SECTION 1.

OVERVIEW OF RESIDENTIAL CARE AND ASSISTED LIVING POLICY

INTRODUCTION

This compendium describes regulatory provisions and Medicaid policy for residential care settings in all 50 states and the District of Columbia. It updates an earlier report completed in 2002. Information was collected between February and June 2004 by reviewing state web sites and regulations and calling key state contacts to verify information. Section 1 provides an overview of residential care and assisted living policy. Section 2 presents six tables, which compare states' policy in selected areas. Section 3 provides summaries of each state's regulations and policy for residential care settings, including assisted living facilities.

This edition of the compendium differs from earlier editions in that it uses "residential care setting" or "residential care facility" as the generic terms for all types of group residential care settings, rather than the term assisted living. Although many states use the term assisted living generically to cover virtually every type of group residential care on the continuum between home care and nursing homes, for many stakeholders the term assisted living still represents a unique model of residential care that differs significantly from traditional types of residential care such as board and care. When discussing state statutes and regulation, the compendium uses the terms that each state uses.

Although adult foster care/adult family care is a type of residential care, it is not included in this report. However, some states now license adult foster/family care under their assisted living regulations. For example, North Carolina's statute defines adult family homes as serving two to six residents and adult care homes serve seven or more residents, but licenses both settings as assisted living residences.

Thirteen states (Alabama, Connecticut, Georgia, Kentucky, Louisiana, New Hampshire, New Mexico, North Carolina, Oklahoma, Rhode Island, South Carolina, South Dakota, and Utah) define at least one licensing category to include all residential care settings that serve one or more residents. Three states (Florida, Minnesota, and Tennessee) have a threshold of two or more, and eight states (Alaska, Arkansas, Colorado, Idaho, Illinois, Massachusetts, Missouri, and Vermont) have a threshold of three or more. A few states have different thresholds within a licensing category.

Consequently, in some states, the number of people served is no longer a major factor distinguishing the licensing category of adult foster/family care from that of assisted living. However, these states may still designate the number of people who may be served to distinguish between types of settings for other regulatory purposes, e.g., staffing requirements. Information about thresholds is generally noted in the state summary tables in Part III of this compendium.

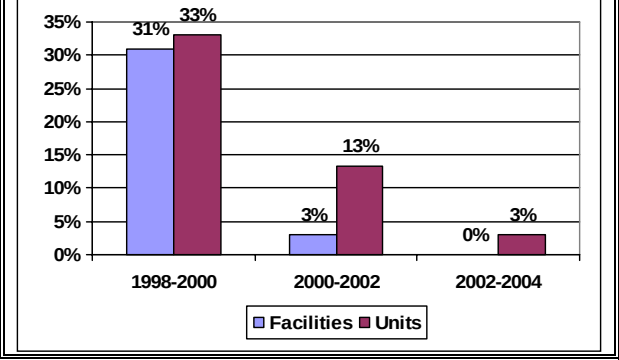
Residential care is an important long-term care service option, particularly for individuals who cannot live alone but do not require the skilled level of care that nursing homes provide. The purpose of this compendium is to inform residential care policy by

providing detailed information about each state's approach to regulating residential care, as well as its funding for services in these settings.

OVERVIEW OF POLICY DEVELOPMENTS SINCE 2002

In 2004, states reported 36,451 licensed residential care facilities with 937,601 units/beds compared to 36,283 facilities with 909,196 units/beds in 2002; these numbers do not include facilities licensed as adult foster/family care or facilities licensed by Departments of Mental Retardation/Developmental Disabilities (MR/DD) or Mental Health.[1] Compared to the previous four years, the growth rate in the supply of licensed facilities was basically flat between 2002 and 2004, and the number of number of units or beds rose only 3 percent. See Figure 1-1 for a comparison of growth rates in these years.

FIGURE 1-1. Supply Changes



While growth was considerably higher between 1998 and 2000--30 percent nationwide--much of that increase resulted from high growth rates in a few states (214 percent in Delaware; 144 percent in Iowa, 139 percent in New Jersey, and 119 percent in Wisconsin); and ten states with growth rates between 40 percent and 100 percent (Alaska, Arizona, Kansas, Indiana, Massachusetts, Minnesota, Nebraska, New York, South Dakota, and Texas). Between 2000 and 2002, only two states, Arizona and Kansas, reported growth above 40 percent, and three--Nebraska, Nevada, and New Jersey--above 36 percent.

While the growth rate in units/beds nationwide was only 3 percent between 2002 and 2004, growth in ten states exceeded 20 percent (Alabama, Delaware, Hawaii, Kansas, Louisiana, Michigan, New Jersey, Oregon, Utah, and Wisconsin) as smaller facilities closed and larger, new facilities were licensed. Seven states reported a decline in the number of facilities but modest growth in the number of units (Colorado, Florida, North Carolina, Oklahoma, Pennsylvania, South Carolina, and Tennessee). Oregon extended a moratorium on new assisted living and residential care facilities. In 2004, three states --California, Florida and Pennsylvania--account for 33 percent of all units/beds, down slightly from 34 percent in 2002 and 36 percent in 2000.

[1] The data were reported by state licensing agencies. Partial information was reported for some categories in Delaware, Kentucky, Minnesota, New Jersey, New York, New Mexico and West Virginia. (See Table 2-1 in Section 2 for each state's information.) While these numbers do not include facilities licensed by state Mental Retardation/Developmental Disabilities (MR/DD) agencies, some individuals with MR/DD may be living in facilities licensed as residential care/assisted living.

The 2004 review of state policy and activity found that regulation of residential care settings continues to evolve. Regulatory changes tend to address the challenges posed by serving frailer and sicker residents and concerns among state licensing staff about inappropriate retention, adequacy of care, and the shortage of trained staff. Provisions revised include those related to staffing requirements, direct care and administrative training requirements, criminal background checks, admission and retention criteria, disclosure requirements, and resident agreements.

Twenty-eight states revised their regulations in 2003 and 2004, and 22 states reported current activity to revise regulations. States continue to address the need for specialized care for residents with Alzheimer's disease and other dementias; 44 states now have requirements for residential care facilities serving people with dementia**.** These requirements address disclosure, services available, admission/discharge criteria, staffing, training, activities, environment, and security. Twenty-six states have specific disclosure requirements for facilities that market themselves as special care facilities for persons with dementia.

States also continue to revise their residential care regulations to add a service philosophy. Finally, the number of states using the term assisted living for residential care settings continues to increase. Since 2002 the term was adopted in Rhode Island, Vermont, and in statute in New Hampshire (regulations were still being drafted in 2004). Forty-one states and the District of Columbia now have a licensing category or statute that uses the term *assisted living.*

TABLE 1-1. Number of Medicaid Waiver Clients in Residential Settings (selected states)

State	2000	2002	2004
Arizona	1,240	2,300	3,067
Colorado	2,654	3,773	3,804
Florida[1]	1,458	2,681	4,167
Georgia	2,262	2,759	2,851
Minnesota[2]	397	2,895	4,144
New Jersey	699	1,500	2,195
Oregon[1]	2,572	3,600	3,731
Washington[1]	2,919	3,762	4,404

1. These states also serve individuals in residential care settings using the Medicaid state plan personal care option: Florida (14,188), Oregon (1,127), and Washington (1,331).
2. Minnesota also serves 2,238 people in residential care through a state funded program.

Another continuing trend is the increase in Medicaid coverage of services in residential care settings. In 2004, 41 states reported serving about 121,000 residents in residential care settings--including assisted living but excluding adult foster/family care--up from 102,000 in 2002.[2] Since 2002, Medicaid coverage has been implemented in Arkansas,

[2] The number of residents receiving Medicaid in residential care settings is slightly underreported because it does not include data from Kansas. Kansas' reporting system does not differentiate between waiver clients served in their own homes and those served in residential care settings. Additionally, Alabama and the District of Columbia have not yet implemented approved 1915(c) waivers.

extended to a new licensing category of residential care in Vermont, and approved in Alabama and the District of Columbia. California is developing a 1915(c) waiver application for a demonstration project. CMS approved a Medicaid HCBS waiver for West Virginia to conduct a pilot program in public housing sites in four counties. The number of people served under Medicaid grew more slowly between 2002 and 2004 compared to earlier years. Table 1-1 presents the number served under Medicaid waivers in six states over a 4-year period.

TABLE 1-2. Summary of Activities in Residential Care Policy Since 2002

State	Activities	Public Financing
Alabama	The state revised rules governing building requirements for assisted living facilities and special care assisted living facilities in July 2003; and revised provisions for incident investigations provisions in 2004. A waiver to serve persons with dementia in assisted living facilities has been approved but not implemented due to budget constraints.	Medicaid Waiver approved
Alaska	The state is consolidating state licensing statutes, which are expected to be completed in 2004 and effective by the end of 2005. The state transferred the Assisted Living Licensing Unit from the Division of Senior and Disability Services to the Division of Public Health.	Medicaid Waiver
Arizona	The state is forming a small workgroup to make recommendations for revisions to the assisted living rules which were expected to be final by the end of 2004.	Medicaid Waiver
Arkansas	The state approved rules for a new category of assisted living. A Medicaid waiver was approved to cover services in ALFs. Personal care services in RCFs are covered under the Medicaid state plan.	Medicaid State Plan Waiver Planned
California	State agencies are studying broad changes to the regulations. A task force has been formed to develop Medicaid coverage for two models: licensed residential care facilities and supportive housing and services.	Medicaid Waiver Planned
Connecticut	The state is reviewing provisions related to the level of care provided by managed residential communities. The state revised medication administration rules in 2002. The state's Housing Finance Agency and Medicaid are implementing a pilot affordable assisted living program.	Medicaid Waiver State funds
Colorado	The state approved rules changing the licensing category to assisted living and adding intermediate sanctions in March 2004.	Medicaid Waiver State funds
Delaware	Changes in the definition of "incident" and "reportable" have been proposed by the state's licensing agency in 2004.	Medicaid Waiver State funds
District of Columbia	An RFP has been issued to develop rules for an assisted living category approved by the District Council. The Medicaid waiver will be implemented once the rules are adopted.	Medicaid Waiver approved
Florida	The state is considering technical changes to the assisted living regulations. The Department of Elder Affairs transferred responsibility for training administrators and direct care workers to private organizations.	Medicaid Waiver State Plan
Georgia	The state issued rules for a new residential care category called community living arrangements in 2002.	Medicaid Waiver
Hawaii	The licensing agency is planning to establish licensing fees that would be used for training and other activities related to licensing. The state is considering changes to the structural requirements for facilities.	Medicaid Waiver
Idaho	The state is reviewing residential care statutes and rules and is developing draft revisions for comment in 2004.	Medicaid Waiver
Illinois	The state modified life safety code requirements for shelter care facilities rules in 2003. In 2004, the licensing agency proposed rules allowing designation of licensed units in assisted living and shared	Medicaid Waiver

	housing establishments.	

TABLE 1-2 *(continued)*

State	Activities	Public Financing
Indiana	The state revised regulations in 2003.	Medicaid Waiver
Iowa	Revised regulations became effective in May 2004. The state has transferred oversight authority from the Department on Aging to the Department of Inspection and Appeals.	Medicaid Waiver
Kansas	The state transferred responsibility for regulating assisted living facilities to the Department of Aging in 2004.	Medicaid Waiver
Kentucky	No reported changes since 2001.	None
Louisiana	The state will consider revisions to the regulations dealing with dementia care, negotiated risk agreements, and other issues during 2004 and 2005.	Medicaid Waiver for demonstration planned
Maine	New regulations consolidating several categories of assisted living (congregate housing, residential care facilities, and adult family homes) became effective in September 2003.	Medicaid Waiver State Plan State funds
Maryland	The state formed a work group in 2003 to conduct a thorough review of the regulations and recommend changes to the legislature at the end of 2004.	Medicaid Waiver State funds
Massachusetts	The state revised regulations in December 2002 and continues to review statutes and regulations to determine if further changes are needed.	Medicaid State Plan
Michigan	In 2004, the licensing agency submitted revisions to the Homes for the Aged rules to the legislature for review before being promulgated. * *Michigan's Medicaid waiver serves residents in elderly housing buildings that are called assisted living but are not required to be licensed.*	Medicaid Waiver* State Plan
Minnesota	The state adopted new training requirements for facilities that serve people with dementia in 2003. The state amended its waiver to cover residents with incomes up to 300 percent of the federal SSI benefit in 2003.	Medicaid Waiver
Mississippi	The state adopted rule revisions in 2002 and 2003. The most significant change expanded requirements for criminal background checks.	Medicaid Waiver
Missouri	The Department of Health and Senior Services submitted revisions addressing fire safety and evacuation and administrator requirements to the Board of Health. The changes are expected to be finalized in the fall of 2004.	Medicaid State Plan
Montana	In 2003, the state enacted legislation changing the licensing category from personal care facilities to assisted living and modifying the requirements for assisted living facilities. The state is working on regulations, which are expected to be effective in May 2004. The state developed separate requirements for facilities serving people with dementia.	Medicaid Waiver
Nebraska	The state revised its regulations for assisted living facilities in 2003. Facilities may not use the assisted living term unless they are licensed.	Medicaid Waiver
Nevada	In 2004, the state amended its Medicaid waiver to cover a broader array of services in assisted living and clarified various definitions in the licensing rules. The state also enacted a new law limiting sharing of units to two residents by consent and requires toilet facilities in each unit.	Medicaid Waiver
New Hampshire	The state is still revising rules for its assisted living category and will operate under expired rules until the new rules are issued.	Medicaid Waiver
New Jersey	The regulations expire in 2004 and the state is drafting revisions, which will be published in the fall of 2004. In the same year, the state enacted legislation establishing training requirements for staff serving people with dementia.	Medicaid Waiver

TABLE 1-2 *(continued)*		
State	**Activities**	**Public Financing**
New Mexico	The state is revising rules for adult residential care facilities. A Committee formed by the Department of Health is working on revisions to education and training requirements for direct care workers and administrators, which are expected to be finalized in 2004.	Medicaid Waiver
New York	In 2004, the state enacted an assisted living reform law creating a new level of service for assisted living facilities. Facilities may obtain a certificate allowing them to offer enhanced assisted living services to support aging in place.	Medicaid State Plan
North Carolina	The state gave its Division of Facility Services temporary rule making authority to enable it to respond quickly to priority issues such as discharge requirements, compliance, and training.	Medicaid State Plan
North Dakota	In 2003, the state replaced its registration process for assisted living programs (housing with services) with new licensing requirements.	Medicaid Waiver State funds
Ohio	The state is revising its residential care facility rules.	None
Oklahoma	In 2004, the Department of Health proposed rules to change physical plant standards.	None
Oregon	The state extended a moratorium on new assisted living facilities until June 2005. The state adopted substantial changes to the regulations for residential care facilities in 2004, and revised requirements for criminal background checks.	Medicaid Waiver
Pennsylvania	The state expects to finalize revisions to its personal care home rules in September 2004. Legislation is pending that would create an assisted living services licensing program and expand Medicaid coverage of assisted living services.	Medicaid Waiver pilot
Rhode Island	The state implemented rule revisions in 2004, which address dementia training requirements, quality improvement, staff training, functional assessments, and care philosophy. The state also implemented a pilot residential care project for low-income persons, designed by the state Department of Elderly Affairs and the RI Housing Finance Agency.	Medicaid Waiver
South Carolina	The state issued guidelines for conducting criminal background check in October 2002 and enacted legislation allowing trained aides to administer selected prescribed medications. Coverage under the Medicaid state plan was implemented.	Medicaid State Plan
South Dakota	The state made minor rule changes in December 2002 and is working on revisions to the life safety code. The state is planning to amend its Medicaid waiver to broaden coverage of services available in assisted living centers.	Medicaid Waiver State funds
Tennessee	The state revised assisted care living facility rules in 2003, which addressed reporting of unusual events, policies and procedures for health care decision-making for incompetent residents, and the retention of residents.	None
Texas	The state revised regulations in 2002 and 2003 and is considering further revisions that would authorize electronic monitoring, set an administrative penalty schedule, and require central air conditioning in new facilities.	Medicaid Waiver
Utah	The state revised rules in 2002 and has formed a work group to review provisions regarding medication administration. In 2004, the state expanded its Medicaid state plan managed care program that covers assisted living.	Expanded Medicaid State Plan
Vermont	New regulations for a category of assisted living were made effective in March 2003. Medicaid waiver coverage was extended to assisted living residences, and the state has implemented a program to reimburse for “assistive care services” under the Medicaid state plan.	Medicaid Waiver State Plan

TABLE 1-2 *(continued)*		
State	**Activities**	**Public Financing**
Virginia	The state is reviewing regulations. Some revisions were made effective in March 2003. **Virginia uses state funds to support a limited number of residents formerly served under a discontinued waiver.*	None*
Washington	The state has completed a two year process for revising its regulations. Revisions will be effective in September 2004. The state also revised its Medicaid reimbursement methodology and implemented a case mix reimbursement system in 2003.	Medicaid Waiver State Plan
West Virginia	In 2004, the state received CMS approval for a pilot Medicaid waiver to serve elders in converted public housing buildings in four counties. In 2003, the state combined personal care homes and residential board and care homes into one category of assisted living residences. The state finalized rules for assisted living residences in February 2004.	Medicaid Waiver pilot
Wisconsin	The state is working with providers and stakeholders to develop strategies to improve quality and to identify needed changes in the rules for Community Based Residential Facilities.	Medicaid Waiver State Plan
Wyoming	No reported changes since 2001.	Medicaid Waiver

DEFINING ASSISTED LIVING

The widespread use of the term assisted living and the considerable state variability in its definition continues to fuel debate about what assisted living is and should be, how it should be regulated, particularly as the number of residents with higher levels of need increases, and whether facilities that do not support key assisted living principles should use the term.

States historically have licensed two general types of residential care: (1) adult foster care or family care, which typically serves five or fewer residents in a provider's home; and (2) group residential care that typically serves six or more residents in a range of settings (from large residential homes to settings that look like commercial apartment buildings or nursing homes). States have used many names for these larger group residential care settings, including: board and care homes, rest homes, adult care home, domiciliary care homes, personal care homes, community-based residential facilities, and assisted living. Until recently, the most frequently used term was board and care, though today all types of group residential care are generally referred to as assisted living.

