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

GUIDE TO ASSISTED LIVING AND STATE POLICY

May 1995

Office of the Assistant Secretary for Planning and Evaluation

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PREFACE

Using this Guide. The 1995 edition of the Academy's *Guide to Assisted Living and State Policy* builds upon the 1992 publication. We have expanded the scope to include all states we can identify that have a program or licensure category called assisted living. We have tried to analyze how states are developing and implementing assisted living to develop a model, if not a definition, that differentiates the term from board and care and other equivalent supportive housing or housing with services models. The Guide includes a narrative discussion of state policy directions and a summary of each state's statute, regulations or process for designing state policy.

We have also updated the financing section to include new developments in sources of financing for services and housing. Since the first edition, a number of state Housing Finance Agencies (HFAs) have begun making loans for assisted living and we have interviewed officials in several HFAs to learn how they approached these loans, the issues or obstacles encountered and how they have addressed them.

Finally, we have included a question and answer section based on the comments from a survey of state agencies. We asked each responding agency what issues they would like to see addressed in the Guide. While we attempted to cover the issues raised, we added the Q&A section to make sure that we responded to the priorities of the staff that we rely upon to gather our information.

Assisted living is a fast moving policy trend within state government and we plan to continue to monitor developments and provide assistance to states seeking information about other state efforts and options for their state. The Academy welcomes comments, suggestions and updates of information and developments in each state.

Note: Sections of the Guide were updated in August to reflect legislation that has passed in Kansas, North Carolina and Wisconsin.

EXECUTIVE SUMMARY

In 1992 the Academy published a guide to assisted living for state policy makers that analyzed policies in five states: **Florida, Massachusetts, New York, Oregon and Washington**. In 1994, the Academy surveyed the Departments of Aging, Health and Medicaid and the Housing Finance Agency in all 50 states to identify states that have passed legislation, issued regulations or established policies concerning assisted living or that have established a process to develop recommendations. Based on responses to the survey, we contacted key respondents in each state that indicated that assisted living legislation, regulations or policy has or was being developed. We identified 22 states that have passed legislation, issued regulations or have implemented programs through Medicaid home and community based waiver services programs. In addition, 6 states have issued draft regulations or have legislation pending that would establish a program. Another 5 states have created a task force to make recommend s or conducted a study.

The study analyzed state approaches to assisted living and compared states according to their definition of assisted living, the living unit requirements, tenant policies, services, financing, medication policy, and staffing requirements. State approaches can be grouped into three distinct models: institutional or board and care; a new housing and services model and a services model (see matrix). The institutional model is followed by **Alabama, Rhode Island, South Dakota, Virginia and Wyoming**. Models were classified as institutional if they allowed multiple occupancy rooms and separate bathrooms shared by more than two persons. These models either do not allow people who qualify for placement in a nursing facility to be served, did not allow any skilled services to be provided or have adjusted their service and level of care criteria to facilitate aging in place but have retained an institutional approach to care.

The new housing and services model generally requires apartment settings or private rooms, allows skilled nursing services to be provided and allow occupancy by tenants who qualify for placement in a nursing facility. States in this category include **Arizona, Hawaii (proposed), Iowa (pending), Massachusetts, Ohio, Oregon and Washington**.

The **Hawaii** model has been recommended by a task force and legislation creating a definition of assisted living passed the end of April. **Ohio's** classification follows passage of legislation in 1993 and issuance of draft rules in 1994. Implementation has been halted as the legislature is considering a repeal of the bill and creation of a Medicaid waiver program that would be implemented under rules that are similar to those issued by the Department of Aging.

Under the service model, states certify or license the provider of services rather than the setting in which services are provided. A few states have created a financing source for assisted living through Medicaid waivers rather than a separate licensure

category. The waivers define the service requirements and do not create a new licensure category.

States using the service model approach can be further divided into states that allow assisted living services to be provided only in apartment settings and those that allow services in a range of settings. States certifying the service provider and limiting service to apartment settings include **Connecticut, Minnesota, New Jersey, North Dakota and Wisconsin**. Programs in **Minnesota and North Dakota** have been developed through Medicaid waivers rather than a separate licensure category. **Wisconsin's** model has been recommended by a task force and legislation approving funding through a Medicaid waiver is pending.

States which focus on the service component of assisted living and allow delivery in both apartment, single and double occupancy bedrooms include **Alaska** (proposed rules), **Florida, Maine, Maryland, New York, North Carolina** (proposed), **Oklahoma** (task force report), **Utah and Texas**.

The study examined the definitions used by states as well as federal agencies, associations and companies selling long term care insurance policies. While the definitions have much in common, there is little likelihood that a definition will be developed that is commonly accepted for two primary reasons. First, the private market is extensively developed in many states and attempts to define public policy that conflicts with the directions of the market will adversely affect current and future projects. Second, allowing the delivery of skilled nursing services in residential settings creates competition with nursing facilities for “patients” needing personal care, assistance with medications and some skilled services. On the other hand, state policy makers are seeking to offer more choice and service options in residential settings to people who are aging in place. Those conflicts are likely to yield resolutions and result in definitions and models that are suited to each state.

Definitions

State definitions follow the purpose of the state's policy. States seeking to address and encourage “aging in place” in a range of settings have defined assisted living in a way that allows higher levels of service (personal mm and skilled nursing) to be delivered in multiple settings. States seeking to develop residential settings for people who may need to move from their home or apartment have developed assisted living as a setting in which personal care and skilled services can be provided. These states tend to require apartment settings for assisted living residences.

State definitions tend to address the services and/or settings that are covered by assisted living, the needs that may be addressed, the services provided and the autonomy and decision making that must be provided to residents.

Units

Perhaps the most controversial component in assisted living is the requirement for the living unit. The study identified three general requirements. A number of states require apartment settings in order to maximize the residential and homelike qualities. A second model offers private bedrooms with attached baths or double occupancy bedrooms shared by agreement of the residents. A third model offer shared bedrooms with bathrooms or bathing facilities that may not be attached to the room and can be shared by more than two residents.

While some contend that apartment style models raise costs and require features that residents may not use or that may be harmful (stoves, microwaves), others contend that kitchens or kitchenettes do not add significant costs, can be safe and provide an ambiance that is familiar and encourages autonomy. Kitchenettes can be used for snacks and facilitate socialization when friends or family members visit who often prepare a meal during their visit.

Feasibility studies, market strategies and reimbursement policy for low income residents shape a developer's position on how state regulations should deal with the type of living unit.

Tenant Policy

The study differentiated licensing rules that specify whom may be served in assisted living versus program requirements that determine whom will be subsidized. Tenant policies follow four approaches. New Jersey offers the broadest criteria and allows residents with unstable health conditions and extensive medical needs as long as the residence is staffed to meet the service need. The second approach allows people needing skilled services to be served as long as their health conditions are stable and they do not require 24 hour nursing care. A third model ties residency to the need for skilled care for a specified period of time (45, 90 or 120 days) or allows health related services in a part time or intermittent basis. Finally, states have listed the specific conditions and diagnosis that people may or may not have to live in an assisted living residence.

Services

State rules all allow or require the provision of personal care or personal assistance services that are provided or arranged by the assisted living residence. State policies vary on the extent to which skilled nursing services can be provided. Some states limit skilled services to a number of days. One state requires that skilled services must be provided by a certified home health agency while other states allow assisted living residences to provide services directly or through contracts with outside agencies. A few states license the service and allow a number of options for its provision.

Facilities providing assisted living services may be required to obtain a separate service license or contract with an outside agency. While all states allow assisted living residences to provide assistance with administration of medications, the specific tasks listed in statute or regulations vary.

Financing Services

Medicaid and SSI continue to be the primary sources of financing for low income tenants. Major changes are anticipated in federal housing programs and proposals to cap the rate of growth in Medicaid or to create a Medicaid block grant, if passed, will significantly change the climate and policy directions. If a Medicaid block grant is passed by Congress, two directions are likely. Because states spend the vast majority of Medicaid funds for institutional long term care, states will either cut back on community and residential alternatives in order to maintain funding for the major source of long term care or develop strategies which shift resources from institutional models to residential and in-home services.

Under current policies, states have combined SSI and Medicaid financing to support tenants in existing assisted living residences. The use of HUD mortgage insurance, tax exempt bonds and tax credits allows developers to construct more affordable projects and both the tax exempt bonds and tax credit programs have set aside requirements for low income tenants (50% or 60% of median income). Combining SSI and Medicaid policy allows states to support tenants with incomes up to 40% of median income. States can combine SSI and Medicaid eligibility options to make assisted living affordable for a broader range of people. Since Medicaid cannot be used to pay for room and board in non-institutional settings, states must rely on SSI to cover these costs. The SSI payment may not be adequate in states with higher development costs and a higher state supplement may be needed. States should consider the net state cost of an additional state supplement **and** Medicaid compared to the net state cost of care in a nursing home.

People who receive social security and/or small pensions who do not qualify for SSI also lack sufficient income to afford the monthly fees. Medicaid rules allow eligibility to be set at 300% of the federal SSI payment (about 40% of median income) for people who qualify for placement in a nursing home. States then establish a maintenance allowance that is sufficient to allow tenants to pay for room and board. Combining these SSI and Medicaid options can limit, but not eliminate, the affordability gap. See the later discussion of these options.

Significant changes may be made in financing of services as Congress considers steps to reduce the rate of growth in Medicaid. Approaches that would cap the rate of growth at 5 % for five or seven years or convert Medicaid to a block grant will significantly affect state policy development.

Financing Housing

Major changes have also been proposed in HUD housing programs. While legislation implementing these proposals has not yet been submitted, the Administration's summary of the proposal may give state's additional flexibility to finance assisted living. The implications of funding levels will affect the extent to which this flexibility can be utilized by states seeking to address multiple housing needs.

HUD has implemented rules adding assisted living to its mortgage insurance, section 232, program. The program helps developers obtain lower cost loans to build new facilities.

The study identified a number of state housing finance agencies that are or plan to provide loans for assisted living. Only a few states have coordinated policy development between Housing Finance Agencies, Medicaid, Health and Aging Departments.

ASSISTED LIVING AT A GLANCE: STATUS OF STATE ACTIVITIES

State	Status	Model
Alabama	Multiple categories are licensed based on size.	Institutional model.
Alaska	Statute passed in 1994. Draft regulations were issued in January 1995.	Board & Care/housing model.
Arizona	Demonstration program operating.	New housing and services model.
Connecticut	Regulations were effective in December 1994. Licensure process implemented.	Licensed as a service in settings meeting certain requirements.
Florida	Regulations issued in 1992. Regulatory and legislative amendments are pending. An HCBS waiver has been approved to serve Medicaid recipients.	Service model in multiple settings.
Hawaii	A task force has been formed to pursue assisted living. Legislation directing the development of assisted living regulations modeled after Oregon & Washington and a study of Medicaid HCBS waiver options passed in April. A task force is revising the nurse practice act.	New housing and services model.
Idaho	A concept paper has been developed by the Residential Care Council. Legislation will be submitted by the Council for the next legislative session.	
Illinois	An effort is in the early phases of development through an initiative of the Illinois affiliate of the American Association of Homes and Services for the Aging.	
Indiana	Study completed in 1994. No follow up activity to date.	
Iowa	Legislation has passed the Senate and amendments have been added by a House Committee. The bill, SF 454, has been carried over to the 1996 session when final action will be taken. Draft rules will be prepared in 1995. Implementation is planned for 1997.	New housing and services model.
Kansas	In 1995, a bill creating a definition of assisted living was signed into law. Regulations are being drafted.	New housing and services model.
Louisiana	Draft regulations are being prepared as a cooperative effort by the Aging, Health and Medicaid Departments.	
Maine	New regulations are effective in April, 1995 that re-classify current programs. The legislature has passed a bill creating a task force to examine the rules and make further recommendations.	Service model in public housing and residential care settings.
Maryland	Service model in elderly housing and small group homes.	Service in multiple settings model.
Massachusetts	Legislation creating an assisted living certification process was signed in January 1995. Regulations are being drafted. Certification process created for settings meeting specified criteria. Financing for services and housing (SSI) are available for purpose built and conventional elderly housing projects.	New housing & services model.
Michigan	The Department on Aging chairs a work group charged with developing recommendations.	

State	Status	Model
Minnesota	Assisted living has been implemented as a Medicaid HCBS service.	Licensed as a service in settings meeting certain requirements
Montana	Legislation creating an assisted living category is pending.	
New Hampshire	The Housing Finance Agency has initiated a working group to study assisted living.	
New Jersey	Regulations creating a new licensure category were implemented. 3 facilities have been licensed and 35 applications are pending. An HCBS waiver request for 1500 slots has been submitted to HCFA.	Service in multiple settings model.
New Mexico	Assisted living has been added as a service through the Medicaid HCBS waiver.	
New York	Contracts with 63 projects and 3500 units have been approved. An RFP for 700 units in New York City is being issued. Budget proposal may repeal the program.	Service in multiple settings.
North Carolina	Chapter 535 (1995) was passed which defines assisted living residence as a category of adult care homes. A January 1996 effective date is expected for new assisted living guidelines.	Services in multiple settings.[1]
North Dakota	Assisted living services are funded through the state's Medicaid waivers and two state funded service programs.	Service model in apartment settings.
Ohio	Legislation was passed in 1993. Regulations implementing the bill were postponed pending review by a special committee in 1994. Legislation passed in 1995 repealing teh statute, and authorizing funding for 1300 assisted living Medicaid waiver slots effective 7/96. With the repeal, assisted living is licensed as a residential care facility.	New housing and services model.
Oklahoma	A task force has been created to review and develop assisted living recommendations. A draft bill has been circulated and is being revised by the task force.	Service model.
Oregon	Program rules operational. Supply continues to expand.	New housing and services model.
Rhode Island	About 45 residential care and assisted living facilities are licensed. Newer buildings offer units with private bath.	Institutional model.
South Dakota	Assisted living category exists in statute. Limited services allowed.	Institutional model.
Texas	Assisted living has been added to the Medicaid HCBS waiver.	Licensed as a service in settings meeting certain requirements.
Utah	Program rules have been approved; rules governing the buildings were approved by a state board in March. An amendment to the HCBS waiver will be submitted in May 1995 to add assisted living.	Covers apartment style units and models with single/double occupancy rooms with shared lavatories & baths.
Vermont	Department of Aging & Disability is developing a program as part of the process to renew their Medicaid HCBS waiver. An advisory group has been established with a subcommittee on assisted living.	
Virginia	Regulations allowing assisted living services in adult care residences are pending. Expected to be effective in July, 1995.	Institutional model.

State	Status	Model
Washington	A demonstration program has been expanded to 35 facilities and 1200 units. Further expansion approved. Draft rules have been developed based on the demonstration experience.	New housing and service model.
Wisconsin	Legislation certifying assisted living and authorizing funding for the Medicaid HCBS program was passed as part of the governor's budget. Regulations will be submitted by December 1995.	New housing and services model.
Wyoming	Regulations upgrading board & care rules were issued. New rules allow skilled nursing and medication administration.	Institutional model.

1. This model allows multiple settings (apartments, single rooms or shared rooms), but licenses the setting.

TABLE 1. Comparison of State Models According to Characteristics of Assisted Living

State	Apartments Required	Bathroom Attached	Lockable Doors	Double Occupancy	Admissions[1]	Service Package[2]	Staffing	Philosophy[3]
Arizona	X	X	X		X	X	X	X
New Jersey	X	X	X		X	X	X	X
Ohio	X	X	X		X	X	X	X
Oregon	X	X	X		X	X	X	X
Connecticut	X	X	X		X	X	X	
Wisconsin	X	X	X		X	X	X	X
Washington	X	X	X		X	X	X	X
Massachusetts	X	X	X	X	X	X	X	
Minnesota	X	X	X		X	X		
New York	X[4]		X	X[4]	X	X	X	
Texas	X	X	X		X	X		
North Dakota	X	X	X		X	X		
Iowa	[5]				X	X		X
Utah			X	X	X	X	X	X
Florida			X	X	X	X	X	X
Virginia					X	X	X	X
Alaska					X	X	X	
Alabama				X				
Rhode Island				X				

1. Regulations allow tenants who require nursing facility level of care or skilled services.
2. Services regulations allow provision of some skilled nursing service although the extent of skilled services may vary.
3. Philosophy: means a policy that emphasizes resident autonomy, privacy, choice and participation in decisions.
4. Apartments required in "Enriched Housing" settings; double occupancy allowed in Adult Home settings.
5. Senate 454 requires private space for sleeping and dressing which will be defined by regulation.

SUMMARY OF STATE ACTIVITY

State	Task Force Formed	Report Issued	Legislation Filed	Legislation Passed	Regs Being Drafted	Regs Proposed	Regs Final	Medicaid Funds[1]
AL							X	
AS		X	X	X			X	
AZ[2]								X
CN							X	
FL				X			X	X
HA	X	X	X	X	X			X[5]
ID	X	X	X					
IA	X	X	X		X			X[5]
IN		X						
KN				X	X			
LA	X				X			
ME	X	X	X	X			X	
MD								X
MI	X							
MA			X	X		X	6/95	X
MN								X
MT			X					
NM								X
NJ				X			X	X[5]
NY				X			X	X
NC	X	X	X	X	X			
ND								X
OH[3]				X		X		X[5]
OK	X	X	X					
OR							X	X
RI							X	
SD							X	
TX	X							X
UT				X			X	X[5]
VA							X	
VT	X							
WA[4]			X			X		X
WI	X	X	X	X	X			X[5]
WY							X	

1. Means a financing sources has been developed for low income persons or Medicaid recipients.
2. Pilot program.
3. Legislation in Ohio repealed the existing statute and replaced it with a broad authority to offer assisted living, as well as authorize a Medicaid waiver using proposed rules.
4. The existing program operates as a demonstration program through Medicaid contracts. Legislation establishing the program and draft rules are pending.
5. Medicaid waiver financing planned or likely.

I. INTRODUCTION

In 1992, The Academy published “Building Assisted Living For The Elderly Into Public Policy: A Guide For States” to help state policy makers examine an emerging concept for providing residential, home-like settings for elders. The Guide examined the confusion surrounding the use of the term “assisted living” and the principles that are associated with assisted living as distinct from board and care, residential care, personal care homes and models using similar terms. The Guide also described policy initiatives in five states: Florida, Massachusetts, New York, Oregon, and Washington and the financing sources for housing construction and operation and services. Since 1992, a number of states have issued regulations, are presently developing regulations or have initiated a study process to consider assisted living as a separate category. As the trend continues, the use of the term assisted living still brings confusion and variations in definition and meaning among states.

