursing home regulatory model, which most viewed as both overly prescriptive and not particularly effective in assuring good quality care. Whatever people's views, consensus existed that model standards should not be mandated. As one person in Oregon stated succinctly: "Best practice models? Absolutely. National oversight? Not on your life."

At the same time, a few felt that some type of rating system for residential care settings would be helpful for consumers who currently find it very difficult to evaluate what is available. One respondent suggested a rating system with key features that would enable different settings to be compared in a meaningful way.

Prescriptive Regulations

Respondents in every state acknowledged that regulations were necessary, if for no other reason than to "keep the bad providers out." But many felt that some prescriptive regulations at best did not guarantee good care and at worst impeded it. A few stated that regulations "got in the way of quality of life."

Several noted that licensing and regulatory provisions are too rigid and need to be more person-centered and outcome-based, though one respondent noted that outcome-based provisions would be better included in Medicaid provider contracts than in licensing and regulatory provisions.

Regulations related to assuring a nutritious diet were most frequently cited as too rigid. Several noted that facilities are required to serve nutritious meals based on the food pyramid, but these meals may not provide the type of food that people like to eat. Some suggested an outcome-based alternative: to simply determine if the residents were maintaining an appropriate weight and were happy with the meals provided.

Inflexible, prescriptive non-person-centered rules were viewed as particularly problematic when caring for persons with dementia. For example, one respondent noted that North Carolina has a rule that there must be a minimum of ten hours between breakfast and dinner, but a resident with dementia wanted to sleep late, have breakfast at 10 AM, and dinner at 5:30 PM. Unless a facility followed this schedule, the resident became agitated; nonetheless, the facility was cited for not adhering to the ten hour rule.

Several providers in Oregon expressed concern that the state had started with a resident-centered model but that the regulations were becoming more prescriptive and more costly for providers to meet. One noted that the state prohibits bed rails because they are considered restraints, but some residents have used bed rails at home and want to continue doing so when they move to an ALF because it makes them feel safer at night. One felt that a potential consequence of more regulations is that ALF providers will admit more private pay residents to help meet the cost of the new regulations, resulting in Medicaid clients having fewer choices and ending up in double occupancy residential care facilities. On the other hand, several respondents felt that more regulation was needed because the nursing needs of the average resident have increased.

Another complaint related to licensing and regulatory provisions that were perceived to increase cost but not quality. For example, Florida prohibits stock supplies of over-the-counter medications for multiple residents and requires all non-prescription drugs to be labeled with a resident's name. One provider noted that this rule prevents providers from giving a resident an aspirin for a headache from a stock bottle. On the other hand, several respondents had major concerns about medication administration by unlicensed, untrained, and unqualified personnel, and felt that additional regulations might be needed to prevent medication errors.

Staffing

In general, respondents' concerns about staffing related to quantity and quality.

Staffing Levels. Nearly every respondent in every state had concerns about staffing levels in residential care settings, noting that even with highly trained, competent staff, insufficient staffing would compromise the quality of care. All acknowledged that low pay, lack of benefits, lack of a career ladder, poor management and oversight, and, in some cases, an unpleasant work environment made it very difficult to recruit and retain staff and that general workforce shortages exacerbated the problems.

Most felt it would be difficult to impossible to increase staffing at current Medicaid reimbursement rates. On the other hand, some felt that states needed to have a better picture of what care actually costs in residential care settings before simply putting more money into them.

A few said that staffing regulations needed to be based on care needs and not fixed staff-to-resident ratios. In North Carolina, prior to 2000, adult care homes could have one personal care aide for 50 residents on the night shift. Although this was changed to one aide for 30 on the night shift and 1 for 20 on the day shift, one provider stated that 1 aide for 20 residents is “totally insufficient” if residents have heavy care needs. There was agreement that North Carolina needs an improved assessment form and improved methods to determine the level of care people need.^{xxiv}

Staffing Qualifications and Training. Many respondents in every state had concerns about staffing qualifications, some noting that the basic quality problem was staff not knowing and not recognizing signs of need. They noted that many residents are very old, with major health problems and cognitive impairment, and many if not most residential care staff are not adequately trained to provide good care for this vulnerable population.

Respondents in all the states expressed concerns specifically about staff qualifications to administer and manage complex medication regimes, noting that many residents have cognitive impairment and need assistance in this area. In North Carolina, several expressed concerns about medication errors and said there was inadequate nurse or pharmacy supervision. Many noted the need for additional training, and some mentioned the need for certification to be able to dispense and administer medications. Others were concerned about the lack of training to monitor the effects and side effects of medications.

In North Carolina, several expressed concern that new regulatory requirements for increased staff training were not being enforced, and in Wisconsin some providers expressed considerable concern about the additional cost of training requirements.

Nursing Services

The need for and provision of nursing care in residential care settings was a major issue that nearly all respondents commented on. Respondents in every state had concerns that providers were keeping residents longer and that regulatory changes were needed to address the increased nursing needs and acuity levels of residents in residential care settings.

Many noted that the average age of residents was the early to mid-eighties, and that this age group has more medical needs. They also noted that with shorter hospital and nursing home stays, residents were returning to residential care settings with higher acuity needs. In several states, respondents felt that residential care settings are, to a large extent, serving the population that used to be served in intermediate care facilities (ICFs); however, they

noted that in contrast with the ICFs, residential care settings do not have licensed practical nurses (LPNs) on staff providing direct nursing care, supervision, and oversight.

The problem was seen as particularly acute in North Carolina, where adult care homes are not licensed to provide nursing care; but many felt that there is no difference in the type of residents served by these homes and those that used to be served in ICFs. If a resident needs nursing care, the facility arranges for it through Medicare or Medicaid Home Health. However, one person noted that providing nursing care in this one-on-one manner was not only very expensive but was insufficient because the visit lasts a half hour and there is no registered nurse (RN) or LPN oversight the rest of the day. However, another respondent said that having nurses on staff in these homes was not the solution, because if the state allowed these homes to provide health care, they would become “unlicensed substandard nursing homes.”

In Oregon, several people noted that assisted living residents need and want more health and medical services from an RN or certified nursing assistant (CNA), but ALFs are not required to hire CNAs. Several acknowledged that when the state began paying for waiver services in residential care settings, it focused on ADL needs to the exclusion of chronic illness management. Now there is recognition that more nursing is needed in these settings, but they believe a nursing teaching and consultation model should be used, not a nursing services model.

While many states have nurse delegation provisions, Oregon is unique in its extensive use of nurse delegation and nurse consultation services in its HCBS system, and most said that this nursing model was an essential prerequisite for expanding its system. But several in Oregon acknowledged that questions remain about how nursing should be provided in residential care settings, and that if the state was going to require more nursing, it would have to increase reimbursement rates.

In Florida, there were differences of opinion about whether residential care settings that provided nursing care should have higher licensure standards. One respondent expressed concern that facilities licensed under extended congregate care, which enabled residential care settings to admit waiver clients and provide nursing care, were moving toward a medical model and becoming too much like nursing homes.

Admission and Retention Requirements

Most respondents felt that their state’s admission and retention requirements were appropriate, but many expressed considerable concern about how these requirements worked in practice. With the exception of Texas, people did not have problems with admission requirements. In Texas there was some concern that current licensing standards are too focused on life and safety distinctions. One person noted that fire and safety regulations have made it possible for facilities to deny residence to people who use

wheelchairs. On the other hand, another person noted that the waiver program sometimes pressured facilities to take residents with needs beyond what the facility could provide.

While very few had concerns about admissions, nearly every respondent in every state had concerns related to discharge and agreed that issues related to the ability to age in place were far from settled.

In general, there are two approaches to retention/discharge requirements. One approach sets a maximum, and providers can offer any amount of services up to this limit. Wisconsin uses this approach, allowing CBRFs to provide up to three hours of nursing care per week and RCACs up to 28 hours of care overall, with exceptions for recuperative care.

The other approach sets a minimum, and residential care providers are permitted to set their own ceilings, which allows them to retain residents based on their ability to provide the services needed. Oregon uses this approach, which is less prescriptive, and based on the premise that people should be able to age in place and not be discharged when they reach a specific limit.

However, both approaches recognize that there are circumstances and conditions when nursing home care will be needed. States uniformly require that anyone needing 24-hour-a-day nursing oversight be served only in a nursing home, and some states specifically exclude certain conditions from being cared for in settings other than nursing homes. In Florida, for example, an extended care license permits residential care settings to serve waiver clients, but the statute prohibits them from admitting or retaining persons with specific conditions, such as persons on ventilators.

While most support this latter style of regulation because it permits residents to age in place, they note that it can lead to problems related both to inappropriate retention and inappropriate discharge. A few noted that aging in place policies bring with them liability issues, and this view was supported by others, who noted that with an increasingly older, more impaired and chronically ill population, providers were concerned about lawsuits and increasing premiums for liability insurance.

Even though most respondents felt that retention and discharge problems needed to be addressed, they agreed that rigid discharge requirements were not the solution.

Inappropriate Retention. In all six states, most frequently in North Carolina, inappropriate retention was mentioned as a problem. Inappropriate retention was attributed to residents not wanting to move from familiar surroundings, as well as to providers wanting to retain residents due to low occupancy rates. Several noted that while providers market to healthy, high functioning seniors, there are very few in that category who want to leave their homes to live in a residential care setting, no matter how nice. As one person said, “they can market to the healthy and independent, but the frail show up.”

In just one state – Texas – a few respondents stated that waiver case managers often pressured facilities to retain a resident, even though rules allowed the facility to discharge based on the resident's condition or behavior. In some states, the reasons mentioned for inappropriate retention were more complex. For example, in North Carolina, there are no residential care settings licensed to care for individuals who need a nursing home level of care. Thus, when residents age and their needs increase, they need to be discharged to a nursing home. However, respondents cited several factors that keep residents in adult care homes past the point where they should be in a nursing home.

A few noted that a major problem in North Carolina is the lack of nursing home beds. Due to a previous moratorium and current CON program for nursing homes, nursing home occupancy rates are quite high. Given high nursing home occupancy rates, some said that it can be very difficult to find a Medicaid bed for a long-term heavy care resident, particularly as facilities often prefer to admit shorter stay Medicare funded residents. Additionally, the state has instituted more stringent nursing home level-of-care criteria for the Medicaid program, making it difficult for some residents whose needs exceed what can be provided in an adult care home from meeting this criteria.

Inappropriate Discharge. Many said that giving discretion to providers to determine when to discharge residents made it easy for them to discharge heavy care or “difficult” clients, even though these residents could be cared for in the community.

Some in Oregon felt that the state was moving away from an aging in place philosophy and was giving providers too much leeway over discharges. They felt that by allowing providers to set their own ceilings, corporate owned ALFs were able to “cream” the lighter care residents. They pointed out that on average, adult foster homes served more severely impaired residents than did ALFs, and that this was true in the state of Washington as well.

On the other hand, some felt that the state was taking a more realistic approach to aging in place, recognizing that individual facilities may have limits on the services they can provide. For example, a small facility that has only one staff person for ten residents can discharge a resident who needs a two-person transfer. Another facility with 20 beds may be able to handle three or four very heavy care residents, but not five or more.

In Minnesota, one respondent said the leading complaint about residential care settings was not lack of care, but “they are making me move.” Similarly, in Wisconsin, several noted that a key complaint about RCACs was premature or involuntary discharge and that over half of the residents left because they needed more care than the facility provided. As mentioned previously, Wisconsin sets hourly limits on the amount of care that can be furnished, but providers are free to limit certain types of care, such as nursing, above the minimum required, and to discharge persons who exceed their own established limit.

One person in Wisconsin noted that hours of care is not the only indicator of need, noting that transfer issues cause some people to leave a facility long before they reach the

maximum hours. This person also noted even if a facility provided 16 hours of hands-on care a day, it would not address the needs of persons with dementia who could not safely be left in their own unit with a locked door.

Several respondents in different states felt that states need to move away from the idea of aging in place, noting that in order to promote a range of residential care options, facilities needed to be able to market to a particular group. Some providers may want to market to the less frail and others to those with more acute needs. Those supporting this approach stated that people would have to choose a facility knowing they may not be able to stay there forever. However, those advocating this approach stated that to protect the clients and their families, there should be “no surprises down the road” and that full disclosure about the conditions for discharge should be provided before someone entered a facility.

In sum, the concept of aging in place appears to be one that is widely supported. However, even its strongest supporters recognize that many unresolved issues complicate its operationalization, even in states that are strongly committed to the concept, as is Oregon. In general, there was a feeling that aging in place was not working in practice. As one person in Wisconsin noted, the typical service approach is to “fit people into facilities rather than get the facility to match the person’s needs.”

Negotiated Risk Agreements

While some respondents strongly supported or opposed negotiated risk or shared responsibility agreements, many said they did not think there were any issues related to them, and others said they didn’t know enough about them to comment. Those that were knowledgeable had conflicting views.

The most frequently cited situation where risk agreements were thought to be needed was the non-compliant diabetic. One provider, asked by a state inspector to explain why a diabetic was eating chocolate cake, responded: “Whose choice is it? The elderly person, the provider, or the government who is paying for service?” Many felt that properly prepared service plans should be able to address such situations and that negotiated risk agreements were not needed.

Others said that providers were very reluctant to have residents assume risk due to both outmoded paternalistic views and concerns about lawsuits. In Florida, where there is a major liability insurance crisis, some saw them as a potential solution, but one noted that trial lawyers opposed them and felt they would not hold up in a lawsuit. In other states, some felt that while families wanted freedom and autonomy for their loved ones, they still wanted the facility to be liable for anything bad that might happen.

A few respondents held the view that until elderly persons are adjudicated incompetent, they should be able to do whatever they want. While others agreed, they said that families would still hold a facility responsibility for a negative outcome.

Some felt that there were certain health and safety responsibilities that providers should never relinquish, and that since providers were paid to use their professional judgment to provide a safe environment, negotiated risk agreements should never be used where there are safety issues. For example, one provider noted that a resident with dementia should not be permitted to use a gas stove. This same person noted that it would be helpful if the state regulatory agency would define parameters – and identify areas that are not appropriate – for shared risk agreements.

Very few raised the issue of assessing competency to enter into and continue in a shared responsibility or negotiated risk agreement. When asked specifically about this issue, most agreed that the lack of a standardized method for assessing cognitive impairment and competency, particularly in persons with mild cognitive impairment, was potentially a major problem. One lawyer noted that if he were representing a resident who had signed such an agreement, the first thing he would look at was how a provider determined that the resident was competent to enter the agreement.

Oversight and Enforcement

Lack of oversight and enforcement of regulations was cited as a concern by at least one person in each state, but many Wisconsin respondents cited it as a major problem. Although some in Wisconsin felt that Community Based Residential Facilities (CBRFs) were over-regulated, most felt that the regulations were excellent but provided a good example of how regulations by themselves do not guarantee quality. All agreed that the major reason for lack of oversight and enforcement was inadequate funding.

On the other hand, Wisconsin's new assisted living model – called Residential Care Apartment Complexes (RCACs) – was developed as a minimal regulation model, and many felt that this model required more oversight. Several noted that the state's ombudsman program was not authorized to oversee the care of residents in RCACs and that consumer advocates in the state were working to amend the statute to allow them to do so.

One respondent noted that after several years of a consultative approach to RCACs, the state had realized that more oversight is needed and is now issuing citations. Initially, the state had only one staff person statewide for a new industry that built 5000 units in five years, which one respondent noted did not provide sufficient opportunity for consultation. With recent nursing home closures and reduced nursing home capacity, the state has transferred some of the nursing home enforcement staff to oversee RCACs.

BARRIERS TO EXPANDING MEDICAID COVERAGE OF SERVICES IN RESIDENTIAL CARE SETTINGS

Respondents in all states cited similar barriers to expanding Medicaid coverage of services in residential care settings.

General Lack of Funding

In every state, respondents noted that expansion of residential care for low income elderly persons in general, and Medicaid-eligible persons in particular, would be very difficult given state budget shortfalls. In Florida, one respondent noted that people in residential care settings are not eligible for many public benefits, such as Food Stamps and energy rebates, because of program requirements regarding residency. Eligibility for such benefits was viewed by several respondents as a way to make the room and board component of residential care settings more affordable. In fact, persons who live in specific types of group community living arrangements with no more than 16 persons can receive Food Stamps if they are either blind or disabled and meet the federal financial eligibility criteria. Wisconsin has an initiative to encourage use of this option for residential care residents who would qualify.

Insufficient Capacity in the Waiver Program

Minnesota. Currently, insufficient capacity is not an issue because there is no waiting list for services. However, several respondents expressed concerns about future funding due to increased utilization of the more expensive *Assisted Living Plus* waiver service package, which includes a requirement for 24 hour supervision. These respondents felt that if the number of people receiving this package continues to increase, waiver slots may be capped.

Texas. All respondents agreed that the large waiting list for waiver slots was a major barrier preventing access, rather than affordability or provider availability issues. One felt that the lack of a guaranteed number of waiver slots was a disincentive for providers to enroll in the program. One provider said the state's bed hold policy was a major disincentive for providers to participate in the waiver program. This respondent said that providers could not afford to have a bed empty for 120 day periods, particularly more than once a year, because the room and board rate is only about \$14.00 a day, much less than the private pay rate.

Another provider disincentive is the long time it takes to reduce the number of beds available to waiver clients in a participating facility even when there are no waiver clients to fill the beds. One respondent said that reducing the number of beds set aside for waiver clients usually takes 3 months after the request has been submitted, during which time the facility is losing money on the empty bed.

Wisconsin. In Wisconsin, respondents agreed that the major barrier to expansion is insufficient capacity in the waiver program. Approximately 9000 elderly and working age persons with disabilities are on waiting lists for the state funded Community Options Program and waiver services. Some noted that people who spend down to Medicaid eligibility in residential care settings often have to move to a nursing home because there is no waiver slot.

A few noted that residents and families do not understand why the state would pay more for a person in a nursing home rather than provide waiver services in residential care. But, as one respondent said, while on an individual basis it would cost less to keep people who spend down in residential care, fear of induced demand and fear of having a state funding source drive what's available keeps the state from expanding the waiver to cover people in residential care settings who have spent down. This person noted that doing so would make the waiver program an entitlement for people who spend down in residential care settings but not for people in their own homes. Over time, if the state kept everyone who spent down in residential care on the waiver, then it would wind up spending all of the waiver money in these settings and have very little left for home care.

Issues Related to Service Rates

Inadequate service rates were cited by some respondents in every state as a disincentive for providers to serve Medicaid beneficiaries. They said that service rates have not kept pace with the cost of doing business, noting that if the state restricts room and board payments to SSI or SSI plus a state supplement, then the service rates had to be high enough to cover not only the cost of services, but other costs such as training and, in Florida in particular, liability insurance.

Florida. One respondent noted that while the payment rate was 62 percent of the nursing home rate when the state started the Assisted Living for the Elderly waiver program in 1994, it had dropped to 37 percent in 2002. Another noted that the number of providers was decreasing because they couldn't afford to be in a program that pays so far below the industry standard that it becomes impossible to make a living.

Minnesota. Most respondents felt that Medicaid rates for residential care services are generally adequate; while lower than market rates, some providers accept Medicaid in order to fill empty beds. A few, however, voiced concerns that the state set a maximum rate but gave counties the discretion to negotiate lower rates. They felt that this led to inequities in payment rates. Several said that the state needs to develop tools to help counties determine the number of service hours needed by each resident, which would enable them to better match the reimbursement level to the services needed. One respondent noted that the state is working on developing a service rate that will vary according to the services provided and a more effective contracting mechanism for the counties to use, which will tie the service rate to the care plan.

North Carolina. A few respondents mentioned the need for a different rate system than the current one. There was consensus that the Medicaid payment rates are inadequate, particularly for residents with high service need, noting that Medicaid pays for only one hour of service a day and the rate for that hour – \$8.00 – is inadequate to cover costs. Several noted that under the current payment system, there is no incentive to take heavy care residents and no incentive for providers who aspire to a higher level of care.

However, the low service rate was not perceived as a barrier to serving Medicaid clients in adult care homes because the state supplement for room and board was so high. But one respondent said that inadequate rates for dementia Special Care Units was a disincentive for providers to accept Medicaid residents. This respondent said that Special Care residents do not qualify for the enhanced personal care rate because Medicaid only pays this rate for hands-on physical assistance. He noted that because cueing a person to perform a task takes more time than doing the task for them, the reimbursement policy encouraged dependence. He felt that a case mix system would solve this problem.

Oregon. Most respondents did not believe that low service rates posed a barrier to residential care for Medicaid waiver clients. A few noted that because Oregon had capped room and board rates for Medicaid eligibles, the state had to pay sufficient service rates to attract providers. One noted that when the program began, setting the assisted living rate at 80 percent of nursing home payment was a clear signal to the industry that the state was encouraging assisted living development and the availability of assisted living for Medicaid waiver clients.

Others felt differently, noting that while rates had been sufficient for a while to get providers to participate, they had not kept pace with inflation and, in particular, rising insurance costs. One noted that acuity levels have gone up but the rates have not. Many felt that the proposed Medicaid budget cuts would lead some facilities to close, especially those that are highly dependent on Medicaid.

A few noted that if the state wants providers to enable people to age in place, the reimbursement rate structure has to take into account that it takes more time to take care of certain people, particularly those who need a two-person transfer or who have behavioral problems.

Texas. A few respondents thought that low rates were a barrier to the expansion of residential care for Medicaid clients. However, one respondent disagreed, noting that waiver payment rates used to be much lower, but that there had been increases to make the rates more competitive with private pay rates. This respondent said that there are now enhanced rates in exchange for the provision of better wages, workers' compensation coverage, and benefits to facility staff, but these rates might be at risk given the state's large budget deficit.

Wisconsin. There were major differences in views regarding the adequacy of service rates. Most respondents felt that market charges for room, board, and services were too high, and that the variation in these charges did not appear to be correlated with the quality of care. A few providers cited the state's payment policies as a problem, saying that Medicaid rates were too low or "wholly inadequate" to cover costs. Some expressed concern that people who spend down in RCACs will not be able to remain there because the facilities will not accept the waiver rate.

One respondent said that a major barrier to serving waiver clients in RCACs is that the state's statutory limit on waiver rates, which is 85 percent of the state's average nursing home rate, is almost double the actual waiver rate of \$43 a day. Another respondent strongly disagreed, saying that the counties pay what they are asked to pay and do not have the expertise to figure out from the facility's cost report if they are overcharging. Wisconsin limits the profit on services provided to public pay residents to 10 percent, and a financial audit is required of all providers receiving \$25,000 per year or more in public reimbursement. Some felt that counties do not have the expertise to enforce the 10 percent limit, and many facilities exceed it.

A few respondents expressed concerns about the effect of high Medicaid rates on the overall amount of funding available for home and community services, stating that the more money spent in residential care settings, the less available for home care. One said that serving people in residential care settings should offer economies of scale but, in fact, does not, noting that it can cost more to serve people in these settings than it does to provide services in their own homes.

A few respondents stated that the rates are not just for the services themselves, but cover additional operating costs, particularly those incurred to meet regulatory requirements such as training. At the same time, most who were critical of the rates recognized that the state does not have the money to increase them. A few others stated that the problem was not the rate per se, but the lack of a payment system that offers incentives to provide good care. One noted that the state needs to get away from a cost-based program because it does not provide an incentive to be efficient: "when you get efficient your rate goes down."

There was a consensus that it is not possible to get residential care costs low enough to be affordable for people with low incomes. One noted that providers think \$2000 is a fair price and that \$1600 a month is the minimum for good residential care, but most elderly who need it have only \$500 a month to spend.

Administrative Requirements

Respondents in two states felt that some providers did not participate in the Medicaid program due to what was perceived as excessive paperwork. In Florida, one noted that quarterly inspections of Extended Congregate Care Facilities were a barrier to getting more providers into the program because of the substantial paperwork required.

In Texas, a few respondents said that the amount of paperwork involved in accepting waiver clients and the difficulties of dealing with a state agency keep some providers from serving these clients. For example, when a waiver client is involved in an incident in an ALF, the facility has to go through two different report processes, one with the regulatory agency and the other with the waiver program agency. Another said that the waiver program's audit process and the potential fines for what are essentially "clerical errors" are a disincentive for some providers to take waiver clients.

In some states, particularly North Carolina and Texas, respondents noted that residential care providers had to deal with too many agencies, which increased operation costs through the duplication of effort on both the part of the provider and the state.

Geographic Variability

A few respondents in Wisconsin commented that access can be limited in those parts of the state that have few residential care facilities and service providers. One noted that the state does not have a planning process to determine where residential care settings and nursing homes should be built, leading to overbuilding in some areas and inadequate supply in others. In some counties there may not be a facility within 100 miles of a person's home.

In Minnesota, where assisted living is a service model that can be provided in multiple housing types, only one person said that geographic maldistribution was a problem. A recent survey on the availability of housing with service settings in Minnesota reported variations of one facility per 5,000 persons to one facility per 10,000 persons.

Room and Board Charges are Unaffordable for Waiver Clients

Minnesota. Room and board or rental rates are not defined or controlled directly by Medicaid. However, Medicaid's financial eligibility rules do limit the amount of income that Elderly Waiver or Personal Care clients will have available to pay rent or room and board. If the client has inadequate income for room and board, the client may be eligible for the state's Group Residential Housing (GRH) program, which can be paid to a licensed or registered setting with which a county human service agency has negotiated a monthly rate. The amount of the GRH payment is based on a federal/state standard of what an individual would need, at a minimum, to live in the community. The maximum GRH room and board payment limit in 2003 is \$680.

However, a few respondents noted that if private pay residents spend down to Medicaid waiver eligibility in a facility that does not accept Medicaid clients, they will have to move. Others may spend down to waiver eligibility in a facility that accepts Medicaid, but they may not be able to afford the rent, and have to move to other subsidized housing with lower rents. One said that many providers don't take Medicaid payment because they are concerned about having to continue serving people who spend down.

A few respondents said there are anecdotal reports that people are having to move when they spend down, but no data are available on how frequently this occurs. The state plans to start looking at the number of people applying for the waiver while in residential care to get some idea of the extent of spend down. One noted that most people who leave purpose-built assisted living go on to nursing homes and that it is not clear whether it is due to increased frailty or spend down.

Wisconsin. Wisconsin also does not limit the amount that Medicaid clients can be charged for room and board. There was general agreement among respondents that room and board costs in both RCACs and CBRFs were unaffordable for waiver clients. Some noted that the SSI payment does not cover the cost of room and board and said they didn't know any CBRFs that accepted the SSI benefit as the full rate. An industry survey in 2000 found that the average room charge without meals was \$841 per month, but the typical waiver client's income is in the \$545-\$725 range.

There was disagreement about whether Wisconsin should limit the amount that can be charged to Medicaid clients for room and board. One noted that the issue had been discussed but rejected by the state's legislators, who wanted the market alone to decide the rates.

Another noted that while room and board costs are a barrier, there is no way to supplement these costs without cost shifting to other public funding sources, such as the Community Options Program (COP) – the state's general revenue funded HCBS program. Some counties opt to use COP funding to pay for room and board for a few waiver clients in smaller CBRFs. Others felt it was a good idea to have facilities cross subsidize the Medicaid population – have a small percentage of Medicaid residents with the majority private pay. They noted that each facility should be able to afford to take a few Medicaid residents and that a mix of clients also helps to assure quality.

A number of respondents felt that using state dollars with no federal match to pay for room and board gives too large a proportion of the state's HCBS funds to the residential care industry. Several respondents discussed the need for a greater supply of affordable residential care and stated that state and federal policy needs to create incentives to build more affordable units.

Philosophy of Home Care

Only respondents in Wisconsin felt that a philosophy favoring home care presented a barrier to serving Medicaid beneficiaries in residential care settings. They noted that many of the counties did not want to use public funding in residential care settings because they favored home care. One stated that many counties thought some CBRFs, particularly larger ones, were more like institutions. Given that the intent of the waiver program is to provide alternatives to institutions, some counties do not want to use limited funds in what they view as quasi-institutional settings. Others disagreed, saying that people living in residential care settings view that setting as their home and should be able to receive waiver services there if eligible.

FUTURE PLANS

When asked about each state's future plans with regard to Medicaid funding of services in residential care, most respondents discussed efforts to address problems with the current systems. A few discussed efforts to address barriers to increasing the number of people served.

Florida. A few respondents noted that Medicaid funded residential care could only expand if nursing home use was reduced and mentioned that a task force was meeting to study ways to reduce the nursing home bed base.

Minnesota. Most respondents agreed that the state is likely to continue the model of assisted living that is currently in place. However, they noted that while the budget is not having an impact on the availability of waiver service in the short term, it is not clear what will happen in the longer term, particularly if the *Assisted Living Plus* service continues to grow at its current rate.

Minnesota is developing ways to help the counties that administer the waiver program to set accurate service rates. One respondent stated that consumer advocacy was needed in the future to advocate for a bill of rights and to develop requirements for staffing and supervision.

North Carolina. The state is planning to move from a tiered rate for Medicaid personal care in adult care homes to a case mix reimbursement system to better match payment rates to residents' needs. It is developing a computerized system to enable them to perform the data analysis needed to support a case mix reimbursement methodology. In another area, a number of stakeholders are working with the legislature on a bill to allow family supplementation of room and board costs for people who spend down in assisted living facilities, as is currently allowed in nursing homes.

Oregon. One respondent stated that in the absence of a budget crisis, Oregon would probably want to expand and improve the current HCBS system, noting that the state is pretty close to a balanced system. Another said that the state's program has changed since its inception and will continue to change, noting that it is important for the state to continually assess the strengths and weaknesses of its program and make necessary changes. For example, the state is currently updating its residential care facility rules and is examining the role of community nurses in all residential care settings. It is also working on initiatives related to person-centered planning.

Another noted that the state's system for determining eligibility for nursing home and waiver services has been helpful in times of budget cuts because it provides a mechanism for the state to reduce the number of people being served based on level of need. However, this respondent said that the system is not perfect and the state wants to revise the criteria to incorporate more risk factors, such as chronic health care needs and medical acuity.

Texas. A number of respondents mentioned ongoing activities related to the Olmstead decision, with several advisory boards working on a range of issues. They noted that the state is asking for more waiver slots in the next legislative session, and that the state is conducting a pilot study using Olmstead relocation specialists to provide individuals in nursing homes with information on the full range of community options. The state is also developing a standardized care assessment process.

A number of respondents mentioned regulatory issues that the state is planning to address, including the 120 day bed hold rule that many providers oppose. The state is also tracking individuals transitioning out of nursing facilities into the waiver program. Because their funding is supported by the nursing home budget, the state wants to see if there are cost savings or whether those leaving the nursing facilities are simply replaced by new Medicaid clients.

Wisconsin. Wisconsin is developing a rate setting methodology and a model contract for counties and facilities to use for waiver clients in Residential Care Apartment Complexes, and is exploring ways to bill the Medicaid fee-for-service system for coverable services provided in residential care as a way to make optimal use of limited waiver funds. To do this, the facility would have to partner with a home health agency or county agency that is certified to bill Medicaid.

Several respondents noted that Wisconsin is also attempting to address the shortage of affordable residential care for low income persons in rural areas through a grant from the Robert Wood Johnson Foundation's *Coming Home Program*. They noted that the state was very interested in identifying new ways to combine housing and services that would be affordable for low income and Medicaid-eligible persons, such as maximizing the use of HUD Section 8 housing vouchers. However, others noted that these vouchers were not the solution because the amount of the voucher is not sufficient to pay rent in some areas. Additionally, they said that there are too few vouchers and many locales keep them for families with children because there is a real housing crisis for low income families and seniors have more housing subsidies. Given this, they felt it would be difficult to get housing authorities to designate money for residential care for elderly persons.

One respondent mentioned a legislative proposal under development that would enable persons leaving nursing homes to have the nursing home funds follow them to the community instead of having the money stay in the nursing home budget. This respondent noted that this measure is particularly important given that future Medicaid expansions are unlikely.

3. Suggestions for Improving the Medicaid-Funded Residential Care System: State and Stakeholder Views

SUGGESTIONS FOR IMPROVEMENT

Those we interviewed had numerous suggestions for improving the Medicaid funded residential care system. Across the six states, there was general agreement about the most important areas to address. We present respondents' suggestions for these areas first, followed by suggestions specific to each state's system.

Increased Funding

Respondents agreed that additional revenue was needed to fund all components of the states' long term care system and that states needed to make more extensive use of the Medicaid program. However, given the current budget crisis in the states, virtually all realized that increased state funding was highly unlikely. Since many of the specific suggestions for improving the residential care system require funding, most were not optimistic that suggested changes would happen. However, several respondents in Florida felt that Medicaid coverage of services in residential care lowered nursing home utilization, and so saved the state money.

Increase the Availability of Residential Care

To expand the availability of affordable residential care, several suggested using other resources, such as HUD subsidies, social service block grant funding, food stamps, and any other public benefits for which elderly persons might be eligible. Some noted the difficulty of doing this when responsibility for the waiver program was in a separate agency that had few, if any, connections with the agencies handling other benefits.

Because Wisconsin does not limit the amount that residential care providers can charge for room and board, several respondents felt that the state needed to address this barrier in order to increase the availability of residential care for the Medicaid population.

Money Follows the Person Funding

Several respondents felt that states should allow long term care funding to "follow the person." Texas is using this approach by allowing money from its nursing home budget to pay for waiver services for people transitioned to home and community settings. State staff in Wisconsin are working on a similar "money follows the person" measure, which they plan to submit to the General Assembly for consideration.

Quality

Another area of consensus across all six states was the need to pay more attention to quality of care issues generally, and staffing issues specifically. To increase the recruitment and retention of direct care staff, many respondents noted a need for better pay and benefits, more training, career ladders, improved management, and better work environments.

In light of the older ages, higher levels of impairment, and chronic health conditions characteristic of residential care residents, several noted the need to increase both the quantity and quality of health and nursing services provided in residential care settings. However, one person in Oregon cautioned that what was needed was not more direct nursing services, but more nursing being taught and appropriately delegated.

Two respondents noted that more research is needed to help develop systems that assure quality in residential care settings that do not have nursing services available 24 hours a day. In particular, more information is needed to develop effective training for medication administration and management, and to identify methods to teach unlicensed personnel about disease management.

Several said that more outcome-oriented regulations would better assure quality, and that comprehensive standardized assessment instruments tied to quality indicators would help providers identify areas where improvement was needed. A number suggested a quality assurance approach that focused on identifying and fixing problems.

In Wisconsin, many said that the state needed to do a much better job of overseeing residential care settings, particularly Residential Care Apartment Complexes, and that greater enforcement of the state's regulations were needed. At the same time, they acknowledged that scarce resources were responsible for the state's falling short on enforcement.

Education

In Texas and North Carolina, some felt that physicians and hospital discharge planners needed to be educated about the differences between residential care settings and nursing homes. At least one person in each state felt that the state needed to help consumers better understand the long term care system generally, and the differences between different services options. Several said that consumers and their families needed a method to help them compare residential care options and choose those that were best suited to their needs and preferences.

Retention/Discharge

One person suggested that providers needed incentives to keep residents longer and disincentives for discharging them too soon. One respondent suggested denying additional

Medicaid admissions to providers who “creamed” by discharging Medicaid residents too soon.

Service Rates

Rates were a major concern among respondents in all states, with agreement among state staff, providers, and consumer advocates that service rates must reflect actual costs. In states with relatively high rates, such as Wisconsin, some were concerned that providers are making too much of a profit. In states with relatively low rates, such as Florida and North Carolina, there are concerns about inadequate care.

In North Carolina, many said that the state needed to move to a case mix system, which the state hopes to do when it gets sufficient cost data and automated assessment data, sometime in 2004. In Florida, many said that the rates were insufficient to cover costs, and that the state needed to use tiered or case mix rates that were tied to nursing home rates and adjusted annually to account for increases over which providers had no control, such as liability insurance.

One respondent in North Carolina said that adequate rates for dementia care were a particular concern. The state recently enacted new regulations for dementia special care units in residential care settings, but did not authorize funding for it. As a result, few Medicaid clients with dementia are served in these units.

Family Supplementation

Oregon prohibits family supplementation and North Carolina allows it only in nursing homes. Florida, Minnesota, Texas, and Wisconsin allow it in residential care settings. Some respondents in Oregon and North Carolina recommended that families be allowed to subsidize the cost of a private room for people who spend down in residential care because it can improve the quality of life for Medicaid clients who otherwise would have to move from private to shared living quarters.

In addition to the general areas discussed above, respondents in each state also made suggestions for improving various aspects of the residential care system specific to their state.

Florida

Nearly every respondent believed that unless the liability insurance crisis was addressed, there was little possibility of expanding the waiver program, because facilities accepting waiver clients were getting increases in their insurance premiums in the 500 percent and higher range. Agreement on the solution was lacking. Some felt that the state should increase reimbursement rates to cover the additional insurance costs, while others felt the issue could not be resolved without major tort reform.

Minnesota

Several felt that the state should require all residential care settings to provide 24 hour oversight and supervision. Others believe that a home care bill of rights is needed for residential care residents, who are considered by the state to be living in their own homes.

North Carolina

Several respondents said the state should require adult care homes to serve distinct populations (e.g., frail elderly, persons with developmental disabilities, working age adults with serious mental illness), and should develop separate licensing standards and regulations to assure the quality of specialized services to address distinct population needs. Some said that the physical plant of the state's large stock of adult care homes needs to be upgraded.

Oregon

One respondent said that assisted living facilities built with low interest loans obtained from state bond financing should be required to serve a certain percentage of Medicaid residents for the duration of the loan. Another felt that the state should permit family supplementation for private or larger rooms in adult foster homes and residential care facilities. (Assisted living facilities have only private apartments.)

Texas

One respondent said that the state needs to use an aggregate rather than a per capita cap for waiver expenditures. Another said that the state needs to market the waiver program to residential care providers because some do not understand how the program operates, and others feel there is a stigma in taking Medicaid residents. Another felt that Texas needs to continue authorizing its "money follows the person" initiative, which allows funding from the state's nursing home budget to pay for waiver services for people who transition from nursing homes to the community.

Wisconsin

One said that the use of the term "assisted living" should be restricted to RCACs, which provide only private apartments. Several said the state should authorize the operation of the ombudsman program in RCACs. Several also said that the state should expand the pilot Family Care program statewide, recognizing that it may be difficult during the current budget crisis.

RECOMMENDATIONS FOR OTHER STATES

We asked our respondents, particularly those who worked for the state, if they had recommendations for other states seeking to use or expand Medicaid funding in residential

care settings. Most of the recommendations came from Oregon state staff, in large part because their program has been in effect for a long time. Oregon's system is often held up as an ideal because over 80 percent of Medicaid clients receiving long term care services are served in home and residential care settings.

The recommendations provide guidance for other states who want to offer a range of residential care options for both the low income private pay market as well as the Medicaid population. Virtually all of these recommendations assume that a state will be using a waiver program to pay for services in residential care settings. Key points made in all the recommendations are summarized below.

Development

- Determine how Medicaid-funded services in residential care settings will fit within the overall publicly funded long term care system. Decide what target population to serve at what level of care, and be sure that all the pieces of the long term care system work together.
- Secure buy-in from providers, including nursing home providers, and consumer advocates. Don't sell assisted living as saving money by taking people out of nursing homes or diverting them from nursing homes. Even if there are no cost savings, it is still better to have more options than just the home and the nursing home.

Room and Board

It is not possible to provide residential care options for the Medicaid population unless the room and board component is affordable. States need to figure out a method to make room and board costs affordable for the Medicaid population and low income persons.

Services

- Services must address not only functional limitations but the health and nursing needs of an increasingly older population with chronic health problems. If the program is going to allow people to age in place, a "light care" model is not going to work for waiver clients.
- A good case management system is essential, as is a system of nurse consultation and teaching, nurse supervision, and nurse delegation.

Quality Assurance

- Build in an adequate quality assurance system from the outset. Start with a well-defined idea of what the service package will be and what quality outcomes are expected.
- Assure that the state's regulatory agency subscribes to the planned service philosophy.

- Recognize that different licensing and regulatory provisions may be needed to serve the Medicaid population, particularly those who meet the criteria for a nursing home level of care.
- Special training requirements and other rules may be needed for facilities that market themselves as special care units for people with dementia.
- Residential care settings providing services to waiver clients need to be surveyed on a regular basis with a similar but different focus than nursing homes. Residential care needs a different model of quality, one focused on protection, service needs being met, and livability.
- Provide flexible oversight and quality improvement activities that are designed to take more of a teaching role rather than an inspection and sanction role.

Administration

- If at all possible, have the responsibility for policy in one administrative agency that designs programs, pays for Medicaid, regulates the entire long term care system, and encourages development of the residential care sector. Having a single administrative agency can help to ensure that licensing rules will be effective for both private pay and Medicaid clients.
- Good lines of communication between the program and licensing staff are essential when developing the licensing requirements and establishing program operating procedures.

Financing

Given the budget crises facing most states, if a state is planning to start covering services in residential care settings through Medicaid, they should consider using a separate waiver program for assisted living only and limiting the number of slots. This approach will enable the state to fine tune the program and keep spending under control. Additionally, if funding is limited, home care will not wind up competing with residential care for the same funds.

Public Education

Assure that individuals and their families have sufficient information about the different types and levels of care provided in different types of residential care settings. Both private pay and Medicaid clients need to understand the limits. States need to set strong disclosure requirements so that prospective residents understand they may have to move if the setting cannot meet all their needs.

4. Concluding Remarks

This report is the first to examine in depth the issues with which states are dealing when using Medicaid to cover services in residential care settings. In each of the six states, there is very strong interest in developing affordable residential alternatives to nursing homes that will provide quality care. All of the respondents we interviewed believed that their states' decision to use Medicaid to provide services in residential care settings was the right one. In states using the personal care option in their state plan, respondents felt that Medicaid had brought much needed revenues to a residential care sector that historically had been under-funded for SSI recipients. In states using the waiver program, respondents felt that by providing an alternative to nursing homes for waiver clients who cannot be served at home, Medicaid funding had both afforded consumers additional long term care options and had saved the states money.

The individuals interviewed for this report were typically quite candid in their comments, which frequently reflected their frustration in coping with the challenges of developing affordable residential care. State staff, in particular, find themselves grappling with a number of issues that require the reconciliation of what appear to be inherently contradictory goals. These issues are:

- finding ways to cover the actual costs of serving frail older individuals with chronic care needs in residential care settings, when Medicaid is not permitted to pay for room and board and the payment sources available to cover room and board are insufficient;
- finding ways to meet expectations for privacy, amenities, and quality services that have been set by the private pay dominated model of “assisted living” when Medicaid cannot afford to pay private pay rates;
- finding ways to make it possible for individuals to “age in place” without making residential care settings into de facto nursing homes by virtue of having to meet the needs of ever older and more impaired residents;
- finding ways to give consumers a sense of what they should reasonably be able to expect from a setting that calls itself “assisted living” or “adult foster care” or some other name, without imposing uniform definitions through state regulation; and
- finding ways to assure a minimally acceptable quality of care without imposing rules that stifle improvements and without the regulated “floor” becoming the “ceiling.”

The appropriate balance point between these goals will vary depending on the unique characteristics of each state's long term care system and residential care systems. While the states may face the same challenges, the tradeoffs in attempting to reach the balance will also differ based on the states' characteristics. However, states can gain valuable

insights by examining the experiences of other states as they work to develop affordable residential care alternatives to nursing homes for low income and Medicaid-eligible elderly persons.

ENDNOTES

ⁱ Newcomer, R. and Maynard, R. (2002). *Residential Care for the Elderly: Supply, Demand, and Quality Assurance*. The California HealthCare Foundation.

ⁱⁱ Kane, R.A. and Wilson, K.B. (2001). *Assisted living at the crossroads: Principles for its future*. Portland, Oregon: Jessie F. Richardson Foundation. (Discussion Paper).

ⁱⁱⁱ Hawes, C., Lux, L., Wildfire, J., Green, R., Packer, L. E., Iannacchione, V., and Phillips, C. (1995). *Study of North Carolina domiciliary care home residents*. Report submitted to the North Carolina Department of Human Resources.

^{iv} Kane, R.L. and Kane, R.A. (2002). *Re-thinking housing with services in Minnesota: Interim evaluation report on demonstration projects on affordable housing with services for older people*. A program conducted by the Minnesota Department of Human Services.

^v Facilities can have either a single rate or multiple rates. Facilities with multiple rates have a base rate which includes a limited amount of services, and charge more for additional service. Hawes, C., Rose, M., and Phillips, C. D. (1999). *A National Study of Assisted Living for the Frail Elderly: Results of a National Survey of Facilities*. Prepared for the Office of Disability, Aging, and Long Term Care Policy, Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services.

^{vi} A compendium prepared by Robert Mollica – *State Assisted Living Policy: 2002*. Portland, Maine: National Academy for State Health Policy – is the only source of descriptive information about Medicaid coverage of services in residential care facilities.

^{vii} Smith, G., O’Keeffe, J. , Carpenter, L., Doty, P., and Kennedy, G. (October 2000). *Understanding Medicaid Home and Community Services: A Primer*. U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging, and Long Term Care Policy.

^{viii} A description of the study methodology, including site selection criteria, is presented in Appendix A.

^{ix} The information in this section is summarized from Chapter 5 of *Understanding Medicaid Home and Community Services: A Primer*. Op. cit. The complete text of Chapter 5 can be found in Appendix H.

^x Mollica, 2002. Op. cit.

^{xi} Formerly known as the Health Care Financing Administration (HCFA).

^{xii} The information in this section is drawn from the state descriptions in Appendices B through G.

^{xiii} Some comments are paraphrased to assure the anonymity of the respondent and edited for brevity.

^{xiv} Florida calls social services “personal services.” The term “social” is used here to distinguish them from personal care services.

^{xv} Assistive Care Services are also available to residents of mental health residential treatment facilities, which serve primarily younger adults with mental illness.

^{xvi} In 2003, the state approved a measure which will allow 800 persons with disabilities living in their own homes to receive the state supplement.

^{xvii} Bolda, E. (1991). *Initial Report on North Carolina Domiciliary Care Policy*. The Long Term Care Resources Program, Duke University Center for the Study of Aging and Human Development.

^{xviii} Hawes, C. et. al. (1995). Op. cit.

^{xix} There are a few changes in the regulations for correctional clients, e.g., provisions related to residents' rights do not apply.

^{xx} Oregon also serves waiver clients in adult foster care and residential care facilities, which may not have private rooms and bathrooms.

^{xxi} Of the six study states, only Minnesota and Wisconsin do not restrict the amount that Medicaid residents can be charged for room and board.

^{xxii} The Keys amendment is virtually unused to address quality issues. General Accounting Office. (1989) *Board and Care: Insufficient Assurances that Residents' Needs are Identified and Met*. Washington, D.C.

^{xxiii} Mollica, R.L., *State Assisted Living Policy: 1998; State Assisted Living Policy: 2000; State Assisted Living Policy: 2002*. All published by the National Academy for State Health Policy, Portland Maine.

^{xxiv} The state has projects under way to address both issues.

Appendix A

Methodology

Methodology

SELECTION OF STATES

We used a number of criteria to determine which six states to include in the study:

- Diversity in state options for covering Medicaid services in residential care settings: through the waiver, the state plan, or both;
- Length of experience using Medicaid to pay for services in residential care settings;
- A significant number of people served;
- Geographic/regional diversity; and
- Program diversity.

To inform the final selection, we also reviewed published information about each state’s residential care systems and consulted several experts. Based on their input and our review of the literature, we selected Florida, Minnesota, North Carolina, Oregon, Texas, and Wisconsin.

Key features of the six states that were considered in making our selection are listed below.

<p>Florida <i>Southeast region</i></p>	<ul style="list-style-type: none"> • Covers services in residential care through both the waiver program and the personal care option. State uses the 300 percent special income option. The state sets rates for services only and allows family supplementation of room and board costs. State uses flat rates and pays \$28 a day. Nursing home/waiver level-of-care criteria are not stringent. The state has major litigation problems.
<p>Minnesota <i>Midwest region</i></p>	<ul style="list-style-type: none"> ▪ Covers services in residential care through the waiver program. Approximately 3190 participants. State uses the 300 percent special income option. The state sets rates for services and room and board and does not allow family supplementation. ▪ Most states define and regulate residential care facilities. Minnesota defines assisted living as a service and not a place. The housing component is more like rental housing and is licensed like hotels. Other entities provide the services. The state has a housing subsidy program to help Medicaid clients pay for room and board.
<p>North Carolina <i>Mid-Atlantic region</i></p>	<ul style="list-style-type: none"> ▪ Covers services in assisted living through the personal care option. Approximately 18,533 Medicaid beneficiaries in residential care settings, the largest number of any state. ▪ The state allows family supplementation in nursing homes and is currently looking at allowing it in residential care settings.

<p>Oregon <i>Northwest region</i></p>	<ul style="list-style-type: none"> ▪ Covers services through the waiver program since the early 1980s. Approximately 2572 participants. State uses the 300 percent special income option. The state sets rates for services and room and board and does not allow family supplementation. ▪ The state uses nurse delegation extensively. They've enacted recent regulatory changes related to negotiated risk agreements.
<p>Texas <i>Southern region</i></p>	<ul style="list-style-type: none"> ▪ Covers services in assisted living through the waiver program. State uses the 300 percent special income option. The state also uses the state plan to cover personal care in small group homes under very specific circumstances. ▪ The state legislature has authorized a “money follows the person” initiative, which allows funding from the state’s nursing home budget to pay for waiver services for people who transition from nursing homes to the community.
<p>Wisconsin <i>Midwest region</i></p>	<ul style="list-style-type: none"> ▪ Covers services in residential care settings through the waiver program and the personal care option, and serves approximately 1018 participants. State uses the 300 percent special income option. State does not allow family supplementation. Counties negotiate rates with providers, which include a basic payment and variable payments based on client care needs. ▪ The state has two different models of residential care, one highly regulated and the other not.

SOURCES OF INFORMATION

Written Documents

We reviewed information about each state’s Medicaid program and residential care systems that we obtained from the states’ websites and from documents sent to us by state staff. We also reviewed published sources of information about each state from standard references. Sources of information for each state are included at the end of each state’s description in Appendices B through G.

Consultation with State Staff and Policy Makers

We consulted with Medicaid program staff and policy makers and other key staff to obtain information not otherwise available and to clarify information obtained through the Internet and other sources. We asked the most knowledgeable staff person in each state to review the state description for accuracy. In some states, more than one person reviewed particular sections of the report, depending on their expertise.

Interviews

We consulted with experts to obtain the names of knowledgeable people in each state to interview. We also identified individuals from each state’s website, for example, directors of state provider associations. We then used a “snowball” approach to identify other individuals to interview. To obtain a range of views, we conducted interviews with several types of stakeholders: (1) current and former state Medicaid staff and policy makers as well as key state staff in relevant areas such as housing and licensing, (2) residential care providers and representatives of professional associations that represent providers, (3) representatives of consumer interests, including ombudsman and consumer advocacy groups, and (4) academic experts and independent policy analysts.

Appendix B

Florida

Florida

The information in this appendix is presented in three major sections:

- The first section provides an overview of the state's long term care system, with a primary focus on the Medicaid program. Although a state may pay for services in residential care settings through the Medicaid program, the program's financial eligibility criteria and related financial provisions for home and community services can present barriers to serving Medicaid clients in these settings. Thus, the first section of each state's description presents detailed information about rules related to financial eligibility, spousal financial protections, and cost sharing requirements.
- The second section describes the state's residential care system.
- The final section presents the views of respondents interviewed for this study on a range of issues related to Medicaid coverage of services in residential care settings in their state.

Because the information in the first two sections is intended to serve as a reference, some information is presented under more than one heading to reduce the need for readers to refer back to other sections for relevant information.

Unless otherwise cited in endnotes, all information presented here was obtained from the sources listed at the end. Supplemental Security Income levels, the federal poverty level, federal spousal protection provisions, state supplemental payments, and state reimbursement rates are for 2003, unless otherwise noted.

I. Overview of Long Term Care System

NURSING HOMES

Florida has two types of nursing homes—Skilled Nursing Facilities and Skilled Nursing Units. Skilled Nursing Facilities (SNFs) are either freestanding or part of a continuing care retirement community (CCRC) and are governed through special contracts. Skilled Nursing Units (SNUs) are based in hospitals. They typically provide only short term care and rehabilitation services. The skilled nursing unit is licensed as part of the hospital.¹ The state has a moratorium on nursing home construction, effective July 1, 2001 through July 1, 2006.

Medicaid reimburses for nursing facility services for Medicaid clients who meet Florida's Institutional Care Program (ICP) eligibility requirements. There are three levels of nursing facility care—Skilled, Intermediate 1, and Intermediate 2. Approximately 77 percent of the state's 2002-03 long term care budget is for nursing home services.

Financial Eligibility

Three groups are financially eligible for Medicaid-covered nursing home care:

- *Group A* includes individuals who are receiving Supplemental Security Income (SSI), and those who have incomes no higher than the SSI payment combined with the State Supplemental Payment (SSP).
 - *Group B* includes persons with incomes up to the special income standard of 300 percent of SSI, which is \$1656. This group is subject to cost sharing. After certain deductions are made for a personal needs allowance, and a spouse or dependent allowance, any remaining income must be spent on nursing home care.
 - *Group C* includes individuals with incomes up to 88 percent of the Federal poverty level (FPL).² The State uses 1902(r)(2) less restrictive income and resource methodologies for this group. Spousal impoverishment protections apply to community spouses.
- Florida has a Medically Needy program for the aged, blind, and disabled, but nursing home care is not a covered service for the medically needy. In accordance with federal law, categorically eligible individuals in need of nursing home care—whose income exceeds the special income standard but is insufficient to cover the cost of care—may place income in excess of the special income level in a Qualified Income Trust, known as a Miller Trust, and receive Medicaid coverage for nursing home care and other Medicaid state plan services.
 - The monthly personal needs allowance (PNA) is \$35 for individuals and \$70 for couples. Persons who lose their federal SSI monthly payment upon entering a nursing home receive a federal PNA of \$30. For these individuals, the state provides a supplement of \$5 per month.

Spousal Protections

- Community spouses may keep any income in their own name. The State allows the institutionalized spouse's income to supplement the community spouse's income up to a maximum of \$2267.
- The community spouse of a nursing home resident may keep up to the federal maximum of \$90,660 in assets. The institutionalized spouse may keep \$2,000 of assets or \$5,000 if the individual's income is less than 88 percent of FPL. All assets over these amounts must be spent on nursing home care before Medicaid will begin to pay.