The physical character of a substantial portion of older group residential care facilities is quite institutional, with two to four persons sharing a bedroom, and as many as eight to ten residents sharing a bathroom. Concerned about the institutional character of these settings, policymakers in Oregon--and gradually in other states--developed a new licensing category called assisted living. What was new and desirable about assisted living was that it offered residents what traditional board and care facilities did not--a philosophy of care that emphasized privacy and the ability to have greater control over daily activities such as sleeping, eating, and bathing.

Consumer preference for the new assisted living model of residential care led providers to market all types of residential care facilities as "assisted living"--whether or not they provided private units or operated with a service philosophy that assures resident autonomy. Forty-one states and the District of Columbia now use the term assisted living in their residential care regulations. In some states, assisted living is a specific model with a consumer-centered service philosophy, private apartments or units, and a broad array of services which support aging-in-place. In others states, residential care licensing categories have been consolidated under a new general set of "assisted living" rules that might cover the new model of assisted living, as well as board and care, multi-unit elderly housing, congregate housing and sometimes even adult family or foster care (e.g., Maine, Maryland, and North Carolina).

Assisted living may be *a licensed setting* in which services are delivered or *a licensed agency* that delivers services in a range of settings. Four states (Connecticut, Maine, Minnesota, and New Jersey) describe assisted living *services* that may be provided in two or more settings. 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). Other 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. See Box 1-1 for a more detailed description of state's licensing and regulatory approaches.

Generic use of the term assisted living obscures the differences between types of residential care settings, and makes it difficult for consumers to determine which setting will best meet their current and future needs. A recent study of six states' use of Medicaid to fund services in residential care settings, stakeholders in every state except Oregon cited public confusion about residential care options as a major problem.[3]

In 2000, the U.S. Senate Aging Committee held a hearing and challenged the industry to address concerns raised in a General Accountability Office (GAO) report, one of which was the lack of a common definition of assisted living and resulting consumer confusion about this long-term care option. This and subsequent hearings led to the formation of the Assisted Living Workgroup (ALW) designed to bring together assisted living stakeholders to make recommendations to ensure high-quality care for all assisted living residents and to develop a common definition. The workgroup included over 50 organizations with a variety of interests including industry associations, professional organizations, consumer and advocacy groups, and regulators. See Box 1-2 for examples of various definitions of assisted living, including the one proposed by the ALW.

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[3] The six states were Florida, Minnesota, Oregon, North Carolina, Texas, and Wisconsin. Oregon is the only state of the six that requires assisted living providers to offer private apartments. (See Janet O'Keeffe, Christine O'Keeffe, and Shula Bernard. *Using Medicaid to Cover Services for Elderly Persons in Residential Care Settings: State Policy Maker and Stakeholder Views in Six States.* Report prepared for the U.S. Department of Health and Human Services, Office of Disability, Aging, and Long-Term Care Policy.)

BOX 1-1. State Licensing and Regulatory Approaches

Institutional Model. This model has minimum building and unit requirements; typically, multiple occupancy bedrooms without attached baths, and shared toilets, lavatories, and tub/shower areas. Generally, states permit these facilities to serve people who need assistance with activities of daily living (ADLs). But they either do not allow nursing home eligible residents to be admitted or do not allow facilities to provide nursing services. Historically, this model did not allow residents who met the criteria for placement in a nursing home to be served. However, as residents have aged in place, some states have made their rules more flexible to allow a higher level of service. For example, some states allow skilled nursing services to be provided for limited periods by a certified home health agency. North Carolina is one of the states that using this approach.

Housing and Services Model. This model licenses or certifies facilities to provide a broad range of long-term care services in apartment settings to persons with varying service needs, some of whom may be nursing home eligible. The state allows providers to offer relatively high levels of care, although licensed facilities may set their own admission/retention polices within state parameters and may choose to limit the acuity of its residents. Depending on the state, some or all of the needs met in a nursing home may also be met in residential care settings. By creating a separate licensing category for this model and retaining other categories, states distinguish these facilities from board and care facilities. Oregon is one of the states using this approach.

Service Model. This model licenses the service provider, 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. Approaches for regulating services may also specify the type of buildings, apartment or living space that can qualify as assisted living. Minnesota is one of the states using this approach.

Umbrella Model. This model uses one set of regulations to cover two or more types of housing and services arrangements: residential care facilities, congregate housing, multi-unit or conventional elderly housing, adult family care, and assisted living. Maine is one of the states using this approach.

Multiple Levels of Licensing for a Single Category. Some states set different licensing requirements for facilities in a single category, based on the extent of the assistance the facility provides or arranges and on the type of residents served. For example, Maryland licenses facilities based on the characteristics of residents they serve. The state categorizes low-, moderate-, and high-need residents based on criteria for health and wellness, functional status, medication and treatment, behavior, psychological health, and social/recreational needs. The state may grant a limited number of waivers to facilities allowing them to serve residents who develop needs that exceed the facility's licensing level.

Some of these approaches are not mutually exclusive and may be combined.

As states allow residential care settings to provide more health-related and nursing services, many observers believe that the key challenge in defining assisted living is to distinguish it from nursing homes while recognizing that both settings may serve some similar residents.

Federal law defines a nursing facility as an institution (or a distinct part of an institution) that is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, rehabilitation services for injured,

disabled, or sick persons (a skilled level of care), *or* on a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities (the minimum level of care).[4]

BOX 1-2. Examples of Definitions of Assisted Living

Assisted Living Workgroup[5]

Assisted living is a state regulated and monitored residential long term care option. Assisted living provides or coordinates oversight and services to meet the residents' individualized scheduled needs, based on the residents' assessments and service plans and their unscheduled needs as they arise. Services that are required by state law and regulation to be provided or coordinated must include but are not limited to:

- 24-hour awake staff to provide oversight and meet scheduled and unscheduled needs
- Provision and oversight of personal care and supportive services
- Health related services (e.g., medication management services)
- Meals, housekeeping, and laundry
- Recreational activities
- Transportation and social services

These services are disclosed and agreed to in the contract between the provider and resident. Assisted living does not generally provide ongoing, 24-hour skilled nursing. It is distinguished from other residential long-term care options by the types of services that it is licensed to perform in accordance with a philosophy of service delivery that is designed to maximize individual choice, dignity, autonomy, independence, and quality of life.

Joint Commission on Accreditation of Healthcare Organizations

An assisted living residence is "a congregate residential setting that provides or coordinates personal services, 24-hour supervision and assistance (scheduled and unscheduled), activities, and health-related services. It is designed to minimize the need to move; accommodate individual residents' changing needs and preferences; maximize residents' dignity, autonomy, privacy, independence, choice and safety; and encourage family and community involvement."[6]

Oregon

Assisted living means a building, complex or distinct part thereof, consisting of fully self-contained individual living units where six or more seniors and persons with disabilities may reside. The facility offers and coordinates a range of supportive personal services available on a 24-hour basis to meet the ADL, health services, and social needs of the residents described in these rules. A program approach is used to promote resident self-direction and participation in decisions that emphasize choice, dignity, privacy, individuality, independence and homelike surroundings." No facility in Oregon may use the term assisted living unless they are licensed.

Many individuals who qualify for Medicaid coverage of nursing home care--particularly those who do not require a skilled level of care--receive care at home from family

[4] 42 U.S.C. 1396r.
[5] The ALW final report and recommendations may be found at http://www.aahsa.org/alw.htm.
[6] Joint Commission on Accreditation of Healthcare Organizations. 2003-2005 Accreditation Manual for Assisted Living.

members, home health agencies and publicly funded programs such as the Medicaid home and community-based services (HCBS) waiver program. Because HCBS programs may only serve Medicaid beneficiaries who meet each state's nursing home criteria, their emergence challenged the assumption that persons who needed nursing home care could only be served in a nursing home. It is now recognized that many nursing home eligible persons can be appropriately served in multiple settings, including residential care settings.

Because HCBS waiver programs serve some nursing home eligible persons in home and residential care settings, it is not really possible to develop mutually exclusive definitions for nursing homes and residential care, except for the provision of a skilled level of care. Doing so would severely limit states' ability to offer these residential care settings as a service alternative for nursing home eligible persons. States want to be able to serve at least some nursing home eligible individuals in more homelike residential care settings without imposing the nursing homes' regulatory structure.

Some observers believe there is perhaps too much emphasis on developing a common definition of assisted living given that all 50 states have the authority to define it how they want. Some believe that a better approach would describe assisted living in a way that recognizes the overlap of needs that can be met and the services that can be offered by both nursing homes and assisted living, yet highlights differences between them. One state regulator has suggested the following definition--"Assisted living is a facility which provides housing, meals and long-term care services in a group residential setting that is not a nursing home"--adding that specific requirements for different types of assisted living should then be spelled out in regulation. At the same time, providers need to understand what their liability is in taking a medically fragile individual and their requirements to meet a resident's needs.[7]

To help prospective residents understand the differences between nursing homes and different types of residential care, some states might require--as Oregon does--that facilities use standardized disclosure forms to describe their scope of service, rate structure, caregiver and nursing staff levels. Many believe that this approach will be much more helpful for consumers than a uniform definition of assisted living.

In short, individuals with health needs and impaired abilities can be served in a range of settings by a variety of service providers: home health agencies, home care agencies, adult day care, different types of residential care (adult foster care, board and care, assisted living), and nursing homes. Residential care is an important service option for people who cannot live alone and do not have informal care.

States have the responsibility for regulating residential care settings and their definitions and approaches reflect each state's unique policy environment and preferences. Consequently, development of a standard definition of assisted living is unlikely. The

[7] Wendy Fearnside, Program and Planning Analyst, Bureau of Aging and Long Term Care Resources, Wisconsin Department of Health and Family Services.

approach to defining and categorizing residential care for research purposes depends on the research question. One national survey grouped facilities according to the level of services and the amount of privacy they offered (high and low).[8] A study comparing resident outcomes in residential care and nursing homes would need to categorize facilities according to characteristics relevant to outcomes, such as staffing levels and the provision of nursing services and oversight.

ASSISTED LIVING PHILOSOPHY

Twenty-nine states and the District of Columbia reported that they include provisions regarding assisted living concepts such as privacy, autonomy and decision making in their residential care regulations or Medicaid standards. (See Table 1-3.) Some states regulations are more detailed in these matters, others are less so. For example, regulations may state the importance of privacy, but only 11 states with a statement of the philosophy of assisted living require private apartment units;[9] five have mixed requirements, allowing bedrooms in some settings and individuality apartments in new construction; and 14 allow sharing (apartments or bedrooms) only by resident choice. (See section on *Occupancy Requirements and Privacy* for additional information.) Examples of state provisions that reference assisted living principles follow.

TABLE 1-3. States with Regulations that Include Assisted Living Philosophy

Alaska	Iowa	Nevada	Rhode Island
Arizona	Kansas	New Jersey	South Carolina
Arkansas	Louisiana	New Mexico	Texas
District of Columbia	Maine	New York	Vermont
Florida	Maryland	North Dakota	Washington
Hawaii	Massachusetts	Oklahoma	Wisconsin
Idaho	Montana	Oregon	Wyoming
Illinois	Nebraska		

- ***Florida's*** statute describes the purpose of assisted living as "to promote availability of appropriate services for elderly and disabled persons in the least restrictive and most homelike environment, to encourage the development of facilities which promote the dignity, privacy and decision-making ability" of residents. The Florida law also states that facilities should be operated and regulated as residential environments and not as medical or nursing facilities. Regulations require that facilities develop policies to maximize independence, dignity, choice, and decision-making.

[8] Catherine Hawes, Ph.D. and Charles D. Phillips, Ph.D., M.P.H. *A National Study of Assisted Living for the Frail Elderly: Final Summary Report*. Texas A&M University System Health Science Center. US DHHS, Office of the Assistant Secretary for Planning and Evaluation, contract number HHS-100-94-0024 and HHS-100-98-0013. November 2000.

[9] Oregon defines a "unit" as an individual living space constructed as a completely private apartment, including living and sleeping space, kitchen area, bathroom and adequate storage areas.

- ***Illinois'*** statute defines assisted living, in part, as a model that (1) assumes that residents are able to direct their services and will designate a representative to direct them if they are unable to do so; and (2) supports the principle that there is an acceptable balance between consumer protection and resident willingness to accept risk and that most consumers are competent to make their own judgments about the services they are obtaining. The statute states that regulation of assisted living establishments and shared housing establishments "shall be operated in a manner that provides the least restrictive and most homelike environment and that promotes independence, autonomy, individuality, privacy, dignity, and the right to negotiated risk in residential surroundings."

- ***New Jersey*** requires facilities to 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 homelike environment," as well as "aging in place and shared responsibility."

- ***Texas'*** authorizing statute specifies that rules must be developed to promote policies that maximize the dignity, autonomy, privacy, and independence of each resident; and that service delivery should be driven by a philosophy that emphasizes personal dignity, autonomy, independence, and privacy and should enhance a person's ability to age in place.

- ***Oregon,*** the first state to adopt a specific philosophy for assisted living, states that: "Assisted living … is a program that promotes resident self-direction and participation in decisions that emphasize choice, dignity, privacy, individuality, independence and homelike surroundings."

- ***Washington*** requires that the basic training curriculum for staff in residential care settings includes instruction on how to perform tasks while incorporating resident preferences; how to maintain residents' privacy and dignity; and how to create opportunities that encourage resident independence.

Unless states operationalize assisted living concepts as specific regulatory requirements--for example, assuring privacy by requiring private rooms or apartments--the choices that facilities make in their physical and organizational structures and their service and training policies will generally determine whether the state's intent is realized. In the absence of specific regulatory requirements, it may be difficult to determine whether a facility is carrying out the regulations' philosophy.

Consumer advocates have questioned whether staff that inspect or survey nursing facilities should also inspect residential care facilities operating under an assisted living philosophy and related rules, without having specific training about this philosophy. Some states provide this training (e.g., Texas requires training for state inspectors on how assisted living differs from nursing homes). The National Academy of State Health

Policy (NASHP) 2002 survey of state licensing agencies found that 24 states use different staff to survey residential care facilities than they use for nursing facilities; survey staff in the remaining states inspect both.

Negotiated Risk Agreements

As illustrated in the examples above, assuring resident autonomy is a central concept in the assisted living philosophy. Fifteen states and District of Columbia have regulations referencing a process or approach for negotiating disagreements about residents' autonomy and risk taking and providers' concerns about risk (Alaska, Arkansas, Delaware, Florida, Hawaii, Illinois, Iowa, Kansas, New Jersey, Ohio, Oklahoma, Oregon, Vermont, Washington, and Wisconsin.) States use different terms to describe the process--negotiated risk, managed risk, shared responsibility, compliance agreement, and negotiated plan of care.

Despite differences in the term, most of the regulations share common features, such as requiring that the agreement be written and signed by the resident and the appropriate facility administrator. State regulations typically require that the agreement describe the possible consequences of the resident's actions, the specific concerns of the facility, options that will both minimize the risk and respect resident's choices. They also generally require documentation of the negotiation process, and agreement or lack thereof, and the decision reached by the resident after consideration of the facility's concerns. Several states allow surrogates or sponsors to negotiate risk agreements.

Examples of state's specific provisions follow.

- The ***District of Columbia*** defines a shared responsibility agreement is a "tool to recognize a resident's right to autonomy by respecting his or her right to make individual decisions regarding lifestyle, personal behavior, safety and individual service plans.

- ***New Jersey*** defines managed risk as the process of balancing residents' choice and independence with the health and safety needs 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, the facility may discuss such risks or consequences with the resident (and their representative if the resident wants). The facility can then negotiate with the resident a formal plan to avoid or reduce negative or adverse outcomes.

- ***Oregon's*** rules do not allow managed risk plans "with or on behalf of a resident who is unable to recognize the consequences of his/her behavior or choices."

- ***Vermont's*** rules require that the facility notify the resident that the state Long Term Care Ombudsman is available to assist in the negotiated risk process.

- ***Wisconsin's*** rules state that risk agreements do not mitigate or waiver any tenant's rights.

State licensing officials indicated that the negotiated risk process is not widely used.

OCCUPANCY REQUIREMENTS AND PRIVACY

Historically, the physical character of a substantial portion of residential care was quite institutional--as permitted by state regulation--with two to four persons sharing a bedroom, and as many as eight to ten residents sharing toilet and bathing facilities. The new assisted living model of residential care became popular with older people in large part because it offers what traditional board and care facilities generally do not: privacy and the concomitant opportunity to have greater control over daily activities such as eating and sleeping. Another reason for its popularity is that assisted living facilities built in the 1990s have more desirable physical environments than do board and care facilities, many of which were built in the 1960s and 1970s.

Consequently, single occupancy apartments or rooms dominate the assisted living private-pay market. A survey of non-profit facilities conducted in 1999 by the Association of Homes and Services for the Aging found that 76 percent of the units in free-standing facilities and 89 percent of units in multi-level facilities were private (studio, one-, or two-bedroom units).[10] A similar survey by the Assisted Living Federation of America found that 87.4 percent of units in its member facilities were studio, one-, or two-bedroom units and 12.6 percent were semi-private.[11] In a national survey of assisted living facilities in the late 1990s, Hawes, et al. found that 73 percent of the units were private, 25 percent of the units were semi-private (shared by two unrelated persons), and 2 percent were "ward-type" rooms that housed three or more unrelated persons.[12]

A 1998 survey of assisted living facilities by the National Investment Conference (NIC) found that 17 percent of the residents shared a unit. Of these, 52 percent said that they shared their unit for economic reasons, 30.4 percent for companionship, and 14.9 percent because a private unit was not available. Just under 65 percent of those who shared a unit were satisfied with the arrangement and 35.7 percent preferred a single unit.[13]

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[10] Ruth Gulyas. *The Not-for-Profit Assisted Living Industry: 1997 Profile*. American Association of Homes and Services for the Aging. Washington DC. 1997. Also, *2000 Overview of the Assisted Living Industry*. The Assisted Living Federation of America and Coopers and Lybrand. Washington, DC. 2000.