This report is intended to update information provided in the original guide and to describe policies in all states that can be identified as licensing or providing assisted living. In addition, it seeks to differentiate assisted living from board and care and other models of institutionally based long term care.

State Surveys

In July 1994, the Academy conducted two brief surveys to identify state activity in assisted living. The first survey focused on licensing and service delivery while the second dealt with housing financing. The regulation/services survey was designed to identify states that have promulgated or are developing or considering assisted living policies or regulations. The survey was sent to the Health, Aging and Medicaid Agencies in each state. The survey was intended to gather initial information and to identify states that would receive follow up calls to learn more about the specifics of their program. States were asked to submit copies of their most recent statutes, regulations, or draft regulations/policies.

The survey did not offer a definition of assisted living. Instead, the survey sought to identify states that indicated, using their own frame of reference, that they have an assisted living program or licensure category. Eighty six respondents from 48 states answered the survey (Aging, 32; Medicaid, 32; Health, 22). Responses to the question “does your state have an assisted living model, program or category” sometimes brought conflicting answers from respondents in the same state. The conflict resulted from varying perceptions about the question and possibly a lack of knowledge about programs outside their own agency. The question was intentionally worded to gather information about how state agency staff thought assisted living is defined. Follow up calls were made to states that responded positively to the question. Many people view the term assisted living generically and considered residential care, personal care

homes and other variations as assisted living. Others indicated that they needed a definition before they could answer.

Based on follow up interviews and analysis of regulations and legislation, 23 states either have legislation authorizing assisted living, a licensure category, or an assisted living service program. Legislation authorizing assisted living is pending in three states (**Idaho, Iowa, and North Carolin**) and legislation that was filed did not pass in **Montana**. Interagency work groups or task forces are operating in five states to develop policy (**Illinois, Louisiana, Michigan, Oklahoma and Vermont**) and a study was completed in **Indiana**.

Legislation that would repeal or modify existing program authority is pending in **Florida** (modify), and **New York** (repeal). Legislation has passed in **Ohio** repealing the statute and substituting a service program for a licensure category. As this report was finished, two states, **Maine and Utah**, had finalized their regulations.

Because of the overlap between assisted living and other forms of supportive housing, we asked respondents if the state's assisted living program or category differed from board and care or equivalent programs (personal care homes, rest homes, residential care facilities, etc.).[1] An analysis of state policies found that assisted living and board and care models were the same in five states (**Alabama, Rhode Island, South Dakota, Virginia and Wyoming**). Regulations in these states provide for multiple occupancy rooms and generally limit the extent of services that can be provided and the conditions and services needs that tenants may have.

The second survey was mailed to Housing Finance Agencies and asked if the state HFA had financed assisted living projects in the last five years or, if not, whether the HFA had plans to do so in the future. The response rate was much lower -- only 15 states. Nine states indicated that they provided financing for assisted living or planned to do so and 6 state HFAs said they did not. Confusion about the definition may be present here as well since several of the state answering affirmatively do not have an assisted living category or program. However, HFAs provide financing for private sector facilities that either are not required to be licensed or use the term “assisted living” rather than the term specified as a licensure category. The survey also asked HFAs to identify the sources of financing (tax exempt bonds, tax credits, HUD loans). Analysis of the HFA survey is continuing.

[1] Throughout the study, board and care is used generically to refer to models such as adult homes, residential care facilities, personal care homes and other terms. State regulations generally allow multiple occupancy bedrooms with shared lavatories and bathrooms.

II. FINDINGS

In order to bridge the gap between states which explicitly use the term “assisted living” and states that do not, we have developed a working framework which delineates several components found in state policy that may be used to differentiate assisted living from board and care models. We developed a matrix that identifies the components in each state. As a result, some states that use the term assisted living may not in fact meet the framework (**Alabama, Rhode Island, South Dakota, Wyoming**) and others that do not use the term may be included (**Florida**). Florida uses the term adult congregate living facility and extended congregate care although legislation is pending that would change the term to assisted living.

Defining Assisted Living

In developing our approach to assisted living, we struggled with a starting point. No one in the long term care field enters a discussion about assisted living without a frame of reference. For many, it's the nursing home and for others a housing setting. We pictured three buildings standing side by side, a single family home, an apartment building and an assisted living site (we prefer to avoid using the term “facility” and have chosen to use the term “residence” instead). Within each building, an individual -with chronic but stable health conditions and dependencies in activities of daily living lives. The person living in their own home can receive skilled nursing care, personal care and a host of other services. Relatives can perform tasks that only a licensed professional can perform if the caregiver were not related. Except in relation to local building codes, government agencies do not consider the condition of the structure. Subject to a rental agreement, a similar person living in an elderly housing project can receive a wide range of ADL and nursing services from certified home health agencies and other community providers. For reasons related to the preferences of the housing owner or management company, rental agreements may not allow someone who is incontinent, forgetful or exhibits aggressive behaviors to reside in the project, state policy may not permit certain frail persons to reside in that setting. However, these conditions are not a function of the government's regulation of the building, but rather, a statement of state policy regarding the service environment in a specific setting. If a multi-housing project provides or arranges for services, and the cost of the service is included in the monthly rate, a license would be needed in most states.

When the person moves from their single family home or apartment to a building in which all the residents receive services, a totally different government perspective and regulatory requirements take over. Until the advent of assisted living, policy makers and regulators tended to focus not only on the organization providing the actual service and the credentials of the direct care staff, but on the building itself apart from the application of local and state building and fire codes. While a person may live at home with skilled nursing needs, extensive ADL needs and unstable medical conditions, regulations often will not allow the same person to receive care in other settings. In

apartments, assisted living and other settings, government regulation focuses not only on the person's conditions and service needs, but also on the source of care and the source of payment. Licensed facilities may be prevented from providing skilled nursing services but the resident may receive the very same care from an outside agency! These incongruities highlight the contradictions of many regulatory policies and provide a sound basis for re-examining how states license, regulate and finance long term care for their citizens.

This perspective leads to consideration of assisted living as a service, rather than service in a particular setting, but, if so, how then would it differ from home care or in-home services? The value of the assisted living trend is its emphasis on two factors: residential settings, which raises a debate over whether buildings with multiple occupancy bedrooms and shared baths should be considered residential, and a consumer focused values orientation which emphasizes autonomy, dignity, privacy, independence and choice.

We have approached assisted living as a home setting in which services are provided. Boundaries can be drawn around the conditions and needs that can be met -- how much skilled nursing can be provided, what types of health conditions can be treated -- the types of living environments or structures which define the setting, and the philosophy or goals that differentiate assisted living from other models of care. We have not developed a definition, per se, but instead have identified factors which we believe constitute assisted living in state models.

A range of definitions have been developed by national associations, states and the US Health Care Finance Administration (HCFA) (see appendix). The definitions have different sources and purposes. Unlike its approach to nursing homes, the federal government has not developed a universal definition. The term “assisted living” is used in two federal programs. The Health Care Financing Administration's definition serves a narrower purpose than a state licensing requirement. It was developed to help states define the services which are reimbursed through the Medicaid waiver program. The Department of Housing and Urban Development (HUD) has issued regulations under Section 232 to provide mortgage insurance for assisted living developments. Although the question of developing a uniform national definition and standards for assisted living have been raised, thus far, there has not been movement to do so.

Developing a definition that would be accepted nationally is unlikely in the near future. States have historically retained the authority to license service providers and, despite similarities, each state has developed definitions and requirements to meet their own circumstances. Definitions can be found in state law, regulations, Medicaid waiver programs and even provider contracts. They can be used to set licensure standards and requirements and to describe purchasing expectations. A few states use their definition to set purchasing standards (**Minnesota, Texas**) for the services that will be reimbursed and they also set requirements for the housing in which people who receive such services can reside. This approach does not affect the state's licensure categories and instead sets parameters that differentiate providers within a licensure category.

As they develop their lending policies, state Housing Finance Agencies are developing their own definitions which often differ from the definitions used by licensing agencies. HFAs have defined a niche that is closer to the private market trends and often constitutes a subset of settings covered by licensing criteria.

Policy makers, providers and consumers would benefit from a commonly understood meaning for the term “assisted living.” Regulations is five states (**Alabama, Rhode Island, South Dakota, Virginia and Wyoming**) use the term for their licensure category but it used to describe a board and care model. Some states use the board and care regulations as the basis of their assisted living program and require higher standards for the living unit or allow a higher level of services to be provided to residents who need some skilled services. **Florida** does not use the term but differentiates Extended Congregate Care from the basic level of service in adult care homes. Assisted living providers in **Washington** must have a boarding home license but must offer apartment style units to participate in the state's program. **Maine's** draft regulations use the term assisted living but define it as a service which essentially renames existing programs.

Definitions from the Assisted Living Facilities Association of America and the American Seniors Housing Association (ASHA) emphasize the service focus and the resident's prominent role. Definitions or frameworks developed by associations usually do not deal with or define the nature of the housing component. The ASHA definition makes reference to residential surroundings but does not describe what constitutes residential surroundings. The National Association of Residential Care Facilities considers that the definition of assisted living is interchangeable with residential care, foster homes, board and care homes, sheltered care homes and other terms. They believe that board and care carries a negative meaning and assisted living has emerged as a market and public relations oriented strategy.

A potential for consensus …

After examining definitions and models from these sources, we offer a path for arriving at a standard understanding of assisted living. Consumers, providers, advocates and policy makers all feel the term “facility” conveys an institutional environment that is contrary to the goals of their program. They consider assisted living as someone's home with all the meaning “home” implies (bedroom, living room, bathroom, kitchen, control of space, belongings). Yet referring to assisted living as “home” is also confusing. The recently passed statute in **Massachusetts** uses the term “assisted living residence.” Perhaps we need to create a term that has no other meaning. We would give it meaning for at least a segment of the assisted living market or in states that have defined assisted living as a purpose-built building with apartments. Otherwise tenants in conventional elderly housing buildings would refer to the building differently depending upon whether they were independent and did not receive any service or if they participated in the project/state's assisted living program.

As the field evolves, it is likely that we may need several terms that differentiate the settings in which assisted living is found. We may need one term for apartment style buildings in which all residents receive services and have sought tenancy in the building because of their service needs. We may need another term to describe services provided to some but not all residents in elderly housing buildings. This housing with supportive services model meets the needs of people as they age in place. Still another term is needed to describe modifications to the existing or historical board and care licensure category of facilities as they serve residents with higher needs for personal care and routine nursing services. Models that identify assisted living as a service that can be provided in a range of residential/ institutional settings create a further conflict. Assisted living, as it first emerged in state policy, conveyed a combination of a service package (emphasizing personal care and nursing services) provided in a home-like setting. Many of the settings were covered by the state's board and care license but offered an environment that exceeded minimum standards and emphasized privacy. Yet the emphasis on apartment style units conflicts with emerging concepts concerning assisted living models to serve people with Alzheimers' Disease. Studies have found that 29% to 42% of the residents in assisted living settings have cognitive impairments.[2] Hyde contends that “best practices” in dementia care show that shared rather than private units are more successful serving people with dementia.

An examination and analysis of licensure categories alone is not sufficient to develop a clearer understanding of assisted living since several states have defined assisted living through their service systems, most notably the Medicaid Home and Community Based Services Waiver program. These efforts in **Minnesota and Texas** have led to adoption of apartment criteria for participants to qualify to receive assisted living services under a waiver and for providers to participate in the program. Recipients in conventional elderly housing projects can receive similar services in their apartment and many waivers allow personal care, home health aide and skilled services to be delivered to residents in licensed board and care facilities.

Based on the patterns of state policy, it may be possible to differentiate services from the setting in which services are received. The service component can be called “in-home” services which recognizes that wherever a person lives is their home although some might not consider their setting their “home” but rather a place they have to live. If services are defined by a separate term, then assisted living can refer to a building with apartment-like settings, in which all residents live in order to take advantage of the services which are provided. This approach allows settings which are licensed as board and care but do not provide single occupancy units to retain a separate and distinct meaning. Buildings currently licensed as board and care which do offer single occupancy units would be licensed or certified under the new category of assisted living. Apartments in elderly housing projects would not be called assisted living.

[2] Hyde, Joan. ***Serving People with Dementia: Toward Appropriate Regulation of Assisted Living and Residential Care Settings***. Publication pending. University of Massachusetts-Boston.

While this approach may appeal to those who are not involved in a state's program or who do not operate assisted living or board and care facilities, it is unlikely that any state would modify their program after many months, often several years, of work, negotiation and compromise to develop their definition or program. As such, this section is perhaps an academic exercise that may have relevance to states that are now defining their program and it may help people in states with an existing assisted living definition or program place their policy in the broader context of assisted living and identify similarities and differences with other models.

State flexibility means variation in approach. People who prefer a standard definition will be satisfied if the final definition is consistent with their approach. The other alternative is to develop a definition that is broad, flexible and encompasses a range of models such as the ALFAA definition. The quest to develop a standard definition becomes a circular exercise guaranteed to end in frustration! For policy makers who seek a standard, acceptable definition, readily understood by all, the need will pass once your state has arrived at its own definition. Unfortunately, based on the experience of states that have persevered through the process, it is time consuming, labor intensive, requires skills in listening, negotiation and compromise. Meanwhile, consumers must receive adequate information to understand what assisted living is, what services will be provided and how much they will cost.

III. COMPARING STATE MODELS

States have defined assisted living as a program approach in a new model of housing and services (**Arizona, Iowa, Massachusetts, Ohio, Oregon, and Washington**), a service in an apartment setting (**Connecticut, Minnesota, North Dakota and Wisconsin**) and a service model in multiple settings (**Alaska, Florida, Maine, Maryland, New Jersey, Utah Texas**). In **New Jersey**, assisted living services can be provided to residents in personal care homes, free standing assisted living facilities or conventional elderly housing developments. Extended congregate care can be provided in **Florida** to residents in a wide range of settings: "any building or buildings, section of a building, or distinct part of a building, residence, private home, boarding home, home for the aged, or other place..." **Connecticut** licenses assisted living as a service but limits its provision to managed residential communities which can be purpose-built facilities or conventional elderly housing. The pending definition in **Maine** proposes a definition of "assisted living services provider" which means a provider of assisted living services licensed either as a residential care facility, certified as congregate housing services or licensed as a home health agency. **Maine's** statute (Chapter 661 of the Acts of 1994) requires that the definition include a range of services from in-home to facility based care and varied levels of regulation depending upon the level of care provided.

State definitions use a number of common terms to define their program although many key program requirements are found elsewhere in regulations or statute. For example, the definition of the housing unit is not contained in the definition of assisted living in **Connecticut, Massachusetts or Oregon** while it is included in the definition used by **New Jersey and Ohio**.

A few states have separated licensing of the housing from service provision. **Connecticut, Minnesota, New Jersey, and North Dakota** have created requirements for the provision of services and do not add new licensing requirements as part of the assisted living p designation. **Massachusetts and Wisconsin** provide for certification rather than licensing of assisted living facilities. **Minnesota** defines assisted living as a service through their Medicaid Home and Community Based Services (HCBS) Waiver programs and requires that units must consist of individual apartments. **Texas**, which has also created assisted living through a Medicaid HCBS waiver, allows assisted living to be provided in apartments and non-apartment settings.

A proposal in **North Carolina** takes a variation of the same approach. This proposal addresses the residences in which services are provided. It would define assisted living residences as "any group housing and service program for two or more unrelated adults, by whatever name it is called, which makes available, at a minimum, one meal a day and housekeeping services and provides personal care services directly or through a formal written agreement with one or more licensed home care agencies." The draft policy does not affect the unit requirements and instead allows personal care and nursing services "to the extent allowed under Medicare home health regulations" to

be delivered in two settings -- multi-unit independent housing and adult care homes. Multi-unit independent housing sites can arrange for the delivery of services by a licensed home care agency. Residents would have a choice of provider and housing managers must register with a state agency. This supportive housing model provides in-home services to frail tenants in conventional elderly housing. Services are provided by management in the second category, adult care homes or adult family care homes which are subject to state licensure.

Virginia's regulations define assisted living as “a level of service provided by an adult care residence for adults who may have physical or mental impairments and require at least a moderate (2 or more ADL impairments) level of assistance with activities of daily living.” Facilities must describe the characteristics of the people served and program components and services that will be provided.

The confusion around the use of the term is further complicated when comparing similar programs by states that do not use the term assisted living but, when asked on the survey ff they have assisted living, respond affirmatively. **Missouri** is a good example. The state licenses residential care facilities and reimburses for personal care and advanced personal care through Medicaid. Prior to Medicaid payment, facilities also provided personal care. SSI covered room and board and state payments covered the service component. Though the term “assisted living” is not used, the program resembles the program in **Virginia**, which has issued draft regulations using the term “assisted living.” Personal care is provided by a home health agency, an in-home services provider or residential care facility. Personal care is available to recipients who need an institutional level of care who have chronic, stable conditions that can be safely maintained at home. Services include bathing, dressing, hair care, oral hygiene, nail care, assistance with toileting, walking, transfers, meal preparation, light housework and other tasks. Advanced personal care covers assistance for persons with altered body functions who have a catheter, or ostomy, require bowel and bladder routines, range of motion exercises, skin care and other tasks. The RCF licensure regulations allow up to four beds per room and require 1 tub/shower per 20 residents and I toilet/lavatory for every 6 residents. These requirements are typical of many board and care type regulations.

While confusion about the definition of assisted living continues to frustrate policy makers, providers, developers and consumers, because it reflects a new market product (the term is used by operators and state regulators, and providers have formed their own association), we have assumed that it differs from board and care, and it is possible to identify characteristics that differentiate assisted living from board and care models. An examination of state policies suggests that several variables can be used to compare assisted living models. The variables include: the characteristics of the living unit, range of services provided or arranged by the facility, the health, functional and cognitive status of the residents and the philosophy used to guide the model. Assisted living can be identified by one or more of the following components of the above categories:

The living unit

- Individual apartments with kitchenettes or cooking capacity or individual rooms in a homelike setting, shared by consent.
- Attached bathrooms.
- Lockable doors.
- Resident controlled heat.
- Resident supplied furnishings.

Services provided or arranged

- Service package that includes some nursing services.
- Service capacity is available to meet unscheduled needs.
- Individualized service plans.
- Access to ancillary services.
- Special services such as dementia care.
- Flexible staffing requirements.

Health, functional and cognitive status

- Admission criteria that allow people with nursing needs to be served.

Philosophy

- A philosophy that emphasizes resident independence, dignity, privacy and participation in developing the plan of care and service delivery.