Family Supplementation

Family supplementation is allowed for services not covered by Medicaid and to pay the difference in cost between a shared and private room, as long as the payment is made directly to the facility.

Level of Care Criteria

To determine eligibility for both nursing home care and waiver services, applicants must be assessed through the Comprehensive Assessment and Review for Long Term Care Services (CARES) program administered by the Department of Elder Affairs. To be eligible, individuals must meet one of the following criteria:

- Require assistance with four or more activities of daily living (ADLs) or three ADLs plus assistance with medication administration; OR
- Require total help with one or more ADLs; OR
- Have a diagnosis of Alzheimer’s Disease or another type of dementia and require assistance with two or more ADLs.

CARES will periodically perform assessments on nursing facility residents to ascertain that they continue to meet the eligibility criteria, and to assess their potential for returning to the community. Private pay individuals may be assessed at their request at no charge. The goal of CARES is to place the applicant in the least restrictive, most appropriate setting with a preference for community placement whenever possible.

WAIVER PROGRAMS

Florida has twelve home and community-based waiver programs, including several that serve substantial numbers of elderly persons or only elderly persons.³ The two major waiver programs that serve older persons are:

- The Aged/Disabled Adult (ADA) waiver, which was implemented statewide on April 1, 1982. Generally, it does not serve people in residential care settings, only eligible individuals in their own homes.
- The Assisted Living for the Elderly (ALE) Waiver serves recipients who reside in qualified Assisted Living Facilities (ALFs). The waiver program was implemented in 1995 as a small pilot and was expanded to statewide waiver status in 1997.

When the ALE waiver was initiated in 1995, the State planned to serve 220 individuals with a \$2.3 million appropriation, averaging \$10,454 per person a year. In 2001, the state served 3,179 ALE recipients receiving an average annual ALE reimbursement of \$9,937.

Financial Eligibility

- Three groups are financially eligible for waiver services:
 - *Group A* includes individuals who are receiving SSI, and those who have incomes no higher than the SSI/SSP level.

- *Group B* includes persons with incomes up to the special income standard of 300 percent of SSI, which \$1656.
- *Group C* includes individuals with incomes up to 88 percent of the Federal poverty level (FPL).⁴ The State uses 1902(r)(2) less restrictive income and resource methodologies for this group. Spousal impoverishment protections apply to community spouses.
- Florida has a Medically Needy program for the aged, blind, and disabled, but HCBS waiver services are not covered for the medically needy. In accordance with federal law, categorically eligible individuals in need of nursing home care—whose income exceeds the special income standard but is insufficient to cover the cost of care—may place income in excess of the special income level in a Qualified Income Trust, known as a Miller Trust, and receive Medicaid coverage for waiver services and other Medicaid state plan services.

Cost Sharing Requirements

Persons who qualify for waiver services under the special income rule of 300 percent of SSI have a cost sharing obligation. The amount depends on the specific waiver and the monthly protected income, which varies according to a number of factors, including the person's living arrangement and the number of dependents.⁵

- For those receiving waiver services in their own homes there is no cost-sharing obligation.
- If an assisted living facility accepts the optional state supplement (OSS) rate for payment of room and board, OSS recipients may keep a personal maintenance allowance of \$630.40, of which \$54.00 is retained as a personal needs allowance, and the remainder—\$576.40—is paid to the facility for room and board. Any income over \$630.40 must be paid to the facility as the resident's share of service costs.

Assisted living facilities may not charge more than the OSS rate for room and board for Medicaid eligibles. There is no limit on the amount they can charge private pay residents for room and board.

Spousal Protections

The state does not use the option to provide federal spousal impoverishment protections for the incomes of spouses of waiver clients. The state allows a maximum of \$552 per month in protected income for an HCBS waiver spouse, whereas the community spouses of nursing homes residents have a maximum protected income of \$2,232 per month. This policy creates an economic incentive to enter a nursing home even though a person could receive services at home or in an assisted living facility.

In a recently implemented pilot nursing home transition program, which was part of the Assisted Living for the Elderly waiver, nursing home residents who were suitable and willing to be moved to an assisted living facility were identified. Four hundred nursing home residents were moved,

some of whom had been in the nursing home for two or more years. However, there were others who wanted to transition but could not because their community spouse would lose too much income as a result.

Florida is in the process of implementing revised spousal impoverishment policies in the Assisted Living for the Elderly waiver program. However, the community spouse will still have less income to keep than if their spouse is in a nursing home.

- The maximum income protected for a community spouse—whether the waiver client is receiving services at home or in an assisted living facility—is the SSI standard, which is \$552 per month. If the community spouse has less than this amount, the spouse in the assisted living facility can make up the difference. For example, if a waiver client living in an assisted living facility has a monthly income of \$1200.40, and the community spouse has an income of only \$200, the following calculations would be made:
 - 1) Subtract \$630.40 from \$1,200.40 for the recipient's personal maintenance allowance (of which \$54.00 will be retained by the resident as the PNA and \$576.40 will be paid for room and board). The remainder is \$570.00.
 - 2) The SSI income standard of \$552 is applied to the spouse, minus the spouse's \$200 income, leaving \$352.00 which can be diverted from the waiver recipient's remaining income (\$570 minus \$352 = \$218).
 - 3) The waiver client's cost-sharing responsibility is \$218.
- With few exceptions, all waiver programs consider applicants/recipients as individuals and only the assets in their names count in determining if their assets fall within program limits. The applicant/recipient may transfer assets to their spouse without penalty up to the federal maximum of \$90,660.

Family Supplementation

The Medicaid program does not consider money paid to an assisted living facility for a private room or for services and supplies not covered by Medicaid to be in-kind income to the Medicaid beneficiary. However, payments must be entirely voluntary and not a condition of providing services, and must be paid directly to the residential care setting.

Regardless of state rules regarding family supplementation, SSI recipients will have their federal benefit reduced by the amount of the family supplement—to a maximum of one third of the SSI payment. The family has to pay the facility the amount that is reduced as well as its initial contribution.

Level of Care Criteria

Waiver applicants have to meet the same level of care criteria as nursing home applicants. Two additional criteria are applicable for Assisted Living for the Elderly waiver applicants:

- Has a diagnosed degenerative or chronic medical condition requiring nursing services that cannot be provided in a standard licensed assisted living facility but are available in assisted living facilities licensed to provide Limited Nursing Services or Extended Congregate Care Services; or
- Is a Medicaid-eligible resident awaiting discharge from a nursing home who cannot return to a private residence because of the need for supervision, personal care services, periodic nursing services, or a combination of the three; and
- Is receiving case management, is in need of assisted living services as determined by the community case manager, and is determined to meet eligibility criteria.

PERSONAL CARE OPTION

Personal care services were added to the Medicaid state plan in 2001 and are provided through a program called Assistive Care Services. Persons who live in their own homes are not eligible to receive personal care services through the Assistive Care Services program. Only persons who need an integrated set of services on a 24-hour basis and who live in licensed assisted living facilities or licensed adult family care homes may receive Medicaid funded personal care services. These services are also available to residents of some mental health residential treatment facilities, which serve primarily younger adults with mental illness. Services must be based on need as confirmed by an assessment and provided in accordance with an individual service plan for each resident.

Prior to the addition of personal care services to the Medicaid state plan, the state paid for some personal care services in residential care settings with a state supplement through the Optional State Supplementation (OSS) program, which is funded by general revenue funds. (OSS is not provided to individuals who live in their own homes.) Once personal care services were added to the Medicaid program, the state reduced the OSS payment and used the money saved to provide the state match for Medicaid personal care services.

Prior to Medicaid coverage of personal care services, residential care facilities that provided room and board and some personal care could receive up to \$730 a month (the combined SSI+OSS payment level). Although the maximum OSS payment has been reduced,⁶ with the addition of Medicaid personal care service payments, residential care providers can now receive up to \$847.80 per month to cover room and board and personal care services. This amount includes \$569.40 paid from the resident's income for room and board, plus \$9.28 per day for personal care services paid by Medicaid.

Financial Eligibility

Two groups are financially eligible for Medicaid state plan services, including Assistive Care Services:

- *Group A* includes individuals eligible for Supplemental Security Income (SSI) (\$552) or those determined eligible for optional state supplementation (OSS).

Individuals who have monthly incomes below \$630.40 (\$1260.80 for a couple) and who live in residential care settings are eligible for OSS. They are allowed to keep a \$54 personal needs allowance and the remainder (\$576.40) is used to pay for room and board, which is the maximum that Medicaid residents can be charged.

- *Group B* includes individuals with incomes up to 88 percent of the federal poverty level (\$659.00 for an individual and \$888 for a couple) who are enrolled in the Medicaid for Aged or Disabled program. The State uses 1902(r)(2) less restrictive income and resource methodologies for this group.

Florida's Medically Needy program does not cover Assistive Care Services.

Spousal Protection

There are no spousal income and asset protections for Medicaid state plan services, including Assistive Care Services. When spouses live together in a home, a spouse's income is counted in determining whether a person meets the income eligibility standard. However, if one of the spouses enters a residential care facility, they are each treated as an individual and the community spouse's income is not counted in determining eligibility.

Family Supplementation

For individuals receiving Optional State Supplementation (OSS), Florida allows third party supplementation for room and board and services not covered by Medicaid.⁷ Supplementation can be made by family or friends to cover the costs of room and board that the low OSS payment does not cover (e.g., for a private room) under the following conditions:

- 1) Payments shall be made to the assisted living facility, or to the operator of an adult family-care home, family placement, or other special living arrangement, on behalf of the person and not directly to the optional state supplementation recipient.
- 2) Contributions made by third parties shall be entirely voluntary and shall not be a condition of providing proper care to the client.
- 3) The additional supplementation shall not exceed two times the provider rate recognized under the optional state supplementation program.
- 4) Rent vouchers issued pursuant to a federal, state, or local housing program may be issued directly to a recipient of optional state supplementation.

When contributions are made in accordance with the statutory provisions listed above, the state does not count them as income to the client for purposes of determining eligibility for Medicaid or for OSS benefits. However, the SSI program does consider in-kind supplementation to be income to the client and reduces the SSI benefit by one third. Florida does not increase the

OSS payment to offset the reduction in SSI benefits that occur due to third-party contributions. Thus, in addition to the original contribution, the third party has to pay the facility the amount that is reduced as well as its initial contribution.

Service Criteria

To be eligible for Assistive Care Services individuals must need an integrated set of services on a 24-hour basis and must have a health assessment establishing the medical necessity of at least two of the program's four service components, which are described below.⁸

- *Health Support Component*—defined as requiring the provider to observe the recipient's whereabouts and well-being on a daily basis; remind the recipient of any important tasks on a daily basis; and record and report any significant changes in the recipient's appearance, behavior, or state of health to the recipient's health care provider, designated representative, or case manager.
- *Assistance with Activities of Daily Living (ADLs) Component*—defined as providing individual assistance with ambulating, transferring, bathing, dressing, eating, grooming, and toileting. At least one service component must be required daily.
- *Assistance with Instrumental Acts of Daily Living (IADLs) Component*—defined as providing intensive assistance with shopping for personal items, making telephone calls, and managing money.
- *Assistance with Self-Administration of Medication Component*—defined as assistance with or supervision of self-administration of medication at least daily in accordance with licensure requirements applicable to the facility type.

LONG TERM CARE PROGRAMS FUNDED WITH STATE REVENUES ONLY

The state has three major programs for elderly persons funded solely by state general revenues, namely, Alzheimer's Disease Initiative, Community Care for the Elderly, and Home Care for the Elderly.⁹ Local areas, called Planning and Service Areas, provide a range of services that are instrumental in keeping frail elders out of nursing homes, including: Personal Care, Homemaker, Chore, Respite, Case Management, Skilled Nursing, Home Health Aide, Home Delivery Meals, Transportation, Adult Day Care, Emergency Alert Response, and Home Repair and Modifications.

Alzheimer's Disease Initiative (ADI) provides services to people with Alzheimer's Disease and other types of dementia who do not meet Medicaid financial criteria or who are waitlisted for HCBS waiver services. Respite services are provided to caregivers in all 67 counties of the state, with a service limit of 30 consecutive days for extended (24 hour) respite.

Although there is no income eligibility ceiling for ADI, cost sharing is required, beginning at 150 percent of FPL and ending at 300 percent FPL, at which point the consumer pays 100 percent of costs. If assets are over \$2,000, 5 percent of the value divided by 12 is added to the monthly income amount. The maximum cost-sharing amount that an individual pays is 15 percent of adjusted monthly income.

Community Care for the Elderly (CCE) is a program for frail elderly persons, age 60 and older, who do not meet Medicaid financial or service criteria, or who are waitlisted for HCBS waiver services. Eligibility is based, in part, on a client's inability to perform certain daily tasks essential for independent living, such as meal preparation, bathing, or grooming. This program provides case management along with additional home and community services. Financial eligibility criteria are the same as for the ADI program and cost sharing is required on the same sliding scale basis. Agencies may use the CCE program while waiting for a waiver slot, but sometimes the CCE program also has a waiting list.

Home Care for the Elderly (HCE) provides a subsidy (\$104 per month in 2002) to help relatives keep a low-income elderly person in their own home or in the home of a caregiver. There is also a special subsidy available as a supplement for specialized health care needs. The program serves individuals aged 60 or older who do not meet Medicaid service criteria. HCE has an income eligibility ceiling of \$1,635 per month (300 percent of SSI) with an asset limit of \$2,000 in countable assets. An eligible HCE participant must be at risk of nursing home placement.¹⁰

II. Residential Care Settings

Florida has two major types of residential care settings primarily for elderly persons: assisted living facilities (ALFs), which were called adult congregate living facilities until 1997, and adult family-care homes (AFCHs). Each type of setting has similar but separate licensing and regulatory requirements. ALFs that meet basic license requirements may apply for a special license for specific purposes, as described below.

Residents in AFCHs and ALFs can receive personal care state plan services as long as they meet Medicaid's eligibility requirements and the facilities meet the regulatory requirements for providing these services.

Residents in only two types of ALFs—those with a Limited Nursing Services (LNS) license and those with an Extended Congregate Care (ECC) license—can receive Medicaid waiver services, as long as they meet the nursing home level-of-care criteria and the facilities meet the regulatory requirements for providing these services.

ADULT FAMILY CARE HOMES¹¹

Adult family-care homes (AFCHs) are defined as a family-type living arrangement in a private home providing room, board, and personal care for no more than five disabled adults or frail elderly persons. Persons who provide room, board and personal care services in their own homes must obtain an AFCH license unless they are caring for one or two adults who do not receive a state supplement, or they are caring only for relatives. Persons who wish to care for more than five disabled adults or frail elders must obtain an assisted living facility license. A maximum of two residents may share a room.

AFCHs are an alternative to more restrictive, institutional settings for individuals who need housing and supportive services, but who do not need 24-hour nursing supervision. The personal care available in these homes, which may be provided directly or through contract or agreement, is intended to help residents remain as independent as possible in order to delay or avoid placement in a nursing home or other institution. A terminally ill resident who no longer meets the criteria for residency may continue to reside in the AFCH if receiving hospice services from a licensed provider who coordinates any additional care needed. In 2002, the state had 416 adult family care homes with 1784 beds.¹²

Room and Board

The state limits the amount that can be charged to OSS recipients and Medicaid ACS clients for room and board to the amount of SSI, which is \$552 plus the maximum Optional State Supplement of \$78.40, which equals \$630.40, minus a \$54 personal needs allowance (PNA), which equals \$576.40. Licensed AFCHs are required to designate at least one of their beds for an individual receiving OSS.

Family supplementation—capped at twice the amount of the SSI/OSS combined payment for room and board—is allowed. The state does not limit room and board charges for private pay residents.

Medicaid Reimbursement

- An adult family care home must be enrolled as a provider in order to bill for Medicaid personal care services through the Assistive Care Services (ACS) program.
- Services covered under ACS are expected to take an average of about one hour per day and are reimbursed at a single per diem rate of \$9.28. There is a recommendation to increase the daily rate by \$2.00.
- ACS providers who serve Medicaid clients receive a total of \$854.80 for 30 days to cover room and board and services.

- No payment is made for ACS services if the resident is absent for as few as 24 hours. However, the ACS program builds an allowance into the rate that assumes the resident will be absent about 10 days a year.¹³

ADULT CONGREGATE CARE FACILITIES / ASSISTED LIVING FACILITIES

Adult Congregate Living Facilities (ACLFs) have operated in Florida since 1975. In 1992, the state had 1500 facilities (most of which had 16 or fewer beds) serving approximately 50,000 people a year, most of them private pay. These facilities provided room and board, assistance with one ADL plus personal services, and supervision of self-administered medication.¹⁴

In 1993, a new licensing category of ACLF was implemented, called Extended Congregate Care (ECC).¹⁵ The rationale for the creation of this new category was that the state did not have a residential care option for people who needed substantial levels of personal or home health care, but not the level of skilled nursing care provided in nursing homes. Consequently, individuals with this level of impairment had to enter a nursing home, at a much greater expense to the state. The ECC licensing category addressed this gap.

- The ECC licensure category was designed to allow residents to age in place but was not intended to be a scaled down nursing home license. Rather, it was intended to create a residential care entity that incorporated the values of the state's in-home programs: autonomy, privacy, dignity and aging-in-place in the least restrictive environment.
- Initially, ECC services were only available to private pay residents. Few facilities serving lower-income residents applied for the license until the Assisted Living for the Elderly (ALE) waiver program was implemented as a small pilot in 1995 and was then expanded statewide in 1997.

In 1995, adult congregate living facilities were renamed assisted living facilities (ALFs). ALFs are defined as a residential care setting that provides housing, meals, personal care services, and supportive services to one or more adults of all ages who are typically unable to live independently and are not related to the owner or administrator by blood or marriage. ALFs are for elderly or disabled persons who do not need 24-hour nursing supervision, except for those receiving hospice services from a licensed hospice, who may continue to reside in an assisted living facility.

- Four ALF licensure types are available: standard, limited nursing service, limited mental health, and extended congregate care. Facilities applying for a specialty license must first meet the criteria for a standard license.
- In 2002, Florida had 2307 ALFs with 77,369 beds; of these, 3,207 were ALE waiver beds. In 2002, ALFs reported 13,338 potential beds for persons eligible for OSS and ACS, though as of June 2002, not all were filled.¹⁶ During the state fiscal year 2001-2002, the Assisted Living for the Elderly waiver program served 3,982 individuals.

Physical Plant Requirements

The rules require ALFs to be located, designed, equipped, and maintained to promote a residential, non-medical environment, and provide for the safe care and supervision of all residents.

- ECC facilities must provide rooms or apartments with lockable doors unless the resident's safety would be jeopardized. Residents not in private units must have a choice of roommates. Those that offer rooms rather than apartments must have bathrooms shared by no more than four residents. Private rooms must offer 80 square feet and shared rooms 60 square feet per resident.
- Non-ECC facilities licensed after October 1, 1999, shall have a maximum bathroom occupancy of two persons. A toilet and sink must be provided for every six residents, and one bath tub or shower for every eight residents.
- Facilities licensed prior to October 1999 may allow four people to share a bedroom.

Medicaid sets a maximum of two persons per room for waiver clients. One respondent noted that the maximum was strictly enforced and that facilities with more than two residents sharing a room could not participate in the program. When drafting rules for the waiver, discussions about privacy were contentious and advocates were unsuccessful in their attempts to make single occupancy a requirement of the waiver program. However, many providers do offer private rooms to waiver clients as their standard practice.

Room and Board

The state limits the amount that can be charged to ALE waiver clients for room and board to the amount of SSI, which is \$552.00 plus the Optional State Supplementation of \$78.40, which equals \$630.40, minus a \$54 personal needs allowance, which equals \$576.40.¹⁷ The facility is legally required to accept the OSS rates for waiver clients. Any income over this amount is required cost sharing.

Family supplementation—capped at twice the amount of the SSI/OSS combined payment for room and board—is allowed. The state does not limit room and board charges for private pay residents.

Services

Services provided in assisted living facilities (ALFs) vary depending on the type of license. Only facilities with an LNS or ECC license may provide services to waiver clients.

Standard License. Facilities with this license must provide housing, meals, and one or more personal care services. Personal care services include direct physical assistance with or supervision of a resident's activities of daily living and the self-administration of medication and

similar services. The facility may employ or contract with a licensed person to administer medication and perform other specialized nursing tasks such as taking vital signs.

Any facility with a standard license can provide personal care services to Assistive Care Services (ACS) clients. All ALFs must have a standard license before they can apply for a specialty license.

Limited Nursing Services (LNS) License. Facilities with an LNS license may provide any of the services under a standard license and additional nursing services, such as ear and eye irrigations; replacing established self-maintained indwelling catheter or performing intermittent urinary catheterizations; applying and changing routine dressings for abrasions, skin tears, and closed surgical wounds; caring for stage 2 pressure sores; conducting nursing assessments if conducted by, or under the direct supervision of, a registered nurse; and for hospice patients, providing any nursing service permitted within the scope of the nurse's license, including 24-hour supervision.

Extended Congregate Care (ECC) License. Facilities with an ECC license may provide any of the services provided under a standard and LNS license including any nursing service permitted within the scope of a nurse's license, consistent with ALF residency requirements and the facility's written policy and procedures. A facility with this type of license allows a higher level of service, including total care with bathing, dressing, grooming and toileting, and enables residents to age in place in a residential environment despite mental or physical limitations that might otherwise disqualify them from residency under a standard or LNS license.

ECC facilities must make available a range of nursing services, including nursing diagnosis or observation and evaluation of physical conditions; ongoing medical and social evaluation to determine when the person's conditions cannot be met within the facility; routine measurement and recording of vital functions; administration of medications; and preventive regimens for residents likely to develop pressure sores.

The Medicaid waiver program reimburses for the following services for recipients in ECC settings: personal care, homemaker, attendant and companion, medication administration and oversight, therapeutic social and recreational programming, physical, occupational and speech therapy, intermittent nursing services, specialized medical supplies, specialized approaches for behavior management for people with dementia, emergency call systems, and case management.

Reimbursement

Services in ALFs can be paid through a number of mechanisms:

- Combined SSI/OSS payment for room and board
- Assistive Care Services (ACS) under the Medicaid Personal Care option

- Medicaid Assisted Living for the Elderly (ALE) waiver program
- Payment from private resources of the resident or family for the full cost of room and board and services, or to supplement public payment sources. About 80 percent of ALF residents are 100 percent private pay.

Requirements for Medicaid Waiver Reimbursement

Requirements include the following provisions:

- An ALF must have an ECC or LNS license and must be enrolled as a provider in order to bill for services under the Medicaid Waiver program. The ALF must also provide private or semi-private rooms and bathrooms for all waiver clients.
- Medicaid residents may be required to share the cost of services depending on their cost sharing obligation. The ALF can bill the maximum billable amount of \$28.00 per day *less* the resident's required cost share. The ALF is responsible for collecting the cost share obligation from the resident. In addition to the daily rate, ALFs may bill Medicaid up to \$125.00 per month for incontinence supplies.
- Case management activities are provided by enrolled case management agencies and are paid on a fixed monthly rate of \$100. Case Management agencies must be enrolled as Medicaid waiver providers and maintain a contractual relationship with the state. No cost-sharing is required for case management services.
- Assisted Living Facilities participating in the ALE Waiver are required to bill Medicaid for *both* the ACS state plan service and the ALE waiver services for recipients who are enrolled in the waiver and have income below \$730 per month. The services must be specified in the resident's plan of care and *must not be duplicative*. ACS is billed first, which in effect, saves waiver dollars.

Requirements for Medicaid Assistive Care Services Reimbursement

- An assisted living facility must be enrolled as a provider in order to bill for Medicaid personal care services through the Assistive Care Services (ACS) program.
- Services covered under ACS are expected to take an average of about one hour per day and are reimbursed at a single per diem rate of \$9.28. There is a recommendation to increase the daily rate by \$2.00.
- ACS providers who serve Medicaid clients receive a total of \$854.80 for 30 days to cover room and board and services.

- No payment is made for ACS services if the resident is absent for as few as 24 hours. However, the ACS program builds an allowance into the rate that assumes the resident will be absent about 10 days a year.¹⁸ There is no similar allowance built into the waiver rate.

Negotiated Risk Agreements

Statutory requirements require ECC ALFs to allow residents to make a variety of personal choices, participate in developing service plans, share responsibility in decision-making, and implement the concept of managed risk. The statute defines the following:

- “Managed risk” means the process by which the facility staff discuss the service plan and the needs of the resident with the resident and, if applicable, the resident’s representative or designee or the resident’s surrogate, guardian, or attorney in fact, in such a way that the consequences of a decision, including any inherent risk, are explained to all parties and reviewed periodically in conjunction with the service plan, taking into account changes in the resident’s status and the ability of the facility to respond accordingly.
- “Shared responsibility” means exploring the options available to a resident within a facility and the risks involved with each option when making decisions pertaining to the resident’s abilities, preferences, and service needs, thereby enabling the resident and, if applicable, the resident’s representative or designee, or the resident’s surrogate, guardian, or attorney-in-fact, and the facility to develop a service plan which best meets the resident’s needs and seeks to improve the resident’s quality of life. In 2001, a requirement to report adverse incidents to the licensing agency was added to the statute.

Admission, Retention, Discharge Criteria, and Aging In Place

- ALFs may admit and retain residents with dementia. No special license is required for dementia care unless an individual with dementia does not meet standard residency criteria. Training requirements have been increased for ALFs that market themselves as providing special care for persons with Alzheimer’s disease or other dementias.¹⁹
- ALFs with ECC licenses can adopt their own requirements for continued residency within regulatory guidelines and must provide each resident with a written copy of facility policies governing admission and retention. However, they may never retain residents who require 24-hour nursing supervision, which is equivalent to a skilled nursing level of care.
- As stated in the assisted living statute, aging in place means the process of adjusting or increasing services to a person to compensate for the physical or mental decline that may occur with the aging process, in order to maximize the person’s dignity and independence and permit them to remain in a familiar, non-institutional, residential environment for as long as possible.
- ECC ALFs are required to promote aging in place by determining the appropriateness of continued residency based on a comprehensive review of the resident’s physical and

functional status; the ability of the facility, volunteers, family members, friends, or any other pertinent individuals or agencies to provide the care and services required; and documentation that a written service plan consistent with facility policy has been developed and implemented to ensure that the resident's needs and preferences are addressed.

- A facility is not required to retain residents who require more services or care than the facility is able to provide in accordance with its policies and criteria for admission and continued residency.
- Terminally ill residents may continue to reside in any assisted living facility if a licensed hospice agency coordinates services, an interdisciplinary care plan is developed, all parties agree to the continued residency, and all documentation requirements are maintained in the resident's file.
- If an ALF resident no longer meets the criteria for continued residency, or the facility is unable to meet the resident's needs, the resident may be discharged as long as the facility provides at least 45 days' notice of relocation or termination of residency. Special provisions apply in specific situations, e.g., emergency relocations for medical reasons and harmful behavior.

III. Summary of Interviews

In addition to consulting with thirteen state staff and policy makers regarding the technical details of the state's programs, we also interviewed seven of them. In addition, we interviewed seven key stakeholders, including representatives of residential care provider associations, residential care providers, consumer advocates, a consumer association, the state ombudsman program, and the agencies that administer the state's home and community services programs.

The interviews focused on respondents' views about several key areas and issues. This section summarizes their views and provides illustrative examples of their responses. These comments are not verbatim quotes, but have been paraphrased to protect the respondents' anonymity and edited for brevity. A list of information sources for the state description and the individuals interviewed can be found at the end of this summary.

GENERAL COMMENTS ABOUT THE STATE'S RESIDENTIAL CARE SYSTEM

Because residential care facilities serve both private pay and Medicaid residents, a few respondents expressed views about the industry as a whole.

- *There is confusion among the public about long term care options.*

- *One study showed that the most satisfied folks were those in assisted living, whereas people at home were not doing so well, primarily because there is a tremendous amount of unmet need at home.*
- *Adults receiving HCBS services at home are like latch-key adults, they should be in an ALF, where we provide emotional security.*

A number felt that the state was achieving its goals and being responsive to stakeholders.

- *I have been writing regulations since 1990 and supervising statewide training, and implementing the ACS program. It takes a long time but you do get to see some goals accomplished.*
- *I am pleased with the willingness of the state to look at ideas and experiment and come up with different concepts, to listen to providers, and to be flexible; there is a good dialogue.*

Comments about privacy in residential care settings indicated disagreement among providers and other respondents.

- *It is very clear that people want private rooms; it is so important in terms of their dignity. But sometimes, there are more than four in a room in an ALF, it looks like a ward.*
- *The ECC regulations define “privacy” as encompassing dual-occupancy with a choice of roommate where possible. This is the stated philosophy of “privacy.”*
- *Sometimes when we’re conducting surveys we see more than four individuals sharing a room in ALFs. In our work, we have found that the issue of privacy is very important to consumers, and single rooms are definitely preferred.*
- *Some elderly people prefer to have a roommate as it gives them a sense of security.*

There was disagreement about the need for additional adult foster care homes.

- *We should expand the use of adult foster care homes. They have slightly less stringent regulations, and are very successful in Oregon. In Florida the AFCH program has been shown to have good outcomes.*
- *I disagree 100 percent that adult foster care homes should be expanded because they do not have enough oversight.*

GENERAL COMMENTS ON MEDICAID’S ROLE IN RESIDENTIAL CARE SETTINGS

On the whole, most respondents were pleased with the success of the Assisted Living for the Elderly waiver program and the more recently introduced Assistive Care Services (ACS)

program. They felt that these Medicaid programs have made a real contribution to long term care options for low-income elderly.

- *The state added Medicaid funded personal care services because the state supplement was woefully inadequate to cover services.*
- *People were becoming more frail and needing more services, but not qualifying for a nursing home, and couldn't afford a private ALF. Under ACS they can now get some services.*
- *The waiver program has achieved the primary goals of cost saving, reduction in the nursing home bed base, and more humane alternatives. Each dollar spent on the waiver would have cost \$2.70 cents in the nursing home. The Nursing Home Medicaid average cost is \$2,835 per month.*
- *More exciting than the ALE waiver was the inclusion of personal care in the Medicaid state plan and the creation of the Assistive Care Services program. It is the key to the state's efforts to provide additional revenues to ALFs.*
- *ACS has been instrumental in attracting providers who were reluctant to take state supplement recipients in the past and provides Medicaid funding for frail elders who are not as impaired as waiver clients.*
- *We have made some real strides, even in the last 5 years; it was a big step to get Medicaid funds into assisted living.*

However, there were criticisms regarding unequal treatment for those with mental health diagnoses, and other inequities.

- *The biggest barriers in Medicaid are for those with serious mental illness (SMI). A high percentage of people receiving state supplements have SMI and have not been able to access Medicaid-funded services.*
- *There is an arbitrary definition of mental illness according to income. In the statute it specifically states that persons with "certain psychiatric impairments who receive a state supplement" must be served in a facility with a Limited Mental Health (LMH) license. Because facilities that serve private pay residents did not want to meet LMH requirements, only poor people get a mental health diagnosis.*
- *The waiting list for waiver services is prioritized by acuity levels. Based on acuity some people can wait two years for waiver services and others can be served straight away.*

LICENSING AND REGULATORY REQUIREMENTS

Respondents had conflicting views about licensing and regulatory requirements. Many expressed concerns that the combination of ECC licensing and Medicaid waiver funding is moving some assisted living facilities more towards a medical model.

- *ECCs should be regulated because they are providing nursing services. The only difference between nursing homes and ALFs is that nursing homes are an entitlement program. But many people served in both settings have the same needs.*
- *Really sick people are being served in Extended Congregate Care ALFs, but you can find nursing home residents having a drink in a bar. Some nursing home residents have cars, one man was running his business from the nursing home.*
- *ECC ALFs do not want to become mini nursing homes, we want to be part of home and community services. But in most peoples' eyes we are considered institutions; we need to get out of our 400 chapter, and into the 430 chapter.²⁰*
- *My biggest concerns about all these studies is that they will lead to additional requirements. We need to be aware of the diversity of ALFs in Florida. Prescriptive regulations do not help anyone. We need to be creative and respond to needs. Making facilities take more impaired people isn't a good idea either.*

One had very strong recommendations about licensing and regulation.

- *We should abolish specialty licenses, that is, limited nursing services, limited mental health, and extended congregate care. ALFs are the residents' home and we should apply the same approach that is used when relatives can no longer provide proper care in the home, i.e., acquire more services through alternate resources. The individual should have a choice and the caregiver should have a choice. Delivery of care should be based upon the agreed tenets of shared risk or negotiated risk.*

By moving ALFs out of Chapter 400 (Public Health, Nursing Homes and Related Health Care Facilities) and into Chapter 430 (Social Services, the Department of Elder Affairs), there would be more sharing of resources and consumers could be offered a greater selection of programs. I also suggest amending Chapter 430 to allow the governor to appoint an additional member to the Department of Elderly Affairs Advisory Council from the Florida Assisted Living Association. This would allow the assisted living industry to represent this continuum within the department's structure.

Several expressed concerns about specific licensing and regulatory requirements that were considered unnecessary and in some cases, added unnecessarily to costs.

- *We are in the people profession and we are being controlled by the politicians. You cannot legislate heart and caring, only criminal intent. How do you keep a homelike environment with all these signs on the walls?*
- *Regulations should not get in the way of quality of life; they should address health and safety issues but not constrain the facility's ability to meet residents' preferences.*
- *Rigid nutrition regulations are one of the industry's pet peeves. Facilities are required to prepare meals based on the pyramids, but nutritious meals may not provide the food that people like to eat.*
- *I had a diabetic on medicine, she was in her 80s. The inspector wanted to know why she was eating chocolate cake. The question is, "Whose choice is it, the frail elder who requires services, the provider of the service, or the Government who is paying for the service?"*
- *The rules state that a stock supply of over-the-counter medications for multiple resident use is not permitted in any facility and non-prescription drugs, when centrally stored, must be labeled with the resident's name. In practice, this means that I cannot give a resident an aspirin for a headache from a stock bottle.*

One noted that regulations were always needed to deal with bad providers, and said that the best regulations can do is to require the key indicators of health and safety and then "get out of the way" and let providers deliver care. Another noted that the ombudsman program used to take a problem solving approach, but recently have adopted an adversarial approach.

A number expressed concerns about the proliferation of unlicensed (i.e., illegal) facilities.

- *There are many unlicensed board and care homes providing services for private pay. It is an underground network; you can see them all around the neighborhood; they are family businesses, Filipino and Hispanic, which provide services to members of their communities.*
- *There are board and care homes, unlicensed, that are not supposed to provide personal care services. But they do and try to get away with it. Residents with incomes higher than SSI will pay for services. But OSS and Medicaid won't pay for anyone in a facility that is not licensed.*

Oversight and Enforcement

No respondents mentioned lack of enforcement as an issue. A few said the state was doing alright and most facilities were in compliance.

- *Since Spring 2000, there has been statewide training for ALF surveyors to educate them on the different philosophy for assisted living as compared to nursing homes. They reorganized the survey offices so that there was a designated supervisor and primary surveyors for ALFs in each office.*

- *The state just implemented Assistive Care Services a year ago, and did its first preliminary monitoring in August. Compliance was pretty good.*

Several respondents described a government quality assurance initiative called Operation Spot Check, which found that 98 percent of facilities were in compliance with regulations. However, some providers had problems with how the initiative was carried out.

- *In my facility 22 people came in unannounced.*
- *Operation Spot Check was not cost effective and it was frightening for the residents. They didn't find anything wrong in most ALFS; there were more problems with the nursing homes.*

Staffing Requirements

All respondents felt there was a need to increase staffing levels in ALFs.

- *Nursing homes have minimum staffing requirements and are paying higher wages with better benefits. ALFs are vying for the same pool of staff and have no way of competing.*
- *We need to increase the staffing levels; ALFs cannot have high quality without better staffing.*

Two respondents mentioned abuse of residents by staff, but stated that it was atypical.

- *Staff abusing residents is the exception to the norm. We try to do criminal background checks. Given that Florida has over 2,200 ALFs, 600 nursing homes, and numerous home health agencies, the number of horrific incidences is not high. Florida is pretty safe.*
- *Periodically, there are horror stories of violence occurring with no prior indicators—but they don't always involve staff—sometimes other residents and sometimes family. The same things that happen in the home and community can happen in a residential care setting. Just like you can't expect the police to have 24 hours oversight of your neighborhood, you can not expect that level of vigilance to prevent incidents in an ALF.*

Medication Issues

Many respondents felt the state needs to help individuals pay for medications if they are in a standard ALF and not eligible for Medicaid.

- *Residents living in ALFs or AFCHs who do not qualify for Medicaid because of too much income (e.g., those Medicaid clients who lost eligibility when the criteria was reduced from 90 percent FPL to 88 percent FPL) or who do not meet level of care criteria for the waiver, have only a personal needs allowance, which all residents retain regardless of income. This is totally inadequate to pay for medications as well as shoes or dentists. Sometimes elderly persons need to get new dentures because of old age or illness.*

- *One of my residents no longer qualifies for Medicaid because she turned 62 and received an increase in her Social Security payment. Her medicines are over \$400 per month and the facility is now having to pay for them, so I am losing money, but I can't throw her out on the street.*
- *There is a regulation that could be interpreted to mean the facility is responsible for payment of medications. I went to a workshop on these rule changes and the trainer said that if the family or the individual does not pay for medications, the facility would be responsible for it.²¹*
- *For people without families and resources, there is no backup, and it is left to the scruples of the provider whether to pay medication expenses themselves or discharge the resident.*
- *I go to the drug companies with hardship cases, which requires loads of paperwork. I get samples from physicians and use generics. I also maintain a good relationship with the pharmacy to facilitate late payments of bills.*

National Standards

Most respondents were not in favor of adopting national standards or model standards for assisted living.

- *Every state has its own set of issues and conditions. For example, Florida has a higher percentage of elderly persons and the climate increases utility costs because we need air conditioning almost year round.*
- *With assisted living there is no uniform type of resident, and unless we changed the entire program, there is no uniform type of provider.*
- *Assisted living serves a very heterogeneous population: with and without families, demented, wards of the state. It wouldn't be fair to the people receiving the service to have standards that didn't take this into account. The states should be charged with setting the standards, using set guidelines under Medicaid, and incorporating relevant national standards. Each state has its own issues and problems.*
- *There are different needs in different areas of the country. If you have a national standard, it has to be regionalized, to meet each state's unique needs.*

However, a small number of respondents stated they would like to see federal standards.

- *We need regulations like the nursing home; we are deficient in ALF regulation; the state makes excuses saying the federal government does not say we have to do certain things.*
- *I believe that there should be federal regulations for the type of staff because I am concerned about uncertified staff giving assistance with medication, particularly staff who don't know how to look for signs of adverse reactions.*

- *I did a side-by-side comparison of draft national model standards and Florida's regulations, and Florida's were more stringent. I think model standards are good. If I had a facility I would want to use the national standards for guidance for running the facility.*

ADMISSION AND RETENTION REQUIREMENTS, AND AGING IN PLACE

Most respondents were satisfied with admission and retention regulations, but several raised concerns.

- *They are about right, I would like minor variations for standard ALFs. For example, under current regulations, if a resident's doctor orders support hose, that person needs to go into an ECC. Also, portable oxygen is controversial, but you see people in the supermarkets with it, so why not in a standard ALF?*
- *I think the regulations for retention are fair, but when residents deteriorate staff may not pick up on it. The press have reported horror stories of people in ALFs who did not get the care they needed.*
- *Mixing old and young folks in the same facility can work but can also cause problems between residents and there are no regulations for discharging an undesirable resident. Facilities need to give notice of 30 to 45 days, and it must be an appropriate discharge.*

Negotiated Risk Agreements

A number commented on the potential role of negotiated risk agreements to reduce the number of lawsuits; others felt they would not have any impact.

- *Managed risk agreements do not hold up in law and there is opposition to them from trial lawyers.*
- *There is confusion amongst consumers about negotiated risk agreements.*
- *I have a friend whose mother has mild dementia and lives in an ALF. The facility wants to restrict her movements to a particular area. She doesn't wander but the facility is one mile from a highway, and the ALF is afraid she'll wander and be hit by a car. I advised the friend that if he believed his mother's quality of life is more important than her safety, to instruct a lawyer to draft an agreement that the family will sign to release the ALF from liability if the resident gets run over. But, typically, he hasn't done anything about it. The families want freedom for the residents, but they don't want to sign any special agreements releasing the facility from liability.*
- *The residents are willing to live with the risk, but in Florida there are lawyers that advertise to the residents of nursing homes and ALFs. The Florida Supreme Court has ruled that however unethical it may be, it is not illegal. They suspended a license for 30 days when*

one lawyer was aggressively soliciting on people's doorsteps. The court said it was against the code; they are not supposed to solicit.

- *There is the case of a nursing home resident who got killed crossing the road in a wheelchair. They had crossed the road a thousand times before, so whose fault was it?*
- *Neglect from a wet floor is one thing, but dying is a natural occurrence unless it happens in a licensed facility. Then it's something that is not supposed to happen.*

BARRIERS TO SERVING MEDICAID CLIENTS IN RESIDENTIAL CARE SETTINGS

Respondents noted a number of barriers.

General Lack of Funding

- *The barriers to expanding assisted living for low-income elderly persons in general and Medicaid eligible persons in particular are limitations in the state budget and the cost of liability insurance.*
- *Lack of money is the main barrier.*
- *People in residential care are not eligible for public benefits such as food stamps. I think facilities don't qualify if they have over 22 beds. They also don't qualify for energy rebates, like the other community programs.*
- *Combining funding streams would probably help, but it's extremely difficult to do so; most people do not have the inclination.*
- *We had HUD housing and have applied to do a conversion, but in Florida the waiver is attached to a person not to a building. If I convert a floor using HUD dollars, I still need somebody to subsidize the care for the residents.*
- *We need to get additional dollars, not just take money from the nursing home budget.*

Service Rates

- *Expansion is very unlikely with current reimbursement rates. The biggest barrier that we have had in this state is the money. In 1994, when we started using the ALE waiver, payment was set at 62 percent of the nursing home rate; now it is 37 percent.*
- *A big concern is that there has been only one cost of living adjustment since the waiver started. We had more providers involved, now it is decreasing. They can't afford to be in a program that pays you so far below the industry standard that it becomes impossible to make a living.*

- *ALFs that serve people in Assistive Care Services and not the waiver do not get any reimbursement for incontinence supplies.*
- *I could get more done if I had Medicaid dollars. I get no money for incontinence supplies, vitamins or preventive services.*

One respondent noted that in response to low service rates some providers ask families to contribute to the cost of services. This practice is called either “family supplementation” or “up-charging.” Others expressed concerns about the practice.

- *During monitoring visits, state staff sometimes find that residents’ families are asked by the provider to contribute to the cost of a service when its cost exceeds the Medicaid cap. For example, the Medicaid cap for incontinence supplies is \$125 but the resident may use \$300 of supplies each month.*
- *There is some confusion about whether family supplemental payments affect Medicaid eligibility. Up-charging is not strictly illegal, it is a stretch of state rules which allow third party supplementation.*
- *Some higher pay facilities have contracts that will allow a resident to be in a private room if the family pays a supplement. Nobody is challenging it, and if we throw them off the program the resident will be on the street.*

Liability Insurance

The increase in the cost of liability insurance was cited by most respondents as the biggest problem facing Florida’s assisted living industry, and a major barrier to assuring the availability of residential care options for older persons who do not want to live in a nursing home.

Recently, ALFs licensed to provide Extended Congregate Care or Limited Nursing Services have been notified by insurers they will be charged the same rate as nursing homes because insurers now consider them to be equally at risk for lawsuits because they are licensed to serve waiver clients who meet the state’s nursing home level-of-care criteria.

- *My annual liability insurance premium has increased from \$7,000 three years ago to \$55,000.*
- *Since January 1, 2002, no one can get ECC or LNS liability insurance. We are going backwards here in Florida, the closure of ECC beds will result in a reverse diversion of the low-income elderly on the waiver program back into nursing homes.*
- *We are hearing that many facilities no longer have an interest in having ECC licenses, which will reduce the number of facilities licensed to serve waiver clients.*

In 2002, the Florida legislature authorized a state insurance program called the Long Term Care Risk Retention Group (RRG). RRG is an insurance product that could provide as many as 800 assisted living facilities with affordable general and professional liability insurance with good coverage and reasonable premiums. RRG was also developed to offer coverage for facilities with Extended Congregate Care and Limited Nursing Services licenses, which are practically uninsurable at this time. The cost for initial capitalization of the Long Term Care Risk Retention Group is \$6 million. There was disagreement among respondents about whether the RRG program would adequately address the liability insurance crisis.

- *I do not think that the new insurance will ultimately solve the problem. Tort reform is what is needed.*
- *Risk Retention will solve the situation right now, but it is not the answer, we need tort reform.*

Many respondents recommended tort reforms that would set a limit on compensation and punitive damages.

- *Now a plaintiff might get \$150,000 for damages, but the facility gets hit with \$2 million for punitive damages which goes to the plaintiff. Damage awards shouldn't just punish, they should be put into the industry to address the problems.*

There were many different suggestions from providers, consumers and advocates, and not all were in agreement.

- *We want to see strict liability as specified in the statutes maintained as the standard for resident rights litigation. We do not want the medical malpractice model.*
- *The same rules should apply to long term care facilities as to other health care providers, which are governed by negligence law rather than strict liability.*
- *I would like to see the law changed so that facilities can be released from liability.*
- *They should transfer liability to the state for people on Medicaid or add on the cost of insurance to the Medicaid reimbursement, similar to how they pay extra for case management.*

Many respondents said they would support federal action to address the liability insurance crisis, and expressed the need for some real leadership in Congress to address the issue.

Paperwork

Some felt that quarterly inspections for ECCs are a deterrent to obtaining an ECC license, because of the substantial paperwork required. Some ECC providers have reported extensive survey action on the part of surveyors conducting the quarterly monitoring visits.

- *The official line is to only go and look at the ECC residents, and for the most part the surveyors don't have time for much more, but some are overly zealous.*

Another noted similar problems to participate in the waiver program.

- *Administrative headaches with the ALE waiver are a problem. The more hoops that you put up for the provider the less desirable it is to be enrolled in the program. The application process is very difficult.*

SUGGESTED CHANGES TO IMPROVE THE MEDICAID-FUNDED RESIDENTIAL CARE SYSTEM

Most of the recommendations were tied to funding and eligibility issues.

- *I would like to see greater expansion of assisted living by tapping into all the potential funding sources. We need to have Housing and Elder services talking to each other.*
- *People should be able to get the state supplement and remain in their homes. Sometimes, a nursing home resident is discharged to a homeless shelter because they don't have enough money to pay rent.*
- *I would raise the financial eligibility to 400 percent of SSI. There are many people who are middle class and have a parent who can pay \$1,000 a month for an ALF, but they have no extra money to pay for medications, etc. I recommend a sliding scale for cost sharing.*
- *The budgetary and insurance barriers could be overcome through cost of living adjustments and tying waiver reimbursement to a percentage of nursing home costs in each area. We also need tiered rates, and reimbursement that covers the extra cost of liability insurance.*
- *The number one reason that people go into nursing homes is that they don't have a caregiver. I would change the Aged and Disabled Adult waiver, because it does not pay a caregiver subsidy like the state programs do, which is significant in keeping frail elders out of a nursing home.*
- *I wish there were more targeting of the lower income folks. Right now, one-third of the folks on the waiver qualify at the 88 percent Poverty Level, and the other two-thirds are above that threshold. The waiting list should not be prioritized by acuity but by income.*
- *The reimbursement for providers participating in the Assisted Living Waiver should be adjusted annually to cover increases in expenses, including liability insurance costs.*
- *You need a program that says here is a pot of money, not earmarked for nursing homes, tie the money to the individual not to the program. Tie the Medicaid to an individual care plan, not to a program*

- *We need tiered rates and we require a case manager to assess on a semi-annual basis, so the provider can report changes in levels of care.*

FUTURE PLANS

Most respondents were optimistic about the future of assisted living, although realistic about the barriers to Medicaid funding as noted in the previous section.

- *Assisted living has to expand because it is cost effective. It is the best option for nursing home diversion.²²*
- *State plans to expand have not been articulated in writing, but are being discussed. There is a work group now trying to control the growth of nursing home beds. There is a moratorium on new beds, but some were already planned before the moratorium went into effect.*
- *Right now there is a task force meeting to study ways to reduce the nursing home bed base. The nursing home industry doesn't want more Medicaid clients because the reimbursement is well below real costs. They are making money with Medicare, but they can't expand because of the moratorium.*
- *Expansion of publicly-funded assisted living is inevitable. The future looks great, we have to look at how we spend our dollars because there are going to be less of them.*

Other reasons given for optimism is that the ALE waiver is popular with the legislature and Assistive Care Services has received real support.²³ One respondent was very optimistic about expansion in rural areas.

- *The Robert Wood Johnson Coming Home program has helped to develop affordable assisted living in rural areas where before there was only the nursing home option. Grant dollars are available to develop programs that are maybe a little different than what we have seen already.*

One respondent reported that the state could expand in-home services.

- *There is an amendment to the state constitution which would exempt from zoning regulations people applying for the conversion of single family residences to two family homes, so they can keep an elderly relative at home. It will be significant. It would not need licensing if it was only for relatives, and services could be funded through some of the State programs or the Aged and Disabled Adult waiver.*

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ENDNOTES

¹ There were 703 SNFs (including SNUs) in the year 2000 in Florida, with 81,163 beds; 52,649 were Medicaid beds. (Personal communication, Jennifer Salmon)

² Due to state budget shortfalls, the income eligibility criteria was reduced in April 2002 from 90 percent to 88 percent of FPL (from \$662 to \$651), which resulted in a loss of Medicaid eligibility for an estimated 5,000 people in Florida.

³ Two additional waiver programs that serve elderly persons are:

- The Consumer-Directed Care Research and Demonstration Waiver is an 1115 waiver program, which is available in certain counties for individuals receiving services through the Aged/Disabled Adult and other waivers. Individuals chosen to participate in the experimental group are allowed to “cash out” services on their current care plans and receive a monthly benefit through a fiscal intermediary to purchase services directly from a provider of their choice. The program was implemented in 2000. There was difficulty in getting CMS to approve operational protocols related to coverage of services in assisted living facilities.
- The Medicaid Nursing Home Diversion (NHD) Waiver provides services to 868 functionally impaired elderly persons age 65 and over who are at risk of nursing home placement in Palm Beach and the Orlando area. Dual eligible (Medicare and Medicaid) individuals that meet clinical eligibility criteria may choose to receive both long-term care and acute care services under the NHD Waiver. Managed care providers that have contracted with the state under the NHD Waiver are responsible for Medicare co-payments and deductibles. Providers are reimbursed at a capitated rate, on a per member, per month basis to enrolled Medicaid providers.

⁴ Due to state budget shortfalls, the income eligibility criteria was reduced in April 2002 from 90 percent to 88 percent of FPL (from \$662 to \$651), which resulted in a loss of Medicaid eligibility for an estimated 5,000 people in Florida.

⁵ Cost sharing is required in only three waivers: Long Term Care Diversion Project (Nursing Home Diversion Waiver), Assisted Living for the Elderly and Cystic Fibrosis. There is no cost sharing required in other waiver programs, unless the individual qualified under an income trust.

⁶ The maximum payment is \$78.40 per month.

⁷ Florida Statutes, Title XXX, Chapter 409.212.

⁸ Chapter 59G-1.010, Florida Administrative Code, defines medical necessity as medical or allied care, or services furnished or ordered that must be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.

⁹ The financial and service eligibility information is taken from Kassner, E. and Williams, L., *Taking Care of their Own: State-funded Home and Community-based Care Programs for Older Persons*, AARP, September 1997. Other details of the programs are from the Department of Elder Affairs website and personal communications.

¹⁰ One respondent felt that this program is more cost effective than the waiver program in preventing nursing home placement because many caregivers become financially dependent on the subsidy, which while not large, can be critical for a poor family. If this situation occurs, it may not always be in the best interests of the elderly person who needs services that the family can not provide.

¹¹ The information in this section draws heavily from Manard, B. et al., op.cit., with some additional comments from personal interviews with current state staff. Adult Family Care Homes were originally called Adult Foster Home (AFHs), a licensing category created in 1968 to provide a community housing alternative for mental hospital patients being de-institutionalized. While some de-institutionalized mental health clients were also sent to Adult Congregate Living Facilities, proportionally more were in Adult Foster Homes. Over time the program evolved to serve elderly persons almost exclusively.

¹² Personal communication.

¹³ One respondent stated that providers do not seem to understand that the rate is a little higher based on the assumption that residents will be away from time to time.

¹⁴ Manard, B. et al., op.cit.

¹⁵ The information on the creation of the ECC licensing category is drawn from a report prepared for the Commission on Long Term Care in Florida, *Assisted Living and Extended Congregate Care: The Florida Experience*, by Larry Polivka, Victoria M. Sims and Jennifer R. Salmon, Florida Policy Exchange Center on Aging, August, 1996, with additional comments from a number of personal interviews conducted in October 2002.

¹⁶ Salmon, J. R., et al., *Affordable Assisted Living Facilities: Government-Sponsored Benefits for Reimbursing Assisted Living Services, Room, and Board*, Florida Policy Exchange Center on Aging, Tampa, Florida, September 15, 2002.

¹⁷ The maximum OSS payment is \$78.40 per month.

¹⁸ One respondent stated that providers do not seem to understand that the rate is a little higher based on the assumption that residents will be away from time to time.

¹⁹ Staff must receive four hours of initial training covering understanding Alzheimer's disease; characteristics of the disease; communicating with residents; family issues; resident environment; and ethical issues. An additional four hours of training must be obtained within nine months of employment covering behavior management; assistance with ADLs; activities for residents; stress management for the caregiver; and medical information. Four hours of annual training must be obtained on topics specified by the Department of Elder Affairs (DOEA).

²⁰ Florida Statutes, Chapter 400 is the "institutional" chapter and covers nursing homes, adult day care centers, adult family care homes, and assisted living facilities. Chapter 430 covers the community based services, such as Community Care for the Elderly, Home Care for the Elderly, Alzheimer's clinics, Respite for elders, and others.

²¹ F.A.C. 58A.5.0185(7)(f) states: "The facility shall make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration or medication administration are refilled in a timely manner." The respondent was not sure if the rule is actually interpreted this way and if facilities are doing it or making sure families understand that this is a reason for discharge (i.e., not paying their medication bills).