[11] Ronald K. Tinsely, Robert G. Kramer, et al. *Overview of the Assisted Living Industry.* Assisted Living Federation of America. Fairfax, VA. 2000.

[12] Hawes et al., *op. cit.*

[13] *National Survey of Assisted Living Residents: Who Is The Customer?* National Investment Conference and the Assisted Living Federation of America. Washington, DC. 1998.

Nationally, consumer demand, the availability of subsidized units, and the extent of competition are more likely than regulatory policy to determine whether studio or apartment-style living units are available for private pay residents. However, for Medicaid eligible residents, state regulatory policy and Medicaid policy determine the types of units available. For example, Medicaid contracting requirements in Washington require participating facilities to provide private apartments shared only by choice.

Due to the popularity of assisted living, many providers of all types of residential care settings market themselves as assisted living, whether or not they give all private rooms to all residents. Some board and care homes that want to be licensed as assisted living may have an interest in opposing rules requiring apartment-style units and single occupancy. On the other hand, advocates of assisted living as a unique model of care oppose the use of the term assisted living by facilities that do offer private rooms or units to all residents. Consequently, occupancy requirements have become a contentious issue. States have taken a number of approaches to setting occupancy requirements.

Some states have simply amended their statutes to rename board and care homes as assisted living and continue to permit dual occupancy. Others have allowed dual occupancy standards in grandfathered buildings but require new buildings to offer single occupancy units. Some states maintain separate licensing categories, allowing dual occupancy in some settings and requiring single occupancy in others. Several states have multiple licensing categories, and the two-person limit may apply to only one of the categories.

Thirty-five states have rules that allow two people to share a unit or bedroom. Several of these states have multiple licensing categories, and the two-person limit may apply to only one of the categories. Ten states have licensing categories that allow four people to share a room; three states allow three people to share units. A few states to do not specify how many people may share a bedroom.

States that have developed a multiple-setting assisted living model vary the requirements by the setting. For example, 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. Additional examples of states’ requirements follow.

- ***Florida*** licenses two types of assisted living, one which allows up to four people to share a bedroom, and extended congregate care, which requires private apartments or private rooms shared only by a resident’s choice.

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

- ***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).

Four people may share a room under what might be considered board and care licensing rules in Delaware, Georgia, Indiana, Iowa, Michigan, Mississippi, Missouri, Nebraska, Pennsylvania, Rhode Island, South Carolina, and Virginia. Shared toilet facilities and bathing facilities are the rule among states with board and care regulations. State rules that allow bedrooms to be shared by two to four residents require bathrooms and lavatories for every six to ten residents.

While a state's policy sets the parameters for what may be offered and provided, the actual practice may be narrower. 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 the assisted living model may offer shared units while most, if not all, newly constructed buildings have predominantly or solely private units.

DISCLOSURE REQUIREMENTS AND RESIDENCY AGREEMENTS

A GAO study of assisted living facilities in four states concluded that while most facilities provide information about the services available, they do not routinely provide information about discharge criteria, staff training and qualifications, services not available from the facility, grievance procedures, and medication policies. The GAO report concluded that the need to provide adequate information to prospective and current residents is a major issue that requires additional oversight.[14]

With few exceptions, states that license residential care require facilities to include specific information in residency agreements. Two states do not require residency agreements and Connecticut and Minnesota do not use residency agreements because they license the service provider and the housing provider executes a lease agreement with tenants. Table 1-4 lists the type of information that states may provide in resident agreements and the number of states that require the provision of this information.

[14] *"Assisted Living: Quality of Care and Consumer Protection Issues."* GAO. T-HEHS-99-111. April 26, 1999.

TABLE 1-4. Residency Agreement Provisions			
Topics Covered	**States Requiring**	**Topics Covered**	**States Requiring**
Services included in basic rate	49	Grievance procedures	21
Cost of service package	44	Termination (including admission and discharge)	20
Admission/discharge	29	Terms of occupancy	18
Refund policy	29	Temporary absences	14
Cost of additional services	27	Accommodations	12
Service beyond basic rate	26	Advance payments	7
Rate changes	25	Period covered	11
Payment/billing	23	Services not available	9
Residents rights	22	Other	20

As can be seen, the majority of states provide information about services, but only about half or less provide information about most of the other topics. Few states require information about medication policy and staffing.

Examples of "other" requirements follow:

- ***Colorado*** requires facilities to disclose whether it has an automatic sprinkler system.

- ***Kansas*** requires facilities to give prospective residents citations of relevant statutes, information on advance medical directives, resident rights, and the facility's grievance procedure, before an agreement is signed.

- ***Maine*** does not allow the resident agreement to contain any provision for discharge which is inconsistent with state rules or law or which implies 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.

- ***Maryland*** requires 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. The state also requires facilities to disclose policies concerning shared occupancy and procedures that will be followed when a resident's accommodations are changed due to relocation, change in roommate assignment, or an adjustment in the number of residents sharing a unit.

- ***New Hampshire*** issued regulations in 2003 requiring disclosure of information to allow residents to compare assisted living residences, independent retirement communities and elder housing, in order to make an informed choice about where to live. The state requires facilities to disclose whether they are licensed; the basic rate; the personal care and other services included in the rate; meals provided; transportation services; recreation and leisure activities; amenities in the living unit; policies regarding deposits/advance payment requirements and

refundability; services not included in the basic rate and their cost. Facilities must also provide information about their staffing, including whether staff are available 24-hours a day, and the availability of licensed nurses, personal care attendants, nursing assistants, and maintenance staff.

- ***Wisconsin*** requires that the qualifications of staff that will provide services be included in the agreement as well as whether services are provided directly or by contract.

Some states require facilities to provide some of the information listed in Table 1-4 in a residents' rights statement rather than a residency agreement, particularly information about grievance procedures.

The GAO study cited unmet consumer expectations for aging-in-place and forced moves as a major resident complaint. Only 20 states require agreements to include information about the facility's criteria for admission, discharge, or transfer.

Finally, several states have rules regarding the format of resident agreements. Kansas requires that agreements be written in clear and unambiguous language in 12-point type. Maryland requires agreements to use accurate, precise, easily understood, legible, readable, "plain" English. Wisconsin requires that agreement formats make it easy to readily identify the type, amount, frequency, and cost of services. Some states require information about provisions that allow staff to inspect living quarters, with the resident's permission.

Most state rules do not have rules for revising or updating resident agreements. However, Alabama, Illinois, Mississippi, and Oregon require that agreements include the period covered by the agreement. Wisconsin required that the agreement be reviewed and updated when there is a change in the resident's condition or at the request of the facility or the resident. Updates are otherwise made as mutually agreed to by the resident and the provider.

ADMISSION AND RETENTION CRITERIA

States regulations pertaining to admission and retention typically consider applicants' or residents' general condition, health-related need including the need for nursing care, physical and cognitive function, and behavioral problems.

Only a few states (e.g., North Carolina and Illinois) do not allow individuals who meet their minimum nursing home level of care criteria to be served in residential care settings. However, virtually all states do not allow persons who need a skilled level of nursing home care to be served in residential care settings (e.g., individuals who require 24 hour-a-day skilled nursing oversight or daily skilled nursing services).

State approaches for setting admission and retention policies can be grouped into three categories:

- *Full Continuum*--states allow facilities to serve people with a wide range of needs;
- *Discharge Triggers*--states develop a list of medical needs or treatments that cannot be provided in a facility and that will result in a resident's discharge from a facility; and
- *Levels of Licensure*--states license facilities based on the needs of residents or the services that may be provided in a specific kind of facility.

These approaches are not mutually exclusive. States may use more than one approach and may also grant waivers for facilities to serve residents whose needs exceed those allowed. Since 2002, Arkansas, Delaware, South Carolina, South Dakota, Vermont, and Washington have modified their admission criteria.

Full Continuum

States using a full continuum approach have broad criteria that allow facilities to serve residents with a wide range of needs, permitting residents to age in place. However, providers are not required to serve everyone who meet these criteria and can establish their own admission and discharge standards within state parameters. They are required to inform prospective residents about these standards and the type of conditions that would trigger discharge. For example, Massachusetts allows providers to meet personal care needs and at a minimum must provide assistance with bathing, dressing, and ambulation. However, they are not required to offer assistance with other ADLs such as toileting and eating. Most other states allow, but do not require, residences to serve people with ADL needs.

States using the full continuum approach include Hawaii, Kansas, Maine, Minnesota, Nebraska, New Jersey, and Oregon, and those with the most flexible rules include Arizona, Hawaii, Kansas, Maine, Maryland, Minnesota, New Jersey, Oklahoma, and Oregon. Examples of this approach follow.

- ***Oregon*** generally does 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. However, facilities are not required to serve all residents whose needs increase. Providers may ask residents to move if: (1) their needs exceed the level of ADL services available; (2) the resident exhibits behaviors or actions that repeatedly interfere with the rights or well being of others; (3) the resident, due to cognitive decline, is not able to respond to verbal instructions, recognize danger, make basic care decisions, express need, or summon assistance; (4) the resident has a complex, unstable, or unpredictable medical condition; or (5) the resident has failed to make payment for charges.

- ***Hawaii's*** rules do not specify who may be admitted and retained. Rather, each facility may use its professional judgment and the capacity and expertise of the staff to determine who it will serve. Facilities are required to develop their own admission and discharge policies and procedures. Discharge with 14 days notice is allowed based on behavior, needs that exceed the facility's ability to meet them, or a resident's established pattern of non-compliance.

- ***Washington*** may accept and retain residents if: (1) they can meet the individual's needs, and provide required specialized training to resident-care staff; (2) the individual's health condition is stable and predictable, as determined jointly by the boarding home and the resident or the resident's representative if appropriate; and (3) the individual is ambulatory, unless the boarding home is approved by the Washington state director of fire protection to care for semi-ambulatory or non-ambulatory residents. Individuals must also meet all of the boarding home's established acceptance criteria.

- ***Maine's*** rules are flexible to allow residents to age in place. The rules allow facilities to determine whom they will admit and the type of services they will provide. They may discharge residents 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. Rules regarding the provision of nursing care vary by setting. Residential care facilities may provide nursing services with their own staff only to residents who do not meet the state's nursing home level of care criteria. Residents who meet the level of care criteria 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 (RNs) employed by the program.

- ***New Jersey's*** rules state that assisted living is not appropriate for people who are incapable of responding to their environment, expressing volition, interacting, or demonstrating independent activity. The rules allow facilities to provide a very high level of care, but they are not required to do so. The rules specifically state that facilities may choose to serve residents who:

  – Require 24-hour, 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 III or IV pressure sores or multiple Stage II sores,
  – Are a danger to self or others, or
  – Have a medically unstable condition and/or special health problems.

  The state also has a provision that can be characterized as a discharge trigger: facilities may not serve residents who require a respirator or mechanical

ventilator or people with severe behavior management problems, such as combative, aggressive, or disruptive behaviors.

- ***Vermont*** has two levels of licensure. One level--for assisted living--allows for a full continuum of care to be provided to residents who meet the nursing home level of care to be served if the facility can meet their needs except for the following conditions:

  – A serious acute illness requiring medical, surgical, or nursing care provided by a general or special hospital;
  – Ventilators;
  – Respirators;
  – Care of Stage III or IV ulcers;
  – Suctioning; or
  – Two person assistance with transfer or ambulation.

  Vermont's other level of licensure--for residential care facilities--allows the provision of personal care and nursing services. Facilities may retain current residents who develop a serious, acute illness as long as the care needs are met by appropriate licensed personnel. However, if the resident wanders, the facility must document appropriate interventions to manage this behavior. Residents may be discharged if they pose a serious threat to self or other residents and are not capable of entering into a negotiated risk agreement; are ordered by a court to move; or fail to pay rent, service, or care charges.

Discharge Triggers

Discharge triggers are used by states to regulate the specific medical needs or treatments that can and cannot be provided by certain kinds of facilities and to determine when a resident can no longer reside in a facility. Most prohibited treatments require performance by skilled nursing personnel. States that use these triggers include: California, Delaware, Florida, Idaho, Illinois, Maryland, Mississippi, Nevada, New Mexico, South Carolina, Tennessee, Virginia, and West Virginia. State rules may overlap as Idaho, Maryland, and Mississippi also license by level of care, and New Jersey, which allows a full continuum of care. Examples of this approach follows.

- ***Tennessee*** allows facilities to retain for up to 21 days (but not admit) individuals who require intravenous or daily intramuscular injections; gastronomy feedings; insertion, sterile irrigation, and replacement of catheters; sterile wound care; or treatment of extensive Stage III or IV decubitus ulcers or exfoliative dermatitis; or who, after 21 days, require four or more skilled nursing visits per week for any other condition.

- ***Virginia*** does not allow residential care facilities to serve people who are ventilator dependent; have Stage III or IV dermal ulcers (unless a Stage III ulcer is healing); need intravenous therapy or injections directly into the vein except for

intermittent care under specified conditions; have an airborne infectious disease in a communicable state; need psycho-tropic medications without an appropriate diagnosis and treatment plan; or have nasogastric tubes and gastric tubes (except when individuals are capable of independently feeding themselves and caring for the tube or by exception.)

Levels of Licensure

Several states--Arizona, Arkansas, Idaho, Maine, Maryland, Mississippi, Missouri, and Vermont--have two or more levels of licensure based on the needs of residents or the services that may be provided. Examples of this approach follow.

- ***Arizona*** licenses three levels of care: supervisory care, personal care, and directed care. Residential care facilities providing supervisory care may serve residents who need health or health-related services if these services are provided by a licensed home health or hospice agency. Those with a personal care service license may not accept or retain any resident who is unable to direct self-care; requires continuous nursing services unless the nursing services are provided by a licensed hospice agency or a private duty nurse; has a Stage III or IV pressure sore; or is bed bound due to a short illness unless the primary care physician approves, the resident signs a statement and the resident is under the care of a nurse, a licensed home health agency, or a licensed hospice agency. Facilities licensed to provide directed care may serve residents who are bed bound, need continuous nursing services, or have a Stage III or IV pressure sore.

- ***Arkansas*** licenses two levels of facilities. Level I facilities cannot serve nursing home eligible residents or residents who need 24-hour nursing services; are bedridden; have transfer assistance needs that the facility cannot meet; present a danger to self or others; and require medication administration performed by the facility.

  Level II assisted living facilities can serve nursing home eligible residents and participate in a Medicaid HCBS waiver, but cannot serve residents who need 24-hour nursing services; are bedridden; have a temporary (no more than 14 consecutive days) or terminal condition unless a physician or advance practice nurse certifies the resident's needs may be safely met; have transfer assistance needs, including but not limited to assistance to evacuate the facility in case of emergency, that the facility cannot meet with current staffing; present a danger to self or others; or engage in criminal activities. Facilities may be licensed for both levels of care in distinct parts or separate wings but separate licenses are required for the beds providing each level.

- ***Florida*** licenses four types of facilities: basic assisted living facilities, limited nursing services, limited mental health services, and extended congregate care (ECC) which is the highest level of care. ECC facilities serve residents with higher needs and provide more services than the other levels including total help

with bathing; nursing assessment more frequently than monthly; measurement and recording of basic vital functions; dietary management; supervision of residents with dementia; health education and counseling; assistance with self-administration and administration of medications; provide or arrange rehabilitative services and escort services to health appointments.

- ***Utah*** licenses two levels of facilities. Type I facilities serve residents who are ambulatory, have stable health conditions, require limited assistance with ADLs and need regular or intermittent care or treatment from facility staff. Type II facilities serve residents who need substantial assistance with ADLs, offer separate living units, and enable residents to age in place as much as possible. Level II residents may be independent or semi-independent but not dependent (needing in-patient or 24-hour continual nursing care for more than 15 days, or needing a two-person assist to evacuate the building). Both types of facilities may assist with or administer medications under supervision of a licensed nurse.

NURSING HOME LEVEL OF CARE ISSUES

States typically have two or more levels of nursing home care and not all persons served in nursing homes may be served in residential care. States distinguish among levels of care primarily for payment purposes. As noted in the discussion of admission and retention policies, above, states typically do not allow facilities to serve persons who require a skilled *level* of nursing care (as opposed to discrete skilled services, which many states allow in residential care on a limited basis). Only a few states do not allow facilities to serve persons who do not meet the minimum or threshold nursing home level of care criteria.

Generally, it is individuals who meet a state's minimum level of care criteria who can be and are served in residential care settings and states' minimum nursing home criteria vary markedly. Individuals who meet the nursing home criteria in one state may not meet the criteria in another state. Thus, the statement that most states permit residential care settings to serve individuals who are "nursing home eligible" obscures sometimes significant differences in the type and level of care provided in these facilities in different states.

States fall on a continuum from low to high thresholds for nursing home admission. Some states require a person to need assistance with only two ADLs, while others may require that a person be totally dependent in three or more ADLs. Some states require individuals to have a combination of medical conditions/needs and functional limitations; others require only certain medical needs. Of the 45 states whose criteria were reviewed for this study, two used medical criteria only; 13 used medical and functional needs; eight used an assessment score based on a combination of medical and functional needs; and 22 used ADL thresholds. Section 3 provides information about

each state's nursing home level-of-care criteria.[15] A few examples of states' criteria follow.

- ***Medical.*** Alabama requires an individual to need daily nursing or medical services that as a practical matter can only be provided in a nursing facility on an in-patient basis.

- ***Medical and/or functional.*** Maine requires individuals to need skilled care on a daily basis (nursing or rehabilitation therapies); *or* extensive assistance with three of the following ADLs (bed mobility, transfer, locomotion, eating, and toileting); *or* one of several specified combinations of nursing and functional needs.

- ***ADL Threshold.*** New Hampshire requires individuals to either need assistance with two or more ADLs, or to need 24-hour care for at least one of the following: medical monitoring and nursing care; restorative nursing or rehabilitative care; or medication administration.