Goals and Categories

State policy makers begin their efforts to define assisted living for specific programmatic reasons. As residents in board and care settings become frailer and exhibit increased needs for health services, regulations have been amended to allow a higher level of service to be provided and admission/retention guidelines are relaxed to prevent further pressure to increase the supply of nursing home beds (**South Dakota, Virginia**).

Aging-in-place also affects residents in conventional elderly housing buildings. A number of states have adopted assisted living policies to provide services to allow elders living in subsidized housing to remain. Policy makers are also concerned about people who need a more structured and supervised setting, but do not require extensive 24 hour nursing care. This group must move from their single family home or apartment because of the lack of 24 hour staffing to respond to needs that arise during the evening when caregivers or service provider staff are not available. Until recently, the only choice was a nursing home. Several states have developed assisted living as a residential model which allows a person who must move an alternative to a nursing

home. These programs set standards that are more residential and home-like than board and care facilities. Finally, states have seen similarities in the service needs of residents in multiple settings and have focused on the service-rich nature of assisted living rather than the setting in which services are provided.

As a result, state models can be grouped into three general categories:

- board and care/institutional,
- a new housing and services model
- a service model.

The new housing and service model licenses or certifies facilities providing assisted living services which are defined by law or regulation. These models require apartment settings. Service models, though they may include apartment requirements, focus primarily on the provider of assisted living services.

Service models can be subdivided into models that allow assisted living services to be delivered in multiple settings and those in which services are delivered only in apartment settings. Table 2 presents state assisted living policies by the type of model. Table 6 compares states by the components of assisted living identified during the study. State models were developed to meet defined needs in different settings. A state's policy may address needs in more than one setting. The upgraded board and care approach recognizes that residents are aging-in-place and need more care to prevent a move to a nursing home. State policies have allowed these facilities to admit and retain people who need ADL assistance and some nursing services. Mutually exclusive level of care criteria can blur and people who would qualify for admission to a nursing home might be retained. The model retains the minimum requirements for the building and units (usually multiple occupancy bedrooms with shared bathrooms and tub/shower areas).

The “services in multiple settings” model also addresses aging-in-place in both board and care and larger elderly housing projects. Residents in both settings are aging-in-place. A higher level of service may be available in settings which were previously licensed as board and care. In addition, similar services are provided in a supportive housing program to residents in conventional elderly housing. In these settings, some tenants may be totally independent and do not receive assisted living services while others require assistance with IADLs, ADLs and health care needs. This model includes settings which may be licensed and others which are not. States representing this approach include **Alaska, Florida, Maine, Maryland, New York, North Carolina (proposed), Utah and Texas**.

Maryland provides assisted living services through its Medicaid Home and Community Based Waiver. The waiver was developed to support elderly (62 or older) residents in 150 small group homes and conventional apartment buildings, called Senior Assisted Housing, throughout the state. Projects are primarily federally subsidized. The

program is administered by the Office on Aging through contracts with housing management companies or other community organizations to deliver services.

TABLE 2. Models in States Using the Term "Assisted Living"

New Housing and Services Model	Service Model		Institutional Model
	Multiple Settings	Apartment Setting	
Arizona Hawaii[1] Iowa[2] Massachusetts Ohio[5] Oregon Washington	Alaska Florida Maine Maryland New York North Carolina Oklahoma[1] Utah[4,7] Texas*	Connecticut Minnesota* New Jersey[3] North Dakota Wisconsin	Alabama Rhode Island South Dakota[4] Virginia Wyoming

* Created through Medicaid Home and Community Based Waiver Services Programs.

1. Based on tentative recommendations from a task force.
2. Based on Senate 454 which is expected to pass during the 1996 legislative session.
3. New Jersey provides services in multiple settings but each unit participating in the assisted living services program must meet apartment standards.
4. Proposed rules.
5. Based on existing law. Legislation is pending that would change the model from a licensure category to a Medicaid program.
6. Depending on the extent of its regulations, Wisconsin could be considered a new housing and services model.
7. Provides for both apartments and bedrooms with shared bathrooms and shower/tub but introduces assisted living philosophy into the institutional model.

The service delivery model licenses or contracts with the agency providing assisted living services that may be provided in housing settings. **Connecticut, Minnesota, New Jersey, and North Dakota** are examples of this approach although the basis of the programs differ. The **Connecticut and New Jersey** programs are contained in an assisted living regulation while **Minnesota's and North Dakota's** programs are defined through a Medicaid HCBS waiver program. Regardless of the basis, local and state building codes or existing licensure rules sometimes govern the physical structure and new regulations focus on the services provided.

States which separate the housing and service components provide greater flexibility, encourage aging-in-place and recognize important realities in the fragmentation of funding sources and the existing supply of "housing" types. However, these approaches do not address the institutional character of board and care programs, nor are they intended to do so. Yet, approaches that focus on services do address one of the limitations in board and care models that specifically exclude residents who require the level of care provided in a nursing home. It recognizes that residents in board and care facilities throughout the country may require more care than is allowed through original licensure guidelines. Though many states allow services to be delivered by community organizations, the "assisted living as a service" model can respond to the important dynamics in the resident characteristics of board and care facilities. In other settings (non-board and care), it is also a useful way to minimize state

licensing, focus on meeting service needs and allow residential building codes to address the housing structure.

Units

Apartments are required in **Arizona, Connecticut, Kansas (new law), Minnesota, North Dakota, Oregon, Washington and Wisconsin**. **Arizona, Oregon and Washington** require 220 square feet per unit in new construction, excluding bathrooms. **New Jersey's** regulations require that all units include 150 square of usable floor area, plus an additional 80 square feet for each additional occupant. Unlike most rules that allow for multiple occupancy, **New Jersey** requires that each unit include a bathroom with sink, toilet, bathtub and/or shower, a kitchenette that includes a refrigerator, cabinet for food storage, sink, and outlets for small electrical appliances (eg., microwave, two burner cook top, toaster oven). This policy would provide assisted living services in facilities licensed as board and care but which meet a higher standard for living units. Residents or family members may request that cooking appliances may be removed if it is unsafe. In addition, residents may elect to bring their own appliances if they meet code requirements.

Ohio's draft rules also required single occupancy units, unless shared by choice, with private cooking, bathing, washing and toilet facilities, lockable doors, temperature controls and sprinkler equipment. Buildings in **Massachusetts, New Jersey, Ohio, and Oregon** also have to meet local building codes.

Legislation pending in **Iowa**, Senate 454, would require that regulations developed by the Department of Aging provide for private space sleeping and dressing.

The opportunity to prepare a meal or snack is an important variable in determining whether a unit is home-like. While many residents may be too impaired to prepare their own meal, operators reports that family members and friends often fix meals for residents when they visit and the presence of a kitchenette adds to the residential ambiance even for people who do not regularly prepare their own meals. All residences' must provide a kitchenette or access to cooking capacity (kitchen, microwave) in **Arizona, Connecticut, Massachusetts, Oregon, Ohio, Minnesota and Wisconsin**.

Alaska's policy does not specify requirements for units although shared rooms are allowed and the policy is flexible to accommodate small group homes which are needed in such a rural state. **Florida** requires private rooms, apartments, or semi-private rooms. If shared rooms are offered, there must be no less than one bathroom for every four persons. **Massachusetts** allows single and double occupancy units with lockable doors. New construction must include private baths for each unit. Existing buildings may provide private half baths and one bathing facility for every three units.

Two types of units are allowed in **New York**. Enriched housing models (conventional housing) must provide single occupancy apartment units, unless shared

by agreement, with full bathroom, living and dining space and equipment for preparing and storing food. Adult care homes offer single or double occupancy bedrooms and must have I toilet for every six residents and 1 tub/shower for every ten residents. **Texas** also allows several occupancy types including assisted living apartments with 220 square feet or 160 square if the building is being remodeled to participate in the assisted living program; residential care apartments (double occupancy, bedroom, kitchen and bathroom with 350 square feet); and residential care non-apartments (double occupancy, 16 or fewer units).

The institutional model is predominantly a shared model. Residents share bedrooms, although many states limit occupancy to two persons per room, bathrooms and tub/shower rooms. **Alabama** requires bedrooms with 80 square feet for single occupancy and 130 square feet for double units. If sitting areas are included, the square footage requirements are 160 for single rooms and 200 square feet for double rooms. **Virginia's** existing adult care residence rules allow single rooms (100 square feet) and multiple occupancy (80 square feet per occupant) with toilet and wash basins for every seven residents and a bath tub for every ten residents.

Tenant Policy

Two distinctions are drawn concerning tenant policy. State licensure rules often set parameters on who may be served in an assisted living residence regardless of payer source, however, state reimbursement policies may set different criteria for residents that will be reimbursed in assisted living. In fact, most states, except **Massachusetts**, limit their reimbursement to low income tenants that meet the level of care criteria for placement in a nursing home.

While many states have defined the characteristics of tenants who may be served, a draft report from an advisory group in **Wisconsin** has recommended that services be limited to 28 hours a week as a means of assuring that tenants would not be discharged prematurely. The limit exceeds the average hours of service provided to participants in the state's home care program and would prevent residences from discharging tenants needing higher levels of service. The policy implies that tenants needing more than 4 hours of service per day are 9 best served in a different setting.

A few states have modeled tenant policies on the definition of Medicare skilled services. Anyone needing services beyond the Medicare definition for a period that exceeds the definition are not consider appropriate for assisted living. The definition has been equated with a judgement about safety and the level of care that can safely be provided in a homelike setting. However, Medicare definitions have been developed for reimbursement purposes and do not define the line between care that can be delivered at home and care that should be provided in a nursing home.

Florida developed precise rules for admission and continued residency. New residents must be able to perform ADLs with supervision or assistance; do not require

24 hour nursing supervision; are capable of taking their own medication or may require administration of medication and the residence has licensed staff to provide the service; do not have bed sores or stage 2, 3, or 4 pressure ulcers, are able to participate in social activities; capable of self-preservation; is not bedridden; non-violent; and does not require 24 hour mental health care.

The criteria for continued residency do not allow residents to be retained if they develop a need for 24 hour supervision; become bedridden for more than 14 days, become totally dependent in 4 or more ADLs (exceptions for quadraplegics, paraplegics and victims of muscular dystrophy, multiple sclerosis and other neuro-muscular diseases if the resident is able to communicate their needs and do not require assistance with complex medical problems). Residents may stay if they develop stage 2 pressure sores but must be relocated for stage 3 and 4 pressure sores. Residents who are medically unstable, become a danger to self or others or experience cognitive decline to prevent simple decision making may not be retained.

This lengthy list of resident conditions which may and may not be treated may be replaced by using the Medicare skilled nursing definition to establish the admission and retention policy.

New Jersey has developed the broadest tenant policy by allowing, but not requiring, care for people 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 three or four pressure sores or multiple stage two sores, are a danger to self or others or have a medically unstable condition and/or special health problems. The admission agreement has to specify if the residence will retain residents with one or more of these characteristics and the additional costs which may be charged.

Alabama, which has a board and care model, does not allow residents to be served in assisted living who require the level of care provided in a nursing home. **Rhode Island**, another board and care model, allows people who need nursing assistance to be served, but does not allow people needing skilled care to be served.

The **Virginia** requirements offer flexibility for adult care residences to develop a service program that reflects their market segment and the service needs of the market. The regulations do set some parameters on who may admitted and retained. ACRs may not serve people who are ventilator dependent, have dermal ulcers (III and IV), receive intravenous therapy, or require continuous nursing care.

Services

The extent and intensity of services has been a key component of assisted living policy. Mutually exclusive resident policies, which prohibit anyone needing a nursing

home level of services from being served in board and care, are being revised. State policy makers are focusing on the level of care that can be provided in a person's single family home or apartment and allowing the delivery of similar services in assisted living settings. Drawing the line has been controversial. Some nursing home operators see assisted living as competition for their “patients” and oppose rules which allow skilled nursing services to be delivered outside the home or nursing home setting.

Most states require an assessment and the development of a plan of care that determines what services will be provided, by whom and when. Residents often have a prominent role in determining what they will receive from the residence and what tasks they will do for themselves.

The key factor in assisted living policies is the extent of skilled nursing services. **Connecticut** allows client teaching, wellness counseling, health promotion and disease prevention, medication administration and skilled services to clients with chronic but stable conditions.

In response to complaints from the nursing home industry, **Florida** developed specific regulations that list the services that may be provided and those that cannot be provided. Facilities may provide limited nursing services (eg., medication administration and supervision of self-administration, applying heat, passive range of motion exercises, ice caps, urine tests, routine dressings that do not require packing or irrigation and others), intermittent nursing services (eg., change of colostomy bag and related care, catheter care, administration of oxygen, routine care of an amputation or fracture, prophylactic and palliative skin care).

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

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

Legislation in **Massachusetts**, as in other states, does not allow twenty four hour nursing services. However, skilled services may only be provided by a certified home health agency on a part time or intermittent basis not to exceed 90 days in a one year period. Medical conditions requiring services on a periodic, scheduled basis are also

allowed. In addition, residents may “engage or contract with any licensed health care professional and providers to obtain necessary health care services .... to the same extent available to persons residing in private homes.” The **Massachusetts** statute only allows skilled nursing services to be provided by a certified home health agency. As a result, although regulations have not been issued, registered nurses, if hired by an assisted living facility, presumably, would not be allowed to deliver skilled care. **Ohio's** pending policy will limit skilled services to 120 days with exceptions for diets, dressing changes and medication administration.

The **Massachusetts** statute specifies a minimum level of personal care services that must be provided (bathing, dressing, ambulation) and requires that tenant agreements include the services which will be provided and those which will not be provided. Facilities certified under the law may offer a broader range of personal care services. **Alaska's** regulations also require that tenant contracts spell out the services and accommodations that will be provided which reflects the diversity of providers and varied availability of service providers in the state. Intermittent nursing services are allowed for residents who do not require 24 hour nursing care and supervision and tasks approved by the Board of Nursing may be delegated to unlicensed staff. **Arizona** also allows intermittent home health (nursing, home health aide, supplies, equipment and therapies) in its demonstration program.

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

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

A concept paper in **Idaho** would require personal care (eating, bathing, dressing, toileting and walking), three meals a day in a common dinning room, housekeeping, transportation, medication management, social and recreational activities and laundry services. **Maryland's** policy includes a similar list but adds 24 hour on-site supervision in group homes but not in the Senior Assisted Housing setting. Skilled nursing is not included in **Idaho and Maryland**. In **Utah**, which has a similar list of services, facilities must arrange for necessary medical and dental care although medication administration of prescription drugs is allowed. **Maine's** pending policy only allows skilled services when they are provided by a licensed home health agency. Skilled services cannot be provided by congregate housing or residential care providers that may be licensed as assisted living.

Financing and Reimbursement

States have developed a number of methodologies to set rates for subsidized residents. **Oregon** uses a five tiered methodology for reimbursing providers based on the type and degree of impairments (See table 3). Arizona has developed three rate classes based on the needs of the resident. **Ohio** is also planning to use a service rate structure with five tiers ranging from $200 to $1400 a month that vary based on the number and type of ADL impairments, skilled nursing needs and behavior needs (table 4). The room and board payment is likely to be $700 a month. The service rate was developed after consultation by the Department of Aging with assisted living providers. **North Dakota** uses a rate classification system that is derived from a point system that measures a person's level of service need.

TABLE 3. Oregon Service Priority Categories and Payment Rates

Impairment Level	Service Priority	Rate
Level V	Service priority A or priority B and dependent in the behavior ADL.	$1586
Level IV	Service priority B or priority C with assistance required in the behavior ADL.	$1283
Level III	Service priority C or priority D with assistance required in the behavior ADL.	$978
Level II	Service priority D or priority E with assistance required in the behavior ADL.	$736
Level I	Service priority E or F or priority G with assistance required in the behavior ADL.	$553

Flat rates are used in **Massachusetts, Texas and Washington**. **Massachusetts** uses two sources of financing to pay for assisted living. Medicaid state plan services are available to reimburse for Medicaid recipients and a special program (Managed Care in Housing) funded with general revenues is available for elders who are not eligible for Medicaid is administered by the Executive Office of Elder Affairs. The service payment is $33.70 per day for Medicaid recipients and the Managed Care in Housing program rate is $817 a month. The financing sources were developed prior to passage of the assisted living legislation and the program represents combines two approaches: services in conventional elderly housing projects and purpose built assisted living sites. **Massachusetts**, with its higher development costs, is the only state that has set a separate SSI payment for assisted living of $900 a month which is considerably higher than the community standard (the payment for an aged person living alone in the community) and the board and care standard. The increased rate reflects the higher real estate and development costs in the state and provides access for Medicaid recipients to many market rate and mixed income developments. However, legislation creating an assisted living certification program also suspended use of the higher rate until the Medical Assistance Division completed a report showing the projected demand and costs to the state. The report was submitted to the legislature on March 1, 1995 and concluded that a higher payment standard would save $2389 per participant for a total savings of $239,800 in FY 95 rising to savings of $4.8 million in FY 99 as the supply of assisted living residences for low income residents increases.

Texas varies its rate by the number of occupants. Single occupancy assisted living apartments receive $29.39 a day for services. Residential care units receive $22.96 a day for double occupancy. The SSI rate for room and board is $11.88 a day for all settings. A tiered rate is under consideration.

TABLE 4. Ohio Assisted Living Waiver Service Levels (Proposed)	
Service Level	**Minimum Waiver Service Needs**
One	• Assistance with 2 secondary ADLs
Two	• Assist with 1 primary ADL & 1 secondary ADL; or • Level one + medication administration; or • Level one + behavior management; or • Level on + plus unstable medical condition; or, • Level one + daily skilled nursing services not covered under the state Medicaid Plan
Three	• Assist with 4 ADLs (any type); or • Assist with 3 ADLs (including 1 primary ADL) plus medication administration; or • Level two plus behavior management; or • Level two plus unstable medical condition; or • Assist with 3 ADLs (including one primary ADL) plus daily skilled nursing services not covered under the state Medicaid Plan.
Four	• Assist with 5 ADLs (any); or • Assist with 4 ADLs (any) plus medication administration; or • Level three plus behavior management; or • Level three plus unstable medical condition; or • Assist with 4 ADLs (any) plus daily skilled nursing services not covered under the state Medicaid Plan.
Five	• Assist with 5 ADLs plus medication administration AND daily skilled nursing services not covered under the state Medicaid Plan; or • Level four plus behavior management; or • Level four plus unstable medical condition.

Washington uses a flat per them rate is $47.37 a day for 1995 consisting of $27.06 for services and $20.31 for room and board. However, **Washington** is also planning to develop a new rate structure that includes three payment rates for low, moderate and high service needs based on ADLs.

