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

STATE ASSISTED LIVING POLICY:

1998

June 1998

Office of the Assistant Secretary for Planning and Evaluation

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Robert L. Mollica, Ed.D.

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PREFACE

Project Overview

Assisted living facilities are a rapidly expanding source of supportive housing with services. In the view of many, such facilities represent a promising new model of long-term care, one that blurs the sharp distinction between nursing homes and community-based long-term care and reduces the chasm between long-term care in one's own home and in an institution. In this model, consumer control and choice are central to the philosophy of "assisted living." Indeed, the ability of consumers to control both key features of the environment and to direct services, under a "negotiated" or "managed risk" model, and to receive care and supervision in a "home-like" setting are considered hallmarks of the philosophy of assisted living. Further, assisted living, at least conceptually, is distinguished by a flexible service arrangement, in which there is no set "package" of services but facilities provide services to meet scheduled and unscheduled needs of residents, allowing residents to "age-in-place."

Despite the growing interest in and expansion of places calling themselves assisted living facilities, relatively little is known about their actual role and performance and the degree to which they represent a viable option for frail and disabled elders. Indeed, there is not even agreement or information on the number of such facilities currently in operation. As a result, the Office of the Assistant Secretary for Planning and Evaluation (ASPE) of the U.S. Department of Health and Human Services is undertaking a national study of the role of assisted living. ASPE entered into a contract for a comprehensive study to be conducted by Research Triangle Institute (RTI), the Myers Research Institute, as well as its collaborators, Lewin, Inc., the University of Minnesota Long-Term Care Resources Center, and the National Academy for State Health Policy.

Purpose of the Study

The intent of the *National Study of Assisted Living for the Frail Elderly* is to determine where "assisted living" fits in the continuum of long term care and to examine its potential for meeting the needs of a growing population of elderly persons with disabilities. Within this broad objective, the study will address several specific goals, including:

1. To identify trends in demand for and supply of assisted living facilities;
2. To identify barriers to the development of assisted living and supply-demand factors that contribute to those barriers.

In addition, the study has further descriptive and "evaluative" goals:

3. To determine the extent to which the current supply matches the central philosophical and environmental tenets embodied in the concept of "assisted living" and to describe the key characteristics of the universe of assisted living facilities; and
4. To examine the effect of key features, particularly source, mix and privacy, on selected outcomes, including resident satisfaction, autonomy, affordability, and the potential to provide nursing-home level of care.

Overview of the Study Design

ASPE's approach to this study includes the following activities:

- We will select and interview a purposive sample of lenders, developers and multi-facility owners.

- We are conducting annual surveys of all state licensing agencies involved in assisted living, as well as of Medicaid agencies that provide funding for assisted living.

- The study will draw a national probability sample of facilities. This will allow us to generalize our findings and make valid estimates about the status of assisted living facilities across the nation.

- Using this sample, the study will describe the key characteristics of places holding themselves out to be "assisted living" facilities, based on a telephone survey of about 2,500 facilities.

- We will also conduct a more in-depth telephone survey of about 200 facilities. In addition, we will select a sample of about 450 facilities that will be visited, with in-person interviews with administrators, staff and residents.

- We also plan to interview families of residents with cognitive impairment and to conduct follow-up interviews at six months with residents who have been discharged or otherwise exited the facility.

ACKNOWLEDGMENT

The author thanks the many people in state agencies throughout the country who completed surveys and provided copies of statutes, regulations and reports needed to conduct this study. We also appreciate their willingness to review draft summaries of the material related to their state. This project is possible because of the support of dedicated professionals in state agencies who are willing to share their time and knowledge in this endeavor. We hope the information is helpful to states as policies on assisted living continue to emerge and develop over time.

EXECUTIVE SUMMARY

This study reviewed the assisted living and board-and-care policies in each of the 50 states. States reported a total of 28,131 licensed facilities with 612,063 units or beds.[1] Over 25% of the beds are located in three states: California (123,238), Florida (66,293), and Pennsylvania (62,241). Twenty-two states have existing licensing regulations using the term *assisted living*, up from 15 in the previous study. Wisconsin has re-named their assisted living regulations as residential-care apartment complexes. Draft regulations using the term assisted living have been developed by an additional nine states including Maryland which is significantly expanding the scope of an earlier program which a state agency considered assisted living. Four states are revising existing assisted living regulations; one state, West Virginia, is developing rules for a new category and New Hampshire will revise rules which sunset in 1998.
Thirty-five states reimburse, or plan to reimburse, services in assisted living or board-and-care facilities as a Medicaid service. Eleven states had created a task force or a process within a state agency to make recommendations for developing assisted living rules.

While a common or standard definition of assisted living is still unlikely, state approaches share some common components. This new model for providing long-term care is developing as a residential, rather than institutional, model. While many observers equate institutional with medical, the distinction between medical and social lies less with the services delivered than the setting itself. State rules generally require residential settings in which personal care and health related services are provided. Even though the setting is residential, health or medical services are provided, either by facility staff or through contracts with community agencies.
The major issues addressed by state policies concern requirements for the living unit, for tenant admission/retention, for the level of services allowed, and for administrator and staff training.

Living Unit: Existing or proposed policy--regulations or Medicaid standards--in thirteen states would require apartment settings, while fourteen states allow facilities with apartments and facilities with shared rooms to be licensed or reimbursed as assisted living. In seven states with assisted living rules, shared bedrooms meet the minimum standards. Sixteen states with boardand-care standards allow shared rooms. Licensing standards in Arizona, Minnesota, North Dakota, and Washington allow shared rooms, although facilities contracting with Medicaid must offer apartments.

Admission/Retention: These standards can be grouped into five categories: general, health conditions, functional capacity, Alzheimer's disease and dementia, and

[1] These licensing categories and the number of facilities were reported by state licensing agencies. The total numbers differ from those used to create a national sample of assisted living facilities for the larger component of this project by the Research Triangle Institute which used a specific definition of assisted living and obtained data from multiple sources.

behavior. Recent rules in Kansas, Nebraska and Maine and draft rules in Arizona, Hawaii and Vermont will join Oregon and New Jersey as states with the broadest parameters for admission/retention. These states allow extensive services to be provided, sometimes with a review by the licensing agency for certain conditions. State regulations set the parameters for assisted living, while owners/operators define the practice. Despite regulations that may allow a higher level of care, facilities themselves may set their admission/retention policy to care for less impaired residents than the rules allow and provide a less intensive service package than allowed. Though strong market demand from moderate- and upper-income residents for residential settings supports this practice, changes are likely over time as the number of facilities expand, residents age in place, and providers adjust to maintain high occupancy rates.

New Jersey's rules require 20% of the residents in each facility to meet the nursing home level of care criteria within three years of licensing.

Policies in 22 states include a statement of philosophy that describes assisted living as a model which emphasizes consumer or resident independence, autonomy, dignity, privacy, and decision-making.

Level of service: Increasingly, state rules allow higher levels of care, sometimes equivalent to the care a person receives in their single-family home or apartment. While a few states require that health related services be delivered by a licensed home health agency, many allow assisted living facilities to hire nursing professionals to provide, supervise, or direct care.

Administrator credentials/training: Compared to board-and-care rules, assisted living regulations are more likely to require higher credentials and often training in the philosophy of assisted living. Criminal background checks of administrators and staff are being required to respond to concerns for safety and quality care for residents.

Staff training: These requirements vary extensively. Resident rights is the most frequently cited area for required training. Many states are now adding requirements that staff in facilities serving people with Alzheimer's disease receive special training to respond to their unique needs.

Public subsidies: The booming assisted living market has raised questions about its relevance for older persons with low incomes. By the spring of 1998, 28 states covered services in assisted living and/or board-and-care settings, and nine states were planning to add coverage during the year. There are two primary options for covering services under Medicaid: state plan services and home and community waiver programs. Six states use the Medicaid state plan, and 23 states use the waiver. (Maine covers services under both options and is therefore counted twice).

Although Medicaid coverage is widespread and growing, the number of participants is just over 40,000 beneficiaries, roughly half of whom are in North Carolina. States using personal care under the state plan to cover care have higher participation

than states using the waiver. Factors affecting waiver participation may include the higher level of impairment required, the assessment and screening process, lack of familiarity with assisted living among waiver case managers, and the ceiling on waiver expenditures.

Five approaches are used to pay for services in assisted living settings: flat rates, flat rates that vary by the type of setting, tiered rates, case-mix related rates, and care plan or fee for service rates. Flat monthly rates are the most prevalent.

Twenty-six states have special provisions for facilities serving people with Alzheimer's disease. These provisions cover disclosure, admission/retention, staffing and training, activities, and the environment.

This paper describes the primary approaches states are taking to license assisted living, discusses Medicaid reimbursement and other selected areas, and summarizes each state's licensing rules.

SUMMARY OF STATE ASSISTED LIVING AND BOARD AND CARE ACTIVITY						
State	Existing Assisted Living Regulations	Drafting or Revising Regulations[1]		Medicaid Funding	Studying Assisted Living	Board & Care
		Assisted Living	Board & Care			
AL	X				X	
AS	X	X		X		
AZ		X[5]		X		
AR					X	X
CA					X	X
CO				X[2]		X
CT	X			X[3]		
DE	X			P		
FL	X			X		
GA				X[2]		X
HA		X		P		
ID 4						X
IL				X[3]	X	
IN					X	
IA	X			X		
KS	X			X		
KY	X					
LA		X		P		
ME	X			X		
MD		X				
MA	X			X		
MI					X	X
MN		X		X		
MS					X	X
MO				X[2]		X
MT				X[2]		X
NE	X			P		
NV				X[2]		X
NH			X	P	X	X
NJ	X	X		X		
NM				X		X
NY		X		X[5]	X	
NC	X			X		
ND				X		
OH						X
OK	X					
OR	X	X		X		
PA					X	X
RI	X			X		
SC					X	X
SD	X			X		
TN	X					X
TX[4]				X		
UT	X			P		
VA	X			X		
VT		X		X[2]		X
WA				X		

SUMMARY OF STATE ACTIVITY (*continued*)						
State	**Existing Assisted Living Regulations**	**Drafting or Revising Regulations[1]**		**Medicaid Funding**	**Studying Assisted Living**	**Board & Care**
		Assisted Living	**Board & Care**			
WV		X[6]				X
WI	X[7]			X		
WY	X					

1. Includes both assisted living and board and care.
2. Medicaid covers services in board and care settings through a waiver or as a state plan service. (Vermont will also cover services in assisted living facilities when its regulations are finalized.)
3. Pilot projects authorized.
4. Idaho and Texas have revised their board and care regulations.
5. These states are consolidating multiple licensing categories.
6. West Virginia is developing rules for residential care apartments.
7. Wisconsin changed the name of its category from assisted living to residential care apartment complexes.

P = states planning to cover assisted living.

ASSISTED LIVING AT A GLANCE: STATUS OF STATE ACTIVITIES		
State	**Status**	**Medicaid Coverage**
Alabama	Multiple categories of assisted living are licensed based on size. The Public Health Department is developing revisions to the regulations.	No
Alaska	Regulations were effective in 1995. Criminal background checks are required by legislation passed in 1997.	Waiver
Arizona	A major consolidation of multiple categories will be effective in November 1998. Services are reimbursed as a Medicaid service through the ALTCS managed care program (1115 waiver).	Waiver
Arkansas	Licenses residential care facilities. State agencies are exploring licensing and Medicaid reimbursement for assisted living.	State plan
California	A work group was formed in 1996. The state's budget bill directed the Department of Health to submit a report in January 1997. Currently licenses residential care facilities for the elderly.	No
Colorado	Licenses personal care boarding homes.	State plan
Connecticut	The state has licensed assisted living services agencies since 1994. Legislation creating a Medicaid pilot program was signed in June 1998.	Pilot
Delaware	New regulations were effective in 1998.	Waiver submitted
Florida	Regulations issued in 1992. Legislative amendments were passed and new regulations issued in 1996 and 1998.	Waiver
Georgia	Licenses personal care homes.	Waiver
Hawaii	Legislation creating assisted living was passed 1995. Draft regulations are pending.	Waiver planned
Idaho	Regulations revising residential care facility rules were adopted in 1997.	No
Illinois	Two five-year demonstration programs are underway to test alternative assisted living models.	Waiver for demonstration
Indiana	A disclosure bill passed in 1997. State agencies are continuing to study assisted living.	No
Iowa	SF 454 was signed by the governor in May 1996. New regulations were effective in 1997.	Waiver
Kansas	Law was passed in 1995 defining assisted living. Regulations were effective in 1997. Revisions are being considered.	Waiver
Kentucky	Legislation was passed in 1996. Regulations for voluntary certification were adopted in 1997.	No
Louisiana	New regulations creating core licensing requirements and modules for assisted living have been filed. A pilot project for Medicaid beneficiaries is being designed based on legislation passed in 1997.	Waiver for demonstration planned.
Maine	Final regulations creating several categories of assisted living (congregate housing, residential care facilities, and adult family homes) were effective May 1998.	Waiver and state plan
Maryland	New regulations based on legislation were passed in 1996, have been issued, and are expected to become final in June 1998.	Waiver
Massachusetts	Legislation creating an assisted living certification process was signed in January 1995. Regulations implementing a certification process created for settings meeting specified criteria are in place.	State plan
Michigan	Following a reorganization of state agencies, an interagency group is reviewing licensing rules.	No

ASSISTED LIVING AT A GLANCE (*continued*)		
State	**Status**	**Medicaid Coverage**
Minnesota	Assisted living has been implemented as a Medicaid service. New licensure rules of assisted living service providers have been drafted.	Waiver
Missouri	No current activity to create assisted living is underway. Medicaid reimbursement is available for residential care facilities.	State plan
Mississippi	A report on assisted living is expected in June 1998.	No
Montana	Assisted living is covered in personal care facilities under a Medicaid waiver.	Waiver
Nebraska	Regulations implementing legislation creating assisted living are effective July 1998. Legislation authorizing $40 million in grants and loan guarantees to convert nursing homes to assisted living was signed in April.	Waiver planned
New Hampshire	Rules for two levels of supportive residential and residential care facilities will be revised in 1998 or early 1999. A Medicaid HCBS waiver to cover assisted living was planned.	Waiver planned
Nevada	Licenses residential care facilities for groups. Limited Medicaid reimbursement is available.	Waiver
New Jersey	Regulations creating an assisted living licensing category were implemented.	Waiver
New Mexico	Residential shelter care facility rules have been revised.	Waiver
New York	New regulations consolidating several existing categories are being developed. A report assessing the assisted living industry is expected in the summer of 1998.	State plan
North Carolina	Chapter 535 (1995) defines assisted living residence as a category of adult care homes. Regulations revising the adult care home model and registration requirements for assisted living in elderly housing sites have been issued.	State plan
North Dakota	Assisted living services are funded through the state's Medicaid waivers and two state funded service programs.	Waiver and state funds
Ohio	Residential care facility rules have been revised. A decision on submitting the Medicaid waiver has been delayed pending a study of the entire Medicaid program.	No
Oklahoma	New rules implementing assisted living are effective in 1998.	No
Oregon	Revisions to program rules are expected in early 1999.	Waiver
Pennsylvania	Personal care homes are licensed. An interagency task force will make recommendations on assisted living in 1998.	No
Rhode Island	About 45 residential care and assisted living facilities are licensed. A pilot project for low income residents, authorized by the legislature in 1997, is being designed by the state Department of Elderly Affairs and the RI Housing Finance Agency.	Waiver
South Carolina	A brief report describing assisted living was submitted in 1997.	No
South Dakota	Assisted living category exists in statute. Limited services allowed.	Waiver
Tennessee	New assisted living regulations were effective in April 1998.	No
Texas	Regulations were revised in 1998. Regulations covering special care facilities have been prepared.	Waiver
Utah	Program rules were approved in 1995. Rules governing the buildings were also approved by a state board.	Waiver under consideration
Vermont	Regulations developed by the Department of Aging and Disabilities will be effective following a hearing and approval by a legislative committee. Medicaid waiver coverage of services in enhanced residential care facilities has been added. Waiver coverage of assisted living is planned.	Waiver planned

ASSISTED LIVING AT A GLANCE (*continued*)		
State	**Status**	**Medicaid Coverage**
Virginia	Regulations allowing assisted living services in adult care residences were effective in February 1996.	Waiver
Washington	Rules covering assisted living as a Medicaid waiver service were issued June 1996. Licensing responsibility has been transferred from the Department of Health to the Aging and Adult Services Administration.	Waiver
West Virginia	Licenses personal care homes. Legislation creating a new category--community residential care facilities--passed in 1997.	No
Wisconsin	Regulations implementing a new residential care apartment complexes registration program were implemented in 1997.	Waiver
Wyoming	Regulations upgrading board-and-care rules were issued. New rules allow skilled nursing and medication administration.	No

STATES TO WATCH IN 1997: WHAT HAPPENED?		
State	**1997 Activity**	**Outcome**
Alabama	Report from State Health Coordinating Council; proposed changes by the Public Health Department	Draft regulations due in 1998
California	Report and draft legislation	Report issued. No legislative action
Delaware	Task force recommendations and legislative action	Regulations are final and a Medicaid waiver has been submitted
Hawaii	Implementation of regulations, Medicaid waiver submission	Regulations in comment period
Idaho	Recommendations from state agencies	Revised regulations
Illinois	Implementation of pilot projects	Implementation underway
Indiana	Task force recommendations	Legislature requested study and report
Iowa	Draft regulations	Regulations and Medicaid coverage effective
Kansas	New regulations	Regulations and Medicaid coverage effective
Kentucky	New regulations	Regulations for voluntary certification effective
Louisiana	Draft regulations	Law passed authorizing pilot project. Regulations filed in the register.
Maine	Draft regulations	Regulations effective October 1997
Maryland	Draft regulations	Regulations pending
Nebraska	Draft regulations by Health Department	Law passed and regulations effective July 1998.
New Jersey	Possible new rate methodology	Still under consideration
New Mexico	Possible new rate methodology	No changes made
Oklahoma	Legislative action pending	Legislation passed, regulations being drafted
Pennsylvania	Recommendations for changes in regulations	Task force working on recommendations
South Carolina	Task force recommendations	Report submitted
Tennessee	Draft regulations	Regulations final April 1998
Vermont	Task force recommendations and regulations	Regulations proposed for comment
Wisconsin	Draft regulations	Regulations and Medicaid coverage implemented

STATES TO WATCH IN 1998-1999	
State	**Activity**
Alabama	Revised regulations expected
Arkansas	New category and Medicaid coverage being considered
Arizona	Multiple categories are being consolidated
Connecticut	Status of Medicaid pilot project
Hawaii	Finalize regulations and implement waiver coverage
Illinois	Implementation of pilot projects
Indiana	Task force recommendations, possible legislation
Kansas	Revisions to the regulations are being reviewed
Louisiana	Draft regulations should be finalized
Maine	Case mix reimbursement system pending
Maryland	Draft regulations should be final by July 1998
Michigan	Revisions being considered
Mississippi	Task force considering assisted living regulations
Nebraska	Grants available for nursing home conversion. Medicaid waiver coverage.
New Hampshire	New regulations will be drafted
New Jersey	Possible new rate methodology
New York	Draft regulations consolidating multiple categories
North Carolina	Case mix reimbursement system, possible changes in moratorium on new construction
Oregon	Revisions to regulations being developed
Pennsylvania	Draft regulations should be issued
Rhode Island	Implementation of demonstration with Housing Finance Agency
Texas	Draft requirements for special care facilities and amendments to personal care home staffing and training requirements will be adopted
Vermont	Implementation of Medicaid waiver coverage for assisted living and a tiered payment system
West Virginia	Draft regulations for a new category

METHODOLOGY

This study was designed to review, describe, and analyze state policy on assisted living. Two surveys were developed covering general licensing issues and Medicaid reimbursement policy. The surveys were mailed to state Aging, Health, and Medicaid agencies. The information was collected between January and March 1998. Copies of existing and draft regulations, where appropriate, were received from each state. Telephone interviews were conducted as necessary with state agency staff to clarify survey response information or to discuss key issues. The narrative describes state policy trends for licensing and reimbursing assisted living. Summaries of each state's policy and regulations covering assisted living and board and care are presented.