- ***Combination of Factors.*** Illinois requires individuals to have a specific score on a standardized assessment. The score is derived using a score on the Mini-Mental State Examination (MMSE), and impairments in six ADLs and nine instrumental activities of daily living (IADLs) (including ability to perform routine health and special health tasks, and ability to recognize and respond to danger when left alone).

Because Centers for Medicare and Medicaid Services (CMS) gives states considerable flexibility in setting minimum nursing home level of care criteria, states may choose to make this criteria more stringent in response to budget deficits, as Oregon has recently done. In states that cover Medicaid waiver services in residential care settings, increasing the threshold level of care criteria for nursing homes will also increase the threshold for residential care. For example if a state raises its threshold criteria from 2 out of 5 ADL impairments to 3 out of 5 ADL impairments, a person in the former category will no longer be eligible for Medicaid coverage in both nursing homes and residential care settings.

If a state markedly increases the stringency of its minimum nursing home level of care criteria to control nursing home admissions, it would need to ensure that admission and retention criteria for residential care settings allow these settings to continue serving Medicaid waiver clients with the higher level of need required for Medicaid nursing home admission.

[15] Some state summaries do not include this information because it was not readily available.

SERVICES

One of the attractive philosophical tenets of assisted living is that it allows aging-in-place--meaning that as individuals age and become more disabled, additional services can be provided so that they will not have to move to another residential care setting or to a nursing home.

States seeking to facilitate aging-in-place and to offer consumers a full range of long-term care options allow more extensive services to be provided in residential care facilities, just as they can be provided in an individual's home through home health agencies and in-home service programs.

However, facilities vary in the extent to which aging-in-place is possible, because states generally specify the range of allowable services and a minimum that must be provided, but do not require facilities to provide the full range of allowable services. Facilities are usually authorized to determine which services they will provide within state parameters. Facilities may offer very limited, moderate, or extensive services. Thus, both state regulations and facility policy govern the type, amount, frequency and duration of services provided, and, hence, the ability to age in place.

Thus, although state regulations frequently state their support for aging-in-place, they may also allow facilities to discharge individuals with higher levels of need. A key determinant of the ability to age in place is the extent to which states permit residential care facilities to address residents' nursing and health related needs.

Some experts contend that residential care settings cannot and should not be expected to meet the needs of persons with a high level of disability and/or medically complex conditions. Others agree, arguing that residential care should be a social care model and having nurses on staff is not only unnecessary but undesirable. However, other regulators, particularly in states that allow nurses to delegate specified nursing tasks, believe that residential care settings, like a person's own home or apartment, are appropriate settings for people with severe disabilities and/or health needs. But some observers have expressed concern about direct care staff's ability to recognize and address health problems in medically fragile residents when they are not trained nursing assistants. Many states do allow residential care facilities to provide skilled nursing care, as indicated in the following examples.

- ***Illinois*** allows health services such as medication administration, dressing changes, catheter care, and therapies, if provided on an intermittent basis.

- ***Florida*** allows the provision of nursing services under two types of licensure: limited nursing services and extended congregate care. A license for limited nursing services allows facilities to provide nursing services including medication administration and supervision of self-administration, heat and ice cap application, passive range of motion exercises, urine tests, routine dressing changes that do not require packing or irrigation, 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). A license for extended congregate care permits a facility to provide nursing services in addition to those provided under the limited nursing services license.

However, the state specifies nursing services that may not be provided under either type of license, including oral or nasopharyngeal suctioning, assistance with tube feeding, monitoring of blood gasses, intensive rehabilitation services for a stroke or fracture or treatment of surgical incisions that are not clean and infection-free, and any treatment requiring 24-hour nursing supervision.

- ***Washington's*** regulations specify which skilled services may and may not be delivered by licensed nurses and unlicensed staff in residential care settings. RNs or licensed practical nurses (LPNs) may insert catheters, provide nursing assessments, and glucometer readings. Unlicensed staff under the supervision of a licensed nurse may provide Stage I skin care, routine ostomy care, enemas, catheter care, and wound care. Statutory changes in the nurse practice act that would allow greater delegation are pending in the legislature.

- ***New Jersey*** allows levels of skilled nursing care that are specifically barred in many states; for example, care of Stage III or IV pressure sores, ostomy care, and 24-hour nursing supervision.

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

- ***Maine*** allows residential care facilities and congregate housing programs to provide skilled nursing services.

Several states limit the provision of skilled nursing services in residential care settings by restricting their frequency and duration. Others prohibit facilities from providing these services directly, but allows them--and/or residents--to arrange for their provision through a home health agency. Some states use a combination of approaches, all of which are illustrated in the following examples.

- ***Massachusetts*** like many states, does not allow residential care facilities to serve residents who need 24-hour nursing services. Skilled services may only be provided by a certified home health agency on a part-time or intermittent basis to persons whose medical conditions require services on a periodic, scheduled basis. In addition, the state allows residents "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."

Because the Massachusetts statute allows skilled nursing services to be provided only by a certified home health agency, RNs hired by an assisted living facility are not allowed to deliver skilled care. An initial draft of new state regulations did not allow the provision of skilled services for more than 90 days in a 1-year period. When the state attorney general's office determined that such limits may conflict with fair housing rules, the state removed the 90-day limit.

- ***Ohio*** limits the provision of skilled services in residential care facilities to 120 days in a 12 month period with exceptions for special diets, dressing changes, and medication administration.

- ***Iowa*** allows facilities to provide health related care (i.e., services provided by a RN, a LPN, or home care aide; and services provided by other licensed professionals as defined in regulations). 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 eight hours personal care and health related services provided seven days a week for temporary periods not exceeding 21 days.

- ***Kentucky*** allows residents to arrange for additional services under direct contract or arrangement with an outside agent, professional, provider, or other individual designated by the client if permitted by facility policy.

QUALITY ASSURANCE AND MONITORING

In 2003 and 2004, hearings held by the U.S. Senate Special Committee on Aging, reports by the GAO, and newspaper articles all raised concerns about the quality of care in residential care settings, and the challenges providers and state oversight agencies face in assuring quality. In April 2004, the GAO issued a report on quality assurance initiatives in Florida, Georgia, Massachusetts, Texas, and Washington.[16]

The report stated that assisted living facilities are more likely to meet and maintain licensing standards if they can obtain help in interpreting those standards and in determining what concrete changes they need to make to satisfy them. It described an initiative in Washington, which established a staff of quality consultants to provide such training and advice to assisted living providers on a voluntary basis. Evaluations at 6 months and 2 years after implementation documented improvements in provider compliance as well as resident health and safety. However, a statewide budget crisis required the state to end funding for the program in order to maintain traditional licensing enforcement functions.

[16] _____. Assisted Living: Examples of State Efforts to Implement Consumer Protections. U.S. General Accounting Office. GAO-04-684. Washington, DC. April 2004.

Wisconsin and Kansas have recently initiated activities to better assure quality. The Wisconsin Bureau of Quality Assurance created an *Assisted Living Forum* for stakeholders to discuss current issues, interpretation of regulations, best practices, quality improvement, staffing issues, national and state trends, and other public policy issues.

Wisconsin has also revised its survey process for residential care apartment complexes, its apartment model of assisted living, which is not licensed but has to be either registered, or certified to serve Medicaid clients. The new process includes a technical assistance component to interpret requirements, provide guidance to staff on consumer quality of life and care; review provider systems, processes and policies; and explain new or innovative programs. The revised survey strategy includes seven types of surveys: initial, standard, abbreviated, complaint, verification, monitoring and self-report. The state determines which type of survey to conduct for each facility based on a range of factors, including its citation history. Abbreviated surveys are performed for facilities without any enforcement actions over the past 3 years and no substantial complaints or deficiency citations.

Kansas has adopted a collaborative oversight approach. Facility staff accompany the surveyor during the review. Observations are discussed during the process and, when necessary, problem areas are reviewed in the context of the regulatory requirements. Deficiency statements focus on consumer outcomes. The licensing director also conducts a full day training course several times a year on the role of licensed nursing in assisted living facilities for nurses, operators and owners. The training covers use of the assessment, developing a services plan, managing medications and the nurse practice act. The state believes that the combination of regular visits, consistent application of the regulations, and a more collaborative oversight process and training have resulted in better compliance with the regulations and fewer complaints.

Several states reported organizing periodic trainings for facility staff or including articles in a newsletter about specific problems that surveyors find are occurring in a number of facilities. Others cited a conflict between oversight and consultation functions. One state indicated that facilities are responsible for resolving quality problems and the state provides consultants to assist them to do so. Other states clarify rules or statutes with facility staff during the survey or during exit interviews after the survey is completed. If the facility is able to correct the problem during the survey, no deficiency is issued. Utah allows new administrators to request assistance, and has procedures for the licensing agency to review survey forms with administrators, as well as previous reports and deficiencies. Pennsylvania provides guidance by disseminating information about best practices.

A few states indicated that they could not provide consultation and technical assistance due to staff shortages and the need to complete surveys.

In 2002, NASHP conducted a survey of licensing officials in all the states and asked them to rank ten areas by the frequency of deficiencies and complaints. Thirty-four states ranked the areas in the following order:

- Medications (48 percent indicated that problems occurred *frequently* or *very often*)
- Problems with staff quality and qualifications (41 percent indicated that problems occurred *frequently* or *very often*)
- Sufficient staff (36 percent)
- Records (32 percent)
- Care plans (24 percent)
- Inadequate care (21 percent)
- Admission/discharge (15 percent)
- Access to medical care (3 percent)
- Abuse (3 percent)
- Billing/charges (3 percent)

Fifty-eight percent of the states indicated that their penalty trends remained about the same in 2001 compared to 1999-2000; 34 percent reported that the number of penalties increased and 8 percent reported that they had declined. Eighty percent of the states felt their monitoring and enforcement systems were effective or very effective. The survey asked states to describe aspects of their process that were working well. A number of states identified the process of making follow-up visits when survey findings/complaints indicated areas of concern. Several states noted that having a range of remedies available to act on survey findings was effective as well as making unannounced visits. Progressive enforcement based on the facility's history and response was also cited as an effective strategy.

One state indicated that counties are involved in monitoring Medicaid waiver participants and that service negotiations helped clarify service contracts. Another said that using state nurse consultants and specialty staff, such as pharmacists and dieticians, to monitor facilities with serious or numerous problems was effective.

Other quality assurance strategies cited include providing technical assistance and follow-up; acting within 10 days on complaints; having clear lines of communication for and definition of duties for survey staff; developing clear enforcement procedures that are well understood by staff; meeting with providers to discuss issues; providing training; conducting follow-up visits; and maintaining a consumer perspective that focuses on improving care not just punishing past failures. States described a number of quality initiatives underway including:

- Furnishing provider training;
- Implementing new training requirements for medication aides;
- Revising the survey process;
- Developing a more formalized consultation program;
- Providing more technical assistance;

- Conducting forums for providers to discuss quality issues; and
- Implementing quality assurance and quality improvement regulations.

Other strategies focused on revising standards for assessment, training, and level of care, including:

- Working with providers to develop minimal standards for assessments, service plans, negotiated risk agreements, and disclosure requirements;
- Adding disclosure requirements for dementia care providers;
- Increasing the licensing authority for staffing, training, disclosure, and Alzheimer's care;
- Working to increase staff training requirements;
- Working to establish specific staffing requirements for special care units;
- Conducting regulatory reviews to bring provisions up to national standards; and
- Increasing requirements for a comprehensive resident assessment.

Over half the states reported that the number of staff available for survey and monitoring was not keeping pace with the growth in the supply of facilities.

MEDICATION ADMINISTRATION

As facilities are allowed to serve residents with greater needs, regulators have cited medication administration and assistance with self-medication as a major concern. A study cited in a literature review on medication use in assisted living found that residents were prescribed an average of 4.6 medications per month; 37 percent took four to seven medications a month; and 11 percent took eight or more.[17] Comparing prescriptions to the "Beers List," the study found that 25 percent of the residents had inappropriate medication orders.[18] Another study found that 11 percent of residents were taking two or more psychotropic medications and 70 percent were taking psychotropic agents without receiving mental health services. The literature review found that there was substantial use of medications considered inappropriate for use by elders; widespread use of psychotropic medications; under-treatment of depression; and use of medications with undocumented diagnosis or reason for use.

States were asked to indicate how often problems with medications were reported or identified during survey activity. Eighty-two percent of the responding states said the incidence of medication problems has remained the same since 2002, 12 percent reported a decline in medication problems, and 6 percent report an increase in problems with medications.

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[17] Thomas Clark, Director of Professional Affairs for the American Society of Consulting Pharmacists Medication Use and Pharmacist Impact in Assisted Living Facilities, located at http://www.ascp.com/public/pr/assisted/2003/rximpact.pdf.

[18] The Beer's List identifies medications to avoid or use within specified dose and duration ranges for elderly persons, and medications to avoid in elderly persons with specific diseases.

However, while most states reported that the incidence of medication problems remained the same as in 2002, the number of states reporting that problems occurred *frequently* or *very often* rose significantly. For example, 61 percent of the 46 states and the District of Columbia reported that problems with medications occurred *frequently or very often* (up from 51 percent in 2002). Twenty-three percent responded that this was a problem *sometimes*, and 18 percent responded *rarely or occasionally*.[19] Other reported problem areas included pharmacy and physician medication errors.

Several states noted that its licensing agency is paying more attention to medication issues as the acuity level increases and more residents are taking increasing numbers of medications. States that did not previously track the prevalence of medication issues are now doing so.

The 2002 study asked whether states allowed trained aides to administer medications or to assist with self-administration of medications. Of the responding states, 98 percent allow trained aides to assist with self-administration, and 63 percent allow aides who have completed and passed a training program to administer medications. Thirteen percent of responding states require facilities to have a consulting pharmacist. Several states require record reviews of medications by a RN.

States are addressing problems with medication administration by offering additional training, enacting changes to nurse delegation provisions, and tracking medication issues on survey reports. A few states indicated that problems with medication administration are consistently among the top eight or ten deficiencies and a few reported it was the most frequently cited deficiency. On the other hand, states reported that deficiencies and problems dropped after the licensing agency offered more training on medication administration to administrators, supervisory and direct care staff.

TRAINING REQUIREMENTS

Staff training requirements are a key component of quality assurance. A national study found that the types of required staff training and orientation varied across facilities, but for the most part, relatively little training was required.[20] Three-quarters of unlicensed personnel were required to attend some type of pre-service training or orientation, most commonly lasting between 1 and 16 hours. Only 11 percent of the staff who received required training completed it prior to the start of work; the remainder received on-the-job training or a combination of pre-service and on-the-job training. In contrast, nursing homes aides are required to have a minimum of 75 hours of training (10 days) and to pass an exam before they can work on a unit providing direct resident care.

[19] Due to rounding, the percentages add to 102.
[20] Catherine Hawes, Ph.D., et al. *op.cit.*

Staff reported receiving training on--or an orientation to the philosophy of assisted living and how that philosophy differs from traditional nursing home care and other residential care settings. However, the study found the staff were not well informed about normal aging and care for persons with dementia.

States regulations specify initial and ongoing training requirements for staff and administrators but the level of specificity in the training requirements varies considerably. Some states specify only general requirements, while others specify topics to be covered, the number of training hours required, the completion of approved courses, or some combination thereof.

NATIONAL ACTIVITIES

At the national level, stakeholders involved in the ALW implemented its recommendation to establish a Center for Excellence in Assisted Living (CEAL).[21] The CEAL's mission is to "foster access to high quality assisted living by creating resources and acting as an objective resource center to facilitate quality improvement in assisted living; increasing the availability of research on quality in assisted living; providing a national clearinghouse for information on assisted living; building upon the work of the Assisted Living Workgroup; promoting availability of and innovation for high quality affordable assisted living; and providing information, tools, and technical expertise to facilitate the development and operations of high quality affordable assisted living programs to serve low and moderate-income individuals."

The CEAL will provide reports on quality using objective measures and data, disseminate information, promote research, identify and describe effective practices and provide technical assistance to states on policy, programs, effective practices, the integration of outcome measures, and the ALW recommendations into state policies and programs.

LACK OF INFORMATION ABOUT RESIDENTIAL CARE FACILITIES FOR CONSUMERS

The 2004 GAO report cited earlier found that consumers faced with choosing an assisted living facility often do not have key information they need in order to identify the one most likely to meet their individual needs. Such information includes staffing levels

[21] The Board of Directors comprises representatives from four consumer or advocacy groups (AARP, Paralyzed Veterans of America, Alzheimer's Association, Consumer Consortium on Assisted Living); four provider associations (American Association of Homes and Services for the Aging, Assisted Living Federation of America, American Seniors Housing Association and National Center for Assisted Living); and three representatives from professional organizations or associations (National Cooperative Bank Development Corporation, the Pioneer Network, America Assisted Living Nurses Association).

and qualifications, costs and potential cost increases, and the circumstances that could lead to involuntary discharge from the facility.

The report described initiatives in Florida and Texas that have made critical data to aid consumer selection more readily available. Florida created a Web site that provides information about facilities by geographic area and identifies those providing the services the consumers are seeking at a specified price range. Texas has mandated a standardized disclosure statement for assisted living facilities, giving consumers concise and consistent data that facilitates comparisons across providers regarding services, charges, and policies.

Many states help consumers compare assisted living facilities by publishing brochures, consumer guides, and by providing information on Web sites. The following list offer examples of Web sites that have been developed by states, provider associations, and consumer groups. Many other states have Web sites, which the reader can find by conducting standard searches.