Several states have modeled their reimbursement rates on their case mix system for paying nursing homes. In **New York**, the service reimbursement is set at 50% of the resident's Resource Utilization Group (RUG) which would have been paid in a nursing home. The state has created RUG rates for 16 geographic areas of the state. The reimbursement category is determined through a joint assessment by the Assisted Living Program and the designated home health agency or long term home health care program. The assessment and the RUG category are reviewed by the Department of Social Services district office. The residential services (room, board and some personal care) are covered by SSI which also varies by region. In 1992, the SSI rates were $827 to $857 a month.

Service rates in **Minnesota** (table 5) are negotiated between the client and the provider with caps based on the client's case mix classification. Service rates under the Alternative Care program, a state funded program for people who do not meet the Medicaid eligibility criteria, cannot exceed the state's share of the average monthly nursing home payment. The client pays for room and board (raw food costs only -- meal preparation is covered as a service). The cost of services in addition to assisted living services may not exceed 75% of the average nursing home payment for the case mix classification. Under the HCBS waiver, rates for assisted living services are also capped at the state share of the average nursing home payment and the total costs, including skilled nursing and home health aide, cannot exceed 100% of the average cost for the client's case mix classification.

TABLE 5. Service Rates: Minnesota Case Mix Categories and Average Rate Limits

Category	Rate		Description
	Elderly	Disabled	
A	$565	$597	Up to 3 ADL dependencies[1]
B	$638	$671	3 ADLs + behavior
C	$722	$755	3 ADLs + special nursing care
D	$798	$831	4-6 ADLs
E	$876	$909	4-6 ADLs + behavior
F	$881	$914	4-6 ADLs + special nursing care
G	$948	$980	7-8 ADLs
H	$1073	$1105	7-8 ADLs + behavior
I	$1117	$1150	7-8 + needs total or partial help eating (observation for choking, tube or IV feeding and inappropriate behavior)
J	$1186	$1218	7-8 + total help eating (as above) or severe neuro-muscular diagnosis or behavior problems
K	$1330	$1363	7-8 + special nursing

1. ADLs include bathing, dressing, grooming, eating, bed mobility, transferring, walking and toileting.

The statewide maximum rates for elderly recipients ranged from $565 a month to $1330 a month depending upon the case mix classification. Rates in a particular county could be higher or lower than the averages. Rates for participants with physical disabilities ranged from $597 to $1361.

New legislation in **Wisconsin** caps rates at 85% of the statewide average Medicaid nursing home service rate (excluding room and board). It is assumed that counties will have flexibility to negotiate rates with providers within the overall cap set by the state agency.

Medications and Staffing

Nearly all states allow assistance with self-administration of medications or administration of medications by licensed nurses. The predominant provisions for staffing require that facilities provide an adequate number and type of staff necessary to

fulfill the service needs of residents as required by plans of care. A few states require ratios of awake or on-site staff but the clear trend substitutes flexible staffing plans and schedules for specific staffing ratios.

States Developing Policy Options

The trend among states to develop assisted living continues. As frequently as states move from study, analysis and recommendations to passing legislation and issuing regulations, other states have begun their own initiatives. Assisted living has attracted interest in a number of states that have created a process to examine options and make recommendations. In **Ohio**, a task force was created to re-examine legislation passed in 1993 and draft regulations developed to implement the legislation. Language was added to the state budget bill in 1994 that halted implementation. As the process for developing the regulations proceeded, segments of the assisted living and nursing home industries expressed concerns about the model and the direction of the regulations. A special committee consisting of 6 legislators, 4 state agencies, 4 provider groups (3 nursing home and 1 assisted living), the Area Agency on Aging Association, the Ombudsman Association, AARP and a taxpayer group was created to review the program.

The task force was created to address opposition to Chapter 3726 and the proposed regulations dealing with the unit requirements, the level of services provided in assisted living and the medical conditions of tenants. While a formal consensus report was not submitted, the governor's budget included several proposals contained in the draft report. The budget bill would repeal the assisted living statute and create a new category of residential care facility to replace the current rest home classification. Residential care facilities would be able to provide up to 120 days of skilled nursing services with exceptions for special diets, medication administration and dressing changes. In addition, the **Ohio** Department on Aging would be authorized to create an assisted living program, funded through a Medicaid HCBS waiver, that is likely to use the rules developed for the licensure category.

Legislation has passed the **Iowa** House creating an assisted living program. Amendments have been added in the Senate and the bill will be considered for final passage in 1996. The bill grew out of a long term care task force appointed by the governor in 1994. An interim legislative committee drafted the bill. An interagency policy committee will develop draft rules that would be finalized when the bill passes.

A task force consisting of state agencies, consumers, nursing home associations, and assisted living providers has been meeting in **Delaware** to recommend a policy. A requirement for self-preservation has been a contested issue. The task force has considered private apartments, elderly housing and residential care as settings for the provision of assisted living. **Louisiana** state officials have begun drafting an assisted living policy statement. A meeting with Aging, Health and Medicaid staff was held to initiate discussion of the primary elements of the policy statement. Monthly meetings

between staff of the Governor's Office on Aging, the Department of Health and Hospitals (Medicaid) and the Department of Social Services (regulations) have been held. It is anticipated that the Department of Health and Hospitals will submit a Medicaid Home and Community Based Services waiver to fund two pilot assisted living projects. Licensing rules are being drafted with a projected effective date of July 1, 1995.

In **Hawaii**, the 1994 legislative session passed House Concurrent Resolution 377 which directed the formation of a task force to study and make recommendations on assisted living. A 7 member legislative task force that includes three state agencies and provider groups has been meeting weekly. The task force is chaired by the Gerontology Administrator of the Child and Family Services agency which is a large social services agency. The group organized a conference on assisted living in the fall of 1994 and presented a report to the legislature which has resulted in several bills being filed. Members made site visits to facilities in Oregon and Washington. The report recommended adoption of a common definition of assisted living to mean “a special combination of housing, personalized supportive services and health care designed to respond to individual needs. Assisted living promotes choice, responsibility, independence, privacy, dignity and individuality and encourages the involvement of a resident's family and friends. The setting within an assisted living facility is usually a private studio apartment and bath.”

The state faces constraints due to high land costs and must examine the use of existing housing capacity rather than new construction to implement a new model. The report recommends that counties be encouraged to modify their land use policies to support assisted living and that state loans and bonds be made available a favorable interest rates to stimulate development.

Legislation authorizing development of assisted living regulations and authorizing funding through a Medicaid waiver is pending before the state legislature which meets until the end of April. The legislature is expected to pass a bill directing the development of assisted living regulations modeled after the Oregon and Washington programs and another bill providing for nurse delegation in a range of settings (nursing home, hospitals, assisted living and others). Another bill is expected to pass that provides mortgage insurance through the state housing finance agency for non-profit agencies which develop assisted living programs.

A resolution directing the Department of Human Resources to study and report to the legislature on the feasibility of developing a Medicaid Home and Community Based Services waiver for assisted living has also been filed. In addition, **Hawaii** is implementing an 1115 demonstration waiver, called Health QUEST, that provides health care for Medicaid recipients and uninsured residents with incomes below 300% of the poverty level through managed care plans. Planning has begun to expand the waiver to SSI recipients and to include long term care in the service package. The work group is interested in including assisted living as part of the benefit package. Implementation is not expected until 1999 to allow ample time for implementation of the current “1115” waiver.

A seven member Residential Care Council examined assisted living options for 18 months in **Idaho**. A change in administrations and lack of funding limited the scope of the work. A concept paper was issued which may serve as the basis for legislation that was expected to be filed by the Assisted Living and Residential Care Associations. A legislative task force was created in **Indiana** to make recommendations on assisted living. After a series of hearings, a report was issued but no action has been taken to develop a formal proposal.

In **Michigan**, the Long Term Care Working Group, appointed by Governor Engler, is developing administrative rules for assisted living. Officials from the Office of Services to the Aging, Public Health, Mental Health, the Department of Social Services (Medicaid) and the State Housing Authority are members of the Working Group. Draft rules are being developed for review by the Working Group at their January, 1995 meeting.

Legislation consolidating the licensing of personal care homes, retirement homes, adult foster care and adult day care under a broader residential care category will be filed with the **Montana** legislature for consideration during the 1995 session. Another proposal will provide funding for 50 slots for Medicaid waiver participants in residential care homes that are comparable to assisted living.

The **Oklahoma** Aging Services Division organized a task force to study assisted living in the spring of 1994 which included representatives of both aging and people with disabilities, providers and others. The task force developed a broad definition that considered assisted living as a service available in multiple settings 24 hours a day for unscheduled needs. The group also identified a philosophy to guide their work that emphasized privacy, dignity, and resident involvement in the assessment and care planning process. Committees were formed to focus on the housing environment, services to be provided, clients to be served and funding sources. Legislation was drafted and circulated for comment that would have replaced the current residential care licensure category with a new assisted living category. The task force is refining the legislative proposal based on reactions from affected groups. The task force is addressing issues dealing the level of care that can be provided outside a nursing home, the role for residential care facilities, financing for low income residents, and the appropriate models for serving people with dementia versus people with disabilities who prefer an independent living model.

State agencies in **Texas** have formed a task force to build on their Medicaid waiver program and develop a more formalized licensure policy on assisted living.

The **Vermont** Department of Aging and Disabilities convened a working group to consider options for developing assisted living models. The group recommended conducting pilot projects to gain experience with several approaches, including the supportive or congregate housing services model in which frail residents in conventional elderly housing buildings receive services. This approach would be comparable to

Maryland's model. The **Vermont** Department of Aging and Disability has subsequently created an advisory group to assist with the development of the state's Medicaid home and Community Based Services Waiver renewal. A subcommittee has been formed to deal with assisted living and the renewal application may contain a proposal to add assisted living as a service as Minnesota and Texas have done. The governor's proposed 1996 budget included funds to implement an assisted living demonstration program through a Medicaid HCBS waiver.

The policy development process need not begin with public officials. In **Illinois**, The Center for Eldercare Choices (a Foundation formed by the Illinois Association of Homes and Services for the Aging, the Life Services Network of Illinois) initiated a statewide, two day summit on assisted living in October 1994. Thirty three policy leaders (legislators, state agency officials, housing and service providers) were invited to examine issues around residential alternatives to develop a framework for working on an assisted living proposal for the state. The session reviewed background information on assisted living and created a coalition to guide policy development.

TABLE 6. Components of State Assisted Living Programs

Component	AL	AK	AZ	CN	FL	MD	MA	MN	NJ	NV
Licensure										
Facility	X	X			X					X
Services				X	X			X	X	X
Certification			X	X[3]			X			
Medicaid Contracts						X		X		
Residential										
Apartments			X	X	X	X	X	X	X	X[10]
Private room w/bath							X			
Private BR, shared bath	X				X	X	X[4]			
Multiple occupancy	X[8]	X			X[8]	X				X[10]
Access to cooking				X			X			
Lockable doors			X	X	X		X	X		X
Tenant policy	E	C	C	B	C	--	B	B	A	C
24 hour on-site staff		X	X	?	X				X	X[11]
Nursing services	X	45 days[2]	X	X	X[5]		90 days[2]			X
Staffing pattern	Ratio	Care plans	Care plans	Ratio & Care plans	Care plans		Proposed by residence			Plans of care
Medicaid Financing		X	X		X	X	X	X	X[6]	X
Reimbursement	Market	2 Levels	Three classes	Market	Flat	Subsidy caps	Per diem	Case mix with caps[9]		Case mix[9]
Resident focus[1]			X		X				X	

TABLE 6 (*continued*)										
Component	**IA**	**ND**	**OH**	**OR**	**RI**	**TX**	**UT**	**VA**	**WA**	**WI**
Licensure										
Facility			X	X	X			X	X	
Services										
Certification	X									X
Medicaid Contracts	X	X				X				X
Residential										
Apartments		X	X	X		X	X		X	X
Private room w/bath										
Private BR, shared bath	X									
Multiple occupancy					X[8]		X	X		
Access to cooking										
Lockable doors	X	X	X	X					X	X
Tenant policy	B	D	B	B	E	--	B	C	C	A
24 hour on-site staff	X			X			X			
Nursing services	X	X	120 days[2]			X			X	X
Staffing pattern		Plans of care							Plans of care	X
Medicaid Financing	X	X	X[6]	X		X	X[6]		X	X[6]
Reimbursement		Multiple	5 tiers	5 tiers	Market	Per diem		Flat rate	Per diem	Tiers[7]
Resident focus[1]	X		X	X			X	X	X	

Table Key:

1. Resident focus eg., promote self-direction, independence, autonomy, dignity, choice, privacy.
2. Exceptions allowed to skilled limit.
3. The housing setting is certified.
4. Existing buildings must have private half bath and may share bathing facilities.
5. Regulations specify services that may and may not be provided.
6. Medicaid waiver under consideration.
7. Tiered rates will be developed to reflect resident needs.
8. Bedrooms may be shared by no more than two people.
9. Based on nursing home case mix methodology.
10. In New York, Enriched housing settings require apartments, Adult Home settings allow sharing by no more than two residents.
11. Adult home settings.

Tenant Policy key:

A. Meet nursing home criteria, may have extensive nursing needs.
B. Stable medical conditions, must not need 24 nursing supervision.
C. Nursing home eligible with specific conditions included or excluded.
D. Needs assistance with ADLs.
E. Do not allow nursing home eligible residents.

The group identified seven elements of assisted living: risk, services, choice, cost, home, internal community and external community and phrases which describe each area (see appendix). A matrix presenting the strengths and weaknesses, opportunities and threats posed by assisted living was devised as well as a plan with 6 options for action. Three options were considered a priority, and task forces were established. The three priorities identified were: to develop a definition of assisted living, to create strategies for identifying and educating stakeholders, and to study and recommend provisions for legislative and regulatory oversight. One year timetables were established for each task force.

Interest in the work of the task forces has attracted the attention of other interest groups around the state. Subsequently, membership of the task forces was extended well beyond the original summit participants.

Serving People with Dementia

Caring for persons with dementia has become an important issue in the assisted living arena. Inherent within the assisted living philosophy is the fostering of resident choice, empowerment, shared decision-making, negotiated risk, independence, and privacy. An estimated 40% of assisted living residents have Alzheimer's disease or related disorders[3] and as residents “age in place,” many cognitively intact residents are likely to develop some form of dementia over time. As we introduce new models to provide services to older persons, states struggle to devise an appropriate mechanism to ensure safety for confused residents,quality care, and the promotion of a philosophy inherent within the assisted living model.

The ability of residents to participate in their own care, make decisions regarding life choices, and maintain their own living space is diminished as residents become confused. It is often difficult for cognitively intact residents to see others who are no longer able to engage in autonomous decision-making. Providers and policy makers ask how far residences should go to accommodate a resident who is losing the ability to make important life choices? Providers struggle to determine the extent to which policies should protect residents from potentially dangerous situations, which depend on the stage of dementia (eg., electric appliances and stoves); to balance the needs of all residents and the impact one or more residents may have on the whole community or neighboring tenants; and to maximize normalization of the environment.

Assisted living differs from other models of long term care such as nursing homes and board and care homes because of the way the service package is developed and delivered. Regulations reflect this difference by encouraging active resident participation, to the extent the person is able, in the care plan development and the delivery of services. Given the nature of Alzheimer's disease and other related illnesses, these regulations sometimes conflict with the specific needs of this group. As a result, many states are rethinking their assisted living or board and care regulations to reflect the needs of the Alzheimer's resident. These changes range from physical plant modifications and new staffing requirements to special service packages and social activities. The structure and routine of the facility is designed to create a soothing environment. State strategies should address the functional, cognitive and behavioral needs of residents with dementia. Special care approaches are most often developed to serve people that exhibit physically and verbally disruptive behaviors.

[3] Kane, Rosalie A. and Wilson, Keren Brown. ***Assisted Living in the United States: A new Paradigm for Residential Care for Frail Older Persons***. Public Policy Institute, American Association of Retired Persons. 1993.

Within the last several years the assisted living industry and state regulatory agencies have responded to the challenges of serving people with dementia in assisted living settings. One of the key questions for site managers, staff and regulatory staff is defining the point at which care in assisted living settings is ineffective, inefficient and unable to provide the level of care needed. Providers seek to offer a setting that:

- develops an individualized, personalized service plan;
- preserves privacy for all residents;
- provides small group activity according to the interests and abilities of each resident;
- implements a pro-active process that involves tenants to address community issues;
- provides specialized training for staff;
- and uses outside experts as appropriate.

Providers can make minor changes, such as locking or alarming selected doors to respond to wandering. Other changes might modify the facility to respond to the need of residents in early to mid-phases of dementia. The Pioneer Homes in Alaska installed locks on selected doors which allow residents access to specified areas for wandering, while prohibiting entrance to other areas. Providers in Maryland are developing more “cluster-style” living arrangements with an emphasis on common areas. This strategy allows residents to congregate in one area for activities. States such as **Oregon** require providers to address the behavioral problems of residents with dementia.

Some believe that purpose-built wings and floors are needed for residents with dementia. This approach includes color sensitive walls, floors, and decor, special wanderguard systems, alarm systems, increased staffing, behavior modification strategies, and architectural changes to facilitate wandering. While more costly, many larger providers are adopting such changes nationwide. Whether major or minor changes are appropriate depends, in part, upon the resident mix, the stage of dementia and, in relation to low income residents, the adequacy of funding for subsidized residents.

Others contend that a purposeful design is important in all settings whether segregated or integrated since it provides clues to orientation and location in a building and assists people who are not cognitively impaired in determining where they are. Perhaps more importantly, the decision to create specialized settings depends upon the philosophy of care and experience with strategies that are the most effective in maximizing an Alzheimer's resident's ability to function.

Hyde[4] has described eight key components for structuring assisted living programs which were developed by the Alzheimers' Association. The Association's "Guidelines for Dignity: Goals of Specialized Alzheimer/Dementia Care in residential Settings" include philosophy, pre-admission and admission, care planning and implementation, change in

[4] Op. Cit.

condition issues, staffing patterns and training, physical environment and success indicators. Hyde and Zeisel have developed a best practices model that include eight care management principles and eight environment design concepts.

The care management principles include a focus on individual dignity, purpose-driven team care models, adaptable management, staff suitability, activities richness, family contact, community-unit continuum and sound business practices. The environmental design principles deal with exit control, wandering paths, individual away spaces, common space structure, outdoor freedom, residential scale, autonomy support and sensory comprehension.[5] The paper examines regulations in ten states to determine how they reflect these principles.