THE CHALLENGE GROWS: WHAT IS ASSISTED LIVING AND DOES IT DIFFER FROM BOARD AND CARE?

Defining assisted living and differentiating it from board and care has proved a challenge in recent years. And a common definition or understanding of assisted living remains unlikely as state policy makers, regulators, legislators, consumers, and providers develop models that address local circumstances. In many states, there is considerable overlap between board and care and assisted living rules. Assisted living is both a generic concept and a specific model. Facilities and state regulators in states with board and care rules often use the terms assisted living and board and care synonymously and include the ability to age in place and offer higher levels of care under their board and care rules. A review of state polices finds that four states use assisted living and board and care interchangeably: Alabama, Rhode Island, South Dakota, and Wyoming. Yet other states describe assisted living as a specific model that has a consumer centered philosophy, apartment settings, residential environment, and a broad array of services which support aging in place.

Assisted living policy in other states generally differs from board and care rules in three primary areas:

- Assisted living statutes/regulations often contain a statement of philosophy that emphasizes privacy, independence, decision-making and autonomy.

- Assisted living is more likely than board and care to emphasize apartment settings shared by choice of the residents.

- Assisted living allows facilities to provide or arrange nursing or health related services and to admit or retain residents who may meet the level of care criteria for admission to a nursing facility.

Some states have gone even further with their efforts to differentiate services. Washington state has developed Medicaid regulations which differentiate assisted living, residential care, and enhanced residential care. Assisted living contractors must offer private apartments and may provide limited nursing services. Enhanced adult residential care providers may provide limited nursing services while adult residential care contractors may not. Adult residential care and enhanced adult residential care providers are not required to offer private units with bathrooms and kitchens, while assisted living facilities are required to do so.

TABLE 1. Assisted Living and Board and Care: Washington			
Component	**Assisted Living**	**Enhanced Adult Residential Care**	**Adult Residential Care**
Room and board	Yes	Yes	Yes
Personal care	Yes	Yes	Yes
Nursing services	Yes	Yes	No
Private unit	Yes	No	No
Private bathroom	Yes	No	No
Kitchen	Yes	No	No
Nurse delegation	Yes	No	No

States may create a new assisted living licensing category and retain older categories (e.g., residential care facilities, personal care homes) which allow shared bedrooms and limited services. Other states have consolidated categories and now have one general set of assisted living rules that might cover assisted living, board and care, multi-unit elderly housing, congregate housing and sometimes adult family or foster care (e.g., Maine, Maryland and North Carolina). Still others set core requirements for licensed facilities and require an additional license to offer limited nursing services or a higher level of care. To add to the variation, Wisconsin has changed its category from assisted living to residential care apartment complexes.

States also differ in their description of the focus of assisted living. Connecticut and Minnesota see assisted living as a service, and license the service provider (which may be a separate entity from the organization that owns or operates the building). Others states see assisted living as a building in which supportive and health related services are provided. The operator of the building is licensed, and services may be provided by the operator's staff or contracted to an outside agency.

Draft rules in Louisiana establish core rules and separate modules for assisted living facilities, personal care homes, and shelter care facilities. The modules contain separate requirements for administrators, staff training, and living units. The draft rules state that the purpose of the regulations is to promote the availability of appropriate services for elderly and disabled persons in a residential environment; to enhance the dignity, independence, privacy, choice, and decision-making ability to the residents; and to promote the concept of aging-in-place. This extends the principles of assisted living to other categories while requiring (1) more training for administrators and staff, and (2) apartment units in assisted living settings. Oregon, which was the first state to adopt principles of assisted living, and Washington have extended the principles to other categories of care.

Will There be Consensus?

Reaching consensus on a definition of assisted living can only occur if the federal government sets standards as they have for nursing facilities. However, federal standards are unlikely for several reasons. The federal government is not likely to become a major payer of assisted living. The expansion of Medicare managed care has generated expectations that assisted living can offer HMOs an excellent vehicle for

managing rehabilitative services and providing a supportive environment for frail HMO members. Medicare HMO membership continues to grow, from 3.1 million in December 1996 to 5.7 million in May 1998, and the Congressional Budget Office projects enrollment will reach 15 million by 2007.

Although many experts predict coverage of assisted living through HMOs with Medicare risk contracts, it is the flexibility of the Medicare capitation payment which encourages HMOs to provide added or alternative services. Medicare HMOs are required to cover all regular Medicare benefits, and they may cover additional services. One of the attractions of Medicare HMOs is their coverage of additional services such as physical exams, prescription drugs outside a hospital, eye glasses, dental care, and others. But even if HMOs begin to cover services in assisted living, assisted living is not likely to become a regular Medicare benefit. As Congress and a Commission explore ways to protect the future of Medicare, further benefits, especially non-medical benefits, are not likely to become a regular covered benefit.

Second, Medicaid payments for assisted living are expanding, but, here again, assisted living is most often covered as a service under home- and community-based waivers. Personal care services in assisted living can also be covered under the state Medicaid plan, but assisted living itself is not covered. Room and board cannot be covered by Medicaid except in hospitals and nursing homes. States have the responsibility for setting provider standards, and regulations governing assisted living facilities participating in Medicaid remain a state responsibility. Further federal action through regulation is unlikely given the manner of Medicaid coverage, state options, and continuing state responsibility in this area.

Third, quality-of-care concerns could stir federal interest in assisted living but, historically, quality, standards, and monitoring have been a state responsibility. During the late 1970's and early 1980's Congressional hearings were held on the quality of care in board-and-care homes. Little federal action followed, and states retained licensing and monitoring responsibility. In the current political climate, government responsibilities are more likely to shift to states rather than flow from states to the federal government.

Without a major federal financial interest or a major change in federal-state responsibilities, there is little likelihood that federal action will be forthcoming in the near future. Assisted living will continue to be defined through legislation and regulation on a state-by-state basis and through marketing and advertising by facilities. The result is likely to be continued divergence, differences, and innovation as states develop definitions, licensing criteria, and standards that reflect the priorities and philosophy of each state.

THE ROLE OF THE MARKET IN DEFINING ASSISTED LIVING

Regulations set parameters for what is possible. Admission/retention criteria establish the maximum boundaries for tenants, and the services allowed define the maximum allowable package that may be delivered. Operators still determine which tenants may be admitted or retained and what services are provided. State regulations often specify that the residence must develop written policies concerning whom it will serve and what services it will provide. As a result, providers may choose not to offer all the services allowed by regulation. Companies that own or manage assisted living facilities and nursing homes may view the nursing facility as their primary line of business and develop assisted living as a referral source. While this policy may be a sound business strategy, it is not consumer or customer focused and does not maximize a resident's ability to age in place.

Despite broader rules, facilities may be successful at offering a limited service package. If competition is limited, and demand and occupancy are high, facilities can operate successfully offering limited services. The staffing requirements are easier to manage, and rates can be relatively low. As more facilities locate in an area and residents age and require more services, these facilities will have a more difficult time maintaining a lower service package. If, as residents leave, new residents are harder to attract, the residence will have to increase the service intensity to retain residents rather than allow a lower occupancy rate.

Existing Providers

Many providers may seek protection for the product they market today, while others will diversify and develop new products to keep pace with a changing market place. New assisted living licensing categories which require more privacy and autonomy may displace older shared occupancy models. Providers who build new facilities that reflect current consumer preferences face challenges for what to do with an existing facility. Can it be sold, rehabilitated, or converted to another use? If not, is the organization solvent enough to withstand its closing? As states develop policy, the interest and vision of those directly affected are likely to influence the direction of new public policy.

States can help nursing home owners deal with a changing market. Nursing homes can diversify their product mix, convert portions of a facility for other uses including assisted living, or provide in-home services. Although many states do not track nursing home conversions to assisted living, the survey responses from six states indicated that 72 nursing facilities have converted 2,428 beds to assisted living. Responses from seven additional states reported that a total of 117 facilities had converted to assisted living, but the number of nursing home beds involved was not

known. The largest number of conversions has occurred in Iowa (24 facilities and 1,114 beds) and Kansas (38 facilities and 952 beds).

Legislation passed in Nebraska in 1998 provides $40 million in grants or loan guarantees to nursing homes to convert wings or entire facilities. The program will be administered by the Nebraska Department of Health. Grants will be made when conversion is considered efficient and economical. Grantees must agree to maintain specified occupancy levels of Medicaid beneficiaries for a period of ten years. The Department will develop rules specifying minimum occupancy rates, allowable costs, and refund methods. Grants may cover capital or one-time costs and operating losses for the first year to facilities that have participated in the Medicaid program for at least three years. Facilities must provide 20% of the cost of conversion. Facilities may convert existing space or construct additional space to include assisted living or other alternative services. Construction of a new assisted living facility may be funded if the nursing home beds are de-licensed and it is more cost effective to construct new space rather than convert old.

Living Unit Options

Single occupancy apartments or rooms dominate the private market. A survey of non-profit facilities conducted by the Association of Homes and Services for the Aging[2] found that 76% of the units in free-standing facilities and 89% of units in multi-level facilities were private (studio, one- or two-bedroom units). A similar survey by the Assisted Living Federation of America found that 79% of units in member facilities were studio, one- or two-bedroom units.

The issue that often creates conflict in policy development is the requirement for the living units. Older board-and-care rules allow shared rooms, toilets, and bathing facilities. Existing facilities that want to be licensed as assisted living would oppose rules requiring apartment-style units and single occupancy. Some states have grandfathered existing buildings or maintained separate board-and-care categories which allow shared rooms.

To some extent, market forces rather than minimum licensing standards will define the type of units built for and occupied by the private market. Older, shared room models will have a more difficult time competing for residents. However, older providers may increasingly seek low- income older people. As the upper-income market becomes saturated and more companies seek to serve low- and moderate-income elders, efforts to develop "affordable" models may compromise on single occupancy. Medicaid policy will play a critical role in shaping the market over time as it serves lower-income residents. Some facility operators contend that shared occupancy is the only way to develop affordable units. While historically, low Medicaid rates are cited as the reason

[2] Ruth Gulyas. “The Not-for-Profit Assisted Living Industry: 1997 Profile.” American Association of Homes and Services for the Aging. Washington DC. 1997. Also, “An Overview of the Assisted Living Industry: 1996.” The Assisted Living Federation of America and Coopers and Lybrand. Washington, DC. 1996.

for offering double occupancy, owner pricing policy also plays a role. Offering double occupancy allows an operator to set a higher price for single occupancy and scale prices by room size. The actual cost difference of single versus double occupancy units over the life of a mortgage is minimal. However, the revenue stream that can be generated by shared occupancy may be significant. Some providers contend that shared occupancy models actually require more staff time than single occupancy units because of the problems and conflicts between tenants that must be resolved. Under the guise of affordability, developers may market shared occupancy models to lower-income residents and single occupancy units to people who can afford to pay a higher rate.

Thus far, Medicaid policy in several states has recognized the importance of single occupancy in fulfilling the principles stated in their policy and developed a reimbursement level that allows facilities to contract with Medicaid at the market rate. Other states have required apartments but do not specify that apartment units can be shared only by choice. Whether Medicaid's role in maintaining the apartment and single occupancy threshold for low-income residents continues remains to be seen.

STATE POLICY DEVELOPMENTS

The rapid development of assisted living regulations and revision of board-and-care regulations continued in 1997 and during the first half of 1998. Thirty-three states have taken steps to implement an assisted living policy, and 11 others have instituted a process to study the issue.[3] In 1997 and 1998, laws were passed in Florida, Indiana, Nebraska, and Oklahoma. Florida amended its existing statute to modify training requirements especially for facilities serving persons with Alzheimer's disease. Laws passed in Indiana create a disclosure requirement and direct the Department of Health to conduct a study of assisted living facilities.

Regulations were finalized in Delaware, Iowa, Kansas, Kentucky, Maine, Nebraska, Oklahoma, Tennessee, and Wisconsin. Draft regulations were issued in Hawaii, Louisiana, Maryland, and Vermont, and efforts to consolidate or revise regulations are now underway in Alabama, Arizona, New York, and Oregon. New Hampshire's rules sunset the end of 1998, and new rules will be developed.

Three states added assisted living to their Medicaid waivers: Kansas, Rhode Island, and Wisconsin, and waiver coverage is planned or under consideration in Connecticut, Delaware, Hawaii, Nebraska, New Hampshire, South Carolina, and Utah.

Proposed rules in Hawaii are still in the comment period. Iowa has created a certification process for assisted living, developing rules which certify facilities providing home-like environments and follow the principles of assisted living. Regulations in Kansas were finalized and a Medicaid Home and Community Based Services (HCBS) waiver has been approved that allows assisted living facilities to become providers of waiver services. Kentucky's regulations voluntarily certify facilities offering apartment or home-style housing units in assisted living residences. Regulations in Tennessee were effective in April 1998 and were developed by a 13 member task force headed by a state agency.

Four states are developing demonstration programs designed to test models for serving low-income residents. Two pilots are being conducted in Illinois, one by the Department of Public Aid (DPA) and another by the Department of Aging. The DPA program targets lighter-need nursing facility residents who are unable to remain in their homes or independent settings but do not need 24-hour nursing care. As participants in the project, contractors may convert nursing home units or free standing buildings to units that integrate housing, health, personal care, and supportive services in home-like residential settings. The program is consistent with the definition of assisted living used by the HCBS program.

The Illinois Department on Aging is testing a Community Based Residential Facilities service model. Services will be reimbursed as home care services through the

[3] Several states with existing policy have formed a task force to review the policy and make recommendations.

Medicaid Home and Community Based Services Waiver or state funds. The pilot may include three facilities and serve no more than 360 people. The authorizing statute allows the programs to serve people with short or long term needs as a means of relieving family caregivers. Two facilities have been selected, including an Alzheimer's care facility. The Department may contract with a third program involving a nursing home seeking to convert its facility.

The Rhode Island legislature authorized the Housing and Mortgage Finance Agency (HMFA), working in collaboration with the Department of Human Services and the Department of Elderly Affairs, to implement a pilot program. The pilot can serve (in facilities certified and financed by the HMFA) up to 200 low- and moderate-income chronically impaired or disabled adults who are eligible for or at risk of entering a nursing home.

Louisiana agencies are designing a pilot program to test the feasibility of covering assisted living under Medicaid. The project will be implemented by the Department of Health and Hospitals. A task force was appointed to draft guidelines for the project. The project will include two assisted living facilities and use Medicaid waiver funds to pay for assisted living services. The bill defines assisted living as "a residential congregate housing environment combined with the capacity by in-house staff or others to provide supportive personal services, twenty-four-hour supervision and assistance, whether or not such assistance is scheduled, social and health related services to maximize residents' dignity, autonomy, privacy, and independence and to encourage facility and community involvement." One rural and one urban site will be selected through an RFP. Each facility may serve up to 30 Medicaid beneficiaries. Residents must be offered a chance to live in private quarters with a lockable door, bedroom, kitchenette, and bathroom.

Legislation authorizing a pilot program has passed in Connecticut. The bill authorizes Medicaid coverage for assisted living services in three cities with a maximum of 300 units.

To summarize state activity:[4]

- Thirty-one states had existing regulations (22) or Medicaid provisions (9) using the term "assisted living" as of June 1998.

- Six states have issued draft rules.

- Twenty-eight states provide Medicaid reimbursement for services in assisted living or board-and-care.
  - Nine states plan to add Medicaid coverage of services in assisted living facilities.

[4] States may be counted in more than one category.

- Six of the twenty-eight states reimburse for services in board-and-care facilities.

- Eleven states are studying assisted living.

State Regulatory Models

Earlier NASHP studies of state assisted living policy described three approaches to categorizing state models that highlight particular features of state policy. Based on further policy developments, a fourth approach has been added to better define state approaches to licensing, unit requirements, and the service level. The approaches are:

- Board-and-care/institutional,
- New housing and services model,
- Service model, and
- Umbrella model.

Institutional models are based on older board-and-care regulations. They allow shared bedrooms without attached baths and either do not allow nursing home eligible residents to be admitted or do not allow facilities to provide nursing services. Two states, Alabama and Rhode Island, adopted "assisted living" as the name for their board-and-care licensing category. South Dakota and Wyoming re-named an existing category as assisted living and allowed a higher level of service to be provided without changing the unit requirements. Arkansas and Illinois are two states that do not allow anyone requiring nursing home services to be served in a board-and-care facility. Some states allow skilled nursing services to be provided for limited periods by a certified home health agency. The upgraded board-and-care approach recognizes that residents are aging-in-place and need more care to prevent a move to a nursing home. State policies have allowed these facilities to admit and retain people who need assistance with activities of daily living (ADLs) and some nursing services. Mutually exclusive level of care criteria have been revised to allow people who would qualify for admission to a nursing home to be retained. The model retains the minimum requirements for the building and units (usually multiple occupancy bedrooms with shared bathrooms and tub/shower areas).