- *State Web sites*

  - Colorado--http://www.cdphe.state.co.us/hf/broch/assist.htm. *The state's Web site for its licensing agency--www.cdphe.state.co.us/hf/static/pcbhpp.htm--lists each facility with links to survey findings and complaints. The site has other consumer information such as a brochure for solving problems and a checklist for selecting facilities.*
  - Florida--http://www.floridaaffordableassistedliving.org/
  - New Jersey--http://www.state.nj.us/health/ltc/alinnj
  - Oregon--http://www.dhs.state.or.us/seniors/publications/oregon_consumer_guide.pdf
  - Washington--http://www.aasa.dshs.wa.gov/Library/publications/htmlversions/CARE%20IN%20ADULT%20FAMILY%20HOME.htm
  - Wisconsin--http://dhfs.wisconsin.gov/guide/find/asstliving.htm

- *National and State Association Web sites*

  - Assisted Living Federation of America--http://www.alfa.org/public/articles/index.cfm?cat=6
  - American Association of Homes and Services for the Aging--http://www2.aahsa.org/
  - National Center for Assisted Living--http://www.ncal.org/consumer/consumer.htm
  - MassALFA--http://www.massalfa.org/docs/assist.htm
  - NorALFA--http://www.noralfa.org/tips.cfm

- *National Consumer Groups Web sites*

  - Consumer Consortium for Assisted Living--http://www.ccal.org/
  - AARP--http://www.aarp.org/life/housingchoices/Articles/a2004-02-27-assistedlivingchecklist.html
  - National Cooperative Bank Development Corporation--http://www.ncbdc.org

PROVISIONS FOR RESIDENTS WITH ALZHEIMER'S DISEASE AND DEMENTIA

Forty-four states have specific regulatory provisions for facilities serving people with Alzheimer's disease and other dementias, an increase from 36 in 2002 and 28 in 2000. Examples of state activities regarding dementia care and the regulations for facilities serving residents with dementia follow.

- ***Rhode Island*** requires a license for dementia care when one or more resident's dementia symptoms affect their ability to function as demonstrated by behaviors that adversely impact the rights of others; elopement; or an inability to self-preserve. Facilities that advertise or represent special dementia services or that segregates residents with dementia also need a license for dementia care. In addition to basic license requirements dementia care licenses require staff training specific to dementia care; a RN on staff and available for consultation at all times; and a secure environment appropriate for the resident population.

- ***Pennsylvania*** has drafted rules that contain provisions for securing units and providing adequate indoor and outdoor wandering space. They also specify competency-based training requirements for administrators and staff covering mandated topics such as the definition and diagnosis of dementia, differences between dementia, delirium, and depression, managing behavioral symptoms, and working with family members.

- ***Montana*** created a new licensure category for facilities that serve residents who are not capable of expressing their needs or making basic decisions. Requirements include staffing provisions; general staff education, training, and experience requirements; dementia specific annual continuing education requirement, including the teaching of skills necessary to care for, intervene and direct residents who are unable to perform ADLs; and techniques for minimizing challenging behavior. Other requirements apply to locked units or distinct parts of facilities.

- ***Washington*** revised its regulations to require staff with experience and training in dementia care to coordinate outside services, offer monthly educational and family support meetings, and advocate for residents. Staff training requirements include a minimum of 30 hours on care for residents with dementia; nature,

stages, and treatment of the disease; therapeutic interventions; communication techniques; medication management; therapeutic environmental modifications; assessment and care planning; the role of family and their need for support; staff burn-out prevention; and abuse prevention. Eight hours of continuing training is required annually.

Staff must be able to provide 2.25 hours of direct care per resident per day. At least two staff must be present for units serving more than five residents. An RN must be available if residents require nursing procedures. The rules describe special requirements for the physical environment with security measures, including secured outdoor spaces.

Licensed facilities that do not market themselves special care units but serve residents with early symptoms of dementia must provide staff training on dementia care, including strategies to help residents manage their behaviors.

Disclosure

Twenty-four states have disclosure requirements for facilities that advertise themselves as operating special care facilities or units, or that care for people with Alzheimer's disease or other dementias. These facilities are required to describe in writing how they are different from other facilities. 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 that are available, and differences in the environment. See Table 1-5 for an overview of disclosure requirements. Specific examples of regulations regarding disclosure requirements follow.

- ***California*** has a voluntary disclosure process for facilities offering special services for people with dementia. The state developed a consumer's guide that alerts family members to key questions that should be asked when seeking residential care for people with dementia. They include how the program meets the needs of people with Alzheimer's; the facility's pre-admission assessment process; the transition from the individual's current living arrangement to residential care; the care and activities that will be provided; staffing patterns and the special training received by staff.

- ***Illinois'*** standard disclosure form, which all providers must use, addresses the form of care or treatment; philosophy; admission and retention policies; assessment care planning and implementation guidelines; staffing ratios; physical environment; activities; family members' roles; and the cost of care.

- ***Minnesota*** adopted disclosure requirements in 2001, which require facilities to provide information about the form of care or treatment; the treatment philosophy; unique features for screening, admission and discharge; assessment and care planning; staffing patterns; the physical environment; security features;

type and frequency of activities; opportunities for family involvement; and the costs of care.

- ***Texas*** requires a disclosure statement that describes the nature of the care or treatment provided the pre-admission and admission processes, discharge and transfer policies, the planning and implementation of care, policies related changes in residents' condition, staff training on dementia care, the physical environment, and staffing.

Staffing and Training

Thirty-six states have requirements for dementia specific training and staffing for facilities serving people with Alzheimer's disease and other dementias. Examples follow.

- In ***Alabama***, staff in specialty care facilities must complete a training program developed by the Department of Mental Health and Mental Retardation and receive six hours of ongoing training a year on topics specified in the regulations.

- ***Arizona*** requires staffing ratios of one staff per six residents during the morning and evening, and one per twelve residents at night.

- ***Indiana*** requires six hours of training for direct service workers within 6 months of employment and three hours annually.

- ***Rhode Island*** requires new direct service workers to receive at least twelve hours of orientation and training about dementia, communicating effectively with dementia residents, and managing problem behaviors. The state also requires that a RN be available to residents on site as needed, and available for consultation at all times.

- ***Massachusetts***, ***Nevada***, and ***Oklahoma*** require 24-hour coverage by awake staff.

TABLE 1-5. Comparison of Disclosure Requirements														
Topics Required	**AR**	**CA**	**CO**	**DE**	**FL**	**GA**	**ID**	**IL**	**KY**	**MD**	**ME**	**MI**	**MN**	**MO**
Philosophy	X	X		X		X	X	X		X	X		X	X
Services	X					X		X		X			X	X
Cost				X		X			X	X		X		
Population served	X	X		X			X							
Admission and discharge process	X	X		X		X	X	X		X	X		X	X
Assessment and care planning process	X	X		X				X		X	X		X	X
Staffing	X	X		X		X	X	X	X	X	X		X	X
Training	X	X		X		X	X	X	X	X	X			X
Physical environment	X	X		X		X		X		X	X		X	X
Resident activities	X	X		X		X					X		X	X
Family role	X			X		X		X			X		X	X
Psychosocial services				X										
Nutrition				X										
Form of care								X					X	
Security features							X					X		
Other			X		X									
Topics Required	**MT**	**NH**	**NJ**	**NC**	**OH**	**OK**	**OR**	**PA**	**RI**	**SC**	**TX**	**VT**	**WA**	**WV**
Philosophy	X			X	X	X	X		X			X		X
Services	X			X				X						X
Cost				X	X	X	X	X	X	X		X		X
Population served												X		
Admission and discharge process	X			X	X	X	X	X	X	X	X			
Assessment and care planning process	X			X	X	X	X		X	X	X			X
Staffing	X			X		X	X		X	X	X	X		X
Training	X			X	X				X	X	X	X		X
Physical environment	X			X	X				X	X	X			X
Resident activities	X			X	X				X	X				X
Family role	X			X	X				X	X				
Psychosocial services														X
Nutrition														
Form of care					X			X	X	X	X			
Security features														
Other		X		X		X		X					X	

PUBLIC FINANCING

Medicaid Financing for Services in Residential Care Settings

Medicaid is a significant payer of long-term care services, comprising about 64 percent of all nursing home care expenditures and 33 percent of Medicaid spending overall (see Table 1-6). States are steadily shifting the balance of long-term care spending from

institutional to home and community settings. Although Medicaid spending for institutional care in nursing homes and intermediate care facilities for persons with mental retardation (ICFs-MR) rose from $35.4 billion in 1993 to $56.1 billion. In 2003, spending for home and community services (state plan personal care, home health, and HCBS waivers) grew from $6.7 billion to $27.8 billion during the same time period.[22] Consequently, Medicaid spending for institutional care dropped from 86 percent of all Medicaid long-term care spending in 1991 to 67 percent in 2003.

TABLE 1-6. Medicaid Long-Term Care Spending (in billions)

Service	1993	2003
Home Health	$1.4	$2.9
Personal Care State Plan	$2.5	$6.3
HCBS Waiver	$2.8	$18.6
ICF-MR	$9.3	$11.3
Nursing Home	$26.1	$44.8
Total Long-Term Care	$42.1	$83.8
Total Medicaid	$126.4	$259.6

Much of the growth in HCBS spending has been for services for persons with mental retardation and other developmental disabilities, which account for 75 percent of all spending.[23]

The expansion of home care programs, home health services, and residential care options has afforded persons with long-term care needs a number of alternatives to nursing homes. People with fewer ADL impairments are less likely to enter a nursing home.[24] Thus, while the absolute number of nursing home beds increased from 1.8 million in 1985 to 1.9 million in 1999, the rate per thousand persons over age 75 declined from 141 beds to 117 beds, and nursing home occupancy rates dropped from 92.3 percent in 1987 to 87.0 percent in 1996,[25] and further declined to 85.6 percent in December 2003.[26] See Table 1-7 for occupancy rates in each state.

Declining nursing home occupancy rates create some concerns for states. First, as higher income elders choose assisted living, the proportion of nursing home residents who are Medicaid beneficiaries increases. Increased reliance on Medicaid creates pressure to raise payment rates to replace revenue formerly received from private pay residents. Second, excess capacity creates a greater likelihood that Medicaid nursing home expenditures will rise if Medicaid beneficiaries do not have access to sufficient home and community services, and must rely to nursing homes at greater expense to the states.

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[22] Medicaid spending for services delivered in residential care settings is not reported separately.
[23] Data provided by Brian Burwell, The MEDSTAT Group. Memorandum, 2004.
[24] Jones, A. "The National Nursing Home Survey: 1999." National Center for Health Statistics. *Vital Statistics* 13(15) 2002.
[25] Rhoades, Jeffrey A. and Krauss, Nancy A. *Nursing Home Trends, 1987-1996.* Rockville, MD: Agency for Health Care Policy and Research; 1999. MEPS Chartbook No. 3. AHCPR Pub. No. 99-0032.
[26] American Health Care Association. Based on CMS-OSCAR form 671:F41-F43. 2003.

TABLE 1-7. Nursing Home and Residential Care Supply Data, 2003							
State	NF Supply/ 1000 65+	Occupancy Rate	Residential Care Supply/ 1000 65+	State	NF Supply/ 1000 65+	Occupancy Rate	Residential Care Supply/ 1000 65+
US	50.0	85.6		**US**	50.0	85.6	
AL	44.8	90.0	16.8	**MT**	60.9	77.0	30.4
AK	20.6	83.9	12.3	**NE**	70.5	86.7	39.4
AZ	23.4	82.7	34.9	**NV**	21.6	83.6	16.7
AR	78.6	73.3	21.3	**NH**	51.0	92.4	26.3
CA	35.8	85.5	41.7	**NJ**	45.1	87.8	14.3
CO	46.3	81.9	31.7	**NM**	33.6	85.4	n.a.
CT	66.1	93.4	7.9	**NY**	49.6	92.7	17.6
DC	45.4	91.8	2.7	**NC**	43.1	89.0	17.6
DE	44.4	91.0	16.5	**ND**	69.4	93.5	30.3
FL	28.9	88.0	26.2	**OH**	79.3	86.0	27.7
GA	49.1	90.9	31.3	**OK**	71.1	67.3	21.0
HI	22.4	95.0	23.3	**OR**	28.8	67.8	47.5
IA	93.2	83.2	12.1	**PA**	47.6	89.9	40.0
ID	41.4	76.0	40.8	**TN**	52.8	92.0	19.3
IL	71.0	80.1	9.7	**SC**	36.4	91.8	33.1
IN	72.9	83.2	15.5	**SD**	68.0	92.4	31.0
KS	76.2	85.7	22.4	**TN**	52.8	89.3	19.3
KY	50.3	91.1	14.5	**TX**	56.4	77.5	19.6
LA	73.1	77.2	9.6	**UT**	37.4	72.7	22.5
MA	60.2	91.2	12.3	**VA**	38.5	89.9	42.3
MD	47.7	86.1	27.8	**VT**	44.5	92.4	30.4
ME	40.8	93.0	48.4	**WA**	35.0	85.7	36.2
MI	39.9	87.2	38.6	**WI**	60.2	86.6	38.9
MN	65.2	92.5	n.a.	**WV**	40.7	89.9	11.9
MO	71.9	75.7	28.8	**WY**	51.7	80.8	21.7
MS	52.4	88.6	14.2				

Sources: Population Division, U.S. Census Bureau. *Annual Estimates of the Resident Population by Selected Age Groups for the United States and States: July 1, 2003*. American Health Care Association: December 2003. The supply of residential care settings was calculated by NASHP using Census data and data reported by state licensing agencies. (n.a.--not available)

State officials thus have an interest in ensuring that the supply of nursing facilities declines as the supply of home and community services expand. The 1999 U.S. Supreme Court *Olmstead* decision gives further impetus for shifting spending from institutions to home and community settings. That decision, and guidance to states from CMS, requires that states have plans for serving people with disabilities in the most integrated setting. Additionally, the ruling states that if states have a waiting list for services, the list must move at a "reasonable pace."

While some areas of the country, particularly rural areas, have an inadequate supply of residential care facilities, in other areas, developers have over-built facilities. As nursing homes compete with assisted living facilities for market share, these facilities are competing among themselves for residents. Low occupancy rates in assisted living

facilities may lead to greater interest in serving low-income beneficiaries, thereby increasing the availability of this service option for Medicaid beneficiaries.

MEDICAID COVERAGE OPTIONS

States have several options for using Medicaid to fund services in residential care settings (see Table 1-8): the Medicaid state plan, HCBS waivers (also called 1915(c) waivers), Section 1115 demonstration programs, and 1915(b) managed care initiatives. States most often use the HCBS waiver. See Table 1-9 for the sources of funding each state uses to pay for services in residential care settings.

- 36 states have CMS approval to cover services under a 1915(c) waiver;
- 14 states use the Medicaid state plan;
- 10 states use solely state-funded long-term care programs;
- 8 states use both Medicaid waivers and the state plan;
- 3 states use all three sources;
- Arizona uses a managed care program authority under an 1115 waiver; and
- Utah uses a 1915(a) state plan amendment managed care authority.

TABLE 1-8. States Using Medicaid to Cover Services in Residential Care Facilities

Waiver Only (29)		State Plan Only (6)	Waiver & State Plan (8)
Alabama*	Montana	Massachusetts	Arkansas
Alaska	Nebraska	Missouri	Florida
Arizona	Nevada	New York	Idaho
Colorado	New Hampshire	North Carolina	Maine
Connecticut	New Jersey	South Carolina	Michigan
Delaware	New Mexico	Utah	Minnesota
District of Columbia*	Oregon		Vermont
Georgia	Pennsylvania		Wisconsin
Hawaii	Rhode Island		
Illinois	South Dakota		
Indiana	Texas		
Iowa	Washington		
Kansas	West Virginia		
Maryland	Wyoming		
Mississippi			

* Alabama and the District of Columbia have not yet implemented approved 1915(c) waivers.

TABLE 1-9. Sources of Public Funding for Services in Residential Care Settings							
State	Source of Funding			State	Source of Funding		
	Medicaid Waiver	Medicaid State Plan	State Funds		Medicaid Waiver	Medicaid State Plan	State Funds
Alabama	1915 (c)			Missouri		X	
Alaska	1915 (c)			Montana	1915 (c)		
Arizona	1115			Nebraska	1915 (c)		
Arkansas	1915 (c)	X		Nevada	1915 (c)		
California	Planned			New Hampshire	1915 (c)		
Colorado	1915 (c)		X	New Jersey	1915 (c)		
Connecticut	1915 (c)		X	New Mexico	1915 (c)		
Delaware	1915 (c)			New York		X	
District of Columbia	1915 (c)			North Carolina		X	
Florida	1915 (c)	X		North Dakota	1915 (c)		
Georgia	1915 (c)			Oregon	1915 (c)		
Hawaii	1915 (c)	X		Pennsylvania	1915 (c)		
Idaho	1915 (c)	X	X	Rhode Island	1915 (c)		
Illinois	1915 (c)			South Carolina		X	
Indiana	1915 (c)		X	South Dakota	1915 (c)		X
Iowa	1915 (c)			Texas	1915 (c)		
Kansas	1915 (c)			Utah		X	
Maine	1915 (c)	X	X	Vermont	1915 (c)		
Maryland	1915 (c)		X	Virginia			X
Massachusetts		X		Washington	1915 (c)		
Michigan	1915 (c)	X		West Virginia	1915 (c)		
Minnesota	1915 (c)	X	X	Wisconsin	1915 (c)	X	X
Mississippi	1915 (c)			Wyoming	1915 (c)		
				Total	39	14	10

Congress authorized HCBS waivers in 1981 under Section 1915(c) of the Social Security Act. Under this provision, states may apply to the U.S. Department of Health and Human Services for a waiver of certain federal requirements to allow states to provide home and community services to individuals who would otherwise require services in an institution.

Under the HCBS waiver authority, states can provide services that are not covered by a state's Medicaid program, such as personal care not covered by the state plan, home delivered meals, adult day care, personal emergency response systems, respite care, environmental accessibility adaptations, and other services that are required to keep a person from being institutionalized. The waiver authority also allows states to provide waiver participants a greater amount, duration, and scope of services than are provided under the state plan.

The waiver authority also allows states to limit services to specific counties or regions of a state and to target services to certain groups--strategies that are not normally allowed under Medicaid. State Medicaid agencies must ensure that waiver programs have provisions to assure the health and welfare of participants. In addition, states must establish in advance how many people they will serve during the course of a year. Thus, in contrast to the regular Medicaid program, states may establish waiting lists for waiver programs.