We contacted providers and state agency staff in selected states to obtain a brief description of their approach to serving people with dementia in assisted living settings. **Alabama** serves residents with dementia in its board and care model of assisted living. Settings can accommodate residents in the beginning to middle stages of dementia when continuous supervision and assistance with ADLs is minimal. Severely confused residents, who are no longer able to make their needs known, require nursing care under state guidelines. Providers are concerned, however, that segregating residents during the early stages may exacerbate the course of the disease. They point to evidence that suggests that segregating residents during the earlier stages increases the level of confusion as less confused residents seem to imitate the behavior of those who are more confused. Providers believe that with the appropriate staff training and organized management, residents with dementia can be served effectively in mixed environments.

The **Alabama** Department of Health, Division of Licensure and Certification has convened a task force to study Alzheimers related issues in assisted living settings. They plan to develop a framework to serve people with greater needs which includes the creation of a new level of dementia care facilities. This facility would continue to serve residents with dementia as they do in assisted living; however, this level would serve those individuals who are too confused for basic assisted living yet do not need skilled nursing care. The state is working with a psychiatrist to assess interior design, colors and patterns and locking devices for Alzheimer's care. Current regulations place no restriction on physical plant changes. Providers may make any changes necessary to accommodate the needs of their residents as long as they do not violate fire and safety codes. The state will not waive any fire and safety code regulations to accommodate providers. Existing regulations have been modified to require sprinkler systems for all small homes (generally 16 units and smaller).

In **Alaska** new state regulations do not include additional requirements for Alzheimer's care. If a resident has a deteriorating condition or Alzheimer's disease, they may choose to stay in the assisted living residence as long as they do not require ongoing nursing supervision and skilled nursing services. A resident who requires

[5] Ibid.

skilled nursing care may, with the consent of the provider, arrange for a licensed nurse to provide such services as long as this arrangement does not interfere with services to other residents. In addition, the home may provide 24 hour skilled nursing to a resident for 45 consecutive days to avoid transferring to a hospital. The resident may negotiate with the home to stay beyond the 45 day limit in the absence of 24 hour skilled care. This negotiation requires the input of the family, physician, resident's representative, and the home.

The Pioneer Homes in Alaska are state funded homes founded in the 1930's. These homes care for all Alaskans, and have modified their program to accommodate the special needs of people with Alzheimer's Disease and related disorders. The Pioneer Homes originally had two levels of care: Residential and Skilled Nursing. They recognized that many residents living in the residential homes were moving into the skilled level of care due to a lack of adequate staffing resources. Furthermore, many residents in the skilled level were found to have less need for skilled nursing and more support in ADLs and supervision. As a result, in 1993 the Pioneer Homes developed new levels of care: Assisted Living and Special Assisted Living. The Assisted Living level includes 19 beds for residents who require assistance with ADLs. The Special Assisted Living level includes 16 units that fosters a safe and quiet environment for residents with dementia.

The Special Assisted Living level does not provide a description of a typical resident or their needs, but includes guidelines for assessing the needs of applicants at this level:

> Applicants may have a history of wandering, confusion as to place and person, require a safe environment for personal health and safety, poor or nonexistent judgment concerning personal well-being, difficulties in socialization, non-cognitive, and other general symptoms associated with Alzheimer's disease and related dementia.

The Assisted Living and Special Assisted Living models have RN oversight and RNs are available for consultation. A weekly nursing clinic assesses and treats residents as needed. LPNs administer medications and CNAs staff the units in an expanded role. The CNA engages the resident in physical therapy maintenance programs, psychosocial events, and support with ADLs.

Two levels of training are provided to the Assisted Living Unit and the Special Assisted Living Unit staff. Level 1 includes basic training on dementia. Level 2 includes training on behavior management. Ongoing training programs include two levels: Level 1 is for all staff and includes 3 hours of Alzheimer's training in communication techniques, common dementia behavior, and a basic overview. Level 2 is 8 hours mandatory training on people management such as working in teams, attitudes, body positioning, and verbal and non-verbal communication.

An informal group has formed to examine Alzheimer's care in assisted living in **Massachusetts**. The primary issues include:

- security and how far providers should go to push independence
- the appropriate “locking” system for assisted living
- who belongs in a segregated setting
- at what point is assisted living inappropriate for people with dementia.

Many state regulators and providers believe that different levels of monitoring and safety are needed for people with dementia. Such changes might include special wings or floors for residents in later stages of dementia, increased staffing, and additional training for staff and structured activities. It has been found that people with more severe dementia benefit from routine activities which start in the early morning and continue throughout the day.

Currently, **Massachusetts** has no additional requirements for Alzheimer's care and regulations for special care units do not deal with interior design requirements or safety and security issues which concerns both providers and regulators. Both sides agree that further discussion is warranted to more appropriately address safety issues, admission and discharge policies, staffing requirements, and nursing oversight.

New Jersey's assisted living regulations allow a provider to request a waiver of the physical plant requirement for kitchenettes and private baths if they are providing services to special populations. Currently, staff requirements are very basic. Unlicensed personnel are providing most of the care. An RN must be on call to meet unscheduled nursing needs; however, the only staffing requirement is for 1 personal care attendant to be on staff 24 hours a day.

States and providers are still searching for appropriate standards and guidelines. Currently, many providers are setting their own policies regarding appropriateness for assisted living. For example, in Ohio, one provider states that residents with dementia are not appropriate for assisted living (at least as defined or operated by this facility). Without appropriate safeguards such as wanderguard systems, the provider was unwilling to take on the responsibility of caring for confused individuals. Another provider in Ohio is working to develop special and mixed units which look very similar, but require heavier staffing around the clock and larger walking areas.

Hyde[6] cites the draft regulations in **Ohio** as “thoughtful on issues of autonomy and risk” for people with dementia yet questions whether prohibiting residences from serving people who cannot make simple decisions or respond to prompting may limit their ability to serve this population. Hyde also highlights the limitations on serving people with dementia imposed by regulations dealing with exits. Hyde highlights Virginia's miles as a model of regulations that addresses the needs of people with dementia. The rules require a secure egress: “Doors leading to the outside shall have a system of security monitoring, such as door alarms, cameras, or security bracelets which are part of an alarm system, unless the door(s) leads to a secured outdoor area.”

[6] Op. Cit.

In 1989, the California legislature approved a 3 year demonstration program to test the feasibility of serving people with Alzheimer's Disease in Residential Care Facilities for the Elderly (RCFEs). Over 4300 RCFEs are licensed in California with a capacity of over 10,000 beds. Seventy five percent of the facilities have 6 or fewer beds. Prior to the demonstration, RCFEs could serve people with mild or moderate dementia who require protective supervision as long as they can make their needs known and can follow instructions. The pilot was approved to test whether people with more advanced dementia who were required to transfer to nursing facilities could be served in RCFEs. The independent study variables were special staff training, resident activities and the use of either locked or secured (alarmed) perimeters. No facilities were willing to participate as a control group without using the interventions. Staff in both groups received 25 hours of training in residential care, normal aging, Alzheimer's disease, managing problem behaviors, recreational activities, communication, medication use and administration, medications used for disruptive behavior, ADLs, and staff stress and burnout.

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

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

The report found that the staff to resident ratio was more important than the size of the facility and that requirements for specialty staff included in the legislation were not necessary. Beyond requiring 1 awake staff and two persons at all times, the report suggested that staffing patterns should reflect resident needs for assistance with planned activities and supervision. However, the report did emphasize the need to require adequate outdoor space for resident use. Regulations should specify standards for the amount of space, and other physical characteristics based on the size of the facility.

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

The California pilot projects have been extended until 1996.

The movement to revise regulations, seek waivers from physical plant requirements, rethink staffing patterns and educational training, and rethink philosophical tenets will shape future assisted living policy. The ability to foster true "aging in place" is a constant challenge as people's ability to engage in decision-making diminishes. The development of “special care wings,” round the clock activities and mixed versus segregated models may provide the experience from which better concepts and guidelines will emerge.

Nurse Delegation

Critics contend that the long term care system is over-medicalized and more expensive than necessary. A major source of the concern is state requirements that only licensed personnel, RNs and LPNs, provide hands on care in nursing homes and other noninstitutional settings. Government regulations often require staffing patterns based on ratios prescribing the number and type of staff per number of residents. As a result staffing costs comprise a major portion of the cost of providing long term care services.[7] A recent study[8] concluded that long term care costs vary significantly from state to state and the variation was attributed to differences in staffing standards rather than variations in wage levels and real estate costs. Responding to strict staffing ratios and licensure requirements, states have developed more flexible staffing requirements in assisted living residences and nurse delegation laws that allow registered nurses to train and delegate the performance of specific tasks to staff who are not licensed. Staff roles are being revised to avoid job segmentation and the need for higher numbers of personnel. Staff are being cross-trained to perform a number of tasks. Wilson and Kane[9] found that “costs can be reduced by elimination of unnecessary division of labor (caused by regulations, job categories that, for example, prohibit an attendant from

[7] Kane, RA, Illston, L, Kane, RL, and Nyman, J. Meshing Services with Housing: Lessons Learned from Adult Foster Care and Assisted Living in Oregon. 1990.

[8] Kane, RA, Policy Development and Quality of Care. Journal of Long Term Care Administration. Fall, 1993.

[9] Wilson, KB and Kane, R. Assisted Living in the United States: A New Paradigm for Residential Care for Frail Older Persons? American Association of Retired Persons. 1993.

doing laundry at night), by permitting split shifts and staffing up for heavy times, and other innovative approaches." Delegation reflects both a concern for costs but also recognizes that many tasks previously performed by nurses can be safely performed by non-licensed personnel. It also recognizes the tradition of nurses training family members to perform many tasks associated with post hospital care. The principle of training family members is being applied to non-licensed staff in various settings to allow them to perform tasks after receiving training from a registered nurse.

We examined nurse practice acts, which are administered by state boards of nursing, in a limited number of states. As in most areas in which states have the authority to set their own policies and standards, there is wide variability in the extent to which boards on nursing will allow nurse delegation.[10]

Nurse practice acts generally allow unlicensed staff to provide hands on assistance with activities of daily living and assistance with the self administration of medications. **Alabama, Arizona, Delaware and New York** have stricter nurse practice acts but are considering allowing medication administration and subcutaneous injections to be delegated. Training programs in medication administration are being developed in some states (**Maine, New Jersey**) that would certify unlicensed personnel to perform these tasks.

Oregon's practice act is among the most progressive in the nation. For several years, the act has allowed its nurses the flexibility to decide which tasks may be delegated to unlicensed staff for a specific resident. The Board of Nursing differentiates between basic tasks, which do not have to be delegated, and special tasks which require delegation. Basic tasks may be "assigned" rather than delegated by a physician or nurse (various tasks of medication administration of non-injectable medications). They may also assign basic tasks of nursing care. Nurses may also delegate the administration of subcutaneous medication injection and nursing tasks. The Board considers the client's condition rather than the **tasks** to be delegated.

In assessing the client's specific situation, the nurse determines what tasks may be safely performed under delegation given the level of competence of the unlicensed person. The nurse has to train staff for each resident for which a delegated task will be performed. RNs and MDs may delegate nursing tasks to unlicensed persons which include but are not limited to the administration of non-injectable medications and subcutaneous injections. The or MD gives the initial direction after client assessment, provides written instruction to RN the unlicensed person, which includes common side effects, and performs periodic inspections of performance. The RN has the authority to decide that a certain drug does not require nursing supervision (i.e. ongoing assessment, monitoring of side effects, evaluation of unlicensed person's competence to continue tasks). Physicians are able to delegate to unlicensed persons directly. Once medications are ordered through pharmacies, MDs feel that the instructions on the

[10] A more complete study of nurse practice statutes, related regulations and customary practices is being developed by the University of Minnesota Long Term Care Resource Center which will be completed during 1995. For more information on this forthcoming report, contact the Center at 612-624-5171.

medicine label are enough to provide guidance to unlicensed persons for the administration of such medication. Except for assessments and procedures which require the education and training of an RN or LPN, the board of nursing has not developed a list of tasks that may or may not be delegated and instead allows nurses to make professional judgements about which tasks may be delegated on an individual basis. The nurse also determines the frequency of supervision that will be provided but a minimum of every two weeks is required for delegated tasks.

Some nurses complain that the broad scope of the act places too much responsibility on nurses, and guidelines for delegation would be welcome; however, others believe that professional training and clinical judgement should be exercised. Nurses who are not comfortable making delegation decisions are not required to do so.

Alabama, which has a board and care model of assisted living, does not plan to allow unlicensed staff to administer medications. Licensed staff are not required in assisted living settings, but the setting should provide for a registered nurse consultant to supervise residents during periods of temporary illness. If medication is administered, a licensed nurse must be employed to administer medications and supervise the resident. The facility may contract out for this service. Unlicensed staff may provide limited assistance to a resident capable of self-administering their own medications. However, the nursing board is considering allowing specific medications to be administered by unlicensed staff.

Alaska has developed rules, effective January, 1995, which allow the supervision of medication administration by home care staff. The assisted living setting may provide intermittent nursing services to residents who do not require 24 hour supervision and services, and the services may be provided by a licensed nurse or by persons to whom nursing tasks have been delegated. The Alaska Board of Nursing developed a position statement on activities of unlicensed assistive personnel which was adopted in November 1993. This position statement recognizes the growth of unlicensed staff in health care settings and seeks to provide broad guidelines in client care situations. These guidelines also apply to settings where licensed nurses are not regularly scheduled and/or are not available to provide ongoing direct supervision. This includes assisted living settings.

In 1993, the **Louisiana** Department of Health and Hospitals developed procedures for delegating tasks to unlicensed staff, including medication administration. The policy states that unlicensed staff who have completed and passed a drug administration course may administer oral medications, ointments and suppositories, but it does not allow administration by any other route. Delegatory authority is from the physician to unlicensed staff. RNs may only delegate the administration of medications to other nurses. RNs may delegate selected, non-complex nursing functions to licensed and unlicensed staff if it falls within the Nurse Practice Act. This proposal is still under consideration.

Both RNs and LPNs in **Maine** may delegate to and oversee completion of selected nursing tasks by unlicensed personnel who are listed with the Maine Registry of Certified Nursing Assistants (CNAs). The state has a standardized medication course for CNAs which certifies CNAs to administer selected non-injectable medications. Medication administration must be performed under the direct on-site supervision of a licensed nurse only in long term care nursing settings. The Department of Aging has statutory authority to develop recommendations for the administration of medications in assisted living settings. Currently, the state is convening a task force with the state nursing board to analyze which nursing tasks performed in assisted living settings may be performed by unlicensed personnel. The nursing board is concerned about CNAs practicing without nursing supervision as proposed by the state. Unlicensed personnel are currently working in housing models without the supervision of a licensed nurse. Regulations require facilities with more than 10 residents to employ a nurse consultant to assess the needs of the residents. If residents in assisted living settings have underlying medical conditions, care must be overseen by a licensed nurse.

A pilot project has begun in **Maryland**, jointly sponsored by the Board of Nursing and the Office of Licensing and Certification, to create a new category of a skilled geriatrician who would perform delegated tasks. LPNs and RNs may delegate any task within their scope of practice to a skilled geriatrician. Like **Oregon**, the goal is to allow the licensed nurse the flexibility to determine which tasks may be delegated, given the competence of the unlicensed individual, rather than to design a list of tasks which may be delegated. These include but are not limited to nursing activities such as tube feedings, treatment of non-sterile dressings, bowel and bladder incontinence, but currently does not include catheter care at this point in time. The only criteria for delegation is that the individual's condition is chronic, stable, and the setting unchanging.

The practice act in **Massachusetts** permits RNs and LPNs to delegate nursing activities to unlicensed personnel. Licensed nurses are given the final decision as to what nursing activities may be delegated. These activities include, but are not limited to nutrition, hydration, mobility, comfort, elimination, socialization, rest and hygiene.

The **Montana** Board of Nursing has proposed changes to its Nurse Practice Act which specifies nursing activities which may be routinely delegated to unlicensed personnel. The nursing tasks to be delegated must be within the scope of practice of the nurse delegating the act. The nurse retains full responsibility for medication administration, but may delegate the administration of oral medications and suppositories to unlicensed personnel. Unlicensed personnel may assist with ADLs, supervise resident's self-administration of medication, and perform non-invasive and non-sterile treatments. The Department of Health and Environmental Services believes that the nursing delegation proposal did not go far enough, and would prefer to include tube feeding, performance of invasive procedures and other routes of medication administration by unlicensed personnel. In addition, they would like the Practice Act to permit nurses to make decisions on their own and to develop quality standards for delegation.

Legislation that would revise nurse practice acts is expected to pass this year in **Hawaii and Washington**. The **Washington** Department of Social and Health Services's proposal is broader than Oregon's. The delegation of nursing tasks would extend beyond community and residential settings to include any setting where licensed nurses are regularly scheduled. There is concern from the nursing board that this will create a loss of licensed nursing positions as providers seek to cut costs and substitute unlicensed personnel for licensed staff. In response, the nursing board is criticized as being territorial. Currently in assisted living settings, licensed nurses administer medications and supervise unlicensed personnel in assisting with medication management.

The **Wisconsin** act permits the delegation of nursing acts that are within the licensed nurse's scope of practice. The licensed nurse must provide direction and assistance to unlicensed personnel, observe and monitor delegated activities and evaluate the effectiveness of the delegated acts under supervision. In addition, the Board of Nursing has issued a position statement on medication administration by unlicensed personnel and strongly recommends that unlicensed personnel complete additional training related to medication administration prior to performing such tasks. Licensed nurses are required to supervise unlicensed personnel in the administration of medications. This supervision is analogous to that required for the delegation of other nursing activities.

Questions and Responses

What Issues Would You Recommend That We Examine in the Study?

The survey of state Medicaid, Health and Aging agencies included space for respondents to list the issues or questions that they would like to see addressed in the study. Responses to many of the issues have been included in the narrative section and individual state summaries. However, the narrative may address the issues raised but fail to provide a clear response to specific questions. In order to provide direct comments on the subjects identified by survey respondents, we have grouped the questions by subject area and attempted to offer a direct response. The responses reflect the opinions and experience of the authors and do not represent the position of any organization or government agency.

Policy Development

Q. What has been the private sector involvement in setting policy and regulations of the industry?

Industry representatives have played a key role in developing assisted living in most states. The activity has ranged from organizing and promoting a process to develop assisted living policy (Illinois) to actively lobbying legislators to adopt or modify

pending legislation. Involvement from assisted living owners/developers and nursing home associations has varied state to state depending upon the impact that proposed rules or legislation may have on existing providers and whether nursing home providers see assisted living as a new business opportunity or competition for existing business. Many states organized task forces to develop recommendations that included representatives of nursing homes, assisted living facilities and other providers.