²² The Nursing Home Transition Program, which began last year, provides funding for eligible nursing home residents who can be cared for under the ALE Medicaid Waiver. Separate funding for these residents was again provided for the 2002–2003 fiscal year at \$2,300,000. The Capitated Nursing Home Diversion Program increased funding to \$30,916,013 and will create approximately 100 additional slots for this program. The state also directed AHCA and DOEA to jointly develop a plan to expand the opportunities for diversion projects in rural and underserved areas of the state.

²³ The Assisted Care Services (ACS) State Plan Amendment maintained current funding for the 2002–2003 fiscal year at \$32,871,249, which includes \$3,200,000 for program growth. The Assisted Living for the Elderly (ALE) Medicaid Waiver maintained current funding for the 2002–2003 fiscal year at \$30,754,351.

Appendix C

Minnesota

Minnesota

The information in this appendix is presented in three major sections:

- The first section provides an overview of the state's long term care system, with a primary focus on the Medicaid program. Although a state may pay for services in residential care settings through the Medicaid program, the program's financial eligibility criteria and related financial provisions for home and community services can present barriers to serving Medicaid clients in these settings. Thus, the first section of each state's description presents detailed information about rules related to financial eligibility, spousal financial protections, and cost sharing requirements.
- The second section describes the state's residential care system.
- The final section presents the views of respondents interviewed for this study on a range of issues related to Medicaid coverage of services in residential care settings in their state.

Because the information in the first two sections is intended to serve as a reference, some information is presented under more than one heading to reduce the need for readers to refer back to other sections for relevant information.

Unless otherwise cited in endnotes, all information presented here was obtained from the sources listed at the end. Supplemental Security Income levels, the federal poverty level, federal spousal protection provisions, state supplemental payments, and state reimbursement rates are for 2003, unless otherwise noted.

I. Overview of Long Term Care System

NURSING HOMES

Minnesota has relied extensively on the institutional model of long term care since the 1960s, when the availability of federal funds for nursing home care spurred considerable growth in the state's nursing home industry. Nursing homes provide a more medical model of long term care than many elderly persons need or want, but have often been the only option available.

A moratorium on new nursing home beds has been in effect since 1983, and even though the elderly population is increasing, nursing home utilization has dropped. Because projected utilization indicates that Minnesota's current bed supply will be adequate through 2025, the moratorium on new nursing home beds will continue, except in situations of "extreme hardship," e.g., when a county's ratio of beds per 1,000 is very low.¹

Because Minnesota still has the 6th highest number of beds per 1,000 persons age 85 and over in the nation, two recent initiatives have been undertaken to reduce the number of beds. First, in 2000, the state created the nursing home bed layaway program, permitting nursing homes to take licensed beds temporarily out of service and have those beds treated as though they were de-licensed. In the 18 months since enactment about 2,350 beds have been put in layaway and the occupancy level of remaining beds has reportedly increased substantially. Given the nursing home moratorium, without this program, nursing homes would be reluctant to de-license beds.

Second, in 2001, with the goal of accelerating the re-balancing of the state's long term care system, the state provided incentives for the closure of up to 5,140 nursing home beds during fiscal years 2002 and 2003. This program was combined with initiatives to conduct local long term care systems planning and to develop and expand home and community service programs. As of June 30, 2003, Minnesota had already closed 2,500 beds and had received applications to close another 2,000.

Financial Criteria

- Three groups are financially eligible for nursing home services:
 - *Group A* includes persons with incomes no higher than the Federal poverty level (FPL), of \$749. Individuals receiving federal Supplemental Security Income benefits (SSI) or state supplement payments (SSP), or who have incomes no higher than the combined SSI/SSP level ($\$552 + \$81 = \$633$) are automatically included in this group.
 - *Group B* includes persons with incomes up to the special income standard of 300 percent of SSI (\$1,656).
 - *Group C* includes medically needy individuals who spend down to 75 percent of the FPL. There is no upper limit on income, but income can be no greater than \$562 after deducting medical expenses.² The applicant may choose a 1 month or 6 month budget period for determining medical need.
- Asset limits for all three groups are \$3,000 for an individual and \$6,000 for a couple.³
- The monthly personal needs allowance for nursing home residents is \$72. The Minnesota Supplemental Aid program, which is the state's SSP program, will pay a maximum of \$42 to supplement the federal SSI \$30 PNA for individuals who are no longer eligible to receive SSI because they are residing in an institution.

Spousal Protections

- Community spouses may keep any income in their own name, and the state allows the institutionalized spouse's income to supplement the community spouse's income up to the federal maximum permitted, which is \$2267 per month.⁴

- The spouse of a nursing home resident may keep the greater of \$25,601 or one-half of the couple's assets, up to a maximum of \$90,660. All assets over this maximum must be spent on nursing home care before Medicaid will begin to pay.

Family Supplementation

Minnesota allows family supplementation for nursing home residents. A family can pay the difference in cost between a standard semi-private or a “nicer” semi-private or private room. The family can pay the difference as long as it is clear that the resident is receiving additional amenities only due to family supplementation.

Level of Care Criteria

The eligibility determination is made on the basis of a comprehensive assessment and the professional judgment of the assessors who use guidelines provided by the state. The criteria considered in the level of care determination include health and nursing needs, physical and mental functioning, and behavior. The state uses a case mix classification to determine eligibility. A person must have either functional or nursing needs to be eligible.⁵

WAIVER PROGRAM

Minnesota has had an Elderly Waiver program since 1988, which funds home and community services not normally covered under Medicaid for seniors who are at risk of nursing facility placement. The waiver program covers two types of services: those necessary to avoid institutionalization that are not offered in Minnesota's state plan, and those that are extensions of Minnesota's state plan services—“extended” to avoid institutionalization. Extended services allow more than the state plan in terms of type, amount, duration and scope of services and are only available to people eligible for waiver services.

The program is administered by the counties, and has a set number of slots. To date there has been no waiting list for waiver services in Minnesota. In the event that the state sees that the waiver slots are filling up, the state amends the waiver to include additional slots because it believes that the waiver services will save money by keeping people in the community. In FY 2002, the state served 12,208 waiver clients.

The Elderly Waiver program covers a wide range of services in a person's home or in certain residential care settings. Residential care settings include adult foster homes, both family and corporate, board and lodging homes, non-certified board and care homes, and apartment complexes called residential centers. Services include: skilled nursing, home health aide, homemaker, companion services, personal care assistants, adult day care, case management, home-delivered meals, respite care, supplies and equipment, transportation, limited modifications to the home and training for caregivers.

There are two packages of waiver services called *Assisted Living* and *Assisted Living Plus*, both of which are provided in approved residential care settings.

Financial Criteria

- Three groups are financially eligible for waiver services:
 - *Group A* includes persons with incomes no higher than the Federal poverty level (FPL), which is \$749. Individuals receiving SSI/SSP benefits, or who have incomes no higher than the combined SSI/SSP level ($\$552 + \$81 = \$633$) are automatically included in this group.
 - *Group B* includes persons with incomes up to the special income standard of 300 percent of SSI (\$1,656).⁶
 - *Group C* includes medically needy individuals who spend down to 75 percent of the FPL. There is no upper limit on income, but income can be no greater than \$562 after deducting medical expenses.⁷ The applicant may choose a 1 month or 6 month budget period for determining medical need.
- Asset limits for all three groups are \$3,000 for an individual and \$6,000 for a couple.⁸

Cost Sharing Requirements

- For persons in Group B, there is a cost sharing requirement. Once individuals are receiving Elderly Waiver services, if they are living at home, they may keep \$752 as a personal maintenance allowance in order to pay room and board and personal expenses. The remaining income, if any, must be paid toward the cost of care.
- Elderly Waiver clients living in residential care settings also retain \$752 as the personal maintenance allowance from which \$72 is deducted as their Personal Needs Allowance, leaving \$680 for room and board costs, which is the maximum that the state-funded Group Residential Housing supplement program will pay for low-income residents. The remaining income, if any, must be paid toward the cost of care.⁹

Spousal Protections

The spouses of waiver clients have the same spousal impoverishment protections as the spouses of nursing home residents, but only if the waiver client is 65 or older.¹⁰

- Community spouses may keep any income in their own name, and the state allows the waiver client's income to supplement the community spouse's income up to the federal maximum permitted, which is \$2,267 per month.
- The community spouse of an Elderly Waiver client may keep the greater of \$25,601 or one-half of the couple's assets, up to a maximum of \$90,660. All assets over this maximum must be spent before Medicaid will begin to pay for services.

Family Supplementation

Minnesota allows family supplementation for the housing costs of waiver clients in residential care settings. Those receiving family supplementation remain eligible for waiver services.

Level of Care Criteria

Waiver applicants have to meet the same level of care criteria as nursing home applicants. The eligibility determination is made on the basis of a comprehensive assessment and the professional judgment of the assessors who use guidelines provided by the state. The criteria considered in the level of care determination include health and nursing needs, physical and mental functioning, and behavior. The state uses a case mix classification to determine eligibility. A person must have either functional or nursing needs to be eligible.¹¹

A reassessment of an Elderly Waiver client is conducted at least every 12 months and when there has been significant change in the client's functioning, e.g., after a hospital discharge.

PERSONAL CARE OPTION

Minnesota covers personal care services under the Medicaid state plan through the Personal Care Assistance program. This program provides services to individuals who need help with daily activities to allow them be more independent in their own home. A personal care assistant is an individual who is trained to help with some basic daily routines for individuals who have a physical, emotional or mental disability, a chronic illness or an injury.

Financial Criteria

- Two groups are financially eligible.
 - *Group A* includes persons with incomes no higher than the Federal poverty level (FPL), which is \$749 as of July 2003. Individuals receiving federal Supplemental Security Income benefits (SSI) or state supplement payments (SSP), or who have incomes no higher than the combined SSI/SSP level ($\$552 + \$81 = \$633$) are automatically included in this group.
 - *Group B* includes medically needy individuals who spend down to 75 percent of the FPL. There is no upper limit on income, but income can be no greater than \$562 after deducting medical expenses. The applicant may choose a 1 month or 6 month budget period for determining medical need.
- Asset limits for both groups are \$3,000 for an individual and \$6,000 for a couple.¹²

Spousal Protections

There are no spousal income and asset protections for community spouses of persons receiving personal care services in their home or in residential care settings. Only the spouses of nursing home residents and waiver participants receive income and asset protections.

Family Supplementation

Family payments made for support and maintenance may be counted when determining Medicaid eligibility, in accordance with SSI policy.

Service Criteria

To be eligible for the Personal Care Assistance program, a person must require services that are medically necessary and ordered by a physician; and be able to make decisions about their own care or live with someone who can make decisions for them.

The services include assistance with:

- Activities of daily living, including eating, toileting, grooming, dressing, bathing, transferring, mobility and positioning.
- Health related functions, that, under state law, can be delegated or assigned by a licensed health care professional to be performed by a Personal Care Assistant.
- Instrumental activities of daily living, including meal planning and preparation, managing finances, shopping for essential items, performing essential household chores, communication by telephone and other media, and getting around and participating in the community.
- Redirection and intervention for behavior, including observation and monitoring.

LONG TERM CARE PROGRAMS FUNDED WITH STATE REVENUES ONLY

The state has a Long Term Care Consultation Services (LTCCS) program that is funded by a combination of federal, state, and privately paid funds. Formerly called Preadmission Screening, the purpose of LTCCS is to assist persons with long term or chronic care needs in making long term care decisions and selecting options that meet their needs and reflect their preferences. The availability of, and access to, information and other types of assistance is also intended to prevent or delay certified nursing facility placements, thereby containing costs associated with unnecessary nursing facility admissions. In FY 2001, LTCCS conducted 62,570 assessments.

The state's Alternative Care program is funded solely with state revenues. It was implemented in 1991 and provides certain home and community services for persons age 65 and over, who are at risk of nursing home placement, have low levels of income and assets, but do not meet Medicaid financial criteria. The program is administered by counties, which may offer consumer-directed service options. The state caps the monthly cost of Alternative Care services at 75 percent of the average state Medicaid payment made for persons age 65 and older with the same case mix classification residing in nursing facilities.

The program offers a comprehensive array of home and community services including home modifications, adult day care, adult foster care, assisted living and residential care services

Financial Eligibility

A person is eligible if their income and assets would be inadequate to fund a nursing facility stay for more than 180 days. Premium payments equal to 25 percent of the monthly service costs are paid by some enrollees (those with assets greater than \$10,000). There is no cost-sharing obligation if an individual's available income is less than 150 percent of the FPL.

Spousal Protections

The same spousal impoverishment rules apply as for nursing home residents and waiver clients.

Service Criteria

A person age 65 and older who is assessed through the Long Term Care Consultation Services process is eligible for Alternative Care funding when the person is in need of a nursing facility level of care and admission is recommended; and the person chooses to receive community services instead of nursing facility services; and no other funding source is available for the community services.

II. Residential Care Settings

BACKGROUND

In the mid-1980s, after a nursing home moratorium had been in effect for several years, the State was increasingly concerned that many frail elderly persons, who once would have lived in nursing homes, were now living in a variety of unregulated out-of-home residential settings that lacked supportive services. In order to assure that they were receiving appropriate and adequate services, the Minnesota Department of Health proposed that many of these settings be regulated as residential care homes, with requirements modeled after nursing homes. In response, the Residential Care Home Licensing Act (RCHLA) was enacted. Due to opposition to the act, implementation was postponed while an alternative act, the Housing with Services Contract Act,¹³ was considered.

After reviewing the institutional type of regulatory system proposed in the RCHLA, the Minnesota Health & Housing Alliance met with hundreds of providers, consumers, and others and concluded that a consumer-driven model, using the well-understood concept of a legal contract, was a preferable regulatory model.

Both consumers and providers identified choice as a value that should be a dominant aspect of any quality assurance system for housing-with-services providers. Important aspects of choice identified were:

- People have a right to make choices for themselves.
- People should be assumed to be competent to make their own choices. Those who may not be competent should receive assistance.
- Consumers have a right to be educated and informed about providers' policies and procedures and the services they are purchasing.
- Any system focusing on choices must consciously accept that choices entail risks and that consumers will sometimes make decisions that others perceive as "bad choices."

The Housing-with-Services Contract Act was developed by the MHHA over a four-year period and was passed in 1995, effective in 1996. The Act covers a broad spectrum of senior housing in Minnesota called "Housing-With-Services Establishments." The term was chosen because of its general nature, which can be applied to a wide range of settings and levels of services. Different types of residential care settings market themselves as "assisted living," but there is no category of licensure called "assisted living facility."

With the passage of the Housing-with-Services Contract Act, Minnesota initiated an innovative approach toward assuring quality in residential care settings by making a conscious decision to avoid a detailed, prescriptive regulatory system. Instead, Minnesota adopted a more flexible, consumer-driven model, which is based on the concepts of consumer choice and negotiated risk. This approach gives consumers a choice of a variety of physical settings and service packages, and permits providers to develop innovative housing with services models.

Quality Assurance

The contract between the housing provider and the resident is the primary mechanism for assuring quality. By reviewing information in their contracts and negotiating items related to their individual needs, consumers receive the information they need to make informed decisions about where to live and the services they want. The signed contract is a legal document that sets standards for the housing-with-services provider and, if necessary, can be legally enforced.

While the overall quality assurance mechanism for housing-with-services is under the control of the resident, the Minnesota Department of Health does regulate residential care settings and surveys health-related services, which are considered to be critical to the well-being of frail residents. (See *Licensing* below) In addition, Minnesota Department of Health has the authority to intervene if it appears that a building is out of compliance with the Contract Act.

The Contract Act requires all Housing-With-Services Establishments to:

- register each year with the Minnesota Department of Health for a \$35 fee;
- execute a written contract (lease) with all residents of the building; and
- obtain a home care license if the establishment will directly provide any health-related services.

No specific format is required for the contract. The state does not approve contracts but may review them upon request. The legally enforceable contract with the building owner has 17 mandatory items that must be addressed, including:

- registration and licensure status of the establishment
- term of the contract
- description of the services provided and the base rate
- fee schedules for any additional services
- process for modifying, amending, or terminating the contract (e.g., the process the establishment will follow when changing its fees);
- complaint process
- billing and payment procedures
- resident's designated representative
- criteria for determining who may reside in the establishment
- statement regarding the ability of tenants to receive services from providers that do not have an arrangement with the establishment
- statement regarding the availability of public funds

In addition to the requirements of the Contract Act, Housing with Services Establishments must comply with a variety of other state and federal laws, such as Minnesota's Vulnerable Adults Act, the Nurse Practice Act, landlord-tenant law, criminal background check laws, contract law, and civil rights laws such as Fair Housing and the Americans with Disabilities Act. State and local building and fire codes, lodging licensing, food/restaurant licensing, adult foster care licensing, zoning and other local requirements are applicable to these establishments as well.

Residents in facilities that are not required to register as Housing With Services Establishments do not have the protection of a legal contract, and these facilities are surveyed only for environmental compliance in terms of the physical plant and kitchen. If a resident receives waiver services in these settings the services are provided by a licensed home health entity and the resident's case manager oversees the services.

In 2001, the state enacted legislation creating disclosure requirements for Alzheimer’s special care units. The legislation states that Housing With Services Establishments that secure, segregate, or provide a special program or special unit for residents with a diagnosis of probable Alzheimer’s disease or a related disorder or that advertise, market, or otherwise promote the establishment as providing specialized care for Alzheimer’s disease or a related disorder are considered a “special care unit.”¹⁴ Special care units are required to provide a written disclosure addressing the following areas:

- the form of care or treatment
- the treatment philosophy
- unique features for screening
- admission and discharge criteria
- assessment
- care planning and implementation
- staffing patterns
- the physical environment
- security features
- frequency and type of activities
- opportunities for family involvement
- the costs of care.

The legislation also included requirements that the facility’s direct care staff and their supervisors must be trained in dementia care. Areas of required training include: an explanation of Alzheimer’s disease and related disorders; assistance with activities of daily living; problem solving with challenging behaviors; and communication skills. The establishment shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered.¹⁵

Licensing of Service Providers

Regulations implementing the Housing with Services Contract Act were effective in 1996 and required services to be provided through licensed home care provider agencies.¹⁶ A home care license may be obtained by the same entity that owns the housing, or the housing entity may develop an arrangement with an outside home care agency to provide the services. Categories of licensure for home care providers are as follows:

- *Class A provider*—traditional professional home health agency that serves the community in private homes as well as in housing with services establishments. A subset of Class A providers are also Medicare certified. Home care agencies provide one or more home care services, at least one of which is nursing services, physical therapy, speech therapy, respiratory therapy, occupational therapy, nutritional services, or medical social services.
- *Class B provider*—paraprofessional home care agency that provides only personal care or home management services.

- *Class C provider*—a home care provider who is an individual providing only personal care or home management services.
- *Class D provider*—a provider of a hospice program.
- *Class E provider*—a provider of individualized personal care services or home management services to residents of a residential center in their living units, when the provider is either the management of the residential center or another provider under contract with the management. “Residential center” means a building or complex of buildings in which residents rent or own distinct living units.
- *Assisted Living Home Care Provider*—means a home care provider who provides nursing services, delegated nursing services, other services performed by unlicensed personnel, or central storage of medications, solely for residents of one or more Housing With Services Establishments. The housing entity must be registered as a housing with services provider to be eligible for this license.

The Assisted Living Home Care Provider license was created in August, 1999, specifically for Housing with Services Establishments, to address the industry’s desire to have unlicensed personnel provide the same services as a Class A agency, under the supervision of a registered nurse, thereby making the services less costly.

The *Assisted Living Home Care Provider* rules allow medication administration. Staff who administer medications and actively assist with self-medication must complete the appropriate assisted living training program and be instructed by a registered nurse in the procedures to administer the medications to each client/resident. The instructions are specific to each resident and must be written, and the person must demonstrate competence in following the instructions.

When the new category of licensure was created, the state also changed the licensing requirements for some settings, and added a new service, called *Assisted Living Plus (AL+)*, to the menu of services already provided through the Elderly Waiver and the state’s Alternative Care program. *Assisted Living Plus* can only be provided in Housing with Services Establishments that meet the home care provider standard of either a Class A license or the new *Assisted Living Home Care* license.

The most common licenses for Housing With Services Establishments are the *Class A* home care provider license, the *Class E* provider license, and the *Assisted Living Home Care Provider* license.

The registered nurses and licensed practical nurses who provide nursing services and oversee unlicensed caregivers in all residential care settings must comply with the Nurse Practice Act, which is monitored by the Minnesota Board of Nursing. The central storage of medications, which is permitted in a Housing with Services establishment under the *Assisted Living Home*

Care Provider License, is managed under a system that is established by a registered nurse and addresses the control of medications, handling of medications, medication containers, medication records, and disposition of medications.

OVERVIEW OF RESIDENTIAL CARE SETTINGS

Minnesota envisions assisted living as a service not as housing. Assisted living services are available in multiple settings, including senior housing, foster care, purpose built settings and other congregate housing. In this way the state provides an option for people who are unable to remain in their own home and need supportive services to avoid nursing home placement. The state does not regulate a specific category of facilities called assisted living. Instead, the state regulates services provided in residential care settings through the various home care provider licenses described above.

Not all residential care settings are considered Housing-With-Services Establishments. The state specifically excludes the following residential care settings from the Housing-with-Services establishment category:

- nursing homes licensed under chapter 144A;
- certified boarding care homes licensed under sections 144.50 to 144.56;¹⁷
- board and lodging establishments licensed under chapter 157.17; (they are excluded because they have their own regulations and serve a predominantly non-elderly population);
- family adult foster care homes licensed by the Department of Human Services; and
- private homes in which the residents are related by kinship, law, or affinity with the providers of services.

Not all Housing-With-Services Establishments have to be separately licensed in some way. For example, an apartment building with separate units has only to comply with local building codes. However, buildings with a central kitchen may be required to have a food license.

In most cases, an “umbrella requirement” of Housing with Services registration is superimposed over the separate regulation of services and facilities. The state requires any establishment providing sleeping accommodations to one or more adult residents, at least 80 percent of whom are 55 years of age or older, and offering or providing, for a fee, one or more regularly scheduled *health-related services* or two or more regularly scheduled *supportive services*, to register with the Minnesota Department of Health as a Housing with Services establishment.¹⁸

- *Supportive services* are defined to include only the following: help with personal laundry; handling or assistance with personal funds of residents; or arranging for medical services, health-related services, social services, or transportation to medical or social services appointments.¹⁹

- *Health-related services* are defined to include professional nursing services; nursing services delegated to aides (such as medication administration), bathing and other personal care; and other services that may be performed by paraprofessional staff (stand-by assistance with dressing or grooming); and central storage of medications.

Services provided in Housing-With-Services Establishments must be provided through licensed home care provider agencies. The Housing with Services entity may obtain such a license or contract with a licensed agency. Services usually include some combination of supportive and health-related services. The various service programs may or may not have caregivers or other staff on-site 24 hours a day. Residents can contract for services with the owner of the building if the owner has a home care provider license or they can obtain services from an outside agency that has a Medicaid license.

Buildings registered as a Housing with Services Establishment may vary in size and type and include corporate adult foster care settings, board and lodging establishments (without individual kitchens), non-certified boarding care homes, and apartment buildings. Consumers choose the housing-with-services setting that they believe will best meet their needs. Medicaid pays for services through the Elderly Waiver and the Personal Care option for eligible individuals in all of these settings, which are described in the following sections.²⁰

TYPES OF RESIDENTIAL CARE SETTINGS

Adult Foster Homes

Adult foster homes provide food, lodging, supervision, and household services in a small, family-like setting. They may also provide personal care and medication assistance. Some adult foster homes have to register as Housing-With-Services Establishments and some do not. Effective August 2, 1999, the state made a distinction between family and corporate adult foster care, and authorized new services names as follows:

- *Family Foster Care* is a service or group of services provided in a residence of 1 to 5 clients that is licensed by the Department of Human Services under Rule 203²¹ or certified by the county. The residence must be the primary residence of the license holder and the license holder must be the primary caregiver. *The setting is exempt from registration as a Housing with Services Establishment.*
- *Corporate Foster Care* is a service or group of services provided to 1 to 5 clients in a home-like setting with shared common spaces where the license holder is not the primary caregiver and/or the residence is not the primary residence of the license holder. Hired staff provide care. A few adult foster care “suites” have been created within larger apartment buildings. Most of the corporate foster care homes in Minnesota are designed specifically to serve those with memory loss.

This setting is licensed by the Department of Human Services under Rule 203²² and is *exempt from registration as a Housing with Services Establishment, unless 80 percent of the individuals served are 55 years of age or older and the provider offers one or more regularly scheduled health-related services or two or more regularly scheduled supportive services.*

Any licensed adult foster care provider may provide family adult day care under their foster care license if all the recipients are 60 years and older, none of the recipients are seriously and persistently mentally ill or developmentally disabled and the combined number of people receiving adult foster care and adult day care does not exceed the number licensed for adult foster care.

Resident bedrooms must meet the following criteria: (1) A single occupancy bedroom must have at least 80 square feet of floor space with a 7-1/2 foot ceiling. A double occupancy room must have at least 120 square feet of floor space with a 7-1/2 foot ceiling.

Board and Lodge Homes (also known as Residential Care Homes)

Residential care homes are licensed as *Board and Lodge Homes with Special Services* under Chapter 157.17 and are not required to register as Housing with Services Establishments because they have their own regulations under that chapter.²³ They serve a predominantly non-elderly population, but occasionally serve an elderly resident. The governing statute refers to these homes as Residential Care Homes, and the services provided are called residential care services.

If a Board and Lodge Home meets the housing-with-services criteria—i.e., 80 percent or more of its residents are aged 55 or older and they are providing services according to the rule—they must register as a Housing with Services establishment, obtain a home care license, and provide the services under that home care license. If a provider does not acquire a home care license, arrangements can be made for a licensed home care agency to provide the necessary services. Waiver services delivered in this setting are then no longer called Residential Care services, but are called either *Assisted Living* services or *Assisted Living Plus* services, depending on which package of services is provided.

- Settings may vary greatly in size, some resembling small homes and others large apartment buildings. Residents have private or shared rooms, but do not have individual kitchens.
- In addition to three meals per day, many settings offer a variety of supportive services (such as housekeeping and personal laundry) or home care services (such as help with dressing and bathing, medication administration, etc.) and may also provide a full range of health-related assisted living services.
- Board and Lodge Homes in which *assisted living* waiver services are provided are mostly high-end homes which typically provide a private room and private bath with congregate

dining, i.e., no private kitchen or kitchenette. Older settings will have some double rooms, but the recent trend has been to develop private rooms with a private bath.

Non-Certified Boarding Care Homes

Non-certified boarding care homes are licensed as health care facilities by the Minnesota Department of Health, but they are often quite homelike. These homes are not certified to participate in the Medicaid waiver program, although qualifying residents may receive Medicaid waiver services provided under a home care license from an outside provider. They may also register as a Housing with Services establishment provided they obtain a home care license.

- These settings may not accept or retain residents for whom care cannot be provided in keeping with their physical, mental, or behavioral condition.
- At least five percent of the rooms in these settings must be designed for single-person occupancy (one bed) and have private toilets. At least 75 percent of the beds must be located in rooms designed for one or two beds. No room may have more than four beds.
- In existing facilities, the usable floor area per bed shall not be less than 100 square feet for single rooms; 80 square feet for two-bed rooms; and 70 square feet for three- or four-bed rooms. In new construction the usable floor area per bed shall not be less than 100 square feet for single rooms, and 80 square feet for two-, three-, or four-bed rooms.

Residential Centers

Residential centers are another type of setting in which Medicaid waiver services can be provided. The state defines a residential center as a building, or a complex of contiguous or adjacent buildings with 3 or more separate and distinct living units in each building, which residents rent or own. With such a broad definition, there are many types of residential centers.

Some are market-rate apartment buildings designed specifically to serve frail seniors, and some are either market rate or HUD subsidized apartment buildings that are arranging services for residents who are aging-in-place. Some HUD buildings arrange for services using the HUD service coordinator model, which is paid for by public housing funds.

The Class E home care provider license was created specifically for residential centers that were providing fairly light services, such as individualized personal care services or home management services (also called *Assisted Living* waiver services), and therefore does not allow the provision of *Assisted Living Plus* waiver services. In order to provide the higher level of care, the residential center would need to be licensed as a Class A provider or contract with a Class A agency to provide the services. If the residential center is registered as a housing-with-services establishment, it would also have the option of providing services under the Assisted Living Home Care Provider license.

Since the new licensure category of assisted living home care provider came into effect, at the same time as the assisted living plus service package, there are now fewer residential centers using the Class E license.

Residential centers do not have to register as a housing-with-services establishment unless they provide sleeping accommodations to one or more adult residents, at least 80 percent of whom are 55 years of age or older, and offer or provide, for a fee, one or more regularly scheduled *health-related services* or two or more regularly scheduled *supportive services*.

PHYSICAL PLANT REQUIREMENTS FOR RESIDENTIAL CARE SETTINGS

Each type of residential care setting must meet its own licensing and regulatory requirements, which can include physical plant requirements. For example, adult foster care and boarding care establishments have physical plant requirements and rules regarding shared rooms. Minnesota does not require residential care settings registered as housing-with-services establishments to meet any additional specific physical plant requirements.

Regarding the provision of private rooms for low-income, publicly supported individuals, their availability depends on the residential care setting and its location. Some market-rate projects—whether apartments or board and lodges—can provide private rooms or apartments for Medicaid waiver clients, particularly where the state’s Group Residential Housing (GRH) supplement (see *Room and Board Payment* below) is adequate or where the private pay rental revenue from other residents can help subsidize the costs of the low-income resident.

The Medicaid waiver program strongly supports the provision of private rooms and counties will negotiate placements with residential care settings in order to provide Medicaid clients with privacy. A few settings have private foundations that can help low-income residents pay the shortfall between what they (or the GRH supplement) can pay and the actual costs.

However, in many board and lodging or adult foster care settings, Medicaid wavier clients may share a room with another resident, while private pay residents may have the option of paying higher rents for a private room. A GRH client living in a shared room could move to a more expensive private room if the family was willing and able to pay the difference between the GRH rate and the rent.

ROOM AND BOARD PAYMENTS

Residents who receive services through the Elderly Waiver program, the Personal Care option, or the state’s Alternative Care program must pay rent and raw food costs from their income. Room and board or rental rates are not defined or controlled directly by Medicaid or the Alternative Care program. However, Medicaid’s financial eligibility rules do limit the amount of income that Elderly Waiver or Personal Care clients will have available to pay rent or room and board. If the client has inadequate income for room and board, the client may be eligible for the state’s Group Residential Housing program.

Group Residential Housing Program

Group Residential Housing (GRH) is a state-funded income supplement program that pays for room-and-board costs for low-income adults in a licensed or registered setting with which a county human service agency has negotiated a monthly rate. In FY 2002, the state spent approximately \$75 million serving a monthly average of 12,425 disabled and elderly people. Approximately 9 percent of GRH recipients are seniors receiving Elderly Waiver services.

Aged, blind or disabled adult individuals with incomes no higher than the maximum GRH payment and assets no higher than \$2,000 are eligible for the GRH program.²⁴ If a person is eligible for the GRH program, he or she is eligible for Medicaid. To be eligible for the program, individuals must also be at risk of institutional placement or homelessness.

The amount of the GRH payment is based on a federal/state standard of what an individual would need, at a minimum, to live in the community. The maximum GRH room and board payment limit in 2003 is \$680.²⁵ A person eligible for SSI and receiving \$552 would get the full state supplement of \$81, retain a personal needs allowance of \$72, and then the GRH payment would make up the difference of \$119. If income is from a source other than SSI, there would be the same \$20 SSI disregard applied, and then the personal needs allowance deduction of \$72, and the GRH program would pay the balance up to \$680. The GRH payment is made directly to the provider of housing on behalf of the eligible person.

The GRH rate is automatically adjusted each year based on changes made in the SSI benefit rate, changes in the value of Food Stamps for an individual, and change in the personal needs allowance.

- Residential care settings eligible for GRH supplements include Adult Foster Care Homes, Board and Lodging Establishments, non-certified Boarding Care Homes and various residential settings registered under the Housing with Services Act. A county human service agency must approve placement in the GRH setting. There are over 4,800 GRH settings in the state.
- Although three meals per day are provided by many assisted living programs, other assisted living programs in apartment buildings where residents have their own kitchens may offer only one or two congregate meals per day. These latter settings would not qualify for a GRH payment because it includes a full board component of three meals a day.
- If the base room and board rate pays for a bed in a double room, a resident's family may pay extra for a private room, but settings with GRH agreements must be able to accommodate clients whose income limits them to the GRH rate. To contract with a county to be a GRH setting, a provider has to have at least one unit available for the GRH room and board rate. Family supplementation of the GRH rate may only occur if the other unit is "substantially better" such as being larger, better view, better amenities etc.

- GRH does allow payment within limits for room and board costs if a person is temporarily absent from the establishment and is expected to return. GRH can pay up to 18 days per episode of absence, not to exceed 60 days in a calendar year, for a GRH recipient who is temporarily absent.

SERVICES PROVIDED IN RESIDENTIAL CARE SETTINGS

Overview

Residential care settings may have specific service requirements and limitations based on their particular licensing category. Beyond those requirements, they may choose from an array of possible “supportive” and “health-related” services to develop their own service packages based on the needs of their community and their target market.

Services furnished or arranged for by a provider may include supervision, supportive services, individualized home care aide tasks, individualized home health aide-like tasks, and individualized home management tasks (*see description below*). *Individualized* means services are chosen and designed specifically for each resident’s needs, rather than provided or offered to all residents regardless of their illnesses, disabilities, or physical conditions.

Supervision is defined as a service which includes an ongoing awareness of the residents’ needs and activities. It is provided by an employee of the assisted living provider whose primary job responsibility is to supervise residents of the congregate living setting, and who is capable of communicating with residents, recognizing the need for assistance, providing the assistance required or summoning appropriate assistance, and following directions.²⁶

The setting must provide the resident with a means to summon assistance, for example, with a pull cord near the toilet, and the employee must be able to respond, in person, to the request for assistance within a reasonable amount of time, not to exceed 10 minutes, depending upon the physical plant.

Supportive services includes assisting clients in setting up medical and social services, assisting clients with funds, arranging for or providing transportation, and socialization (when socialization is part of the plan of care, has specific goals and outcomes established and is not diversional or recreational in nature),

Home care aide services include:

- preparing modified diets, such as diabetic or low sodium diets;
- reminding residents to take regularly scheduled medications or perform exercises;
- household chores in the presence of technically sophisticated medical equipment or episodes of acute illness or infectious disease;

- household chores when the resident's care requires the prevention of exposure to infectious disease or containment of infectious disease; and
- assisting with dressing, oral hygiene, hair care, grooming and bathing, if the resident is ambulatory, and if the resident has no serious acute illness or infectious disease.

Home health aide-like services include:

- administration of medications under the supervision of a licensed nurse;
- performing routine delegated medical or nursing or assigned therapy procedures;
- assisting with body positioning or transfers of clients who are not ambulatory;
- feeding of clients who, because of their condition, are at risk of choking;
- assistance with bowel and bladder control, devices and training programs;
- assistance with therapeutic or passive range of motion exercises;
- providing skin care, including full or partial bathing and foot soaks; and
- during episodes of serious disease or acute illness, providing services for a client or to assist a client to maintain hygiene, to satisfy nutritional needs, and to assist with the client's mobility, ADLs, grooming, basic housekeeping, and meal preparation.

Home management tasks include housekeeping, laundry, preparation of regular snacks and meals, and shopping.

- Home care provider regulations cover the service agreement, which includes a description of the service to be provided and the frequency of each service, the persons or category of persons who will provide the service, the schedule or frequency of sessions of supervision or monitoring, fees for each service, and a plan for contingency action if scheduled services cannot be provided.
- Providers may not accept anyone whose service needs they cannot meet. Orientation and training are required based on the tasks performed by the worker.
- Providers of any service must hold all required license(s) and/or registration(s). The county is responsible to take all necessary steps to ensure that such license(s) and/or registration(s) are current, and that providers meet applicable provider standards as stated in state or federal statute or rule.
- Counties must develop a contract for Elderly Waiver or Alternative Care services with providers before any services can be approved. Each setting must be licensed to provide a distinct set of services and each provider may choose to provide some or all of those services they are licensed to deliver, depending upon their mission and their targeted market.

Services through the Elderly Waiver Program

Minnesota began covering services for aged and disabled beneficiaries under the Elderly Waiver program in 1988. Waiver services are provided both in people's homes and in residential care settings. In FY 2001, the Elderly Waiver program served 2,895 beneficiaries in 291 residential settings.

Although the Elderly Waiver program has provided services (and some service packages of bundled Medicaid services) for many years to elderly persons in residential care settings, the development of the *Assisted Living* and the *Assisted Living Plus* service packages for the Elderly Waiver program (and the state's Alternative Care program) helped facilitate the provision of a more comprehensive set of services, particularly under the *Assisted Living Plus* program, in Housing-With-Services Establishments. With "packaged" or bundled services, Medicaid can reimburse for "generalized" services such as supervision, that could not easily be billed on a fee-for-service or hourly basis.

The state's Medicaid waiver program defines *Assisted Living Services* as "up to 24-hour oversight and supervision, supportive services, home care aide tasks and individualized home management tasks..." Under the Elderly Waiver program (and Alternative Care), residents may also receive home health and skilled nursing services, which are reimbursed separately from the payment for assisted living services.

The provider requirements for offering the *Assisted Living* and *Assisted Living Plus* packages are as follows:

Assisted Living Providers must be either:

1. registered as a Housing with Services Establishment AND licensed as a Class A Home Care Agency or a Class E Home Care Agency or an Assisted Living Home Care Provider, OR
2. be a Class A Home Care Agency contracting directly with the county to provide the Assisted Living package of services to persons in a congregate living setting, OR
3. be a Class A Home Care Agency or a Class E Home Care Agency delivering services in a residential center which is exempt from registration as a Housing with Services Establishment.

Assisted Living Plus providers must meet more rigorous standards. They must be both:

1. Registered as a Housing with Services Establishment, AND
2. Licensed as either a Class A Home Care Agency or an Assisted Living Home Care Provider, AND
3. The *Assisted Living Plus* service package they provide must include 24 hour supervision.

Both *Assisted Living* and *Assisted Living Plus* service packages can be provided in the following settings:

- one to five unrelated people in a residential unit (adult foster homes).
- six or more unrelated people in a setting licensed as a board and lodge establishment.
- a residential center which is a building or complex of adjacent buildings with separate living units which clients rent or own.

As a general rule, services provided in all settings that are registered as Housing with Services Establishments are called *Assisted Living* or *Assisted Living Plus*. If the provider is not so registered, the name of the services will be different, e.g., Corporate Foster Care in Corporate Adult Foster Care Homes or Residential Care Services in Board and Lodge establishments, and they will carry different payment codes.

In the last legislative session, the Housing with Services Act was modified to allow residential care settings that don't have at least 80 percent elderly persons to voluntarily register as Housing with Services Establishments, thus enabling their residents to be served with the *Assisted Living Plus* package. However, they were specifically prohibited from receiving new Group Residential Housing payments unless they already had a GRH contract with the county. The GRH budget is a state forecast-spending amount based on demographics, and under the Governor's budget proposal at the time, could not be increased to accommodate any increase in utilization.

REIMBURSEMENT

Overview

The state uses a case-mix classification system to reimburse *Assisted Living* and *Assisted Living Plus* services. Individuals must fit into one of eleven case-mix categories, four of which include people with behavior problems. The lowest category is for people with few or no Activity of Daily Living (ADL) dependencies. Someone with cognitive and other mental impairments without ADL dependencies could fit in this category.²⁷

The Elderly Waiver program and the state's Alternative Care program set a maximum rate for providers for a package of services. Each county determines what services are included in its "base service package" and negotiates a rate for those services, which may not be the maximum allowed under the programs. Currently, service providers do not have information to determine which services should be included in a basic assisted living service package in order to receive the maximum allowable rate.

Half of the Elderly Waiver and Alternative Care budgets is spent on *Assisted Living* services. To assure appropriate payment levels, the state has been developing a rate negotiating tool for

counties to use for the *Assisted Living* and *Assisted Living Plus* packages. The tool is intended to ensure the provision of only those services actually needed by residents. Oversight and supervision will be specifically addressed as the majority of residents do not need 24 hour oversight, or supervision beyond what is needed for ADLs. The tool will help to specify exactly how much supervision is required, which is particularly important for persons with cognitive impairment.

Contracting with Providers

Clients' service needs are unique to each person in each setting and must be addressed individually in the contract language. However, there are certain principles involved in developing and negotiating a contract for packaged services, including:

- Counties have the option of creating a “base rate” that defines payment to the provider for certain services all residents of the setting receive, such as supervision or meal preparation. The law says that each client is to receive an individualized service plan and that the county only pays for those services in that service plan. However, if all the clients referred to a particular provider always need a particular set of services, the county may have a “base rate” set for those services and, in addition to that rate, pay for the other individualized service needs of each person. Thus, the base rate may or may not include personal care services. When the contract is renewed, the county has the option to re-negotiate rates, based on of increases or decreases in the amount of funding available from the state.
- Service package payments are limited to services that meet chronic needs. Services that meet episodic or acute needs should not be included in the package, but should be billed on a fee-for-service basis to the appropriate payer. These payers include fee-for-service Medicaid, Pre-paid Medicaid, Medicare or private insurance.
- Personal care services (which meet chronic client needs) and incidental nursing services (which are limited to medication set-ups and the drawing up of insulin) may be included as an *Assisted Living* service, payable by the Elderly Waiver or Alternative Care programs. Those that are not included in the *Assisted Living* or *Assisted Living Plus* group of services (e.g., those for episodic or acute needs) must be delivered by a Medicare certified Class A Home Care agency or by the client's Prepaid Medical Assistance Plan provider (the state's managed care program.)
- Individualized service rates negotiated within a payment package should not exceed the fee-for-service rate limits for similar services delivered outside of an *Assisted Living* or *Assisted Living Plus* group of services.²⁸
- Per state and federal regulation, payment shall not be made for homemaking service in addition to the *Assisted Living* service payment package; it is expected that any homemaking service needed is always included within the payment package.

Contracts for *Assisted Living* or *Assisted Living Plus* services must enumerate which appropriately licensed services are offered by the provider and the service payment methodology the county will use to pay for each needed service.

Although county contracts with Residential Care, Family Foster Care or Corporate Foster Care providers may not detail the service rate payments for each service provided to Alternative Care or Elderly Waiver clients to the same level that *Assisted Living* or *Assisted Living Plus* contracts do, the service(s) these providers are responsible for delivering to Alternative Care or Elderly Waiver clients must be detailed in the client's care plan.

Service Rate Limits

- The *Assisted Living Plus* package, which can only be provided to residents of a Housing with Services Establishment, permits counties to approve monthly packages under the maximum rate available to the client.
- The Elderly Waiver monthly service plan limit is the statewide average monthly Medicaid payment rate to nursing facilities for the 11 case mix categories to which the person would be assigned under the Medicaid case mix reimbursement system.²⁹ Around 90 percent of Elderly Waiver participants fall into the first five of the eleven categories, the monthly rates for which range from \$1,963 to \$2,985.³⁰
- For Elderly Waiver clients who do not participate in a Pre-Paid Medical Assistance Plan (PMAP), a state managed care program, the cost of all state plan home care and Elderly Waiver services including extended medical supplies and equipment, skilled nursing, home health aide, and personal care services reimbursable by Medicaid are included when determining the cost effectiveness of Elderly Waiver community support plans. For PMAP clients, some of these services are services provided under the PMAP contract and premium.
- Additional services, which do not duplicate any of the services provided by the *Residential Care* or *Assisted Living* service package, may be added to the person's community support plan and authorized for payment if the total cost of services does not exceed the person's monthly service cap.
- The Group Residential Housing program also makes service payments for disabled and elderly adults in foster care and other settings if the person is not eligible for service payment from another source. The GRH limit for services is \$461.36 per person per month. The services, called "supplemental services", must be necessary for an individual to remain independent, and are typically provided to an individual who has not been able to get Alternative Care or Elderly Waiver services due to their not meeting nursing home level of care criteria.

III. Summary of Interviews

In addition to consulting with eleven state staff and policy makers regarding the technical details of the state's programs, we also conducted more in-depth interviews with four of them. In addition, we interviewed seven stakeholders, including representatives of residential care provider associations, consumer advocates, the state ombudsman program, and an academic expert.

The interviews focused on respondents' views about several key areas and issues. This section summarizes their views and provides illustrative examples of their responses. These comments are not verbatim quotes, but have been paraphrased to protect the respondents' anonymity and edited for brevity. A list of information sources for the state description and the individuals interviewed can be found at the end of this summary.

GENERAL COMMENTS ABOUT THE STATE'S RESIDENTIAL CARE SYSTEM

Respondents raised a number of issues that they believed constituted existing or potential problems with the residential care systems generally.

- *The system is confusing for the typical consumer. There is a perception by residents and families that the assisted living services constitute 'nursing home lite'—or getting all the services of nursing homes, but a la carte. However, that is not the case. Twenty four-hour supervision cannot be assumed, although family members and residents are surprised to learn that it is not available when they are receiving assisted living services and not the assisted living plus package. Many families are surprised to hear that although a residence is licensed it is not regulated. They don't understand the system. Some refer to a residence as an "assisted living nursing home" and are surprised to learn that the assisted living model is licensed as a home care provider. We need education, education, and more education for consumers, their families and physicians.*
- *We have more folks taking advantage of these services and avoiding a nursing home—and that's good—but we have some egregious situations and they will increase if we don't respond in a responsible manner. The Department of Health has been upfront about the fact that many of these places have not had onsite inspections and they are frustrated about the lack of staff to conduct these inspections. The tools in place to address poor providers are not adequate. There are discussions within the long term care task force to assure quality—there is recognition that a problem exists. But the state lacks adequate oversight of residential settings.*
- *We don't have assisted living that focuses on dementia, but do have some foster homes that provide a high level of care.*

Some respondents expressed concerns about lack of funds to build housing, and the impact of converting senior housing to assisted living.

- *On the housing side—we are flat broke. We cannot afford to build assisted living for low income seniors. We already have a large stock of housing that serves seniors—so there is no point in putting money into purpose built assisted living. We need to look at what we have and enhance it when needed; provide services in the existing housing stock and remain solvent.*
- *I'm concerned about the impact of providing the assisted living service package on the character of low income public housing and congregate housing. This is an issue that is likely to be somewhat unique to Minnesota, however, it is worth noting. People are struggling with how far the state should go with the level of support before adversely affecting the living climate or environment for the other residents. Or, how far can services go in providing coverage for increasing levels of acuity and support, and where should the line be drawn? When should people move to other settings that can better meet their needs? This is a work in progress—we are implementing a philosophy.*
- *It is complex when trying to turn subsidized senior housing into assisted living; it has not panned out. Many seniors in these settings are doing fine and not signing up for services. When there are vacancies and you bring in people who need services and supervision it changes the mix and character of the setting, although in some small towns it works out fine. You then change your stock of low and moderate income housing and turn it into assisted living. So for those who are poor and need housing you've limited their choice—an unintended consequence.*
- *We have buildings where people who are being served don't need a lot of the services but they get the entire package.*

GENERAL COMMENTS ON MEDICAID'S ROLE IN RESIDENTIAL CARE SETTINGS

Overall satisfaction was expressed with the program; there was pride in the lack of a waiting list and in the fact that many people have been served in settings outside the nursing home.

- *It's worked pretty well—providers have been happy.*
- *We're really happy with our program—it provides flexibility for the community to build a program that is right for them.*
- *On the housing side, because Minnesota did not have the resources to build assisted living for low income seniors, the waiver assisted living program was built on the idea that assisted living services would be mobile. There was already a large stock of housing where low income seniors resided so that the Minnesota approach to assisted living was viewed as a successful way to deal with the housing piece of residential care.*
- *Originally we thought housing with services establishments would be for people headed to nursing homes—to provide another option for people who didn't feel that they could stay in*

their own home or when services could not be delivered in their home settings. We do find that nursing home admissions have decreased and people are staying in their homes longer. Assisted living is another option for people whose needs cannot be met in their own homes.

- *Minnesota generally has pretty good delivery—many of the providers are religious organizations—church related entities are major real-estate holders and provider entities. A climate where the care is good—many are nursing home managers trying to avoid the over regulation, but they are concerned about assuring quality in these looser entities.*
- *Minnesota has senior housing stock that has been subsidized—now they are attempting to introduce varying levels of services to enable aging in place—through Assisted Living Plus. Adding assisted living waiver services to these settings mean that buildings stay occupied, the state does not have to subsidize purpose built facilities, and the people served are able to remain in their apartments.*
- *The cooperation between housing and services is due to the fact that human services is all under one big umbrella. An individual who was hired to straddle housing and services sits on joint committees and understands both perspectives. I believe this makes a difference in terms of coordination.*
- *The most successful part is that we are not creating senior Medicaid ghettos. In an assisted living place, if the residents aren't talking to each other about who's paying—you don't know who is private and who is Medicaid. Of course, rich seniors will live in nicer places. Medicaid coverage provides more options for seniors. One of the goals of covering assisted living services through the waiver program is to allow seniors who have spent down in assisted living to stay there as long as their needs can be met.*

LICENSING AND REGULATORY REQUIREMENTS

Minnesota is one of the few states that does not have a licensing category for assisted living. There were differing points of view regarding this. While those representing the providers voiced that from their perspective there is an adequate regulatory structure and they did not see anything that needs to be added, this sentiment was not consistently shared by others.

- *We need to license administrators of assisted living to assure a minimum skill set or knowledge base for dealing with this vulnerable population.*
- *Licensing the services but not the property or building is not sufficient.*
- *Many providers of assisted living are former nursing home managers that are trying to avoid what they perceive as the-over regulation that is found in the nursing home industry. They understand that to avoid this type of over-regulation they need to self-impose quality standards.*

- *We think there is an adequate regulatory structure—we don't see that anything needs to be added. Home care entities can be surveyed, and anyone receiving waiver or alternative care services has to go through the counties, so that's another vehicle for oversight.*
- *Quality assurance—the people who do the surveying of the home care agencies are very concerned about the frail elders who are not getting adequate care. There is concern that licensure of the services—but not the building—is not sufficient. The owner can obtain a home care provider license, which is not a big deal, but an outside home care agency needs to have a home care Medicaid license, which is a big deal.*
- *Housing with services registration has been in place since '95 or '97. It was promoted by long term care trade associations because state regulations to set up assisted living were not available and the industry wanted some regulations. Over time, this has worked fairly well and is supported by private and public entities. One of the non-profit long term care associations has a quality initiative. They want to keep what Minnesota has: flexibility without extensive regulation.*
- *Right now, assisted living is primarily private pay—80 percent or more. The way it works in Minnesota is that there is a presumption in the Housing with Services Act that two competent parties enter an agreement: the provider and the resident. We think this creates the best opportunity to create maximum choices. We fear that as more and more waiver dollars flow into assisted living, there will be pressure to create a regulatory scheme that will look like nursing homes. We do not regulate assisted living to the worst case scenario like nursing homes do and don't think we should have to.*
- *Minnesota doesn't have very specific regulations, e.g., about how and when meals are to be provided. We operate under the assumption—whether it's private pay or Medicaid—that you have two competent parties entering an agreement. There is a 17 point contract that must be signed by both parties. This eliminates the need for lots of regulations. Alterra had a problem at one of their places and the state attorney general had them in court over a contract violation and it was in the paper. This is a faster way to address quality problems than lots of regulations.*
- *The state should not have approved Assisted Living Plus in the Elderly Waiver program without additional standards.*

National Standards

With few exceptions there was agreement that national model standards for assisted living would not be helpful. There was a sense that Minnesota has developed a unique approach to providing services in residential care settings and would not adopt national standards if it required abandoning their approach.

- *Our approach provides freedom of choice but we want to make sure that quality issues don't arise—both because of their human cost and because they can lead to over-regulation with its attendant costs. It's in everyone's best interest to assure quality.*
- *The industry has carved out something unique and is fighting hard so it won't be changed. Even a little tweaking is seen as threatening.*
- *The Assisted Living Workgroup (in DC) has 110 recommendations—they've said they don't want the feds to regulate, so they've sent recommendations to the states. In August we're having a town hall meeting to discuss the recommendations and the current state regulations. The meeting is for providers and the state Attorney General will attend, because in Minnesota, the attorney general enforces the regulations against Medicaid fraud and regulations regarding landlord / tenant relations.*

ADMISSION AND RETENTION REQUIREMENTS, AND AGING IN PLACE

Because Medicaid's assisted living program is not tied to a particular type of housing, admission and discharge decisions are left up to the housing owner or manager. Respondents had conflicting views about this approach.

- *The county case manager determines eligibility for assisted living services under the waiver and the hours of service needed, however, it is the property owner that decides whether the resident's needs can be met in their property. If a resident's condition deteriorates and more care is needed, then the property owner can claim that the increased need for services cannot be met, requiring the resident to leave that setting.*

Currently, there is no bill of rights that enables the resident or family to appeal this decision. Once the decision to terminate is made the resident is given a ten day termination notice and a list of other providers.

- *We need a resident bill of rights to give a right of appeal when discharged.*
- *Giving the property owner discretion over discharge is not a problem because typically a lease addendum gets executed at the time the property is leased. This addendum informs the resident what services are available with the rent, services that are available a la carte and who can provide these, as well as information about when the resident would need to move on to a different residence.*
- *Families are often unaware that a setting does not have the capability to provide 24 hour a day coverage. There needs to be a resident bill of rights that would support an appeal process. The resident in these settings is under a home care bill of rights which is much more limited than a nursing home bill of rights. This bill of rights was written when it was assumed that the individual receiving services was in their own home so that privacy and termination issues were not applicable.*

- *When retention issues arise they are more typically due to an inability to pay the rent portion of the housing because the services can always be provided under the waiver.*
- *To be honest it is an open question whether assisted living serves those headed for a nursing home. For some it does, but it tends to be for those who are not as disabled. When you have people who are very disabled or have a lot of incontinence, or get to the point that they can't be sustained in the assisted living setting, then they tend to end up in a nursing home.*
- *Termination of lease requires only a 10 day notice, not a 30 day notice, and there is no appeal, the provider just gives you a list of other providers. This is not an eviction, it never gets to that point because once the services are stopped the person has to move to a nursing home. There are no appeal rights for service termination—even if you are a public assistance client and the case manager authorizes the services. But the home care provider can determine that they cannot meet your needs in that setting and the consumer is stuck.*
- *If a provider accepts a Medicaid client and is providing services, and the resident begins to have other needs that the provider can't meet, the provider should not be required to use his or her capital and money to bring the services in for one person at the expense of other residents. The providers who keep people because they don't want to give up the money are the ones that will get into trouble.*

Providers have to fully disclose up front what they do and do not provide. Anyone moving in has to do so with the knowledge that at some point they may not be able to stay. If someone is receiving home health services but can no longer be served safely at home, he has to move. Someone living in a housing with services establishment is still considered to be living in his own home.