The **new housing and service model** licenses or certifies facilities providing assisted living services which are defined by law or regulation. These models require apartment settings and allow facilities to admit and retain nursing home eligible tenants. Depending on the state, rules may allow some or all of the needs met in a nursing home to also be met in assisted living. Policies in states with this approach included a statement of philosophy that emphasizes resident autonomy and creates a prominent role for residents in developing and delivering services. By licensing the setting and services, states distinguish these facilities from board-and-care and have attempted to develop more flexible regulations. Examples of this approach to licensing can be found

in Hawaii, Kansas, Oregon, and Vermont and Medicaid waiver standards in Arizona, North Dakota and Washington.

The **service model** focuses on the provider of service, whether it is the residence itself or an outside agency, and allows existing building codes and requirements--rather than new licensing standards--to address the housing structure. This model simplifies the regulatory environment by focusing on the services delivered rather than the architecture. Unfortunately, newer residential models serving frailer residents may not be as familiar to local building inspectors and code enforcement officials who may want to apply more institutional requirements than are needed. Service regulation approaches may include requirements that define which buildings (apartment units, minimum living space) may qualify as assisted living, but the licensing agency's staff do not otherwise apply their standards to the building's characteristics. The service model can be developed for apartment settings (Connecticut) or multiple settings (Texas Medicaid waiver program).

States using an **umbrella model** issue regulations for assisted living that cover two or more types of housing and services: residential care facilities, congregate housing, multi-unit or conventional elderly housing, adult family care, and assisted living. States representing this approach include Florida, Maine, Maryland, Louisiana, New Jersey, Maryland, New York, North Carolina, and Utah.

Elderly Housing or Assisted Living?

Assisted living can be regulated as a service in a purpose built facility and in elderly housing buildings. Purpose built facilities involve new construction or renovation of a building that is designed to serve frail residents. The term is clear as it refers to a building in which *all* the residents receive some level of care. Buildings which are built explicitly to operate as assisted living settings can be built to existing codes for multi-unit residential environments.

Assisted living may also be regulated as a service that can be provided in a conventional elderly apartment complex. To some extent, existing elderly housing buildings can also be considered assisted living. Because a significant percentage of, but not all, residents need service, the assisted living component may be considered a more comprehensive, organized service package provided in subsidized housing with a mix of residents, some of whom are impaired and others who function independently. In this setting, comparisons with in-home service programs and confusion between independent and dependent residents concerning the type of building they live in is more likely.

Questions can be raised about approaches that regulate the service rather than the setting. In some settings, differentiating assisted living from more common community based services programs becomes difficult. As a new trend, the term "assisted living" may be expected to mean something different from board-and-care or in-home-services models of care. Policy makers need to respond to aging-in-place that

is occurring in conventional elderly apartment complexes since many residents have both health and personal care needs. The key question is: when does an apartment building become an assisted living residence? For residents who are receiving personal care and some nursing care, elderly housing may resemble buildings that were designed and built as an assisted living residence. For independent residents, it's an apartment building. Even if all the residents required some supportive services, many contend that the building would not constitute an "assisted living" site because of licensing and architectural characteristics.

Participants at a 1995 round table on assisted living discussed the environmental differences between conventional elderly housing and assisted living. Buildings designed and built as assisted living tend to have higher lighting levels in common spaces, more common spaces for activities and socialization, different flooring, small refrigerators raised above floor level, handicapped accessible bathrooms in every unit, roll-in showers, wider corridors with hand rails, two-way voice communication, and other features. Conventional elderly housing generally may not have been renovated to accommodate the decreasing independence of residents needing care.

The important factor is that residents receive the service they need to maximize functioning in the most independent and autonomous way possible. Whether the term "assisted living" is applied broadly or more narrowly may be a function of the presentation of the concept in a way that generates the level of political support to make the resources available. Regarding assisted living solely as a service, not a place, may omit setting important requirements for living units. In licensing or certifying assisted living as a service, however, state regulations can require that assisted living services be provided in buildings with apartments or private rooms and attached baths while still allowing state and local building codes to govern the structure itself. Connecticut, New Jersey (assisted living program category), and North Carolina (multi-unit housing category) are examples of this approach.

Connecticut licenses assisted living service agencies which provide assisted living services in managed residential communities. Living units in these communities are defined as a living environment belonging to a tenant(s) that includes a full bathroom within the unit including water closet, lavatory, tub or shower bathing unit, and access to facilities and equipment for the preparation and storage of food. The housing owner or operator does not need a license to manage the residential property.

New Jersey defines assisted living as "a coordinated array of supportive personal and health services, available 24 hours per day to residents who have been assessed to need these services including residents who require formal long term care." In this state, assisted living services can be provided in three settings: assisted living residences, comprehensive personal care homes, and assisted living programs. The assisted living program model is provided in elderly housing projects. New Jersey wanted a model that was suitable for urban environments, assuming that limited land availability and high costs limit new construction in major cities. To develop its assisted living program model, the state funded a two-year pilot project in a large elderly housing

site. Prior to the pilot, residents who needed assistance received one meal in a congregate dining room, one or two hours of housekeeping a week, laundry, and shopping.

As part of the pilot, personal care, additional meals, medication assistance, and escort services to doctors appointments were added, and wellness and health education programs (flu shots, health fair, guest lectures, referrals to podiatrists, dentists, and physicians) were available to all tenants. In addition, a health clinic was established using a vacant apartment that was staffed by a geriatrician and a geriatric nurse practitioner two and a half days a week. Security guards were used to implement a 24 hour emergency response capacity. Twenty-four hour, on-site staff coverage was not identified as a need. Twenty-five percent of the participants met the nursing home admission criteria. The evaluation found the program was cost effective, consumer centered, and worthwhile.

Based on the results, regulations were drafted and issued for public comment. The New Jersey rules now refer to assisted living residences (purpose built facilities), comprehensive personal care homes (previously licensed homes which meet new standards), and assisted living programs which are services provided to residents in publicly subsidized housing sites. These regulations took effect January 1, 1997.

North Carolina has developed requirements for registration and disclosure for a category of assisted living residences called multi-unit assisted housing with services. Services in these settings are arranged by housing management but provided by a licensed home care or hospice agency and not the housing provider, unless the housing management company is also licensed as a home care agency. The disclosure statement describes the services which may be arranged, the cost of services, tenant admission/retention criteria, a list of service providers, a grievance procedure, and any financial relationships between service providers and the housing management. This category seems to formalize but not alter the existing in-home delivery system serving residents in elderly housing sites.

While the primary vehicle for reimbursing care in residential settings in North Carolina is through the Medicaid state plan, the combination of rules and Medicaid funding create some interesting contrasts. North Carolina reimburses assisted living residences in adult care homes and multi-unit assisted housing with services models. Personal care in adult care homes is reimbursed as a state plan service while the Medicaid HCBS waiver may cover eligible residents in multi-unit assisted housing with services settings. Participants must meet the nursing home level of care criteria while adult care home residents must have ADL impairments. It has not been determined whether residents in subsidized elderly housing sites which register as multiunit assisted housing with services settings will be eligible for both programs.

States designing policies to facilitate aging-in-place must recognize the importance of meeting unscheduled needs for personal care, especially during the night, holidays, and weekends. In terms of capacity to serve frail residents, these are

key variables. Whether services are provided directly by the building management or through a contract to serve all residents with a community agency (certified home health agency, licensed home care agency) is less significant than the availability of 24-hour staffing capacity and the ability to meet unscheduled needs for assistance with activities of daily living. Issues of cost are also significant. A certified home health agency may have a higher cost structure in order to maintain its Medicare certification which adds to the cost of delivering services. Home health agencies which have created home care subsidiaries can deliver a similar level of care with lower costs.

Assisted Living Philosophy

Assisted living in many states represents a more consumer focused model which organizes the setting and the delivery of service around the resident rather than the facility. States which emphasize consumers use terms such as independence, dignity, privacy, decision-making, and autonomy as a foundation for their policy. Statutes, licensing regulations, and Medicaid requirements in twenty-two states, up from 15 states in 1996, contain a statement of their philosophy of assisted living. (See table in appendix.) States which have adopted or proposed this philosophy are Arizona, Delaware, Florida, Hawaii, Illinois (demonstration program), Iowa, Kansas, Kentucky, Louisiana (draft), Maine, Maryland, Massachusetts, Nebraska, New Jersey, New Mexico, Oregon, Rhode Island, Utah, Vermont, Virginia, Washington and West Virginia. Massachusetts includes their language in a section that allows the Secretary of Elder Affairs to waive certain requirements for bathrooms as long as the residences meet the stated principles.

Oregon's definition states that: "Assisted living promotes resident self-direction and participation in decisions that emphasize choice, dignity, privacy, individuality, independence and home-like surroundings." Florida's statute states the purpose of assisted living is "to promote availability of appropriate services for elderly and disabled persons in the least restrictive and most home-like environment, to encourage the development of facilities which promote the dignity, individuality, privacy and decision-making ability...." The laws also state that facilities should be operated and regulated as residential environments and not as medical or nursing facilities. The regulations require that facilities develop policies which allow residents to age-in-place and which maximize independence, dignity, choice, and decision-making of residents.

New Jersey amended its rules to emphasize the values of assisted living and introduce managed risk. Facilities must provide and coordinate services "in a manner which promotes and encourages assisted living values." These values are concerned with the organization, development, and implementation of services and other facility or program features so as to promote and encourage each resident's choice, dignity, independence, individuality, and privacy in a home-like environment. The values promote aging-in-place and shared responsibility.

Although the philosophy of assisted living is increasingly found in state policy, facilities must take additional steps to operationalize it. Aspects of assisted living that might be considered to convert philosophy to action include the living units required or provided, whether living units may be shared by choice, use of a shared-risk process to develop a service plan and training for facility staff on the principles of assisted living. Eight of the twenty-two states with a statement of the philosophy of assisted living also require apartment units. Rules in four states have mixed requirements, allowing bedrooms in some arrangements and apartments in new construction. Fifteen of the states allow sharing (apartments or bedrooms) only by choice of the residents. Ten states use a shared risk process for developing tenant service agreements or service plans. Connecticut, which licenses assisted living service agencies and not facilities, does not have a statement of philosophy, but residences must offer apartments, and sharing is allowed only by choice. Two other states, Ohio and Oklahoma (draft rules), have a shared-risk provision and no statement of philosophy. Four states include a philosophy of assisted living but do not address the remaining areas which would operationalize the philosophy. Eleven states require that the training curriculum for staff must cover the principles of assisted living.

Resident Agreements

State rules often include requirements for agreements or contracts with residents. The scope of the agreement varies but usually includes provisions dealing with services, fees, resident rights and responsibilities, occupancy, and move-out or discharge issues.

The agreements include a description of the fee or charges to be paid, the basis of the fee or what is covered, who will be responsible and the method, and time of payment. Refund policy is also covered by agreements in many states. Rules covering agreements specify the amount of advance notice tenants must be given when rates are changed. A thirty-day notice is usually required. Policies governing the management of resident funds, when applicable, may also be included in resident agreements.

Service provisions generally describe the services to be provided that are covered by the basic fee and any additional services that might be available. Maryland's rules require disclosure in the agreement of the level of care that the facility is licensed to provide and the level of care needed by the resident at the time of admission. Wisconsin requires that the qualifications of staff who will provide services are included in the agreement and whether services are provided directly or by contract. The resident agreement in Colorado includes a care plan which outlines functional capacity and needs.

Resident rights and the provisions that allow staff to inspect living quarters, with the resident's permission, are also required by some states. Other states require that a copy of residents' rights provisions must be provided to each resident, without including

it as part of the resident agreement. Grievance procedures may also be included in the agreement or provided separately to residents.

Terms of occupancy may also address provision of furnishings and the policy concerning pets. Other terms often include admission policy and descriptions of the reasons for which a resident may be involuntarily moved as well as the time frame and process for informing the resident and arranging for the move. Policies concerning shared occupancy must be included in agreements under Maryland's rules as well as procedures which will be followed when a resident's accommodations are changed. The changes could be due to relocation, change in roommate assignment, or an adjustment in the number of residents sharing a unit. Agreements may also include the facility's "bed hold" policy when residents temporarily enter a hospital, nursing home, or other location.

Agreements in Colorado must disclose whether the facility has an automatic sprinkler system.

Rules in Maine do not allow the resident agreement to contain any provision for discharge which is inconsistent with state rules or law or imply a lesser standard of care than is required by rule or law. Agreements in Maine must also include information on grievance procedures, tenant obligations, resident rights, and the facility's admissions policy.

Kansas requires that citations of relevant statutes and copies of information on advance medical directives, resident rights, and the facility's grievance procedure must be given to residents before an agreement is signed.

Kansas specifies that the agreement must be written in clear and unambiguous language in 12 point type. Draft rules in Maryland direct that the agreement must be a clear and complete reflection of commitments agreed to by the parties and the actual practices that will occur in the facility. The language must be accurate, precise, easily understood, legible, readable, and written in plain English. Wisconsin's rules require that the format of agreements make it esay to readily identify the type, amount, frequency, and cost of services.

Most state rules do not address revising or updating resident agreements. However, Alabama includes the period covered by the agreement. Wisconsin's rules provide that agreement must be reviewed and updated when there is a change in the comprehensive assessment, or at the request of the facility or the resident. Updates are otherwise made as mutually agreed by the parties.

Unit Requirements and Privacy

Privacy is primarily measured by the type of unit, the ability of residents to lock their doors, and the behavior of staff. States which have based their policy on privacy

have emphasized apartments with attached bath. Autonomy is promoted by the availability of cooking facilities within the unit. Of the states that have established or proposed assisted living policy in this area, the following require apartments: *Arizona*, Connecticut, Hawaii, Kansas (draft), Louisiana (draft), Minnesota, New Jersey,[5] *North Dakota*, Oregon, Vermont (draft), Wisconsin and *Washington*. (Note: States in italics require apartments under the Medicaid program rather than the state's licensing requirements).

Thirty-one states have rules that allow two people to share a unit or bedroom, and eleven of these states allow sharing of units only by choice of the residents. Several of these states have multiple licensing categories, and the two-person limit may apply to only one of the categories. Fifteen states have licensing categories that allow four people to share a room; five states allow three people to share units, and one state allows up to five people to share a room.

Washington requires private apartments shared only by choice. New Jersey's policy requires apartments for newly constructed units but allows two people to share an apartment. Florida now has two types of assisted living, one which allows up to four people to share a bedroom, and extended congregate care, which requires private apartments, private rooms or semi-private rooms or apartments, shared by choice of the residents. Massachusetts allows two people to share a room or apartment. Kentucky's statute requires apartments or home-style units. A home-style unit is a private room with a semi-private bathroom and use of kitchen facilities.

States which have developed a multiple-setting assisted living model vary the requirements by the setting. New York allows sharing for board-and-care facilities participating in the Medicaid program but requires apartments in the "enriched housing category," which includes purpose-built residences and subsidized housing.

New Mexico's Medicaid assisted living waiver covers two types of facilities offering "home-like" environments which are either units with 220 square feet of living and kitchen space (plus bathroom) or single or semi-private rooms in adult residential care facilities; however, rooms may be shared only by choice.

Regulations in Maine allow residential care facilities and congregate housing projects to operate as assisted living. Residential care facilities may offer shared rooms, and congregate housing projects are typically built as elderly housing projects. North Carolina allows up to four residents to share a room in adult care residences, but the multi-unit assisted housing with services category contains apartments in elderly housing projects. Texas covers assisted living services through Medicaid to residents in three settings: assisted living apartments (single occupancy); residential care apartments (double occupancy allowed); and residential care non-apartments (double occupancy rooms). Utah also establishes separate requirements based on the units offered rather than the setting. Facilities offering apartments must be single or double

[5] New Jersey’s rules require apartment settings for all new construction but allowed existing Personal Care Homes with shared rooms to convert to assisted living.

occupancy with a bathroom, living room, dining space, and kitchen facilities. Facilities may also provide double occupancy rooms. Virginia's new rules for assisted living also build on board-and-care requirements which allow four people to share a room.

Shared rooms, toilet facilities, and bathing facilities are the rule among states with board-and-care regulations. Board-and-care rules generally allow bedrooms shared by 2-4 residents and bathrooms shared by 6-10 residents. Board-and-care and/assisted living rules in Alabama, California, Colorado, Idaho, Nevada, New Hampshire, New Mexico, New York, South Dakota, Utah, and Wyoming limit sharing of units to two residents. South Dakota requires a toilet room and lavatory in each room. Three people may share a room in West Virginia. A few states do not specify a limit on the number of people sharing a room.

Four people may share a room under board-and-care rules in Delaware, Georgia, Indiana, Iowa, Michigan, Mississippi, Missouri, Nebraska, Pennsylvania, Rhode Island, South Carolina, and Virginia.

TABLE 2. State Policy Concerning Living Units[1]

Assisted Living Rules		Shared Rooms	
Apartments Units	**Multiple Settings**	**Assisted Living Rules**	**Board-and-Care**
Arizona (Medicaid)[2]	Alaska	Arizona	Arkansas
Connecticut	Delaware	Alabama	California
Hawaii (draft)	Florida	Nebraska	Colorado
Illinois (pilot)	Iowa	Rhode Island	Georgia
Kansas	Kentucky	South Dakota	Idaho
Louisiana (draft)	Maine	Virginia	Indiana
Minnesota (Medicaid)	Maryland (draft)	Wyoming	Michigan
New Jersey	Massachusetts		Mississippi
North Dakota (Medicaid)	New Mexico (Medicaid)		Missouri
Oregon	New York (Medicaid)		Montana
Vermont (draft)	North Carolina		Nevada
Washington (Medicaid)	Oklahoma		New Hampshire
Wisconsin	Utah		Ohio
	Texas (Medicaid)		Pennsylvania
			South Carolina
			West Virginia

1. The first two columns describe the policy of existing or draft assisted living regulations that require apartments or license multiple settings (apartment units and rooms). The last two columns list states whose policy addresses only bedrooms through assisted living or board-care regulations.
2. Arizona's new regulations require apartments in assisted living centers (facilities with eleven or more units) and allow shared rooms in assisted living homes (<10).

Space requirements under board-and-care rules typically require 80 or 100 square feet for single units and 60 or 80 square feet per resident in shared units. Alabama requires 130 square feet for double units, and New Hampshire requires 140 square feet. Several states with assisted living rules that require apartments do not

specify a square footage (Connecticut, New Jersey), while Arizona, Oregon, and Washington require at least 220 square feet of living space, not including closets or bathrooms.

Table 2 presents state policy concerning living units. States that allow shared units generally have developed policy that broadens the scope of residential options and may create two or more types of buildings, each with different requirements (eg., Florida, New York, Texas, Utah). The table may also be expressed as a continuum. On one end are residences that offer single occupancy units with kitchenette and skilled services to residents. On the other end are residences that provide shared units without cooking capacity to residents who cannot receive skilled services in an assisted living setting. While a state's policy sets the parameters for what may be offered and provided, the actual practice may be more narrow. Shared units may be allowed, but the market may produce very few or no projects that offer shared units. Further, facilities constructed prior to the development of assisted living may offer shared units while most, if not all, newly constructed buildings have private units.