Q. Is assisted living meeting the expectations of providers, regulators, residents, communities and political entities?

While experience with assisted living is relatively recent, state policy leaders in **Oregon** and **Washington** cite the value of assisted living in both reducing reliance on nursing homes and offering residents a more residential and home-like setting. The HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) has commissioned a national study of assisted living which will survey residents, owners and staff and include measures for these areas. The study is being conducted by the Research Triangle Institute, Lewin\VHI and the University of Minnesota/National Academy for State Health Policy. The final report from the study will be completed by February, 1997.

In addition, Rosalie A. Kane at the University of Minnesota National Long Term Care Resource Center has been awarded a grant from the Robert Wood Johnson Foundation to conduct an evaluation of the Oregon program. The study will begin in the summer of 1995.

Status

Q. What is the status of state legislation and regulations governing assisted living?

Assisted living is a fast moving trend that has or is being reviewed in a majority of states. While 21 states have been profiled in the state summary section, interest in assisted living is expanding rapidly. Before long, nearly every state will have studied, developed or implemented this model. See the executive summary for a synopsis of state activity and the appendix for state descriptions.

Definition

Q. Please present a clear definition of assisted living?

The definitions developed by states are somewhat clear yet the variations among states are so substantial that there is no consensus on a standard definition that could be used nationally. Several policy makers and organizations prefer a broad definition that allows flexibility for states to develop programs which meet individual state needs, preferences and “politics” and for facilities to develop market driven strategies that define their unit configuration, amenities, service plan and price. The ALFAA definition

presents an excellent approach which encompasses most of the primary components of assisted living.

Q. Can you develop a national definition that will aid states in establishing appropriate regulation and funding for services and settings below nursing facilities?

Several membership organizations have developed definitions that allow a great deal of variation among states. Organization sponsored definitions and policy statements, however, are developed by and for the members of the organization to focus their development, lobbying and member recruitment strategies. The organizations may have goals and purposes that vary from those of government agencies whose definitions structure assisted living for consumers, regulators and government payer sources.

Definitions adopted or proposed by a number of states have been included in the state summary section of the Guide. Generally, the definitions used by states and national organizations allow a broad range of services to be delivered to residents who are more impaired than were previously allowed in board and care settings, although board and care rules are now changing to respond to "aging-in-place" trends. The most controversial issue is the setting in which services are provided. Some states require residential environments that include single apartments with kitchenette or cooking capacity, an attached bath and a lockable door. This excludes many board and care facilities which often provide multiple occupancy bedrooms, and also many assisted living projects which provide single bedrooms but do not include kitchenettes, or cooking capacity. Other definitions focus on assisted living as a service in either apartments, private rooms with baths or double occupancy rooms.

Q. Identify and give a clear description of the components contained in the definition of assisted living. What at criteria are used to define or measure the programs?

While there are no standard criteria that define or measure assisted living, a review of state policies finds several common factors: the setting or physical structure, the services provided, the residents or tenants that may be served and the philosophy of the model. The settings range from apartment style units (private bathrooms and kitchenette) in purpose built housing to conventional elderly housing to facilities with multiple occupancy bedrooms that are currently licensed as board and care facilities. All programs identify the following services: personal care, housekeeping, laundry, transportation and recreation/socialization. There are significant variations in the provision of skilled nursing and medication administration. Tenant policies also differ, reflecting the policy variations on the range of skilled nursing services that may be provided or arranged. Decisions about who can be served and what services can be delivered reflect state decisions about the purpose of assisted living. These decisions are often based on the status of private sector activity and compromises between slowing or reducing the growth on institutional Medicaid spending, providing consumers more choices, and offering supportive residential options to nursing home admission. States with an extensive supply of board and care homes and private market activity in

assisted living face pressure to parallel market developments with assisted living policies or provide additional funding for board and care facilities.

Q. Please define assisted living: is it your own home or a community placement?

Policy makers in many states have developed models that contain a philosophy that considers the assisted living unit as a person's home by requiring apartment style units (or private bedrooms and baths), lockable doors, heat controls and privacy. The philosophy encourages residents to bring their own furniture and structures the roles of staff to give residents maximum control over their service plan and living environment.

Q. Is assisted living an alternative to nursing homes or a lower level of care?

This question can be separated in two parts. First, how does the state's licensure rule structure assisted living and second, how do state funding policies affect who will be subsidized in assisted living? Several states (Minnesota, Oregon, Texas, Washington) have developed guidelines and reimbursement policy that consider assisted living as a nursing home replacement model for the traditional ICF level of care. Massachusetts does not restrict subsidies to nursing home eligible recipients. The use of assisted living as a nursing home replacement model depends in large part on the sources of funding for the service component. Most states use the Medicaid Home and Community Based Services Waiver to pay for services which requires that recipients meet the state's level of care criteria.

The replacement strategy also relates to the nursing home level of care criteria used by states. Assisted living has been developed as an alternative for people who qualify for placement in a nursing facility in most states. Depending upon the vision and politics of provider interest groups, assisted living may be seen as a competitive threat to existing models (nursing homes, board and care) and proposals may be made to establish mutually exclusive level of care criteria that are common in existing definitions of nursing home and board care arrangements, eg., if you need services provided in a nursing home, you cannot be served in board and care. States who are interested in facilitating aging-in-place in board and care models have eliminated mutually exclusive levels of care between nursing homes and board and care. States interested in developing assisted living as a residential, home-like model to replace nursing home beds will develop criteria for occupancy that allow people with nursing needs to be served and allow the provision of skilled services. Debates in **Florida, Massachusetts and Ohio** reflected concerns among nursing homes that assisted living competed with nursing homes operators under more relaxed rules.

Q. Should assisted living be an alternative to nursing homes or a step in the continuum of care?

Steps in the continuum of care connote that specific settings are appropriate for people with certain characteristics but when the characteristics change, the person must move to new setting. In the past, government regulations have compounded the

problem by requiring that people move from subsidized housing or board and care settings when they become incontinent or need nursing care. Government regulations in some instances affect who is reimbursed for services rather than what services a resident can receive. For example, board and care facilities may be prohibited from providing nursing services but they often arrange for a certified home health agency to serve the resident. This creates artificial barriers to delivering cost effective care. There is considerable overlap of resident characteristics across settings, however, several states have set maximum thresholds for assisted living residences and require that residents must not require 24 hour skilled nursing supervision and have stable medical conditions. Requiring that home health agencies deliver services can add to the cost of care. Proponents argue that only licensed professionals should provide some services. While others argue over what services can be provided by unlicensed but trained staff and which require a license, the issue here is which agency/organization is reimbursed for and responsible for providing the service.

Home and community services and assisted living attempt to support people in a setting as their care needs increase. Many state policy makers believe that many nursing home eligible residents should be cared from in assisted living rather than a nursing home since a significant percentage of people need assistance with ADLs and routine nursing care. Data in several states suggests that as many 25-30% of the nursing home residents have few ADL impairments and could be cared for in a residential setting.

Q. Why should we create a separate category and how does assisted living differ from board and care? Please distinguish between board and care and assisted living and include a matrix with components of both.

State policies on assisted living have been developed to create a residential model of care that encourages resident choice and control and avoids institutional overlays. However, there is considerable overlap and in many states, board and care and assisted living are the same. Assisted living can be separated from board and care to the extent that state policies set more flexible standards than either nursing homes or board and care requirements. In some states, the terms board and care and assisted living are used interchangeably. Alabama has an assisted living licensure category that is the equivalent of board and care, personal care homes, residential care facilities, etc. in other states. States that have defined assisted living within the past five years have intentionally separated the term from board and care. While a few states approach assisted living as a service provided in a range of settings, states that combine services and a setting differentiate it from board and care by requiring single occupancy apartments, kitchenette or cooking capacity, attached bathroom and lockable doors. State policy makers also contend that the philosophy of assisted living differs from that found in nursing homes and board and care. The primary difference is the prominent role that residents play in controlling their living space and developing and implementing the plan of care.

In several states (**Connecticut, Minnesota, Oregon, Texas, Washington**), assisted living differs from board and care by requiring single occupancy (double only if voluntary) apartments or bedrooms with private bathrooms while board and care regulations allow multiple occupancy bedrooms, shared bathrooms and congregate dining. However, many board and care facilities offer a higher level of amenities and units which reflect marketing strategies rather than compliance with minimum requirements. Historically, board and care licensure requirements have not allowed facilities to provide skilled nursing or admit or retain people who needed a nursing home level of care. Further, board and care regulations have been premised on maximum safety and protection of residents. Assisted living generally represents a new philosophy of service that maximizes resident autonomy, decision making, dignity, choice and involvement in service decisions.

Differences between Assisted Living and Board and Care Models		
Component	**Assisted Living[1]**	**Board and Care**
Units	Apartment or private bedrooms	Multiple occupancy
Tenants	May require nursing care (routine or skilled services)	Generally cannot require nursing home level of care
Services	Usually include routine nursing and often skilled nursing	Nursing care usually cannot be provided by the facility
Philosophy of care	Resident autonomy, independence	Safety and protection
1. As reflected in the models that we define as a new housing and service model and a service model in apartment settings.		

Q. What are the barriers to developing assisted living?

As a relatively new and diverse phenomenon, the assisted living market is several steps ahead of public regulatory and financing sources which have been developed for specific and familiar programs (elderly housing, in-home services). Existing financing programs have to be modified to fit assisted living. Since it is unlikely that a new national program will emerge, states will continue to use existing programs to stimulate development of the supply of assisted living. Private market developments have access to many conventional sources of financing. However, many of these facilities cannot easily accommodate low income residents. Sources of public financing that contain set asides for low and moderate income tenants (tax exempt bonds, tax credits), are being successfully used by developers to build assisted living. It is also difficult to combine housing and services financing streams. Medicaid waiver funding is available for nursing eligible low income people who meet Medicaid financial eligibility criteria. Some states use general revenue funds to subsidize people who are not eligible for Medicaid. These policies leave out people who have too much income to qualify for Medicaid and not enough income to pay the room and board and service costs. Developers have a difficult time convincing bond underwriters that financing for the service component can be guaranteed over the term of the mortgage to help the facility meet its low income set aside requirements. However, coordination between state agencies (state Housing Finance Agency, Medicaid, Aging and Health Departments) can overcome the obstacles. The emerging proposals to combine a number of federal housing programs

and increase state flexibility may create new opportunities to use federal resources for assisted living.

Q. Should you consider other levels of care as options to assisted living.

The array of services should be considered just that -- an array of services from which consumers select the most appropriate service and setting. Services and settings are considered options when few choices exist and new programs' emerge to provide more choice. While they are presented as options, they really expand the choices people have based on their income, functional eligibility and service needs.

Resident Characteristics and Level of Care Issues

Q. What are the demographic and clinical profiles of residents?

A 1993 report by the Assisted Living Facilities Association of America[11] surveyed 201 facilities in 25 states and found that the average age of residents was 83, approximately 79% of the residents were female and less than 3% of all residents were married and living with their spouse in the residence. The survey also covered the impairment characteristics of residents (see table)

ALFAA 1993 Survey	
Function	**Percent Needing Assistance**
Bathing	64%
Dressing	34%
Toileting	18%
Transferring	8%
Eating	6%
Medication reminders	63%
Medication dispensing	52%
Cognitive impairments	42%
Use wheelchair or walker	27%
Daily incontinence	15%

Data from a limited sample of residents in Oregon shows that the average age of current assisted living residents was 85, and the average age of discharged residents was 80. 66.4% entered assisted living from their own home, 19.2% from a nursing home and 14.4% from other supportive housing. Among discharged residents, 42.6% entered from their home, 33.8% from nursing homes and 23.2% from other supportive housing. See table for dependencies. Sixty nine percent are private pay residents. Among discharged residents, 51.5% left due to death, 29.4% needed more care and 19.1% left for other reasons. Among the five payment levels, residents who moved out or died had an average level of 4.2. Nearly 78% of the residents who left due to death had 3 or more ADLs dependencies compared to 68.2% for non-death move outs.

[11] An Overview of the Assisted Living Industry. Assisted Living Facilities Association of America. October, 1993.

Impairments Among Residents in Oregon		
ADL	**Current Residents**	**Discharged**
Grooming		
Needs assistance	29.0%	70.6%
Totally dependent	14.0%	22.1%
Eating		
Needs assistance	24.0%	48.55
Totally dependent	8.0%	11.8%
Dressing		
Needs assistance	27.0%	70.6%
Totally dependent	12.0%	25.0%
Walking		
Needs assistance	19.9%	61.8%
Totally dependent	10.0%	26.5%
Transferring		
Needs assistance	30.9%	57.4%
Totally dependent	15.0%	23.5%
Toileting		
Needs assistance	47.0%	66.2%
Totally dependent	16.1%	27.9%
Bathing		
Needs assistance	31.0%	83.8%
Totally dependent	12.0%	33.8%

A study of 947 tenants in Oregon's program by Kane and Wilson Yielded different findings about the level of impairments: 43% were dependent or needed help in ambulation, 32% with eating, 39% with toileting; 30% with transferring, 46% with dressing and 63% with bathing and 43% needed intervention because of behavioral problems.[12] Residents in Oregon also have nursing needs. Kane and Wilson found that 75% needed medication management, 12% received skin care and dressing changes, 9% received daily injections, 3% received ostomy/catheter care and 3% received oxygen. The study also sampled 63 facilities in 21 states and described the admission and general client characteristics of people served.

An extensive study of assisted living residents is being undertaken by the Research Triangle Institute under contract with ASPE and will provide information on this area.

Q. What are the equivalent nursing home levels for persons served in assisted living?

Data on the number of assisted living residents who would qualify for admission to a nursing facility will vary by state and by funding source. First, level of care criteria vary widely by state.[13] States that provide subsidies for low income residents generally limit eligibility for subsidies only to people who meet the nursing home level of care criteria. However, the percentage of residents who are state subsidized and therefore eligible for a nursing home, is limited. Comparison data is very difficult to find. Assisted living

[12] Kane and Wilson. Ibid.

[13] For a comparison of state level of care criteria, see "How States Determine Nursing Facility Eligibility: A National Survey," a paper prepared by the Academy for AARP. Publication pending.

facilities do obtain data on ADL and cognitive impairments, but these measures do not convert to nursing home eligibility.

Data from the Oregon Senior and Disabled Services Division indicates that approximately 18% of assisted living residents have 3 ADL impairments compared to 15% for nursing residents; 15% have 4 ADLs compared to 24% for nursing home residents; 20% have 5 ADL impairments in both settings and 10% of assisted living residents have 6 ADL impairments compared to nearly 70% in nursing homes.

Finally, a pending evaluation by Rosalie A. Kane of assisted living in Oregon will compare assisted living tenants with nursing home residents. However, the availability of a full range of services (home care, residential care facilities, adult foster care and assisted living), and policies which support and finance their expansion, may have affected the profile of nursing home residents. Dr. Kane is developing a methodology that will develop a comparable sample of assisted living and nursing home residents.

Q. How do you determine when people can be cared for in assisted living versus nursing homes? What level of care is appropriate for a residential model?

States have set varying thresholds to determine whom may be served in assisted living versus a nursing home. Generally, people with stable health conditions who do not require 24 hour skilled nursing supervision can be served in assisted living. If the residential model is considered a person's home, then whatever needs a person has and services a person can receive in their own home or apartment might become the baseline for the level of care that is appropriate. However, state regulations frequently specify the level of care that can be provided. One might argue whether it is the "appropriate" level that can be provided. The fact that state policies vary so widely suggests that little consensus exists. State regulations in **Florida, New Jersey and Washington** contain guidelines for the specific services that can be provided or conditions that residents may have and be accepted. Other states set general guidelines that allow people who do not need 24 hour skilled nursing supervision and have stable medical conditions to be served. **New Jersey** allows the broadest scope of skilled services.

Q. What are the levels of care (maximum and minimum) that are permitted?

Most states allow some skilled nursing services. Several list what services can and cannot be provided (**Florida, Washington**) while New Jersey has the most extensive criteria. A few states limit the duration of skilled services (**Massachusetts, Ohio**). See the state summaries section for further details.

Q. What is the procedure for addressing inappropriately placed residents? If a person is too frail, who arbitrates when there is a disagreement about move out?

Regulations generally require periodic reassessment of resident health and functional status. Regulations that specify "move out" criteria set the maximum

thresholds for people to remain in the setting. Within broad guidelines, some states allow facilities to specify what types of needs can be met and the resident agreement identifies the facility's policy. When a disagreement arises, family members and outside agencies are asked to intervene. A clear rental or resident agreement as well as a process that involves family members from the initial assessment and care plan is useful in setting the framework for discussions involving relocation.

Q. Who controls placement?

Residency guidelines are usually contained in state statutes and regulations. They can be specific or broad. In several states, individual facilities or residences are given flexibility to determine their own 'move in and retention' criteria within broad state guidelines. In these instances, facilities are required to specify in a resident agreement what services will be provided, who can be served, the charges for services and the conditions which require relocation.

Q. Do facilities specialize? Should there be a separate model for dementia care?

There is considerable debate about models for people with dementia care. People with dementia benefit from structured activity and special designs. Specialized training for staff members is also needed. A number of facilities specialize in the care for people with dementia. Many professionals believe that specially designed facilities help maintain functioning while others believe that facilities with mixed populations also do well with people in the early stages of dementia. A number of features are important such as color coded areas, interior and exterior “wandering paths,” and secure outdoor areas. Routine, structured activities which provide socialization and stimulation seem to facilitate higher levels of functioning.

The question of segregated or mixed facilities can be examined from several perspectives -- residents who are cognitively intact and residents with dementia; market demand and strategy; and degree of dementia. As long as residents do not exhibit aggressive behavior, settings providing separate apartments meet needs for privacy for cognitively intact residents. However, the greater debate focuses on the needs of residents with dementia. Increased monitoring and staff contact are necessary for residents in apartment settings.

Financial considerations also play a role. Building double occupancy rooms reduces costs and generates revenue that can be invested in the increased staffing needed by residents with dementia. While demand for both models may be available, a decision to build a facility to serve people with dementia makes it difficult to change strategies to serve a mixed population.

Finally, residences that care for people in the early stages of dementia face challenges that differ from those of facilities serving people in the middle to later stages when interaction with cognitively intact residents is quite different.

Q. How should we balance health and safety regulations and maintaining a home environment?

Many advocates of assisted living believe that government has placed the highest value on safety in its approach to nursing homes. Yet, despite extensive regulations, accidents, fires and poor quality care do occur. Regulation by itself does not prevent poor quality nor can it ensure protection of health and safety.