- *The biggest complaint in Minnesota is “they’re making me move” not “they’re not taking care of me.”*

Negotiated Risk Agreements

There was consensus that consumers should have the option of assuming risk, but uncertainty about the correct process for doing so, particularly for persons with cognitive impairment.

- *Negotiated risk is not specifically identified as such; it is addressed indirectly. Providers are using negotiated risk—but mainly as a communication tool.*
- *The state has begun to talk about negotiated risk but there are no regulations in place. There is a move to introduce this into pre-admission screening, which is done on the county level by a social worker or public health nurse. The emphasis in current thinking is not so much about insuring health and safety but whether the individual is willing to take the risk of*

remaining in the community and what the state is able to do to make the home more conducive to their staying in that setting. Negotiated risk is a piece of that but the state is not there yet.

- *This is a hot button issue in the state and we have not yet come to a consensus because I think we have not had sufficient consumer agreement. Younger consumers want negotiated risk, but another large group—families of the cognitively impaired—question whether people are capable of making the decisions about the risk. We are looking for a way to provide enough of a safety net in these settings to provide for the cognitively impaired. We want cognitively intact people to have the ability to accept risk, but we haven't found the right mechanism for the cognitively impaired.*

BARRIERS TO SERVING MEDICAID CLIENTS IN RESIDENTIAL CARE SETTINGS

Concerns about Future Capacity in the Waiver Program

Currently, insufficient capacity is not an issue in Minnesota. But due to the potential for budget cuts, several respondents expressed concerns about sufficient funding for the waiver program in the future.

- *There is no waiting list and everyone who needs assisted living services under the waiver receives them. But more and more people are getting the Assisted Living Plus service package, which includes the requirement for 24 hour supervision, and this is the more expensive option for waiver services. If costs continue to increase for this service package, the waiver may be capped.*
- *At this point in time the governor's budget does not cut the funds too severely for the elderly in assisted living—but younger disabled clients have been capped. If our costs continue to grow we may see that happening for the elderly as well. The costs have shot up in the Assisted Living Plus program—our numbers looked really good prior to the inclusion of the Assisted Living Plus option. Assisted Living Plus has been in place a couple of years and that has made program costs look similar to nursing home cost, but overall they can do an average cost per client that is less.*

Affordability of Room and Board Charges

A few respondents noted that private pay residents may spend down to Medicaid eligibility and not be able to afford room and board. However, they noted that there were no data to know to what extent this was or could be a problem.

- *The rent piece is the hardest to subsidize. Families can supplement what the resident can afford to pay for room and board when the resident is getting Alternative Care or Elderly Waiver services. If the state lodging supplement covers a shared room, the family can pay for a private room.*

- *For people who go into purpose-built assisted living—if they spend down, the Elderly Waiver or Alternative Care can cover the services but it's typically the rent that becomes a problem. They may not be able to afford the rent and have to move to other subsidized housing where the rent is cheaper.*
- *Many providers who don't take Medicaid payment are concerned about continuing to serve those who spend down.*
- *There's a lot of discussion about spending down—but no data. There is a recognition that this is happening but we are not tracking it. We've had calls that rates are going up beyond the calculations of the elderly regarding what they thought they could afford.*
- *People talk about it and worry about it but as for how often that happens we don't know. We will be doing an analysis of that by looking at the number of people applying for the waiver while in Assisted Living. We hear anecdotally that this is happening, but not a large enough number to cause major concern. Most people who leave purpose built assisted living go on to nursing homes but it's not clear whether that's due to increased frailty or spend down.*

Geographic Maldistribution

- *There is a geographic maldistribution in availability—we had a recent report on availability and there are some areas where there is 1 per 5,000 and another 1 per 10,000. Persons eligible for Medicaid of course, have fewer options than those with means. But that too varies by geography.*

Service Rates

Most respondents felt that rates for assisted living services are generally adequate. Some, however, voiced concerns that the State set a maximum rate but allowed counties to negotiate lower rates. There is a desire to develop tools to help counties determine the number of hours of service needed by each individual, which would enable them to better match the reimbursement level to the services needed.

- *Sometimes working with individual counties can be a challenge. Funding is viewed generally as adequate; when it's not, it's a disagreement between the county and the provider. The state sets rate limits for each client—some counties go close to full rate—other counties try to come in under that rate.*
- *Providers of market rate assisted living have taken in Medicaid at a little less than the going rate to fill beds.*
- *Medicaid rates should be equal to the private pay market rates. By law the waiver rate has to be at or below what the private pay rate is. The State caps what the counties can pay for services but they have discretion in negotiating rates. You can have two places on the same street—one in one county and one in another—each getting a different rate.*

SUGGESTED CHANGES TO IMPROVE THE MEDICAID-FUNDED RESIDENTIAL CARE SYSTEM

Respondents views on needed changes focused on quality of care and rights issues, as well as the need to help counties determine appropriate service rates.

- *Two things are needed. One is a specific bill of rights for residents of assisted living and the second may be a requirement for a licensing of administrators of assisted living to have a minimum skill set or knowledge base for dealing with this vulnerable population.*

Consumers living in their home, whether its their own home or a congregate residence considered as a home, have fewer rights than residents of nursing homes. There are substantial federal requirements for rights in nursing homes for non-discrimination. The home care bill of rights is much more limited.

- *There are specific problems with the landlord / tenant contract where we will need to plug holes—assisted living is in the gray area so that the rights of the resident are not clear. The rights of the resident versus the rights of the landlord. I would like to see a specific bill of rights for residents of assisted living facilities.*
- *Because the regulatory scheme was built on a home care model we do need to do some thinking in three areas:*
 - 1) *We need to come up with a universal bill of rights for long term care. The current one does not provide an appeal process or due process prior to termination.*
 - 2) *The current assisted living regulations are poorly written in terms of supervision—consumers think that monitoring means 24 hour availability of a nurse. The state needs to ‘clean up’ supervision and to clarify communication with the consumer so individuals clearly understand what they are getting. Someone should be available 24 hours a day. The current requirement: they have to have someone in the building with no specificity as to ratio, sleep or awake, who this person is. This is the case under Assisted Living Plus as well—with no ratio required. “Present and aware” but no requirement to be awake.*
 - 3) *The number and training of staff needs to be addressed. The little training that assistants receive is not directed toward the type of residents they will be taking care of. Resident assistants are not required to complete a nursing aide course.*
- *We need to give county health departments tools with which to determine the hours of service needed for a particular level of care. To have better model procedures that the state can provide to the counties as to what they can do before a person can be placed in a particular setting. The state needs to give the county some model language and enforcement language if quality is not adequate. In addition to licensing, the county needs*

to have a greater role to ensure that waiver clients are actually getting their needs safely met over time.

- *In Minnesota we have folks on Medicaid who are elderly who need to be in a managed care situation—it is still being developed in some counties—the PMAP program—it's supposed to provide all benefits, but if someone is eligible for the waiver they refer them to the county. If you're at risk for institutionalization and meet income guidelines you get moved to the waiver—otherwise you get PMAP (and Medicaid state plan services).*

This creates an incentive for PMAP to move people to the waiver but they should keep them and use Medicaid Home Health. Once they move to the waiver, care coordination is lost.

You have these perverse incentives and you have these two programs that go back and forth—we would get more bang for our bucks if we could coordinate both acute and long term care for this population. Minnesota's managed care program should be giving 90 days post acute care, but it's not working. There was a desire to move the waiver patients to PMAP but counties did not want that because they wanted to hold on to the case management dollars but can only do that if they manage Elderly Waiver. There are reasons to think about a more integrated model—if political and financial realities could be overcome then another more integrated model would be possible and would have a positive effect on assisted living services.

FUTURE PLANS

Most respondents agreed that the State is likely to continue the model of assisted living that is currently in place. While the budget is not having an impact on the availability of waiver services in the short term it is not clear what will happen in the long term, particularly if the *Assisted Living Plus* service continues to grow at its current rate.

- *We need to examine the Assisted Living Plus option carefully to understand its rapid rate of growth.*
- *From the advocacy side, we need to advocate for a bill of rights and develop requirements for staffing and supervision.*
- *We want to make affordable assisted living available as an option. We need to make sure that assisted living provides only the services that people need. To do this we are planning to help the counties to figure out how to set rates. Providers can't expect to be paid for a package of services, when some of them are not included in a person's plan of care. We're going to give the counties tools and training for setting rates in 2003.*

RECOMMENDATIONS FOR OTHER STATES

We asked the respondents to make recommendations for other states interested in using Medicaid to fund services in residential care settings, based on their experience doing so in their

own state. Most agreed that the regulatory model should not be based on a nursing home model.

- *Think through the need for both regulation and flexibility. It is a challenge to design a regulatory system that provides safety and quality for the consumer but does not impose a nursing home like regulatory environment.*
- *Consider the Minnesota approach and disaggregate housing from services, particularly if there is an existing stock of elderly low income housing.*
- *The biggest challenge is to design a regulatory system that provides safety for residents without bringing in the entire nursing home regulatory system.*
- *Defer to folks in human services. From the housing vantage point—people were looking for capital to build affordable assisted living but it simply was not there. Section 202 HUD projects that provide housing and services—we have a high number of these, have a resource already—from our vantage point it was not practical to use a site specific, purpose built assisted living program.*
- *I'd advise them that whatever the system—it needs to be consumer driven—consumers making choices—deciding whether services are adequate—that they focus on the contract between the individual and provider and let that be the guiding regulatory principle. Require lots of disclosure and transparency of information.*

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Sharon Zoesh, State Ombudsman
Office of Ombudsman for Older Minnesotans
Minnesota Department of Human Services

ENDNOTES

¹ Long term Care Task Force: *Reshaping Long term Care in Minnesota*.

² The State applies the following §1902(r)(2) less restrictive resource methodologies for Group C: household/personal goods are excluded and a more liberal homestead exclusion is allowed for certain long term care residents.

³ Asset limits for the Minnesota Supplemental Aid program are lower, i.e., \$2,000 for an individual and \$3,000 for a couple.

⁴ “If the community or institutionalized spouse establishes that the community spouse needs income greater than the monthly maintenance needs allowance determined in this paragraph due to exceptional circumstances resulting in significant financial duress, the monthly maintenance needs allowance may be increased to an amount that provides needed additional income.” (*Minnesota Statutes 2003, Chapter 256B.058: Treatment of income of institutionalized spouse.*)

⁵ O’Keeffe, J., *People with Dementia: Can They Meet Medicaid Level-of-Care Criteria for Admission to Nursing Homes and Home and Community-Based Waiver Programs?* AARP, August 1999.

⁶ The 300 percent of SSI rule is for the aged only. *CRS Report for Congress, Medicaid: Eligibility for the Aged and Disabled, updated July 5, 2002.*

⁷ The State applies the following §1902(r)(2) less restrictive resource methodologies for Group C: household/personal goods are excluded and a more liberal homestead exclusion is allowed for certain long term care residents.

⁸ Asset limits for the Minnesota Supplemental Aid program are lower, i.e., \$2,000 for an individual and \$3,000 for a couple.

⁹ “The commissioner shall seek to amend the federal waiver and the medical assistance state plan to allow spousal impoverishment criteria as authorized under United States Code, title 42, section 1396r-5, and as implemented in sections [256B.0575](#), [256B.058](#), and [256B.059](#), except that the amendment shall seek to add to the personal needs allowance permitted in section [256B.0575](#), an amount equivalent to the group residential housing rate as set by section [256I.03](#), subdivision 5.” (*Minnesota Statutes 2003, Chapter 256B.0915, subdivision 2: Spousal impoverishment policies*)

¹⁰ CRS Report for Congress, *Medicaid: Eligibility for the Aged and Disabled*, updated July 5, 2002.

¹¹ O’Keeffe, J., *People with Dementia: Can They Meet Medicaid Level-of-Care Criteria for Admission to Nursing Homes and Home and Community-Based Waiver Programs?* AARP, August 1999.

¹² Asset limits for the Minnesota Supplemental Aid program are lower, i.e., \$2,000 for an individual and \$3,000 for a couple.

¹³ Minnesota Statute 144D.

¹⁴ Typically Board and Lodge with Special Services entities would not have a special care unit unless it registered as a Housing with Services Establishment to enable it to receive waiver payments. If it is not registered as a Housing with Services Establishment, it cannot serve

waiver clients, but may be receiving GRH Supplemental Service payments for non-elderly clients who are ineligible for waiver services (usually dual diagnosed with mental illness and chemical dependency).

¹⁵ Minnesota Statutes 2003, Chapter 144D.065, *Establishments that serve persons with Alzheimer's disease or related disorders*.

¹⁶ Under Minnesota law, most agencies or individuals regularly providing home care services to clients for a fee are required to have a Minnesota home care license. Some individuals do not need to be licensed or registered if they provide limited types of services for 14 or fewer hours a week to only one client. Family members and volunteers providing such services without charge generally do not need a license. When Minnesota's home care license requirements were implemented, only services provided in single-family homes and apartments were covered. Although the Housing with Services Contract Act created no new licensing program, it did extend the existing home care licensing requirements to additional types of residential settings—including, board and lodging establishments and corporate adult foster care homes, if they meet the Contract Act criteria.

The home care license requirements spell out the services the agency or individual is allowed to provide and other requirements such as those related to the training and supervision of unlicensed caregivers, assessment of client needs, and the development and implementation of clients' service plans. Some home care providers are also Medicare-certified and must meet federal Medicare requirements in addition to the state licensing requirements. Liability insurance is a requirement for licensure.

¹⁷ Certified Boarding Care Homes are considered nursing homes and are eligible to receive Medicaid payments. However, these homes may only provide "light" care and cannot provide skilled nursing home care.

¹⁸ When the Housing-with-Services Contract Act was passed in 1995, it was designed to apply to various types of buildings serving seniors, rather than settings serving other groups, such as persons with developmental disabilities. To distinguish which buildings served seniors, the state used the definition from the federal Fair Housing Act, which requires that 80 percent of the residents be age 55 or older.

¹⁹ The state purposely excluded housekeeping services, meal programs, routine van transportation to shopping or recreational activities from the definition of supportive services so that the providers of these services would not have to meet all the requirements of the Contract Act.

²⁰ There is an erroneous belief that Minnesota's Medicaid waiver program only provides *assisted living* services to elderly persons living in private apartments with a full kitchen. It stems from the fact that when the Elderly Waiver service packages were first created, the package of services that were provided in apartment settings (where there were individual kitchens) was labeled "assisted living" while a very similar package covering essentially the same services could be provided in settings where residents did not have individual kitchens. The latter package was given a different name—*residential care services*. Both service packages covered the same types of personal care and health-related services, but they had two different labels. Consequently, many people made the assumption that because the service package labeled *assisted living* could only be provided in apartments with kitchens that these kinds of services could not be provided in other types of settings. (Personal communication)

²¹ A Rule 203 license for 5 people is only available if all residents are at least 60 years old and none have a serious and persistent mental illness or a developmental disability; otherwise the

setting must be licensed as a board and lodge by the Minnesota Department of Health. (Source: DHS Bulletin #00-25-4.)

²² Ibid.

²³ These settings were grandfathered in with the passing of the Housing with Services Contract Act. A moratorium was put into place so that no more settings of these types could be developed and there remain approximately 125 in the system. See section titled *Background* under Residential Care Facilities.

²⁴ A personal needs allowance and any income allocated for a community spouse is disregarded.

²⁵ The amount is based on the following formula: \$552 (SSI payment) minus \$20 disregard and \$72 personal needs allowance + \$81 (Minnesota Supplemental Aid (MSA) maximum) + \$139 Food Stamps. The state does not get reimbursed from the Food Stamp program, but the state has a workgroup that is looking at how to get food stamps for persons in residential settings. The state uses the \$139 figure to estimate what a person would need to live in the community, as that is the maximum Food Stamps benefit provided to a single person.

²⁶ Supervision may not be provided by a resident who is receiving services.

²⁷ Although this level receives the lowest reimbursement, the people in this category may in fact need extensive supervision. O’Keeffe, J. *op.cit.*

²⁸ Rate equalization exists only in that the service payment rate for a “public-pay” client shall not exceed the service payment rate for a “private-pay” client.

²⁹ The Alternative Care Program’s monthly service cap is limited to 75 percent of the monthly service cap in effect for persons assigned the same case mix classification as persons receiving Elderly Waiver services.

³⁰ Mollica, R. J., *State Assisted Living Policy: 2002*, National Academy for State Health Policy, 2002.

Appendix D
North Carolina

North Carolina

The information in this appendix is presented in three major sections:

- The first section provides an overview of the state's long term care system, with a primary focus on the Medicaid program. Although a state may pay for services in residential care settings through the Medicaid program, the program's financial eligibility criteria and related financial provisions for home and community services can present barriers to serving Medicaid clients in these settings. Thus, the first section of each state's description presents detailed information about rules related to financial eligibility, spousal financial protections, and cost sharing requirements.
- The second section describes the state's residential care system.
- The final section presents the views of respondents interviewed for this study on a range of issues related to Medicaid coverage of services in residential care settings in their state.

Because the information in the first two sections is intended to serve as a reference, some information is presented under more than one heading to reduce the need for readers to refer back to other sections for relevant information.

Unless otherwise cited in endnotes, all information presented here was obtained from the sources listed at the end. Supplemental Security Income levels, the federal poverty level, federal spousal protection provisions, state supplemental payments, and state reimbursement rates are for 2003, unless otherwise noted.

I. Overview of Long Term Care System

NURSING HOMES

North Carolina has had a Certificate of Need (CON) Program for nursing homes since 1981. Consequently, compared to other states, they have a lower number of nursing home beds per person age 65+ than the national average: 3.8 percent compared to 4.2 percent. The current occupancy rate is 87.9 percent compared to the national average of 82.9 percent.¹

Financial Criteria²

- Three groups are financially eligible for nursing home services:
 - *Group A* includes individuals eligible for SSI whose monthly federal benefit is \$552 per month. This group is automatically eligible for Medicaid.

- *Group B* includes individuals with incomes up to 100 percent of the Federal Poverty Level (FPL), which is \$749 in 2003.
 - *Group C* includes medically needy individuals whose nursing home costs exceed their countable monthly income. Income that is not countable includes: a personal needs allowance; health insurance premiums and medical expenses not covered by insurance or government benefits; certain spousal or dependent family members' allowance; and a home maintenance allowance if the if the nursing home stay is less than six months and there is no spouse living in the home.³
- Asset limits for both groups are \$2000 for an individual and \$3000 for a couple.
 - The monthly personal needs allowance is \$30 for individuals and \$60 for couples.

Spousal Protections

- Community spouses may keep any income in their own name, and the state allows the institutionalized spouse's income to supplement the community spouse's income up to the federal maximum permitted, which is \$2267 per month.
- The state protects one half of the couple's assets subject to a minimum of \$18,132 and a maximum of \$90,660. For example, if the couple's assets are \$30,000, one half is \$15,000, but the state will protect \$18,132 for the spouse at home. If the couple's assets are \$250,000, one half is \$125,000, but the state will protect only \$90,660 for the spouse at home.

Family Supplementation

In nursing homes, families can pay the difference in cost between a semi-private and private room for a Medicaid beneficiary only if the beneficiary has been a private pay resident of the nursing home and has spent down to Medicaid eligibility.

Level of Care Criteria

To receive Medicaid coverage of nursing home care, a physician must certify that an individual needs eight hours of licensed nursing care (RN or LPN) per day, either direct care or oversight.

WAIVER PROGRAM

The state's waiver program for elderly persons is called the Community Alternatives Program for Disabled Adults (CAP/DA). Only persons residing in their own or another's home can receive waiver services because North Carolina licensing rules do not permit any residential care settings to serve persons who need a nursing home level of care. Due to a nursing home bed shortage and other factors, some people who meet the state's nursing home level of care criteria do in fact reside in adult care homes. They are not eligible for waiver services but can receive some nursing care through Medicare or Medicaid Home Health services".

Financial Criteria

- Three groups are financially eligible for waiver services:
 - *Group A* includes individuals eligible for SSI, who are automatically eligible for Medicaid with no separate application.
 - *Group B* includes individuals with incomes up to 100 percent of the Federal Poverty Level, which is \$749 in 2003. No cost sharing is required.
 - *Group C* includes medically needy individuals who must spend down to \$242, the amount they may keep to pay for community living expenses such as housing, food, and transportation. Any expenditure that the IRS considers to be a medical expenditure for purposes of tax deductions can be counted as a medical expense
- Asset limits for both groups are \$2000 for an individual and \$3000 for a couple.

Spousal Protections

- Waiver clients do not have the same spousal impoverishment protections as nursing home residents. Spouses of waiver clients may keep any income in their own name, but the state does not allow the waiver client to provide a monthly needs allowance to a spouse with an income under \$2267 per month (the maximum allowed under federal law.) The state protects one half of the couple's assets subject to a minimum of \$18,132 and a maximum of \$90,660. For example, if the couple's assets are \$30,000, one half is \$15,000, but the state will protect \$18,132 for the spouse. If the couple's assets are \$250,000, one half is \$125,000, but the state will protect only \$90,660 for the spouse.

Family Supplementation

Any monetary resources provided to a waiver client are considered income and are counted in determining Medicaid eligibility. Medicaid waiver clients can not be served in residential care settings, so family supplementation to pay the cost of a private room is not an issue in the waiver program.

Level of Care Criteria

Waiver applicants have to meet the same level of care criteria as nursing home applicants. To receive Medicaid coverage of nursing home care, a physician must certify that an individual needs 8 hours of licensed nursing care (RN or LPN) per day, either direct care or oversight.

PERSONAL CARE OPTION

In the 1980's, the state added personal care services to the Medicaid State Plan. At that time, only Medicaid-eligible persons residing in their own homes could be eligible for personal care services. Personal care in people's homes includes assistance with activities of daily living

(ADLs) and instrumental activities of daily living (IADLs), and is capped at 80 hours a month. Between July 2000 and June 2001, 23,661 people received Medicaid personal care in their own homes.

In 1995, the state expanded the settings in which care could be provided to adult care homes. In adult care homes, personal assistance includes assistance with ADLs and medications. Assistance with meal preparation, housekeeping, laundry, and money management is covered under the room and board payment. To be eligible for Medicaid covered personal care services, individuals must first meet Medicaid's financial eligibility criteria. However, these criteria differ for individuals in their own home and individuals in adult care homes.

Financial Criteria For Individuals Living in Their Own Homes

- Three groups are financially eligible for Medicaid:
 - *Group A* includes individuals eligible for SSI, who are automatically eligible for Medicaid with no separate application.
 - *Group B* includes individuals with incomes up to 100 percent of the Federal Poverty Level of \$749. (Effective April 1 2003)
 - *Group C* includes medically needy individuals who must spend down to \$242, the protected monthly income amount.
- Asset limits for all three groups are \$2000 for an individual and \$3000 for a couple.

Spousal Protections

No income and asset protections are provided for the spouses of persons receiving personal care services in their own homes. When spouses live together in a home, a spouse's income is counted in determining whether a person meets the income eligibility standard, according to SSI policy.

Financial Criteria For Individuals Living in Adult Care Homes

- Since 1974, North Carolina has provided a state income supplement called Special Assistance (SA) to aged, blind, and disabled persons who reside in Adult Care Homes.⁴ Special Assistance is funded jointly by the state and the counties, each contributing 50 percent. Effective October 1, 2003, the maximum monthly SSI/SA benefit for an individual is \$1,112 and the personal needs allowance is \$46 (the federal portion is \$552 and the state portion is \$560.) Couples are treated as individuals one month after entering an adult care home.⁵
- To qualify for Special Assistance, a person needs (1) to have a monthly income less than \$1,112 and (2) to reside in an Adult Care Home. The amount of supplementation a person receives depends on their income. A person who is eligible for SSI would receive \$560, whereas a person with an income of \$850 would receive \$262. The combined SSI/SA

amount, minus a \$46 personal needs allowance, is paid to the Adult Care Home for room and board and some services (\$1,066).

- Aged or disabled individuals whose income exceeds 100 percent of the federal poverty level (\$749) but is less than the combined SSI/SA amount of \$1,112 are not eligible for Special Assistance and Medicaid if they live in their own homes.⁶ The only way they can qualify for Medicaid—and thus for personal care services—is to either: (1) spend down the excess income on medical expenses to \$242 (the protected monthly income amount), or (2) enter an Adult Care Home.

Once they enter the Adult Care Home, they are not only eligible for Special Assistance, to help them pay for room and board, but they are eligible for Medicaid, which will pay all their health care costs, including prescription drugs.

- It is theoretically possible for an individual to spend down income and become eligible through the medically needy program while living in an adult care home. However, it is unlikely that this would occur because the medically needy income limit in an adult care home is the same as in a person's own home: \$242. Because this amount would not be sufficient to pay for room and board, spending down in an adult care home is not practically possible.
- The state currently has a demonstration project which is providing Special Assistance to up to 800 persons aged 18 through 64 with disabilities or aged 65 and older, who reside in their own homes but are at risk of placement in an adult care home.
- Special Assistance is also available in some counties for "certain disabled." These are adults between the ages of 19 and 65 who are living in their own homes, are unemployable because of an impairment, but have not been able to meet the Supplemental Security Income (SSI) disability requirement.

Spousal Protections

No income and asset protections are provided for the spouses of persons receiving personal care services in residential care settings. The income of spouses of adult care home residents is not counted in determining eligibility for Special Assistance.

Service Criteria

To be eligible for residence in an adult care home, a physician must certify that an individual needs the supervision and personal care provided by the Adult Care Home.

Family Supplementation

Family supplementation to pay for private rooms is currently not permitted in adult care homes or other residential care settings, but the state is considering allowing it. State provider associations are working with the North Carolina General Assembly to develop a bill.

LONG TERM CARE PROGRAMS FUNDED WITH STATE REVENUES ONLY

North Carolina combines some state funds with Older Americans Act funds into a program called the Home and Community Care Block grant that is distributed to the counties based on an intrastate formula.

II. Residential Care Settings

BACKGROUND

For the past several decades, North Carolina has depended heavily on domiciliary care to meet the long term care needs of its population.⁷ Domiciliary care was a term North Carolina used to define three types of residential care settings: Homes for the Aged (also called Adult Care Homes), Family Care Homes, and Group Homes for Adults with Developmental Disabilities. These homes are licensed by the Department of Human Resources' Division of Facility Services and monitored by county Departments of Social Services staff.

Domiciliary homes were defined in statute as any facility, by whatever name it is called, that provides residential care for aged or under 65 disabled persons whose principal need is a home that provides the supervision and personal care appropriate to their age or disability.

- Personal care is defined as including bathing, dressing, and feeding and instrumental activities of daily living such as shopping and laundering clothes.
- These homes are not permitted to provide medical care, except on an occasional or incidental basis, but they are expected to administer medications.
- These homes are to be distinguished from nursing homes. Their license does not permit them to serve persons who meet the state's nursing home level of care criteria, and so the residents of these homes, even if they meet the state's HCBS waiver eligibility criteria, cannot receive waiver services in this setting. The homes provide custodial care, and if residents needed nursing care or skilled therapies, the state covers them through the Medicaid Home Health benefit.

Prior to 1995 when the state began paying for some personal care in these homes through the Medicaid program, domiciliary care was solely privately purchased. However a significant

amount of the payments to residential care settings was publicly subsidized through the federal SSI program and the state's SSI supplement, called Special Assistance.

Persons eligible for SSI who live in domiciliary care homes are eligible for Special Assistance. Each month they receive a check, which is paid to the home. Monthly benefits for the combined SSI and Special Assistance benefit are established by the North Carolina General Assembly as the "rate" for domiciliary home care. Prior to the use of Medicaid to pay for some personal care in these homes, this rate covered room and board and custodial care provided by the home.

Introduction of Medicaid Personal Care Services in Adult Care Homes

In the late 1980's to mid-1990's advocates for elderly persons urged the state to address perceived quality of care problems in adult care homes. In particular, their concerns focused on the retention of persons requiring a nursing home level of care in these homes, who not receiving appropriate or adequate services. During the same period, the development of a new model of residential care—market-rate assisted living—had become widespread throughout the state. Advocates also urged the state to provide this new care model to elderly persons who needed services in a residential care setting.

The state convened a domiciliary care team that met for 18 months and consulted with a number of experts to assist in the development of new residential care policy. In 1994, the state commissioned a study of North Carolina Domiciliary Care Home Residents.⁸ The study found that residents in domiciliary care homes in North Carolina had significant levels of impairment, with nearly two-thirds having moderate to severe cognitive impairment. Comparisons to domiciliary care home residents in ten other states showed that the North Carolina domiciliary home residents had much higher levels of ADL impairment, cognitive impairment, and incontinence.

These findings were a major impetus for the policy decision to use Medicaid to pay for additional personal care in domiciliary homes. Other important factors included pressure from advocates to increase the amount of care provided in these homes, pressure from providers for higher payments, and U.S. Congressional discussions about block granting the Medicaid program. In response to the latter, many in the state felt it would be advantageous to draw as much Medicaid money as possible before the program was block granted.

By using Medicaid to pay for these services, the state's domiciliary care team developed a budget neutral strategy that would increase the amount of personal care provided in adult care homes and provide case management to oversee residents with heavy care needs. The state reduced the Special Assistance payment and used the savings as the state match for the new federal funding.

Because the State was concerned about the cost of the new benefit, it established three fixed reimbursement levels for personal care in domiciliary care homes—basic and two enhanced levels—to be determined by a case manager.

The Revision of Domiciliary Care Home Licensing Rules

In 1995, considerable debate occurred in the North Carolina General Assembly about the definition of the term “assisted living.” On one side were those who believed the term should only be used by facilities that provided the new model of assisted living, which offered private rooms and individualized service packages. On the other side were those concerned that a segment of the domiciliary care industry would be negatively affected if it could not also call itself assisted living. The latter group convinced the North Carolina General Assembly to define an assisted living residence to mean:

“any group housing and services program for two or more unrelated adults, by whatever name it is called, that makes available, at a minimum, one meal a day and housekeeping services, and provides personal care services directly or through a formal written agreement with one or more licensed home care or hospice agencies. The Department of Human Resources may allow nursing service exceptions on a case-by-case basis. Settings may include self-contained apartment units or single or shared room units with private or common baths.”

The legislature specifically recognized three types of assisted living residences: Adult Care Homes, group homes for persons with developmental disabilities, and Multi-Unit Assisted Housing with Services. Because the new law defined assisted living to include group housing for two or more individuals, Family Care Homes that serve two to six individuals were also included in the new definition of assisted living, and must meet the same licensing and regulatory requirements.

In response to nursing home industry concerns that adult care homes would be turned into intermediate care facilities and would admit the light care residents that were served in nursing homes, the regulations covering assisted living specify that persons with certain medical conditions, such as ventilator dependency, or individuals requiring continuous licensed nursing care, can never be served in these facilities, except when a physician certifies that appropriate care can be provided on a temporary basis to meet the resident’s needs and prevent unnecessary relocation.

One commonality in two types of assisted living—adult care homes and group homes for persons with developmental disabilities—is the ability to provide protective oversight and services to meet unscheduled needs on a 24 hour basis. In contrast, Multi-Unit Housing with Services facilities are not permitted to serve residents who require assistance at night. Multi-Unit Housing with Services facilities may call themselves assisted living, but they are not required to be licensed under the assisted living rules; they only have to register with the state.

In 1997, a moratorium was placed on assisted living facilities for three years, and in 2001, a Certificate of Need program was enacted. Continuing Care Retirement Communities are exempt because they are contractually required to provide whatever level of care is needed.

MULTI-UNIT ASSISTED HOUSING WITH SERVICES

Multi-Unit Housing with Services is a new type of residential care setting named by the 1995 legislation. However, it is more a housing model than a service model. The model was included in the legislation at the request of developers who were interested in a limited service model that did not have to be licensed or highly regulated, but could, nonetheless, be marketed as assisted living.

Because Multi-Unit Housing with Services facilities cannot have in-house personal assistance staff, they do not have to be licensed; they have only to register with the state. Although North Carolina statute defines assisted living as group housing with services that, at a minimum, include one meal a day, housekeeping, and personal care services, Multi-Unit Housing with Services facilities are required to provide protective oversight and social services only. They may choose to provide additional services such as meals and housekeeping, and they may arrange for hands-on personal care and nursing services provided by an outside agency.

Multi-Unit Housing with Services provide private residences—studios and one or two bedroom apartments with private baths and full kitchens or kitchenettes. Persons who live in Multi-Unit Housing with Services are considered to be legal tenants who live in their own rented units.

Persons living in Multi-Unit Housing with Services facilities could theoretically become eligible to receive Medicaid personal care or waiver services in this setting. However, persons who meet Medicaid's financial eligibility rules (those with incomes no higher than 100 percent of the federal poverty level or who spend down to eligibility) are unlikely to be able to afford the rent in these facilities. While some Multi-Unit Housing with Services facilities may set rents on a sliding scale, some facilities charge as much as \$1500 a month as their base rate, which does not include any personal care services.

ADULT CARE HOMES

There are three types of Adult Care Homes, all of which are licensed as assisted living facilities:

- *Family Care Homes*, which are licensed to serve two to six residents. In most other states, these homes are licensed as adult foster care homes. Many are private homes in residential areas. They are required to provide room and board, personal care, supervision, housekeeping and laundry, and “meaningful” activities.
- *Adult Care Homes*, which are licensed to serve seven or more residents over the age of 18. They provide room and board, personal care, supervision, housekeeping and laundry, and social activities.
- *Group Homes for Developmentally Disabled Adults*, which are licensed to serve two to nine unrelated adults.

The remainder of this section will focus solely on the adult care homes licensed to serve seven or more residents.

Physical Plant Requirements

- There is no limit on the number of beds in adult care homes. The current licensed capacity ranges from 7 beds to 200 or more. Most have a capacity of 40 to 60 beds.⁹
- Facilities may serve up to four residents per bedroom. Bedrooms must be 100 square feet, excluding vestibule and closet, for single rooms and 80 square feet per bed for multiple occupancy rooms. One bathroom must be provided for every five residents and a shower for every 10 residents.
- Facilities vary in the availability of private and shared rooms. Some facilities, mostly older ones, do not have private rooms unless they are too small for two residents. Others have a mix of private and shared rooms. The newer facilities have all private rooms and some with private baths, to meet the preferences of the private pay market. Because private rooms typically cost more than shared rooms, they are generally occupied by private pay residents.¹⁰

Room and Board

The state limits the amount of room and board charges only for SSI/SA recipients, an amount determined annually by the North Carolina General Assembly. Facilities are free to charge private pay residents a market rate.

Services

- The services that are provided in assisted living facilities are defined in statute and regulations and include personal care, protective oversight, meals, and housekeeping.
- The eligibility standard for adult care homes requires residents to need assistance with ADLs but not licensed nursing. Medication management is handled by medication technicians, or by RNs in facilities that have them on staff. The administrator must assure the provision of appropriate training for medication technicians.
- Persons with nursing needs can choose to stay in an adult care home and receive nursing services through either Medicare or Medicaid Home Health. Persons with certain medical conditions can not be cared for. Private pay residents may pay for additional nursing care not covered by Medicare.

Service Rates

- The state has several reimbursement levels for personal care provided in adult care homes:
 - Basic level—one hour of personal care per day.

- Enhanced level I—assistance with eating
- Enhanced level II—assistance with eating *and* toileting

The rates are based on the size of facility. In facilities with 1 to 30 residents, the basic daily rate is \$14.71, which pays for one hour of personal care. In facilities with 31 or more residents, the basic rate is \$16.11 per day. The enhanced rates are per diem add-ons to the basic rate and are the same for both sizes of facilities. Enhanced daily rates are provided when a resident needs assistance with: ambulation (+ \$2.64); toileting (+ \$3.69); eating (+ \$10.33); eating and toileting (+ \$13.18).

Admission, Retention, and Discharge Criteria, and Aging in Place

- There are provisions to protect residents from premature involuntary discharge including a mandatory bed hold policy of sixty days per year.
- A study of the state’s system conducted in 1991 found that there was considerable concern about the inappropriate placement in adult care homes of persons who needed a nursing home level of care.¹¹ The report cited a number of reasons for inappropriate placement, including,
 - Residents wanting to age in place,
 - Private pay residents wanting to avoid paying higher nursing home rates,
 - Lack of nursing home beds, and
 - Lack of nursing homes willing to admit “heavy care” residents, i.e., those needing tube feeding, oxygen, or decubiti care.

Several respondents believe that the same reasons for inappropriate placement apply in 2003.

III. Summary of Interviews

In addition to consulting with 9 state staff and policy makers regarding the technical details of the state’s programs, we also interviewed four of them. In addition, we interviewed 9 stakeholders, including representatives of assisted living provider associations, consumer advocates, a former county service administrator, and two university-based policy analysts, one of whom previously worked for the NC Department on Aging.

The interviews focused on respondents’ views about several key areas and issues. This section summarizes their views and provides illustrative examples of their responses. These comments are not verbatim quotes, but have been paraphrased to protect the respondents’ anonymity and edited for brevity. A list of information sources for the state description and the individuals interviewed can be found at the end of this summary.

GENERAL COMMENTS ABOUT THE STATE'S RESIDENTIAL CARE SYSTEM

Because many of the same residential care facilities serve both private pay and Medicaid residents, most respondents expressed views about the industry as a whole.

A few stated that the state's residential care system provides options for those with the money to pay privately and for the very poor but not for elderly persons with low to moderate incomes.

- *There is a huge middle group of people who can't pay for the expensive places. There is a big unmet need for places between the high end and the low end. The new Multi-Unit Housing with Services model is for those who can't afford high end assisted living and it works well for people who can direct their own care or who have someone to provide oversight, and who can afford to pay extra for overnight unscheduled needs.*
- *Assisted living for the private pay market responded to people's desire for options and control. If public funds are paying for the majority of long term care—we need to fund the system people want.*

Two respondents expressed views about the state's Certificate of Need program for assisted living facilities, one noting that it needed to be better targeted.

- *The Certificate of Need program does not distinguish between different models of assisted living, or between non-profits and for-profits. There is a cap on beds by county, but there is a shortage of beds for people who are difficult to place, such as people with HIV AIDS or behavioral problems.*
- *The industry supports the Certificate of Need program because it reduces competition; over-bedding is considered a problem by some in the industry because it costs a great deal of money to maintain unoccupied beds.*
- *When the state established the moratorium on assisted living facilities, industry lobbyists supported it saying they didn't want competition, and it would save the state money. They got the moratorium, but a number of developers came in under the wire—with 14,000 beds. There is probably some overbuilding and bankruptcy—some facilities are struggling to find residents.*
- *The Certificate of Need program does not distinguish between different types of beds. There could be a county that has only two very old facilities in which no one wants to live. If someone wanted to build a better adult care home in that county, as long as the existing facilities had vacancies, the permit would be denied.*

One expressed concern about the lack of oversight of Multi-Unit Housing with Services facilities

- *No one in North Carolina knows how many Multi-Unit Housing with Services units there are and how many people are being cared for in them. They are required to be registered, but there is no oversight of these facilities.*

Others criticized the state's moratorium and Certificate of Need program for nursing homes.

- *The nursing home Certificate of Need program has had a negative impact on consumers. There are not enough nursing home beds and people who should be in nursing homes wind up in adult care homes.*
- *When North Carolina had the moratorium, for the better part of a decade there were no new nursing home beds in North Carolina. During that time there was a large increase in domiciliary care home beds. In effect, these beds substituted for nursing homes. Then in the early 1990's there was a large rush to build assisted living facilities that would cater to the private pay market. This was disconcerting to the traditional homes who depended on some private pay residents.*

One mentioned that the overbuilding of market rate assisted living facilities could result in a larger number of Medicaid clients being served in these newer and "nicer" settings.

- *Very few market rate facilities take Medicaid clients. In one county, the developers had to pay such a steep price for land that their debt service is very high. They overbuilt the market—in one year over 20 facilities went up—now there are too many beds, which could lead to their taking Medicaid residents.*

GENERAL COMMENTS ON MEDICAID'S ROLE IN RESIDENTIAL CARE SETTINGS

Many respondents were very pleased that the state is using Medicaid funds to provide personal care to residents of adult care homes and felt it improved the quality of care. However, while there is a general sense that Medicaid coverage resulted in some quality improvement, some believe that the adult care home population is becoming more and more impaired, and that the homes are not able to provide the level of care residents need.

- *The introduction of Medicaid in 1995 did change things because more people are paying attention to people in these facilities. The residents are now seen by social workers and advocates—more people are in and out of the facilities—so the spotlight on these places has led to some improvement. The more people paying attention to very isolated residents with no family the better.*
- *Introducing Medicaid personal care services into adult care homes was a cost- savings measure. It had very little to do with expanding services, options, or choice.*
- *The primary purpose was to shift costs to the feds. It had the added benefit of increasing training and staffing requirements.*

- *The advantage of having Medicaid in adult care homes is that it provides a dedicated revenue stream for the direct care part of adult care home costs. It allows the state to see if Medicaid dollars are being fairly utilized and if the rates are reasonable for the workload.*
- *Bringing Medicaid into adult care homes was viewed as a means to keep people in domiciliary care safer, and some hoped, to bring more federal oversight of these homes, based on the Medicaid funding.*
- *The state did the best it could at the time—putting more money into the homes to take care of the residents. Some in the state see it as only a temporary solution, and that the state needs to continue looking for better ways to serve the population in adult care homes.*

Others are concerned that the state is using limited resources inefficiently by providing nursing care to this population through the Medicaid Home Health program.

- *Providing nursing care to assisted living residents through Medicare or Medicaid Home Health programs is an extremely inefficient way to provide nursing services to people in residential care facilities when large numbers of people need nursing services. This approach also does not meet all of the residents' nursing needs.*

One respondent mentioned that the state had at one time looked into using the private pay model of assisted living for waiver clients.

- *The state's Housing Finance Agency received a grant under the Robert Wood Johnson's Coming Home Program. The purpose of the Coming Home Program is to encourage the development of affordable assisted living in rural areas. At that time, the Agency was interested in developing an affordable version of private pay assisted living with private rooms and baths and locked doors for persons eligible for SSI and Medicaid. To make this model financially feasible requires both housing subsidies to finance construction and Medicaid coverage to finance services for all the residents.*

The plans were dropped when the state could not guarantee that everyone residing in the facility would be able to receive services, even if they met Medicaid eligibility criteria, due to waiting lists for services and the freeze at the time on North Carolina's waiver program.

One stated that she had opposed allowing waiver clients to receive care in assisted living.

- *If you use the waiver, then the residents must meet a nursing home level-of-care criteria. This would encourage the industry to operate unlicensed nursing homes.*

One noted that not all facilities accept Medicaid residents and discussed some of the reasons for this.

- *There are three types of assisted living facilities (1) those that will take Medicaid if the person has spent down in the facility. A very small percentage will take folks who've spent*

down after 18 months in the facility; (2) those that have no interest in taking Medicaid and take private pay and once you can't afford it you're out; and (3) those that accept both spend down folks and Medicaid admissions—but the available beds are limited.

A disincentive to taking Medicaid residents is that the facilities have to provide cost reports to the state even if they have only one Medicaid resident in a 100 bed facility. Some providers have a huge number of buildings, but there is little movement to accept Medicaid to fill the beds. They are targeting a specific population—elderly folks with the means to pay. Facilities that take Medicaid generally set a percentage of Medicaid beds for their facility. About 35 percent is all you can have on Medicaid. Some facilities are 100 percent Medicaid but they can't provide anything above the bare minimum.

LICENSING AND REGULATORY REQUIREMENTS

Many respondents—both providers and consumer advocates—expressed concerns that the licensing category of assisted living was too broad and created problems, both for consumers and for facilities that provide the new model of assisted living.

- *The state's licensure category is too broad. In the battle that occurred before the new law put all types of adult care homes under one term, I was on the side that assisted living in its purest sense should have been for the frail elderly. If the state is going to use it for all adult care homes, then at least we need separate classifications for homes that serve different populations: the frail elderly, the seriously mentally ill (SMI), and the developmentally disabled (DD).*
- *There was a push by some providers to call everything assisted living—now we have the same regulations for facilities that have 35 year old seriously mentally ill folks and for frail elderly playing bridge all day. Very generic rules; they don't work. It's a disservice to the general public who don't know what's going on. We get lots of inquiries asking about homes and they are given a list and not told that it's a mixed facility. Providers should be given the choice for different licensure requirements and marketing. Combining everyone into one category is a big disservice. I get calls from families who are looking for assisted living for their mothers, and they go to facilities with SMI and DD folks, and call me crying, saying I can't put my Mom there. Then we have to explain that there are some assisted living facilities that serve only the frail elderly.*
- *The public is confused about long term care options. They don't understand the difference between residential care facilities, nursing homes, and assisted living. They also do not understand the difference between skilled and intermediate care, particularly the difference between eligibility requirements and staffing requirements.*
- *In North Carolina, assisted living is nothing but a marketing term; a lot of so-called assisted living is just like institutional care. Many adult care homes look just like nursing homes.*

Most of the rooms are dual occupancy, few have private baths, and none have locked doors, but they can call themselves assisted living just like the \$4000 a month Sunrise assisted living facility in Raleigh.

- *Assisted living in North Carolina does not necessarily mean a studio or apartment with a lock on the door. The domiciliary care industry decided that the words assisted living made them more marketable so they repainted their signs. There may be exceptions, but on the whole it's just a new name for an old program.*
- *Assisted living should mean privacy plus a la carte service options plus the ability to stay and receive additional services as your care needs increase. You don't get that in adult care homes. The private pay folks get it in high end assisted living.*
- *Some people in the state are interested in developing affordable models of assisted living that have private rooms and baths, but it can't be done without the assurance of Medicaid funding for services. With the freeze on the waiver program, it's simply not feasible at this time. If the time comes when we can do, given that North Carolina now uses the term assisted living generically to cover a wide range of facilities of varying levels of care and quality, we would not call it assisted living.*

A few respondents raised serious concerns about quality and safety.

- *Regulations are always minimum health and safety. In the county where I worked, there was a home chronically doing terrible things—violating rights—didn't have food. We documented everything—breakfast—no one there—cook gone to get eggs and milk—nothing in larder—they are supposed to have several days supply of food. Even with media attention—change doesn't happen. People who care get burned out.*
- *When the state authorized the use of the Medicaid Personal Care option in adult care homes, there were concerns about how the extra money was going to be used. The industry had gotten a 10 percent increase. Advocates felt that the extra money should be used to increase staffing (the regulations at the time only required one staff person per 20 residents and 1 to 50 at night).*

Shortly after, there was a fire in a rest home and 7 men died of smoke inhalation (the staff were in the women's wing). There was no sprinkler system. A Governor's Committee was established to look at the issue. The media found out that the people who died were not ambulatory, and that the regulations really applied to a less impaired population. Consequently, there was an increased focus on this issue. Some members of the Governor's Committee insisted that there be a performance standard that if people couldn't evacuate, the facility had to have a sprinkler system, but it was not enacted. There was also a motion to reduce the number of high level needs folks in these homes, but it wasn't allowed to come up for a vote. A positive result of the Committee's works was that the staffing ratio was reduced from one to 50 to one to 30. But how can one person help 30

people to evacuate in the case of a fire? The new facilities have sprinklers, but a lot of older facilities without them were grandfathered.

Staffing

Several expressed concerns about inadequate staffing.

- *Insufficient staff is the key quality issue. We were involved in the effort to change the requirements for staffing ratios for the 11-7 night shift, effective in 2000. Prior to the change, it was only one personal care aide per 50 residents. Now it's one to 30 on the night shift, and one to 20 on the other two shifts.*
- *We need more staff in adult care homes but I don't know if putting more Medicaid money in is the answer. We are just starting to learn about the actual costs of these homes. We've had so many studies, but I'm not sure that we have a sense of what the actual costs are.*
- *Staffing needs to be based on care needs, not a ratio of 1 to 20. If people are heavy care then 1:20 is totally insufficient. We need an assessment form and a point system to determine what people need.*

One respondent noted that it is difficult to recruit and retain good staff.

- *Workers in adult care homes do not receive a living wage and less than 25 percent of workers get any kind of benefits. They spend a lot of time applying for government benefits: health insurance and food stamps. If the industry doesn't pay enough so that their staff are not eligible for food stamps, then the federal government is subsidizing these businesses.*

Others expressed concern about inadequate enforcement of new training requirements.

- *New regulatory requirements for increased staff training have not been enforced. Adult care homes are not held accountable for the additional funding they received to provide this training.*

Medication Administration

Several raised concerns about quality issues relate to medication administration.

- *There is a lot of concern about the administration of psychotic medications and medication errors. Some homes have nurse and pharmacy consultants; others don't. Daily supervision of medication administration is not there.*
- *A facility I visited, which had mental health clients, put the residents' medications in the spoons on the dining room table that was set for lunch. There were no names by the spoons. When I asked about this, the staff told me that the residents knew which pills were theirs.*

- *Many residents are cognitively impaired and the complexity of medication regimens has led to the need for medication management. The statute defining domiciliary care homes states that one of their responsibilities is to administer medications. But assisted living settings are exempt from the North Carolina controlled substances act based on the assumption that persons in domiciliary care homes are self-medicating.*
- *There are lots of medication problems in North Carolina. Until a few years ago you didn't even need a competency test to do medications. One found medication error rates in the 20 to 40 percent range.*

National Standards

A few felt that national standards could be useful as long as they are put forth as a model and not mandated.

- *National standards can be used as a platform to build on. We do not want national regulations. With regard to disclosure requirements, a model would be helpful, but it should not be required.*
- *We can handle regulations at the state level. Model regulations could be helpful. But until North Carolina separates our adult home populations—stops mixing types of residents—I guarantee that model regulations won't help.*
- *It would be very helpful to consumers to have a rating system for adult care homes because it's so hard for them to evaluate what's available. It's much easier in the nursing home. A model of quality would be a good thing, and a system to measure how individual providers stack up against the model.*

Outcome-Based Regulations

A few respondents stated that the regulations are too rigid and need to be more person-centered and outcome based.

- *The regulations are too prescriptive. They look at pieces of paper rather than outcomes. It is easier to check off a chart than visit the residents. The surveyors ask, did they have a bath? They don't have a person-centered process. We need to look at outcomes. For example, with regard to diet, we should ask is the person gaining or losing weight, are they happy with the meals? We can serve them a nutritious meal, but if they don't like the food they won't eat much and they will lose weight. Same thing with hypertension. We can't have salt and pepper on the table because one resident may have hypertension, so everyone walks around with their own salt shakers. We need to spend more time taking care of residents and less time taking care of paper.*
- *The rules are not flexible, which is especially important when caring for people with dementia. There is a regulation that says there must be a minimum of ten hours between*

breakfast and dinner. But this doesn't account for people who like to sleep late. If someone wants to eat at 9, then technically we can't give them dinner until 7 PM. But a lot of people want to eat between 5:30 and 6:30. A building was cited last week for this—a dementia unit. One of the residents sleeps late, eats a late breakfast and nibbles all day and wants dinner at 5:30 PM because that's the time they have always eaten dinner. They were cited for not meeting the 10 hour rule.

One noted that when looking at regulations, consumer advocates need to distinguish between the majority of providers who are doing a good job, and the few providers who are not.

- *Consumer advocates would like to see regulators walking around with a stick. They paint all providers with the same brush. It doesn't help when they come to the rules review committee and say we need a new rule to address one issue at one home.*

ADMISSION AND RETENTION REQUIREMENTS, AND AGING IN PLACE

One noted that the aging in place philosophy is not so easy to implement.

- *Aging in place policy is a conundrum. There will always be people who need to be in a nursing home and so we need a different model of care at the nursing home level—that's the ultimate goal to work towards: resident-centered models of care that can provide skilled care without the institutional and warehousing look and feel.*

Some felt that while retention requirements needed fine-tuning, it was not a good idea to have rigid requirements as in nursing homes.

- *Discharge and transfer policy needs more work. I believe discharge regulations need to be more flexible than in nursing homes where they have rigid distinctions between an ICF and a SNF level of care. Some homes want only the frail and some market to those with more acute needs. It's important to remember that some facilities with a specific area of expertise want to market to a particular group. It's a private business. The advocacy groups and ombudsman want to rigidly define discharge requirements but I will oppose this. The variety and ability to be creative has made our assisted living good.*
- *Many facilities have not bought into aging in place. To protect the public and families—we need to move away from the idea that everyone can age in place. You need full disclosure when someone enters a facility so there are no surprises down the road. There are limitations on tenancy. People have to choose a facility knowing that they may not be able to stay there forever. They just have to enjoy it as long as they can.*

One felt that while flexibility is desirable, parameters are needed.

- *The assisted living umbrella is too big. The state needs to tighten up admission and retention requirements but not so much that consumers don't have choices. You need*

different types of licensing. The public is not served well—they have no idea what the umbrella term of assisted living covers. You want flexibility so people have choices, but you need parameters.

At the assisted living level, there is considerably more variation than at the nursing home level. There are very tight definitions of services at the independent living level and in nursing homes with most of the variation in the level of care at the assisted living level. They are given so much leeway. Some homes say they can do much more than they deliver. Some don't want residents to be too dependent, some will accept people with multiple needs, yet they are all licensed under the same standard. Mental health issues are major.

Many of the respondents expressed a wide range of concerns about the ability of adult care homes to meet the needs of its residents. Most concerns related to homes keeping people beyond the point where they should be discharged.