Tenant Policy or Admission/Retention Criteria

State policy on the level of need that may be served in assisted living varies widely. States have set very general criteria while others are very specific. The criteria can be grouped in five areas:

- General,
- Health related conditions,
- Functional,
- Alzheimer's disease and dementia, and
- Behavioral.

Eighteen states have general criteria that require that the resident's needs can be met by the facility. Initially this domain was included to identify states using only this general criteria. Draft regulations in Hawaii and Vermont rely primarily on these criteria. Wisconsin also uses this threshold but limits the amount of services any resident can receive to 28 hours a week. Other states allow facilities to admit and retain residents whose needs can be met but include other limits as well. In effect, the requirement is used in combination with others that screen out residents with certain conditions and set expectations that any facility admitting residents with allowable service needs must be capable of meeting those needs.

A table comparing admission/retention criteria in the appendix summarizes the provisions of state regulations. Some states use general criteria (such as a resident must have stable health conditions or cannot need 24-hour nursing care). These criteria may be interpreted to mean that anyone needing a feeding tube, sterile wound care, or ventilator care could not be served.

Twenty-six states use criteria that specify that residents must not need 24-hour nursing care. Four states (Arizona, Kansas, New Jersey, and Vermont) specify that 24-hour care can be provided if the facility meets certain criteria (e.g., they are licensed to do so, or a care plan has been approved by the licensing agency). Nine states do not allow residents who need hospital or nursing home care to be served, and rules in eight states specify that facilities may provide part time or intermittent nursing care. States may specifically cite conditions or services that may not be met. For example, ten states include prohibitions against serving anyone with stage III or IV ulcers. Eight do not allow anyone who is ventilator dependent to be served or anyone needing naso-gastric tubes. Fourteen states specify that persons with a communicable disease may not be admitted or retained.

Criteria dealing with functional and Alzheimer's disease are less frequent. Six states require that residents are ambulatory, and five require that residents can evacuate without assistance. Four states specify that residents may not be totally bedfast and other states allow this level of care under specified conditions. Four states specify that facilities can admit people with mild dementia; however, most states allow people with dementia to be served without specifying it in their regulations. Facilities in twenty states cannot admit or retain people who are a danger to themselves or others, and people who need restraints are specifically excluded by regulations in nine states.

While state rules apply uniformly, actual practice may vary within the same state. State rules define the conditions that residents may or may not have in order to be admitted or retained in an assisted living residence. But these standards are not required for each residence. Individual residences are generally allowed to establish their own standards within state parameters, and residences are required to inform prospective tenants what the policy is and what conditions would trigger "move out." For example, Massachusetts' rules allow residences to meet personal care needs. At a minimum residences must offer support for bathing, dressing, and ambulation but are not required to offer assistance with other ADLs. Most other states allow, but do not require, residences to serve people with ADL needs.

Hawaii and Vermont are posed to join Oregon among the states with the broadest policies. Oregon's regulations generally do not limit whom facilities may serve. The rules contain "move out" criteria that allow residents to choose to remain in their living environment despite functional decline as long as the facility can meet the resident's needs. Facilities may ask residents to leave if the resident's behavior poses an imminent danger to self or others, if the facility cannot meet the resident's needs or if services are not available, if the resident has a documented pattern of non-compliance with agreements necessary for assisted living, or for not-payment.

Draft rules in Hawaii would require that each facility develop admission policies and procedures which support the principles of dignity and choice. The policies include a listing of services available, the base rates, services included in the base rates, services not provided but which may be coordinated, and a service plan and contract. Facilities must also develop discharge policies and procedures which allow 14 days

notice for discharge based on behavior, on needs that exceed the facility's ability to meet them, or on the resident's established pattern of non-compliance. The rules do not specify who may be admitted and retained. Rather each facility may use its professional judgement and the capacity and expertise of the staff in determining who may be served.

New rules in Vermont allow residents to be moved if they pose an immediate threat to others or have needs that cannot be met by the residence. A resident may, but is not required to, be moved if he or she requires 24-hour, seven day a week, on-site nursing care, or if he or she is bedridden more than 14 days, is consistently and totally impaired in four or more ADLs, has cognitive decline severe enough to prevent making simple decisions, has stage III or IV pressure sores or multiple stage 2 sores, has medically unstable conditions, and/or has special health problems and a regimen of therapy that cannot be implemented appropriately in the setting. Facilities that want to serve people with these conditions must notify the licensing agency and describe how it will meet the person's needs. The licensing agency determines whether the plan is appropriate.

Regulations in Arizona, Delaware, Kansas, Maine, Nebraska and New Jersey are also flexible, allowing a high degree of impairment. Arizona sets requirements for different supplemental licensing levels. Facilities providing supervisory care services may serve residents needing health or health-related services that are provided by a home health agency or licensed hospice agency.

Additional requirements allow facilities in Arizona providing personal care services to serve residents who require continuous nursing services, are bedbound or have Stage III or IV pressure sores. Residents requiring continuous nursing services may be served if nursing services are provided by a private duty nurse, a hospice agency, or if the facility is a foster care home operated by a licensed nurse. These facilities may serve someone who is bedbound or has stage III or IV pressure sores if a physician authorizes residency and nursing services are provided by a private duty nurse or hospice agency, a licensed nurse, or home health agency, and the facility is meeting the resident's needs. These facilities may not admit residents unable to direct their care.

Facilities in Arizona must have a supplemental license to provide directed care services to serve people with Alzheimer's disease who are not able to direct their care. This license requires policies that ensure the safety of residents who may wander, that control access and egress, and that provide appropriate training for staff.

Two groups of consumers cannot be served in Delaware--unless the attending physician certifies that despite the presence of the following factors, the consumer's needs may be safely met by a service agreement developed by the agency, the attending physician, a registered nurse, the consumer or his/her representative if the consumer is incapable of making decisions and other appropriate health care professionals:

- Consumers whose medical conditions are unstable to the point that they require frequent observation, assessment and intervention by a licensed professional nurse, including unscheduled nursing services, and
- Consumers who are bedridden for 14 consecutive days.

Facilities may not serve residents who need transfer assistance from more than one person and a mechanical device, unless special staffing arrangements have been made, or residents who present a danger to self or others or engage in illegal drug use.

Kansas also has very broad criteria. Each facility develops admission, transfer, and discharge policies which protect the rights of residents. Facilities may not admit or retain people with the following conditions unless the negotiated service agreement includes hospice or family support services which are available 24-hours a day or similar resources:

- Incontinence where the resident cannot or will not participate in management of the problem;
- Immobility requiring total assistance in exiting the building;
- Any ongoing condition requiring two person transfer;
- Any ongoing skilled nursing intervention needing 24-hour a day care for an extended period of time; or
- Any behavioral symptom that exceeds manageability.

Rules in Maine encourage aging in place and have very flexible policies to do so. In its licensing application, facilities must describe who may be admitted and the types of services to be provided. Facilities may discharge tenants who pose a direct threat to the health and safety of others, damage property, or whose continued occupancy would require modification of the essential nature of the program. The rules also require facilities to permit reasonable modifications at the expense of the tenant or other willing payer to allow persons with disabilities to reside in licensed facilities. Facilities must make reasonable accommodations for people with disabilities unless they impose an undue financial burden or result in a fundamental change in the program.

Maine's rules apply differently depending on the setting: congregate housing, adult family care, or residential care facility. Residential care facilities may only provide nursing services with their own staff to residents who do not meet the nursing home level of care. Residents who meet nursing home admission requirements can be served, but nursing services must be provided by a licensed home health agency. Congregate housing programs may receive a license to provide nursing and medication administration services by registered nurses employed by the program.

In Nebraska, anyone needing complex nursing interventions or whose conditions are not stable and predictable can be admitted if:

- The resident, or the resident's designee if the resident is not competent, the resident's physician or the registered nurse agree that admission or retention is appropriate;
- Care is arranged through private duty personnel, a licensed home health agency, or a licensed hospice agency; and
- The resident's care does not compromise the facility operations or create a danger to others in the facility.

Complex nursing interventions are defined as those requiring nursing judgement to safely alter standard procedures in accordance with the needs of residents, which require nursing judgement to determine how to proceed from one step to the next, or which require a multidimensional application of the nursing process. Facilities will be able to develop their own admission and retention policies within state guidelines.

New Jersey's rules allow, but do not require, assisted living residences to care for people who:

- Require 24 hours, seven day a week nursing supervision,
- Are bedridden longer than 14 days,
- Are consistently and totally dependent in four or more ADLs,
- Have cognitive decline that interferes with simple decisions,
- Require treatment of stage three or four pressure sores or multiple stage two sores,
- Are a danger to self or others, or
- Have a medically unstable condition and/or special health problems.

Assisted living in New Jersey is not appropriate for people who are not capable of responding to their environment, expressing volition, interacting, or demonstrating independent activity. Each resident receives an assessment and a care plan by a registered nurse. The admission agreement has to specify if the residence will retain residents with one or more of these characteristics and the additional costs which may be charged.

New Jersey officials report that, although the experience is limited, no complaints have been made about the level and quality of care and monitoring surveys have not detected any violations. Licensing applications show a bell-shaped curve with most facilities selecting 3-4 conditions which they will serve. A few on either end will not serve people with any of the eight criteria while a similar number will serve people meeting all eight criteria.

Oregon and other states have developed assisted living as the equivalent of nursing home care, at least for people at lower acuity levels. The New Jersey regulations require that at least 20% of the occupants meet the nursing facility admission criteria within three of years licensing.

Tenant admission/retention criteria often result from compromises reached with trade associations. In Massachusetts and Tennessee, state home-care associations supported requirements that all skilled services must be provided by a certified or licensed home health agency. However, most of the controversy over admission/retention criteria has been sparked by drawing the line between nursing home and assisted living. State respondents reported consistent, though varied, opposition from nursing home operators to allowing people who need skilled services to be served in assisted living facilities. In at least one state, an association objected to the ability of these facilities to provide personal care. As a result of the policy formulation and legislative process, a number of compromises have emerged. States typically include a general statement that residents must have stable health conditions and do not need 24-hour, skilled nursing supervision. A number of states have specified which conditions may or may not be treated in an assisted living residence.

Nursing home providers participating on a Maryland task force created to recommend policy on assisted living sought upper limits on admission/retention criteria, but the task force adopted a policy which allows residents to remain as long as the care is appropriate to the person's needs. Draft regulations in Maryland do not allow programs to serve anyone who, at the time of admission, requires one or more of a number of listed conditions (see state summary). However, programs may request a waiver to care for residents with needs that exceed the licensing level if they can demonstrate that they can meet the residents' needs and that others will not be jeopardized. Programs are licensed based on their level of service. Waivers for Level I and Level II programs may not be granted for more than 50% of the licensed bed capacity. Level III programs may not receive waivers for more than 20% of capacity or 20 beds, whichever is less.

Utah's facilities may not serve anyone who requires inpatient hospital care or 24-hour continual nursing care that will last more than fifteen calendar days or people who cannot evacuate without physical assistance of one person. Written acceptance, retention, and transfer policies are required of each facility. Facilities may not accept anyone who is suicidal, assaultive, or a danger to self or others, has active tuberculosis or other communicable disease that cannot be adequately treated at the facility or on an outpatient basis or that may be transmitted to other residents through general daily living. Physicians' statements are required to document the resident's ability to function in the facility and to confirm that the resident's health condition is stable and free from communicable disease. They are also required to list the following: allergies; diets; current prescribed medications with dose, route, time of administration and assistance required; physical or mental limitations; and activity restrictions.

Florida's regulations for "admissions" are very detailed. New residents must:

- Be able to perform ADLs with supervision or assistance (but not total assistance);
- Be free from signs and symptoms of communicable diseases;
- Not require 24-hour nursing supervision;

- Be capable of taking their own medication or may require administration of medication and the facility has licensed staff to provide the service;
- Not have bed sores or stage II, III, or IV pressure ulcers;
- Be able to participate in social activities;
- Be capable of self-preservation;
- Not be bedridden;
- Be non-violent; and
- Not require 24-hour mental health care.

Additional criteria affect continued residency. In regular assisted living facilities, people who are bedridden more than seven days or develop a need for 24-hour supervision may not be retained. In Extended Congregate Care facilities, a higher level of care, residents may not be retained if they are bedridden for more than fourteen days. Residents may stay if they develop stage II pressure sores but must be relocated for stage III and IV pressure sores. Residents who are medically unstable, become a danger to self or others, or experience cognitive decline to prevent simple decision making may not be retained. People who become totally dependent in four or more ADLs (exceptions for quadraplegics, paraplegics, and those with muscular dystrophy, multiple sclerosis, and other neuro-muscular diseases if the resident is able to communicate his or her needs and does not require assistance with complex medical problems) may not be retained. State officials are planning to undertake a review of the criteria to evaluate their impact.

Tennessee's new regulations allow residences to retain for 21 days but not admit anyone requiring: intravenous or daily intramuscular injections of feedings; gastronomy feedings; insertion, sterile irrigation and replacement of catheters; sterile wound care; or treatment of extensive stage 3 or 4 decubitus ulcers or exfoliative dermatitis; or who, after 21 days, require four or more skilled nursing visits per week for any other condition.

In Washington, residents may be required to move when their needs exceed the services provided through the contract with the state agency or when the resident requires a level of nursing care that exceeds what is allowed by the boarding home license.

Although Wyoming expanded their regulations to allow skilled services, they do not allow residents who wander or need wound care, stage II skin care, are incontinent, need total assistance with bathing and dressing, or need continuous assistance with transfer and mobility in order to be served.

Negotiated Risk

Sixteen states have adopted or proposed a negotiated risk process to involve residents in care planning and to respect resident preferences which may pose risk to the resident or other residents. Washington provides for negotiated risk agreement that

is developed as a joint effort between the resident, family members (when appropriate), the case manager, and facility staff. The negotiated risk document specifies that the agreement's purpose is to "define the services that will be provided to the resident with consideration for preferences of the resident as to how services are to be delivered." The agreement lists needs and preferences for a range of services and specific areas of activity under each service. (See table.) A separate form is provided to document amendments to the original agreement. Signature space is provided for the resident, family member, facility staff, and case manager. If assistance with bathing is needed, the process allows the resident to determine and choose what assistance will be provided, how often, and when. It allows residents to preserve traditional patterns for eating and preparing meals and engaging in social activities. The negotiated service agreement operationalizes a philosophy that stresses consumer choice, autonomy, and independence over a facility-determined regimen that includes fixed schedules of activities and tasks that might be more convenient for staff and management of an efficient "facility." It places residents ahead of the staff and administrators and helps turn a "facility" into a home.

The process allows the participants to identify a need and determine with what tasks the residents themselves wish to receive help. For example, if the resident has difficulty bathing, the resident may prefer help getting to the bathroom and unfastening clothing. Yet a resident may prefer to undress and get into the tub and bath herself/himself even though the staff member and perhaps a family member feel the resident may be placed at risk of falling. The risk is expressed but the final decision to bathe rests with the resident.

TABLE 3. Washington Negotiated Service Agreement	
Nursing	Health monitoring, nursing intervention, supplies, services coordination, medication, special requests
Personal service	Toileting, bathing, AM preparation, ambulation, PM preparation, hygiene
Food service	Dietary, eating
Environmental	Safety, housekeeping, laundry
Social/emotional	Family intervention, information/assistance, counseling, orientations, behavior management, socialization
Administration	Business management, transportation
Special needs	

Values assume a prominent role in shaping policy in several states. Many states use values language developed in Oregon. The Oregon definition says that "assisted living promotes resident self direction and participation in decisions that emphasize choice, dignity, privacy, individuality, independence and home-like surroundings." Each facility must have written policies and procedures which incorporate the above principles. Services plans are reviewed for the extent to which the resident has been involved, and the resident's choices as well as the principles of assisted living are reflected.

New Jersey defines managed risk as the process of balancing resident choice and independence with the health and safety of the resident and other persons in the

facility or program. If a resident's preference or decision places the resident or others at risk or is likely to lead to adverse consequences, such risks or consequences are discussed with the resident and, if the resident agrees, a resident representative. A formal plan to avoid or reduce negative or adverse outcomes is negotiated. The rules provide that choice and independence may need to be limited when the resident's individual choice, preference, and/or actions place the resident or others at risk. The managed risk process requires that staff identify the cause for concern, discuss the concern with the resident, seek to negotiate a managed risk agreement that minimizes risk and adverse consequences and offers possible alternatives while respecting resident preferences, and document the process of negotiation or lack of agreement and the decisions reached.

Ohio added managed risk provisions to its residential care facility rules in 1996. The rules allow facilities to enter into agreements with residents to share responsibility for making and implementing decisions affecting the scope and quantity of services provided by the facility.

Services

States seeking to facilitate aging-in-place and to offer consumers more long-term-care options allow more extensive services. These states view assisted living as a person's home. In a single family home or apartment in an elderly housing complex, older people can receive a high level of care from home health agencies and in-home service programs. Several states extend that level of care to assisted living facilities.

The extent and intensity of services generally follows state admission/retention criteria. Services can be provided or arranged that allow residents to remain in a setting. Mutually exclusive resident policies, which prohibit anyone needing a nursing home level of services from being served in board-and-care, have been replaced by "aging-in-place" provisions. However, drawing the line has been controversial in many states. Opponents of assisted living legislation in Tennessee initially opposed allowing personal care to be provided. In many states, some nursing home operators see assisted living as competition for their "patients" and oppose rules which allow skilled nursing services to be delivered outside the home or nursing home setting.

Most states require an assessment and the development of a plan of care that determines what services will be provided, by whom and when. Residents often have a prominent role in determining what they will receive from the residence and what tasks they will do for themselves. A key factor in assisted living policies is the extent of skilled nursing services.

Arizona has three service levels that allow supervisory care services, personal care services, and directed care services. Residents in facilities with a supervisory care license may receive health services from home health agencies. Facilities with a personal care services license can provide intermittent nursing services and administer

medications. Other health services may be provided by outside agencies. Directed care service facilities provide supervision to ensure personal safety, cognitive stimulation, and other services for residents who are unable to direct their care.

Alaska's regulations also require that tenant contracts spell out the services and accommodations that will be provided and that reflect the diversity and availability of providers in the state. Intermittent nursing services are allowed for residents who do not require 24-hour nursing care, and supervision and tasks approved by the Board of Nursing may be delegated to unlicensed staff.