The assisted living movement has promoted the concept of consumer choice and managed to strike a balance between health and safety and maintaining a home environment. Allowing consumers to accept risk means that adverse outcomes are possible, just as they are under a tightly regulated system. How well the new approach works will depend in large part on the reaction of elected officials when accidents and poor outcomes occur. A number of approaches are being taken to create a home environment, monitor safety and maintain consumer choice. Visits from ombudsman, family members, case management agencies, and state licensing agencies are components of an overall monitoring system that can be used.

This issue raises a fundamental point made by experts who have studied quality in our long term care system. We want safety for our own parents and our children. For ourselves, we want maximum choice even if it involves risk. Applying our personal standards to the care and services for others requires a change that public policy makers have begun to embrace.

Q. Is case management coverage available or required, especially for mental health population?

Case management type services are normally required by regulation and provided by staff of the assisted living residence. Some states also involve a case manager from a community agency who may perform the initial assessment and authorize placement for Medicaid recipients. Mental health services may be provided by either the staff or arranged through a community agency.

Q. Who provides case management?

Some case management is usually provided by the assisted living residence and some states require case management capacity. In many programs, an outside, independent agency or Area Agency on Aging provides some case management activities such as the initial assessment, care plan development, service authorization and monitoring. Once the person selects assisted living, the case manager may continue to provide regular monitoring but the day to day case management or care coordination is done by staff at the residence. These case management functions are done by external agencies in states that operate programs for low income, usually Medicaid, residents. Private pay residents do not usually receive case management from an outside agency and all the functions are performed by the residence. In some models, the assisted living residence operates as a housing provider and case

management or service coordination staff “arrange” and monitor services for residents from outside providers or organizations that are not provided directly.

Q. Who completes and monitors the plan of care?

This is usually a function of the staff, registered nurse, case manager or social worker, designated by the residence. Many programs describe a decision making role for the resident and/or family member or resident representative in the process.

Q. At what age do most seniors begin to access assisted living and what is the average age of residents and the top ten reasons why elders choose assisted living?

Most people enter an assisted living facility from their mid-seventies to mid-eighties. David Letterman has not yet compiled the “top ten” reasons.

Services

Q. What type and amount of nursing care is permitted? What skilled services are provided?

See narrative and the state summaries in the appendix.

Q. What staff ratios are specified?

Most states do not specify staffing ratios and instead require that facilities have sufficient number and type of staff to provide the services identified in resident plans of care. Regulations also have requirements for 24 hour awake staff and nursing capacity.

Q. How do staffing patterns vary among facilities? Are staff assigned to individual residents or by function?

There is extensive variation among states. There are two variables: what services may be provided in an assisted living setting and who may provide the service. The services allowed are set in conjunction with rental (admission and retention) policies. Limiting what services may be provided must be compatible with resident criteria. New Jersey allows the most nursing services. Washington identified allowable services based on the nurse practice act. Massachusetts allows skilled services provided by a certified home health agency for less than 90 days. Scheduled and periodic nursing services may be provided without regard to the 90 days limit.

Cost Effectiveness and Financing

Q. Access to assisted living is costly (market rates). How do states make it affordable. How do you increase the availability of assisted living for low income persons? What is the adequacy of funding for room and board for low income residents?

Affordability is most difficult for people with incomes just above Medicaid yet below the level that is needed to pay the monthly fee. States have two major options: elect the "special income level" eligibility option under Medicaid and/or create a separate SSI payment standard for assisted living. Combining SSI and Medicaid waiver funding allows access to many market rate assisted living projects. See the discussion below.

Q. What are the sources of financing for construction? What are the sources of federal assistance?

Financing for construction and mortgage costs are available through conventional financing, tax exempt bonds, tax credits, HUD's 232 mortgage insurance program and, depending on the model, HUD 202 and Congregate Housing Services Programs.

The Medicaid waiver program is the most widely used federal source of financing for services. However, OBRA 1993 amendments to the Medicaid personal care service make it easier for states that include personal care in their state plan to use this financing source in assisted living. States that may want to add personal care as a state plan service only for recipients in residential settings may also want to consider the implications of this amendment. Proposed regulations are expected to be promulgated soon by HCFA to implement these changes.

Massachusetts uses a modification of their adult foster care state plan service and New York provides a capitation payment that bundles a range of state plan services (personal care, home health aide, nursing, therapies). SSI is used by all states to pay for room and board. Other potential sources are the Older Americans Act, Social Services Block Grant but these services are more likely to be used by individuals based on community needs and may not be made available as easily on a statewide basis.

Q. Is assisted living cost effective in comparison to alternative services options offered in each state? How does the cost effectiveness of assisted living compare to nursing homes?

Publicly financed assisted living costs between 50% and 85% of the cost of a nursing home in many states. Compared to in-home services, assisted living is likely to be more expensive per person since services are needed 7 days a week, especially if the person does not have a spouse or relative that can provide such care if the resident were to live alone. Presumably, people who receive in-home care and move to assisted living require a level or frequency of care that can no longer be sustained in a single family or apartment setting. While care might be less expensive in the home, it may not be appropriate. Similarly, compared to a nursing home, the setting may be cheaper but as the need for skilled services and medical care increase, the assisted living setting may not be appropriate.

The larger question often relates to the impact of supply of a new service on aggregate spending. Will assisted living reduce spending on nursing homes? Spending projections require assumptions about how a state will respond to expanding demand.

As the population ages and lives longer, will a state ignore the trends and continue to support a fixed supply of all long term care services, or will supply expand to meet some percentage of growing demand? If supply expands, will the marginal growth occur in nursing homes, community or in-home care or residential options like assisted living?

State officials in Oregon have demonstrated that assisted living and community services can reduce nursing home use. As the state has expanded service options, the supply of nursing home beds has declined and occupancy rates continue to drop. The supply of beds has dropped from 15,146 in the 1981-1982 biennium to 14,758 in 1991-1992. The number of Medicaid recipients in nursing homes has declined from about 8,200 in 1981-1982 to 7,557 in 1993-1995. The current occupancy rate is about 83%. Officials believe that consumer choice has created market forces that have influenced supply.

Q. What rates do states pay and what do they cover? What are the reimbursement issues and methodologies used by states? What payment methodologies are used: pre-paid capitation, per service?

The narrative section presents the rates for several states. Typically, the rates cover personal care, assistance with medication administration, housekeeping, some skilled services, transportation, and activities. Rates in a few states also cover therapies, medical equipment and supplies.

All the states use either a daily or monthly capitated rate for publicly subsidized residents. Facilities may offer flat, fixed fee or a la carte service options for private pay residents.

Q. What income or asset levels do states use in 2176 waivers?

Many states set eligibility at 300% of the federal SSI payment level or $1374 a month. States have the option of using a lower threshold under this optional eligibility category. However, once the threshold is established, states then set a maintenance amount that the recipient will keep and apply to the cost of room and board. Any income in excess of the maintenance amount is applied to the cost of services. Asset levels are fairly standard across the states.

A small number of states have used the flexibility under section 1902 (r)(2) to set higher asset levels. These states (Connecticut, New York, Indiana and California) are implementing long term care insurance partnership models that allow middle income people to protect their assets by purchasing long term care insurance. When the cost of long term care exceeds the benefit, the become eligible for Medicaid and retain the level of assets allowed by the state program. This option has not been applied to programs such as assisted living. However, the long term care insurance policies offered by companies participating in the “partnership” cover assisted living.

Q. How do you provide federal funds for assisted living that is not tied to nursing home level of care as in the HCBS waivers?

The Medicaid personal care state plan option is available. Under OBRA 93 amendments, state have greater flexibility to deliver personal care and may limit the service to residential settings. Massachusetts has developed a Group Adult Foster Care program as an ambulatory service under the state plan. This program is directed at residents in assisted living and subsidized housing who are at risk of nursing home admission but need not meet the criteria at the time of service.

Q. What documented cost savings exist for assisted living programs funded through Medicaid? If you pay for assisted living through Medicaid, won't it increase aggregate spending.

The Massachusetts Division of Medical Assistance recently completed a study requested by the legislature that projected savings of $2398 per participant in assisted living. Oregon officials attribute the expansion of community services, including assisted living and adult foster care, as the major reason for a decline in the number of nursing home beds and an occupancy which has dropped to 83% despite the decrease in supply. Washington has expanded their assisted living program to serve people affected by closing of nursing home beds.

Documenting savings is a difficult task. It requires assumptions about how and if people would be served. If the state continues to serve the same percentage of the population over 65 in 2000 as it does today, costs will increase. The growth trend line can be reduced by adjusting the mix of services that will be used to meet the growing need. Assisted living can substitute for nursing home beds and New York has authorized contracting for 4200 assisted living units and reduced the nursing home bed need formula by 4200 beds.

However, a state that decides it will not meet growing need and, despite an aging population, increased demand for nursing home beds for subacute care, increasing waiting lists for people needing lower levels of care, determines that the supply of all services institutional, residential and in-home care -- will be held constant or reduced sets a goal to reduce growth rates by freezing supply. Even with a tough, fiscally oriented policy, costs could be reduced if the supply mix is altered, assisted living units are expanded while the number of nursing home beds is reduced. This approach would allow a state to increase the total number of people served for the same expenditure since assisted living is cheaper per person than nursing home care. Developing policies that are effective at reducing the supply of nursing home beds is likely to be difficult although a combination of market forces and state incentives may be developed to support such a policy goal.

Q. How does state supported assisted living affect Medicare?

Reimbursement policies create incentives for billing Medicare when appropriate. Facilities receiving a fixed payment will always have an incentive to bill Medicare for services covered. However, some Medicare covered services may not be allowed in assisted living settings under some state rules. Further, if allowed, state reimbursements may not cover the services covered by and reimbursable through Medicare and facilities would have to arrange for Medicare certified providers to deliver or seek certification as a home health agency.

Licensing/Accreditation

Q. How do you achieve balance between under-regulation and resident abuses, etc?

Many policy leaders contend that the primary lesson from nursing homes is that government cannot guarantee quality through heavy regulation. While we may not know how to create the most appropriate balance, we know what has not been effective. Assisted living represents a new attempt to build long term care services on a set of principles that gives more status to individual preferences and control rather than safety. States have adopted a number of strategies to also protect individuals from abusive situations and poor care. These include regular visits from independent case management agencies, involvement of state ombudsman programs, and inspections from state licensing agencies. State leaders also fear that a few incidents may lead to further legislative action that will create regulations that have not prevented similar incidents in nursing homes.

Q. How do you develop alternative approaches that stress accreditation, operator compliance through education and technical assistance with a strong role for the ombudsman program.

Oregon has perhaps the most experience using this approach for granting licenses. Instead of setting specific requirements for each facility, the process asks that facilities seeking a license describe how they will operationalize the principles and philosophy of assisted living as described in the state's regulations.

Q. What licensing criteria are being used?

See appendix for the state summaries.

Q. What are the standards for assisted living nationally? How do you avoid regulation, compliance parameters, sanctions, penalties and achieve quality? Have outcome oriented quality assurance standards been developed?

No formal, mandatory standards have been adopted that apply to all facilities. However, the Assisted Living Facilities Association of America has developed a model for its members and others to follow. The American Seniors Housing Association has

also developed a general outline of standards. The Institute of Medicine is reviewing whether it should develop a process for certifying assisted living facilities.

The American Association of Retired Persons has commissioned a paper prepared by Keren Brown Wilson that offers model standards and an approach to monitoring and regulation that varies by the case mix and degree of compliance. For a copy of the paper, contact AARP's Public Policy Institute at 202-434-2277.

Q. How do states deal with staff ratios?

Generally, states are avoiding specific ratios and schedules. Regulations are recognizing that care demands vary by the mix of residents and the time of day. In addition, assisted living models avoid rigid schedules for when services (eg., baths) will be provided in favor of developing a schedule with and by residents. To encourage resident autonomy and decision-making, facilities develop arrangements with residents

Managed Risk, Safety and Autonomy

Q. Are consumers satisfied?

A major national study of assisted living funded by the Office of the Assistant Secretary of Planning and Evaluation of the US Health and Human Services is underway that will include surveys of a sample of residents of assisted living across the country. More information will be available upon completion of the study which has been awarded to the Research Triangle Institute with subcontracts to Value/VHI and the University of Minnesota Long Term Care Resource Center. The investigators involved in the study include Catherine Hawes (RTI); Barbara Manard, Lewin/VHI; Rosalie Kane (Minnesota LTC Resource Center); and Robert Mollica (NASHP). The final report is due early in 1997.

Q. What does the negotiated risk agreement include?

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

activities and tasks that might be more convenient for staff and management of an efficient “facility.” It places residents ahead of the staff and administrators and helps turn a “facility” into a home.

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

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

Q. How do you balance health and safety issues when the consumer's choice conflicts with them?

The negotiated service agreement is a process that recognizes risk and provides a context for dealing with it.

IV. CREATING HOUSING STOCK

Issues in Creating Appropriate Housing Stock

How to pay for services typically dominates conversations related to long term care. In reality, any discussion of assisted living must also explore how to pay for shelter costs. To a certain extent, shelter issues in assisted living are a function of building use. This is likely to remain the case regardless of decisions made at the state level related to the regulation of assisted living as either a setting, a service or both. Building use affects zoning, code requirements, construction costs and even the financing vehicles available.

In the simplest terms, building use may be categorized according to the characteristics of the population service (eg., ambulatory, semi- or non-ambulatory) and/or the types of services provided (eg., health related or hospitality). To specify that more than fifteen persons who will live in a setting with a common roof, whether in apartments, rooms or beds, are likely to be frail and in need of assistance on a regular basis virtually guarantees designation as some type of health care facility. Such a designation will result in restrictive zoning, special construction requirements and higher costs. Conversely, to ignore the overall condition of the tenants is likely to generate restrictions or residency demands imposed by the local Fire Marshall's or state Health Department. This dilemma affects conversions or rehabilitation of existing stock as much or more than new construction.

New Construction vs. Conversion/Adaptation

One of the initial problems in creating housing stock appropriate for assisted living is whether to build new or modify existing settings. The first question which arises is whether available housing stock is suitable for assisted living. The key to determining the viability of using existing settings to provide assisted living is a clear understanding whether modifications would be needed to deliver needed services and to assure the ability of residents to maintain occupancy. Such modifications might require minor construction (eg., provision of social and recreational space); other, major costs (eg., installation of a kitchen or elevator); and others may not be feasible at all (eg., provision of 2 hour fire walls or hilly accessible bathrooms).

A second question is whether any resulting modifications expand the usefulness of the site sufficiently to make the cost of modification worthwhile. Both Washington and Oregon report limited conversions of existing nursing homes and/or congregate type housing with more emphasis on new construction. Other states, such as Massachusetts, report extensive efforts to use existing housing stock. The major barriers to conversions are related to life safety issues (fire walls, type of wiring), accessibility standards (wheelchair access for multistory buildings, bathing) and return on investment if revenues generated do not exceed the cost of modifications. A final

issue in conversion, particularly in nursing facilities, is whether the transformation is sufficient to meet the criteria for a residential environment. Overall this is an issue that will be influenced by policy decisions about shelter and service requirements, state and local building codes, and the economics of the particular market.

Zoning

If the decision is to build new, the first issue which arises is zoning. Zoning laws are not uniform across communities, mush less counties or states. Perhaps the major problem is that assisted living is not a “named use” in most communities. This means that local zoning and planning boards must decide if it should be classified as a health care facility or a high density residential project. It often means requesting a special use or variance. This lack of clarity often adds tot he confusion trying to select sites for development and to the length of time required to obtain a building permit since sites are seldom properly zoned initially.

Lack of understanding sometimes reduces the number of sites which can be utilized (increasing land costs). It also can result in the imposition of inappropriate or expensive site conditions such as parking spaces per unit (if it is treated as residential construction), fire lanes around the building (if it is treated as a health care facility). In fact, sometimes blended conditions are imposed as if the building was both residential and a health care facility, which in some respects it may be.

Construction Type

While zoning issues create a significant amount of delay and confusion, the larger problem in developing new assisted living units is the debate over construction type. Basically, the issues revolve around what code should be used in setting standards and issuing permits. While states may set building standards, permits to construct and occupy a building are obtained locally. It is not unusual to find conflict between the various jurisdictions (municipal, county, state). This conflict typically mean delay in getting a permit either for building construction or occupancy while the conflict is resolved.

The type of construction required, often I or II, or a blend of special residential codes (SR 5) and the I occupancy affects both the “look” of the building and the cost to build. Fire Marshall and Health Department architects frequently favor higher code requirements related to their concerns about the safety of a frail population often with limited physical and cognitive abilities. The I occupancies require things typically unseen such as conduit wiring, fire walls in the attic and sprinkler heads in closets which may add as much as $10 per foot in construction costs. They also may result in requirements which compromise the residential quality of the environment such as crash bars on exit doors, automatic closers on doors or wire glass windows for exterior use.

The Development Process

Overall the development process can take as little as nine months (from site selection to move in for the first tenants) to three years for larger projects in major metropolitan areas. In addition to problems associated with zoning and construction type, there may be problems finding architects and builders familiar with the building product type. This can result in buildings without the appropriate blend of residential or health related characteristics. Inexperienced builders may have difficulty building to satisfy code requirements, particularly when confusion or conflict exists.

Assuming these issues are successfully identified and addressed, financing remains a significant obstacle. Assisted living residences are categorized as purpose-built housing which typically results in lower loan to value ratios being applied when financing is sought. This means a higher “down payment” or equity level is needed to receive a loan from conventional lenders. Even with guaranteed permanent financing (bond financing, REIT loans, HUD 232 mortgage insurance), expensive appraisals, an operating reserve, or 20% equity requirements are common.

The major problem that this presents to states is that the cost of shelter (the amount needed to pay the mortgage, taxes and insurance), may well exceed the amount available from SSI to cover room and board. Low SSI payment levels force decisions about whether to use double occupancy, provide additional state supplements to SSI, or seek ways to reduce development costs as strategies to reduce the cost of affordable housing units. Table 6 illustrates the impact of long term debt financing on monthly shelter costs. While costs in a some states may be higher or lower, the matrix highlights the considerations for developers as well as federal and state policy makers in shaping decisions that will finance services and construction of assisted living residences.

The development costs range from a low of $45,573 to a high of $77,977 per unit in most states depending on land and construction costs and the level of amenities. At 7% interest, the cost of debt service ranges from a low of $303 to a high of $519. Debt service ranges from $708 to $1,211 @ 14% interest for 10 years.

Table 6 also highlights the impact of service costs at three levels: low, moderate and high. Residences providing a low level of care offer housekeeping, meal and laundry services. A moderate level of care includes personal mm in addition to the “hotel” services and residences offering a high level of care add nursing services.