Finally, average expenditures for waiver beneficiaries must be the same or less than they would have been without the waiver (no more than average Medicaid nursing home costs).[27] Importantly, while services may be covered in residential care facilities, room and board may not. Medicaid can cover room and board only in institutions, such as nursing homes, ICFs-MR, and hospitals.

From the inception of the waiver program, states have used waivers to pay for services in residential care settings as an alternative to ICFs-MR. In 1981, Oregon became the first state to use the waiver program to fund services in residential care settings for elderly persons, but few states followed suit until the 1990s.

CMS has streamlined the waiver process, allowing applicants to fill in a pre-printed application form by checking off essential aspects of its proposal. On the waiver application form, CMS defines assisted living as:

> "Personal care and services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under State law), therapeutic social and recreational programming, provided in a home-like environment in a licensed (where applicable) community care facility, in conjunction with residing in the facility. This service includes 24 hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. Other individuals or agencies may also furnish care directly, or under arrangement with the community care facility, but the care provided by these other entities supplements that provided by the community care facility and does not supplant it.
>
> "Personalized care is furnished to individuals who reside in their own living units (which may include dually occupied units when both occupants consent to the arrangement) which may or may not include kitchenette and/or living rooms and which contain bedrooms and toilet facilities. The consumer has a right to privacy. Living units may be locked at the discretion of the consumer, except when a physician or mental health professional has certified in writing that the consumer is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. (This requirement does not apply where it conflicts with fire code.) Each living unit is separate and distinct from each other. The facility must have a central dining room, living room or parlor, and common activity center(s) (which may also serve as living rooms or dining rooms). The consumer retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk. Care must be furnished in a way

[27] States can use either a fixed per capita amount for each beneficiary or they can average expenditures across waiver beneficiaries. The latter method provides more flexibility because it allows some beneficiaries to exceed the nursing facility cost as long as costs for others in the program are lower and the average waiver cost does not exceed the average nursing facility cost. States have the option of setting a cap on waiver services at a percentage of nursing home costs (e.g., 80 percent).

which fosters the independence of each consumer to facilitate aging in place. Routines of care provision and service delivery must be consumer-driven to the maximum extent possible, and treat each person with dignity and respect.

"Assisted living services may also include

Medication administration	Home health care
Intermittent skilled nursing services	Physical therapy
Transportation	Occupational therapy
Periodic nursing evaluations	Speech therapy

"However, nursing and skilled therapy services (except periodic nursing evaluations if specified above) are incidental, rather than integral to the provision of assisted living services. Payment will not be made for 24-hour skilled care or supervision. Federal financial participation is not available for the cost of room and board furnished in conjunction with residing in an assisted living facility."

States that want to provide waiver services in residential care settings do not have to conform their programs to the CMS definition, but may submit different definitions of assisted living in their application, which are subject to CMS approval. States may also choose to provide waiver services in congregate housing even if the waiver does not specifically cover a service category called "assisted living."

Differences Between State Plan and Waiver Services

HCBS waivers and state plan services differ in several 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 for Medicaid payments in a nursing home if they applied. Nursing home eligibility is not required for beneficiaries using state plan services.

Second, states may 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 CMS 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 matches state expenditures without any cap.

Perhaps the most significant difference between the two options is the ability under HCBS waivers to use a more generous eligibility standard. HCBS programs allow states to use the special income level, an optional eligibility category that allows states to set eligibility at up to 300 percent of the federal Supplemental Security Income (SSI) benefit ($1,692 in 2004). To cover beneficiaries through this option under the waiver, it must also be available to individuals in a nursing home. The higher eligibility standard in the

waiver programs is designed to "level the playing field" between institutional and non-institutional services.

In contrast, to be eligible for personal care under the state plan, individuals must meet usual community-based eligibility standards, which (depending on the state) are: (1) the SSI level of income ($564 in 2004) up to 100 percent of the federal poverty level, or (2) the state's medically needy income standard.[28] Table 1-10 summarizes the major differences between waiver services and state plan services.

Although the majority of states use Medicaid to cover services in residential care settings, the number of Medicaid beneficiaries who receive such services is considerably lower than might be expected because many states limit the number of people served under waivers. States using personal care under the state plan to cover services have higher participation rates than states using the waiver because state plan services cannot be capped.

Roughly 20 percent of all Medicaid beneficiaries living in residential care settings are in North Carolina, and another 25 percent are in Missouri and New York. These states cover services under the state plan. Waiver participation, while lower, has risen in many states over the past 2 years. Participation rose in New Jersey from 119 in 1998 to 1,500 in 2002 and 2,195 in 2004. Oregon reported that the number served rose from about 1,500 in 1998 to 3,600 in 2002 and 3,731 in 2004. Other states with relatively high waiver participation rates include Arizona (3,067), Colorado (3,804), both Georgia and Texas served 2,851 each, Florida serves 4,167 in its waiver program and 14,000 through the state plan.

TABLE 1-10. Differences Between State Plan and Waiver Services

Issue	State Plan Service	1915(c) Waiver Services
Entitlement	States must provide services to all beneficiaries who qualify for Medicaid	States may limit spending for waiver services
Scope	Must be available in the same amount, scope, and duration to all beneficiaries across the state	May be limited to specific geographic areas or groups of beneficiaries
Duplication	Provided in accordance with state plan	May not duplicate services available in the plan; may have different limits, definitions, or providers than state plan
Service Criteria	Must meet requirements of the state plan program to receive the service	Must meet the state's nursing home level of care criteria
Income	Must be SSI eligible or meet the state's community eligibility standard for Medicaid	State may set eligibility up to 300 percent ($1,692) of the monthly federal SSI payment standard ($564)
Approval Period	Continuous unless amended by the appropriate state agency	Initial waivers approved for 3 years; 5 years for renewals

[28] Except in 209(b) states which have a Medicaid income eligibility threshold that is lower than the federal SSI payment.

States do not report this information by age or type of disability. The vast majority served are age 65 and older but some may be under age 65. Some may have serious mental illness, acquired brain injuries, mental retardation, or other developmental disabilities. Whatever their age or diagnosis, to be eligible for Medicaid coverage all must meet either the state's nursing home level of care criteria for waiver services, or the state's service criteria for Medicaid state plan personal care services.

Participation figures are under-reported since a few states do not track and report the number of Medicaid beneficiaries by home or community settings. A few states reported the annual unduplicated number of Medicaid beneficiaries served in residential care settings, but most reported the number of people for a given month. Based on available data, participation is estimated to have grown from 58,544 beneficiaries in 2000, to about 102,000 beneficiaries in 2002, and 121,282 in 2004.

LIMITATIONS OF USING WAIVER PROGRAMS TO COVER SERVICES IN RESIDENTIAL CARE AND HOW STATES HAVE ADDRESSED THEM

A major challenge facing policymakers who support a comprehensive range of home and community services is finding the resources to expand their availability. Waiver services are not an entitlement and most waiver programs operate with a specific appropriation based on a number of budgeted "slots." Although states may cover services in residential care settings through a waiver program, limited slots may lead to a waiting list for services. On the other hand, nursing home care is an entitlement, and its budget is likely to rise each year through rate increases. In the event of a budget deficit, non-entitlement services are the most vulnerable to budget cuts. States are addressing this issue in several ways.

- ***Colorado, Oregon and Washington*** have shifted resources from institutions to home and community services by creating a single appropriation for long-term care services, sometimes called "pooled funding" or "unified funding."

- ***Arizona, Florida, Massachusetts, Minnesota, New York, Texas, Utah, Wisconsin*** and states with PACE programs have capitated funding for long-term care services, which gives contracting organizations the flexibility to approve the most appropriate service for beneficiaries.

- ***Kansas, Maryland, and Texas*** have adopted a "Money Follows The Person" policy, which allows funding appropriated for nursing homes to be spent on home and community services for individuals who relocate from a nursing home. Texas has a one year waiting list for waiver services. Since they adopted this policy in 2001, the state has relocated 3,400 people from nursing homes to community settings. Twenty-six percent moved to their own home; 37 percent moved in with family members; and 32 percent moved to a residential care setting.

- ***Illinois*** uses funds from its nursing home appropriation in a demonstration waiver program that provides services for residents of Supportive Living Facilities (SLFs). The program was built on the premise that about 10 percent of nursing home residents could be served in residential care settings with access to supportive services 24 hours a day. Because the program is funded from the nursing home budget rather than the waiver budget, the state is able fund all approved SLF slots and there is no waiting list. Although the waiver was approved to serve 5,000 participants, in November 2001, the state placed a moratorium on new SLFs due to budget difficulties, which is still in effect.

- ***Vermont*** enacted a law in 1996 allowing the Department of Aging and Disabilities to shift funding for 234 nursing home beds over 4 years to fund home and community services. It has allowed the Department to increase HCBS waiver slots for in-home and residential care settings, with priority for people at immediate risk of nursing home placement. Funds redirected but not spent remain available for home and community services in subsequent years. During the first 3 years of the program, 200 nursing home beds were taken off-line. Since enactment, spending on home and community services rose from 11.6 percent of total long-term care spending to 31 percent in 2002.

All of these financing strategies give states a mechanism to assure that people who can be served in the community are not required to stay in nursing homes because of a waiting list for waiver services.

ENABLING MEDICAID BENEFICIARIES TO PAY FOR ROOM AND BOARD

Medicaid beneficiaries with limited income may not be able to pay residential care facilities' room and board rates. As noted earlier, Medicaid pays for room and board only in institutions, except in limited circumstances such as respite care and meals that are served as part of a day care program (§441.360(b)). For Medicaid purposes, room and board comprises real estate costs (debt service, maintenance, utilities, and taxes) and raw food. The costs of preparing, serving and cleaning up after meals can be covered as a waiver service.

Although Medicaid beneficiaries are responsible for room and board costs, states have a range of options to make them affordable.

- Limit the amount facilities can charge Medicaid clients for room and board to the federal SSI benefit, which in 2004 is $564 minus a small personal needs allowance;

- Provide a state supplement to the SSI payment for persons living in residential care settings, and limit the amount that can be charged to the combined SSI plus state supplement payment;
- Use the 300 Percent of SSI Income Standard for waiver eligibility and set the maintenance allowance at a level that allows residents to retain sufficient income to pay for room and board;
- Provide housing subsidies for low-income persons;
- Allow family supplementation to increase the funds available for room and board, particularly to pay the difference in cost between a shared and a private room; and
- Use the federal Food Stamp Program, when possible, to reduce board costs.

Each of these options is discussed below.

Limiting the Amount Facilities Can Charge for Room and Board

States can limit the amount that can be charged for room and board by setting a combined rate for Medicaid beneficiaries that includes service costs and room and board costs, essentially capping the room and board rate that Medicaid beneficiaries pay. See Table 1-11 for a list of states that do so. Medicaid programs that specify how much facilities may charge Medicaid beneficiaries for room and board usually limit the charges to the state's SSI payment for a single elderly beneficiary living in the community, plus a state supplement, if any. This approach guarantees that Medicaid beneficiaries can afford room and board costs.

TABLE 1-11. States That Limit Charges for Room and Board

Arizona	Maryland	Oregon
Colorado	Minnesota	Pennsylvania
Delaware	Mississippi	South Carolina
District of Columbia	Montana	South Dakota
Georgia	Nebraska	Texas
Hawaii	New Jersey	Vermont
Idaho*	New Mexico	Washington
Illinois	North Carolina	Wisconsin
Indiana	North Dakota	

* The limit is "suggested."

If providers feel that the room and board rate is too low to cover costs, they may decide not to admit Medicaid beneficiaries. Only New Jersey has passed a law requiring that facilities licensed after September 2001 set aside 10 percent of their units to serve Medicaid residents within 3 years of licensing.

Persons in residential care settings who qualify for SSI receive a basic federal SSI payment ($564 in 2004). In settings that do not have housing subsidies, they retain a personal needs allowance (PNA), typically $30 or higher as determined by the state, and the remaining income is paid to the facility for room and board. If the resident lives in a Department of Housing and Urban Development (HUD) 202 subsidized unit in

which the tenant's share of the costs for rent and utilities is limited to 30 percent of the resident's income, the resident may have additional income that could be used to pay for services. If a person is SSI eligible and received $564 a month, they will pay 30 percent of this amount for rent ($169.20), and have $394.80 left over.

HUD's housing subsidy rules do not allow residential care settings to impose an additional charge for rent and utilities, but they can charge the resident for board (i.e., meal costs) or for services that are not covered by the Medicaid state plan in a residential care setting. The amount of the permitted meal charge depends on the scope of the Medicaid service payment (i.e., whether it includes the cost of meal preparation). In all cases, Medicaid may not pay for raw food.[29]

Under HCBS waivers, the cost of preparing and serving food may be covered under the service payment. If preparing and serving meals is covered, the meal cost charged to tenants would be lower. If not, charges for a meal program would include raw food, preparation, and serving. States covering personal care in residential care settings under the state plan may also allow payment for the preparation and serving of meals but may not include the cost of food.

Medicaid beneficiaries with incomes over the SSI level must contribute income above the amount of room and board (minus a small personal needs allowance) to pay for services. Medicaid then pays the difference between the resident's payment and the maximum service rate. Because beneficiaries in this category have more income than SSI beneficiaries, when they live in subsidized units, they will pay a higher rent, because the rent is calculated as a percentage of income. They also may have more income available after the rental payment is made.

Providing State Supplements to the SSI Payment

To increase access for SSI beneficiaries in areas with high development costs, states can create a special SSI state supplement for persons in residential care facilities and limit what providers may charge to the amount of the federal payment plus the state supplement.[30] Many states have such State Supplemental Payment (SSP) programs to supplement the federal SSI payment, which in 2004 is $564 a month; the payment is adjusted each January based on the cost of living. 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.

State supplements are totally state-determined and vary widely.[31] Of the 28 states that have a supplement, 21 provide less than $100 a month.[32] States may pay different

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[29] Capitated programs have more flexibility to pay for room and board costs than is allowed under standard Medicaid rules).

[30] Many states have a state supplement for residential care settings that may be too low to cover more intense services needs and higher capital costs in some residential care settings.

[31] See http://www.ssa.gov/pubs/statessi.html.

supplements based on a person's living arrangement. A few states have developed a supplemental payment rate specifically for beneficiaries in residential care settings to provide them with sufficient income to afford room and board.

Some policymakers might question the efficiency of providing 100 percent state funding to enable residents to pay for room and board. However, it is important to consider the net state cost of services in a residential setting compared to a nursing home. If the program diverts people from entering a nursing home or allows individuals to move from a nursing home to the community, states may fund a fairly substantial supplement to the federal SSI payment and still reduce their net state cost. For example, the net state cost for a state with an average nursing home payment of $3,000 a month and a 50 percent federal match is $1,500. A state could use a portion of the state match that would normally pay for nursing home care to raise the payment standard for residential care settings. Policymakers would have to determine how many people would be covered if the supplement were increased in order to calculate whether the change is "budget neutral" (or better) relative to the amount of the supplement.

Providing Housing Subsidies for Low-Income Persons

Many states are exploring ways to combine Medicaid funding and subsidized housing to develop residential care options for low-income persons. Housing subsidies can reduce housing costs for Medicaid beneficiaries and other low-income persons, and are available through a number of programs:

- Low Income Housing Tax Credits;
- HUD Section 202 Assisted Living Conversion Program;
- Section 8 Rental Assistance Vouchers;
- HUD Fair Housing Act Section 232 Mortgage Insurance Program;
- Federal Home Loan Bank Affordable Housing Program;
- Low Interest Bonds;
- U.S. Department of Agriculture (USDA) Housing Services Programs;
- Community Reinvestment Act; and
- State, City, and other Local Programs.[33]

Some federal housing programs either provide direct grants to public housing agencies and to developers or they reduce the debt incurred by the owner and, therefore, the revenue that needs to be raised through tenant rental fees. Others provide rental assistance directly to low-income tenants who would otherwise be unable to afford even reduced rents.

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[32] Stone. J.L. (2002). *Medicaid: Eligibility for the Aged and Disabled*. Congressional Research Service. Report prepared for Members and Committees of Congress.

[33] For further information, see: "A Technical Assistance Guide for Housing Resources and Strategies," prepared by the Technical Assistance Collaborative Inc. for the Rutgers Center for State Health Policy Community Living Exchange Collaborative, funded by CMS to assist Real Choice Systems Change Grantees. http://www.nashp.org/Files/Final_Regional_Forum_guide.pdf. Also, Ruth A. Gulyas. How States Have Created Affordable Assisted Living: What Advocates and Policymakers Need to Know. AARP. Washington, DC.

The HUD Section 8 *Housing Choice* program contains some provisions that states can use to subsidize housing costs for waiver clients in residential care settings. *Housing Choice* offers two broad voucher programs: Fair Share and Special Purpose.

Fair share vouchers are allocated to serve people on waiting lists for Section 8 assistance. They are awarded through a competitive process and an additional 15 points are given to proposals that set aside 15 percent of the vouchers for people with disabilities. In addition, proposals qualify for 5 points if they demonstrate collaboration with Medicaid waiver programs and set aside 3 percent of the vouchers for waiver participants. *Special purpose programs* offer *mainstream vouchers* to help people with disabilities find affordable private housing, which can include residential care settings.

Typically, multiple public programs are needed to provide an adequate housing subsidy. For example, one affordable assisted living development in Vermont was financed by a combination of funds from HUD's Section 202 Assisted Living Conversion Program, the Vermont Housing and Conservation Board, the Community Development Block Grant and City Trust, HUD Special Purpose Funding, and tax exempt bond financing through the Vermont Housing Agency. However, because housing subsidy programs and Medicaid operate under different requirements, including those related to eligibility, extensive planning and collaboration is needed to enable multiple programs to work together.

Using the 300 Percent of SSI Income Standard and Providing an Adequate Personal Maintenance Allowance

States have the option to cover persons in an HCBS waiver program using the special income standard, which sets eligibility at up to 300 percent of the federal SSI payment (i.e., a person's income must be at or below 300 percent of the maximum SSI benefit--in 2004, $1692 per month). This option is attractive for waiver programs that cover services in residential care settings, because it expands the program to include beneficiaries who are better able to afford room and board costs. To make this option effective, however, states must allow eligible persons to retain enough of their income to cover "maintenance needs" including the room and board charges in residential care settings. Setting a higher maintenance allowance may allow more beneficiaries to be served in residential care settings; however, it will increase Medicaid's service payment since it reduces the "excess income" that is applied to the cost of services.