- *As the requirements for SNFs and ICFs have become more stringent, and nursing homes have become more focused on subacute residents, a lot of people wind up staying in lower levels of care far beyond the capability of those levels to provide the care that is needed. These places don't provide adequate staff training and don't have required coverage ratios. But they keep the residents in order to keep the beds filled and because it's difficult to find a nursing home bed for a Medicaid beneficiary. Nursing homes are under a Certificate of Need program—so nursing home growth has been constrained. So the situation is affected by two things—lack of beds and higher acuity hospital discharges.*
- *The State does not have a good system in place to assess residents of Adult Care Homes to be sure their needs continue to be met as they age.*
- *Adult care homes tend not to take people with certain disabilities. They want people they can manage with limited assistance and oversight. But as they age, their needs increase, and some homes do try to accommodate them to the best of their ability. But others take whoever they can get—and the residents get minimal custodial care.*
- *I am particularly concerned about inappropriate placement of persons with SMI. Residents with serious psychiatric problems are retained because it is very difficult to get people into the geriatric wards in the state psychiatric hospitals. The state needs to conduct a study to determine the extent of inappropriate placement of people with SMI, particularly in response to Olmstead.*
- *In some states the nursing home occupancy rate has been dramatically reduced but not here—we still don't have enough beds. The easiest way to get into a nursing home is from a hospital—paperwork is done—Medicare will pay. When we tried to place folks from home, like an Adult Protective Services case, it was very difficult—even if they had a bed—too difficult to admit. Coming from the hospital, they know what medications the person is on*

and whether they have a catheter. Nursing homes don't want to accept the unknown— maybe because they have had very difficult residents or very heavy care folks placed by county folks with no forewarning. It could have made them reluctant to trust the information provided on cases seeking admission from the community.

- *The adult care home client is basically the old ICF nursing home client. We have people in adult care homes in North Carolina that would be in nursing homes in other states.*
- *Prior to 2000, assisted living residents did not have some of the same rights and protections that nursing home residents have. If you were a resident of assisted living, you could be discharged with no notice for no reason. A bill enacted in 2000 gave assisted living residents the same rights as nursing home residents: they can't be discharged without 30 days notice. Basically, the bill applied existing North Carolina law regarding nursing homes to assisted living residents. However, implementation has been problematic. The regulatory body has issued regulations and there has been a lot of discussion about changes in the level of care. Facilities are saying that when there is a change in the level of care designation by the MD on the eligibility assessment form, then it's immediate jeopardy and the 30 day notice doesn't apply.*
- *Residents may desire to stay because it's a familiar setting. Most homes are for-profit businesses so occupancy rates play into this. If they have 100 percent then they look to skim the cream.*

One made a distinction between the need for protections for residents with and without families.

- *Many discount the intelligence of family and residents but they are better regulators than the state. But residents without families who live in adult care homes need different standards.*

Some expressed concerns about the level of nursing care needed by residents in adult care homes.

- *If Catherine Hawes' 1991 study was repeated today, it would find that people need two hours of care a day not one hour.*
- *There are people in adult care homes who need nursing care and it is provided either through the Medicare or Medicaid Home Health benefit. However, providing nursing care through these benefits one-on-one is very expensive. But if you allow these homes to provide health care, then you will have unlicensed, substandard nursing homes. There is a lot of money in the system but it is not focused on getting needs met in the right way.*
- *Many of the current residents of adult care homes in the past would have been in ICF nursing facilities. The old ICF nursing homes had LPNs and there was LPN supervision of aides, and nursing care was provided. Although Adult Care Homes are not licensed to provide nursing care, there is probably no difference in the type of residents they serve. People in private pay assisted living facilities may also be inappropriately placed from the*

perspective that they meet the nursing home level of care criteria. However, people in these places can pay for as much care as they can afford.

Negotiated Risk Agreements

Most respondents had not heard of these agreements or any issues related to them. One felt that the state needed to provide more guidance to providers regarding their use, predominantly in private pay assisted living.

- *Some facilities are using them. They get forms from their national associations and get their attorneys to review them. They deal with things like wanting rugs in their rooms that could pose a fall hazard, and diabetics who want to eat apple pie. The state can cite you for not enforcing special diets. It would be helpful if the regulatory agency identified areas that are not appropriate for shared risk agreements. The state should help to define parameters for shared risk agreement. The county monitors also need to understand them.*

SERVICE RATES

A few mentioned the need for a different rate system than the current one.

- *A case mix system would be preferable over what we have now: a fixed Special Assistance and Medicaid rate. The basic service rate is too low and the enhanced rate is minimal. There has been no increase this year and increases in the past year have not equaled what the cost reports said it should pay. With a case mix system, you could track expenditures to determine whether a resident did in fact get the service that the provider is reimbursed for.*
- *We must assure that the public system supports and demands quality from providers. Medicaid payment is totally inadequate for the level of care required. It pays for one hour a day and the rate for that hour is too low. \$270 per month for one hour a day, plus a little more if enhanced care. There is no direct requirement that all Medicaid money for direct care staffing be actually paid for direct staffing.*
- *Rates are inadequate. Since 1995, the state has used a cost reimbursement method based on cost reports—averaging, a state wide average. Using one rate for the whole state has its plusses and minuses. There are no incentives for those who aspire to a higher level of quality care. We need a case mix system. Then you are paying for the amount of care someone needs. Under the current system, there is no incentive in the reimbursement system to take heavy care residents.*
- *The biggest quality issue is staffing and the Medicaid rate for direct care workers is not adequate. We give the staff too heavy a workload, too many residents to care for in a limited amount of time. Is it fair to the workers and the residents? Medicaid should require that you have to pay staff adequately, using a case mix model to assure that residents' needs are met.*

One mentioned that the Medicaid rates in adult care homes are not sufficient to provide care to persons with dementia.

- *The state does not pay a sufficient rate to take care of people with dementia in special care units. Special care residents don't qualify for the enhanced personal care rate—because Medicaid only pays for hands-on physical assistance. Cueing and set up takes more time than doing something for the resident. So we encourage dependence. Without a case system, we will not get designated funding for dementia and this population gets ignored.*

SUGGESTED CHANGES TO IMPROVE THE MEDICAID-FUNDED RESIDENTIAL CARE SYSTEM

Respondents had numerous suggestions for improving the state's residential care system generally, and Medicaid specifically.

- *We need adequate reimbursement for dementia care, more outcome oriented regulations, and providers need to give full disclosure about what is and is not provided.*
- *We need more congregate housing with private rooms. We're looking how to convert existing bricks and mortar—we need specialized housing for persons with disabilities and those with cognitive impairment that is a notch above what's available in our adult care homes for persons on public assistance. We would like to provide private rooms with a bath and kitchenette and round the clock support.*
- *We do not need more residential care beds in North Carolina. We need to upgrade the beds we have. There are a number of old facilities that are substandard.*
- *We have plenty of beds and facilities, what we need now is better living conditions.*
- *What North Carolina needs is a better mechanism for managing the long term care needs of all the populations we serve. Currently, our system is very fragmented. Too many agencies have responsibility for different pieces of the system: the Division of Facilities Services, the Division of Social Services, the Division on Aging. The state has been looking into ways to consolidate—trying different approaches—to manage funds on a need basis rather than program category, but it constantly faces opposition. There are too many players. No one argues with what needs to happen—they argue about who will do what and who will have control. Each department needs to be better consolidated. It will happen eventually, but not for at least five years.*
- *The state needs a designated funding stream for dementia special care. There are very few Medicaid clients in these units because there is just not enough money. About three years ago there were new dementia regulations, which providers fully supported, and the state said that money would be available but it didn't happen. The model is so cost prohibitive*

that Medicaid folks can't be in it—so they get transferred to a nursing home because they can't afford a special care unit, which provides extensive cueing and supervision.

A few mentioned that adult care homes should serve homogeneous populations, and that the state needed different regulations to assure the quality of care for the different populations.

- *I don't believe in mixing diagnoses in one building. We need to separate the populations. Have separate licensing categories by type of population served.*
- *The market should call for more specialization of clients in adult care homes, and hopefully the industry and policy makers will push it—create rules to not mix types of clients (e.g., putting the young SMI with the elderly.)*
- *There should be separate licensing standards for adults with serious mental illness than for the frail elderly. These populations have very different needs.*
- *Some homes serve a heterogeneous population: Younger SMI and DD and the elderly all together. There are still stories in the media about the non-vulnerable preying on the vulnerable—rapes and even murder.*

A number stated that the state needed better assessment procedures and data for a number of purposes.

- *It is very difficult for the state to figure out exactly what it should be doing because they do not have sufficient data to make decisions. The state does not have a good assessment procedure. The form currently used is only two pages and is not appropriate for care planning. The state needs an appropriate assessment instrument to better understand the needs of those being served.*
- *The State's Department of Social Services has been working to develop and automate an assessment form for three years. It is costing millions and it is still not completed, but the General Assembly will be cutting funding for this project.*
- *There are two questions in North Carolina—are adult care homes being paid enough and what are they doing with the payments they receive? Getting data from the homes after they started getting Medicaid money was like pulling teeth.*
- *The Department of Human Services has consultants who are looking at reimbursement for all long term care facilities. They're having no problem making recommendations for nursing homes and ICF-MRs because they have the data for these facilities. But they don't know what to recommend for residential care because they do not have adequate data. The state hopes to have the data from adult care homes computerized by 2004.*

Two respondents said the that the state needed to better utilize Medicaid funding, noting that North Carolina has a 64 percent match, and the Special Assistance payment is all state and county money.

- *The state should use Medicaid to broaden coverage, specifically for the MRDD, SMI and dementia folks.*
- *If the type of care that could be provided in assisted living facilities were increased, then they could fund more of the care costs under Medicaid.*

Another expressed concern about cuts in the state’s Medicaid budget.

- *The most important issue we are dealing with now is opposing proposed cuts in the Medicaid program, specifically, a proposed across the board decrease in the service rates for all providers.*

A number said that the state needed to better support home care.

- *People shouldn’t have to go into an adult care home to get Special Assistance and Medicaid.*
- *North Carolina has rules allowing spousal separation of income that make it relatively easy for a moderate income household to qualify one member for nursing home benefits without impoverishing the community spouse. Similar generosity is not provided for those applying for waiver services.*

Several noted that the state should permit family supplementation in assisted living settings to pay for private rooms.

- *It would be great if families were permitted to pay the difference in cost between a semi-private and private room in assisted living for folks on Medicaid. But there are concerns about equity. Providers may give priority in admissions to those whose families can supplement.*
- *There are an increasing number of requests for information about SSI/Medicaid and family supplementation from market rate assisted living facilities who have residents who have spent down and they want to see if they can figure out some way to keep them.*
- *Provider associations are getting more calls about this issue than ever before. People have spent down in market rate assisted living and they have to move to an adult care home and the family wants to supplement their income to pay for a private room.*
- *When private pay folks with dementia are in special care units and their resources run out—families often pay the difference in cost between the regular rate and the special unit rate, which is about \$600 a month.*

One noted that even continuing care retirement communities (CCRC) have requested information on how to keep private pay residents who have spent down.

- *A CCRC called the other day and wanted to know how to deal with spend downs. We told them that they have to become a Medicaid Provider and be licensed by DSS, then their residents will be eligible for a state supplement if they meet asset and income tests.*
-

FUTURE PLANS

- *The state is planning to move from a tired rate for Medicaid personal care in adult care homes to a case mix reimbursement system that will be based on assessed needs. The state wants an assessment to determine what someone needs and how much the state should be paying for services. The state thinks it is paying too much for some and not enough for others. The state is waiting to get the assessments of Medicaid enhanced care (required since 1996) computerized to do the data analysis needed to support a case mix reimbursement methodology.*
 - *A number of stakeholders are working with the General Assembly on a bill to allow family supplementation in assisted living facilities.*
-

RECOMMENDATIONS FOR OTHER STATES

- *The boundaries between the new model of assisted living and old forms of residential care are very squishy. How do you regulate a philosophy? What Keren Brown Wilson did in Oregon when she was a hands-on manager is one thing. But when it goes beyond mission driven entrepreneurs into the market place it turns into something else. North Carolina has played it out and we haven't done it well. The Keyes amendment is the only way the feds can weigh in.*
- *North Carolina provides a good example of what not to do. Don't put people who should be in nursing homes into assisted living settings that can't meet their needs.*
- *The big issue states have to think about is that we don't know how to care for very impaired people without a professional component. We don't know how to regulate the settings that provide this care. We don't know what to replace the current regulations with.*
- *In looking at what the states are doing in residential care with Medicaid you have to realize that states are starting from very different places. Oregon was very serious about deinstitutionalization, but its very important to remember that because of the nursing home moratorium, North Carolina had a very low nursing home supply—maybe 35 beds per 1000 people age 65 and older. When Oregon started, they had more than the average—approximately 50 per 1000. When Oregon started to change their system, they had less than 5000 domiciliary care beds; at the same time, North Carolina had 30,000.*

North Carolina had already bifurcated the population—the people in nursing homes were very impaired, and the ones in rest homes—while they may have started out less impaired—were getting more and more impaired. So in effect, North Carolina already had the situation that Oregon was aiming for. North Carolina had difficulty discharging folks from hospitals due to lack of nursing home beds. But people in North Carolina and consumers—older people with family looking for nursing home care—they have not been in favor of decreasing nursing home beds—so consumers said: give us something besides nursing homes—if the occupancy rates are so low—how low can you go and still give consumers a choice. We had virtually 100 percent occupancy. No consumer choice. The nursing homes were going to take some heavy needs patients but not that many. So for a heavy needs person to get placed, someone else had to expire or be transferred. The only place where there was movement was on the adult care home side.

Theoretically, people who meet the nursing home level of care criteria should not be in domiciliary care. There are big issues to consider on the health care side. Moving to a lower level of care shouldn't mean abandonment of health care standards. You need to keep costs manageable, but you also need to assure that people receive the health care and medication management that they need. North Carolina provides a good example of what happens when you serve a lot of folks in a lower level of care than the nursing home. You might have a private room, but if you don't pay enough for services, then people will not get good quality care. Other states should understand all these things before they move forward.

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Formal and Informal Interviews

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Judy Walton, Administrator of Managed Care for Seniors
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Susan Williamson, President and CEO
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Medicaid Eligibility Unit
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Lou Wilson, Executive Director / Facility Operator
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 ENDNOTES

¹ Gregory, S.R. and Gibson, M.J., *Across the States: Profiles of Long Term Care*. Public Policy Institute, AARP, November 2002.

² Prior to 1995, North Carolina (North Carolina) was a 209(b) state and had the option of using more restrictive financial eligibility criteria than that of the Supplemental Security Income (SSI) program to determine financial eligibility for Medicaid. During this time, persons who were eligible for SSI, either because they were disabled or 65 years or older, were not automatically eligible for Medicaid, as they were in most states.

Individuals could become eligible for Medicaid by spending down to \$242, or \$317 for a couple. Resource limits were also more restrictive than SSI. The one exception to this income standard was linked to receipt of the SSI state supplement, called Special Assistance (SA), which was provided only to individuals residing in adult care homes.

In January 1995, the state began covering all SSI recipients under Medicaid, and in 1999 increased the income standard to 100 percent of the federal poverty standard. This standard is used to determine eligibility for all long term care services in the state, including nursing homes. The state also has a medically needy program.

³ As permitted under the §1902(r)(2) less restrictive income methodologies, the state excludes wages paid by the Census Bureau for temporary employment; it also does not count the following: personal effects & household goods; life estate interest and tenancy in common interest (except for optional state supplements); burial plots; cash value of life insurance if the total face value does not exceed a specified amount.

⁴ At a county's option, blind and disabled adults who are not eligible for SSI may also receive a supplement in a private living arrangement. They are covered under "certain disabled" provisions but receipt of the SA does not confer Medicaid eligibility as it does to individuals residing in Adult Care Homes.

⁵ In August 1995, the combined SSI/SA payment was lowered from \$982 to \$800. The savings were used to provide the state match for the new Medicaid personal care benefit. The reduction resulted in some people in adult care homes not meeting the Special Assistance income eligibility criteria, and thus losing Medicaid eligibility. However, the state grand-fathered them for continued coverage.

⁶ There are some exceptions, a discussion of which is beyond the scope of this report.

⁷ The information in this section draws heavily from Elise Bolda's report: *Initial report on North Carolina domiciliary care policy*. The Long Term Care Resources Program, Duke University Center for the Study of Aging and Human Development (1991).

⁸ Hawes, C., Lux, L., Wildfire, J., Green, R., Packer, L. E., Iannacchione, V., and Phillips, C. *Study of North Carolina domiciliary care home residents*. (February 15, 1995). Report submitted to the North Carolina Department of Human Resources.

⁹ One respondent noted that some owners believe a minimum of 60 beds are needed to make a profit.

¹⁰ One respondent stated that people on Medicaid could not afford private rooms because Medicaid only pays for services, not for lodging.

¹¹ Elise Bolda's report: Initial report on North Carolina domiciliary care policy. The Long Term Care Resources Program, Duke University Center for the Study of Aging and Human Development (1991).

Appendix E

Oregon

Oregon

The information in this appendix is presented in three major sections:

- The first section provides an overview of the state's long term care system, with a primary focus on the Medicaid program. Although a state may pay for services in residential care settings through the Medicaid program, the program's financial eligibility criteria and related financial provisions for home and community services can present barriers to serving Medicaid clients in these settings. Thus, the first section of each state's description presents detailed information about rules related to financial eligibility, spousal financial protections, and cost sharing requirements.
- The second section describes the state's residential care system.
- The final section presents the views of respondents interviewed for this study on a range of issues related to Medicaid coverage of services in residential care settings in their state.

Because the information in the first two sections is intended to serve as a reference, some information is presented under more than one heading to reduce the need for readers to refer back to other sections for relevant information.

Unless otherwise cited in endnotes, all information presented here was obtained from the sources listed at the end. Supplemental Security Income levels, the federal poverty level, federal spousal protection provisions, state supplemental payments, and state reimbursement rates are for 2003, unless otherwise noted.

I. Overview of Long Term Care System

Oregon requires most elderly and disabled Medicaid beneficiaries to enroll in managed care. They receive their Medicaid-covered acute care services through a managed care plan, as well as certain services, such as home health care. Nursing home care, residential care, and most in-home services are carved out of the managed care initiative and remain in the fee-for-service system.

NURSING HOMES

Oregon has a statewide nursing home pre-admission screening process. Individuals who enter a nursing home are approved for varying lengths of stay, depending upon the reason for admission and the likelihood of, and timetable for, improvement, and are reviewed periodically to evaluate their potential for discharge to the community.¹ Because the state has a "mature"

long term care system that is widely known among community organizations, service providers, referral sources, families and consumers, it has a strong capacity to divert people from nursing homes.²

Financial Criteria

- There are two groups financially eligible for nursing home services:
 - *Group A* includes individuals who are eligible because they are receiving SSI, or they have incomes no higher than the SSI/SSP level.
 - *Group B* includes persons with incomes up to the special income standard of 300 percent of SSI, which is \$1,656. This group must spend all of their income (minus a personal needs allowance and other permitted deductions) on nursing home care before the state will begin to pay.
- Asset limits for both groups are \$2,000 for an individual and \$3,000 for a couple when both members of the couple are in a nursing home. When only one member of a couple applies and there is a community spouse, spousal impoverishment protections apply.
- The monthly personal needs allowance is \$30 for individuals and \$60 for couples.
- Because Oregon does not have a Medically Needy program,³ in accordance with federal law, categorically eligible individuals in need of nursing home care—whose income exceeds the special income standard but is insufficient to cover the cost of care—may place income in excess of the special income level in a Miller Trust, and receive Medicaid coverage for nursing home care and other Medicaid state plan services.
- Federal Medicaid law requires states to have estate recovery programs, which allows the states to claim assets, such as a home, that could not be counted when calculating eligibility. Oregon has the nation's most effective estate recovery program, in 1997 collecting nearly 5 percent of its Medicaid nursing home expenditures, far more than any other state.⁴ In 2002, the state collected an average of \$1 million a month.

Spousal Protections

- Community spouses may keep any income in their own name, and the state allows the institutionalized spouse's income to supplement the community spouse's income up to \$1,515 per month.⁵ Community spouses are also allowed additional amounts for rent or mortgage payments (including insurance and taxes) and are permitted a standard utility allowance.
- Community spouses may keep the higher of either the first \$18,132 of total nonexempt assets or one-half of the total non-exempt assets owned at the time care began, up to the maximum protected resource amount of \$90,660. For example, if the couple's assets are \$30,000, one half is \$15,000, but the state will protect \$18,132 for the spouse at home.

If the couple's assets are \$250,000, one half is \$125,000, but the state will protect only \$90,660 for the spouse at home.

Family Supplementation

Oregon does not allow family supplementation to pay for private rooms. Families may pay for anything not related to services as permitted under federal law.

Level of Care Criteria

To receive Medicaid coverage of nursing home care, individuals must have functional limitations that match at least one of the following levels:

1. Dependent in mobility, eating, toileting, and cognition.
2. Dependent in mobility, eating, and cognition.
3. Dependent in mobility, or cognition, or eating.
4. Dependent in toileting.
5. Needs substantial assistance with mobility, and assistance with toileting and eating.
6. Needs substantial assistance with mobility and assistance with eating.
7. Needs substantial assistance with mobility and assistance with toileting.
8. Needs minimal assistance with mobility, and assistance with eating and toileting.
9. Needs assistance with eating and toileting.
10. Needs substantial assistance with mobility.
11. Needs minimal assistance with mobility and assistance with toileting.
12. Needs minimal assistance with mobility and assistance with eating.
13. Needs assistance with toileting.
14. Needs assistance with eating.
15. Needs minimal assistance with mobility.
16. Dependent in bathing or dressing.
17. Needs assistance in bathing or dressing.⁶

Services to about 3,600 people in levels 14 to 17 were eliminated in budget reductions in early 2003, and were not restored. Oregon's 2003-2005 budget continues long term care services for people in levels 1 through 11. Subject to federal approval, the budget also restores funding for services to people in levels 12 and 13—about 1,200 clients who need help in such areas as mobility and eating.

WAIVER PROGRAM

In 1981, Oregon received the very first Section 2176 Medicaid Home and Community-Based Waiver. At that time, the state decided that home and community services would be treated as

an entitlement, which meant that no waiting lists would be developed except for lack of providers.⁷

Oregon's waiver program provides in-home nursing, personal care, and housekeeping services, adult day services, and assisted living services. About three quarters of all in-home services are provided through a consumer-directed program—the *Client Employed Home Care Program*—which allows clients to hire, supervise, and fire, if necessary, their own workers, who can be friends, relatives or home care professionals. The state provides clients with administrative support (including the actual payment of wages, unemployment insurance and FICA), and will also help the client find suitable in-home workers.

A key feature of Oregon's waiver program is the use of nurse delegation, which has played an important role in its success. In 1987, the state enacted legislation directing the Board of Nursing to adopt rules allowing licensed registered nurses to delegate basic and special nursing tasks to unlicensed personnel. These tasks include almost all nursing tasks except injections. Nurse delegation has enabled home and community services to be provided at much lower cost than if licensed nurses had to provide all nursing care. The use of nurse delegation has been particularly important in the development of the state's adult foster homes and assisted living facilities.⁸

Financial Criteria

- Two groups are financially eligible for waiver services:
 - *Group A* includes individuals eligible for SSI, or who have incomes no higher than the SSI/SSP level.
 - *Group B* includes persons with incomes up to the special income standard of 300 percent of SSI, which was \$1,656.
- Asset limits for both groups are \$2,000 for an individual and \$3,000 for a couple if both are receiving services. When only one spouse applies and the spouse resides in the community, spousal impoverishment protections apply.
- The state does not allow spend-down to HCBS waiver eligibility levels but does allow excess income to be placed in Miller trusts. An individual places all their income in the trust, which is a conduit for all spending on behalf of the individual. The trust provides the individual with a personal needs allowance, and pays room and board and any other allowable expenses based on rules for determining cost sharing responsibility. Any remaining money must be spent on the cost of care. If the amount is insufficient, Medicaid pays the balance.
- Even if there are sufficient funds in the trust to pay the full cost of long term care services, the person is still eligible for Medicaid state plan services. However, if the funds in the trust at any point in time equal or exceed the cost of one month's stay in a nursing home (\$4,300 in 2003), the person will no longer be eligible for Medicaid.

- For persons in Group B, there is a cost sharing requirement. The share of cost is calculated by subtracting the following amounts from the monthly income of the person receiving care:
 - Personal needs allowance of \$553.70, which is the protected monthly income for individuals receiving waiver services (SSI \$552 + the state supplement of \$1.70);
 - At-home spouse income allowance and dependent family allowance;
 - Incurred medical and remedial care expenses not paid by Medicaid or a third party. Remedial care includes medical costs recognized under state law, but not covered under Medicaid, such as dentures.
- The remaining income, if any, must be paid toward the cost of care.
- Residents of assisted living facilities are permitted to retain \$104 as their Personal Needs Allowance, leaving \$449.70 for room and board costs, the maximum that a facility can charge a Medicaid-eligible resident.

Spousal Protections

- Community spouses may keep any income in their own name, and the state allows the institutionalized spouse's income to supplement the community spouse's income up to \$1,493 per month.⁹ Community spouses are also allowed additional amounts for rent or mortgage payments (including insurance and taxes) and are permitted a standard utility allowance.
- Community spouses may keep the higher of either the first \$18,132 of total non-exempt assets or one-half of the total non-exempt assets owned at the time care began, up to the maximum protected resource amount of \$90,660. For example, if the couple's assets are \$30,000, one half is \$15,000, but the state will protect \$18,132 for the spouse at home. If the couple's assets are \$250,000, one half is \$125,000, but the state will protect only \$90,660 for the spouse at home.

Family Supplementation

Oregon does not allow family supplementation to pay for private rooms in any residential care setting. Families may not pay for anything related to room, board or services.

Level of Care Criteria

Waiver applicants have to meet the same level of care criteria as nursing home applicants.

PERSONAL CARE OPTION

The state covers Medicaid state plan personal care services only in private homes and not in residential care settings.

LONG TERM CARE PROGRAMS FUNDED WITH STATE REVENUES ONLY

The state's Oregon Project Independence program provides in-home services and adult day care to persons who do not meet the financial eligibility criteria for Medicaid. Project Independence serves individuals over 60 years of age, and people under 60 with Alzheimer's or other dementias, who meet the same criteria as for nursing home and waiver services.

II. Residential Care Settings

BACKGROUND

In 1981, the state mandated that long term care services be delivered in the least restrictive setting possible, and that nursing homes be reserved as the placement of last resort.¹⁰ Apart from the 1981 legislation, six other state initiatives were instrumental in reconfiguring Oregon's long term care system, which paved the way for the growth of assisted living and other residential care options.¹¹

- In 1981, Oregon was the first state to obtain a 1915(c) waiver.
- Use of a nursing home certificate-of-need program to limit nursing home growth.
- Relatively low nursing home reimbursement has minimized the incentive for nursing homes to accept Medicaid entrants.
- Expansion of the home and community services infrastructure, focused on developing adult foster care, assisted living, and other non-medical residential settings.
- Enactment of the most liberal nurse delegation act in the nation, enabling more individuals to be cared for in home and community settings at an affordable cost.
- Development of a strong case management system that enabled clients to receive the care they needed in their homes or community settings.
- The 1981 legislation also stated: "... that the elderly and disabled citizens of Oregon will receive the necessary care and services at the least cost and in the least confining situation. (and) that savings in nursing home...allocations...be reallocated to alternative care services..."¹²
- These new concepts led to the development of a different approach to service delivery in congregate settings, one where safety is not considered the most important value, but one of several equal values including dignity, independence, choice, privacy and individuality.¹³

The success of Oregon's approach is reflected in the numbers of people served in residential care settings compared to those in nursing homes. In July 2002, the state's Medicaid long term care caseload was distributed as follows:

In-Home Care Services clients = 14,556
 Nursing Facility clients = 5,782;
 Adult Foster Care clients = 5,399
 Assisted Living Facility clients = 3,662
 Residential Care Facility clients = 1,867.¹⁴

Oregon has three major types of residential care facilities and separate licensing and regulatory requirements for each of them: Adult Foster Homes (AFHs), Residential Care Facilities (RCFs), and Assisted Living Facilities (ALFs). The state also has a number of Specialized Living Facilities of varying sizes that are targeted to serve special populations, e.g., persons with head injuries, quadriplegia, and persons with AIDS. Each of these facilities is unique and has its own reimbursement system. These facilities were developed both because of the desire of these clients to have focused services, and the difficulty in caring for them in regular home and community care programs.¹⁵

Residents of the three major types of residential care facilities can receive Medicaid waiver services as long as the facilities meet the regulatory requirements for providing these services.

ADULT FOSTER HOMES

- Adult Foster Homes (AFHs) are private residences licensed to provide care to five or fewer residents. They offer room and board and personal care from a caregiver who lives in the home 24 hours a day. Planned activities and medication management are available, and some homes provide transportation services, private rooms, and nursing services.
- During the 1980s, state officials vigorously promoted adult foster care as an alternative to nursing home care by recruiting families willing to convert their homes into an adult foster care setting. In some cases, case managers negotiated deals under which facilities received higher reimbursement than was technically allowed under state law. A new system, implemented in March 1998, raises the standard foster care reimbursement rates but makes it harder for case managers to negotiate exceptions to those rates.¹⁶
- Residents of AFHs have varying needs, from minimal personal assistance to assistance with all ADLs and skilled nursing services. The care provided depends on the client's needs and the skills, abilities, and training of the provider.
- Oregon's AFH Program includes Relative Adult Foster Homes. These homes permit relatives (excluding the spouse) to become adult foster home providers and care for the client. They are usually limited to one client who must be eligible for Medicaid.¹⁷
- By 1996, Oregon had approximately 6,500 adult foster care facilities serving approximately 15,000 persons, with roughly one-third of these persons being supported by Medicaid through the waiver program, making Oregon the only state in which adult foster care was a mainstream long term care option. Some analysts believe that the program probably grew

too fast with insufficient attention paid to quality assurance. By 1999, state audits confirmed some problems with quality and the state legislature demanded greater regulatory oversight.

- The private pay market for Adult Foster Homes declined as adults who needed and could afford care gravitated toward assisted living facilities, and the supply of foster care began to exceed demand. Consequently, many facilities became increasingly reliant on Medicaid dollars, although 60 percent of residents remain private pay.¹⁸ Shared rooms are not exclusively for Medicaid residents, but Medicaid residents are more likely to reside in shared rooms than are private pay residents.

RESIDENTIAL CARE FACILITIES

General Description

- Residential Care Facilities (RCFs) serve six or more residents. Many of them are small and even though they typically have shared rooms, they are more homelike than nursing homes. The state has two classes of RCFs. The regulations contain staff ratios for Class I and Class II facilities that vary by time of day and the number of residents.
- RCFs used to serve both the elderly and persons with serious mental illness (SMI) and developmental disabilities (DD) until the Senior and Disabled Services Division (SDSD) transferred oversight of RCFs in which more than half of the residents had SMI or DD to the state mental health agency. SDSD kept responsibility for the RCFs in which more than half of the residents were elderly persons. Over the following years, the RCFs assigned to the different agencies admitted only SMI, DD, or elderly persons. As a result, RCFs now serve a homogenous population.

Physical Plant Requirements

The primary difference between RCFs and assisted living facilities (ALFs)—a third type of residential care in Oregon—is the physical setting. RCFs provide single or double rooms with shared baths. Typically, residents share rooms, which must be 80 square feet per resident and are limited to two residents. Toilets must be provided for every six residents and a tub/shower for every ten residents.¹⁹ Private rooms are not required for Medicaid clients.

Room and Board

- The state limits the amount that providers can charge Medicaid eligible residents for room and board to \$449.70. This amount is equal to the combined SSI/SSP payment of \$553.70 minus \$104 for a personal needs allowance.²⁰ There is no limit on what facilities can charge private residents.

- Those who qualify for SSI are automatically eligible for Medicaid. The state supplement is provided to every SSI recipient in specified living arrangements, including their own homes, adult foster homes, residential care facilities, assisted living facilities and nursing homes.²¹ Persons living in institutions such as a state hospital are not covered.

Services

- RCFs offer room and board with 24-hour supervision, assistance with physical care needs, medication monitoring, planned activities, and often transportation services. If clients in RCFs need delegated nursing services, then the facility must have an R.N. consultant. Oregon's contract nurses are paid by the state to provide consultation services in RCFs.
- Class I RCFs provide ADL assistance only and cannot serve anyone who is non-ambulatory, is medically unstable, who requires feeding or is totally dependent in any ADL.
- Class II RCFs offer a full range of services without any restriction on acuity levels.

Service Rates

- Oregon assesses RCF residents and assigns a payment level based upon the individual's need for assistance with ADLs. In the state's 2003 budget, the RCF base service rate for all clients was \$917.00 per month. Depending on impairment level, there are 3 add-on levels. Base plus 1 add-on is \$1,142.00; base plus 2 add-ons is \$1,367.00; base plus 3 add-ons is \$1,592.00. The add-on is based primarily on how dependent a persons is with ADLs.

Sources of Public Funding for Services in RCFs

The Medicaid program is the only source of public funding for RCFs.

ASSISTED LIVING FACILITIES

Initial Development

- The only distinction between assisted living facilities (ALFs) and other models of residential care in Oregon is that ALFs have private apartments. Other settings have both private and shared rooms and private and shared baths.
- Oregon began developing a nursing home replacement model of assisted living facilities in 1987. The basic concept of assisted living is to combine apartment living with all of the non-skilled nursing services available in nursing homes plus assistance with activities of daily living (ADLs). Twenty HCBS waiver slots were designated for a facility in Portland as a test of this concept and the state developed administrative rules guaranteeing residents the rights of privacy, choice, independence, individuality and dignity.

- In 1990, the state adopted assisted living regulations and policies to substitute for nursing home care and offer home-like environments which enhance dignity, independence, individuality, privacy, choice, and decision making. Facilities are required to have written policies and procedures which describe how they will operationalize these principles.
- In some respects, the regulations are specific, e.g., ALFs must provide private apartments. In other ways, however, the rules are vague, e.g., there are no mandatory staff-to-resident ratios. and few service requirements. Residents negotiate service packages that cover everything from hours of personal care to the type of housekeeping services that will be provided.
- ALFs serve a predominantly elderly clientele. As of December 2002, the state had 184 licensed ALFs, with a capacity of 12,200 units. About 37 percent of ALF residents are Medicaid clients.
- Level II RCFs and ALFs can serve the same population but they operate under different regulations. When Oregon decided to regulate assisted living, it chose not to replace existing RCF rules, instead adding a new licensing category for assisted living with requirements that differ somewhat from its RCF rules, most notably with regard to physical plant requirements.
- The state initiated a moratorium on assisted living facilities from August 2001 through June 2005.

Physical Plant Requirements

- ALFs have six or more single occupancy apartments that are fully accessible with a lockable door, private bathroom, and kitchenette facilities. Units must provide 220 square feet of space, not including a private bathroom. Units in pre-existing structures may provide 160 square feet, not including the bathroom.
- To assure personal choice, an individual written exception is required for each resident who chooses to share a unit with someone other than his/her spouse.

Room and Board

- The state limits the amount that providers can charge Medicaid eligible residents for room and board to \$449.70. This amount is equal to the combined SSI/SSP payment of \$553.70 minus \$104 for a personal needs allowance.²²
- Those who qualify for SSI are automatically eligible for Medicaid. The state supplement is provided to every SSI recipient in specified living arrangements, including their own homes, in-home, adult foster homes, residential care facilities, assisted living facilities and nursing homes.²³ Persons living in institutions such as a state hospital are not covered.

Services

- ALFs are required to offer three meals, laundry and housekeeping services, assistance with ADLs and personal needs, and a program of social and recreational activities. Required health services include providing a licensed registered nurse to conduct health assessments and periodic monitoring, assigning the basic tasks of nurse delegation, and providing intermittent nursing services for residents with stable and predictable medical needs. Before billing Medicaid, ALFs are required to pursue other potential sources of reimbursement such as insurance benefits and Medicare.
- Nursing tasks may be delegated. These tasks include almost all nursing tasks except for intra-muscular, intra-venous, and intra-dermal injections. Nurse delegation is done by licensed nurses for each individual client as deemed appropriate by the nurse. The nursing task is delegated in writing to an individual non-licensed provider and cannot be expanded without the approval of the nurse. Staff or volunteers under 18 years of age may not assist with medication administration or delegated nursing tasks, and must be supervised when providing bathing, toileting or transferring services.
- Facilities are required to provide medication management and administration, and they must have policies and procedures to assure that all administered medications are reviewed every 90 days. Medication and treatment administration systems must be approved by a pharmacist consultant, registered nurse, or physician.
- Facilities also must coordinate home health services for residents with complex, unstable or unpredictable needs, and hospice services for those who meet eligibility criteria for Medicare's hospice program.
- Each facility must have sufficient staff to meet the 24-hour scheduled and unscheduled needs of each resident and to respond in emergency situations.

Service Rates

Oregon assesses ALF residents and assigns a payment level based upon the individual's need for assistance with ADLs. Effective September 2003, the rates are:

Level 1	651.69
Level 2	887.16
Level 3	1,173.56
Level 4	1,534.74
Level 5	1,894.75

Admission, Retention, Discharge Criteria, and Aging in Place

- The state does not regulate admissions. Consequently, facilities have total discretion over who they will admit. admissions. Facilities may care for residents for whom they are able to

provide appropriate services; there are no other limitations. The facility determines whether a potential resident meets its admission requirements. Prior to the resident moving in, the facility performs an assessment to determine the prospective resident's service needs and preferences and the facility's ability to meet those needs and preferences.

- Providers with Medicaid contracts are not obligated to admit Medicaid recipients if they do not believe they can meet their needs. When considering an admission, the Medicaid contract permits the facility to determine if it can meet the needs of person in addition to the needs of the residents they already have.
- Facility capabilities vary and some facilities can take care of people who have high needs and impairments. The state's regulations set the minimum standard of what a facility must provide, but facilities generally go above that standard. Just how much above the standard requirements usually correlates to the resources available to the facility.
- Facilities with Medicaid contracts may not discharge a resident who has spent down to Medicaid eligibility. Conditions under which they may ask residents to move are: if their needs exceed the level of ADL services available; the resident exhibits behaviors or actions that repeatedly interfere with the rights or well being of others; the resident, due to cognitive decline, is not able to respond to verbal instructions, recognize danger, make basic care decisions, express need, or summon assistance; the resident has a complex, unstable, or unpredictable medical condition; or for non-payment of charges.
- Facilities without Medicaid contracts are not obligated to keep a resident who spends down to Medicaid eligibility.
- There is no mandatory bed hold, but a facility can not discharge a resident as long as they pay room and board. If a resident breaks a hip, goes to the hospital, and then to a nursing home for rehabilitation, the assisted living facility may not discharge them. As long as they continue to pay the \$449.70 while they're out of the facility, the facility will hold their unit.
- If a managed risk plan is needed it must be developed with the resident's input or that of their designated representative and be included in the care plan. Facilities are responsible for determining when a risk plan is needed and developing it according to guidelines in state regulation. The results of the agreement must be included in the service plan and the plan must be reviewed at least quarterly and more often if needed.²⁴
- Persons who are unable to recognize the consequences of their behavior or choices may not enter into or continue with a managed risk plan. There is no uniform or systematic method used to determine whether a person is capable of doing so. The state allows the facility administrator and RN to determine if a person can recognize the consequences of their behavior relative to entering into a managed risk agreement.

III. Summary of Interviews

We consulted with three state staff and policy makers regarding the technical details of the state's programs and interviewed two of them. In addition, we interviewed the founding director and a former director of Oregon's Senior and Disabled Services Division (SDSD) (since renamed Seniors and People with Disabilities (SPD)). These two respondents are now private long term care policy consultants. In addition, we interviewed six stakeholders, including representatives of residential care provider associations, residential care providers, consumer advocates, the state ombudsman program, a nurse who works in the program, and a county agency that administers the Medicaid waiver program.

The interviews focused on respondents' views about several key areas and issues. This section summarizes their views and provides illustrative examples of their responses. These comments are not verbatim quotes, but have been paraphrased to protect the respondents' anonymity and edited for brevity. A list of information sources for the state description and the individuals interviewed can be found at the end of this summary.

GENERAL COMMENTS ABOUT THE STATE'S RESIDENTIAL CARE SYSTEM

Most felt that people in Oregon who need long term care have a wide choice of community residential options, depending on their preferences.

- *If you like bed and breakfasts, you'll probably prefer an adult foster home. If you like hotels, you'll prefer assisted living.*

Several noted that because ALFs offered private apartments and were newer relative to many residential care facilities (RCFs) and adult foster homes (AFHs), not surprisingly they were the preferred option for many private pay and Medicaid eligible individuals.

- *Some of the older adult foster homes and residential care facilities (RCFs) are not as desirable to consumers who have a choice. Very few RCF's offer private rooms and if they have them, they are generally kept for private pay residents.*

A few mentioned variation in the physical setting of RCFs and AFHs, some being "very nice" and others less so. The most important feature, most agreed, was that there is a sufficient supply of all types of facilities to guarantee a choice of residence for consumers, with two caveats. First, there is some geographic maldistribution of ALFs, with some areas of the state being overbuilt and others' not having an optimal supply. Second, most felt that with the budget cuts in 2003, many facilities would go bankrupt.

One noted that the state had a certificate of need program only for new nursing facilities, and did not have the methodology to determine appropriate capacity for ALFs. However, data on the current population receiving services—their level of impairment and needs—and projections of population growth would give some idea of future need.

Respondents agreed that the state was right in limiting the use of the term assisted living to facilities that offered private apartments. Compared to the other five states, no one mentioned public confusion about the different types of residential care as an issue.

GENERAL COMMENTS ON MEDICAID'S ROLE IN RESIDENTIAL CARE SETTINGS

Everyone interviewed agreed that Oregon's primary goals in using Medicaid in residential care settings were (1) to reduce nursing home utilization, and in so doing, save money, and (2) to increase community alternatives to nursing homes, thereby providing consumers with more choice. In particular, respondents felt that the program's success lay in its offering Medicaid waiver clients the same residential care options available to the private pay market. As one said, "if the private pay market gets privacy and independence, then so should the Medicaid client." All believed that the state had met its goals and that assisted living had filled a gap in the continuum of care between Adult Foster Homes and Residential Care Facilities, and nursing homes.

- *The state wanted a balanced long term care system, where nursing homes were caring for skilled patients who could not be cared for in any other setting, mostly hospital discharges that still need sub-acute care. It wanted to get to the point where nursing homes were not a high-priced alternative to community care. Assisted living became another tool in the goal—it fit a good niche.*
- *When the state started expanding home and community services in the early eighties, it depended primarily on adult foster homes for residential care. There was a big push to recruit adult foster homes. It made sense because the economy was down and people were out of work. We could sell the concept of using your own home or buying one and taking in older people, combining a social good with a way to make money. For the state, it was a really quick way to increase residential care capacity.*
- *There was a real desire on behalf of program planners to come up with a model that afforded predominantly seniors with a more private and independent residence outside the home. We had lots of experience with adult foster homes and congregate settings—where common space is shared and most residents share bedrooms. We wanted a more private and independent model.*
- *We saw assisted living as another alternative to the nursing home. We were already using Medicaid in adult foster care and residential care facilities. Assisted living was one more option. We knew we could both save money and give people what they wanted by providing more options in the community. Services in AFHs and RCFs had been covered from when the state first got a waiver, so we just added assisted living to the existing waiver by developing rules for ALFs, thereby getting around the need for legislative approval. The state views assisted living as just another form of residential care that it wanted consumers to have as an option.*

- *We used the waiver rather than the personal care option because you could qualify people for the waiver under a higher income standard (300 percent rule) and you have more flexibility under the waiver.*
- *Initially the state needed to save money and private pay folks needed to save money—and the nursing home model back then was very institutional and people didn't like it. So the rationale was to improve quality of life for people who needed long term care and to contain costs. Both were equally important. We figured, we can do this in a different way, give people more control—greater independence and choice. We can do both.*
- *The public has a lot more options and because Medicaid participates in the funding of residential care services, it is a more egalitarian system. Giving people private rooms has been very successful. The downside is that the state has not invested in the physical upgrading of nursing homes—which are stuck in the 50's and 60s.*
- *We have RCFs that look like assisted living but because they do not exactly meet the physical plant requirements, they cannot call themselves assisted living—e.g., you need to have a roll in or flat shower. In every other area they could be identical to assisted living. The good thing about the assisted living physical plant requirements is that there is a greater degree of accessible housing for persons with disabilities. These facilities have offered a housing option for the younger disabled who want privacy and independence but need some oversight and services. Assisted living has been very good for them.*
- *A large number of facilities participate in the Medicaid program, which means there is no access issue for low income persons. Of course, providers with many Medicaid residents will be more vulnerable if reimbursements are cut.*

Everyone interviewed agreed that there are no barriers to serving Medicaid waiver clients in all residential care settings, including apartment style assisted living settings. They felt that Oregon had an adequate supply of ALFs, and that access was good for both Medicaid-eligible and private pay individuals. However, many felt that the impact of the budget cuts on rates and eligibility for waiver services could put some facilities out of business, especially those with a higher proportion of Medicaid residents.

LICENSING AND REGULATORY REQUIREMENTS

Very few felt that licensing and regulatory requirements posed a major obstacle to affordable assisted living in Oregon.

There were varying views on whether the licensing requirements and regulations assured quality. Most acknowledged that quality problems had been a major issue in the program's early years.

- *The state did a poor job in the eighties and has been catching up ever since. The quality now is good—certainly compared to states like Texas and North Carolina. The state of Washington does the best on quality assurance because they looked at Oregon’s mistakes and learned from them and did it right. They bring everyone into the quality assurance system—case workers and surveyors. They also have new training rules but their budget crisis may slow down implementation.*

Some thought the regulations were good overall but felt some fine tuning was needed.

- *The RCF rules are outdated and are being updated by the state—they will be more like the assisted living rules when completed. Many changes will be to administrative requirements, e.g., the need for signatures on specific forms. Others will address major issues such as staffing requirements.*
- *The assisted living regulations are good. The last revision minimized the aging in place requirements and the rules now recognize that individual facilities may have limits on what services they can provide. The state sets the minimum and facilities are permitted to have different ceilings. A small facility may have only one staff person for 8 clients and be unable to do two person transfers.*

A few thought that there were ongoing quality issues and that a lot more work on quality needs to be done in all three types of residential care.

- *There’s nothing about Oregon’s model that provides better care. What it provides is a wonderful environment that is conducive to a better quality of life. Our track record regarding care is no better than anywhere else—we have individual providers with problems like everywhere else.*

A number had complaints about the regulations and varying views on enforcement.

- *I think Oregon has a good regulatory structure. What’s lacking is consistent enforcement.*
- *There is enforcement about silly things like storage and sign placement—things which don’t equate to good care. New staffing regulations may also not be related to better care. Nursing homes are over regulated and that hasn’t equaled good care.*
- *Increasing the choices tenants have and letting care be directed by the client are good things but new regulations are making it more difficult. They give more responsibility and liability to the provider. For example, there is a prohibition on restraints and bed rails are considered restraints, but some residents may want bed rails because they’ve had them at home and it makes them feel safer.*
- *I’m very concerned that given the high cost of new prescriptive regulations, Medicaid clients will end up in double occupancy RCFs and assisted living will be only for the private pay*

market. With the current cut-backs, most providers have stopped taking Medicaid clients until they see what's going to happen.

Outcome-Based Regulations

Two respondents expressed a desire for more outcome based measures of quality.

- *The types of things needed to really assure quality, such as performance based outcomes, would be better put into the Medicaid provider contracts than in licensing and regulatory requirements.*
- *The regulations are getting too prescriptive. Oregon started with a resident centered program because the state wanted people to direct their own care. Now it's getting towards a more prescriptive model. The cause could have been a bad situation prompting media coverage. I prefer the more outcome based regulations—though I don't always know the best outcomes.*

Need for More Nursing Care

A number of respondents mentioned that the state needs to do a better job assuring sufficient nursing consultation, noting that most providers are keeping residents longer even though the state does not require aging in place. Several felt that some regulatory changes were needed to address the increased acuity levels of residents in residential care settings because the average age of residents in these facilities has increased to 85 and people at these ages have more medical needs, whether they are private pay or Medicaid eligible. One respondent disagreed, stating that acuity levels have not increased since the mid-eighties.

- *The current regulations assume that most ALF residents will self-direct their care, and the facility will assist them to do so. This works if the person has intact cognition and can make good decisions. But this is not always the case. Residents in these settings need and want more medical and health services from an RN or certified nursing assistant (CNAs). We do not currently require any of our residential care settings to hire CNAs. They can hire people off the street and train them.*
- *We are seeing an increase in acuity in all residential care settings. In nursing homes, 80 percent of clients stay fewer than 90 days and 30 percent fewer than two weeks. Most are post acute. Many of the nursing home residents go from a 3.8 day hospital stay to a short stay in a nursing home and then back to a residential care facility or home.*
- *When Oregon started paying for waiver services in residential care settings, the state did not understand chronic care management and focused on ADLs only. It's now obvious that there is a need for more nursing in these settings and it should have been brought in sooner. But it's not a nursing service model that's needed, it's a teaching nursing model.*

One respondent noted that changing the regulations to increase the amount of nursing provided would necessitate an increase in the reimbursement level and finding the right balance would be difficult. Another noted that providers were worried the state will go too far with regulations, but stated “if they are going to do chronic care management, they need nursing.” One stated that it was unclear how much nursing care should be provided in ALFs.

- *There are increased levels of medical acuity and complexity. Some people say there is not enough nursing in assisted living as care needs have escalated. The residents say they need more and there is expectation—regulators expect there to be more nursing care—but there are no additional rules regarding the provision of nursing care or increases in reimbursements to match this expectation.*

People also want more prevention to reduce hospital admissions from assisted living facilities. But many facilities don't have 24 hour nursing available. The staff may know how to take a blood pressure, but they do not know how to interpret it. If a person has a stroke he may want to go back as soon as possible after hospital or nursing home discharge to his assisted living facility, but the facility does not have the staff to do the monitoring needing three days post discharge; maybe seven days.

- *There are a lot of questions about how nursing should be provided in assisted living. There is an expectation that assisted living should be able to do certain things, but facilities do not have nurses available at all times. There are lots of questions. Who has access to what drugs and when? How actively should facilities be involved in assessing and monitoring changes in clients' condition? Currently, how often it happens depends on the facility—whether they have a lot of high or low acuity residents. Some facilities have a director of nursing services, some use RN consultants.*

Assisted living facilities are not required to do health assessments unless a resident has a nursing need. If they are diabetic and take oral hypoglycemics, they are considered to not need a health assessment; if they need daily glucose testing then they do need one.

Staffing

Most concerns about quality related to staffing issues, particularly that fact the providers may not have sufficient staff to care for their residents due to problems with recruitment and retention.

- *The basic quality problem is that the staff do not know and do not recognize signs of need. The state does criminal background checks. The really bad things we find are not system problems. Staff incompetence and neglect are the problems. The best nurse managers go to other settings to work, even though they like the business. They don't like working with untrained staff who are not contributing to the health and well-being of the residents.*

- *The biggest quality problem is the lack of training for staff in residential care facilities. Sometimes I'm appalled at the lack of knowledge of basic common sense things. It makes me wonder if they have received any training.*
- *There are major issues with the workforce. Huge turnover due to low pay, no benefits. Managers don't know how to manage people with low skills. It will get worse with less money. Housing is relatively cheap now with low mortgage rates, but the money squeeze on services will lead to staff cuts and quality will become more of an issue.*
- *Recruitment and retention is a major issue. Direct care worker turnover rates are very high. They work in a traditionally undervalued field for low pay and do not have benefits or paid time off. Some solutions are simply monetary, but there is a need to identify ways to make care giving a more attractive profession.*

There was consensus that lack of pay and benefits, lack of a career ladder, poor management and oversight, and in some cases, an unpleasant work environment were responsible for many of the staffing problems. When asked whether the state should require staff to resident ratios, the response was ambivalent:

- *Mandatory staff to resident ratios can help to assure adequate staff, but it's so hard to find staff—some facilities may just not be able to stay within regulatory requirements. For safety reasons and prevention of potential abuse—I'd rather see tighter regulations, but I understand the other side.*

Dementia Care

One respondent stated that overall, the regulations for dementia care are “pretty good,” and that the state has an overlay of rules for RCFs and ALFs for dementia clients, but they are not applicable to AFHs because they serve such a small number of residents.

- *Providers have to have a higher ratio of caregivers to residents. Adult foster homes and smaller RCFs tend to take care of them. These facilities are usually smaller and better for people with dementia.*
- *The solution to providing good dementia care is not regulations, but enforcement of existing ones. If providers are not meeting the needs of residents with dementia, there should be sanctions.*

National Standards

Most felt that Oregon's standards were good, even if they needed fine tuning in a few areas. One noted that it was highly unlikely that Oregon, or any other state, would adopt national standards, because states do not like to use other's rules. One noted a need for standards and said that good ideas are always welcome but strongly opposed the mandating of national standards.

- *Any time you mandate standards you get what is in nursing homes—very prescriptive and not necessarily leading to better care. I don't want federal oversight and a one size fits all approach. Best practices? Absolutely. National oversight? Not on your life. We have quite enough oversight with the waivers. There is no need for federal oversight of residential care.*

ADMISSION AND RETENTION REQUIREMENTS, AND AGING IN PLACE

The state does not subscribe to a continuum of care model, where those with the most severe impairments are cared for only in nursing homes. There is a strong belief that unless a person needs 24-hour medical/nursing oversight, they should be able to be served in their home or the community if that is their choice. While the state's goal is to serve people with a high level of need in residential care facilities, some felt that this goal is met more by AFHs, and RCFs than ALFs.

- *Oregon's experience is the same as Washington's—the AFHs take care of sicker and more impaired folks. Why? In general, assisted living is run by large corporations. They're good at creaming; they don't want to be in the position of taking care of very impaired people, don't want to hire the staff, and don't want to be exposed to the risk of fines and bad publicity.*
- *A lot of providers try to skim; they try to get rid of the high level folks. Regulations are too permissive—they only require disclosure about discharge. I don't know if there is a regulatory solution. The goal of aging in place is problematic given the insurance and lawsuit issues. Oregon's idea was to do a nursing home replacement model with a better living environment. If assisted living is a replacement model, then assisted living should do all it can to care for residents until they need 24 hour nursing oversight. Aging in place used to be a key factor, but now the state is getting away it.*

If providers are going to get Medicaid money, they should be prepared to provide as much care as possible. Small facilities with 30 beds can't do three person lifts. But there needs to be a commitment to keep people as long as possible.

- *Oregon is not like New Jersey and Florida—saying that when you reach a particular level of need you have to go to a nursing home. Admission is not an issue, but retention and discharge requirements are—determining when people in assisted living have become impaired or have greater medical needs and need to be moved to a higher level of care.*

Some providers have difficulty finding a higher care setting that will take a particular resident. Some people in assisted living do not want to move. A facility may be able to take care of one or two people with greater needs but not five or six.