Connecticut allows client teaching, wellness counseling, health promotion and disease prevention, medication administration, and skilled services to clients with chronic but stable conditions. Draft legislation in Illinois would allow intermittent health services (medication administration, dressing changes, catheter care, therapies). Kentucky's statute does not specifically mention nursing services in a listing of services but includes the phrase "is not limited to" which may allow other services to be added when regulations are prepared.

Facilities in Florida may provide limited nursing services (e.g., medication administration and supervision of self-administration, applying heat, passive range of motion exercises, ice caps, urine tests, routine dressings that do not require packing or irrigation, and others), and intermittent nursing services (e.g., change of colostomy bag and related care, catheter care, administration of oxygen, routine care of an amputation or fracture, prophylactic, and palliative skin care).

Facilities in Florida may not provide oral or nasopharyngeal suctioning, assistance with tube feeding, monitoring of blood gasses, intermittent positive pressure breathing therapy, intensive rehabilitation services for a stroke or fracture or treatment of surgical incisions which are not clean and free from infection, and any treatment requiring 24-hour nursing supervision. Washington has developed a list of skilled services that may and may not be delivered by licensed nurses and unlicensed staff. Nursing services are differentiated by licensing category. RNs or LPNs may provide insertion of catheters, nursing assessments, and glucometer readings. Unlicensed staff may provide the following under supervision of an RN or LPN: stage-one skin care, routine ostomy care, enema, catheter care, and wound care. Changes in the nurse practice are pending in the legislature which would allow greater delegation.

Hawaii's draft regulations require facilities to provide nursing assessment and health monitoring; medication administration; services to assist with ADLs; support, intervention and supervision for residents with behavior problems; opportunities for socialization; meals; laundry; and housekeeping. Facilities must also provide or arrange for transportation and ancillary services for medically related care (physician, pharmacist, therapy, podiatry, home health, and others).

In keeping with its admission/retention criteria, New Jersey's rules allow levels of skilled care that are specifically barred in many states (e.g., stage III or IV pressure

sores, ostomy care, 24hour nursing supervision). Oregon's policy allows a wide range of delegation under which nurses must train unlicensed staff for each resident receiving delegated services. Further, there are no explicit discharge criteria based on service needs.

Legislation in Massachusetts, as in other states, does not allow 24-hour nursing services. However, skilled services may only be provided by a certified home health agency on a part-time or intermittent basis. Medical conditions requiring services on a periodic, scheduled basis are allowed. In addition, residents may "engage or contract with any licensed health care professional and providers to obtain necessary health care services...to the same extent available to persons residing in private homes." The Massachusetts statute only allows skilled nursing services to be provided by a certified home health agency. As a result, registered nurses, if hired by an assisted living facility, presumably, would not be allowed to deliver skilled care. The initial draft of state regulations did not allow skilled services to be received for more than 90 days in a one-year period. The attorney general's office reviewed the draft and advised that such limits may conflict with fair housing rules. The 90-day limit was removed.

The Massachusetts statute specifies a minimum level of personal care services that must be provided (bathing, dressing, ambulation) and requires that tenant agreements include the services which will be provided and those which will not be provided. Facilities certified under the law may offer a broader range of personal care services. Alabama's rules mandate personal care for bathing, oral hygiene, hair, and nail care but do not require assistance with eating, dressing, or toileting.

Rules governing residential care facilities in Ohio will limit skilled services to 120 days with exceptions for diets, dressing changes, and medication administration.

Missouri's rules governing residential care facilities allow advanced personal care services to be provided which include residents with a "catheter or ostomy, require bowel or bladder routines, range of motion exercises, applying prescriptions or ointments and other tasks requiring a highly trained aide."

Iowa's legislation allows health related care which are services provided by a registered nurse, a licensed practical nurse, or home care aide and services provided by other licensed professionals as defined by rule. Health related and personal care services can be provided on an intermittent and part-time basis, which is defined as up to 35 hours a week of personal care and health related services on a less than daily basis, or up to 8 hours personal care and health related services provided 7 days a week for temporary periods not exceeding 21 days.

Because of its funding source, New York allows for skilled nursing, home health aide, and therapies. Regular Medicaid state plan services have been included in a capitated rate to include the full range of Medicaid long-term care services that can be delivered in the home.

In Utah facilities must arrange for necessary medical and dental care although medication administration of prescription drugs is allowed. Maine's revised policy allows skilled services to be provided by a residential care facility or a congregate housing program. Previous policy required skilled services to be provided by a licensed home health agency.

State policy generally specifies the range of allowable services but facilities are not required to provide the full range of services allowed under the law. Facilities are usually authorized to determine which services will be provided. Combined with facility-based admission/retention policies, facilities may offer a very light, moderate, or heavy level of care. Owners of assisted living facilities who also own nursing homes may develop assisted living as a "feeder" system for their nursing homes and set policies which require residents to "move out" when they develop multiple ADL impairments or require nursing services. Although state regulations frequently explicitly support aging-in-place and resident involvement in care planning decisions, facility specific policies may be developed which limit the potential impact of assisted living to serve residents with higher levels of need.

Provisions for Residents with Alzheimer’s Disease and Dementia

Twenty six states reported that they have specific requirements for facilities serving people with dementia or Alzheimer's disease. Requirements address one or more of the following: disclosure requirements, staffing patterns and staff training, activities, environmental provisions, and admission/retention criteria. Staff training accounts for the special provisions in the majority of these states. Idaho's rules include a definition of Alzheimer's facilities. The rules define special care facilities as those that "are specifically designed, dedicated, and operated to provide the elderly individual with chronic confusion, or dementing illness, or both, with the maximum potential to reside in an unrestrictive environment through the provision of a supervised life-style which is safe, secure, structured but flexible, stress free and encourages physical activity through a well developed activity and recreational program. The program constantly strives to enable residents to maintain the highest practicable physical, mental or psychosocial well-being."

Arizona licenses directed care facilities which means programs and services, including personal care services, provided to persons who are incapable of recognizing danger, summoning assistance, expressing need or making basic care decisions. Regulations in most other states do not define special care facilities.

Disclosure

Disclosure requirements are included in state regulations in nine states. These provisions typically require that facilities advertising themselves as operating special care facilities or units, or that care for people with Alzheimer's disease, describe in writing how they are different. The regulations may require a description of the

philosophy of care, admission/discharge criteria, the process for arranging a discharge, services covered and the cost of care, special activities available, and differences in the environment.

A voluntary disclosure process has been adopted in California under which facilities offering special services for people with Alzheimer's Disease disclose information concerning their program. A consumer's guide has been developed which alerts family members to several key questions that should be asked. The areas include the philosophy of the program and how it meets the needs of people with Alzheimer's, the pre-admission assessment process used by the facility, the transition to admission, the care and activities that will be provided, staffing patterns and the special training received by staff, the physical environment, and indicators of success used by the facility.

Admission/Retention Criteria

Eight states have admission/retention criteria that directly reference people with Alzheimer's disease. Tennessee does not allow people in the later stages of the disease to be served. People with Alzheimer's disease may be served only after a multi-disciplinary team determines that care can be provided safely. The determination must be reviewed quarterly.

Florida allows people with Alzheimer's disease to be retained in facilities with an extended congregate care license if they can make simple decisions and if they do not have a medical condition requiring nursing services. Georgia also requires that residents must be able to make simple decisions. California's criteria allows people with Alzheimer's disease to be admitted who are not able to respond to verbal instructions. Vermont's draft rules allow but do not require facilities to serve people who cannot make simple decisions.

Washington state has included separate requirements for boarding homes providing special dementia care units or services to people with dementia. Boarding home staff must be qualified to serve people with dementia, and homes must have sufficient staff to monitor and care for residents as well as an alarm or monitoring system to alert staff when a resident leaves the building or enclosed outside area. Boarding homes with dementia units must design floor and wall surfaces to augment orientation and provide access to secured outside space. Units must meet other requirements concerning doors that restrict egress, are alarmed, and release automatically during a fire or power failure. Officials are evaluating whether dementia care units are consistent with the state's assisted living model.

Idaho requires that residents of specialized care units be evaluated by their primary care physician for the appropriateness of placement into the unlocked specialized care unit/facility prior to admission. Residents cannot be admitted without a diagnosis of Alzheimer's disease or related disorder. Residents must be at a stage in their disease such that only periodic professional observation and evaluation is

required. Residents in these units must be re-evaluated quarterly. Residents who require physical or chemical restraints cannot be admitted.

Facilities in South Dakota that admit or retain residents with cognitive impairments must have the resident's physician determine and document if services offered by the facility continue to enhance the functions in ADLs and identify if other disabilities and illnesses are impacting on the resident's cognitive and mental functioning.

Staffing and Training

Twenty states have regulations that address training requirements for staff in facilities serving people with Alzheimer's disease. In Maine, all new employees in facilities with Alzheimer's/ Dementia Care Units must receive a minimum of eight hours classroom orientation and eight hours of clinical orientation. The trainer must have experience and knowledge in the care of individuals with Alzheimer's disease or other dementia. The facility's regular orientation covers resident rights, confidentiality, emergency procedures, infection control, the facility's philosophy of Alzheimer's disease/dementia care, and wandering/egress control. The eight hours of classroom orientation includes the following topics: a general overview of Alzheimer's disease and related dementias, communication basics, creating a therapeutic environment, activity focused care, dealing with difficult behaviors, and family issues.

Florida has recently implemented new training rules for staff in facilities serving people with Alzheimer's disease. The rules require four hours of initial training in areas of the disease in relation to the normal aging process; diagnosing Alzheimer's disease; characteristics of the disease process; psychological issues including resident abuse; stress management and burn-out for staff, families and residents; and ethical issues. An additional four hours is required on medical information, behavior management, and therapeutic approaches. Direct care staff must participate in four hours of continuing education each year.

Core training and Alzheimer's disease training may be obtained from persons approved by the Department of Elder Affairs or the Department staff. The rules contain a sliding fee for training that varies with the percentage of residents supported by public funds.

New rules in Arizona will require a special license to service people who are unable to direct their own care. These facilities are required to have services that are appropriate to people with Alzheimer's disease, including cognitive stimulation, encouragement to eat meals and snacks, and supervision to ensure personal safety. Staff must receive 12 hours of additional training or demonstrate skills in and knowledge of Alzheimer's disease, communicating with residents, providing services including problem solving, maximizing functioning and life skills training for those unable to direct care, managing difficult behaviors, and developing and providing social, recreational and rehabilitative activities.

Staff in specialized care units for Alzheimer's/dementia residents in Idaho must complete an orientation/continuing training program that includes information on Alzheimer's and dementia, symptoms and behaviors of memory impaired people, communication with memory impaired people, resident's adjustment, inappropriate and problem behavior of residents and appropriate staff response, activities of daily living for special care unit residents, and stress reduction for special care unit staff and residents. Staff must have at least six additional hours of orientation training, and four hours of the required twelve hours per year of continuing education must be in the provision of services to persons with Alzheimer's disease.

Draft rules in Texas contain special requirements for administrators and a combination of orientation, on-the-job supervision and in-service education (see state summary).

Vermont's ongoing training requirements include communication skills for residents with Alzheimer's disease and other dementias. South Dakota's rules require that all staff members attend an annual in-service training in the care of the cognitively impaired and those with unique needs.

Activities

Survey responses from 12 states indicated that state rules address activities for people Alzheimer's disease. Regulations in Maine, Nevada, and California require activities that address gross motor skills, self care, social activities, crafts, sensory enhancement, outdoor, and spiritual activities. Draft rules in Texas propose activities that encourage socialization, cognitive awareness (crafts, arts, story telling, reading, music, discussion, reminiscences and others), selfexpression and physical activity in a planned and structured program.

In Idaho, services in specialized care units for residents with Alzheimer's disease include habilitation services, activity program and behavior management according to the individualized plan of care.

Environment

Draft rules in Nebraska's would have required facilities serving special populations must provide an environment that conforms to their special needs to enhance quality of life, reduce agitation and difficult behaviors, and promote safety. The accommodations include offering secured outdoor space; high visual contrasts between floors, walls, and doorways in resident areas; lighting which minimizes glare; plates and eating utensils which provide visual contrast between the plate, food and the table; and chairs that allow for gliding. These provisions were not included in the final regulations.

Delaware's rules require that facilities have policies designed to prevent residents from wandering away from the grounds.

Facilities serving people with Alzheimer's disease in South Dakota must have exit alarms. California operated a three-year demonstration program to test the feasibility of serving people with Alzheimer's disease in Residential Care Facilities for the Elderly (RCFEs). Seventy-five percent of California's residential care facilities have six or fewer beds. Prior to the demonstration, RCFEs could serve people with mild or moderate dementia who require protective supervision as long as they can make their needs known and can follow instructions. The pilot was approved to test whether people with more advanced dementia who were required to transfer to nursing facilities could be served in RCFEs. The independent study variables were special staff training, resident activities, and the use of either locked or secured (alarmed) perimeters. No facilities were willing to participate as a control group without using the interventions. Staff in both groups received 25 hours of training in residential care, normal aging, Alzheimer's disease, managing problem behaviors, recreational activities, communication, medication use and administration, medications used for disruptive behavior, ADLs, and staff stress and burn-out.

Six facilities were selected to participate in the demonstration, three with locked or secured perimeters and three with alarms or other signal devices to alert staff when people were leaving the facility or the grounds.

In April 1994, the California Department of Social Services issued a report with recommendations based on findings from the demonstration program. The report found that both models reduced acting-out behavior, diversion of staff time from direct care, and incidents of wandering. The report recommended a separate licensing category for RCFEs specializing in care of people with moderate to severe dementia. However, the report concluded that RCFEs should not be allowed to serve people with serious medical conditions which would require staffing patterns that would significantly raise costs. Examples of conditions which the study found should not be allowed in RCFEs included urinary catheters, colostomies, ileostomies, tracheostomies, tube feeding, contractures, bedsores, and intravenous injections. Because of the demands of residents, the report recommended at least two staff be on duty at all times. Other recommendations included training in dementia care, pre-admission assessment and reassessments to determine suitability for admission and retention, family meetings, continued standards for the use of "chemical restraints," and increased frequency of monitoring by regulatory staff (quarterly rather than annually).

The report found that the staff-to-resident ratio was more important than the size of the facility and that requirements for specialty staff included in the legislation were not necessary. Beyond requiring one awake staff and two persons at all times, the report suggested that staffing patterns should reflect resident needs for assistance with planned activities and supervision. However, the report did emphasize the need to require adequate outdoor space for resident use. Regulations should specify standards for the amount of space and other physical characteristics based on the size of the facility.

The report concluded that the use of locked or alarmed perimeters had no impact on medication use and reduction in physical or verbal behaviors (kicking, biting, throwing, screaming, threatening harm) or agitation (pacing, repeated movements, hand wringing, rapid speech). The study was limited by sample problems. Baseline measures showed significant differences among residents in each facility (higher or lower wandering, medication use). The report suggested that increasing the time staff spent with residents and increasing resident social interaction may contribute to a reduction in problem behaviors. While outcomes were similar for both alarmed and secured models, the study found high satisfaction among family members and some reduction in disruptive behaviors.

During 1995, legislation (Chapter 550 of the Acts of 1995) was passed that allows RCFEs that serve people with Alzheimer's disease to develop secure perimeters. The law allows facilities to install delayed egress devices on exterior doors and perimeter fence gates. Resident supervision devices, wrist bracelets which activate a visual or auditory alarm when a resident leaves the facility, may also be used. Facilities must provide interior and exterior space for residents to wander freely, must receive approval from the local fire marshal, and must conduct quarterly fire drills. Facilities with delayed egress devices must be sprinklered and contain smoke detectors, and the devices must deactivate when the sprinkler system or smoke detectors activate. The devices must also be able to be deactivated from a central location and when a force of 15 pounds is applied for more than two seconds to the panic bar. In addition facilities shall permit residents to leave who continue to indicate such a desire, and staff must ensure continued safety. Reports must be submitted when residents wander away from the facility without staff. Delayed egress devices may not substitute for staff.

Requirements for Assisted Living Facility Administrators

Regulations in five states do not describe any requirements for the administrators of assisted living facilities or assisted living service agencies. Half the states require that administrators must be at least 21 years of age, six states specify 18 as the age requirement, one state uses 19, and one 25. Seventeen states do not specify an age requirement.

In addition to age, state rules typically set standards for education and training. Eighteen states require a high school diploma or G.E.D., and seven include advanced degree requirements which sometimes vary with the level of care offered by the facility. Ten states have experience requirements, and thirteen identify specific abilities or knowledge that an administrator must have. Licensing or certification of administrators is required by seventeen states. Twenty-two states have an annual requirement for CEUs or hours of in-service training. The number of hours range from six to 40 per year. Finally, twenty-five states include criminal background checks in their requirements for administrators. (See appendix.)

Staff Training Requirements

State regulations typically require on orientation for new staff and annual in-service training. Training requirements can be very general or specific. Ten states require direct care staff to successfully complete an approved course. Other states specify the areas to be covered during training, some specify the number of hours to be spent in training, and many states include requirements for both topic areas and number of hours. Training requirements can be grouped into five domains:

- Direct care,
- Health related,
- Knowledge areas,
- Safety and emergency issues, and
- Process.

Thirty-five states require training on resident rights, the most common of all issues described in state rules. Direct care skills are covered as training in personal care or direct care skills (26 states), as areas that are appropriate or related to the tasks or duties of staff (17 states), and more generally as tasks necessary to meet the needs of consumers (13 states). There is considerable overlap between these areas as fifteen states require training in two or all three of the areas. Other direct care areas included nutrition/food preparation (18), dementia or Alzheimer's care (15), mental health and emotion needs (16), general requirements (13), principles of assisted living (12), housekeeping/sanitation (14), hygiene (11), and training related to the use of restraints (7).

Safety and emergency issues are also important components of training in these facilities. Thirty-three states require training in fire, safety, and emergency procedures. Twenty-three cover first aid, while 15 require CPR training. Infection prevention and control is also required in 24 states.

The most common health related topics were medication administration and assistance (23 states) and observation or reporting skills (14 states). Preventive or restorative nursing services and basic nursing skills is required in three states.

Fewer states address aging process (11), communication skills (9), assessment skills (8), psychosocial needs (6), care plan development (5), and death and dying (4).

Quality Assurance and Monitoring

Developing outcome measures is a major focus in the health care system and interest in similar measures has appeared in long-term care services. Seventeen states indicated that they are either developing outcome measures for assisted living or were interested in doing so: Alabama, Florida, Idaho, Iowa, Kansas, Maine, Massachusetts,

Minnesota, New Jersey, New York, North Carolina, Oregon, Texas, Utah, Vermont, Washington, and West Virginia.