Under Medicaid's post-eligibility treatment of income rules for HCBS waivers, states are allowed to use "reasonable standards" to establish the maintenance allowance, and may vary the allowance based on the beneficiary's circumstances. For example, states can permit Medicaid beneficiaries to keep sufficient income to pay for the needs of a dependent, health care costs not covered by Medicaid, and other necessary expenses.

Beneficiaries living in residential care settings may have different income needs depending on the type of facility: private market-rate facility or subsidized housing

facility. The “rent” component of the monthly fee charged by facilities built with low-income housing tax credits will be lower than the rent charged by privately financed facilities. Through tax credits, rents in assisted living can be reduced to around $400 a month. Setting the allowance based on the area’s average monthly charge for room and board may be overly generous when applied to residents in subsidized units. On the other hand, setting the maintenance allowance based on the amount paid by residents in subsidized units may be too low for private market facilities and create access barriers. If a state wants to improve access to both private and subsidized assisted living facilities, it can set a separate maintenance allowance for each setting.

Interaction with housing subsidies. Under HCBS waivers using the 300 percent eligibility option, treatment of the additional income retained by residents because of rent subsidies depends upon the threshold set by the state for the maintenance allowance. If the state sets the maintenance allowance at the SSI level, all income above that amount is applied to the cost of Medicaid services. If the person has income between SSI and the maximum ($1,692 in 2004), residents receiving housing subsidies may have additional income that is protected. For example, a person with $1,000 a month in social security and other income would have a maintenance allowance of $564 and apply the excess income ($436) to the cost of services. However, instead of paying $564 (less the PNA) for rent and utilities, if the resident is living in HUD Section 202 subsidized housing, the resident pays 30 percent of his or her income ($300) and keeps $264 for other expenses.

If the maintenance allowance is higher, the resident can retain the additional income and use it to pay for other costs. For example, if the resident is allowed to keep the entire $1,000 a month, the resident’s portion of the rent and utility charge would be $300 a month and the resident keeps $700. States typically set one maintenance amount for all waiver participants. However, there can be differences among beneficiaries. Those who do not receive a rent subsidy have a greater need for income to pay for room and board than those with subsidies. Yet, they have the same maintenance allowance and pay different amounts for room and board.

Separate maintenance allowance. Medicaid rules allow states to set different maintenance allowances, for example, for beneficiaries whose rent is subsidized. The Medicaid manual (3590.9 (A)(1)) states: “You may establish a different amount for each individual, or for groups of individuals, if you believe that different amounts are justified by the needs of the individuals or groups.” A lower maintenance amount for individuals with rent subsidies means more income is available to share the cost of services.

States face many challenges in their efforts to expand the supply of affordable assisted living by combining available housing programs and Medicaid funding. Housing subsidies may not be available in a particular area or, as is often true with waiver services, waiting lists may exist for rent vouchers. To be effective, a rent subsidy voucher must be available when a waiver participant applies and at the same time that a facility is available that will accept the voucher as well as Medicaid payment. From application to implementation, close collaboration is needed between public housing

agencies, waiver programs, and service providers. These challenges require knowledgeable housing operators and local housing authorities and state policymakers who are able to identify and address the barriers.

Family Supplementation

Family members may be able and willing to help with room and board costs when the beneficiary is unable to pay them. As presented in Table 1-12, 21states reported that they allow family supplementation, and nine states have not set a policy on this issue. Twelve states do not allow supplementation compared to fourteen in 2002 and eight in 2000. The remaining states either do not cover services in residential care settings or did not report whether they have a policy on supplementation.

TABLE 1-12. Family Supplementation Policy

Allow Supplementation		No Policy	Prohibit Supplementation	
Arizona	Missouri	Alaska	Connecticut	Pennsylvania
Colorado	Montana	District of Columbia	Delaware	Rhode Island
Florida	Nevada	Hawaii	Indiana	South Carolina
Georgia	New Jersey	Indiana	Maryland	South Dakota
Kansas	New Mexico	Massachusetts	Nebraska	Vermont
Idaho	New York	Mississippi	Oregon	Washington
Illinois	North Carolina	New Hampshire		
Iowa	North Dakota	Wyoming		
Maine	Texas			
Michigan	Utah			
Minnesota	Wisconsin			

States set their own rules governing family supplementation. Since Medicaid does not pay for room and board in residential care settings, rules regarding supplementation in nursing facilities do not apply (e.g., families of nursing home residents may not supplement Medicaid payments, which cover room and board and services). Several states indicated that supplementation is permitted to allow beneficiaries to upgrade to a private unit.

While supplementation is not prohibited, it is considered in determining eligibility for SSI. Federal SSI regulations contain provisions for treating unearned income during the eligibility determination process. A family contribution paid directly to an SSI beneficiary is counted as unearned income. Consequently, supplementation can lead to a reduction in the SSI payment or the loss of SSI altogether, and with it, potentially Medicaid as well.

If, however, the family contribution is paid directly to a residential care facility on the beneficiary's behalf, it is treated differently, as an "in-kind" payment, and reduces the monthly SSI benefit by one-third or, if documented, the actual amount of support provided if it is lower than one-third of the federal benefit. The maximum reduction is one-third even if the payment exceeds one-third of the SSI payment.

For example, a facility may have a room and board rate of $800, and because the SSI payment is not high enough to cover the charge, family members agree to help pay the cost. If the payment is made to the resident, it is considered unearned income and the federal SSI payment is reduced $1 for every $1 in unearned income, after a $20 per month exclusion. If the payment is made directly to the facility, the amount of the payment is considered "in-kind," and the one-third reduction rule applies (i.e., the federal benefit is reduced by one-third, or less if documented).

If the room and board rate is $800, the difference between that rate and the SSI benefit of $564 is $236. If the family pays $236 directly to the facility, then the individual's SSI benefit is reduced by one-third ($188) to $376. The family would then have to pay to the facility an additional $188. The consequence of the one-third reduction, then, is that the family must increase its supplementation from $236 to $424.

Because the rule states that the SSI payment will be reduced by up to one-third, there is no federal limit on the amount of money that can be paid to a facility on behalf of the SSI beneficiary. If a family chooses, they can subsidize services other than room and board, as well as pay for room and board costs in more expensive facilities, without jeopardizing an individual's eligibility for SSI.

However, states that provide SSI supplements may choose to set a limit on in-kind payments. Florida, for example, limits the amount families may contribute to twice the amount of the combined SSI payment and state supplement, which is $643. Thus, families or other third parties can provide up to $1,284 directly to the facility, and the beneficiary will still receive a federal payment of $376 plus a $79 state supplement, and remain eligible for Medicaid. However, the state reduces the state supplement dollar for dollar for any payment above $1,284.

Family supplementation also has implications for Medicaid eligibility. Since Medicaid income and resource rules follow SSI rules, payment to a residential care setting would be considered in-kind income to the beneficiary. If the individual still receives SSI, and therefore remains a Medicaid beneficiary, there is no impact.[34] Beneficiaries who are eligible through spend-down or the 300 percent special income level might be affected if the supplementation raises their income above the medically needy income standard or the 300 percent level.

To prevent beneficiaries from losing Medicaid eligibility, states could explore submitting a state plan amendment to exempt in-kind income that supports a person's accommodations or services not covered by the Medicaid payment in residential care settings. Section 1902(r)(2) of the Social Security Act allows states to use such less restrictive income and resource methodologies in determining eligibility for most Medicaid eligibility groups than are used by the cash assistance programs, such as SSI. States can elect to disregard different kinds or greater amounts of income and/or

[34] Payments in 209(b) states might affect Medicaid eligibility since it is not linked to SSI eligibility.

resources than the cash assistance programs, giving states more flexibility to design and operate their Medicaid programs.[35]

FOOD STAMPS

The use of food stamps to pay for meals subsidizes the board component of the room and board cost, making it more affordable for Medicaid beneficiaries and others with low incomes. USDA regulations allow meals provided in certain group living arrangements to elderly, blind, or disabled residents to be supported by food stamps (7 CFR §271.2). Group living arrangements are defined as a public or non-profit residential setting that serves no more than 16 residents. Facilities that can participate as food stamp vendors receive stamps from beneficiaries, which are used as payment toward meal costs.

Wisconsin officials are working with USDA to allow Residential Care Apartment Complexes to become approved food stamp vendors for eligible residents. SLFs in Illinois and Community-Based Residential Care Facilities in Wisconsin have been approved as food stamp vendors. Massachusetts continues to explore this option with USDA. SLFs in Illinois that participate in the program receive about $97 a month for eligible beneficiaries.

One final approach states can use to make room and board costs more affordable is to examine the facility's monthly room and board charges to identify any coverable services--such as laundry assistance, light housekeeping, or food preparation--that Medicaid can reimburse for beneficiaries who require assistance with these IADLs. Including all coverable services in the state's assisted living service payment reduces the beneficiary's monthly payment solely to room and board and any other charges that Medicaid does not cover.

EFFECT OF MEDICALLY NEEDY RULES ON THE ABILITY TO PAY FOR ROOM AND BOARD[36]

States have the option of covering medically needy beneficiaries under their Medicaid programs. The medically needy are persons who, except for income, would qualify in one of the other Medicaid eligibility categories (such as being over age 65 or meeting SSI disability criteria). Medicaid payments can begin for this group once they have "spent down"--that is, incurred expenses for medical care in an amount at least equal to the amount by which their income exceeds the medically needy income level. Any

[35] Medicaid Eligibility Groups and Less Restrictive Methods of Determining Countable Income and Resources. CMS memorandum. 5/11/2001.

[36] Some of the information in this section is taken directly from Smith, O'Keeffe, et al., *Medicaid Home and Community Services: A Primer*.

family supplementation is considered part of the excess income that must be spent down.

The medically needy eligibility option can allow people who have income greater than 300 percent of SSI to become eligible for Medicaid services. But federal law imposes two significant constraints on the use of this option:

- The state must cover medically needy children and pregnant women before it can elect to cover any other medically needy group. Additionally, the state may not place limits on who is eligible for Medicaid by using such characteristics as diagnosis or place of residence. Thus, it cannot use medically needy policies to extend Medicaid services only to HCBS waiver beneficiaries in residential care settings.

- The maximum income eligibility limit that a state medically needy program may use is based upon its welfare program for families--levels that are typically lower than SSI. The income level must be the same for all medically needy groups in the state (i.e., states are not permitted to establish higher income eligibility levels for selected subsets of the medically needy, such as beneficiaries in residential care settings).

These rules have several implications that states need to consider when trying to make the medically needy eligibility option work for higher income individuals in residential care settings. First, these individuals may find it more difficult to incur sufficient medical expenses to meet the spend-down requirements while living in the community than they would in a nursing home. The higher their “excess” income, the higher the amount of their spend-down--which means only beneficiaries with extremely high medical expenses may qualify. Second, community providers are less willing to deliver services during the spend-down period, since payment cannot be guaranteed and collection may be difficult. Third, spend-down rules combined with low medically needy income-eligibility levels mean that individuals may not have enough total income to pay both the bills they incur under the spend-down provision and room and board.

In sum, room and board costs may present a barrier to residential care living for Medicaid beneficiaries unless states take specific steps to make them affordable. Several observers have suggested that the Medicaid program be allowed to pay for room and board in residential care settings as it does in nursing homes, a policy change that would require Congressional approval. However, such a change would likely lead the SSI program to classify residential care as an institution, regardless of how states license it, and SSI pays only a personal needs allowance of $30 to individuals who reside in institutions. Because such a change would shift costs from the federal SSI program to state Medicaid programs, it is highly unlikely.

MEDICAID POLICY ISSUES FOR HOUSING INVESTORS, DEVELOPERS, AND OPERATORS

The growth of assisted living has sparked interest in developing or expanding assisted living for elderly persons with low-incomes. However, facilities may be reluctant to participate in the Medicaid program if they are unsure they will have a reliable source of potential residents and payments. Housing providers and lenders need to project revenues to determine the feasibility of each project. The rent-up period and a stable occupancy rate help them determine cash flow. Public agencies that provide subsidies to developers to build affordable assisted living need assurances that there will be a stable source of funding for residents' service needs. Consequently, in addition to being knowledgeable about the Medicaid program generally, assisted living investors, developers, owners, and operators need to be aware of several Medicaid policy and program issues.

Reliability of Medicaid Funding Options

State plan services are an entitlement and all beneficiaries who meet the service requirements must be served. Personal care is the most common service covered in residential care settings under the state plan, but New York combines payments for personal care, home health services, including skilled therapies. States that do not already cover personal care through their state plan have been reluctant to add it because it is an entitlement and services must be provided statewide. However, CMS has allowed states to limit the provision of personal care provided under the state plan to specific providers, which may address state concerns about adding an open-ended entitlement to personal care under its state plan. South Carolina, for example, allows only licensed community residential care facilities to provide personal care under the state plan.

On the other hand, services provided under Medicaid waivers are not entitlements and states may limit their provision to particular geographic areas, target groups, and care settings. Additionally, states may limit the number of waiver participants and further reduce this number during state budget cutbacks. States can also use solely state-funded long-term care programs to pay for services in assisted living. However, because they also are not entitlements, these programs are also vulnerable during state budget cutbacks.

Types of Waivers

As discussed earlier, states can cover services in residential care settings through a waiver program that provides services in the full range of home and community settings, or through a waiver that covers services only in residential care settings. The type of waiver can affect the pattern of referrals. States that include assisted living as one of a menu of home and community services must always offer beneficiaries a choice of services and cannot guarantee that applicants will choose assisted living. Single service

waivers are better able to assure referrals as long as the number of providers contracting with Medicaid does not exceed the capacity of the waiver.

Waiting Lists

Some states have long waiting lists for waiver services, which can present a significant obstacle to serving Medicaid beneficiaries in assisted living. If waiver slots are not available, Medicaid-eligible persons who cannot be served at home will need to enter a nursing home (if they meet the state's nursing home level of care criteria) and the assisted living facility will have to look elsewhere for new residents. Recognizing this as a potential problem, lenders may require that facilities establish a reserve to cover low occupancy in the event that Medicaid funds are not as available as projected.

States that fund waiver services and nursing homes from a pooled appropriation (Oregon and Washington) or who allow funding to "follow the person" who transfers from a nursing home to community settings (Indiana, Maryland, Texas, and Vermont) have more flexibility.[37] States that permit money to follow the person, essentially allow a person transitioning from nursing homes to bypass the waiting list. States that make a concerted effort to help nursing home residents re-locate to community settings have staff that will generate referrals to assisted living facilities.

State Policy Regarding Room and Board Payments

About half of the states limit the amount that facilities can charge Medicaid beneficiaries for room and board--usually to an amount equal to the federal SSI payment plus a state supplement (if offered). Others do not restrict the amount that can be charged, but providers need to understand their states' income eligibility rules and cost sharing requirements to determine how much Medicaid beneficiaries can afford. Persons eligible for Medicaid because they are receiving SSI have no income other than the federal payment and a state supplement (if any). State supplements vary considerably among states. Of the 28 states that have a supplement, 21 provide less than $100 a month.[38] Even in states that use the 300 percent of SSI income eligibility standard for its HCBS waiver program ($1,692 a month in 2004), beneficiary cost sharing requirements can reduce the amount of income available to pay for room and board.

Time Frame for Determining Medicaid Eligibility

Some states may not determine eligibility for services until financial eligibility has been determined, a process that can take up to 45 days. An extended time frame for determining Medicaid eligibility can be a major deterrent to participation in the Medicaid program, because providers will generally not want to admit someone if they are unsure

[37] Wisconsin has a special waiver to assure community placement for individuals who want to transfer when their nursing home closes.

[38] Stone. J.L. (2002). *Medicaid: Eligibility for the Aged and Disabled*. Congressional Research Services. Report prepared for Members and Committees of Congress.

about payment. If Medicaid eligibility cannot be determined quickly, beneficiaries in the midst of a transition, especially those being discharged from a hospital, may be more likely to enter a nursing home. To address this problem, 11 states report having a process for expediting eligibility determination: Colorado, Connecticut, Florida, Georgia, Idaho, Maryland, New Mexico, North Carolina, Oregon, Washington, and Wisconsin. Some states expedite the determination of Medicaid eligible or allow case managers or eligibility workers to "presume eligibility" based on preliminary information. However, if the eligibility is later found incorrect, states do not receive federal reimbursement for expenditures made while the determination was pending and must pay providers solely with state funds. Nebraska, Ohio, and Washington have provisions for allowing presumptive eligibility, and Michigan allows its Area Agencies on Aging, which administer HCBS programs, to have such provisions as well. Georgia and Pennsylvania have developed initiatives to expedite the application process.

STATE APPROACHES TO REIMBURSING SERVICES

The extent to which low-income older people have access to residential care settings as an alternative to nursing homes depends in large part on the extent to which states use Medicaid to cover services in these settings and providers' views on the adequacy of Medicaid's service reimbursement rates. In addition to the amount of the payment, the reimbursement approach can also serve as incentives or disincentives for providers.

Data suggest that states have increased their payments over the past 4 years, although they are still quite low relative to private-pay rates, and may not cover residents' needs. However, key informants suggest that providers' willingness to accept Medicaid rates is increasingly driven by an over-supply of facilities and difficulty finding private-pay residents.

States face a number of major challenges in developing Medicaid payment methodologies for residential care services, including: (1) defining and distinguishing types of services, (2) collecting data on which to base payments while avoiding complex and burdensome new data collection requirements, (3) developing rates that support quality care and aging-in-place, and (4) providing reimbursement that is sufficient to assure provider participation within state budget constraints.