Negotiated Risk Agreements

Only a few respondents had views on this topic.

- *Generally, in assisted living, the concept of managed risk is incorporated into specialized service planning. Specific risk factors are addressed as part of a person’s service plan. There is new language in the assisted living regulations stating that incompetent residents can’t enter risk agreements. Competence is determined by physicians or an assessment by facility staff and other health professionals. There is no standardized process for determining competency.*
- *This is a big red herring. These risk agreements are not significant—very few clients have them. The regulations state that service plans shall include them if there is one. They are nothing but service planning around a problem. You don’t need a risk agreement, you need a good service plan. A big problem is that consumer advocates want autonomy for elderly persons, but they also want to hold the facility responsible for negative consequences.*

We have lots of diabetics who want to cheat. What we want to do is have the facility and the resident agree on the times they will cheat so we can have a plan to test blood sugar and have sliding scale insulin coverage. But if they don’t adhere to the planned time, then the facility is blamed for not identifying the onset of hypoglycemia.

- *I’m not a fan of negotiated risk agreements (NRAs). To do them right requires a great deal of skill—relying on the informed choice of a consumer. I believe that facilities are responsible for watching over their residents to be sure their needs are being met. Facilities shouldn’t be able to relinquish this responsibility. With good providers I’m not as concerned. The norm is more of a “cookie cutter” approach.*

It’s an easy way to release a facility from the responsibility to carefully work with the residents to help them maximize what they need to do to manage their own care. Oregon’s licensing requirements state that a facility has to have ongoing active involvement to help residents manage if they are going to self manage. It’s a challenge for facilities to deal with resident’s wishes. I’ve seen these agreements end up as excuses for the facility not doing what they need to do.

SERVICE RATES

A few noted that because Oregon set a cap on room and board rates for Medicaid eligibles—particularly for ALFS, which provide private apartments—the state has to pay enough for services to attract providers. In general, most felt that ALF rates were high relative to rates for ACHs and RCFs.

- *Setting the initial assisted living rate at 80 percent of the nursing home payment was a clear signal to the industry that the state was encouraging this model.*

- *The state gave a generous rate structure to providers to encourage assisted living development and the availability of assisted living for Medicaid eligibles. This policy has come under attack every legislative session because the rate is higher than what is paid to other residential care settings. The high service rate has always been an eyebrow raiser in Oregon.*
- *Oregon spends more on services in assisted living settings than any other residential care setting. The lobby for assisted living is the same as for nursing homes—AHCA and AHSA. The persons representing foster care can not compete. The lowered flat rate being proposed for assisted living during the current budget crisis would certainly narrow the payment gap between assisted living and adult foster care.*
- *Oregon is thinking about paying the same set service fee dependent on level of impairment to all three types of residential care but this will be difficult politically.*
- *Rates were OK for a while but they have not kept pace with inflation. We get insurance increases every year, but no rate increase. With the coming cuts, some facilities will close—especially those that are highly dependent on Medicaid.*

A few noted that if the state wants people to age in place, the reimbursement rate structure has to take into account that certain people take more time to take care of.

- *Those with behavioral problems or who need a 2-person transfer cost more. If the state won't pay it, they will wind up in institutions when they could have been served in the community.*
- *The state has chronically under-funded providers in order to let case loads grow. We need to fund them adequately. Assisted living has had a reasonable rate but not AFHs. You can't starve one side of the system to serve another. The state does not require AFHs, RCFs, and ALFs to have cost reports. The rates bear no relationship to the delivery of services. Initially they were generous enough to get providers to participate. But acuity levels have gone up but not the rates.*
- *The state has starved nursing homes. All of the parts of the long term care continuum used to fight each other for funding but we then realized that the entire continuum needs adequate funding. If the proposed budget cuts go through there will be a complete collapse of the Oregon long term care system.*

SUGGESTED CHANGES TO IMPROVE THE MEDICAID-FUNDED
RESIDENTIAL CARE SYSTEM

A number of respondents made specific suggestions for improving the system:

- *The state should allow family supplementation for private or larger rooms for Medicaid residents in AFHs and RCFs. Washington state allows families to contribute the difference in cost between a studio and a one bedroom.*
- *Get away from prescriptive regulations. Tell facilities that if they kick Medicaid folks out too early they won't get any more residents. Give providers incentives to keep people as long as possible. Give them enough money—the amounts in the past were sufficient, but recently have not kept pace with inflation, especially the increases in insurance.*
- *What I would do is move to a standardized assessment tool for providers and develop quality indicators for this tool. You can't track quality without it. The current assessment is not a facility tool. It is used to determine Medicaid eligibility.*
- *We need a quality assurance system that moves to the culture of patient safety—where you identify problems and then try to fix them.*
- *Other than getting higher service rates—rates that accurately reflect costs—I would like the program to have a chronic disease management focus to save money on both the acute and long term care side. The length of stay in nursing homes and hospitals are so short, we have more people in the community with significant health issues. We need to look at the provision of health services in the community. There is a lack of health care in the service component. We need to know what are good outcomes. What level of falls are acceptable in the community. We can't have the same expectations as in nursing homes—that no one will ever fall or develop a decubiti. I'd also like to address the polypharmacy issue. There are too many people on 8 or more medications. I'd also like to replace physicians with nurse practitioners in all settings. The physicians do not understand the setting. They think they can call a nurse and have something done like in a hospital.*
- *We need research on systems for assuring quality in community settings. We need information on best practices. How to teach unlicensed personnel about disease management? How to manage the non-compliant diabetic? How to provide palliative care? How to provide care to the anxious COPD patient with air hunger? All when you don't have nurses available on a 24 hour basis. We need special training for medication administration. We spend a lot of money on training using a train the trainer approach. But reimbursement needs to recognize the need for substitute staff when the regular staff are out of the facility to obtain training.*
- *We need a career ladder for direct care workers.*

One respondent noted that one of the reasons the number of assisted living facilities grew so fast was because the state had a financing mechanism through the housing agency, but the state should have placed requirements on the providers who received these loans.

- *Loans were made with general obligation bonds. About 25-30 percent of assisted living facilities a few years ago were all financed with these bonds. If the state gives a provider a low interest loan, the provider should be required to take a certain proportion of Medicaid clients until the loan is paid off.*

One respondent said that consumers needed more information about the quality of services in each facility. Even though the state has a website, this respondent felt it did not provide sufficient information for consumers to make an informed choice.

FUTURE PLANS

One respondent stated that in the absence of a budget crisis Oregon would probably want to expand and improve the current HCBS system, noting that the state is pretty close to a balanced system. Another said that the state's program has changed since its inception and it will continue to change, noting that it is important for the state to continually assess the strengths and weaknesses of its program and make changes accordingly. For example, the State is currently updating its RCF rules and is examining the role of community nurses in all residential care setting. They are also working on initiatives related to person-centered planning.

Another noted that the state's 18 categories of level-of-care criteria has been helpful in times of budget cuts in that it provides a mechanism for the state to reduce the number of people being served based on level of need. However, the respondent said that it's not perfect and that the state wants to revise the criteria to incorporate more risk factors, such as chronic care needs and acuity.

RECOMMENDATIONS FOR OTHER STATES

Reflecting Oregon's extensive experience covering Medicaid services in a range of residential care settings, respondents had many specific recommendations. Many felt that Oregon's experience could provide guidance for state's looking to make a range of residential care options available for both the private pay market and the Medicaid client. Most did not mention the importance of making the room and board component affordable, because they assumed it was a given. When specifically asked about room and board, they agreed that it is not possible to provide assisted living to the Medicaid population unless the room and board component is affordable.

Several mentioned the importance of addressing quality assurance from the outset.

- *Pay attention to quality assurance from the outset. ALFs need to be surveyed on a regular basis—not the same focus as nursing homes but similar. You have to use a different model of quality—look at protection, service needs being met, and livability.*

- *The state should have paid as much attention to quality assurance as to the requirements for the physical plant. It would have taken a few more steps to assure quality and it would have slowed down provider interest in the beginning, and the state would not have met its obligation to save money. The state stayed in this mode until the mid-eighties, and then we had horror stories, and started to pay more attention to quality. Now Oregon has good quality overall. States should start with a well defined idea of what the service package will be and what quality outcomes are expected.*
- *In the beginning, providers didn't know—even though it was in the rules—exactly what services they needed to provide. They did have a better sense of service needs than in some other states, where the providers getting into assisted living come from the housing world—they don't know services. Assisted living has been sold as a light care model and staffing capacity was based on this—that there would not be highly impaired residents. But you would expect that with aging in place, there would always be a portion of heavy care clients, and you need to plan for this.*
- *One problem when the state started was they it did not fully appreciate quality issues and chronic care needs—and how to put in systems to assure that quality was assured and needs were met. It was not an intentional oversight—it was naïve. They believed that ADLs were the key. But chronic care management and acuity are just as important.*

One respondent said that the state was very concerned about dementia care and had issued special rules for facilities that market themselves as special care units.

A number stressed the importance of not paying for services in assisted living by the hour.

- *Some states fund assisted living like they do home care—they provide so many hours of services and treat it like home care. They do that in Georgia. But you can't grow it that way. States shouldn't pay for services on an hourly basis. Set tiered levels—treat assisted living like a nursing home without room and board. Set it up as a reimbursable entity under the waiver.*

Some mentioned the need to address legislators' concerns about induced demand.

- *There will definitely be an increase in clients when you expand HCBS but you can handle this if you set it up right. HCBS can save money if you target it right. Indiana has twice as many folks in nursing homes as in HCBS. But even though Indiana's per capita spending is lower than Washington's, Indiana's costs are higher than Washington's because Indiana serves more people in nursing homes than in HCBS, whereas Washington does the reverse.*

One respondent said that if the state were starting over, it would probably be willing to compromise on each apartment having a full kitchen, because most people don't use them.

- *You could require a refrigerator and microwave and sink—but most kitchens are quite small. You do need to put some minimums in regulations, however, to ensure that at least the minimum is provided.*

One respondent stated that an immense advantage the State had in setting up its system was that their authority for long term care policy rests in one administrative agency that designs and regulates the entire system and pays for Medicaid.

- *This is a huge advantage in making sure that licensing rules will be effective for both private pay and Medicaid clients. The most important thing is the ability to manage things collectively under one agency—which allows us to implement our vision—to work with advocates—because we control licensing and everything else about the system. The only thing we didn't control was the Oregon Board of Nursing. But we worked extensively with them to get what we needed. You need to put a lot of energy into these efforts to make them happen.*

One respondent said that states wanting to use Medicaid to fund services in residential care needed four things: (1) a method to make room and board affordable for Medicaid eligibles; (2) a funding stream to buy the services you want; (3) a regulatory agency that subscribes to your philosophy; and (4) flexible oversight and quality improvement activities that are designed to take more of a teaching role rather than an inspection and sanction role.

With regard to the third requirement, this respondent noted:

- *Regulatory agencies are often not connected to Medicaid—they're concerned about health and safety and often have a strict continuum of care approach. They don't think you should be putting impaired folks in residential care facilities.*

States need to enable all settings to provide care and to write regulations to support them to do so. To design and develop a complete system—you need both strong home care and congregate care for the people who can't live alone. Another important approach is to design purchasing to buy things that can also be bought by the private sector. There should be no special programs for Medicaid—with the rest of the public stuck in an old model.

One respondent stressed the importance of having the public understand the various options.

- *Be sure that clients have sufficient information about the different types and levels of care provided in different types of facilities; that they understand the limits; that they can not have unfettered expectation of staying on one level for ever. There is a continuum of care. You can sometimes stretch what's provided in a community setting but not always.*

Another addressed more political issues:

- *Don't bash nursing homes to promote assisted living. Don't sell assisted living as saving money by taking people out of nursing homes or diverting them from nursing homes. Even*

if there are no cost savings, it's still better to have more options. You also need a good case management system in place to support home and community care and it's expensive. The reason to do assisted living is that consumers want it and it's good for them.

Finally, given the current budget crisis in Oregon, which will cause some Medicaid clients in ALFs to be dropped from the waiver program, one person said that if a state is planning to use Medicaid to cover services in residential care facilities, it should use a separate waiver program for assisted living only and limit the number of slots. This will help to assure that during a budget cutback there will be less pressure to take away services from people who are already receiving them.

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ENDNOTES

¹ Nursing Home Relocation Services, begun in 1982, are still an important part of Oregon's long term care system, though the average nursing home resident in 2002 is much more impaired. Because HCBS care coordination staff caseloads are high, some Area Agencies on Aging have created relocation specialist positions. Relocation costs may be paid by exempting resident income generally paid to the nursing home, or through the HCBS waiver program.

² Mollica, R.L. and Jenkins, R., *State Assisted Living Practices and Options: A Guide for State Policy Makers*, Coming Home Program, Robert Wood Johnson Foundation, September 2001.

³ Prior to February 2003, the state had a Medically Needy Program for the aged, blind and disabled, which covered only prescription drugs and mental health services, but not long term care. The program was terminated due to budget constraints.

⁴ Sparer, M., *Health Policy for Low-Income People in Oregon*, Urban Institute, September, 1999.

⁵ The state plans to increase the amount in 2003.

⁶ A computerized scoring system weights and adds multiple measures of physical and mental functioning to determine if the criteria are met. The scoring system is also used to determine reimbursement levels for services provided through the waiver program.

⁷ Sparer, M. *op. cit.*

⁸ Kane, R. L., et. al., *Oregon's LTC System: A Case Study by the National LTC Mentoring Program*, University of Minnesota, April 1996.

⁹ The income amount will be increased in July 2003.

¹⁰ Kane, 1996, and Sparer, 1999, *op. cit.* It designated the newly created Senior Services Department (later renamed the Senior and Disabled Services Division and now called Seniors and People with Disabilities) as the state agency responsible for supervising and coordinating the various long term care programs for elderly persons. The legislation also delegated to the local Area Agencies on Aging (AAAs) the responsibility for developing a single point of entry for persons seeking long term care services.

¹¹ Kane, 1996, and Sparer, 1999.

¹² Oregon Revised Statutes 410.010.

¹³ Kane, 1996.

¹⁴ Oregon's Long Term Care Medicaid Caseload by Care Setting, July 2002, cited in Executive Summary of *Governor's Task Force on the Future of Services to Seniors and People with Disabilities*, Initial Report, September 2002.

¹⁵ Kane, 1996.

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²⁰ The state's SSI supplement is \$1.70 per month, the minimum amount required by federal law as state maintenance of effort when the SSI program was first enacted in the early 1970's.

²¹ Federal SSI limitations apply except that the transfer of a home may render a person ineligible for a state supplement for up to 30 months, based on the amount of uncompensated value.

²² The state's SSI supplement is \$1.70 per month, the minimum amount required by federal law as state maintenance of effort when the SSI program was first enacted in the early 1970's.

²³ Federal SSI limitations apply except that the transfer of a home may render a person ineligible for a state supplement for up to 30 months, based on the amount of uncompensated value.

²⁴ Managed risk: OAR 411-056-0015(2)(i) - (L) The facility must document the information set forth in (j) of this rule.

Appendix F

Texas

Texas

The information in this appendix is presented in three major sections:

- The first section provides an overview of the state's long term care system, with a primary focus on the Medicaid program. Although a state may pay for services in residential care settings through the Medicaid program, the program's financial eligibility criteria and related financial provisions for home and community services can present barriers to serving Medicaid clients in these settings. Thus, the first section of each state's description presents detailed information about rules related to financial eligibility, spousal financial protections, and cost sharing requirements.
- The second section describes the state's residential care system.
- The final section presents the views of respondents interviewed for this study on a range of issues related to Medicaid coverage of services in residential care settings in their state.

Because the information in the first two sections is intended to serve as a reference, some information is presented under more than one heading to reduce the need for readers to refer back to other sections for relevant information.

Unless otherwise cited in endnotes, all information presented here was obtained from the sources listed at the end. Supplemental Security Income levels, the federal poverty level, federal spousal protection provisions, state supplemental payments, and state reimbursement rates are for 2003, unless otherwise noted.

I. Overview of Long Term Care System

NURSING HOMES

The state has a process for determining where new nursing home beds will be allowed based on the nursing home occupancy rate in a given county. The statewide occupancy rate is approximately 72 to 74 percent.¹ The state also has a process for determining the proportion of nursing home beds allocated for Medicaid.

Financial Criteria

- Two groups are financially eligible for nursing home services:
 - *Group A* includes individuals who are eligible because they are receiving SSI.

- *Group B* includes persons with incomes up to the special income standard of 300 percent of SSI, which is \$1,656.
- Asset limits for both groups are \$2,000 for an individual and \$3,000 for a couple.
- The monthly personal needs allowance is \$60 for individuals and \$120 for couples.²
- Because Texas does not have a medically needy program, in accordance with federal law, categorically eligible individuals in need of nursing home care—whose income exceeds the special income standard but is insufficient to cover the cost of care—may place income in excess of the special income level in a Qualified Income Trust, known as a Miller Trust. Once the trust is operative, they receive Medicaid coverage for both nursing home care and other Medicaid state plan services.

Spousal Protections

- The institutionalized individual's eligibility is determined using the individual income limit before the protected spousal needs allowance is determined.
- Community spouses may keep any income in their own name, and the state allows the institutionalized spouse's income to supplement the community spouse's income up to the federal maximum permitted, which is \$2267 per month.
- The protected resource amount will be the greater of the following: the state minimum resource standard, which is \$18,132; or one-half of the couple's combined countable resources not to exceed the maximum resource standard of \$90,660; or the amount transferred to the community spouse under a court order. All assets over this maximum must be spent on nursing home care before Medicaid will begin to pay.
- In cases where there is a community spouse, the client can appeal to increase the protected resource amount to produce additional income for the spouse. The hearing officer may then increase the protected resource amount to a level adequate to produce income up to, but not exceeding, the monthly maintenance needs allowance.

Family Supplementation

Family members may pay a nursing home facility the difference in cost between a semi-private and private room.

Level of Care Criteria

Applicants for Medicaid coverage of nursing home care must meet one of the following criteria:

1. Must require licensed nursing care (RN or LVN);

2. Must meet two or more of the criteria for nursing home risk, as specified in the Resident Assessment Instrument-Home Care Assessment for Nursing Home Risk as revised in April 1996 and summarized as follows:
 - needs assistance with one or more of the activities of dressing, personal hygiene, eating, toilet use, or bathing;
 - has had a functional decline in the past 90 days;
 - has a history of a fall two or more times in past 180 days;
 - has a neurological diagnosis of Alzheimer’s, Head Trauma, Multiple Sclerosis, Parkinson’s, or Dementia;
 - has a history of nursing facility placement within the last five years;
 - has multiple episodes of urine incontinence daily; and
 - goes out of one’s residence one or fewer days a week.
3. Must have been living for 30 consecutive days in a medical facility that has a contract to accept Medicaid patients. Persons in this category must still be screened for medical necessity.

WAIVER PROGRAM

Overview

The Community Based Alternatives (CBA) waiver program provides home and community services to persons age 21 and older who qualify for nursing facility care. The goal of the CBA waiver program is to provide individuals with meaningful choices regarding long term care services. Waiver funds are used to allow individuals to avoid premature nursing facility placement and to provide current nursing facility residents an opportunity to return to a home or community living arrangement.

The CBA waiver program currently serves 32,793 persons and has more than 39,000 on an interest list. Placement on an interest list means potential clients have declared an interest in a program for which funding is limited, but have not yet been assessed for financial or service eligibility. The list has an attrition rate of a few thousand per month. The waiting period from the time people get on the interest list to receiving services is approximately 10 months. Eligible individuals are enrolled from the CBA waiver interest list on a “first come, first served” basis.

Within the constraints imposed by the cost ceiling on a participant’s Individual Service Plan, the waiver program promotes the participant’s active involvement and choices regarding the services provided. Participants may choose to live in their own homes or in a residential care setting covered under the waiver: Adult Foster Care homes or Assisted Living/Residential Care facilities. A waiver participant needing nursing care may choose to have that care delivered by

a licensed nurse or, in those situations where delegation is appropriate, by an unlicensed person providing services under the direction of a registered nurse.

The majority of services offered under the CBA waiver program are provided by licensed home and community support services agencies. These agencies provide services to participants living in their own homes, adult foster homes, assisted living/residential care facilities (formerly known as personal care facilities), and other locations where services are needed.

Rider 28 of the General Appropriations Act, 76th Legislative Session³

As part of its Olmsted initiative, the State has tried to increase the ability of individuals in nursing facilities who could transition into the community to do so through the CBA waiver program. Because there are too few slots in the waiver program relative to demand, the State is using a money follows the person initiative to fund home and community care.

Under Rider 37, when there are insufficient slots or funding in the CBA waiver program, funding follows the individual from the nursing home into the community. The cost of services comes from the nursing home budget instead of the CBA waiver budget. Thus, individuals in nursing homes who are Medicaid eligible can move to the community and receive home or community residential care even when CBA waiver funding is not available.

During a recent twelve-month period, 952 individuals have taken advantage of Rider 37, with about 45 percent transitioning to residential care. Many of those who transitioned were between the ages of age 21 and 64.

The lack of CBA waiver slots can result in a person who spends down in the community having to enter a nursing home for a month in order to apply for funding under Rider 37. The state is grappling with the question of what to do with funds when persons funded through Rider 37 are no longer served. Currently, the money that funded their care is being returned to the nursing home budget.

Financial Criteria

- Two groups are financially eligible for waiver services:
 - *Group A* includes individuals who are eligible because they are receiving SSI.
 - *Group B* includes persons with incomes up to the special income standard of 300 percent of SSI, which is \$1656.
- Asset limits for both groups are \$2,000 for an individual and \$3,000 for a couple.
- The state does not allow spend-down to waiver eligibility levels. For individuals with income that exceeds the institutional limit, federal policy requires the state to allow the use Qualified Income Trusts, known as Miller Trusts, to become eligible for Medicaid.

Cost Sharing Requirements

The state does not require persons in Group B who are receiving waiver services in their own home to share the cost of services.

For people in Group B who are living in residential care settings, the cost sharing amount is equal to the client's remaining income after all allowable expenses have been deducted. These deductions include:

- 1) the cost of the client's maintenance needs allowance, which is equal to the SSI federal benefit rate of \$552 per month. The client keeps \$85 as a personal needs allowance and the remainder is used to pay for room and board costs;
- 2) the cost of the maintenance needs of a spouse if the spouse is the only dependent of the recipient. This amount is equal to the monthly SSI federal benefit rate less the spouse's income;
- 3) the cost of the maintenance needs of the client's dependent children. This amount is equivalent to the Aid to Families with Dependent Children (AFDC) basic monthly grant for children or a spouse with children, using the recognizable needs amounts in the AFDC Budgetary Allowances Chart;⁴ and
- 4) the costs incurred for necessary medical or remedial care, which are not covered by Medicare, Medicaid or any other third party insurance, including the cost of health insurance premiums, deductibles and co-insurance.

If any income remains after all these deductions, the cost sharing amount is applied only to the cost of services covered by the waiver program and specified on the client's individual service plan and must not exceed the actual cost of services delivered. Clients must pay the cost sharing amount to the provider contracted to deliver authorized waiver services.

Spousal Protections

- The state's maximum monthly maintenance needs allowance for the spouse of a waiver client is the monthly SSI limit for an individual. The spouse's income is deducted from the SSI limit and the waiver recipient's income is diverted to make up the difference.
- Resource protection is the same as for the spouses of institutionalized persons. The protected resource amount will be the greater of the following: the state minimum resource standard, which is \$18,132; or one-half of the couple's combined countable resources not to exceed the maximum resource standard of \$90,660; or the amount transferred to the community spouse under a court order. All assets over this maximum must be spent before Medicaid will begin to pay.

Family Supplementation

Family payments for an individual's food, clothing, and shelter are considered support and maintenance for waiver clients and a value is assigned. Because support and maintenance are not considered for clients in institutional settings, and institutional and waiver financial eligibility rules are the same, support and maintenance is not considered for waiver clients.⁵

Level of Care Criteria

To be eligible for waiver services, a person must meet the nursing home level-of-care criteria and several CBA waiver specific criteria. They must:

- choose CBA waiver services in lieu of institutional care based on an informed choice;
- have an individual service plan for waiver services with an estimated annual cost not exceeding 100 percent of the individual's actual Texas Index for Level of Effort (TILE) payment rate;⁶
- have ongoing needs for waiver services whose projected costs indicated on their service plan do not exceed the maximum service ceilings set for the services listed below:
 - Adaptive Aids and Medical Supplies cannot exceed \$10,000 per individual per service plan year;
 - Minor Home Modifications service category cannot exceed \$7,500.00 per individual;
- receive waiver services within 30 days after waiver eligibility is established;
- reside either in their own home or in a licensed assisted living facility or adult foster care home contracted with the Texas Department of Human Services to provide CBA waiver services.

PERSONAL CARE OPTION—PRIMARY HOME CARE PROGRAM

Overview

In 1979, Texas added personal care to its Medicaid State Plan. The personal care program is called the Primary Home Care Program, and it serves the aged and disabled. The program provides non-technical, medically related personal care services prescribed by a physician as part of a client's plan of care. Primary Home Care is available to eligible Medicaid clients whose health problems cause them to be functionally limited in performing activities of daily living. It is available statewide, and there is no waiting list.

Services are provided by a primary home care attendant employed by a licensed home and community support services agency. The agency's license must cover the provision of home health services, personal assistance services, or both.

Each eligible client may receive up to 50 hours of primary home care per month (42 hours per week for a client with priority status). The Primary Home Care Program provides three services:

- *Personal care:* help with bathing, dressing, grooming, routine hair and skin care, preparing meals, feeding, exercising, helping with self-administered medication, toileting, and transferring/ambulating.
- *Home management:* assistance with housekeeping activities that support the client's health and safety, such as changing bed linens, housekeeping, laundering, and shopping.
- *Escort:* accompanying the client on trips to obtain medical diagnosis or treatment, or both. This service does not include the direct transportation of the client by the attendant.

Excluded services that must be provided by a person with professional or technical training, include:

- insertion and irrigation of catheters;
- irrigation of body cavities;
- application of sterile dressings involving prescription medications and aseptic techniques;
- tube feedings;
- medication administration; and
- any other skilled services identified by the regional nurse.

Medicaid Financial Criteria—SSI

To be eligible for the Primary Home Care program an applicant must be eligible for SSI or have income no higher than the SSI level, or meet 1929(b) income and resource limits (see Community Attendant Services Program described below).

Spousal Protections

There are no spousal income and asset protections for community spouses of persons receiving personal care services.

Family Supplementation

Family payments made for support and maintenance may be counted when determining Medicaid eligibility, in accordance with SSI policy.

Level of Care Criteria

A client's degree of functional impairment is measured on a 60-point functional needs assessment to determine if the impairment is severe enough to qualify for services. Applicants for primary home care services must meet functional needs criteria as follows:

- Must score 24 or above on the Client Needs Assessment Questionnaire.
- Must have a medical need for assistance with personal care.
- Must have a signed and dated Physician's Order for Primary Home Care.
- Must require at least six hours of primary home care per week. An applicant/client requiring fewer than six hours per week may be eligible if she meets at least one of the following criteria:
 - scores at least 30 on the Client Needs Assessment Questionnaire and primary home care is essential to provide respite care to the caregiver or to enable the applicant/client to remain in the community;
 - lives in the same household as another individual receiving family care or primary home care; or
 - also receives congregate or home-delivered meals, participates in the day activity and health services program, or special services for handicapped adult day care.
- For primary home care clients, the client's medical diagnosis(es) must be the cause of the client's functional impairment in performing personal care tasks. Although mental illness and mental retardation are not considered medical conditions, they do not disqualify a client for eligibility as long as the client's functional impairment is related to a coexisting medical condition.

To receive services the applicant/client must reside in a place other than a hospital, a skilled nursing facility, an intermediate care facility, or any other environment where family members or sources outside the primary home care program are available to provide personal care. Services cannot be authorized if the client lives in a home licensed as an assisted living facility (ALF). If the home is not a licensed ALF, services may be authorized under the following two circumstances:

- Three or fewer persons live in the home. The proprietor can be the attendant for the client(s) who resides there. A client may not receive adult foster care services as well as primary home care services.
- If the home provides only room and board to four or more persons living in the home, it does not require licensure as an assisted living facility. Services can be authorized for clients in this setting, but the proprietor, his agent, or employee cannot be the attendant for clients who reside in the home.

COMMUNITY ATTENDANT SERVICES PROGRAM

In the 1980s, Texas implemented a demonstration waiver program called the Frail Elderly Program, which provided only attendant services. Texas was the only state that participated in

the demonstration and in the early 1990s when the program ended, federal law permitted Texas to retain the program as a personal care option under 1929(b) regulations, which essentially allow higher income eligibility criteria (300 percent of SSI) than is used for other Medicaid state plan services. However, clients served under the program are not eligible for any other Medicaid services, e.g., primary and acute medical care, prescription drugs, and home health services.

Although the program was called Frail Elderly, the statute allowed the program to serve persons of all ages. In 2003, the State changed the name of the program to the Community Attendant Services Program. The program's eligibility criteria and services are the same as for the Primary Home Care program. It currently serves 30,000 persons.

STAR+PLUS

There are two types of Medicaid in Texas: traditional and STAR. People in both programs get the same benefits. Under the traditional program, individuals get medical care from any doctor or provider who accepts Medicaid. Under the STAR program, the enrollee has one provider who coordinates and manages their care.

The STAR+Plus pilot program is a Medicaid pilot project operating since 1998. It is designed to integrate delivery of acute and long term care services through a managed care system. The project requires two Medicaid waivers—1915(b) and 1915 (c)—in order to mandate participation and to provide home and community services.

The project serves approximately 55,000 SSI aged and disabled Medicaid recipients in Harris County (Houston). STAR+PLUS provides a continuum of care with a wide range of options and increased flexibility to meet individual needs. The program has increased the number and types of providers available to Medicaid clients.

Participants may choose from two health maintenance organizations. Certain participants have a primary care case management option in addition to the two HMO choices. The HMO provides both acute and long term care services. STAR+PLUS Medicaid Only clients are required to choose an HMO and a Primary Care Provider (PCP) in the HMO's network. These clients receive all services—both acute and long term care—from the HMO.

Those also eligible for Medicare choose an HMO but not a PCP because they receive acute care from their fee-for-service Medicare providers. The STAR+PLUS HMO provides only Medicaid long term care services to dual eligible clients. Of the approximately 55,000 STAR+PLUS eligibles in Harris County, about half are “dually eligible” for both Medicaid and Medicare. The program has demonstrated significant savings, but there are no plans currently to expand it.

STAR+PLUS Long Term Care Services

All clients receiving long term care services under STAR+PLUS receive care coordination for acute and long term services from the HMO. Care Coordination services include the development of an individual plan of care with the client, family members and provider, and authorization of long term care services for the client.

Long term care services provided by the HMOs include day activity and health services, personal attendant services, and short-term (up to 4 months) nursing facility care. Additional services provided to CBA waiver clients are adaptive aids, adult foster home services, assisted living/residential care services, emergency response services, medical supplies, minor home modifications, nursing services, respite care and therapies (occupational, physical and speech-language). Approximately 200 clients are receiving services in assisted living facilities.⁷

In 1998, the State amended the CBA waiver program to create a new waiver program specifically for Harris County (in effect, there are now two 1915(c) waiver programs in Texas). The providers contract with the HMOs and, as much as possible, deliver the same services as the CBA waiver program, by way of a capitated payment from the CBA waiver budget for Harris County. There is no waiting list. The HMOs may also provide additional “value-added” services, such as CBA waiver services to clients living in the community but not in a CBA waiver slot.

LONG TERM CARE PROGRAMS FUNDED WITH STATE REVENUES ONLY

Community Care for Aged and Disabled (CCAD) is a state program that provides services in a person’s own home or community for aged or disabled persons who are not able to take care of themselves, and who might otherwise be subject to unnecessary institutionalization or to abuse, neglect, or exploitation.

In addition to services provided through the waiver program and the personal care option, CCAD includes a number of home and community service programs funded by state general revenue funds and Title XX funds. Two of these programs cover services in residential care settings: Adult Foster Care (AFC) and Residential Care(RC). The state program serves approximately 200 people in AFC and 800 in RC each year. Reimbursement rates for services are less than those paid for waiver clients.

To be eligible for the Adult Foster Care and Residential Care programs through CCAD, individuals must be financially eligible for Title XX services or must meet the income criteria for Medicaid waiver services (300 percent SSI), and not have assets exceeding \$5,000 for an individual and \$6,000 for a couple. In calculating financial eligibility, a number of exclusions from income and resources are permitted. Clients keep a monthly allowance for room and board and personal and medical expenses, and the remainder of their income is contributed to the total cost of care. Applicants/clients must also score at least 18 on the Clients Needs

Assessment Questionnaire and have the approval of the CCAD led unit supervisor. The applicant's needs may not exceed the facility's capability under its licensed authority.

Adult Foster Care Program

Adult Foster Care is provided in homes enrolled with the Department of Human Services. This service provides 24-hour living arrangements and may include meal preparation, housekeeping, minimal personal care to help with activities of daily living, and provision of, or arrangement for, transportation.

Residential Care Program

The Residential Care program provides services to eligible adults who require 24-hour access to care, do not require daily nursing interventions, and do not meet waiver level-of-care criteria. Services include, but are not limited to personal care, home management, 24-hour supervision, social and recreational activities, and transportation. Services provided under this program are delivered through one of two arrangements:

- *Supervised living* is a state-funded 24-hour living arrangement, e.g., an assisted living facility, in which clients are expected, if able, to contribute to the cost of their care. Clients also pay for their room and board, which is limited to the SSI payment minus a personal needs allowance.
- *Emergency care* is a state-funded living arrangement that provides services to eligible clients while caseworkers seek a permanent care arrangement. Emergency care clients do not contribute toward the cost of their care.

II. Residential Care Settings

OVERVIEW

Historically, personal care facilities (sometimes called personal care homes) and adult foster care were the primary residential care options in Texas. In 1999, personal care facilities were renamed assisted living facilities, which are defined as any facility that serves four or more adults who are unrelated to the proprietor. Adult Foster Care homes that serve four or more persons are also required to be licensed as an assisted living facility.

In the mid-1990's, the state became interested in supporting residential care alternatives to nursing homes for individuals who met a nursing home level of care but could not be safely cared for at home. The Department of Human Services worked with providers and advocates to develop a 1915(c) waiver program to provide services in both private homes and residential care settings. The new waiver program, called Community Based Alternatives (CBA), was

implemented in 1994. Initially, the cost of CBA waiver services was capped at 90 percent of nursing home cost, but the state has now raised the cap to 100 percent.

The primary goal of the CBA waiver program is to offer home and community alternatives to institutional care and to provide the opportunity for those in institutions to transition to the community. In keeping with this goal, the state made efforts to bring about a “culture change” among hospital discharge planners, doctors and families regarding the appropriateness of home and community care alternatives to nursing homes. One respondent noted that these efforts appear to have been successful, given that 95 percent of those receiving CBA waiver services have never been in a nursing facility.

When the CBA waiver program was developed, it was anticipated that 50 percent of waiver clients would be served in personal care facilities, particularly elderly persons who did not need a high level of care. This expectation fueled the development—and some respondents said—the over-development of personal care facilities and other types of residential care settings.

In 1987, Texas had 4,200 beds in personal care facilities. In 2002 there were over 40,000 licensed assisted living beds (including adult foster care homes licensed as Type C assisted living facilities), of which only 67 percent (26,000) were occupied, primarily by private pay residents. The main reason for the low occupancy is that the majority of waiver clients choose to live in their own homes. In 2002, approximately 2,500 CBA waiver clients received services in assisted living facilities through 320 contracts with providers across the state—less than seven percent of the 32,000 clients receiving CBA waiver services.

ADULT FOSTER CARE HOMES

- Adult Foster Care Homes provide a 24-hour living arrangement with supervision for individuals 18 years of age and older who, because of physical or mental limitations, are unable to continue independent functioning in their own homes.
- Providers may serve up to three adult clients in a Department of Human Services (DHS) enrolled adult foster home. These homes do not have to be licensed but those accepting Medicaid clients have to meet Medicaid contracting requirements. Homes with four or more residents are called Small Group Homes and must be licensed under the assisted living licensing rules as a Type C facility, in addition to being enrolled with DHS. Providers must serve no more than eight adult clients in an enrolled Small Group Home. The CBA waiver program contracts with both licensed and unlicensed adult foster care homes.
- Services reimbursed through the CBA waiver include meal preparation, housekeeping, personal care and nursing tasks, supervision, and the provision or arrangement of transportation. Nursing tasks may be delegated by a registered nurse to a foster care provider based on the provider’s abilities and the needs of the participant.

- The client pays the provider for room and board from their own income. Texas limits the amount that can be charged for room and board for Medicaid waiver clients in adult foster care to an amount equal to the SSI federal benefit rate minus a personal needs allowance of \$85.00 which equals \$467. There are no restrictions on the amount adult foster care homes can charge private pay residents.
- CBA waiver clients can be served in private or shared rooms depending on availability and the preference of the client. Adult foster care homes cannot have more than two beds in any room and must provide at least 80 square feet of floor space in a single occupancy room, and at least 60 square feet of floor space per client in a double occupancy room.
- There are three care levels in adult foster care homes, and as of September 2003, the payment rates are \$18.71, \$32.27 and \$65.52 per day. The level of care required is based on an assessment and the recommendations of a Home and Community Support Services nurse.
- Adult foster care providers cannot terminate services to a resident without the prior approval of the adult foster care caseworker or supervisor, unless the resident creates a serious or immediate threat to the health, safety, or welfare of the provider or the other residents of the foster home.

ASSISTED LIVING FACILITIES

In Texas, assisted living is a service delivery model not an architectural model. It is defined as a housing plus services arrangement for persons who, because of a physical or mental limitation, are unable to live their own homes. Assisted living settings provide food, shelter and personal care services to four or more persons who are unrelated to the proprietor of the establishment.

There are five types of licensed ALFs, but there are two primary licensing designations, which are based on residents' physical and mental ability to evacuate the facility in an emergency, and whether nighttime attendance is necessary.⁸ They are:

- Type A facilities, whose residents must be capable of evacuating the facility unassisted, who must not require routine attendance during night time hours, and who must be capable of following directions under emergency conditions. This may include persons who are non-ambulatory but mobile, such as persons in wheelchairs or who use electric carts, and have the capacity to transfer and evacuate themselves in an emergency.
- Type B facilities, whose residents may require staff assistance to evacuate, may not be able to follow directions, who require attendance during the night, and who, while not permanently bedfast, may require assistance in transferring to and from a wheelchair. Facilities that advertise, market, or otherwise promote their capacity to provide personal care services for people with dementia must be certified as a Type B facility.⁹

Only licensed facilities may use the term assisted living, and the statute requires careful monitoring to detect and report unlicensed facilities. An assisted living facility must be licensed to participate in the CBA waiver program.

Medicaid Waiver Contracts

The Department of Human Services (DHS) contracts directly with qualified providers on an open enrollment basis. Any provider agency that meets the enrollment or licensing criteria for the service it proposes to provide under the waiver is eligible to apply for a contract with DHS. Providers are required to maintain current certifications or licenses for the applicable services throughout the time period during which waiver services are delivered.

The Medicaid CBA waiver program contracts with six categories of assisted living providers to cover Assisted Living/Residential Care (AL/RC) services:

- Licensed adult foster care providers
- Licensed assisted living facility (ALF) providers
- Licensed emergency response system providers
- RNs contracted with DHS and nurses employed by or contracted with licensed home and community support services agencies.
- Home and community support services agencies.

In addition to meeting all relevant licensing and regulatory requirements, providers must agree to contractual rules for accepting CBA waiver clients.

The Medicaid contract rules specify three different types of housing options in which waiver clients may be served: assisted living apartments, residential care apartments, and residential care non-apartments. All are considered types of assisted living and all are licensed as assisted living facilities. The three types of housing options are described below.

Assisted Living Apartment

- An assisted living apartment—which may be an efficiency or a one-bedroom—is defined as an apartment for single occupancy that is a private space with individual living and sleeping areas, a kitchen, bathroom, and adequate storage space. The bedroom must be single occupancy except when double occupancy is requested by the participant.
- The apartment must have a minimum of 220 square feet, not including the bathroom. Apartments in pre-existing structures being remodeled must have a minimum of 160 square feet, not including the bathroom. The bathroom must be a separate room in the individual's living area with a toilet, sink, and an accessible bath.

- The kitchen is an area equipped with a sink, refrigerator, a cooking appliance that can be removed or disconnected, adequate space for food preparation, and storage space for utensils and supplies. A cooking appliance may be a stove or microwave.

Residential Care Apartments

- Residential care apartments are units with two bedrooms, each with a single occupant, with a shared kitchen and bathroom providing a minimum of 350 square feet per client. Indoor common space used by residents, such as the dining room and entertainment room, may be counted in the square footage requirement by averaging the total square footage of the common areas and dividing by the number of beds in the facility.
- Kitchens must be equipped with a sink, refrigerator, cooking appliance (stove, microwave, built-in surface unit) that can be removed or disconnected, and space for food preparation.

Residential Care Non-Apartment

- A residential care non-apartment setting has living units that do not meet either the definition of an Assisted Living apartment or a Residential Care apartment.
- These units may be single or double occupancy units and must be in free standing buildings that are licensed for 16 or fewer beds.

These non-apartments tend to be the older personal care facilities (redefined as assisted living facilities in 1999). Most have dual occupancy rooms and some have rooms with up to four residents in a dormitory style. No more than 50 percent of the beds in a given facility can be shared by three or more persons. Bathrooms are required for every six residents.

Single Occupancy

A big hurdle in developing the waiver was obtaining consensus among the consumer advocates and providers regarding occupancy rules in assisted living facilities. The consumer advocates wanted single occupancy to be required for waiver clients, while the providers wanted double occupancy to be the standard because existing providers already had double occupancy rooms in many facilities.

CBA waiver provider participation standards require the assisted living facility to provide each client with a choice of a private or semi-private room. The Texas Waiver Handbook also states that the facility must provide each participant with a separate living unit. However, in practice, dual occupancy rooms and apartments are not excluded from the waiver program. Most assisted living facilities serve a predominantly private pay clientele and single occupancy units are not always available

There are no data indicating the percentage of CBA waiver participants typically served in dual occupancy or dormitory units, but respondents did not think that the percentage was that different from the percentage of private pay residents in dual occupancy or dormitory units. As

of December 31, 2002, 1787 CBA clients were in single occupancy apartments, and 952 CBA clients were in double occupancy apartments.

The CBA waiver contracts specify which of the three housing options will be available for CBA waiver clients. Providers may not deliver CBA waiver services in a housing option which is not specified in the contract. If the AL/RC provider wishes to limit the types of apartments in a facility that are available to CBA waiver participants, this must be specified in the contract. Without this specification, all types of apartments in the facility must be available to CBA waiver participants.

If the facility limits the type of apartment available for CBA waiver clients and there is no apartment of that type available, they can refuse to accept any CBA waiver client, based on not having space available. This would apply both for a client wanting to move into the facility from the outside, or to a private pay client currently in the facility who has spent down to CBA waiver eligibility. The client would then have to move to another assisted living facility or to an adult foster care home.

Room and Board

Texas limits the amount that can be charged for room and board to Medicaid waiver clients in assisted living facilities. The amount is equal to the SSI federal benefit rate minus a personal needs allowance of \$85.00, which equals \$467. There are no restrictions on the amount that private pay residents can be charged.

Services

- Required services in licensed assisted living facilities include but are not limited to: assistance with activities of daily living (ADLs), 24-hour supervision (periodic checks or visits to a client during each eight-hour shift to ensure that the client is safe), three meals a day and special diets, housekeeping and laundry, transportation and escort for Medicaid-covered medical appointments, and a planned program of social and recreational activities in the community.
- Alzheimer's facilities must have a planned and structured program that encourages socialization, cognitive awareness, self-expression and physical activity.
- Each of the following services may be provided according to the needs of the participant as authorized on the individual service plan as a waiver or non-waiver service. The case manager will make referrals for the services and coordinate delivery.
 - adaptive aids and medical supplies
 - skilled therapy services (occupational therapy, physical therapy, speech pathology)
 - nursing services

- All services count towards the client's cost cap, whether they are reimbursed through the state plan or the waiver.
- Nursing services consist of the full range of services provided by an RN or LVN within the scope of his/her state licensure. Nursing service can be brought into the assisted living facility for the participant and may be provided by RNs who have contracted with DHS, as well as nurses associated with licensed home and community support services agencies.
- In 2001, licensing rules were amended to allow nurse delegation under the Nurse Practice Act in assisted living facilities. However, delegation of nursing tasks by agency RNs to facility attendants is not allowed. The facility must employ its own licensed staff to delegate nursing tasks.

Medication Administration

- The AL/RC provider is responsible through their contract with DHS for medication administration, which is defined as either the direct administration of all medications or assistance with or supervision of self- medication. This includes injections if needed. Only licensed personnel can give injections.
- Home and community support services agencies cannot be authorized to provide—or be reimbursed for providing—medication administration because it is the facility's responsibility to provide this service. The cost must be included in the daily rate that the facility bills CBA. All other nursing tasks and waiver services can be provided by an HCSS agency.

Service Rates

- The reimbursement methodology for CBA waiver Assisted Living/Residential Care (AL/RC) services is based on clients' needs as determined by their TILE classification (Texas Index for Level of Effort). The state developed the TILE classification system to group nursing home residents on the basis of the level of effort needed by a licensed nurse to meet their needs and their functional abilities. TILE classifications are numbered TILE 201 through 211, with TILE 201 indicating the highest intensity of care.
- Private pay clients are not assessed for TILE levels and facilities are free to charge different rates for private pay residents.
- Effective September 2000, the state approved rate increases for CBA waiver AL/RC providers. However, the appropriations for these increases are contingent upon the adoption of agency rules that promote increased wages and benefits for attendants, thereby reducing staff turnover and attrition. Providers have a choice of participating in the Attendant Compensation Rate Enhancement option; those who choose not to will receive a single attendant compensation rate regardless of the client's TILE classification.

- Almost half of AL/RC providers have chosen this payment option. State staff reported that participating providers have additional monitoring and reporting requirements, but in return have less recruiting and training costs. In addition, by offering higher rates for attendants, the facility will be more competitive than those offering lower rates. For example, if a participating provider has a client residing in an assisted living single occupancy apartment with a TILE of 210, the client would receive a rate of \$47.55 per day. For a nonparticipating provider the rate for this same type of client would be \$ 39.69.
- There are 11 different TILE levels, 201 to 211, but the CBA waiver decided to combine some of the levels for a total of six payment levels. In 2003, the rates were as follows:
 - apartment assisted living ranged from \$46.13 to \$60.27 per day;
 - residential care apartments from \$39.54 to \$53.68 per day;
 - non-apartment residential care range from \$23.60 to \$37.74 per day.

Admission, Retention, and Discharge Criteria, and Aging in Place

Texas believes that services provided in assisted living facilities should enhance a person's ability to age in place while receiving increasing or decreasing levels of service as the person's needs change.¹⁰ The key distinction between nursing homes and assisted living facilities is that the former provides regular nursing care. Licensing rules do not permit assisted living facilities to serve those who require more than intermittent, short-term acute, or terminal nursing services. If an assisted living resident—either private pay or CBA waiver—requires intermittent, short-term or terminal nursing services, the provider has to contract with an agency to provide them.

The regulations specify that assisted living facilities may admit residents who:

- exhibit symptoms of mental or emotional disturbance, but are not considered at risk of imminent harm to self or others;
- need assistance with movement;
- require assistance with bathing, dressing, and grooming;
- require assistance with routine skin care, such as application of lotions, or treatment of minor cuts and burns;
- need reminders to encourage toilet routine and prevent incontinence;
- require temporary services by professional personnel;
- need assistance with medications, supervision of self-medication, or administration of medication;
- require encouragement to eat or monitoring due to social or psychological reasons of temporary illness;

- are hearing impaired or speech impaired;
- are incontinent without pressure sores;
- require established therapeutic diets;
- require self-help devices; and
- need assistance with meals.

If residents have a change in health or conditions related to the amount and type of care required, the case manager, in conjunction with the other members of the Interdisciplinary Team, the provider and the resident or their legal representative, may explore other means to continue serving them in assisted living. CBA waiver participants (and private pay residents) may receive licensed nursing services in an assisted living facility if they are provided through contracts with certified home health agencies. Another option is to have the resident attend a day activity and health services program, which provides some nursing care. In either case, the cost of all services combined may not exceed the waiver cap.

Rules regarding retention criteria include:

- If participants exhibit behavior that threatens the health or safety of themselves or others, or their needs exceed the licensed capacity of the facility, the AL/RC provider must request the case manager to assess the participant's continued eligibility for CBA waiver services.
- If a CBA waiver client is hospitalized or admitted to a nursing facility, the facility must hold their room as long as they pay the daily room and board charge. The facility may not bill for services while the client is residing elsewhere.
- An ALF resident may be allowed to stay in a facility as long as the resident and/or the family, a personal physician and the assisted living provider all agree that the residents' needs can be adequately met.
- To address concerns regarding the inappropriate retention of residents with a high level of need, the State enacted a requirement, effective September 2002, that facilities conduct a formal assessment of residents' needs annually and whenever there is a significant change in the resident's condition. This requirement is applicable to both Medicaid eligible and private pay residents.

III. Summary of Interviews

In addition to consulting with ten state staff and policy makers regarding the technical details of the state's programs, we also interviewed four of them. In addition, we interviewed nine stakeholders, including representatives of residential care provider associations, consumer advocates, the state ombudsman program, aging services providers, the state agency that administers the home and community services program, the state office of a national advocacy

association for seniors, and a former state administrator (now a long term care policy consultant.)

The interviews focused on respondents' views about several key areas and issues. This section summarizes their views and provides illustrative examples of their responses. These comments are not verbatim quotes, but have been paraphrased to protect the respondents' anonymity and edited for brevity. A list of information sources for the state description and the individuals interviewed can be found at the end of this summary.

GENERAL COMMENTS ABOUT THE STATE'S RESIDENTIAL CARE SYSTEM

Because residential care facilities serve both private pay and Medicaid residents, a few respondents expressed views about the industry as a whole, and about particular issues the long term care system is facing, including a liability insurance crisis.

- *Litigation has been occurring more and more in the nursing homes and is starting in assisted living facilities. Texas is usually named alongside Florida as being in the same litigation crisis. ALF licensure does not require liability insurance, but nursing facilities will be required to have liability insurance as of September 2003.*
- *Providers will challenge the State on liability issues. The 2003 legislative session is going to address tort reform.*
- *An error in the regulations has led to increased liability for providers. The current regulation states that assisted living providers are responsible for care and services. It is supposed to say that providers are responsible for coordinating all care and services. Often, assisted living facilities do not provide the services themselves, but arrange for them to be provided by outside entities.*

Several expressed satisfaction with the state's efforts to involve all stakeholders in the regulatory process and for keeping them informed.

- *The State was very inclusive in seeking input before it promulgated the assisted living rules. Agencies, providers, and advocates/consumers have always had the opportunity to discuss their concerns about regulations. Consequently, the regulations reflect the intent of the legislation because of the good communication. The State has built a framework for assisted living in terms of regulations and has built in accountability.*
- *The state operates an informative website for providers that is very good at keeping them current on new policy and regulatory changes. Providers also appreciate the availability of training sessions. There are some concerns about the quality of training for CBA wavier case managers.*

One respondent expressed concerns about unlicensed assisted living facilities.

- *There are approximately 3,000 small unlicensed facilities that are receiving SSI payments. Some are operating legally by not providing services, but others are offering and providing substandard services illegally.*

Another was very pleased with the state's approach to nurse delegation.

- *The state has been very progressive in moving towards nurse delegation. This is very important given the nursing shortage, the higher cost of nurses, and the potential for over-medicalization in ALFs.*

GENERAL COMMENTS ON MEDICAID'S ROLE IN RESIDENTIAL CARE SETTINGS

There was a consensus among all those interviewed that the CBA waiver program was a very good program and that coverage of assisted living was a success for a variety of reasons.

- *The assisted living program has made extraordinary progress and is considered a model for other states. For example, our mandated disclosure statements are being used by other states.*
- *The state has met its goals of supporting individuals' desires to live in an integrated community setting under the CBA waiver program and in Community Care (which covers those receiving personal care services not under the CBA waiver). For some advocates, living in an ALF is not considered to be a true choice because clients overwhelmingly prefer their own home. However, because some individuals may not have homes, the ALF option is still necessary.*
- *The State and legislature put forth a good effort to meet the Olmstead requirements through Rider 37, which has enabled those in nursing facilities to transition into the community and to receive CBA waiver services. We felt very strongly that efforts to move those in nursing homes into community settings—including ALFs—was critical.*
- *There were fears that the nursing home industry might fight the continuation of Rider 37. However, the state has to support the Olmstead decision, giving some "teeth" to the State agencies' support for the continuance of Rider 37.*
- *The most successful aspect of the program is the ability of individuals to age in place, the stability of the CBA waiver program staff, the ease in managing the CBA waiver program compared with other states, and the willingness of CBA waiver staff to listen to provider concerns and to address them whenever possible.*

Two respondents mentioned that the room and board payment for Medicaid waiver clients was not sufficient to cover the costs and needed to be addressed.

- *Many of the non-profit providers receive supplemental funding and contributions from members of churches, faith-based organizations and foundations. The state has asked for a state supplement for room and board to be funded in recent legislative sessions, but has not been successful. It's not likely to be approved in the next legislative session due to the large budget deficit.*
- *The state should adopt a state supplement for room and board as exists in other states, which could lead to an expansion of providers if additional CBA waiver slots were funded.*

LICENSING AND REGULATORY REQUIREMENTS

There were some issues among those interviewed regarding the content of the state's licensing and regulatory requirements for ALFs, although no one felt that regulations posed a major obstacle to affordable assisted living in Texas.

- *The legislature has moved to set up a more punitive environment related to the assignment of administrative penalties (fines), in part because the legislature has come under increasing pressure from advocacy groups concerned about care and searching for more complete regulations.*
- *Over the past three legislative sessions, we have advocated for quality standards and enforcement tools.*
- *I am concerned that ALFs are moving too much towards the medical model, with the result that the facilities will turn into nursing homes, much like the old intermediate care facilities we had pre-OBRA 87.*
- *There is a need for regulations that focus on the services people need. The current licensing standards are too focused on life/safety code distinctions.*
- *Many providers do not have well developed and realistic plans for how they would care for someone in an emergency*

National Standards

The consensus among those interviewed was that national standards were not warranted, although some advantages were noted.