The initiative has gained attention in part as a result of the work of Keren Brown Wilson, President of Assisted Living Concepts, who developed a paper on this area for the American Association of Retired Persons. Based on her work, officials in the Washington Aging and Adult Services Division developed a review guide that operationalizes the principles of assisted living and the concepts of outcome measures and which tested an outcome-based approach to monitoring quality in assisted living facilities. Using this approach, the inspector--prior to monitoring visits--reviews existing information and prepares a plan for the visit. This includes reviewing the files for complaint history, reviewing DOH inspections reports, checking for information from the long-term care ombudsman program, and contacting the case manager to determine whether any concerns have been raised by clients and whether any clients have special needs. The reviews include visits with a sample of Medicaid residents.

During the visit, the monitor meets with the residence administrator who informs the residents of the visit. The monitor compares the list of the residents to the list maintained by the department. Staff provide an escorted walk-through of the residence to evaluate the home-like quality of the facility and observes activities, interactions between staff and residents, laundry areas, availability of a public telephone, posting of resident's rights as well as the numbers for filing complaints. Based on the size of the facility, a sample of residents is selected for interviews, including at least one resident who receives "limited nursing services" and a resident who does not have a person that can intervene on his/her behalf. The monitor reviews a sample of the negotiated service agreements and notes who was involved in developing the agreement, the extent of the resident's needs, and the agreed upon service plan and ensures that the services required to meet the needs have been delivered. A staff member introduces the monitor to the residents included in the sample. The interviews are held to determine what services were provided, if they were adequate to meet the resident's need, and if they were delivered according to the preferences of the resident.

Direct interviews with residents are the central source of information concerning quality of care. Residents are asked about a range of issues that include the appropriateness of and satisfaction with the service received. Residents are asked to identify what services are being received, whether they are received when and in the manner that is needed, who decided when the services would be delivered, whether any needed services are not being received, and any limitations that need to be addressed.

Residents are asked if they feel as though they are treated with dignity and respect, to describe their daily routine, to discuss who makes decisions about routine activities (getting up and going to bed, eating meals, taking baths) and how well the residence respects the resident's preferences.

Privacy issues are addressed by asking whether the mail is opened, how a person makes personal phone calls, whether service needs have been discussed in front of others. Questions are also asked about support for personal relationships and the maintenance of a home-like environment. (Do you like the way your room is arranged and decorated? Are your personal possessions safe? Is the housekeeping satisfactory?) Other areas covered include understanding and perception of the rules, adequacy of health care services, and the resident's sense of well-being. Monitors also make observations about the resident's living area and appearance and, if concerns are observed, first checks the person's preferences and choices before a conclusion is reached.

When negative outcomes are observed, the monitor conducts a more focused and detailed review of the residence in the problem areas to determine whether the facility's administration, policy, procedures or practices are contributing to the outcome. Additional activities include expanding the sample of residents interviewed, more detailed record reviews, and a review of the minutes of the resident council meetings. Monitors will also review the records of residents who have left the residence as well as activity schedules and menus.

Monitors talk with staff and the administrator to discuss observations from the review and to obtain the provider's perspective on service delivery. Monitors may contact family members or case managers before completing a report. The report covers the physical environment; resident's rights concerning privacy, dignity, and choice as well as the awareness of rights; and service delivery.

Other models: Under Connecticut's rules, assisted living services agencies (ALSAs) are required to establish a quality assurance committee that consists of a physician, a registered nurse, and social worker. The committee meets every four months and reviews the ALSA's policies on program evaluations, assessment and referral criteria, service records, evaluation of client satisfaction, standards of care, and professional issues relating to the delivery of services. Program evaluations are also to be conducted by the quality assurance committee. The evaluation examines the extent to which the managed residential community's policies and resources are adequate to meet the needs of residents. The committee is also responsible for reviewing a sample of resident records to determine whether agency policies are followed, services are provided only to residents whose level of care needs can be meet by the ALSA, care is coordinated and appropriate referrals are made when needed. The committee submits an annual report to the ALSA summarizing findings and recommendations. The report and actions taken to implement recommendations are made available to the state Department of Health.

Oregon's rules require providing for ongoing monitoring by the state Senior and Disabled Services Division staff or its designee, usually an area agency on aging. The staff review the service plans of residents for compliance. Written outcome measures covering functional abilities, psycho-social well-being, stability of medical conditions, and client/family satisfaction are examined.

Nearly final rules in Vermont will require facilities to develop quality improvement programs that identify indicators to be used to monitor performance and describe how monitoring will occur. An internal quality committee will be formed that includes the director, a licensed nurse, one other staff member, and others as needed or desired. Committees will meet quarterly and residents are to be able to provide input on satisfaction and review of any quality improvement plans.

Facilities must allow survey staff access to resident assessments and service plans and outcome measures that reflect planned and actual events related to functional abilities, psycho-social well being, stability of medical conditions, and resident satisfaction. Assisted living residences must establish and maintain a written quality assurance plan and a listing of all residents who moved from the facility since the last monitoring visit.

Role of the Ombudsman Program

In addition to the survey and inspection activities of the state licensing agency, additional monitoring is possible through the state ombudsman program and home and community based case management agencies. Thirty-four states indicated that the ombudsman program monitors care in assisted living and board-and-care facilities. The role is similar to that performed in nursing homes and focuses on receiving and investigating complaints.

Nineteen states indicated that case managers monitor Medicaid beneficiaries receiving services in these facilities. The role of case managers was described in various terms and included observing and monitoring care, ensuring that services were delivered in accordance with a negotiated service agreement, and monitoring the assessment process. Quality of care problems are reported to the licensing agency in several states. Case managers are mandatory reporters of abuse and neglect in Alabama.

Consumer Guides and Report Cards

Five states (Colorado, Massachusetts, Montana, Pennsylvania, and Washington) have developed consumer guides to assisted living facilities for consumers in their states. Agencies in Alaska, Delaware, Minnesota, Nevada, New Jersey, North Carolina, and Vermont are developing consumer guides. The guides may list individual facilities and note the fees, services, and accommodations available while others describe assisted living and contain questions to be asked or information consumers should know as they consider assisted living.

As in the managed health care system, assisted living report cards are also an interest of policy makers. Report cards would identify and measure key characteristics

of facilities that would assist consumers in selecting the most appropriate facility and create incentives for facilities to maintain or improve quality of care. Two states, Iowa and Vermont, indicated that they were developing report cards, and ten states are interested in developing these tools: Michigan, Minnesota, Mississippi, Montana, New Jersey, New Mexico, New York, North Carolina, Utah, and Virginia. Report cards are contingent on developing aspects of assisted living that are measurable and commonly accepted as measures of quality. To be fair and meaningful, measures such as length of stay, resident turnover rates, reason for discharge, and location after discharge may require adjustments to reflect the functional and cognitive status of residents. Without adjustments for acuity, facilities that serve "lighter need" residents may measure more favorably than those that promote aging-in-place or admit residents with greater health and functional needs.

Certificate of Need (CoN)

Six states have certificate of need requirements for assisted living: Connecticut, Illinois, Kentucky, Missouri, New Jersey, and New York. Three states (Arkansas, North Carolina, and North Dakota) have a moratorium on licensing new facilities. North Carolina's moratorium has exceptions for counties in which the average occupancy rate is above a specified threshold. New York, which reimburses assisted living as a Medicaid service, limits the number of contracted units to 4,200 and removes 4,200 beds from the nursing home facility bed need estimates. New Jersey retains a CoN requirement but provides an expedited review. Legislation passed in Connecticut repealing the CoN requirement was awaiting action by the Governor at the time this paper was published.

The certificate of need process was designed to allocate scarce health care resources by controlling the supply, and therefore utilization, of hospital and nursing home care. In today's more service rich environment, certificate of need in long-term care limits consumer choices and protects existing providers. State experience suggests that it is impossible to measure the appropriate supply of nursing homes. The supply of nursing homes ranges from 19.2 beds per thousand elderly in Nevada to as high as 72.9 beds per elderly residents in North Dakota. Applying certificate of need measures in an era in which extensive home care and assisted living services are available further weakens an already flawed policy.

A certificate of need requirement for nursing homes assumes that a given service, e.g., nursing homes, is the only appropriate choice for an individual. If we could measure the number of people who needed a particular service, states could regulate supply to meet the measured need. However, many people have needs that can be met in more than one setting. The same individual may qualify for and enter a nursing home, remain at home with home care and home health services, remain at home and attend an adult day care program, move to an adult foster care program, or move to an assisted living residence. With this overlap of services, measuring the need for one service, nursing home or assisted living, fails to acknowledge the availability of other

existing and/or potential resources. Not only are certificate of need programs unable to accurately measure this overlap, it would limit the choices available to consumers. The value of certificate of need was its ability to control spending. However, other mechanisms have evolved in the health care arena e.g., managed care, that have taken on this responsibility. While controls are not yet needed in Medicaid spending on assisted living, other approaches should be devised to anticipate growing demand over time.

Building Codes

The NASHP survey asked which level of government determines the building code requirements and which codes were used. Usable responses were received from 37 states. State agencies determine which codes will be used in fifteen states. Local government agencies make this determination in seven states, and both state and local agencies are responsible in fifteen states.

TABLE 4. Level of Government and Building Codes

State			Local		State and Local		
AL	MO	TN	AS	MS	CA	NY	PA
ID	NE	UT	CT	OR	CO	MT	SC
IN	NJ	VT	DE	TX	FL	NV	SD
KS	OH	VA	MN		IA	NM	WA
MI	RI	WY			MA	NY	WV

Six states indicated that they use the BOCA code, while nine use the Uniform Building Code, and three use the Standard or Southern Building code. Ohio uses the Ohio Basic Building Code. The remaining states did not indicate which codes were used.

Policy Priorities

The survey asked state respondents to list three top issues facing public policy makers with regard to assisted living. The responses covered a broad range of areas: financing, regulation, quality of care, services, staff training, and the future and direction of assisted living. Policy makers are searching for ways to make assisted living accessible and affordable. Sixteen states identified a range of issues related to affordability. Several are interested in developing public funding for low-income residents or funding ways to make it affordable to residents whose income is too high to meet Medicaid eligibility requirements and too low to pay privately.

A number of general regulatory issues were raised such as whether and how to regulate assisted living, transitioning from licensing to an accreditation model, and dealing with unlicensed facilities. One respondent noted that greater consistency in the application of regulations by survey staff was needed, and another state is seeking ways to improve dealing with facilities that consistently have violations of rules that are

not severe enough to warrant termination of the license. The role of the Fair Housing regulations and ADA were cited as a concern.

States also support but express concern about many of the main tenants of assisted living. How do you balance safety and maximum autonomy and independence? What levels of care are appropriate? How should state policy facilitate or deal with aging in place, and what are the best ways to monitor facilities serving residents with a mix of health and functional needs? The needs of residents with Alzheimer's disease and control of access issues were mentioned by four states.

A number of policy makers dealt with quality in stating their priorities. States are searching for the right level of oversight, developing outcome measures, dealing with abuse and neglect, and handling facilities that admit residents that they are not staffed to serve appropriately.

Several respondents were concerned about the lack of consensus about the definition of assisted living and the potential for medicalizing what is now seen as a social or home-like model of care. Another was concerned that over time the more flexible approach to regulation might give way to more prescriptive regulation. Precedents in licensing and regulating nursing homes were mentioned. Concerns that the spiraling growth of facilities and the emerging dominance by a limited number of chains may undermine what has until now been a "consumer-driven" market were described. A few states were concerned about recruitment and retention of enough trained staff as the number of facilities expands. While states worry about over-supply, some seek to stimulate development in rural areas where the supply has been far slower to develop.

Appropriate training for administrators and staff was cited by three states. Several states are focusing on medication management and the training of staff administering medications. Regulations in most states allow administration of medications and many allow unlicensed staff to administer medications under nurse delegation procedures.

Among the issues related to services, state respondents listed integration of services, linkages between assisted living and other Medicaid waiver services, and the coordination of home health services and assisted living services as areas to explore.

Negotiated service agreements are another area that differentiates assisted living from board-and-care rules, yet states are concerned that consumers do not understand these procedures and may not use them to their full advantage. The need for an effective assessment process and the offering of meaningful activities to residents were also cited.

A few states were interested in exploring how assisted living could serve people with chronic mental illness or adults with physical disabilities.

Public Subsidies

Public policy concerning subsidies for elders in residential settings has paralleled the emergence of new residential long-term care models. Subsidies for low-income older persons may be provided through the federal Supplemental Security Income program (SSI), through state supplements to the federal SSI program, or through Medicaid. Many states have created living arrangements under a state supplement to the federal SSI payment for residential settings. These supplemental payments cover room and board and sometimes personal care. The payment standards typically were created years ago before the emergence of assisted living and the higher level of care provided in assisted living and, more frequently, in board-and-care settings. SSI payments developed primarily for "board," rather than "care," are quite low in relation to the fees in assisted living facilities. Many observers contend they are low in relation to the actual cost of meeting the increasing needs of low-income board-and-care residents. States are now developing policies which combine SSI and Medicaid to provide an appropriate level of service and to encourage aging in place.

The Social Security Administration publishes an annual report describing each state's living arrangements and the amount of the state supplement. Individual states may use a specific term to refer to their supplement and some use the term SSI to refer to both the federal payment and any state supplement. The federal payment in 1998 is $494 a month and is adjusted each January based on the cost of living. For the purposes of this section, references to SSI payments above $494 a month mean that the state supplements the federal payment.

Medicaid Reimbursement

States may fund services in assisted living or board-and-care settings through Home and Community Based Services (HCBS) waivers or as a regular state plan service. States most often use the Home and Community Based Services Waiver (1915 (c)). However, a few states use Medicaid state plan services, typically personal care. The two forms of coverage differ in three important ways:

First, waiver services are available only to beneficiaries who meet the state's nursing home level of care criteria; that is, they would be eligible to enter a nursing home if they applied. Nursing home eligibility is not required for beneficiaries using state plan services.

Second, states set limits on the number of beneficiaries that can be served through waiver programs. The limits are defined as expenditure caps that are part of the cost neutrality formula required for approval. Waivers are only approved if the state demonstrates that Medicaid long- term care expenditures under the waiver will not exceed expenditures that would have been made in the absence of the waiver. States do not receive federal reimbursements for any waiver expenditures that exceed the

amount stated in the cost neutrality calculation. In contrast, state plan services are an entitlement, meaning that all beneficiaries who meet the eligibility criteria must be served. Federal funding continues to match state expenditures without any cap.

Finally, under home and community based waiver service programs, states may use the optional eligibility category that allows beneficiaries with incomes less than 300% of the federal Supplemental Security Income (SSI) benefit ($494 a month) to be eligible and receive all Medicaid services. In the absence of this provision, people who live at home and have too much income to quality for Medicaid would be forced to spend down their income and assets to qualify, often by needlessly entering an expensive nursing home. Using the optional eligibility approach, states can pay for assisted living and other services to give people options to nursing home admission. Tenants who meet the nursing home criteria can become eligible for Medicaid without spending their excess income. They may retain the income to pay the room and board costs while Medicaid covers the services. In contrast to the more generous eligibility option available under 1915 (c) home and community based services waivers, beneficiaries are eligible under the regular Medicaid state plan if they receive SSI or meet the state's medically needy standards.

TABLE 5. Differences in Medicaid Coverage

Issue	State Plan Service	1915 (c) Waivers
Entitlement	States must provide services to all beneficiaries who qualify for Medicaid	States limit spending for waiver services
Functional criteria	Beneficiaries must need the service covered	Must meet the state's nursing home level of care criteria
Income	Must be SSI or otherwise eligible for Medicaid	State may set eligibility up to 300% ($1482) of the federal SSI payment standard ($494)

Available since 1981, HCBS waivers afford States the flexibility to develop and implement creative alternatives to institutionalizing Medicaid-eligible individuals.[6] States may request waivers of certain Federal rules which impede the development of Medicaid-financed community-based treatment alternatives. The program recognizes that many individuals at risk of institutionalization can be cared for in their homes and communities, preserving their independence and ties to family and friends, at a cost no higher than that of institutional care. Waivers are initially granted for three years and may be renewed for five years.

HCFA has streamlined the waiver process. A pre-printed application allows states to simply check off essential aspects of its application. Assisted living has been added as a service on the pre-print although states may submit their own definition of the services, subject to approval. Some states reimburse waiver services--such as personal care, homemaker, chores, and others--in an assisted living setting rather than

[6] Portions of the following have been taken from HCFA's description of the waiver program which is available at its web site (http://www.hcfa.gov).

assisted living services. Waiver services may be provided statewide or may be limited to specific geographic subdivisions.

To gain approval, states must assure HCFA that, on average, it will not cost more to provide home and community-based services than providing institutional care would cost. The Medicaid agency also must provide and document certain other assurances, including that there are safeguards to protect the health and welfare of recipients.

Current State Activity: Use of Waivers and State Plan Services

Describing coverage of assisted living by state Medicaid programs, like many aspects of assisted living, is complex. Coverage can be presented by licensing terms (assisted living or board-and-care), current and planned coverage, and source of coverage (Medicaid state plan or waiver services).

By June of 1998, 28 states covered services in assisted living and board-and-care facilities and nine more planned to do so. Twenty states reimbursed services in facilities licensed as assisted living or designated as assisted living by Medicaid, and eight states covered personal care services in board-and-care facilities that are sometimes considered assisted living. The eight states planning to add coverage will license assisted living facilities.

When presented by type of coverage and current and planned coverage, the number of states totals 37, although Maine and Vermont are counted twice. Maine, which licenses several categories of assisted living, covers services in residential care facilities under its state plan. Services in congregate housing can be covered by a Medicaid waiver. Vermont presently covers care in residential care facilities under its waiver and plans to add assisted living when draft regulations are final.

Twenty-two states now have an assisted living licensing category, although not all the states reimburse services for Medicaid beneficiaries. Other states reimburse for services in facilities licensed as board-and-care facilities, and still others have created assisted living as a Medicaid reimbursed service even though the state may not have an assisted living licensing category (Minnesota, New Mexico, New York, Texas, Washington). The table below presents the three categories of arrangements states have implemented: those with assisted living as a licensing category or a term developed by Medicaid; those that cover services in board-and-care facilities; and those that do not use Medicaid to pay for services in either assisted living or board-and-care facilities.

States that use or plan to use Medicaid reimbursements for assisted living are divided among three categories: states with approved waivers; states planning to seek waiver approval for assisted living; and states using the state plan to pay for care. Board-and-care reimbursement is divided between states using the waiver and those using state plan services.