States use five primary approaches to set rates for Medicaid services provided in residential care settings:

- Flat rates;
- Flat rates that vary by type of setting;
- Tiered rates;
- Case-mix rate; and
- Cost-based reimbursement and fee-for-service rates**.**

Table 1-13 lists the states that use Medicaid to cover services in residential care settings according to their rate-setting approach. Descriptions of each states' reimbursement approach and rates can be found in Section 3 under the heading public financing.

Flat Rates

Under a flat rate system, providers receive the same monthly payment regardless of the amount of services and staff assistance a resident requires. As in the health care system, flat rates for residential care create incentives for facilities to admit residents with lighter care needs, not those with multiple impairments in ADLs, cognitive impairments or health needs. Twelve states use flat rate reimbursements, examples of which are described below.

TABLE 1-13. State Rate Setting Approaches

Flat Rates	Tiered Rates	Case-Mix	Modified Case-Mix	Cost-Based and Fee-for-Service
Colorado	Alaska	Minnesota[d]	Maine	Arkansas[f]
Florida	Arizona	New York	North Carolina[e]	Idaho
Georgia	Arkansas[c]		Washington[a]	Iowa
Illinois[a]	Delaware			Kansas
Massachusetts	Maryland			Maine[e]
Mississippi	Nevada			Michigan
Nebraska	Oregon			Missouri
New Hampshire	Texas[c]			Montana
New Jersey[b]	Vermont			North Dakota
New Mexico				Wisconsin
Rhode Island				
South Dakota				

a. Illinois' rates vary by region.
b. New Jersey has flat rates that vary by setting.
c. Texas has tiered rates that vary by setting.
d. Minnesota uses a combined case-mix and cost-based approach. Counties have basic payment rates that are based on casemix, and a variable payment rate that is based on each client's service plan. The variable payment is negotiated with providers.
e. Maine's reimbursement system combines fee-for-service and case-mix components, depending on the type of residential care setting. Assisted living programs are paid based on a service plan, and residential care facilities are paid on a cost-based system. North Carolina has a modified case-mix payment system.
f. Arkansas uses tiered rates for its wavier program and a fee-for-service system for state plan services.

- **Florida** pays facilities $28 a day for services provided through the waiver program and $9.28 a day for personal care services provide through the Medicaid state plan. Facilities may not charge Medicaid beneficiaries more than $588.40 for room and board, whether they are receiving waiver services or state plan services.

- **Massachusetts** uses Group Adult Foster Care (GAFC)--a Medicaid state plan service--to cover services in residential care settings. Using the state plan to cover services 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. Massachusetts pays a flat daily service rate of $37.75 for Medicaid beneficiaries.

- **Colorado's** Medicaid monthly rate for services is $1094.30 a month ($36.50 a day). The rate covers oversight, personal care, homemaker, chore, and laundry services. The state limits room and board charges for Medicaid beneficiaries to $518 a month.

- **Georgia** pays a flat rate of $31.04 a day for waiver services provided to residents of group homes serving seven to 24 people. The state limits room and board charges for Medicaid beneficiaries to $475, for a combined monthly rate of $1,419.

- **Illinois** has different daily service rates for each of its seven regions, ranging from $47.54 to $61.94. Rates are set at 60 percent of the weighted average nursing facility rate for the region and are adjusted annually to reflect changes in the rates paid to nursing homes.

Flat Rates that Vary by Setting

States may vary its flat rates for different types of residential care settings. Texas pays a higher rate for apartment and other private occupancy settings, reflecting the states' preference for these settings. Varying rates by setting may reflect differences in the average level of resident service needs in each setting. For example, a state may reimburse for services in both traditional 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. Consequently, elderly housing facilities receive a lower rate than purpose-built assisted living facilities with 24-hour staffing.

New Jersey licenses assisted living services, which are provided in a range of settings. The state developed rates for each of three settings regardless of the level of services needed (see Table 1-14). Newly constructed assisted living residences receive $1,800 a month to cover waiver services, and comprehensive personal care homes receive $1,500 a month. Assisted living programs (services provided in subsidized housing) receive $1,200. The state limits room and board charges in both settings to $630.55. Residents in subsidized housing pay a percentage of their income for rent; the housing subsidy pays the difference between this amount and the actual rent.

TABLE 1-14. New Jersey Rate Schedule			
	Assisted Living Residences	**Personal Care Homes**	**Assisted Living Programs**
Room and Board	$630.55	$630.55	n.a.
Medicaid waiver services	$1,800.00	$1,500.00	$1,200.00
Total	$2,434.55	$2,134.55	

Tiered Rates

Tiered rates have been developed to more accurately and fairly reimburse providers for services provided to frailer residents. Tiered systems usually include three to five tiers based on the type, number, and severity of ADL limitations and/or cognitive or behavioral impairments, and create incentives for providers to serve residents with higher service needs. Eight states use tiered rates, examples of which are described below.

- **Arizona's** Long Term Care System has three rate levels based on resident needs. The rate levels vary by type of setting; assisted living homes serve 10 or fewer residents and assisted living centers serve 11 or more residents. The service payments are negotiated and vary by program contractor (county). Daily rates for Level 1 range from $42.59 to $59.26; for Level 2 from $49.10 to $69.00; and for Level 3 from $49.10 to $87.27.

- **Delaware** has three levels of waiver service monthly payments, which were developed based on an analysis of spending for HCBS waiver clients living in their own homes and in adult foster care. Level I is $940; Level II is $1,180; and Level III is $1460. Facilities receive an additional 10 percent for residents with cognitive impairments. The state limits the room and board payment for SSI beneficiaries to $598 in 2004, so maximum payments rates for each level range from $1,538 to $2,058. Residents whose incomes exceed $704 may be charged a higher amount for room and board.

- **Oregon** has five payment levels based on the type and degree of residents' impairments. ADLs assessed include eating/nutrition, dressing/grooming, bathing/personal hygiene, mobility, bowel and bladder control, and behavior Table 1-15 lists the impairments needed for each level, and the payments per level. The state limits the room and board payment for Medicaid beneficiaries to $455.70. The distribution of residents by level is: Level 1--2 percent; Level 2--1 percent; Level 3--6 percent; Level 4--59 percent; and Level 5--32 percent, resulting in an average monthly service cost of $1,643 a month.

- **Texas** uses a tiered payment system for HCBS waiver services derived from their nursing home case-mix system. Payments vary by level and by setting, which are listed in Table 1-16. The state limits the room and board payment for Medicaid beneficiaries to $479 a month.

Rates Based on Case-Mix Systems

Several states have adopted payment systems based on their nursing home case-mix methodology. Like tiered rate approaches, the case-mix approach creates incentives to serve more impaired residents by linking reimbursement to the level of care needed. Case-mix approaches typically have more categories that tiered rates. The case-mix approach requires extensive functional and health data for residents.

TABLE 1-15. Oregon Service Priority Categories and Payment Rates: Assisted Living (July 1, 2004)

Impairment Level	Service Priority	Service	R&B	Total Rate
Level 5	Dependent in 3 to 6 ADLs OR dependent in behavior and 1 to 2 other ADLs	$1,944.02	$455.70	$2,399.72
Level 4	Dependent in 1 to 2 ADLs OR assistance in 4 to 6 ADLs plus assistance in behavior	$1,574.64	$455.70	$2,030.34
Level 3	Assistance in 4 to 6 ADLs OR assistance in toileting, eating, and behavior	$1,204.07	$455.70	$1,659.77
Level 2	Assistance in toileting, eating and behavior or behavior AND eating or toileting	$910.23	$455.70	$1,365.93
Level 1	Assistance in 2 critical ADLs or assistance in any 3 ADLs or assistance in 1 critical ADL and 1 other ADL	$688.36	$455.70	$1,144.06

TABLE 1-16. Texas Reimbursement Rates Effective January 1, 2004

	Assisted Living Apartment	Double Occupancy Apartment	Residential Care Non-Apartment
AL 1	$59.88	$53.29	$37.35
AL 2	$55.78	$49.19	$33.25
AL 3	$50.18	$43.59	$27.66
AL 4	$52.38	$45.80	$29.85
AL 5	$47.16	$40.58	$24.64
AL 6	$45.74	$39.15	$23.21

Both tiered rates and case-mix rates are subject to “category creep” or “gaming,” 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. To address “gaming,” 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 a case management agency or the state agency before being approved. Five states use tiered rates, examples of which are described below.

- **Washington** uses a 12-payment level rate structure for waiver services provided in homes and residential care settings. A case manager conducts a comprehensive assessment to measure level of need and the appropriate rate tier. Three sections of the assessment are used to set the payment level based on a score: health status, psychological/social/cognitive status, and functional abilities and supports. Individuals must be substantially or totally impaired in an ADL to receive a score. Points are also assigned for impairments in speech, sight, and hearing, the number of medications, disorientation, memory impairment, impaired judgment, wandering, and disruptive behavior. The total score determines the payment level. A computer program reviews the assessment and determines the residents "level" and payment amount.

- **New York** modeled its reimbursement rates on its case-mix system for paying nursing homes. The service reimbursement is set at 50 percent of the Resource Utilization Group (RUG) rate for nursing home residents. 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 Department of Social Services' district office reviews the assessment and the RUG category. In 2004, the combined SSI and state supplement rate was $999 in New York City, Nassau, Suffolk, and Westchester counties and $969 in the rest of the state. Beneficiaries retain a personal needs allowance of $127 and the balance is paid to the facility for room and board.

- **North Carolina** covers personal care in adult care homes as a Medicaid state plan service and uses a modified casemix payment system. The payment includes a flat rate for basic personal care with add-ons for residents with specific ADL impairments. Residents with extensive or total impairments in eating, toileting, or both eating and toileting qualify for a higher rate. In 2004, the basic payment is $16.74 for facilities with 30 or fewer beds and $18.34 for facilities with more than 30 beds. The additional daily rate for residents with extensive or total impairments in eating is $10.33, toileting $3.69, and impairments in both eating and toileting are reimbursed at $14.02. An additional payment for residents needing assistance with ambulation/locomotion is $2.64 a day. These payment levels are in addition to the basic rate. Eligibility for the additional payment is based on an assessment by the adult care home, which is verified by a county case manager. The state SSI and state supplement payment standard is $1,112 monthly room. The resident keeps $36 a month for personal needs and pays the remaining $1,066 to the facilities for room and board.

Cost-Based Reimbursement and Fee-for-Service Rates

Cost-based reimbursement pays the facility for aggregate costs incurred for Medicaid eligible residents for allowable services.

Fee-for-service rates are determined by the number of hours of service identified in a care plan or a point system based on an assessment. For example, Kansas treats assisted living facilities as providers of home care services, and reimburses for the services delivered. This approach may be cumbersome for some facilities to implement because they are used to receive a regular monthly payment and providing resident services as needed pursuant to a plan of care. If services are reimbursed on a fee-for-service basis, 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 each resident.

Service delivery in assisted living facilities also differs significantly from in-home service programs. Participants in home care programs typically receive services in block authorizations (e.g., 2 hours of care, 5 days a week). Assisted living residents typically receive services in 15-minute increments at various times 7 days a week including nights. Home care programs typically do not cover services at night, and, of course, cannot meet unscheduled needs.

Tracking, aggregating, and billing can become cumbersome and time consuming, especially for facilities used to charging a single all-inclusive service fee. However, the pricing structure of many facilities includes a basic package of services with additional charges based on the increments of service used by residents. Facilities with this policy for private-pay residents may be better able to participate in Medicaid programs that reimburse using a fee-for-service approach.

Eleven states use fee-for-service rates, examples of which are described below.

- **Arkansas** allows personal care services to be provided through the state plan in a person's home "or other setting" such as a residential care facility (RCF). RCFs can be reimbursed for up to 64 hours of personal care per month.

- In **Missouri**, personal care and advanced personal care services are reimbursed as a Medicaid state plan service in RCFs. Facilities are reimbursed at an hourly rate for the number of hours authorized in the care plan. The hourly payment rate is $13.16 for personal care aides, $15.20 for advanced personal care aide services, and $28.07 for nursing visits. The maximum payment is $2,368 a month, which is equal to the state's Medicaid cost for nursing home care. No more than one nursing visit a week can be authorized. Very few residents receive advanced personal care and nursing visits.

  The state limits the room and board rate for Medicaid beneficiaries to the federal SSI payment plus the state supplement, also called a "cash grant," which varies depending on the type of facility. Type I facilities provide room and board, supervision, and protective oversight and receive a monthly payment of $695, comprising the SSI payment and a state supplement of $131. Type II facilities provide personal care, dietary supervision, and health care in addition to Type I

services, and receive a combined monthly payment of $826, comprising the SSI payment and a state supplement of $262.

- **Montana** uses a payment system that have elements of a tiered system but lack the structure and limited number of payment levels of tiered approaches. The payment amount varies widely based on the number and type of impairments, a structure more like a fee-for-service reimbursement approach. Montana's payment is based on a point system. Agency field staff determine the number of points based on an assessment of impairments, and the provider receives $33 a month per point. Residents with severe impairments, totally dependent in more than three ADLs, can receive $44 a month for each point.

  Monthly waiver reimbursement rates for personal care facilities vary between $520 (the basic service rate) and $1,800, depending on the residents' level of care needs. Additional payments are calculated based on ADL and other impairments. The points determine the actual payment within the range. The state limits monthly room and board payments for Medicaid beneficiaries to $564. The total monthly amount facilities receive (for services, room and board) ranges from $1,084 to $2,363, although very few participants have been approved at the highest service rate.

Adequacy of Rates

At first glance, it appears that states are paying markedly different rates for services, suggesting that some states may not be paying rates that are adequate to meet residents' service needs. However, it is not possible to compare service rates across states due to significant differences in their admission and retention criteria for residential care settings. Most notably, rates for providers who do not serve nursing home eligible residents are not comparable to rates for providers who do serve this population. Additionally, because nursing home level of care criteria themselves vary markedly across states, a person who is nursing home eligible in one state, may not be in another state.

States have no models on which to build reimbursement methodologies for residential care settings. Nursing home payment methods include both room and board and service costs, and must address the needs of higher acuity residents than are generally served in residential care settings, even those that serve individuals who meet a nursing home level of care. Historically, board and care homes have provided room, board and very limited services, and payment rates typically have been set at SSI plus state supplement levels. The trend is for residential care settings to provide a level of care somewhere between traditional board and care and nursing homes.

A potential source of comparable cost data for developing reimbursement rates is in-home services provided under HCBS waiver programs. However, significant differences exist between services provided in-home and in residential care settings. First, in-home service utilization may be constrained by the times during which it is available, state

funding limits, or the lack of in-home workers. Second, in-home utilization may overstate the amount of services an individual needs because services are reimbursed in blocks of time such as 2-hour increments. In contrast, because residential care staff are on-site at all times, this setting is able to offer more intermittent services in smaller time increments. On the other hand, in-home utilization may understate services received because it does not include the sometimes considerable amount of unpaid care provided by family and friends, particularly during the evening, at night, and on weekends, when in-home services are generally not available.

These differences in utilization patterns may or may not offset one another in the aggregate. Consequently, states may need to collect data on service provision in residential care settings in order to develop adequate service rates. Washington and Maine have both conducted time studies to determine the amount of time direct care staff spend with residents.

EXPANDING THE SUPPLY OF ASSISTED LIVING FOR LOW-INCOME INDIVIDUALS

Both federal and state governments recognize that, in order to reduce costly institutionalization, a range of supportive housing and service options is needed. An increasing number of persons 65 and older who can no longer live independently view assisted living as a preferred alternative to nursing home care, or as a means to forestall admission to a nursing home. But market rate assisted living that provides private rooms and a high level of services is generally far beyond the means of most low-income elderly persons.

There are several sources of funding available to finance the development or renovation of housing to create affordable assisted living. The Federal Government's main vehicle for creating affordable housing is the low-income housing tax credit program. Other sources of funding are programs in HUD and USDA, and state programs. These departments provide funds to both finance new housing units and provide rental assistance in existing housing. However, not all programs that create and/or support affordable housing can be used for affordable assisted living.

Developing affordable assisted living is a complex undertaking. Different statutory authorities and administrative structures, and a lack of communication among those who manage housing and service programs, present major difficulties. A major issue for some housing subsidy programs is that the lenders and investors they depend on require evidence of a stable revenue source over the life of their commitment to protect their investment--typically 15 to 30 years. But state service programs may be unable to provide a table revenue source because they are subject to annual appropriations that depend on the state's budget.

Additionally, despite targeting the same or similar populations, housing and service programs often have different and often conflicting income, age, and functional eligibility rules that make it difficult to create the supportive housing plus services arrangements that frail elderly persons need. Medicaid program requirements can also pose barriers to the receipt of services in residential care settings. Medicaid's rules regarding financial eligibility and post-eligibility treatment of income may limit an individual's ability to pay for room and board.

Housing programs also have conflicting requirements. Yet, successful projects often need to combine funding from multiple housing finance programs (e.g., low-income housing tax credits, HUD's HOME program, the Federal Home Loan Bank's Affordable Housing Program, conventional debt, and Housing Choice Vouchers), with two or more service subsidy programs (e.g., Medicaid state plan or waiver programs, state supplements to the SSI program, state funded service programs).[39]

At the state level, some agencies that manage Medicaid waiver programs have begun working with state and local housing agencies, and non-profit housing organizations to explore ways to combine housing subsidies with Medicaid services. At the federal level, HUD and the U.S. Department of Health and Human Services are currently looking at ways in which the agencies can work together to expand housing and service choices for people with disabilities.

[39] Robert Jenkens, Deputy Director, Coming Home Program, Vice President, NCB Development Corporation. Personal communication, June 2004.

STATE RESIDENTIAL CARE AND ASSISTED LIVING POLICY: 2004

PDF Files Available for This Report

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SECTION 2: Comparison of State Policies http://aspe.hhs.gov/daltcp/reports/04alcom2.pdf

SECTION 3: State Summaries http://aspe.hhs.gov/daltcp/reports/04alcom3.pdf

Also available: A complete list of sections and tables, with HTML and PDF links to each, is available at http://aspe.hhs.gov/daltcp/reports/04alcom.htm. This table of contents also includes links to Section 3 summaries, broken down by state.