- *Texas is farther ahead than other states in terms of instituting assisted living licensing and regulations.*
- *While federal model guidelines for services could be useful, regulations and licensing should be a state prerogative. Federal regulations might stifle state creativity.*

- *Texas has done a good job of addressing licensing and regulatory issues, including aging in place. Our regulations are progressive; we have a special license for facilities that serve clients with Alzheimer’s disease (Type B ALF). One company that has several assisted living facilities has gone beyond state standards by always providing private rooms.*
- *The American Association of Homes and Services for the Aging (AAHSA) has formed a workgroup to look at national assisted living standards and is moving towards identifying some commonalities. However, the Texas arm of AAHSA does not have a formal opinion on the issue.*
- *If Medicaid funding is involved, I wouldn’t be surprised to see national standards established.*

ADMISSION AND RETENTION REQUIREMENTS AND AGING IN PLACE

A number of respondents expressed concerns about admission practices and the need to assure that people can age in place.

- *Fire and safety regulations have made it possible for facilities to deny residence to individuals in wheelchairs. One provider claimed he couldn’t admit people in wheelchairs, because they would “knock down” other residents, especially in an emergency.*
- *Some ALFs might be creaming the lesser impaired because they don’t want to take care of people with higher levels of care needs.*
- *Some providers are willing to take clients who need higher levels of care, but they don’t want to deal with more accountability standards.*
- *Providers are required to make an assessment decision within 72 hours, which is too short a time. Facility managers and staff want to meet a prospective client in person to make decisions, which is difficult to arrange within 72 hours, especially if the client lives in another area. Another problem is that facilities are pressured to take clients that “don’t fit” with the current facility population or that have heavier care needs than is desirable for a particular facility at a particular point in time. For example, one facility was pressured to take a 350 pound man prone to falls who also had a very large service dog.*

The CBA waiver contract managers recognize that some clients have particularly difficult needs or problem behaviors, but the CBA waiver requirements—not licensing and regulation—require their admittance. I admit, though, that if the requirements were not there, and providers had full choice in admittance decisions, discrimination would likely occur.

With regard to discharge policy, one respondent reported that it was hard to discharge people from assisted living facilities, but noted that the state was getting better about supporting facilities who had really difficult cases.

- *There is a need for regulatory support for aging in place. I strongly promote the chance for individuals to age in place, but I also recognize that facilities who serve individuals needing higher levels of care are required to pay more attention to fire and safety standards.*
- *CBA waiver clients with Alzheimer's are most at risk for not being able to age in place in assisted living facilities due to extreme problem behaviors and the inability for Medicaid to pay for full-time private sitters that some of the private pay clients have. Caring for these people is so expensive that most facilities don't want them and they wind up in nursing homes.*

Respondents felt that the issues related to aging in place were far from settled, with some providers liking the concept and others not. Most supported the concept but had concerns about its implementation.

- *The state recently instituted new regulations that will allow more people to age in place by allowing short term nursing services to be provided (24 hour skilled nursing is not provided normally). Aging in place is a relatively new concept and providers are still learning the consequences and benefits.*
- *I have concerns that some providers might not have the capacity to really support aging in place.*
- *There have been a few cases of residents inappropriately kept in an ALF, although these were mostly small providers that might not have had a full understanding of how to safely maintain clients.*
- *It's easier to age in place in an ALF that is part of a continuing care retirement community.*
- *CBA waiver case managers fairly often pressure facilities to retain a client even though the client's behaviors or conditions allow the facility to remove that individual under current licensing and regulations.*
- *Several respondents remarked that some providers felt that their facilities would be stigmatized by accepting CBA waiver clients. One has spoken with providers not involved in the program who cited "red tape", financial risks, and fear that the facilities will be known as the "Medicaid house" as reasons for not accepting waiver clients.*

Negotiated Risk Agreements

Few respondents were familiar with negotiated risk agreements. One noted that although the term "negotiated risk agreement" is not used, there are agreements that must be signed

between the facility, the person and the person's attending physician to allow aging in place to occur. Several of those interviewed were aware of these agreements and supported the notion of negotiated risk.

BARRIERS TO SERVING MEDICAID CLIENTS IN RESIDENTIAL CARE SETTINGS

Respondents noted a number of barriers, which are discussed in turn.

Insufficient Capacity in the Waiver Program

The unanimous opinion of all those interviewed was that the number one issue for the CBA waiver program is the lack of funding, and there is pressure from providers to fund more waiver slots.

- *The large waiting list for CBA waiver slots is preventing access, rather than affordability or provider availability issues. In addition, the number of slots is not uniform across the State. Elderly persons in their own homes can get services through the Frail Elderly Program, but the CBA waiver is the only program that serves elderly persons in assisted living settings.*
- *A disincentive for providers is that the state can not guarantee CBA waiver slots. An additional concern is that facilities are restricted in reducing the number of beds available to CBA waiver clients even when there are no CBA waiver clients in that area to fill the beds. Although it is possible to increase the number of CBA waiver beds in a given facility fairly easily, reducing a slot usually takes three months after the request has been submitted, during which time the facility is losing money on the empty bed.*

One respondent felt that there was not much of a demand for assisted living in the waiver program.

- *Many individuals would rather stay in their own homes and receive services than go to an ALF, thus the pressure might be less on expanding access to assisted living than expanding in-home options.*

Service Rates

Some stated that low rates were a barrier to the expansion of assisted living, and one respondent felt that Medicaid rates were low across all settings, not just in ALFs. Another said that Texas is limited in its funding for Medicaid programs, noting that the state ranked 47th in terms of its reimbursement rates. Another disagreed:

- *The CBA waiver payment rates used to be much lower, but there have been increases to make the rates more competitive with private pay rates. There are now enhanced rates in exchange for the provision of better wages, workers' compensation coverage, and benefits to facility staff. These rates might be at risk though, given the large state budget deficit.*

One respondent said that the state's bed hold policy was a major cost problem for providers.

- *The state requires providers to hold a bed for 120 days when a resident is placed in other care (e.g., hospital or rehabilitation unit). The room and board rate is only about \$14.00 a day, much less than the private pay rate. The 120 day rule applies each time a client has an out-of-facility placement, so if a resident returns on the 120th day and stays for 2 days, but then has another emergency, the provider has to hold the bed for another 120 days.*

The facility often knows the likelihood of the client's return better than the case managers, who are sometimes resistant to making decisions before the 120 days, even if it seems obvious that the resident can't return. The state should lower the number of days (it used to be 90 days) or limit it to one 120-day period per year per client.

Paperwork

- *The amount of paperwork involved in accepting CBA waiver clients and the difficulties in dealing with a state agency keep some providers from serving these clients. For example, when a CBA waiver client is involved in an incident in an ALF, the facility has to go through two different report processes, one with the regulatory agency and the other with the CBA waiver program agency.*
- *The audit process done by the CBA waiver program, which looks at ledger receipts and daily census record, and the potential fines and vendor/client holds for what are essentially "clerical errors" are a disincentive for some providers to take CBA waiver clients.*

SUGGESTED CHANGES TO IMPROVE THE MEDICAID-FUNDED RESIDENTIAL CARE SYSTEM

A few respondents did not make specific suggestions about Medicaid, but instead noted that there were general areas that the state needed to pay more attention to.

- *With increased emphasis on aging in place, more attention to quality might be needed in ALFs. There have been some reports that the quality issues in ALFs—regarding food, activities, and staffing—are similar to those in nursing homes.*

Others had very specific recommendations.

- *CBA waiver cost-neutrality should be determined on an aggregate rather than individual basis. Therefore, if one individual's cost for remaining in the community in an integrated setting was higher than the nursing home payment, that individual could remain eligible because overall cost neutrality would be upheld.*
- *More education is needed for discharge planners so they will present the full range of options for living in an integrated community setting. While assisted living services should*

be part of the CBA waiver program, they should be alternatives to nursing homes, not the wing of a nursing home.

- *More staff are needed in ALFs. Greater attention to quality and oversight is given to nursing homes than assisted living facilities due to resource constraints and the need to give priority to clients in higher levels of care.*
- *The state needs to improve the screening process to make sure that clients are set up for the most appropriate services based on their needs. It also needs to increase coordination to support a streamlined point of access into the CBA waiver program. Administrative and contracting processes should be simplified so that the grandmother seeking and receiving CBA waiver services and the child and mother seeking and receiving TANF assistance could go into the “same door” to seek and receive services.*
- *The state needs to do a better job marketing and promoting the CBA waiver program to providers. It also needs to reduce the duplication of effort that results from multiple agencies being involved (licensing/regulation and CBA waiver program staff). The state could also be more flexible in its paperwork requirements. For example, the state requires hand-written ledger forms whereas a company may operate a computerized form. Similarly, the state requires a daily service delivery record whereas a company authorizes a service plan for each client that identifies the service and how many times a week it will be provided.*
- *The state should develop an extensive comprehensive assessment process that all providers would use. Some providers do not know what they are looking for when conducting pre-admission assessments. This is more an issue for private pay clients, because for CBA waiver clients, the DHS managers and home health nurses are involved in the admission decision process with the providers.*

FUTURE PLANS

A number of respondents mentioned ongoing activities related to the Olmstead decision.

- *There are many advisory boards operating at the state level that are discussing long term care and Olmstead issues, with providers, consumers and advocates working together.*
- *The appropriations Rider 37 has supported the Olmstead decision and allowed more than 900 nursing home residents to move into their own homes and ALFs. The state is asking for more CBA waiver slots in this next legislative session a continuation of Rider 37.*
- *There is a pilot study using Olmstead relocation specialists to provide individuals in nursing homes with information on the full range of community options.*

A number of respondents mentioned regulatory issues that the state is planning to address.

- *The state is aware of provider concerns with the 120 day bed hold rule and draft new rules are coming out shortly. Stakeholders are appreciative that the state shares draft rules to obtain input.*
- *Draft CBA waiver rules were due to be circulated to providers months ago. The focus of these regulations is to increase the ability of assisted living residents to age in place, and to develop a monitoring process that involves more site visits and interviews rather than just fiscal and process reviews. While more operationally difficult, this type of review would yield more information on service outcomes. The licensing staff are more used to surveying facilities, but the State CBA waiver program staff are less familiar with this type of review. Both they and the providers are going to need training on the review process.*
- *The state is developing a standardized care assessment process.*

Another mentioned the state's ongoing data monitoring activities.

- *The state is tracking individuals transitioning out of nursing facilities into the CBA waiver program. Because their funding is supported by the nursing home budget, the state wants to see if there are cost savings, or whether those leaving the nursing facilities are merely replaced by new Medicaid clients.*

RECOMMENDATIONS FOR OTHER STATES

Only one respondent had a specific recommendation for other states interested in using Medicaid to pay for services in residential care.

- *It's important to have good lines of communication between the program and licensing staff when developing the licensing requirements for assisted living and establishing program operating procedures. The Texas Department of Human Services now houses both program and licensing staff, which has facilitated communication.*

I also recommend that a state reach a consensus on what population will be served (specific client characteristics) and secure buy-in from providers (including nursing home providers) and advocates. A state may have to convince advocates that assisted living is a valid option under community care.

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¹ Gibson, M. J. and Gregory, S. R., *Across the States 2002: Profiles of Long-Term Care*, AARP, 2002.

² When SSI recipients enter a nursing home, SSI provides only \$30 for personal needs. For these individuals, the state provides a supplement of \$30 per month.

³ The provisions of Rider 28 were originally contained in Rider 37 in the 76th legislative session. The number was changed during the 78th legislative session.

⁴ Although the AFDC program no longer exists, allowable maintenance costs are still tied to the basic monthly grant when it did exist.

⁵ “Support and maintenance are not counted as income if eligibility is being tested for a waiver program; for example, Community Living Assistance and Support Services (CLASS), the Community Based Alternatives (CBA), Home and Community-Based Services (HCS), and Medically Dependent Children’s Program (MDCP). The 1929(b) program is not a waiver program.” Texas Administrative Code, Title 40, Part I, Chapter 15, Subchapter E, Rule 15.455.

⁶ The TILE classification system was developed by the Department of Human Services to group nursing home residents on the basis of their clinical conditions and functional abilities.

⁷ The respondent who provided this figure stated that it is a conservative estimate based on incomplete data, and that a larger number is probably being served in these settings.

⁸ Type C facilities are Adult Foster Care Homes with four or more beds. In 1999, when personal care facilities were renamed assisted living facilities, the state required AFC homes with four or more beds to be licensed as an assisted living facility. Type D facilities are operated by the Department of Mental Health and Mental Retardation for persons with serious mental illness and developmental disabilities. Type E facility residents are the same as Type A except that they do not require assistance with ADLs, but only with medication administration.

⁹ Use of advertising terms such as “medication reminders or assistance,” “meal and activity reminders,” “escort service,” or “short-term memory loss, confusion, or forgetfulness” will not trigger a requirement for certification as an Alzheimer’s facility. (Source: Texas Administrative Code, Title 40, Chapter 92)

¹⁰ Texas Administrative Code, Title 40, Social Services and Assistance, Chapter 92, Licensing Standards for Assisted Living Facilities, Subchapter A, Rule 92.2,a.

Appendix G

Wisconsin

Wisconsin

The information in this appendix is presented in three major sections:

- The first section provides an overview of the state's long term care system, with a primary focus on the Medicaid program. Although a state may pay for services in residential care settings through the Medicaid program, the program's financial eligibility criteria and related financial provisions for home and community services can present barriers to serving Medicaid clients in these settings. Thus, the first section of each state's description presents detailed information about rules related to financial eligibility, spousal financial protections, and cost sharing requirements.
- The second section describes the state's residential care system.
- The final section presents the views of respondents interviewed for this study on a range of issues related to Medicaid coverage of services in residential care settings in their state.

Because the information in the first two sections is intended to serve as a reference, some information is presented under more than one heading to reduce the need for readers to refer back to other sections for relevant information.

Unless otherwise cited in endnotes, all information presented here was obtained from the sources listed at the end. Supplemental Security Income levels, the federal poverty level, federal spousal protection provisions, state supplemental payments, and state reimbursement rates are for 2003, unless otherwise noted.

I. Overview of Long Term Care System

NURSING HOMES

Historically, nursing homes have been the predominant provider of long term care in Wisconsin. In 1981, the State instituted a moratorium for nursing facilities which remained in effect through 1998. The State no longer reviews the building of new facilities that are replacement beds; it has a Certificate of Need program for bed applications that would add to the total.

Over the past 20 years, the state has made an effort to reduce nursing home utilization by developing home and community service options. Between 1996 and 2001, the number of staffed licensed beds in Wisconsin nursing homes declined 12 percent from 47,200 to 41,500. However, even after a decade of decline, the nursing home bed rate in Wisconsin is still higher than the national average.¹

Currently, about 10 percent of Wisconsin's nursing homes are in bankruptcy. The state does not know the current distribution of nursing home beds and whether it matches need. Nursing home closures have created several transition issues, for example, finding alternative housing for residents required to move.

Financial Criteria

- There are three groups financially eligible for Medicaid covered nursing home care.
 - *Mandatory Categorically Needy* includes individuals who are receiving Supplemental Security Income (SSI), those receiving SSI and the State Supplemental Payment (SSP), those who have incomes no higher than the SSI/SSP level, and those who are eligible for full Medicaid benefits through any other eligibility option.
 - *Optional Categorically Needy* includes persons with incomes up to the special income standard of 300 percent of the SSI Federal Benefit Rate, which is \$1,656 in 2003. This group must spend all of their income (minus a personal needs allowance) on nursing home care before Medicaid will begin to pay, unless spousal impoverishment provisions apply.
 - *Medically Needy* includes individuals whose nursing home costs exceed their income.
- Asset limits for all three groups are \$2,000 for an individual in a nursing home. When only one member of a couple applies and there is a community spouse, spousal impoverishment protections apply.
- The monthly individual personal needs allowance is \$45.

Spousal Protections

- Community spouses may keep any income in their own name, and the state allows the institutionalized spouse's income to supplement the community spouse's income up to the federal maximum permitted, which is \$2267 per month.
- The spouse of a nursing home resident may keep the larger of \$50,000 or one-half of the couple's assets, up to a maximum of \$90,660.² All assets over this maximum must be spent on nursing home care before Medicaid will begin to pay.

Family Supplementation

Families may pay the difference in cost between a semi-private and private room directly to the nursing home without jeopardizing Medicaid eligibility. In Wisconsin, these payments are called voluntary family contributions.

Level of Care Criteria

To receive Medicaid coverage of nursing home care, individuals must meet *all* of the following eligibility criteria:

- Have a long-term illness or disability
- Have a medical condition requiring long-term maintenance and prevention
- Need help with two or more IADLs
- Need assistance with two or more ADLs or daily supervision to ensure safety

WAIVER PROGRAM

Wisconsin has several waiver programs. The Aged and Disabled waiver program provides services to persons residing in their homes, supported apartments, and all types of residential care facilities: Adult Family Homes, Community Based Residential Facilities, and Residential Care Apartment Complexes.

Financial Criteria

- Three groups are financially eligible for waiver services:
 - *Group A* includes individuals who are receiving SSI, those receiving SSI/SSP, those who have incomes no higher than the SSI/SSP level, and those who are eligible for full Medicaid benefits through any other eligibility option.
 - *Group B* includes persons with incomes up to the special income standard of 300 percent of SSI, which is \$1,656.
 - *Group C* includes medically needy individuals who spend down to the medically needy income level. There is no upper limit on income, but income can be no greater than \$591.67 after deducting medical and remedial expenses.³ There is a hierarchy of spend down categories starting with out-of-pocket expenditures for medical expenses not paid by Medicaid (e.g., over-the-counter medications), followed by expenditures on long term care and other services not covered by the waiver program, then waiver-covered services, and finally Medicaid state plan services, such as prescription drugs.
- Asset limits for all three groups are \$2,000 for an individual and \$4,000 for a couple when both members of the couple are eligible for the waiver and have been receiving waiver services for one year or longer. When only one spouse applies, spousal impoverishment protections apply.

Spousal Protections

- Waiver clients have the same spousal impoverishment protections as nursing home residents. Spouses of waiver clients may keep any income in their own name. The minimum monthly protected income for the spouse of a waiver client, including residents of residential care facilities, is \$1,935, and the maximum amount is \$2,267, as allowable under federal law.
- The spouse of a waiver recipient may keep the larger of \$50,000 or one-half of the couple's assets, up to a maximum of \$90,660. All assets over this maximum must be spent before Medicaid will begin to pay.⁴

Cost Sharing Requirements

Persons in Group B who are receiving waiver services must share the cost of services if income remains after certain deductions. These deductions are:

- 1) A Personal Maintenance Allowance, which is a combination of three items:
 - the basic needs allowance (\$732) for room and board and personal expenses
 - the earned income disregard (first \$65 and one half of the remainder)
 - a \$20 disregard
 - a special housing amount (which equals certain housing costs in excess of \$350 per month, including rent or mortgage payments, insurance, property tax, utilities). For people in residential care facilities, the state “carves out” the rent from the facility’s room and board costs. The amount carved out is similar to the housing expenses allowed for other waiver participants.
- 2) A Family Maintenance Allowance.
- 3) Exempt income (e.g., to pay court ordered expenses such as child support).
- 4) Health insurance premiums.
- 5) Out-of-pocket medical remedial expenses.

Allowable deductions cannot exceed \$1,114. Income over this amount is the cost sharing obligation.

Individuals residing in Community Based Residential Facilities or Residential Care Apartment Complexes are permitted to keep a discretionary allowance to cover incidental personal expenses.⁵ The counties determine the amount they are allowed to keep. The minimum and typical amount is \$65 per month, the maximum permitted is \$240 per month.

Family Supplementation

Anyone who is eligible for SSI is automatically eligible for Medicaid. If the family of a resident in a Community Based Residential Facility makes a payment directly to the facility for a private

room, the SSI payment will be reduced by one third, and the family must make up this difference as well as paying the additional cost for the private room.

If someone is not eligible for SSI, the Medicaid program does not consider money paid to a Community Based Residential Facility for a private room to be in-kind income to the Medicaid beneficiary because the payment is not made in return for a service. Medicaid only considers in-kind payments to be income to the beneficiary if they are “regular, predictable, and in return for a service.”

In Wisconsin, family members often make voluntary contributions to cover room and board, or the cost of a private room in residential care facilities, or to provide service enhancements, i.e., to pay for something individuals would not be getting under Medicaid, such as monthly hairdressing services.

There is some disagreement at the county level about allowing voluntary family contributions. Some counties fear that it can set a precedent and an expectation, and that some Community Based Residential Facilities and Residential Care Apartment Complexes might start to require it. Even though federal law prohibits such requirements, there is no way for the counties to monitor facility practices. If a family chooses to contribute, some counties require documentation in writing that if the contribution stops, it will not be picked up by any other public funding source.

Level of Care Criteria

Waiver applicants have to meet the same level of care criteria as nursing home applicants.

PERSONAL CARE OPTION

In 1988, personal care was added to the Medicaid state plan. Medicaid personal care services may be provided in a person’s home or in a residential care facility—including Community Based Residential Facilities and Residential Care Apartment Complexes and Adult Family Homes. However, services may not be provided in a Community Based Residential Facility that has more than 20 beds.

To be reimbursed for the provision of personal care services, Community Based Residential Facilities and Residential Care Apartment Complexes may employ people to provide the care that is then billed by a Medicaid certified provider (i.e., independent living centers, county or home health agencies). Alternatively, the county may secure services through an agency that provides personal care. Even if the facilities directly employ people to provide personal care, the county, home health agencies or independent living centers still has to bill for the pre-authorized hours provided because Medicaid does not allow Community Based Residential Facilities or Residential Care Apartment Complexes to be certified providers. If a residential care facility wants to be reimbursed for Medicaid personal care, it must have a billing partner, typically a county. The rationale for this restriction is that it ensures county oversight of the care recipient’s entire care plan and assures that duplication of services does not occur.

In FY 2002 Medicaid provided personal care through the state plan to 10,408 individuals at a cost of \$105.6 million. The FY 2003 personal care budget is \$115.4 million. Data on the number of persons receiving personal care in residential care settings are not available.

Financial Criteria

- To be eligible for services through the personal care option, individuals must meet Medicaid's community income standard, which limits eligibility to those with incomes equal to the combined SSI/SSP benefit of \$635.78 per month for an individual, of which \$552 is the federal SSI benefit and \$83.78 is the SSP. For couples, the income limit is \$961.05. To be eligible for SSP an individual must be eligible for either SSI or some other federal benefit.⁶
- Individuals may have no more than \$2000 in assets; couples no more than \$3,000.
- SSI recipients who need at least 40 hours a month of assistance with activities of daily living are eligible for a larger state supplement of \$179.77, for a total of \$731.77. This amount can be used to pay for room and board in Community Based Residential Facilities. Prior to July 2000, this supplement—called the Exceptional Expense Supplement or SSI-E—was available only to individuals who lived in their own or another's home. Since that date, individuals who reside in (1) certified Residential Care Apartment Complexes, (2) Community Based Residential Facilities certified as consisting entirely of independent apartments, and (3) licensed or certified Adult Family Homes are also eligible for the enhanced supplement.
- The state has a medically needy program for the aged, blind and disabled. The medically needy income standard is \$591.67, with asset limits of \$2000 for individuals and \$3,000 for couples. The budget period for medical need is six months. The state provides the same medical coverage and services for the medically needy as it does for the categorically needy.⁷

Spousal Protections

There are no spousal income and asset protections for community spouses of persons receiving personal care services in their home or in Community Based Residential Facilities, Residential Care Apartment Complexes, and Adult Family Homes. Only the spouses of nursing home residents and waiver participants receive income and asset protections.

Service Criteria

Covered personal care services include assistance with activities of daily living (e.g., bathing, dressing, grooming, toileting), assistance with housekeeping, shopping and meal preparation, accompanying the recipient to medical appointments, and providing assistance with medically oriented tasks that are assigned to a trained personal care worker supervised by an RN.

To be eligible for personal care, an individual's physician must provide a written order that such services are medically necessary. Services must also be based on a plan of care and supervised by a Registered Nurse. Amounts over 50 hours per year must be pre-authorized.

Family Supplementation

The policy regarding voluntary family contributions is the same as for the waiver program.

LONG TERM CARE PROGRAMS FUNDED WITH STATE REVENUES ONLY

Community Options Program

Services are provided through the state's Community Options Program (COP) only if they cannot be provided through the waiver program or the Medicaid state plan. The purpose of the state COP program is to divert or relocate persons of all ages and target groups from nursing homes. The COP program is funded through state and county revenues. The state also has a program that provides help for caregivers of persons with Alzheimer's disease or other causes of dementia.

In some instances, COP funding may be used to pay for room and board in Community Based Residential Facilities. Policies regarding room and board payment vary by county and depend, in part, on whether the county has state-only funds available at the time they are needed for this purpose. One study found that the average COP payment for room and board for a waiver client in a CBRF was \$147 per month.

COP funding may not be used to pay for room and board in RCACs per state law because these costs are perceived as too high and paying for them would disproportionately reduce the amount of money available for home care services.

Financial Criteria

Eligibility for the program is restricted to those who are financially eligible for Medicaid or are expected to be eligible within six months of spend-down in a nursing home. Individuals who would be eligible under this latter criterion can receive COP services if they pay part of the cost of those services. COP recipients are permitted to retain \$29,193 in assets, an amount equal to six months of nursing home care plus \$2,000.

People with incomes over the allowed amounts can become eligible by sharing the cost of their services. Those with incomes over the cost of their services are generally not eligible, because they are assumed able to pay for services themselves.

Spousal Protection

The community spouse of a COP recipient has the same income and asset protections as the spouse of a waiver client.

Service Criteria

Eligibility for the program is restricted to those who meet the state's nursing home level of care criteria.

FAMILY CARE PROGRAM

The Family Care Program is a pilot managed long term care program currently operating in five counties. It is based on the philosophy that service dollars should follow the client. People enrolled in Family Care who meet the nursing home level of care criteria have a choice of home care, Residential Care Apartment Complexes, Community Based Residential Facilities, Adult Family Homes, and nursing homes.

The Family Care program replaces/combines waiver programs and other sources of funding for long term care. It provides greater flexibility in the use of funds and improved access through shorter waiting periods.

II. Residential Care Settings

Wisconsin has three types of residential care settings (RCS) and separate licensing and regulatory requirements for each of them: Adult Family Homes (AFHs), Community Based Residential Facilities (CBRFs), and Residential Care Apartment Complexes (RCACs). The state has never had a moratorium on, or a certificate of need program for, RCS.

The state's primary goal in using the Medicaid waiver to pay for services in residential care settings is to provide an alternative to nursing homes for people who cannot live in their own homes. The state also provides Medicaid state plan personal care services in residential care settings, but relatively few people in these settings receive these services compared to the number who receive Medicaid personal care services in their own homes.⁸

Residents in all settings may be able to receive waiver services or personal care state plan services, as long as the facilities meet the regulatory requirements for providing these services and applicable COP and Waiver policies are met. Residents of CBRFs and AFHs may also receive COP state funded services.

In 2001, 76.8 percent of people receiving waiver & COP services received them in their own homes, 13.6 percent in CBRFs, 5.2 percent in AFHs, and .7 percent in RCACs. The remainder are served in other types of facilities such as supervised apartment living. There are no data on how many personal care clients receive services in these settings.

ADULT FAMILY HOMES

Adult Family Homes (AFHs) serve up to 4 residents. Those serving up to 2 residents need to be certified by county certifying agencies and those serving 3 or 4 residents need to be licensed by the state to be reimbursed for waiver services.

COMMUNITY BASED RESIDENTIAL FACILITIES

General Description

- Community Based Residential Facilities (CBRFs) are group living arrangements that serve five or more residents and provide room, board, supervision and other supportive services. Residents have private or shared rooms and most have shared bathrooms.
- CBRFs were first licensed in the late seventies. CBRF is an umbrella category that includes single family homes used for group living, group homes, dormitories, and apartment buildings with separate apartments. CBRFs vary in size from 5 to over 100 beds. Whatever their size or setting, they are all licensed under the same provisions and subject to the same regulations. Facilities with over 20 beds are subject to additional requirements for fire protection, sanitation, construction and maintenance, and other aspects of the physical environment.
- The licensing term CBRF is an umbrella category that covers facilities that may provide care to people of all ages with all types of physical and mental impairments. CBRFs are intended for people who are neither acutely ill nor need extensive amounts of nursing care, yet cannot live independently. Some CBRFs serve a specific population, e.g., the frail elderly, working age adults with disabilities, elderly with dementia, while others serve a heterogeneous population, e.g., people of all ages with a range of physical or mental impairments.

The CBRF regulations state that it is desirable to provide services to a specialized target group, but the state does not require it, in part because the state has many rural areas and there may not be a large enough population in each target group to guarantee full occupancy. Whatever the population served, the CBRF regulations require that the facility be able to meet the residents' needs. Most residents of CBRFs are elderly persons who pay privately, so generally, public policy does not drive the industry.

Physical Plant Requirements

- Newly constructed CBRFs must have at least 100 sq. ft. of floor area in each single and 160 sq. ft. in each double occupancy bedroom. Minimum bedroom floor area for existing buildings is 60 sq. ft. per resident for multiple occupancies and 80 sq. ft. for single occupancies in facilities serving ambulatory residents only, and 80 and 100 sq. feet for

single and multiple occupancies respectively in facilities serving semi-ambulatory and non-ambulatory residents.

- The proportion of CBRF beds in single rooms depend on the county and the population served. There are many small facilities with eight beds and dual occupancy rooms. Larger facilities tend to offer private rooms and baths, generally to meet the preferences of private pay residents. The newer, larger facilities generally have only private rooms, but there is considerable variability regarding private baths.
- Whether or not Medicaid clients have private rooms depends on the availability of these rooms in a given county, and the county's willingness to pay for private rooms using state Community Options Program funds. Facilities enrolled in the Family Care pilot program vary in the number of private units available from 20 percent to 75 percent of total units. The percent of Medicaid clients in private rooms varies considerably by county, most likely reflecting the availability and cost of private rooms in each county.

Room and Board

- Room and board is paid for with either private funds or public funding through SSI. There are no data indicating what percentage of people in CBRFs are private pay and what percentage are SSI eligible. Wisconsin does not set room and board rates for Medicaid waiver clients in CBRFs because the waiver program is administered at the local level by the counties. Consequently, many people who are eligible for the waiver cannot afford to pay market rate room and board costs in CBRFs, or any other residential care setting. In some instances, a waiver client may be able to receive state COP funds to help them pay for room and board costs.
- Some CBRFs will accept the SSI benefit as payment for room and board costs for people who are eligible for Medicaid through SSI eligibility or through the Medically Needy program.

Services

CBRFs serve people who do not require care above an intermediate level of nursing care and need no more than 3 hours of nursing services per week. Nursing care includes anything that is covered by the state's nurse practice act, including tasks that can be delegated, e.g., dressing changes. Assistance with ADLs is not considered a nursing task. Nurses do not have to be on site to supervise delegated tasks. Nurses can be paid hourly or on retainer for a certain number of hours per week. Exceptions to the hourly limits are made for temporary conditions lasting no more than 90 days or longer with department approval.

Sources of Public Funding for Services in CBRFs

General Revenue Funded Community Options Program

The Community Options Program (COP) was originally designed as a home care program in 1982 and there was no separate funding source for individuals in residential care who required long term care services. Once the state approved funding of services in CBRFs through COP and the waiver program (in the mid-eighties) and established new regulatory requirements for receipt of this funding (see below), the industry responded with a growth in new facilities that met the regulatory requirements.

Consequently, greater and greater amounts of COP and waiver funding went for residential care—80 to 90 percent in some counties. In response, the state set a statewide maximum amount of COP and waiver funding that could be spent in CBRFs. This maximum was set at 25 percent of a county's COP and waiver allocation. Because it was recognized that a statewide cap did not accommodate local needs, the policy was changed. Counties now set their own maximum amount of COP and waiver allocations that will be used for CBRF care.

Medicaid

- All Medicaid state plan services—e.g., personal care, medications, and skilled nursing and therapies through home health care—are provided in CBRFs. Both waiver funds and state plan funds can be used to pay for services in CBRFs. The primary reason for introducing Medicaid waiver payments for care in CBRFs was that it was a more cost-effective way of delivering services than the nursing home for people who, for whatever reason, could not live at home. In the nursing home, the state pays for everything—room and board and services, whereas in CBRFs, they pay only for services.
- In 1988, personal care was added to the state plan. The date when personal care was first covered in Community Based Residential Facilities varies by county. The rationale for adding personal care to the state plan was that existing programs providing personal care were not sufficient to meet the demand, and many persons with disabilities did not qualify for these programs. Prior to coverage under the state plan, personal care provided in Community Based Residential Facilities was paid for through the waiver program, the state's Community Options Program, county funding, and federal block grant funding, e.g., Title XX dollars.

Whereas people eligible for waiver services often face long waiting lists, there is no waiting list for personal care under the state plan because the services are an entitlement for Medicaid eligibles when medically necessary. Once personal care was a Medicaid state plan service, counties, home health agencies and Independent Living Centers could apply for a provider number, which allowed them to provide services.

- In 2001, 2,473 residents in CBRFs were receiving services funded by COP, the Medicaid waiver or the state plan. Together these public pay residents occupy 11.5 percent of the state's total CBRF capacity of 21,468 beds. Only a very small proportion of these residents were receiving personal care services through the state plan.⁹
- State plan personal care services and waiver services used to be limited to persons in CBRFs no larger than eight beds.¹⁰ The reason for this policy was that the state did not want to encourage the payment of public money intended to serve individuals in home-like settings, to quasi-institutional residential care facilities. Historically, the state has used small bed size as a proxy for "home-like." Consequently, residents who spent down to Medicaid eligibility in a facility that was larger than eight beds would have to move to a different facility to receive Medicaid, waiver, or COP covered services.
- In 2002, the state revised the policy that limited Medicaid funding to CBRFs with eight beds or fewer. The state now allows waiver funding to be used in CBRFs with up to 20 beds, and more

than 20 beds with Department approval. Residents receiving personal care through the state plan may not be served in CBRFs with more than 20 beds.

Medicaid waiver coverage in CBRFs with more than 20 beds may be allowed when one of the following applies:

1. The facility consists entirely of independent apartments. Independent apartment CBRFs have a separate kitchen, full bathroom, sleeping and living area within each unit.
2. The Department has approved a variance, requested by the county, to provide COP and/or waiver funding for a specific facility. The variance request has documented how the facility design, environment and programming mitigate the effects of living in a large congregate setting.

This change occurred because many providers, residents, and counties wanted to expand residential options for county clients and no longer felt that size was an appropriate way to define "institutional."

Family Care

Wisconsin's pilot program to redesign long term care financing pays for CBRF services provided to enrollees in the five participating counties. Family Care pays for services in RCACs only in pilot counties where there is a care management organization (CMO) and when the facility is included in the CMO's provider network.

Food Stamps

Persons who live in group community living arrangements, such as RCACs that house no more than 16 persons, can receive food stamps if they are either blind or disabled and meet the program's financial eligibility criteria.

RESIDENTIAL CARE APARTMENT COMPLEXES

Initial Development

Effective March 1997, the state carved out a portion of the residential care market that was most suitable for deregulation and created a new category of residential care setting (RCS), called assisted living, with its own specific regulations. The state's intent was to reduce regulatory burden, give providers the flexibility to be creative in developing quality residential environments, and permit residents to have maximum control over their daily lives. Residential Care Apartment Complexes (RCACs) were intended to be a less regulated type of RCS than CBRFs and to increase residential care choices for older persons.

This new category of RCS required that each unit be a separate lockable apartment with a private bath and kitchenette. The statute clearly defines RCACs in accordance with the assisted living philosophy, with specific provisions to assure privacy, autonomy, and the ability to age in place. The statute says that RCAC residents retain control over their personal space, care decisions, and daily routines, and that services are individually tailored to each resident's capacities and preferences.

Because the new assisted living regulatory category required private rooms, other RCSs were prohibited from using the term assisted living. Because many AFHs and CBRFs called themselves assisted living or used the term in marketing, they lobbied the state to allow them to use the term. The state agreed but wanted to distinguish the new model from other CBRFs and AFHs. Consequently, in March 1997, the state issued a new rule changing the name of the new model from assisted living to residential care apartment complex.

RCACs are frequently described as "nice assisted living facilities," but they vary with regard to the availability of amenities, e.g., some have washers and dryers in each unit while others have laundry rooms; some have more common space, such as private dining rooms for family parties, libraries, and computer rooms.

RCACs that do not serve Medicaid waiver clients need only to register with the state. Those that wish to receive Medicaid waiver funding must be certified. Standards for both are the same, but certified facilities are subject to a higher level of regulatory oversight and enforcement, including yearly site visits, and a full range of enforcement actions. One respondent noted that the state's policy is to visit certified facilities once a year, but in actual practice, there are not enough regulatory staff to do so. Registered facilities are reviewed only

in response to complaints and the state cannot levy fines or impose other “intermediate sanctions.”

Wisconsin has 129 RCACs. Forty six percent are registered because they do not plan to admit Medicaid waiver clients. Sixteen registered facilities have become certified, generally because residents have spent down to Medicaid eligibility.

Over 5000 units have been built in the last 5 years. The newer ones are real apartments with separate bedrooms and living areas; the older ones are more like a large studio apartment.

General Description

- RCACs serve 5 or more residents in single occupancy apartment units and there is no limit on the number of units in RCACs; 69 percent of facilities offer one bedroom apartments and 51 percent have studios; 37 percent have 2-bedroom units, though generally only a few.
- Facilities can include a mix of independent living units and RCAC units, and approximately one third do so. About a third are freestanding facilities and two thirds are in a campus setting.
- RCACs are generally full, with an average occupancy rate of 87 percent. Fifty-five percent of RCACs have waiting lists, with an average of 17 people on the waiting list.
- RCACs serve a predominantly private pay clientele. Only 189 people in RCACs are receiving waiver services—four percent of all RCAC residents.

Physical Plant Requirements

- Apartment units must have at least 250 square feet excluding closets, with a full private bath and kitchen and a separate sleeping and living area. The average unit size is larger than the national average and larger than required by Wisconsin administrative rules.

Room and Board

- Wisconsin does not set room and board rates for RCACs. This policy is based on a philosophy of local control and a belief that the state does not have the information needed to set accurate rates. Counties negotiate the room and board rates for publicly funded clients. As part of a Robert Wood Johnson funded project, the state is developing rate setting methods for counties and facilities to use.
- Facilities are free to charge both private pay residents and Medicaid waiver clients whatever they want. In January 2000, monthly RCAC charges ranged from \$625 to \$3,700 per month. The average total charge was \$1,881 per month, allocated as follows: rent \$841, meals \$259, services \$781.

Based on the special income standard for waiver clients (300 percent of SSI) and required cost sharing for services, the typical amount of income that Medicaid waiver clients have available to spend on room and board is \$667 a month (the minimum amount is \$312 and the maximum is \$1,591). Those eligible for Medicaid through the community financial eligibility standard have no more than this amount. Thus, the great majority of persons eligible for Medicaid waiver services and state plan personal care services will not have sufficient income to pay for room and board in an RCAC without a subsidy. Some may be eligible for Food Stamps, which could make the RCAC more affordable.

If people spend down to Medicaid eligibility in RCACs, some providers (e.g., mission driven non-profits, or religious orders) have an endowment fund to subsidize the cost of care for a limited number of residents.

Services

- Service requirements in RCACs are non-prescriptive, stating only that facilities must provide services that are sufficient to meet the care needs identified in the service agreement, both scheduled and unscheduled, and to have emergency assistance available 24 hours a day. Minimum services that must be provided include: meals, housekeeping and medical transportation; assistance with all ADLs; and nursing services such as health monitoring, medication management and administration.

However, while the regulations require that an RCAC have the ability to meet the needs of residents, which may include a need for three meals a day, only about half of RCACs offer three meals a day in their meal packages. The state does not dictate how many meals need to be provided, only that 3 meals be provided if a resident needs them. If the basic package includes only two meals, the facility can charge an additional amount for the third meal, and if they don't want a lot of residents who need three meals a day, they can charge a very high rate for a third meal.

- Both registered and certified facilities may provide up to 28 hours of supportive, personal or nursing services per resident per week, with no additional restriction on the type or amount of nursing care provided. They may choose to provide fewer than 28 hours a week if they wish. RCACs can discourage the entry of residents with high needs by including only a limited amount of care per week in the basic package (e.g., ten hours) and charging a very high rate for any additional hours.

One respondent noted that when the RCAC regulations were being developed, the nursing home lobby expressed concern that RCACs not become a substitute for nursing homes. In response, the state limited all supportive, personal, and nursing services that can be provided in an RCAC to 28 hours of supportive, personal, or nursing services per week, with no additional restriction on the type or amount of nursing care provided. Private pay

residents may pay for additional services they need or want above the 28 hour limit, as long as the service are provided by an outside vendor.

Among the respondents interviewed there was agreement that 28 hours enables a significant amount of physical care, in fact, more than many nursing home residents get. In contrast, CBRFs are permitted to provide only up to 3 hours of nursing care per week with no restriction on the amount of personal care. For temporary conditions lasting no more than 90 days or longer, RCACs may bring in home health services. They may choose whether or not to keep waiver clients under hospice care.

- RCACs may provide all services directly with their own staff or through contracts with outside entities. The waiver program pays the facility for the care provided. Residents may contract for additional services not included in the service agreement, as long as they comply with applicable facility policies and procedures. Facility policies may limit the total amount of services purchased from the RCAC and outside providers to no more than 28 hours. They may not put an hour limit on services up to 28 hours. Facility policies may require that services be provided by licensed personnel, that providers check in when they enter or leave the property, or comply with other requirements they may set.
- As in CBRFs, to be reimbursed for the provision of personal care services, RCACs have to either employ people to provide the care or have the county secure services through an agency that provides personal care. Even if the facilities directly employ people to provide personal care, the county still has to bill for the pre-authorized hours provided, because the state allows only certain types of providers to bill for personal care: Medicaid certified home health agencies, counties, and Independent Living Centers. If an RCAC wants to be reimbursed for Medicaid personal care, it must have a billing partner, typically a county. The rationale for this restriction is that it ensures county oversight of the care recipient's entire care plan, and assures that duplication of services does not occur.
- Staff must be trained and staffing levels must be sufficient to meet resident needs. The state does not set minimum staffing levels or required training hours. Staff at an adjacent care facility can provide coverage, as long as they are available to provide care on short notice. The average staffing ratio in RCACs is one caregiving staff for 12 residents. Sixty-two percent of staff are certified nursing assistants, and employee turnover is 31 percent per year.

Service Rates

- Wisconsin does not set RCAC service rates for Medicaid waiver clients. Reimbursement is based on cost consistent with the maximum Medicaid waiver reimbursement for RCACs, which is capped at 85 percent of the average cost of nursing home care to the Medicaid program—\$73.50/day or \$2,263/month. However, counties are budgeted for only \$41.86/client/day or \$1,280/month and must keep spending for their entire waiver caseload within this average amount.

Because the waiver reimbursement cap is double what is actually available under the waiver program, the result is that few waiver clients are served in RCACs. One respondent expressed concern about people who spend down in RCACs having to move because the waiver program will not cover the cost of services, assuming that a waiver slot is even available.

- Service rates are negotiated between the county and the facility, consistent with guidelines set by the state. If the negotiated rate turns out to be higher than allowable costs,¹¹ the facility must give back the difference at the end of the year. Some counties also negotiate room and board rates on behalf of their waiver clients. Many counties lack the expertise to contract effectively and to enforce the profit limit, and counties often feel pressured to pay the maximum rate, which includes a high profit margin. The state is working to develop a more effective contracting process wherein the service rate will be tied to the care plan and will vary according to the services provided rather than a flat rate.

Admission, Retention, and Discharge Criteria, and Aging in Place

- The average age of RCAC residents is 83.6 years. The average length of stay is 1.6 years, significantly below the national average of just under 3 years. The average turnover rate is 30 percent, consistent with the national average of 29 percent. About half leave because of increasing care needs (53 percent), one in four die, 12 percent spend down and move elsewhere to receive Medicaid services, and 14 percent move to another assisted living setting.
- RCACs cannot admit someone who is incompetent or who has dementia. Individuals who are subject to guardianship through a court determination of incompetence, people who have an activated POA for health care, and those who have been found by a physician or psychologist to be incapable of recognizing danger, summoning assistance, expressing need or making care decision cannot be served in RCACs. Facilities are required to do a thorough assessment, but there is no standardized method for determining competence.

The rationale for the prohibition is that RCACs are minimally regulated. There are no surveyors for registered facilities. To enable some degree of aging in place, a facility may choose to retain residents who develop cognitive impairment or dementia, but if they do, they are required to provide appropriate services. Because the developmentally disabled and many people with serious mental illness cannot meet the competency test, in effect, RCACs serve only elderly persons.

- There are provisions to protect residents from premature involuntary discharge. There is no bed hold policy, but RCACs have to give 30 days notice for discharges.
- Private pay residents have the option to buy services from somewhere else but they still have to pay the facility base rate. Thus, private pay residents have the ability to age in

place if they have the resources to bring in additional help. However, people can't necessarily age in place better in an RCAC than in a CBRF because RCACs can choose to provide a minimum amount of care or a maximum amount.

For example, RCACs can provide minimal nursing services, such as health monitoring and medication administration. They can select their own discharge criteria as long as they do not conflict with regulatory minimum requirements. One of these minimum requirements is that residents can not be discharged based on hours of services purchased until the total number of hours of service purchased from all sources reaches 28 hours per week.

- RCACs cannot limit the amount of care provided to Medicaid waiver clients by setting limits on hours of care. They have to provide whatever is needed up to 28 hours. They can discourage a high level of care for private pay clients through pricing. Most RCAC residents on the waiver have spent down. RCACs are willing to accept them as Medicaid clients because the overwhelming majority of their residents are private pay.

Sources of Public Funding for Services in RCACs

Medicaid

- Personal, supportive and nursing services provided in RCACs are reimbursable through Wisconsin's HCBS waiver program. Waiver funds pay for services appropriate for the individual participant. However, most counties have long waiting lists for their waiver program and in some cases the wait can be from one to three years or more. There are approximately 9,000 people on waiting lists for waiver services in Wisconsin. No waiver slots are dedicated for use in RCACs or any other facilities.
- All counties administer the Medicaid HCBS waiver program but they are not required to use waiver funds for RCAC services.
- Although the maximum waiver reimbursement is 85 percent of Medicaid nursing home costs, the Wisconsin HCBS waiver program provides counties with a budget and counties generally do not reimburse to the maximum, because doing so enables them to provide services to more people.
- RCAC residents eligible for Medicaid may be eligible for personal care, home health, therapies, and disposable medical supplies and any other benefit under the state plan.¹²

Family Care

Wisconsin's pilot program to redesign long term care financing pays for RCAC services provided to enrollees in the five participating counties. Family Care pays for services in RCACs only in pilot counties where there is a care management organization (CMO) and when the facility is included in the CMO's provider network.

Food Stamps

Persons who live in group community living arrangements such as RCACs, which house no more than 16 persons can receive food stamps if they are either blind or disabled and meet the program's financial eligibility criteria.

Requirements and Funding Sources for Residential Care Facilities in Wisconsin

Facility Type	Who Regulates	Size and Care Limits	Available Funding Sources
Adult Family Home (AFH)	<ul style="list-style-type: none"> ▪ County certifies homes for 1 or 2 residents ▪ State licenses homes for 3 or 4 residents ▪ Standards for certified and for licensed homes are different. Certification or license required for COP or MA Waiver funding 	<ul style="list-style-type: none"> ▪ Maximum nursing care: 7 hrs. per resident per week in 3-4 bed AFHs. No limit on personal care. ▪ Sponsor may arrange but not provide nursing care in 1-2 bed AFHs. No limit on personal care. 	<ul style="list-style-type: none"> ▪ Private income and/or assets, SSI, SSI-E & insurance ▪ Community Options Program (COP) ▪ Community Integration Program (CIP) IA and IB ▪ COP-W and CIP II / Brain Injury Waiver (BIW) ▪ MA card, when service is provided by an MA-certified provider (e.g., home health or personal care agency). AFHs are not an MA provider type under the MA state plan and cannot bill MA directly. ▪ Family Care & County funds/Community Aids
Community Based Residential Facility (CBRF)	<ul style="list-style-type: none"> ▪ State licenses facilities 	<ul style="list-style-type: none"> ▪ Minimum # resident “beds”: 5 ▪ No maximum # of “beds” ▪ Minimum sleeping room size: 60-100 sq. ft. per resident ▪ Max. amount nursing care: 3 hours/resident/week. Residents with temporary conditions may receive more than 3 hrs. of nursing care/week for up to 90 days or longer with DHFS approval. ▪ No limit on personal or supportive care 	<ul style="list-style-type: none"> ▪ Private income and/or assets, SSI and insurance ▪ SSI-E (Exceptional Expense Supplement) in CBRFs with 20 or fewer beds and/or certified as independent apartment CBRFs ▪ COP and COP-W/CIP II in CBRFs with ≤ 20 beds and in CBRFs with over 20 beds when facility is a certified independent apartment CBRF or has DHFS approval. ▪ CIP IA/IB and BIW: only when variance has been granted and CBRF has 8 or fewer beds. ▪ MA card, when the service is provided by a MA-certified provider (e.g., HH or PC agency). CBRFs are not an MA provider type under the MA state plan and cannot bill MA directly. The MA card cannot be used for personal care in CBRFs with ≥ 20 beds. ▪ Family Care & County funds/Community Aids
Residential Care Apartment Complex (RCAC)	<ul style="list-style-type: none"> ▪ State registration or certification is required. ▪ Facilities serving only private pay residents are registered. Certification is needed for a facility to receive MA Waiver reimbursement. Standards are the same for both; the regulatory process and level of oversight differ. 	<ul style="list-style-type: none"> ▪ Minimum # units: 5 ▪ No maximum # units ▪ Units must be apartments with full private bath and full kitchen ▪ Min. unit size: 250 sq. ft., excluding closets ▪ Max. amount of care: 28 hours/resident/week of personal, supportive and nursing services combined. 	<ul style="list-style-type: none"> ▪ Private income and/or assets, SSI, and insurance. ▪ SSI-E in Certified RCACs ▪ COP-W and CIP II in certified facilities ▪ Family Care ▪ MA card, when service is provided by an MA certified provider (e.g., HH or PC agency). RCACs are not a provider under the state plan & cannot bill MA directly. ▪ County funds (not including Community Aids) ▪ Note: COP funds may not be used to supplement Waiver funds or pay room and board costs.

III. Summary of Interviews

In addition to consulting with eleven state staff and policy makers regarding the technical details of the state's programs, we also interviewed four of them. In addition, we interviewed eleven stakeholders, including representatives of residential care provider associations, residential care providers, consumer advocates, the state ombudsman program, aging service providers, and a county agency that administers the state's home and community services programs.

The interviews focused on respondents' views about several key areas and issues. This section summarizes their views and provides illustrative examples of their responses. These comments are not verbatim quotes, but have been paraphrased to protect the respondents' anonymity and edited for brevity. A list of information sources for the state description and the individuals interviewed can be found at the end of this summary.

GENERAL COMMENTS ABOUT THE STATE'S RESIDENTIAL CARE SYSTEM

Because many of the same residential care facilities serve both private pay and Medicaid residents, most respondents expressed views about the industry as a whole.

- *When it created RCACs the state had an idea of a clientele that never materialized – younger and healthier. If Wisconsin did it over again – I doubt they would do RCACs.*
- *The assisted living industry has been overbuilt because the industry thought they'd attract younger, healthier clientele. But people do not want to leave their homes unless they absolutely have to. When you go to a CBRF or RCAC, you give up your home, all or some of your furniture, your support system. People do this only when they feel they don't have another alternative.*
- *People don't go to RCACs unless they really need to and they usually don't plan to go there. Typically the decision is precipitated by a health care crisis. The average age for new entrants is the mid-eighties.*
- *There is considerable over bedding in nursing homes, CBRFs, and RCACs. It's not to the industry's advantage, yet they keep building them. They say they want to develop affordable assisted living but when we sit down to talk about it, their ideas and ours are worlds apart.*
- *There are very few private rooms in CBRFs and most do not have a private bath. The Family Care Program is supposed to look for private rooms and move in that direction. But the industry didn't build that way. It's an outrage that the residential industry has been allowed to treat people as marginal and put two people in a room.*
- *The residential care industry does not understand that most people do not want to move to assisted living. They never bothered to look at what older people actually want. They want*

to eat what they want, when they want, with whom they want. They want privacy. They want to be able to watch a movie on TV at 3 AM and sleep late and have breakfast whenever they wake up.

The entire industry was developed around a medical model – it was supposed to be an alternative to the nursing home, but it looks too much like a nursing home. They can't think outside the box. There are other ways to structure assisted living. All you have to ask is how would you like to live your life when you are old and figure out how to structure services around those preferences, even if a person needs protective oversight.

Confusion Among Consumers

Several expressed concerns that the residential care system was very confusing for the public.

- *Consistency in terms would help because the current situation is very confusing to people who can't figure out the difference among all the options: CBRFs, RCACs, assisted living.*
- *In Wisconsin, "Consumer Beware" is the operative condition because a person with three cots in their basement can call themselves assisted living.*
- *Currently, "buyer beware" prevails. The public does not understand the distinction between Community Based Residential Facilities and Residential Care Apartment Complexes and how they differ from assisted living. I don't understand the distinction. The Wisconsin web site that has information about these facilities is outstanding – but the ability to utilize the web is an issue. Some older persons and their families don't have computers, and some don't know how to use them to find information.*
- *Because CBRFs and RCACs have considerable latitude in what services they offer, the situation is very confusing for the public; it is very difficult for consumers to find what they are looking for.*
- *Most people haven't a clue what an assisted living facility is and don't know the difference between CBRFs and RCACs. They all call themselves assisted living. I pulled up all the assisted living sites on the web and the list included both CBRFs and RCACs. There is some helpful information from the state on the web, but in Wisconsin, the average age of assisted living entrants is 82 or 83 – they are not likely to have computers and the families don't really understand what they need and which facility can best provide it.*
- *Because of the competition, CBRFs are blurring the distinction between the two types of facilities with regard to how they look. There are more new CBRFs with apartments and private rooms and baths. This is good as long as it does not exclude Medicaid eligibles. In fact, Medicaid eligibles will probably wind up in the crummier CBRFs with lower room and board rates.*

- *AARP did a survey last year and asked our members and the general public about who paid for assisted living and most believed that Medicare paid for it.*

GENERAL COMMENTS ON MEDICAID'S ROLE IN RESIDENTIAL CARE SETTINGS

There was a consensus among the respondents that the state's home and community services program – both the state funded portion and the Medicaid portion – were exceptionally good. Most felt that the state's goal in using Medicaid to cover services in residential care settings is to provide an alternative to nursing homes for people who can not live at home, and that CBRFs are fulfilling this goal.