TABLE 6. Medicaid Reimbursement Arrangements							
Assisted Living				Board-and-Care[1]		No Coverage (14)	
Waiver (18)		Pending (9)	State Plan (4)	Waiver (5)	State Plan (2)		
AK	NM	CT	***ME***[2]	CO	AR	AL	OH
AZ	ND	DE	MA	GA	MO	CA	OK
FL	OR	HI	NY	MT		KY	PA
IA	RI	IL	NC	NV		ID	SC
KS	SD	LA		***VT***[2]		IN	TN
ME[2]	TX	NE				MI	WV
MD	VA	NH				MS	WY
MN	WA	UT					
NJ	WI	***VT***[2]					

1. These states do not have a licensing category named assisted living.
2. Maine, using a broad definition of assisted living, uses the state plan and an HCBS waiver. Vermont covers services in residential care facilities and plans to add coverage for assisted living when its new rules take effect.

Although 28 states cover services in assisted living or board-and-care, total participation is just over 40,000 beneficiaries and waiver participation is very low in many states. States using personal care under the state plan to cover care have higher participation rates than states using the waiver. For example, roughly half of all Medicaid beneficiaries nationwide in assisted living or other residential care settings are in North Carolina, and another 25% are in Missouri and New York. Waiver participation is much lower. In 1998, Nevada had approximately 52 recipients participating in the waiver. New Jersey, which is approved for 1,500 participants, has 119 participants. Oregon, Virginia, and Washington have 1,400-1,500 each, and New York has approximately 2,100 participants. It is not clear why participation is low although observers speculate that primary referral sources and eligibility assessors may not be familiar with this new model. Facilities themselves may be slow to sign contracts with Medicaid over concern for the rate of payment or fears that additional regulations will be imposed and future increases may not be adequate. Further work is necessary to determine whether these or other factors contribute to the slower than expected participation rates.

State Approaches to Reimbursement

As in any reimbursement system, the amount of the payment and the approach to reimbursement create incentives for provider behavior. Five primary approaches are used by states in setting rates for assisted living and/or board-and-care services:

- Flat rates,
- Flat rates that vary by type of setting,
- Tiered rates,
- Case mix rate systems, and
- Care plan or fee-for-service based rates.

Table 7 summarizes the rate-setting approaches used by states that reimburse assisted living services.

TABLE 7. State Rate-Setting Approaches				
Flat Rates	**Vary by Setting**	**Tiered Rates**	**Case Mix**	**Care Plan**
Colorado Florida Georgia Maine Maryland Massachusetts Nevada New Mexico North Carolina Rhode Island South Dakota Virginia Vermont[2]	Alaska[1] New Jersey[1] Texas	Arizona Delaware[2] Florida[1] Oregon Washington Wisconsin Vermont[2]	Maine[1] Minnesota New York North Carolina[1]	Arkansas Iowa Kansas Missouri Montana North Dakota

1. Alaska, Florida, New Jersey, and North Carolina are exploring new rate-setting approaches. Maine plans to implement a case mix system in 1998 for residential care facilities. Note that Florida, Maine, and North Carolina appear under more than one category.
2. Delaware and Vermont are also developing tiered rate systems as waivers are developed for new assisted living regulations.

1. Flat Rates

As in the health care system, flat rates in the assisted living system create incentives for facilities to admit tenants who need lighter care. Facilities receive the same monthly payment regardless of the level of care and staff assistance needed. Facilities may tend not to admit tenants with multiple impairments in activities of daily living.

Thirteen states currently use flat rate reimbursements. Florida, which is exploring a tiered payment system, pays facilities $1350 a month, a fee that includes a service payment and a room and board component. Massachusetts uses Group Adult Foster Care (GAFC), which is listed as a Medicaid state plan service, to reimburse for services to Medicaid recipients in assisted living. The service payment averages $33.70 per day for Medicaid recipients. The program was developed prior to passage of the assisted living legislation and combines two approaches: services in conventional elderly housing projects and purpose-built assisted living sites.

Massachusetts, recognizing that high development costs create barriers for low-income residents, is the only state that has set a separate SSI payment for assisted living of $924 a month. This payment is considerably higher than the community standard (the payment for an aged person living alone in the community) or the board-and-care standard. The increased rate reflects the higher real estate and development costs in the state and provides access for Medicaid recipients to many market rate and mixed-income developments.

The state Medicaid agency prefers to retain coverage of assisted living through the GAFC program as a state plan service rather than as a waiver service. Although

spending would be capped under the waiver, the state plan approach allows Medicaid to serve people who are frail but are not eligible to enter a nursing home following a tightening of the level of care criteria.

Four states--Colorado, Nevada, South Dakota, and Georgia--cover services in licensed board-and-care settings that are sometimes referred to as assisted living. Colorado's Medicaid rules limit room and board charges for Medicaid recipients to $448 a month. Effective July 1998, the Medicaid rate for services will be $29.88 a day ($896.40 a month). The rate covers oversight, personal care, homemaker, chore, and laundry services. The total monthly rate for an SSI recipient is $1344.40.

In Nevada, personal care services are reimbursed through a Medicaid HCBS waiver in group residential settings if the resident meets the SSI eligibility criteria. Facilities receive a total payment of approximately $1000 a month which includes $781 from SSI for room and board and $9.09 a day ($277.20 a month) for personal care.

The SSI payment, including state supplement, in South Dakota for assisted living facilities is $910 per month. Residents retain a personal needs allowance of $30 a month. If the Department of Social Services determines that a Medicaid eligible individual also needs medication administration, the facility receives $150 per month through the Medicaid HCBS waiver for a total payment of $1,030 per month.

Georgia has implemented a small Medicaid HCBS waiver that reimburses two models of personal care homes: (1) group homes serve 7-24 people, and (2) family homes serve 2-6 people. Group homes which are more comparable to assisted living, are reimbursed at $23.49 per day. Family homes, also called assisted living, are called adult foster care in other states.

Under its assisted living regulations, North Carolina licenses adult care homes, family care homes, group homes for the developmentally disabled, and multi-unit assisted housing with services. All are considered variations of assisted living under state law although some observers would consider adult care homes as a board-and-care model.

North Carolina uses a modified flat rate with add-ons for tenants with specific ADL impairments. In 1998, the SSI payment for room and board is $893 a month (plus a $43 personal needs allowance), and the state covers personal care in adult care homes as a Medicaid state plan service. Providers receive a flat rate for basic personal care. Residents with extensive or total impairments in eating, toileting, or both eating and toileting qualify for a higher rate. In 1998, the basic payment is $8.07 a day which assumes each resident receives one hour of personal care a day. Providers receive higher payments for residents with extensive or total impairments in three specific ADLs: eating, toileting, or both. The rate for residents with extensive or total impairments in eating is $16.00 per day, toileting $10.87 per day, and impairments in both eating and toileting are reimbursed at $18.80 per day. These three payment levels *include* the basic rate of $8.07 per day. Eligibility for the added payment is based on an

assessment by the adult care home which is then verified by a county case manager. North Carolina is developing a case mix payment system using assessment data and cost report data for tenants in adult care homes.

TABLE 8. North Carolina Medicaid Rates--Monthly (1998 data)				
	Basic Rate	**Eating**	**Toileting**	**Eating & Toileting**
Room and board	$893.00	$893.00	$893.00	$893.00
Personal care	$242.70	$480.00	$326.10	$564.00
Total	$1135.70	$1373.00	$1219.10	$1457.00

2. Flat Rates that Vary by Setting

Flat rates that vary by setting generally reflect a state's preference for apartments and private occupancy without excluding facilities offering rooms or shared occupancy. However, unless the reimbursement also takes into account the differing service needs of the residents, the total amount of the payment may be more important to provider participation than the differential rates facilities receive based on the type of units offered (apartments or rooms) or occupancy arrangements (private or shared).

In some cases, varying rates by setting may reflect differences in the average acuity level of residents in each setting. For example, a state may reimburse for services in conventional elderly housing buildings and purpose-built assisted living facilities. Generally, tenants in elderly housing sites are less impaired than those in purpose-built assisted living facilities. Unlike purpose-built assisted living facilities, elderly housing sites typically do not have 24-hour staffing and the capacity to meet the unscheduled needs of tenants. Elderly housing facilities, therefore, receive a lower rate than purpose-built assisted living facilities with 24-hour staffing.

Texas has developed flat rates that vary by location rather than acuity. Separate service rates are based on the setting and the number of occupants. Single occupancy assisted living apartments receive $29.39 a day for services. Residential care units receive $22.96 a day for double occupancy and $18.99 a day for non-apartment, double occupancy models. The SSI rate for room and board is $11.88 a day for all settings.

New Jersey licenses assisted living as a service provided in a range of settings. Rates have been developed for each of three settings rather than level of service or other factor. Newly constructed assisted living residences receive $571 for room and board and $1800 a month for Medicaid services. Comprehensive personal care homes receive $571 for room and board and $1500 a month for services. Assisted living programs (subsidized housing) receive $1200 a month for services. Residents are charged a percentage of their income for rent with the remaining amount subsidized by the project. State officials plan to review the methodology and develop a new rate structure.

TABLE 9. New Jersey Rate Schedule			
	Assisted Living Residences	**Assisted Living Programs**	**Personal Care Homes**
Room and board	$571.55	NA	$571.55
Medicaid waiver services	$1800.00	$1200.00	$1500.00
Total	$2371.55		$2071.55

3. Tiered Rates

Tiered Rates Based on Acuity Levels

Tiered rates have been developed to more fairly reimburse facilities for the care provided to frailer residents. Tiered systems usually include 3-5 tiers based on the type, number, and severity of ADL and/or cognitive or behavioral impairments. They create incentives to serve higher acuity tenants who are more likely to enter a nursing home.

Arizona has developed three rate classes based on the needs of the resident. Ohio was also planning to use a service rate structure with five tiers ranging from $200 to $1400 a month that varies based on the number and type of ADL impairments, skilled nursing needs, and behavior needs. The room-and-board payment was proposed to be $700 a month. The service rate was developed after consultation by the Department of Aging with assisted living providers.

TABLE 10. Oregon Reimbursement Categories				
Impairment Level	**Service Priority**	**Service**	**R&B**	**Total Rate**
Level V	Service priority A or priority B and dependent in the behavior ADL.	$1643.48	$420.70	$2064.18
Level IV	Service priority B or priority C with assistance required in the behavior ADL.	$1330.48	$420.70	$1751.18
Level III	Service priority C or priority D with assistance required in the behavior ADL.	$1016.48	$420.70	$1437.18
Level II	Service priority D or priority E with assistance required in the behavior ADL.	$767.48	$420.70	$1188.18
Level I	Service priority E or F or priority G with assistance required in the behavior ADL.	$579.48	$420.70	$1000.18

Oregon reimburses facilities using five levels based on the type and degree of impairments of residents. The total rate includes a room and board payment of $420.70 and a service rate. The levels are assigned based on a service priority score determined through an assessment. ADLs include eating/nutrition, dressing/grooming, bathing/personal hygiene, mobility, bowel and bladder control, and behavior. Service priority ratings are assigned based on the number and type of impairments in ADLs. Service priority A is assigned to people who are dependent in 3-6 ADLs; priority B those

dependent in 1-2 ADLs. (See table.) About 60% of the Medicaid residents are in Level IV.

Vermont has developed a unique three-tiered system that was developed using MDS 2.0 and assessment data. Residents receive a score in five areas: ADLs, bladder and bowel control, cognitive and behavior status, medication administration, and special programs (behavior management, skin treatment, or rehabilitation/restorative care). Residents are assigned to a level (1 or 2) based on the extent of ADL impairments. Scores of 6-18 are assigned to level 1 and scores between 19-29 are assigned to level 2. The four remaining areas are rated, and additional points are assigned. The payment tier is determined by combining the ADL level and the additional points. Payment rates have not been devised. The Department of Aging and Disability has piloted the classification system and will be developing rates for each tier.

TABLE 11. Vermont Payment Areas and Scoring System (proposed)

Area	Maximum Points	Factors
ADLs	29	Eating, toileting, mobility, bathing, dressing
Continence	13	Bladder and bowel
Cognitive/behavior status	65	Sleep pattern, wandering, danger to self/others
Medication	5	Administration
Special programs	49	Mood, behavior, cognitive loss. Skin: Turning/ repositioning, nutrition or hydration, dressings, ulcer care, surgical wound care. Rehab: range of motion, skin brace assistance, transfer, walking, dressing/grooming, eating/swallowing, prosthesis care, communication.

TABLE 12. Vermont Rating System (proposed)

Tier 1		Tier 2		Tier 3	
Level	Points	Level	Points	Level	Points
1	0-30	1	31-59	1	60+
-	-	2	0-35	2	36+

Tiered Rates with Geographic Variations

Washington has developed a unique approach to developing rates. The state initially offered contractors a flat per diem rate of $47.37 a day in 1995 consisting of $27.06 for services and $20.31 for room and board. In 1995, the state Aging and Adult Services Administration (AASA) initiated development of a tiered rate structure based on three levels of care needs. AASA sought information from facilities on rate related costs. Working with assisted living facilities and the state Housing Finance Agency, model rates were constructed based on staffing, operations, and capital costs. The model assumed an average size facility of 60 units and variations in levels of care. Each level of care assumed residents would receive some nursing services though not every resident necessarily receives such services. Nursing services are differentiated by licensing category. RNs or LPNs may provide insertion of catheters, nursing assessments, and glucometer readings. Unlicensed staff may provide the following

under supervision by an RN or LPN: stage-one skin care, routine ostomy care, enema, catheter care, and wound care. Unlicensed staff may provide assistance with transfer, mobility, hygiene and incontinence.

The process set the rate for nursing costs in King County at $15.16 a day for Level 1 residents, $21.24 for Level 2 residents, and $27.82 for Level 3 residents. Operating costs were $32.28, $32.72, and $33.16 respectively. Capital costs were $8.30, $8.36, and $8.44 respectively. Capital costs varied because of changing assumptions about occupancy rates across levels. In addition, a capital add-on was created for new construction. The rates are increased for new facilities by $4.49 a day in King County. (See Table 13).

The methodology sets upper limits that facilities may charge to Medicaid residents. Since Medicaid may only reimburse for services, the room and board portion of the rate is paid by the resident from his or her social security, pension, or SSI benefit. Residents who rely solely on SSI will pay $14.79 a day for room and board. The rates in the table represent total rates that include $14.79 per day for room and board.

TABLE 13. Washington Rate Structure

	Level I			Level II			Level III		
Component	**King County**	**MSA**	**Non-MSA**	**King County**	**MSA**	**Non-MSA**	**King County**	**MSA**	**Non-MSA**
Nursing	$15.16	$13.44	$12.75	$21.24	$18.72	$17.75	$27.82	$24.47	$23.21
Operations	$32.28	$29.97	$30.24	$32.72	$30.35	$30.65	$33.16	$30.73	$30.78
Capital	$8.30	$7.95	$6.94	$8.36	$8.01	$6.99	$8.44	$8.09	$7.06
Total	$55.74	$51.36	$49.93	$62.32	$57.07	$55.39	$69.41	$63.29	$61.05
Add-on	$4.49	$4.08	$4.34	$4.49	$4.08	$4.34	$4.49	$4.08	$4.34
Total	$60.23	$55.44	$54.26	$66.81	$61.15	$59.72	$73.90	$67.37	$65.38

Under the new system, case managers use a comprehensive assessment to measure the person's level of need. Three sections of the assessment are used to determine the payment level: health status, psychological/social/cognitive status, and functional abilities and supports. A three-step process is used to determine the appropriate rate. Six ADLs are weighted and measured: eating, toileting, bathing, ambulation, body care, and transfer. Eating, toileting, bathing and ambulation are assigned a weighted value of 2, while body care and transfer a given a value of 1. Residents must be substantially or totally impaired in an ADL to receive a score. Scores of 0-4 are assigned to level 1; 5-10 level 2.

The second step measures speech, sight, hearing, disorientation, memory impairment, impaired judgement, wandering, disruptive behavior, and medication administration. Ten points are assigned to people who have impairments in speech, sight, and hearing. Points are assigned based on the number of medications and a weighting which gives higher scores as the number of medications increase. In addition, points are assigned for disorientation (12), memory impairment (16), impaired judgement (17), wandering (15) and disruptive behavior (20).

Step three combines the scores from each section to arrive at a payment level. A computer program reviews the assessment and determines the residents "level" and

payment amount. Prior to the new system, a survey of facilities showed that Medicaid residents were "light care" and had relatively fewer ADL impairments. Since its implementation in January 1996, very few complaints have been received. While some facilities were worried that their rates might be reduced, most responded to the incentives created and began seeking residents who required higher levels of care.

4. Rates Linked to Nursing Home Case Mix Systems

Several states have adopted, or are developing, systems based on their nursing home case mix methodology approach. Like tiered rate approaches, the case mix approach also creates incentives to serve more impaired tenants by linking reimbursements to levels of care needs, but case mix approaches have more groupings. In addition, the case mix approach requires extensive functional and health data on residents. Both tiered rates and case mix rates are subject to "category creep" or "gaming;" that is, a tendency for facilities to interpret assessment data to support payment of the next higher rate or to request an adjustment because the resident has become more impaired and requires more staff support than upon admission. States may use an assessment by an independent case management agency to determine the original payment level. Subsequent requests to adjust the payment level can be reviewed by either the case management agency or the state agency before being approved.

Minnesota and New York have modeled their reimbursement rates on their case mix system for paying nursing homes. In New York, the service reimbursement is set at 50% of the resident's Resource Utilization Group (RUG) which would have been paid in a nursing home. The state has created RUG rates for 16 geographic areas of the state. The reimbursement category is determined through a joint assessment by the Assisted Living Program and the designated home health agency or long-term home health care program. The assessment and the RUG category are reviewed by the Department of Social Services' district office. The residential services (room, board, and some personal care) are covered by SSI, which also varies by region. In 1998, the SSI rates are $827 to $857 a month.

Service rates in Minnesota are negotiated between the client and the provider with caps based on the client's case mix classification. Service rates under the Alternative Care program, a state funded program for people who do not meet the Medicaid eligibility criteria, cannot exceed the state's share of the average monthly nursing home payment. The client pays for room and board (raw food costs only; meal preparation is covered as a service). The room and board payment standard under the SSI and state supplemental payment is $667 a month less a $54 personal needs allowance. To determine cost effectiveness, costs for assisted living and all other waiver services are combined. Residences receive a payment for assisted living services, and any other waiver services used are billed by the provider directly to the county.