- *The most important feature of Medicaid paying for services in residential care facilities is the ability to be flexible and to provide services based on people's needs.*
- *It's important that the state is involved in residential care – it's trying meet the needs of residents and operators.*
- *Wisconsin has done especially good work with CBRFs because Medicaid funding has driven the expansion of the pool of facilities. It has no effect on RCACs – the private pay market is driving the development of RCACs.*
- *Just having the option of residential care other than nursing homes is a good thing. Better than having just a choice of a nursing home if you can't live at home. Some people do choose to live in CBRFs. It's also a safety net for people who wind up there because they have no other choice.*
- *I think the use of Medicaid funds to support older persons with dementia in CBRFs has been highly successful. A good CBRF environment is highly preferable to a nursing home.*

However, some thought that the state has not done a good job of developing facilities that are alternatives to nursing homes for the Medicaid population.

- *People shouldn't have a choice only of CBRFs and nursing homes – they should also be able to choose home care and adult family homes (Wisconsin does not have a lot of them.) We need more alternatives to nursing homes for the Medicaid population – like Oregon has – we're getting there.*

With regards to RCACs, there was agreement that the state had met its objective for facilitating the development of apartment style assisted living, given that 5000 RCAC units were built since 1997. This model, however, was not developed specifically to serve Medicaid clients; only 189 RCAC residents are receiving waiver funded services.

- *The state wanted to encourage the development of an apartment style of assisted living modeled after the Oregon model, which it believed was a good model. At the time, the state was also committed to deregulation, and the idea was to create a model of assisted living*

that was less regulated than the existing model at the time – CBRFs. Coverage of the Medicaid population was not a driving factor. The state knew it would have to find a way to pay for the Medicaid population in these settings and to get providers interested in accepting Medicaid eligibles.

- *The state never intended to cover room and board or to limit it to an affordable amount for Medicaid eligibles. There were insufficient powerful people in the housing and social services field to take on the industry. They couldn't even enforce the exclusive use of the term assisted living for RCACs.*

LICENSING AND REGULATORY REQUIREMENTS

No one felt that regulations posed a major obstacle to affordable assisted living in Wisconsin.

- *The RCAC regulations have strong support from assisted living providers and, judging by the rapid growth of the industry in the state, they have not been an obstacle to development. Most facilities exceed the minimum physical plant and staffing requirements included in the regulations.*

Several respondents had concerns about too much regulation in the CBRFs and too little in the RCACs, particularly given that RCACs certified to serve waiver clients are less regulated than CBRFs, even though they are permitted to provide up to 28 hours of care per week, including nursing care. One provider felt that the CBRF regulations were more stringent than nursing home regulations, and another expressed concern that the state will adopt a nursing home enforcement approach in assisted living settings, noting that this approach is not working in nursing homes.

One respondent expressed concerns that the state regulates facilities that serve very different types of people under the same rules.

- *CBRFs range from 5 to 203 residents – there are even CBRFs for unwed mothers and veterans and TBI and DD and corrections clients – all under the same regulations (there are a few changes in the regulations for correctional clients – some of the residents' rights provisions don't apply.) The state needs to regulate differently for different populations in different settings. Some standard nomenclature is needed. Assisted living is a generic term – it can be applied to any setting. I have no answer to the question of what to call the different facilities and why.*

Oversight and Enforcement

The majority felt that the regulatory requirements for oversight in both CBRFs and RCACs were inadequate, and as a result the state was not enforcing regulatory standards.

- *I don't have a good answer to how you keep the bad providers out. More regulations in nursing homes have not solved the problem. The quality of care in Wisconsin is good compared to what we hear about in other states. We need more enforcement of existing regulations. There are very few license revocations.*
- *The CBRF licensing guarantees only minimum oversight – with an annual visit. RCACs don't even get that.*
- *Severe under-funding (and more to come with the budget crisis) has led to inadequate oversight of RCACs by the state agencies. At least CBRF residents have the ombudsman program. RCAC residents have nothing. Anecdotally, I hear as many horror stories about bad care in RCACs as in CBRFs, but they have no recourse except the legal system.*
- *In an RCAC, which has much less oversight than a CBRF, you can get 28 hours of nursing care compared to a three hour limit in CBRFs. There is a lot less supervision in RCACs. Most CBRFs have a two staff to eight resident ratio. In RCACs – it's all contracted services – they have one staff person on duty for 100 folks.*
- *In general, the regulatory process needed to be overhauled. But we are concerned about the cost of the licensing process. There are no facilities that would argue against the necessity for regulations as long as the cost is not exorbitant, particularly for small facilities with 4 to 8 beds who can't afford the training costs on top of recruitment costs. We're spending \$1200 to get folks into jobs and then they leave in six months.*
- *RCACs were created based on a philosophy of de-regulation. The state now realizes that there are enough problems that it needs to visit these facilities more frequently than required in regulation. The state had only one staff person to deal with the oversight of 5000 units. The industry was basically off the hook and got used to this, but then the state got additional staff and started issuing citations.*
- *The requirements are excellent and the oversight to assure the requirements are met is abysmal.*
- *There should be oversight and regulations should be enforced. There is a system for fining providers, but it's not implemented well. Providers are not fined the full amount. There is inadequate enforcement of existing rules.*
- *The state's top regulatory initiative is to shift from a consultation to an enforcement mode in RCAC regulation. The state has identified the need to develop a consistent policy framework for interpreting the RCAC rules as the initial enforcement actions are taken.*

Another state goal is to seek increased program revenue to support a more substantial level of enforcement activity – increasing the certification fee (currently \$350 +\$6 per bed per

year), extending fees to registered as well as certified facilities, and pursuing Medicaid administration funding for regulatory staff costs.

- *More enforcement of existing regulations is needed. The CBRF industry is a good example of how regulations by themselves don't equate to quality. We don't want to over-regulate. The Ombudsman program is not regulatory. The providers should see this as an advantage. It's better than having crises lead to heavy regulation.*

A number of respondents mentioned that when the RCAC regulations were being developed, the industry opposed oversight by the ombudsman program.

- *In some ways Wisconsin is progressive in their standards and some ways not. For example, the Ombudsman Program is not allowed into RCAC's. The rationale was that the state did not want to burden the providers. The law specifically states that the Ombudsman is not permitted to advocate for people in RCACs. Even if an RCAC resident calls the Ombudsman's office, the program is not legally allowed to respond. We are promoting the involvement of the Ombudsman Program in RCACs. However, with the budget crunch, it may not be a priority issue this year.*

Several noted that the way in which RCACs are regulated reflects a compromise among the industry, state staff and consumer advocates; but some felt that the industry had the upper hand.

- *We didn't get what we wanted, e.g., like a requirement that all RCACs provide three meals a day. We had to fight for every thing. It was very hard. We did the best we could but the decision not to license RCACs is questionable as is the decision to not allow the ombudsman program in RCACs. Not having enough staff at state level at the outset of the program was a problem – one person statewide for a new industry. There was little opportunity for adequate consultation.*

One respondent noted that after four and a half years of a consultative approach to RCAC regulation, Wisconsin is now citing and fining violators for the first time: three citations have been issued in the last 6 months, and 11 complaints are currently under investigation.

Staffing Requirements

Many felt that insufficient regulations inevitably lead to problems and if the media picks up on it and reports the problems, then the pendulum swings the other way with a demand for regulation to address the problems, such as a need to assure a higher quality of staff in CBRFs and RCACs.

- *We have a lot of concerns. We have a list of homes in the community and social workers give information about what's available. We get feedback from families about quality and some issues are pretty serious. For example, a resident left the facility and the staff did not*

know they were missing for eight hours; families go to the facility and can't find the staff; the staff are not trained properly; and the staff did not know who to call in an emergency.

- *With regards to quality the major problem faced by all states is staffing. There is a lack of trained staff to work in both nursing homes and assisted living. There are major problems recruiting and retaining which leads to poor quality. The turnover rate is phenomenal – about 100 percent. Pay is low and benefits are non-existent. The State has to do more regarding the pay scale and the quality of the work environment. There have been some promising quality initiatives in nursing homes to improve the work environment. McDonalds and Lands End are competitors for staff – they pay \$8-10 an hour plus benefits.*

One respondent stated that there were major concerns about quality, based on a six-month investigative report by a major newspaper, which reviewed 460 assisted living facilities (CBRFs and RCACs) and found numerous citations for violations over the past 4 years relating to untrained staff, medication errors, not calling the doctor when a resident got sick, leaving residents alone, and abuse. Other respondents felt that there are always a few bad providers, which get the media's attention, but that most providers do their best to provide good care.

- *In my 21 years experience in the field, I can say that those providers who are in the business to provide good services do wonderful things. Those doing a lousy job are always complaining about too little money. I always tell the industry, this is not a place to expect to make huge amounts of money.*

A number felt that the major causes of poor quality were inadequately trained staff, a lack of training requirements and competency testing, and lack of enforcement of existing training requirements.

One provider related the inadequacies of staff, in part, to the increased needs of the typical resident.

- *The original concept for RCACs was good – folks who were pretty independent and needed protective oversight and less care than CBRFs – could be cared for in a supervised apartment setting. But what's happened is that once the first layer of higher functioning people are placed then you get people with higher and higher needs, the same as in CBRFs.*

And I agree with the state that the industry is taking care of people who are too highly impaired. But there is also a push to get people out of nursing homes. The original concept of CBRFs was also to take care of the mildly impaired. But if they are caring for some very impaired residents, obviously more training is needed. I understand the state's perspective. But the state needs to understand that the extra training costs more.

Outcome-Based Regulations

Some respondents, both providers and those representing consumer interests, felt that the industry needs more outcome-based regulations.

- *We're concerned that the legislature will be pushed to apply nursing home type regulations to assisted living and we do not want this. There are always stories in the newspaper about someone being hurt in assisted living and so there is pressure to "do something."*

While many expressed dissatisfaction and at times conflicting views about the state's regulations, there was a consensus that the nursing home regulatory model is not appropriate for residential care settings.

Dementia Care

A number of respondents felt that the state needed better standards for dementia care. One stated that the industry opposes regulation in this area, but another disagreed:

- *We need regulations for dementia care but the industry is not opposed. They just don't want nursing home style regulations. The better providers are not against regulation. They don't want rotten apples to spoil the barrel.*
- *Dementia standards would be a good thing. But the state needs need to figure out its capacity to regulate because there is no point in enacting regulations that can't be enforced. Model standards for dementia would help. The state could encourage the adoption of these standards through incentives. Facilities that operate according to the model standards could advertise that they were certified as meeting the standards. Regulations just set a floor – they don't get you to a desirable level of care – they just set a minimum.*

One respondent noted that cognitive impairment is a real problem in RCACs, because while the regulations prohibit the admission of people who are incompetent, it's possible to be competent but be incompetent at managing medications.

National Standards

With few exceptions, respondents agreed that national or model standards for assisted living would not be helpful. One respondent felt that model standards are intended to be minimum standards, but in many instances become maximum standards. Most felt that each state's long term care system is unique and what is appropriate for one state is not appropriate for another.

- *We've picked our poison – we know what we're dealing with. The model standards I've seen from the DC based assisted living advisory group would destroy the small provider, and most of our CBRFs are under 8 beds.*

ADMISSION AND RETENTION REQUIREMENTS, AND AGING IN PLACE

No one interviewed raised issues about admission requirements, but many had concerns about retention requirements. Some were concerned about their affect on the ability to age in place.

- *A key complaint about RCACs is premature and/or involuntary discharge. The average time spent in RCACs is fairly short – approximately 18 months – and fifty three percent of those leaving RCACs do so because they need more care.*
- *The CBRF limit of three hours of nursing care is unrealistic – there is some confusion as well about the definition of nursing care.*
- *The hourly limits are ridiculous. People should have to move from their homes only once and they should get the care they need in the new setting. What difference should the setting make? The nursing homes pushed this – they want people to think nursing homes are the only place to get skilled nursing care. We have paid for people that nursing homes won't admit – those needing tube feeding and on ventilators. We pay more than \$42 a day on some folks. You spend what it takes to support the care plan.*
- *I advocated for the hour restrictions, but I feel that if CBRFs and RCACs can demonstrate their ability to care for people then they should be able to keep them, even if they need a half hour more care than is permitted by regulation. This would promote the notion of aging in place.*
- *The concept of aging in place in place is one thing. The reality is a disappointment. But I think it's doable to a greater extent than it is currently being done. We still try to fit people into facilities rather than get the facility to match the person's needs. We say, here's a package of service – if it meets your needs OK. If not, you have to go somewhere else.*

Several raised the issue of inadequate guidance in the RCAC regulations regarding the retention of people who develop cognitive impairment and dementia while in an RCAC. One commented that the state needs to expand the options for people with dementia, and noted that the general public does not know what to do about family members with dementia.

One provider stated that the hours of care needed is not the only indicator of the amount of care needed.

- *Even if a person needs only three hours of care a day, if they need a two-person transfer or one-on-one feeding, we can not serve them because we do not have the staff. Transfer and feeding issues cause people to leave long before they need 28 hours of care. The average number of hours of care people get is about 16 per week. Dementia is also not an hours issue, but a safety issue. Is the person safe behind a locked door? If a family can pay for a one-on-one companion, then they can stay. We don't have the staff to be with someone every moment.*

Negotiated Risk Agreements

Respondents varied considerably in their views about these agreements. Some felt that such agreements can be useful for both providers and residents, enabling a less “paternalistic” approach to service delivery. Some felt they should not be mandated, while others that they should be required in all residential care settings.

- *I don't think negotiated risk agreements will stand up legally. Consumers pay us to use our professional judgment regarding their safety. We have to have risk agreements on certain things – e.g. non-compliant diabetics. We do not use them for safety issues, e.g., people who can start a fire because they are unsafe with a stove.*
- *We hear about individuals who are not given the opportunity to accept risk and are discharged long before they approach the 28 hours of care limit. The industry needs to grow into the modern concept of taking risks. Many RCAC operators come out of the nursing home industry, which is very paternalistic. Providers say we can't afford to take risks because of liability issues. But they can take steps to minimize risk. They need to treat RCACs as rental agreements not nursing homes. If a provider were sued for allowing a person to take risks, I would be on their side. The issue regarding competency to enter into negotiated risk agreements is a legitimate concern. I don't know why the RCAC industry isn't concerned about this.*
- *I'm not as concerned about these agreements in CBRFs because they have a pretty standard package of services. Plus the ability to complain to the Ombudsman. You don't need them as much in CBRFs, because the consumer does not negotiate the services package, and many elderly residents are not competent to execute them. In RCACs, theoretically there is more negotiation about services, and a prohibition to admit incompetent people.*
- *In a CBRF, a facility may not abrogate responsibility for providing medication monitoring. Now the state is telling us that RCACs cannot abrogate responsibility in this area as well, that you can't let go of certain responsibilities in a risk agreement.*

One respondent felt strongly that the existence of such agreements were a sign of ageism in service delivery because they required older persons to negotiate the right to be autonomous rather than have it assumed.

- *I believe that until a person is adjudicated incompetent they should be able to do whatever they want – eat what they want – not exercise if they want, not socialize if they want.*

Another noted that a major issue in risk agreements is the lack of an accepted method for determining the competency of individuals to enter into them. One respondent raised the issue of liability concerns and mentioned that liability insurance problems are starting in Wisconsin. Another noted that there has not yet been any litigation related to risk agreements, but there is a

need for more individualized agreements, noting that there are too many “cookie cutter” agreements than is desirable.

BARRIERS TO SERVING MEDICAID CLIENTS IN RCACS AND CBRFS

Respondents noted a number of barriers, but overall, the consensus was that the costs are too high and that it is not possible to get assisted living costs low enough for people with low incomes to pay for themselves.

- *Providers think \$2000 a fair price; \$1600 a month is the minimum for good care. Most folks don't have this. They have \$500 a month.*

Insufficient Capacity in the Waiver Program

There was a consensus that the major barrier to providing affordable assisted living in Wisconsin is insufficient capacity in the statewide waiver program. Even though the Medicaid waiver program provides services in residential care settings, few people benefit because of the long waiting lists. There are over approximately 9000 elderly and working age disabled on waiting lists for state COP and waiver services.

- *Typically, people do not spend down by paying privately for home care; rather, they go to residential care as private pay. The problem for many is that it is very likely that there will be a waiting list for services once they spend down. Providers cannot count on residents being able to access funds when needed, so they wind up moving to a nursing home.*
- *Many RCACs do not bother to become certified to serve waiver clients because they see no need to do so. Only about 20 percent of registered facilities have become certified, generally because residents have spent down.*
- *On an individual basis, it would cost the state less to keep people who spend down in an RCAC than put them in a nursing home. But fear of induced demand and fear of having a state funding source drive what's available keeps the state from expanding the waiver to cover people in RCACs who have spent down. Doing so would make the waiver program an entitlement for people who spend down in RCACs. Another concern is that if the state kept everyone who spent down in an RCAC on the waiver, then it would wind up spending all of the waiver money in RCACs, and have very little left for home care.*
- *The state pays lip service to the goal of providing alternatives to nursing homes. There are insufficient waiver services. It is a major disconnect for families when their relative can't stay in an RCAC or CBRF because there is no waiver slot, but the state will pay more money to put them in a nursing home.*

Room and Board Charges are Unaffordable for Waiver Clients

There was general agreement that room and board costs in RCACs and many CBRFs were unaffordable for waiver clients.

- *If you're low income you will need assistance to be in a residential care facility. If you run out of money and there is no COP money available, you will have to go to a nursing home. If you don't meet the nursing home level of care criteria, then you're in trouble.*
- *I don't know of any CBRFs who accept SSI as full rate. The SSI payment does not cover the cost of room and board. Even facilities with high functioning elderly charge more than SSI. RCACs can't get by on the SSI rate either.*
- *An industry survey in 2000 found that the average room charge without meals was \$841 per month, but the typical waiver client's income is in the \$545-\$725 range.*
- *We use CBRFs more than RCACs, primarily because the RCACs won't contract with us because we won't pay them what they charge the private pay. We will only pay the industry median.*

One respondent noted that while room and board costs are a barrier, there is no way to supplement these costs without cost shifting to other public funding sources, such as COP (the state's general revenue funded HCBS program). Others felt that each facility should be able to afford to take a few Medicaid residents. Some counties opt to use COP funding to pay for room and board for a few waiver clients in smaller CBRFs.

- *The state should limit room and board charges. The average cost of an assisted living facility is \$2500 – how can a person on SSI afford this? It is best to have facilities cross subsidize – have a small percentage of Medicaid residents, and a majority private pay. A mix of clients also helps to assure quality for the publicly-funded residents.*

A number of respondents felt that using state dollars with no federal match to pay for room and board gives too large a proportion of the states HCBS funds to the residential care industry.

Several respondents discussed the need to develop a greater supply of affordable assisted living facilities and stated that state and federal policy needs to create incentives to build more affordable units.

There was disagreement about whether the state should cap the amount that can be charged to Medicaid clients for room and board. Some felt that without a cap, Medicaid clients would never have access to “real” assisted living, meaning a facility with private rooms and baths and sufficient services to age in place. One noted that the issue had been discussed but rejected by the state's legislators, who wanted the market alone to decide the rates.

Philosophy of Home Care

A few respondents stated that many of the counties did not want to use public funding in residential care settings, because they subscribed to a philosophy that favored homecare. One stated that many counties thought some CBRFs, particularly larger ones, were more like institutions. Given that the COP and waiver program are intended to provide alternatives to institutions, they do not want to use limited funds in what they see as quasi-institutional settings.

- *The state gives counties tremendous power – even when there is pressure for counties to fund assisted living, some won't fund it. Some of the resistance comes from the COP philosophy of providing services at home. But if someone lives in an assisted living facility, it is their home.*
- *There has been a bias towards providing services to people in their homes and in small facilities (eight beds or smaller). It took years to get the state to allow waiver funds to be used in facilities with up to 20 beds. You need special authorization to provide waiver services in facilities with 20+ beds. But some places have 160 beds and they have waiting lists because that's where people want to be.*

Geographic Variation in the Distribution of Facilities

A few respondents commented that access can be limited due to maldistribution of assisted living facilities.

- *It's a big issue in Family Care where you're supposed to have a choice. In some of the counties, there may not be a facility within 100 miles. This is a major access issue. The RWJ project is supposed to address this. There is also a maldistribution of service providers, particularly in the northern part of the state.*
- *I've heard that in certain areas they're overbuilt – other areas have none or not enough. The same for nursing homes. The state does not have a planning process to determine where they should be built. The developers build wherever they want and they don't even do a market analysis – they don't look at the demographics of the area. They also assume that lots of elderly people are going to move in. But clients still consider assisted living to be institutional (CBRFs primarily). Private pay clients going into assisted living are not thrilled, but it's less of a stigma than a nursing home – more like a hotel.*

Service Rates

There were major differences in views regarding service rates and whether they constituted a barrier to serving Medicaid clients. Some, but not all, providers felt the state's rates were too low or "wholly inadequate." Most other respondents felt that the RCAC and CBRF combined market rate (room, board, and services) was too high and that the variation in these charges did not appear to be correlated with the quality of care.

- *This is an area where I'm more sympathetic to the industry. Medicaid rates have been suppressed to hold down costs and need to be re-evaluated.*
- *Providers always say they are too low, but I know Wisconsin pays a higher rate than other states.*
- *I think we're paying too much. Someone puts up a ranch house with 4 bedrooms and 2 people per room and they charge \$3800 a month for each person. That's outrageous. The DD rates are \$6500 a month. Half of the rooms might be empty and then they come to us and want us to pay these rates.*
- *The assisted living industry thinks there is this large private market of people who want to move to their facilities and that they will have enough money until they die. When the money runs out, they come to the counties and want us to pay their private pay charges of \$4500 a month, but the counties won't. Under Family Care, the state negotiates rates.*

One respondent said that a major barrier to serving waiver clients in RCACs is that the state's statutory limit on waiver rates, which is 85 percent of the state's average nursing home rate, is almost double the actual waiver rate of \$43 a day. Another respondent strongly disagreed:

- *It's not true that counties limit waiver payments to \$43 a day. It's exactly the opposite. The counties pay what they're asked to pay and they don't have the expertise to figure out from the facility's cost report if they are overcharging.*

Several respondents expressed concerns that people who spend down in RCACs will not be able to stay in their RCAC apartments because the facility will not accept the waiver rate, and a number of providers specifically cited the state's payment policies as a problem.

- *The profit on services provided to public pay residents is limited to 10 percent and a financial audit is required of all providers receiving \$25,000/year or more in public reimbursement.*

Others stated that counties do not have the expertise to enforce the limit, and that many facilities exceed the 10 percent profit limit.

- *We had to hire outside auditors to look through the CBRF contracts because they hire expensive accountants to hide stuff. We hired retired accountants who'd worked in big auditing firms – we recouped a lot of money – hundreds of thousands. But most counties can't do this, so the facilities have the upper hand.*

A few respondents expressed concerns about the effect of high rates on the overall amount of funding available for HCBS.

- *The more money spent in RCACs, the less available for home care. Additionally, because RCACs require private apartments, they can be more expensive than CBRFs. Counties are*

also reluctant to pay for private rooms for Medicaid beneficiaries in CBRFs due to the additional cost. Many counties perceive RCACs as too costly for the waiver program and won't pay for waiver clients who've spent down in these facilities.

One respondent noted that with so Waiver participants living in RCACs (189 out of about 13,500 individuals), many RCAC providers have little experience working with counties and *vice versa*. Counties are afraid they will be charged too much and providers are concerned that they won't be paid enough. Another noted that the state does not have a cost-effective method for reimbursing services in CBRFs and RCACs, noting that these settings should offer economies of scale but, in fact, it costs more to serve people in these settings than it does to provide services in their homes.

One respondent noted that the state is aware of these issues and is taking steps to address them.

- *The state is developing a rate setting methodology and a model contract for counties and facilities to use for waiver clients in RCACs, and is exploring ways to bill the Medicaid fee-for-service system for coverable services provided in assisted living as a way to make optimal use of limited waiver funds. To do this, the facility would have to partner with a home health agency or county agency that is certified to bill Medicaid.*

A few respondents stated that the rates are not just for the services themselves, but that they need to cover other costs, particularly those incurred to meet regulatory requirements such as training. At that same time, most recognize that the state does not have the money.

- *I see both sides of the issue. But if there's not enough money we need to look at the state's priorities – isn't taking care of our parents and brothers and sisters who can't be cared for at home more important than some other priorities?*

A few others stated that the problem was not the rate per se, but the lack of a payment system that offers incentives to provide good care.

- *We need to get to the point where we have a system that purchases quality and pays fairly for it. We don't have a way to reward the higher quality providers.*
- *The state needs to get away from a cost-based program because there is no incentive to be efficient. When you get efficient your rate goes down. Negotiated rates are better. One rate does not work for everyone. Family Care uses negotiated contracts with a capitated rate that is not a function of cost. The County operates as a managed care provider and is therefore exempt from audit requirements. Audits are required for cost-based systems and you have to fill out an 80 page contract.*

SUGGESTED CHANGES TO IMPROVE THE MEDICAID-FUNDED RESIDENTIAL CARE SYSTEM

Most respondents suggested changes to address the specific issues and barriers they had identified.

- *The overriding issue is that more people need services than services are available, so we need to generate revenue to make it possible to serve more people. We also need to downsize nursing home capacity.*
- *We need more affordable facilities that provide good care. We need the non-profit and religious-based mission sector to develop affordable assisted living.*
- *Mandate that only RCACs can call themselves assisted living. This would reduce the current confusion among consumers.*
- *Make qualitative evaluations of facilities available to consumers. This would be very useful. We need to make it easy for consumers to get information from regulatory agencies about facilities. Some facilities feel enforcement activities do not reflect quality of care. But with folks making decisions in a brief time in a crisis situation, they must have information.*
- *Lift restrictions around hours of care in CBRFs and RCACs. Nursing homes are the most regulated industry and they have the worst care.*
- *Use more process measures built on outcomes – not regulations about the length of the blanket and the food pyramid. This is what Family Care does. Does the person live with whom they want to live with? Do they engage in desired activities? Do they choose what they want to eat?*
- *Allow oversight by Ombudsman Program in RCACs. The Ombudsman can really help with quality assurance. They can't issue fines but they can report things. They can get involved in areas that the state regulatory body can't get into, e.g., they can consult with a facility about quality. At a minimum, the Ombudsman program should have the ability to investigate complaints in RCACs. I'm not for over regulation – but residents of RCACs need some independent advocacy entity to call if they can't get a grievance addressed.*
- *Make sure assisted living is part of a coordinated service package under Family Care or Partnership throughout the state, and develop a state plan for assisted living development (distribution) – address over bedding.*
- *Develop more public housing models with a service component.*
- *Address the staffing problems by funding the community college system to train workers and create a career ladder; institute more requirements for staff who work in assisted living – training and standards to measure the quality of work; give them more money and benefits.*

- *Give more power to the counties in running the long term care system because they are accountable to local residents.*
- *There is a correlation between oversight and care. I'd move all oversight to the local level, to the people who pay for services. That will improve quality. The closer the money is to the local level, the better will be the quality assurance. Quality assurance needs to be tied to reimbursement. If a county pays millions of dollars it has the ability to demand quality. One county asked the state to de-license a facility that it felt was providing poor quality but the state said there were not enough technical violations. However, the county terminated its contract with the facility. When a Family Care client enters a nursing home, the R.N./ Social Worker team monitors care and will pull clients out of nursing homes if the care plan isn't met.*
- *Fix the room and board issue. People on Medicaid should be able to live in RCACs.*
- *The whole home and community care system needs to be better funded. In many cases people need congregate care because there is insufficient home care.*
- *Increase funding and staff to enforce regulations and increase the sanctions against the bad operators. Most of the industry is not in the business to make a profit – rather, they want to provide a service. We need to get to the point to trust the caregivers and facilities – get rid of the people not doing a good job – enforce what's there and don't reinvent the wheel every few years.*
- *Develop more residential care options by expanding the supply of adult foster homes. Oregon has a lot and I wish Wisconsin had more. We have some counties that make a lot of use of them; they have a staff person who recruits them.*

With very few exceptions, the respondents cited the state's pilot Family Care Program as the solution to many of the current issues regarding accessibility and believe that the program should be expanded statewide. However, most recognized that expansion was unlikely due primarily to the state's budget crisis, but also because many counties do not yet have the capability of implementing the program.

- *The Family Care program should be expanded throughout the state – it has eliminated waiting lists in the five pilot counties (bringing the statewide list from 11,000 to 9,000) and it gives people choices. However, in the current budget climate, nothing remotely like that would happen.*

A few respondents expressed concern that the cost of expanding Family Care statewide would “bankrupt” the state because it treats home and community services as an entitlement.

- *As a taxpayer I do not want to see Family Care go forward. If Family Care was universal there would be no need to purchase private long term care insurance in Wisconsin. People could take a year's worth of long term care insurance premiums, hire an estate planning*

lawyer and create a trust that will make them eligible for Family Care when they need long term care.

Others felt that the fear was unwarranted or could be dealt with.

- *There is a fear that the cost of expanding Family Care statewide will bankrupt the state. But you could tighten up the eligibility criteria if needed.*
- *Reducing the waiting list by 9000 folks would make Family Care expensive to implement. It's an entitlement now – though it didn't start that way. In the current system, the nursing home is an entitlement – but people may not need to be there. The state does not believe in a strict continuum of care. Family Care looks at what people need and tries to find where they can best be served and folks with severe disabilities can be served in homes. Family Care operates according to the assumption that people should have the choice to live in the community. It's difficult to know if expanding Family Care statewide would be more expensive.*

Several respondents expressed more general concerns about the ability of the publicly funded long term care system to meet the needs of the Baby Boom cohort, and made suggestions to address this concern.

- *To reduce the number of people on Medicaid, the state has to stop the divestiture of assets that is going on by tightening loopholes. There are a set of older people who don't see Medicaid as welfare, and a lot of people divest assets. There is a lot of estate planning – a seminar every day. Older people think they need to leave a legacy to their children. They don't understand the difference between Medicare and Medicaid. They paid into Medicare when they were working and they think it covers Medicaid and that they are entitled to it.*
- *Something needs to be done other than the very small tax break for long term care insurance to get people to start planning for and funding their future long term care needs.*
- *More financial planning is needed for folks thinking about entering an RCAC. They need to understand how to financially plan for it – deal with the spend down issue.*

FUTURE PLANS

A number of respondents mentioned state activities aimed at addressing the shortage of affordable assisted living for low income persons.

- *The state is trying to get developers to do affordable RCACs in rural areas.*
- *The state is working on developing a service rate that will vary according to the services provided and a more effective contracting mechanism for the counties to use, which will tie the service rate to the care plan.*

- *A proposal is being developed for the legislature to enable persons leaving nursing homes to have the nursing home funds follow them to the community instead of having the money stay in the nursing home budget. This is particularly important given that future Medicaid expansions are unlikely.*

Several respondents mentioned that the state had a grant from the Robert Wood Johnson Foundation's *Coming Home Program* to develop affordable assisted living in rural areas, and that the state was very interested in identifying new ways to combine housing and services that would be affordable for low income and Medicaid-eligible persons, such as maximizing the use of HUD Section 8 housing vouchers. However, others noted that these vouchers were not the solution.

- *There are too few Section 8 Vouchers, and the amount of the voucher is not sufficient. In some locales, the vouchers are not being used because they do not provide the subsidy needed to make up the difference between what a person can afford and what the rents are. Many locales keep the vouchers for families with children because seniors have more housing subsidies. There is a real crisis with low income families. Getting housing authorities to designate money to assisted living is very difficult.*

RECOMMENDATIONS FOR OTHER STATES

We asked the respondents to make recommendations for other states interested in using Medicaid to fund services in residential care settings, based on their experience doing so in their own state. The majority of recommendations related to assuring a method to pay for room and board for low income persons, assuring adequate funding, and recognizing that different licensing and more restrictions are needed to serve the Medicaid population, particularly those who meet the criteria for a nursing home level of care.

- *Figure out what affordable really means, both for the Medicaid eligibles and for low and moderate income folks. For Medicaid make room and board affordable first.*
- *You can't make it work for large numbers of low income people and Medicaid eligibles without subsidies for room and board.*

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ENDNOTES

¹ Gregory, S.R. and Gibson, M.J., *Across the States: Profiles of Long Term Care*, Public Policy Institute, AARP, November 2002.

² The state is currently revising the formula for determining the amount of assets that can be retained.

³ The state does not use any of the options for less restrictive income or resource methodologies for determining financial eligibility in the medically needy program.

⁴ The state is currently revising the formula for determining the amount of assets that can be retained.

⁵ The discretionary allowance is not in addition to a personal maintenance allowance.

⁶ Prior to 1995, a person could be eligible for the state supplement without being eligible for SSI. Since 1995, a person must be eligible for some federal benefit to be eligible for the supplement. Persons ineligible under current law who were receiving the state supplement in 1995 continue to receive it under a grandfathering provision.

The state does not use less restrictive income disregards when determining eligibility than it does when determining eligibility for SSI. It uses the following Section 1902(r)(2) less restrictive resource methodologies for this group: income used to pay court ordered fees and guardianship and guardian ad litem fees is excluded.

⁷ The state does not use Section 1902(r)(2) less restrictive income or resource methodologies for this group.

⁸ Personal communication from state staff. Data on the number of persons receiving Medicaid personal care in residential care settings are not available.

⁹ While there are no data on how many were receiving personal care services through the state plan, given that the number receiving COP and waiver services was 2,363, only about .5 percent of the 11.5 percent could have been receiving services through the personal care state plan option.

¹⁰ The SSI-E benefit (a state SSI supplement for persons with high needs) also used to be limited to persons in CBRFs no larger than eight beds.

¹¹ Most county contracts are for cost-based rates. Allowable cost distinguishes between what costs can be paid for with state/federal funds and what cannot; it says nothing about how much the rate is. The State requires an audit where publicly purchased services cost more than \$25,000 per year. If the audit shows costs that were not allowable, which have been paid for in the rate, they must be returned.

¹² Some facilities have an arrangement with a Medicaid-certified home health or personal care agency to either (1) provide and bill Medicaid for these services or (2) “lease” their staff to the Medicaid-certified agency in order to be able to bill Medicaid. In 2001, eight percent of waiver recipients living in RCACs had personal care services billed to the Medicaid card (state plan), averaging \$367/month. The state does not have comparable data for CBRF or AFH residents at this time.

Appendix H

Factors for States to Consider When Choosing to Cover Medicaid Services in Residential Care Settings

Factors for States to Consider When Choosing to Cover Medicaid Services in Residential Care Settings¹

It has long been recognized that, in order to reduce institutionalization, it is necessary to develop a range of residential options that provide supportive services. Given a choice, most people with long-term care needs would prefer to receive services in their own homes. However, some people prefer to live in residential settings other than their homes for a variety of reasons—such as the desire to have someone available 24 hours a day to meet unscheduled or emergency needs because they feel safer in such a setting. This preference is reflected in the recent private-sector growth in various forms of supported housing arrangements (called assisted living or residential care) for persons age 65 and older.

Services covered by or in an assisted living facility are governed by state law and regulations. There are no applicable Federal statutes, other than the Keys Amendment to the Social Security Act, which is applicable to board and care facilities in which a “substantial number of SSI recipients” are likely to reside. State rules vary widely, and many are currently being updated because assisted living is a relatively new concept, not envisioned by many state legislatures or rulemaking bodies in the past.

Using Medicaid to pay for services in assisted living settings for elderly persons is of increasing interest to states looking to offer a full array of home and community services and to reduce nursing home use. By 2000, 35 states were using Medicaid to reimburse services to support assisted living for people with long-term service and support needs. Twenty-four states cover services in assisted living settings under 1915(c) waivers; six cover it in their state plans through the personal care option; three cover it in both the waiver and the personal care option; one covers it through an 1115 waiver; and one covers it under a 1915(a) waiver.

Assisted living may refer to a generic concept that covers a wide array of settings and services, or to a very specific model—or both—depending on who is using the term. Twenty-nine states have a licensing category called assisted living, each with its own definition. Assisted living is also often used as a marketing term for facilities that may be licensed under another category, such as residential care facilities and personal care homes. The term is even used by facilities that are not licensed to provide services but whose residents receive services provided by outside agencies. CMS includes a definition of assisted living in the standard HCBS waiver application, but states have the option to use a different definition.

Assisted living is used here to mean care that combines housing and supportive services in a homelike environment and seeks to promote maximal functioning and autonomy. Medicaid will pay for services provided in assisted living facilities as long as the “homelike environment” is preserved. Thus, Medicaid will not pay for assisted living services if the assisted living facility is located in the wing of a nursing home (or ICF/MR). Emergence of assisted living as a residential rather than an institutional model—combined with changes in state licensing regulations—has provided many people who need supportive and health services with an important alternative to the nursing home. This type of living arrangement is very popular among private-pay older persons and their families. Covering assisted living through Medicaid

provides safety net funding for this group, many of whom may one day be unable to afford it out of their own resources.

The logistics of setting up an assisted living program can be quite complex. Most important is the recognition that assisted living is more than just a setting for potentially cost-effective service delivery. It represents a philosophical approach to residential services that supports independent living, autonomy, and consumer choice—a philosophy that should guide decision making for regulations and payment policy. In making such decisions, states must address a number of key issues, each of which is discussed in turn.

TARGET POPULATION

Determining what population will be served will depend in large part on the state's current long-term care system and its policy goals. Is assisted living intended to fill a gap in the current set of options? Will the target population be different from the population usually served in board and care facilities? Is assisted living intended to enable people who cannot be served in their homes to avoid institutionalization? Once these questions are answered, the state must decide which age groups will be served, and whether services will be designed to address the specialized needs of specific populations (e.g., persons with dementia). It is also crucial to make certain that licensing and other facility regulations in a given state match the target population. For example, if the state wants to target nursing home-eligible beneficiaries, the assisted living facilities will need to be able to serve a population with a nursing home level of need.

SERVICE DELIVERY MODELS

The definition of assisted living varies from state to state and sometimes from residence to residence. Some states have used regulations or licensing requirements to define assisted living services. States using Medicaid HCBS waivers define the service to suit the purpose of their particular program. A variety of service delivery models are possible. The assisted living residence may be the provider of services, for example, or the service provider may be a separate agency. Yet a third alternative is to consider the assisted living setting a person's home; this permits a state to provide home and community services to persons in assisted living through the existing delivery system. Whatever the model chosen, it is important to note that assisted living in no way compromises a person's right to receive other Medicaid services. The overriding criterion for receipt of services under any model is medical necessity.

PERSONAL CARE OPTION OR WAIVER OR BOTH?

States can cover assisted living services through either a waiver program or the personal care option under the state plan or both. The waiver approach is advantageous in that states can broaden eligibility by using the 300 percent of SSI rule to reach persons in the community who would not ordinarily meet the financial qualifications for Medicaid. However, since waiver services are available only to beneficiaries who meet the state's nursing home level-of-care criteria, serving people through a waiver will target a more severely impaired population than is generally served through the personal care option. The waiver program also offers the advantage of predictable costs for states concerned about utilization of a new benefit. The combination of nursing facility level-of-care eligibility criteria, a set number of slots (as is

permitted in a waiver program), and expenditure caps will limit the number of people potentially eligible.

The personal care option is advantageous in that it will broaden eligibility by allowing a less severely impaired population to be served. This is because states may impose reasonable medical necessity criteria but may not restrict the benefit to persons who require a nursing home level of care. One disadvantage of using the personal care option is that it lacks the higher income eligibility standard used for waiver programs. When deciding which approach to use—or whether to use both—states may want to estimate how many people would be served under the different options in order to judge both the reach of the potential service and its likely cost.

TYPE OF WAIVER

When using the waiver program approach, should states add assisted living as a new service to an existing waiver program or implement it under a separate waiver program? From one perspective, adding to an existing waiver program is simple and minimizes reporting and tracking requirements. However, advocates for home and community services may perceive the addition of assisted living to the list of waiver services already covered as increased competition for a limited number of slots available for home services more generally. Coverage under a separate waiver program may be a better approach, not only for this reason but also because it enables a state to test the demand for and cost-effectiveness of assisted living per se. Separate waiver programs designed by a state to expand the total number of people served under waiver programs may also make it easier to reassure facilities in that state that they will have access to a sufficient number of consumers. Since providers receive Medicaid payments based on the number of beneficiaries they serve, facilities may be reluctant to participate in the Medicaid program at all if they are unsure they will have a reliable source of potential residents.

LEVEL OF CARE AND LICENSING RULES

HCBS waiver regulations require that any facility in which waiver services are furnished must meet applicable state standards. When services are furnished by the assisted living facility, the facility must meet the standards for service provision that are set forth in the approved waiver documents. Thus, states planning to cover assisted living through a waiver program need to be sure that the admission/retention provisions of state licensing requirements permit assisted living facilities to serve individuals who meet Medicaid's nursing home level-of-care criteria. Licensing must also address a facility's qualifications to provide assisted living services. In a few states, the facilities do not themselves provide these services. Instead, outside agencies come into the facility to provide them. For example, Minnesota covers assisted living provided by outside agencies to residents of facilities that provide only room and board and limited supervision. In such cases, the facility may need to meet only minimal housing standards, while the outside agency may be held to state licensing and program standards for home care providers. Residents in such settings may be personally responsible for making arrangements with an outside agency for service delivery, or, more typically, the state may provide case management services to assist the resident in doing so.

States that use a waiver program to provide assisted living need to contract with facilities that are willing and able to provide the services needed by someone who meets the state's Medicaid nursing facility level-of-care criteria. The assisted living industry is perceived as generally serving people with lighter needs. For example, about one-quarter of assisted living residents need no assistance with ADLs, according to a recent study by the National Center for Assisted

Living. The same study found that 43 percent of residents who move out of assisted living enter nursing homes. To the extent that these statistics suggest an orientation toward serving a population that is less impaired than Medicaid waiver clients, facilities may not be capable of or willing to serve residents with greater needs.

LICENSING AND CONTRACTING ISSUES

State licensing rules set the minimum requirements for Medicaid providers. The Medicaid program may set more stringent standards if desired, however. For example, some states allow facilities to offer rooms shared by two, three, or more residents. But since one of the purposes of assisted living is to foster independence and autonomy, some state Medicaid programs will only contract with facilities that offer private occupancy unless the resident chooses to share a room/unit. Some states also require facilities contracting with Medicaid to offer apartment-style units rather than bedrooms. (These include Oregon, Washington, and North Dakota.) Further, if licensing rules do not include sufficient requirements for facilities serving people with Alzheimer's disease, the Medicaid contracting requirements may specify additional training or other requirements.

ENABLING BENEFICIARIES TO PAY FOR ROOM AND BOARD

Payment for room and board is one of the critical issues for states seeking to expand assisted living for Medicaid beneficiaries. Surveys by national associations have found that care in assisted living facilities may be unaffordable for many low-income individuals. Monthly fees in market rate facilities range from \$800 to over \$3500—with the majority in the \$800-\$2000 range. These fees vary by facility design and size of units and encompass amenities in addition to room and board. But assisted living facilities are marketed as a total package and people who are eligible for Medicaid cannot afford these fees.

Medicaid can be used to pay for assisted living services, but cannot pay for room and board. Except in very limited circumstances (such as a weekend stay provided as respite care under an HCBS waiver), the Medicaid beneficiary is responsible for room or board costs, whether paid through pensions, savings, Social Security, or SSI.

States can and do use a number of approaches to ensure that the room and board rate for assisted living does not exceed the income available to Medicaid beneficiaries. These approaches include the following:

- States can examine the facility's monthly room and board charges to identify any coverable services—such as laundry assistance, light housekeeping, or food preparation—that can be reimbursed by Medicaid for a beneficiary who requires assistance with these IADLs. Including all coverable services in the state's assisted living service payment reduces the beneficiary's monthly payment solely to room and board and any other charges that Medicaid does not cover.
- Some states set only the service rate, leaving determination of the room and board rate to the facility. Florida and Wisconsin are examples of state Medicaid programs that set only the service rate. Beneficiaries choose among the assisted living facilities they can afford. Other states limit the room and board amount that can be charged to Medicaid beneficiaries. One option is to limit these costs to the amount of the Federal SSI payment rate. In the year

2000, that amount is \$512 a month, which may be too low to provide a sufficient incentive for assisted living facilities to serve Medicaid beneficiaries.

- If the state has a State Supplemental Payment (SSP) program to supplement SSI payments, the assisted living room and board rate can be set at the amount that represents the Federal payment plus state payment. A few states have developed a supplemental payment rate specifically for beneficiaries in assisted living facilities, to provide them with sufficient income to afford the room and board component. Massachusetts has done this, for example, setting a payment standard of \$966. The state uses its own funds to raise the Federal SSI payment to an amount sufficient for assisted living residents.
- States are also exploring ways to provide assisted living services to residents of subsidized housing. Because subsidized housing is developed with tax credits and other specialized financing mechanisms, the rent component may be much lower than market rate and the resident may receive rental assistance that covers room and board costs. However, housing subsidy programs and Medicaid operate under very different rules. Careful planning and close collaboration is necessary to enable the programs to work together.

Assisted Living and the Special Income Limit: Post-Eligibility Treatment of Income

Some states cover persons in an HCBS waiver program using the so-called 300 percent of SSI eligibility option (a person's income must be at or below 300 percent of the maximum SSI benefit—roughly \$1500 per month.) This option is attractive for waiver programs that include assisted living, because it expands the program to include beneficiaries who are better able to afford the room and board costs of assisted living. To make this option effective, however, states must allow eligible persons to retain enough of their income to pay the room and board charges of an assisted living facility.

Medicaid beneficiaries who qualify under the 300 percent option are required to contribute toward the cost of their services. To determine the beneficiary's share of cost, the state must follow Medicaid rules governing post-eligibility treatment of income. These rules require states to set aside (protect) certain amounts of income for personal use and to assume the remainder is contributed to the cost of services. The state has the option to specify the amount of income that needs to be protected, and can take the costs of assisted living room and board into account when doing so.

Protecting sufficient income for room and board in assisted living, of course, reduces the amount the beneficiary pays toward the costs of services, thus raising service costs to the Medicaid program. When states are considering how much to protect, they need to balance this source of increased costs against the consequence of not protecting sufficient income to pay room and board. In such a case, the beneficiary will not be able to afford room and board and share of service cost, and may be forced to move into a nursing home (where the room and board costs are covered by Medicaid).

Some states may be concerned about the fiscal impact of an across-the-board increase in the maintenance allowance. But states are not required to increase the amount of income protected for all waiver beneficiaries who pay a share of cost in order to address the needs of beneficiaries who reside in assisted living. States have the option to vary the amount of income that is protected based on the circumstances of a particular class of beneficiaries. For example, a beneficiary living alone may need to retain more income than a beneficiary living with a family member. A person living in an assisted living facility may have higher or lower need than a

person living alone in a single-family home, or vice versa. Colorado, for example, allows people living in their home or apartment to retain nearly all their income and those living in personal care homes to retain an amount equal to the SSI benefit standard, which is the amount for room and board.

The state can further refine its treatment of income to account for variations in the cost of assisted living. Some states contract with both private (market rate) and subsidized assisted living facilities; the beneficiary's need for income will depend on the type of assisted living facility chosen. The "rent" component of the monthly fee charged by facilities built with low-income housing tax credits, for example, will be lower than the rent charged by privately financed facilities. If the state protects income based on the area's average monthly charge for room and board in private assisted living, the beneficiary living in a subsidized unit may be allowed to keep income that could be applied to service costs. But if income is protected based on the rent in subsidized units, beneficiaries may be allowed too little income to afford private market facilities. Setting a separate maintenance allowance for each setting allows a state to improve access to both private and subsidized assisted living facilities.

Income Supplementation by Family Members or Trusts for Payment of Room and Board

When the beneficiary is unable to pay all room and board costs, family members may be willing to help pay them and other expenses not covered by Medicaid. A trust's funds may also be used to help pay for a beneficiary's costs not covered by Medicaid. However, families and trustees need to be aware of how any funds they contribute may affect beneficiaries' eligibility for various benefits (and therefore their net living standard). Any amount paid can reduce the recipient's SSI benefit—and in the worst-case scenario cause the recipient to lose SSI altogether, and with it potentially Medicaid as well. This is because SSI rules consider such supplementation in determining the individual's financial eligibility.

If the contribution is paid directly to the SSI beneficiary, it is counted as unearned income—the same as unearned income from any other source—and will reduce the individual's SSI benefit dollar for dollar. However, if the money is paid instead to the assisted living facility on a beneficiary's behalf, it is treated differently. SSI counts payment to the facility as "in-kind" income to the beneficiary and reduces the monthly Federal SSI benefit by up to one-third. Even if the "in-kind" contribution exceeds one-third of the SSI payment, the payment is only reduced by one-third. (See box.)

Medicaid rules follow SSI rules when families give money directly to an individual. That is, the money counts as income just like any other unearned income. Therefore, if the individual is in a Medicaid eligibility group expected to pay a share of the cost of medical services, all a family cash supplement accomplishes is to increase the individual's share and decrease Medicaid's share of that cost. In some cases, as noted, such supplements can result in the individual losing eligibility altogether.

Effect of Income Supplementation on SSI Benefit

Assume that:

- Room and board charge is \$800
- Individual has no income from other sources
- Full SSI benefit is \$512
- The first \$20 of unearned income is disregarded.

The difference between the SSI benefit and the room and board charge is \$288. If the family pays \$288 directly to the individual, this amount (minus the \$20 disregard) is subtracted from the individual's SSI benefit, leaving only \$264. The individual will be even less able to pay room and board costs than without the family's payment.

If the family pays \$288 to the facility, then the individual's SSI benefit is reduced by one-third to \$341. The family would then have to pay the difference between \$341 and \$800 (the room and board cost), which is \$459. The consequence of the one-third reduction, then, is that the family must increase its supplementation from \$288 to \$459.

Because the rule states that the SSI payment will be reduced by up to one third, there is no limit on the amount of money that can be paid to a facility on behalf of the SSI beneficiary. If a family chooses, they can subsidize services other than room and board, as well as pay for room and board costs in more expensive facilities, without jeopardizing an individual's eligibility for SSI.

Medicaid also follows SSI rules regarding payments made by the family directly to a facility for room and board. These payments are counted as "in-kind" income, the dollar value of which is determined under special SSI rules. Thus, like a family payment made directly to the individual, the family's payment to the facility can affect Medicaid eligibility as well as increase the individual's share of cost.

If families want to provide support to their family member who can cover room and board expenses, they should directly purchase anything other than food, clothing, and shelter. In an assisted living setting, for example, families could pay for any service not included in the facility rate or covered by Medicaid, such as cable television or personal phone service. In no such case may the state require supplementation.

ASSISTED LIVING AND THE MEDICALLY NEEDY

Medically needy beneficiaries are persons who, except for income, would qualify in one of the other Medicaid eligibility categories (such as being over age 65 or meeting the SSI disability criteria). Medicaid payments can begin for this group once they have spent down—that is, incurred expenses for medical care in an amount at least equal to the amount by which their income exceeds the medically needy income levels.

The medically needy eligibility option can allow people who have income greater than 300 percent of SSI to become eligible for Medicaid services. But Federal law imposes two

significant constraints on the use of this option: The state must cover medically needy children and pregnant women before it can elect to cover any other medically needy group. Additionally, the state may not place limits on who is eligible for Medicaid by using such characteristics as diagnosis or place of residence. Thus, it cannot use medically needy policies to extend Medicaid services only to HCBS waiver or assisted living beneficiaries.

The maximum income eligibility limit that a state medically needy program may use is based upon its welfare program for families—levels that are typically lower than SSI. The income level must be the same for all medically needy groups in the state (i.e., states are not permitted to establish higher income eligibility levels for selected subsets of the medically needy, such as beneficiaries in assisted living settings).

These rules have several implications that states need to consider when trying to make the medically needy eligibility option work for higher income individuals in assisted living. (1) These individuals may find it more difficult to incur sufficient medical expenses to meet the spend-down requirements while living in the community than they would in a nursing home. The higher their “excess” income, the higher the amount of their spend-down—with the implication that only those with extremely high medical expenses may qualify. (2) Community providers are less willing to deliver services during the spend-down period, since payment cannot be guaranteed and collection may be difficult. (3) Spend-down rules combined with low medically needy income-eligibility levels mean that individuals may not have enough total income to pay both the bills they incur under the spend-down provision and the room and board component of assisted living. This is ironic since they start off with more income relative to other eligibility groups. As of the publication date, HCFA is actively examining this issue to find possible solutions (watch the HCFA website for updates).

SERVICE PAYMENT RATES: ADEQUACY CONCERNS

Unless the monthly rate is considered reasonable by assisted living facilities, they will not be willing to contract with Medicaid. In some states, rates in the \$1500-\$2500 a month range may be needed to attract enough facilities to serve Medicaid beneficiaries. When considering what rate might be necessary and reasonable, states might sample the rates charged by facilities (excluding very high end facilities) to assess (a) how they compare with Medicaid nursing home rates and (b) how many facilities might potentially contract with Medicaid at rates the state might be willing to pay.

It is also important for the state to be sensitive to the potential need to set payment levels that vary based on the assisted living residents’ current needs. Doing so will enable people whose condition deteriorates to stay in the assisted living facility rather than having to move to a nursing home. A number of states use such tiered rates (including Arizona, Delaware, Oregon, and Washington). Rates set by case mix (as used in Minnesota, Maine, Wisconsin, and New York) also create incentives to accept people with high needs and retain people whose needs increase. Flat rates, in contrast, tend to force facilities to discharge residents whose needs exceed what can be covered under the rate. As a final point, instead of reimbursing facilities on the basis of specific services delivered, states are permitted to develop a bundled monthly rate. A bundled rate is easier to administer for the state under a waiver program, and for providers under any coverage option.

ENDNOTES

¹ The information in this Appendix is taken verbatim from Chapter 5 of *Understanding Medicaid Home and Community Services: A Primer*. October 2000. U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. The complete version of this chapter, with citations and an annotated bibliography can be found at the following website: <http://aspe.os.dhhs.gov/daltcp/reports/primer.htm>