TABLE 14. Minnesota Case Mix Categories and Maximum Statewide Rate Limits for Assisted Living and All Other Waiver Services -- Effective 10/1/97[1]				
Case Mix	**Assisted Living Monthly Limits**	**Total Maximum Payment[2]**		**Description**
		AC Program	**Elderly Waiver Program**	
A	$684	$1072	$1429	Up to 3 ADL dependencies[3]
B	$771	$1209	$1612	3 ADLs + behavior
C	$871	$1356	$1820	3 ADLs + special nursing care
D	$962	$1507	$2010	4-6 ADLs
E	$1023	$1654	$225	4-6 ADLs + behavior
F	$1029	$1663	$2217	4-6 ADLs + special nursing care
G	$1105	$1786	$2382	7-8 ADLs
H	$1249	$2020	$2693	7-8 ADLs + behavior
I	$1300	$2102	$2803	7-8 + needs total or partial help eating (observation for choking, tube or IV feeding & inappropropriate behavior)
J	$1380	$2320	$2974	7-8 + total help eating (as above) or severe neuro-muscular diagnosis or behavior problems
K	$1546	$2500	$3333	7-8 + special nursing

1. The maximum rate limits vary by region of the state but cannot exceed the maximum statewide limits.
2. Rates include assisted living and all other waiver services which the residence is responsible for providing or arranging but are billed by the provider to the county. The residence does not receive payment for the non-assisted living waiver services.
3. ADLs include bathing, dressing, grooming, eating, bed mobility, transferring, walking, and toileting.

The total cost of all waiver services, including assisted living, may not exceed 75% of the average nursing home payment for the case mix classification. Under the HCBS waiver, rates for assisted living services are capped at the state share of the average nursing home payment and the total costs, including skilled nursing and home health aide, cannot exceed 100% of the average cost for the client's case mix classification.

The average statewide rate for assisted living services ranges from $684 a month for case mix A to $1595 for case mix K. About 70% of the participants were assessed as Category A and 96% fall between A and D. The Alternative Care program rates *for all services including assisted living* range from $1072 to $2500 a month. The Medicaid waiver statewide maximum rates for assisted living services and all other waiver services for elderly recipients ranged from $1429 a month to $3333 a month depending upon the case mix classification. Rates in a particular county could be higher or lower than the averages.

5. Care Plan and Fee-for-Service Rates

A few states use a system that is more like an in-home service system. This approach has three components: an assessment, a care plan, and the payment. Rates are determined by the number of hours of service identified in a care plan or a point system based on the assessment. For example, Kansas considers assisted living facilities as providers of home care services, and they are reimbursed on a fee-for-service basis. This approach may be cumbersome for some facilities to implement.

Facilities are used to receiving a regular monthly payment and providing services as needed by the tenant pursuant to a plan of care. If the services are reimbursed fee-for-service, facilities must track service delivery and prepare and submit bills to the payment agency. Depending on the pricing structure, assisted living facilities may not be set up to prepare and submit itemized bills for each increment of service delivered to a tenant.

Service delivery in assisted living facilities is also very different from the delivery pattern of in-home service programs. Participants in home-care programs typically receive services in block authorizations, e.g., two hours of care, five days a week. Assisted living tenants typically receive services in 15-minute increments at various times during each day of the week including nights and weekends when home care programs usually do not offer services. Tracking, aggregating, and billing become cumbersome and time consuming, especially for facilities used to charging one, all-inclusive fee for services. However, the pricing structure of many facilities includes a basic package of services with additional charges based on the increments of service used by tenants. Facilities with this policy for market-rate or private-pay tenants may be better able to participate in the fee-for-service approach.

In Missouri, personal care and advanced personal care services are reimbursed as a Medicaid state plan service in residential care facilities. The payment varies by resident based on an assessment and a plan of care completed by a case manager from the Division of Aging. Facilities are reimbursed at an hourly rate for the number of hours authorized in the plan of care. The maximum payment is $1700 a month which is tied to the state's Medicaid nursing home costs. The actual number of hours authorized ranges from 5-6 hours to 70 or 80 hours a month. The average number of hours authorized is 25-30 hours a month. The payment rate is $10.07 an hour for personal care aides, $14.61 for advanced personal care aide services and $25.00 an hour for nursing visits. No more than one nursing visit a week can be authorized. Very few residents receive advanced personal care and nursing visits.

The room and board rate is paid through the federal SSI payment and a state "cash grant" or SSI supplement payment. Type I facilities receive a combined payment of $645 a month and Type II facilities receive a combined payment of $752 a month. With an average personal care payment of $302.10, the total payment would equal $947 in Type I facilities and $1054 in Type II facilities. Type I facilities provide room and board, supervision and protective oversight. Type II facilities also provide personal care and supervision of diets and health care.

Montana and North Dakota use payment systems that have elements of a tiered methodology but lack the structure and limited number of payment levels of tiered approaches. However, payment is based on an assessment. Assessment data in Montana is converted to points and the facility receives so much per point. The Medicaid waiver reimburses adult foster care home and personal care facilities between $520 and $1800 a month depending on the level of care needed by residents. State agency field staff complete the assessment and determine the payment rate. In addition

to the room-and-board component, the basic service payment for residents is $520 a month. Additional payments are calculated based on ADL and other impairments. Points are calculated for each impairment. The functions measured are: bathing, mobility, toileting, transfer, eating, grooming, medication, dressing, housekeeping, socialization, behavior management, executive cognitive functioning, and other. Each function is rated:

1. With aides/difficulty: Individual needs consistent availability of mechanical assistance or expenditure of undue effort;
2. With help: Individual requires consistent human assistance to complete the activity, but the individual participates actively in the completion of the activity;
3. Unable: individual cannot meaningfully contribute to the completion of the task.

Each point equals $33 a month. For example, a resident consistently needing help with toileting would be scored a two and would earn $66 a month for that impairment. Residents with severe impairments, totally dependent in more than three ADLs can receive $44 a month for each point. The room and board payment under SSI is $564 a month. The total payment (services and room and board) ranges from $1084 to $2363 a month, although very few participants have been approved at the highest rate.

North Dakota uses a rate classification system that is derived from a point system measuring a person's level of service need. Systems in Montana and North Dakota have some similarities to tiered systems, but they do not have as defined a structure or a limited number of categories as the tiered approaches. The amount of payment varies widely based on the number and type of impairments which have more in common with care plan and fee for service systems.

DISCUSSION

States face a number of major challenges in developing payment methodologies for assisted living and other residential care services, including: (1) defining and distinguishing types of services, (2) finding existing models to replicate or seeking new models for payment approaches, and (3) dealing with the unique challenges and opportunities of developing payment approaches for people with differing needs when Medicaid cannot pay for room and board.

The extent to which low-income older people will gain access to this important alternative to nursing homes depends in large part on the extent to which states cover services in assisted living facilities and on the willingness of facilities to accept the rates set by state Medicaid programs. States continue to work on developing methodologies for setting rates. No single approach has yet emerged, although the trend is toward methodologies that reflect variations among tenants. As the private assisted living market expands, state policy concerning rates will determine the extent to which residents with low-incomes have access to this residential option. Rates must be high

enough to encourage facilities to contract with Medicaid yet lower than the cost of a nursing facility. The experience in New Jersey, Oregon, and Washington suggests that states can set rates to meet these criteria. As the supply expands, facilities may be more willing to contract with Medicaid in order to maintain acceptable occupancy levels.

Comparing rates across states is difficult because of significant differences in the definition of assisted living and admission/retention criteria among states. States that do not allow tenants who meet the nursing home level of care criteria to live in assisted living cannot develop rates that compare to Medicaid nursing facility rates. States that allow higher levels of care will need higher rates than states that limit the provision of health services.

Seeking New Models

States exploring assisted living reimbursement methodologies have no existing models to replicate. Nursing home methodologies include both room and board and service costs and generally have higher acuity residents than assisted living. Residential care facility models typically have been limited to SSI standards that cover room and board and limited service costs. Assisted living often provides more intensive services and a more home-like environment. Providing access to such services for older persons with low incomes will require enhancements to the services and room and reimbursements beyond those typically provided in other residential settings.

In terms of acuity levels and service utilization, the best comparable cost data may come from in-home services provided under home- and community-based waiver programs. Waiver programs require that participants meet the level of care criteria for placement in a nursing home. While expenditure data is available for state plan services, assessment data is not collected, and the population is not likely to be comparable to people in nursing homes. However, using in-home services as a model would have to recognize significant differences between payment approaches and utilization patterns under in-home services and assisted living. As described above, reimbursing for in-home service units may overstate the amount of service utilized by a tenant because of the time increments required. On the other hand, in-home utilization may be constrained by the times during which it is available, state funding limits, or the lack of in-home workers. Because staff are on-site at all times, assisted living is able to offer more intermittent services in smaller time increments. In addition, assisted living provides more services during the evening and weekends when in-home services are generally not available. Since the perfect system is not likely to emerge, these differences in utilization patterns and payment approaches may tend to offset one another. As long as the populations are comparable, utilization in traditional in-home services programs may be the best current source of comparable reimbursement data.

Separating Room-and-Board from Service Costs

States have a long tradition of dealing with incentives created by reimbursement policy. Some of that experience guides rate setting as new models emerge. States have

set rates for nursing homes and prohibited facilities from collecting additional payments from residents or family members. Facilities complained that Medicaid rates were too low and forced them to charge higher rates to private pay residents. Rates in the private assisted living market currently range from under $1,500 to over $3,500 a month. The reimbursement approach adopted by states may determine how many facilities will be willing to contract with Medicaid.

Important differences between nursing homes and assisted living settings open up a number of alternative reimbursement strategies. Specifically, Medicaid pays both the room and board and service costs in nursing homes and hospitals but pays only the service costs in assisted living. Expenses for room and board are paid by assisted living residents. Separating the room and board from the service components of assisted living creates a number of reimbursement and rate setting possibilities. In general, states will have to develop different strategies for SSI beneficiaries and for those who are "spending down" their assets.

States using Medicaid 1915 (c) waivers have more flexibility. The typical room and board cost includes the development and real-estate costs, raw food, and meal service costs. Under the waiver, the cost of meal preparation and serving can be covered as a service, reducing the room and board that must be paid through the tenant's income. Waivers allow states to pay a greater percentage of the total cost than state plan services.

States deal with room and board in two ways. First, states can set a combined rate that includes room and board and service costs. The rate caps what can be paid to the facility. The resident pays the room and board and applies any excess income to services. Medicaid can pay the difference between the resident's payment and the maximum rate. Second, states set a rate only for assisted living services. The room and board charge is determined between the resident and the facility (e.g., Wisconsin). The former approach works best in states with lower development and capital costs since the Medicaid rate is more likely to be comparable to the actual room and board charge. The latter approach works better in states with high development costs and with residents whose income is sufficient to cover these higher costs that cannot be covered by Medicaid.

Rates for SSI and Medically Needy Beneficiaries

In general, states will have to develop different strategies for SSI beneficiaries and beneficiaries who are "spending down" their income and assets. The simplest approach for providing access for SSI beneficiaries or others with very low incomes would be to set a maximum rate for room and board for Medicaid recipients at the state's SSI payment standard. This approach would guarantee that Medicaid recipients could afford the room and board, while limiting Medicaid's payments for the services. Beneficiaries with incomes in excess of the SSI level would contribute that excess income, minus a personal needs allowance, to pay for services, and Medicaid would pay the difference. A major problem with this reimbursement method is that limiting

room and board charges to the SSI rate may understate legitimate costs. As a result, facilities may choose not to accept Medicaid beneficiaries since no state requires that facilities accept SSI recipients or Medicaid beneficiaries.

States may want to consider separate policies that address SSI and non-cash assistance Medicaid beneficiaries. To increase access for SSI beneficiaries in areas with higher development costs, states could create a special SSI state supplement[7] for assisted living in order to give beneficiaries enough income to pay for the room and board costs that cannot be covered by Medicaid. For example, Massachusetts has created a separate payment standard of $900 a month for assisted living compared to the community standard of $610 a month. No other state has adopted a new living arrangement for assisted living while maintaining other living arrangements and payment standards for board-and-care.

A different approach is needed to address the needs of older people who have too much income to qualify for SSI (and, therefore, under regular Medicaid eligibility) but too little income to pay for the private assisted-living rate. This group is sometimes referred to as "non-cash beneficiary" because they are not eligible for SSI yet they have medical expenses that reduce their income to the Medicaid income standard. Unable to afford alternatives, these individuals too often enter a nursing home and spend down in order to qualify eventually for Medicaid. This group accounts for the majority of Medicaid's long-term care spending for nursing home services. In 1995, Medicaid spent, on average, $2626 a year on long-term care services for SSI beneficiaries and $11,612 for "non-cash" beneficiaries.[8] Serving frail older people through the special income option (under 300% of the federal SSI payment) makes assisted living affordable and can avert some nursing home admissions. It is also less cumbersome than the Medically Needy option.

The simplest strategy for serving this "spend down" population would be for states to pay for the services component of assisted living without any restrictions on what residents could spend for room and board. Under the special income option, states would reimburse services much as they do in-home services and allow beneficiaries to pay for room, board, and other supplemental services and amenities with their incomes.

States may wish to consider establishing a maintenance allowance that is higher than the SSI level that may be retained for room and board. Tenants would be required to apply excess income, after room and board payments and a personal needs allowance, to Medicaid service costs.

Reimbursement strategies for the "spend down" population may be especially relevant in states with higher land and construction costs which necessitate room and

[7] Many states have a state supplement for board-and-care facilities that may be too low to cover more intense services needs and higher costs in assisted living settings.

[8] David Liska, Brian Broen, Alina Salganicoff, Peter Lory and Bethany Kessler. “Medicaid Expenditures and Beneficiaries: National and State Profiles and Trends 00 1990-1995.” Kaiser Commission for the Future of Medicaid. Washington, DC. November 1997.

board charges significantly higher than SSI rates. As rate methodologies are developed, an assessment of the room and board and service components of market rate facilities would be helpful in setting appropriate rates. However, to do so requires judgements about the type of construction--"affordable" models or very high-income models--that would be examined. States will have to balance encouraging the use of assisted living with controlling Medicaid spending. This approach would create incentives for more facilities to contract with Medicaid, but the higher the allowance for room and board charges the less money there is available for the service component. Medicaid then must pay an increased amount of the monthly services fee. Since facilities themselves are unlikely to reveal financial data detailing actual room and board costs, discussions with state housing finance agencies and lenders may help formulate costs for prototype facilities from which fee structures may be devised.

State policy needs to address the differences in Medicaid's ability to pay for care in a nursing home and in a residential setting. In particular, the separation of services from room and board costs under assisted living creates an opportunity for state experimentation with a variety of reimbursement strategies. New rate-setting methodologies for assisted living can be expected to evolve in the coming years as more states cover services through Medicaid. Case mix systems for covering services and new approaches to separating service and room and board components are likely to be explored by states. Developments in this area warrant further discussion and research.

An important factor in state decision making will be the comparison between the net state cost for an individual in a nursing home and in assisted living. Using the special income option for people just over the income eligibility level and creating a special SSI state supplement, states can tailor a payment level that saves money compared to the nursing home rate and offers many consumers alternatives that they often prefer. Providing these options requires a higher state SSI supplement, in one instance, and less "excess income" applied to services in the second instance, but Medicaid still saves money when a consumer is able to receive services through assisted living rather than through a nursing home.

Some critics contend that expanding alternative services, even those costing less than a nursing home, add marginal costs by serving people in addition to those who enter a nursing home. There is some anecdotal evidence that the increased supply has resulted in lower nursing home occupancy rates, encouraging some nursing homes to close beds or convert to assisted living. Nebraska recently created a $40 million fund to facilitate conversions. Washington and Wisconsin have adopted occupancy penalties that reduce the nursing home per diem when occupancy drops. Facilities may de-license enough beds to raise their occupancy rate above the required threshold and receive the higher rate for occupied beds. As assisted living and in-home services expand, fewer nursing home beds assures that Medicaid can control institutional spending while expanding options that consumers and family members prefer.

CONCLUSION

The review of state policy and activity shows that before long nearly every state will have reviewed their regulations governing residential care settings. State assisted living policy continues to follow multiple paths. While some states have developed a new category in addition to older board-and-care categories and view assisted living as a distinct model, others are consolidating multiple categories under a single term. Assisted living is increasingly used as a term to define the model of care, although the term has varied meaning across states. Regulations in twenty-two states now contain a statement of the philosophy of assisted living which distinguishes it from other residential care models. States that do not create new categories or use the term assisted living are updating their regulations and allowing a higher level of care to be provided.

This survey found that several states have moved or are seeking to combine multiple licensing categories under a single assisted living category that may include assisted living, board-and-care, multi-unit conventional elderly housing, and adult foster care. Arizona, Maine, Maryland, and New York are joining New Jersey and North Carolina in this approach.

Since the last study, broad, more flexible admission/retention criteria have been developed in Hawaii, Kansas, Maine, Vermont, and Wisconsin. These criteria treat assisted living much like a person's single-family home or apartment. In their own home, people can receive high levels of home health service. Recent state regulations allow a similar level of care as long as the facility has the capacity to deliver care or acceptable arrangements are made with outside agencies.

States are also focusing on the needs of people with Alzheimer's disease and dementia and on state regulations concerning this population. Fourteen states now have requirements that staff be trained in the needs of this population. Regulations also address the environment, activities, and disclosure statements for special care units.

Medicaid coverage of assisted living is likely to expand to more states, and the number of tenants who are Medicaid beneficiaries will also grow in the coming years. In the past, facilities targeted a wealthier, less-impaired population. Over time, supply has expanded, competition for tenants increased, tenants have aged-in-place, and Medicaid coverage has expanded. Today, in order to maintain occupancy levels, facilities are more interested in serving tenants with higher impairment levels. Several assisted living companies are now developing products to serve older people with low- and moderate-incomes. However, participation is still quite low and more work needs to be done.

To facilitate use of this housing and services model for people who can no longer live in their own home or apartment, states need to address both their payment rates and the training of case managers and other staff who serve older people through home- and community-based service programs. The experience in Washington and other states suggests that rates can be set that are compatible with the rates charged to

private-pay residents which are lower than Medicaid nursing home rates. State policy makers may need to work with housing finance agencies and providers to understand the room-and-board costs that cannot be covered under Medicaid as well as the service costs that can be covered. To be able to move into assisted living residences, frail older people with low incomes will need to retain sufficient income to pay for the room and board costs.

As the supply of facilities and Medicaid coverage grows, hospital staff, home health agencies, home-care case managers, and other professional staff will need to become more familiar with assisted living and the opportunity it offers frail older people. States that have not developed or updated their regulations might consider revisions that address the institutional character of older "board-and-care" rules and develop assisted living as an affordable and home-like setting that provides a level of care that enables people to age-in-place.

STATE ASSISTED LIVING POLICY: 1998

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