Table 7 combines the debt service (@ 7% interest) and service costs for three levels of development and three service levels. The table highlights the importance of flexible state policies to allow low income residents to be served. States seeking to serve residents who would qualify for placement in an nursing home (high service level) can expect to set reimbursement rates between $1,372 and $1,588 a month, depending on the development costs. The cost for residents receiving a congregate or low level of

service will range from $989 a month to $1,205 a month, depending on the development costs.

TABLE 6. Per Unit Development Costs*			
	Low	**Moderate**	**High**
Development Expenses			
Land	$1,000	$2,830	$6,000
Construction	$37,000	$43,000	$53,000
Development	$5,449	$10,073	$16,103
Pre-opening/marketing	$2,124	$2,499	$2,874
Total Project Costs	$45,573	$58,402	$77,977
Shelter Cost/Unit Based on Debt Service			
7% - 30 years	$303	$389	$519
11% - 15 years	$518	$664	$886
14% - 10 years	$708	$907	$1211
Operating Expenses	**Level of Care**		
	Low	**Moderate**	**High**
Personal	$286	$460	$630
Operations expenses	$205	$220	$230
Property/utilities	$115	$120	$125
Management fee	$80	$82	$84
Total Operating Expenses	$686	$882	$1,069
* **NOTE**: These development costs are based are presented to highlight the impact of various costs on affordability. While these costs are typical in a number of states, land and construction costs may be considerably higher in some states.			

In many states, the development costs of a large share of projects may be higher, however, as development costs rise, it is likely that the cost of care in a nursing home will also rise. Higher interest rates will also increase the monthly costs. While some developers of upper income projects will have development costs that will exceed government's ability to pay, state policy makers need to understand the impact of development and service costs in a state in order to establish payment policies which will support private market initiatives. However, experience to date has shown that assisted living residences can be developed that are affordable for low income residents who qualify for government assistance in states that have developed explicit policies to encourage its expansion.

TABLE 7. Development and Service Costs @ 7% Interest			
Development Costs	**Service Levels**		
	Low	**Moderate**	**High**
Low	$989	$1,185	$1,372
Moderate	$1,075	$1,271	$1,458
High	$1,205	$1,401	$1,588

Low Income Residents: Policy Options

State policy makers and assisted living facilities have been challenged to serve low income residents. Assisted living may not be affordable for low income residents for two reasons. First, the SSI payment amount may not be adequate to cover an operator's

room and board costs. Individuals whose income exceeds the SSI and Medicaid eligibility levels generally lack sufficient income to afford the private assisted living rates. While some I facilities may serve such residents, their ability to do so is limited.

SSI is the primary resource for covering the room and board component of assisted living for low income residents and Medicaid funds can be used to cover the cost of services. However, a major gap exists for people with too much income for Medicaid and too little to pay privately. Yet both the Low Income Tax Credit and Industrial Revenue Bond programs have set aside requirements for people with up to 50% or 60% of the median income. In effect, people near the 50% income range will not have enough money to pay the service costs. The table below shows that payments from a resident whose income equals 30% of the median in a residence with a monthly fee of $1800 fall $1009 below the fee (assumes 15% of income is needed for personal needs). Fees from a resident with income at 50% of median would be $482 below the monthly fee. Facilities must adjust rents/fees for market rate units in order to offset "losses" from low income units and meet set aside requirements.

States have two options to narrow the gap. First, states can serve people who would not otherwise quality for Medicaid by selecting the "special income level" eligibility option under Medicaid. This option allows states to set eligibility at up to 300% of the federal SSI payment or $1,374 a month in 1995. Second, states may establish a state supplement to the federal SSI payment that applies only to assisted living. Setting a special SSI benefit level for assisted living can provide a means of supporting residents who would become Medicaid recipients if they entered a nursing home and "spend down" to Medicaid levels.

Each option addresses the gap in a different way. The Medicaid special income level eligibility category allows people with income above regular Medicaid levels to use their income to cover the rent and obtain Medicaid funding for the service components. The SSI option allows people without enough income to pay the rent to do so and still remain eligible for the Medicaid.

Medicaid Eligibility -- Special Income Level

States have an option to raise Medicaid eligibility. Assisted living facilities have not been accessible to low income elders because of the high monthly rates required in projects without rent subsidies and the inability of Medicaid to cover room and board costs outside an institution. However, it is possible to establish eligibility under a 2176 waiver to cover nursing home eligible elders who live in an assisted living program that does not have rent subsidies. This approach gives many recipients enough income to cover the monthly fee for room and board charges. It addresses a major gap caused by the absence of rent subsidies and financing for the room and board costs for a segment of the elderly population and allows projects to serve residents with incomes up to 40% of median income.

TABLE 8. Hypothetical Income Profile and Gap		
Category	**Resident B 30% of Median**	**Resident C 50% of Median**
Annual Income	$11,160	$18,600
Monthly income	$930	$1,550
Facility fee	$1,800	$1,800
Personal needs @ 15% of income	$139.50	$232.50
Amount available	$790.50	$1,317.50
Net difference	-$1,009.50	-$482.50

Washington is one of a number of states that have elected the “300% rule” option. Table 9 presents the impact of this option which allows residents with income up to 40% of median to be eligible for Medicaid home and community based waiver services in an assisted living setting. The state provides for an SSI supplement payment of $609.30 a month in assisted living. Residents with income from social security, pensions or other sources that are below $609.30 would receive an SSI supplement.

The table presents three examples. Resident A is a Medicaid recipient who is receiving SSI. SSI recipients are able to retain $38.84 a month as a personal needs allowance (PNA). After deducting the PNA, the facility receives $570.46 for room and board and $811.80 a month for waiver services for a total payment of $1381. (Note: the state's payment is actually $47.37 a day -- $20.31 from SSI and $27.06 from Medicaid. The examples are based on a 30 day month.)

Resident B has social security, pension and investment income of $930 a month or 30% of median. They do not qualify for SSI, however, because Washington sets Medicaid eligibility at 300% of the federal SSI benefit for people who qualify for nursing home admission, the resident is eligible for Medicaid. Under rules, described below, the state set the maintenance amount at $609.30, from which $570.46 is applied to the room and board costs, and all remaining income is used to reduce the Medicaid service payment.

TABLE 9. Income and Payment Examples without Expanded Medicaid Eligibility			
Category	**Resident A (Medicaid Eligible)**	**Resident B 30% of Median**	**Resident C 50% of Median**
Annual Income	$7,311	$11,160	$18,600
Monthly income	$609.30	$930	$1,550
Room & Board	$570.46[1]	$570.46	0
Tenant service payment	0	$321	[2]
Medicaid service payment	$811.80	$490	0
Total Income to residence	$1381	$1381	[2]
Difference		0	

1. SSI supplement minus personal needs allowance of $38.84 a month.
2. Depends upon the residence’s policy and ability to subsidize from revenues from market rate units.

Resident C has income at 50% of the median income which is above 300% of the federal SSI payment and therefore does not qualify for state assistance. If housing development costs were higher and the current SSI payment was not adequate, the

state c could establish a higher maintenance level which would allow the resident to pay divert a portion of their income from the service cost to the room and board cost. While the net state cost would increase, assisted living would still be more cost effective than a nursing home.

Eligibility Steps

Eligibility for Medicaid may be expanded through the following steps. A state may cover people under several “optionally categorically needy” options. One option, the Special income Level (SIL), covers people whose income is below 300% of the federal SSI standard [S1902(a)(10)(A)(ii)(5)]. States may select an SIL between their community standard and 300% ($1,374 in 1995) of the federal SSI payment standard ($458 in 1995). People with incomes above $1,374 a month are not eligible under this category.

The SIL option must be applied in both institutional and community settings, however, states with a Medically Needy program may use both standards in their state plan. States do not have to choose one or the other. The SIL option generally does not expand eligibility for institutional care in states with a medically needy program. However, it may expand eligibility for home and community based services waiver programs. Medicaid may cover people in the community who would be eligible if they were institutionalized and if they would require institutional care in the absence of home and community based services (CFR 435.217). Since people with incomes below the special income level are eligible in an institution, they become eligible in the community.

The SIL option triggers very different procedures for treating income for people living in the community. First the state sets the SIL at any amount between the state's community standard and 300% of the federal SSI payment standard. Second, it must apply the post eligibility treatment of income rules (435.726 & 435.735) rather than the medically needy spend down rules. In so doing, the state must exempt an amount of income that the state determines is necessary to meet the individual's maintenance needs in the community. Until 1986, the maximum maintenance amount was based on the state's SSI standard or its medically needy standard. After 1986, states are free to set an amount for maintenance needs at any level. Income that exceeds the maintenance level must be applied to the cost of waiver services. There is no other spend down. Excess income is not applied to covered medical services. See table.

Assuming a state sets the maintenance level for exempt income at the maximum, client A could keep all their income which allows them to pay a reasonable monthly fee for the room and board component in an assisted living facility. If the maintenance level were set at $800 a month, a recipient with monthly income of $1,374 would have to apply $574 toward the cost of waiver services. They may be able to pay the monthly fees but they win have very little income available once it is paid and excess income is applied to waiver services.

	Client A	Client B
Recipient Income	$1,374	$1,374
Maintenance Level	$1,374	$800
Excess	0	$574

Assisted Living Implications

This option would allow states to expand eligibility under a 2176 waiver to support assisted living. The maintenance level should be determined based on the expected costs of room and board, the cost of waiver services that would be paid by the recipient, and the amount of discretionary income a recipient will need in a such a setting. A higher maintenance level will increase participation. Depending on the room and board costs and the state's maintenance income level, recipients with incomes near the $1,374 maximum may be more likely to participate in an assisted living program than someone with income of $700 a month. The closer the room and board component of the facility's fee is to the recipient's income, the less discretionary income that is available. If a facility's negotiated room and board rate were between $500 and $800 a month, someone with $1,374 a month would have $574 and $874 a month for other expenses. A maintenance threshold of $1,000 would leave the resident with $200 a month after the remaining $374 was applied to the service costs. However, most states would set the maintenance amount at a level that allows a smaller monthly personal needs allowance to be retained ($35-$75 a month) and all other income would be applied to the cost of care. Residents with incomes above $1,374 would not be eligible as Medicaid recipients.

SSI Option

A second state option is to create a separate living arrangement and payment standard for SSI to support assisted living. Depending upon construction and mortgage costs, the existing community standard SSI benefit for a single person living alone may be adequate to cover room and board costs. From the traditional housing operators perspective, room and board includes real estate, raw food and food service costs. Using a Medicaid Home and Community Based Services Waiver to finance services may also reduce the traditional "board" costs since meal preparation (cook, serving staff, dish washer) can be included in the service component. Still, SSI may not be adequate in states with higher development costs. In these circumstances, an enhanced state supplement to the federal SSI payment may be created.

States can change the number and definition of living arrangements, and the payment standard for each, under their SSI state supplementary programs. The existing structure of living arrangements in a state need not prevent modifying and targeting payments to support assisted living programs. Federal regulations have been changed to allow states to define up to six living arrangements (including personal needs allowances to recipients in facilities in which Medicaid pays more than 50% of the cost as one arrangement). The regulations list four examples of acceptable arrangements: living alone, living with an ineligible spouse, personal care facilities and domiciliary care or congregate care facilities. There are no definitions in federal regulations or manuals

that explain these arrangements and federal Social Security Administration staff indicate that it is up to the states to define the categories. Many states list more than six arrangements (New York has seven, Michigan eight).

The process for changing the living arrangements is fairly simple and few states have submitted changes at least during the past five years. States can define the class of recipients that will be included in any new living arrangement, i.e. aged. A state does not have to apply the living arrangement to all categories of SSI recipients but it must apply the criteria to all members of the defined class. Aged recipients could be covered and blind or disabled recipients could be excluded. The living arrangement can be defined by the needs or functional status of the resident and/or the characteristics of the setting. States can also include conditions that require that eligible residents are determined by a screening or approval process.

In some state board and care programs, a higher SSI payment is made to cover the costs of care. As services are added to existing facilities through Medicaid, the combination of SSI and Medicaid will cover the costs of providing care. Facilities often focus on the Medicaid program for rate increases as costs rise. Yet SSI also plays an important role. Increasing the state SSI payment standard for assisted living may enable a state to target people who are eligible to enter a nursing home and are likely to “spend down” to Medicaid levels anyway. In the absence of other programs, this approach enables the state to serve a person in the community through assisted living rather than in the nursing facility. Both the Medicaid eligibility option and SSI approaches offer different ways to expanded coverage to residents in assisted living programs.

To address the supportive services needs of recipients in housing settings, the **Massachusetts** Division of Medical Assistance developed a Group Adult Foster Care (GAFC) program under Medicaid to finance personal care services and administrative costs in assisted living settings. The SSI payment standard for a single individual living alone in the community was $575 month (1994). However, the payment was not considered adequate to cover the rent component in assisted living settings. The state agency created a separate SSI payment category for assisted living in 1994. The maximum SSI payment level was set at $900 a month. Combined with an average GAFC payment of $1,020 a month, assisted living residences could receive $1,920 (minus a living allowance) for Medicaid residents. Applications for the “enhanced” SSI payment were effective July, 1994 but were suspended by the legislative early in January, 1995 pending completion of an analysis of the state budget impact by the Division of Medical Assistance.

SSI and the GAFC program can be combined with a special program developed by the **Massachusetts** Housing Finance Agency (MHFA). Under MHFA's Eder CHOICE program, projects can access two sources of funds for services. The Medicaid Group Adult Foster Care Program provides an average monthly payment of $1,020 for Medicaid recipients. In addition, the Elder CHOICE guidelines allow projects to charge residents up to 75% of their income for rent and services. MHFAs underwriting

guidelines are based on the payment level for a single individual living alone in the community rather than the enhanced SSI rate.

There are two characteristics of the Massachusetts programs that are not typical of other states. First, the Medicaid GAFC program is operated as a state plan service (it is listed as a state plan service) and therefore is not restricted to recipients who are nursing home eligible. Second, the Elder CHOICE guidelines limit the percentage of income that can be charged for rent and services. In licensed settings, state policies allow nursing home eligible residents to retain a personal needs allowance and the remaining income is applied to the cost of care. Since GAFC participants do not reside in a licensed setting nor do are they required to meet the nursing home criteria, the personal needs allowance does not apply. In addition, GAFC participants are presumably somewhat more mobile and perhaps may need to retain a higher living allowance than is available through a PNA. Despite these differences, the principles of the higher SSI payment remain the same and could be applied in other states.

The following discussion and table 10 present three circumstances using Massachusetts' program model: payments to a Medicaid recipient in an assisted living. project who receives the regular, community standard SSI payment; a resident receiving the enhanced SSI payment; and a resident at 50% of median income who does not receive any Medicaid or SSI subsidy.

TABLE 10. Massachusetts Income and Payment Examples

Category	Resident A (Medicaid Eligible)	Resident B Special SSI	Resident C 50% of Median
Annual Income	$6,898	$10,800	$18,600
Monthly income	$575[1]	$900	$1,550
Total Resident payments	$431	$675	$1,162
Medicaid service payment	$1,020	$1,020	0
Total Income	$1,451	$1,695	$1,162
Difference	---	+$244	-$289

1. Payment standard for SSI recipients living alone in 1994.
2. Assisted living developers seeking to use low income tax credits must comply with that program's rules that specify mandatory charges may not exceed 30% or 50% of median income (compared to 75% of income for other financing sources). In such cases, the service package must be optional if payments are received directly from the tenant. If payments are made directly to the residence from the Medicaid program, services may be mandatory and still comply with tax credit rules.

Tenant A receives the standard SSI payment of $574.82 a month or $6,898 (1994 standard) a year. The project receives a total of $1,451 a month in rent, tenant service payments, and GAFC payments.

Tenant B receives the enhanced SSI payment of $900 a month or $10,800 a year. The assisted living residence would receive $1,695 a month, $675 from the tenant for rent and services not covered by the GAFC program and $1,020 from the GAFC program, $244 more than the payment from Tenant A. If traditional Medicaid rules for licensed facilities applied and Tenant B retained only the $65 personal needs allowances, assisted living residences would receive $1,855 a month.

Tenant C has income of $18,600 or 50% of median. The resident's payments is capped at $1,165 a month, and without any state subsidy, the payment is $533 below Tenant B and $289 below Tenant A.

Expanding Medicaid eligibility allows assisted living residences to serve people who qualify under the set aside guidelines but who lack sufficient income to pay the monthly fee.

Savings

An analysis of the budgetary impact of the enhanced SSI payment by the state's Division of Medical Assistance concluded that the combined SSI and GAFC payments saved an average of $2,398 per participant. While the **Massachusetts** GAFC program is not intended to directly substitute for nursing home care, participants must be at risk of nursing home placement, require daily assistance with at least 1 ADL and require daily supervision. The study examined the number of residents in the state that met the financial and clinical criteria (20,000) and used the penetration assumptions in assisted living market studies (10%) to develop participant projections over five years. Supply estimates were generated through the current and pending GAFC applications, the Massachusetts Housing Finance Agency data on applications for the “Elder CHOICE” (assisted living) program and the Massachusetts Chapter of ALFAA surveys of projects that are operating and projects in development. Residences using public financing sources were assumed to reserve 20% of the units for low income residents as required.

Based on a study of terminations from the GAFC program, the study estimated that 29% of participants would delay admission to a nursing home for 8 months; 31% would die without entering a nursing home and 39% would return to another community option. The study projected Medicaid expenditures of $615,025 (net state cost) in FY 1995 rising to 10.9 million in FY 1999 and additional SSI costs of $428,000 in FY 1995 rising to $7.6 million by FY 1999 based on the cumulative projected increase in participants over the five years. **The report projected an annual savings in net state costs of $2,398 per participant**. Based on the report, the expected annual aggregate savings total $239,800 in FY 95 and increase to $4.8 million in FY 99. The legislature is considering the study and may vote later in the session to repeal the enrollment freeze.

V. FINANCING ASSISTED LIVING

Federal Housing Programs

Major changes in federal housing programs are being proposed both by HUD and members of Congress. On March 20, 1995, HUD Secretary Henry Cisneros announced further details on the Administration's proposal to reorganize HUD. The plan wold continue the federal role as a catalyst for housing production. The plan would restructure the Federal Housing Administration as a wholly-owned government corporation -- the Federal Housing Corporation. According to the HUD plan, “this new corporation would function through consolidated, flexible product line authority and new operational flexibility so that it can easily adapt to market demands and customer needs.” The Corporation would focus on home ownership, rental housing and health care facilities (including assisted living). Access to ownership, credit will continue to be a major focus of the Corporation by expanding access to capital for borrowers who otherwise would not be served, developing new mortgage products, stabilizing markets during periods of economic downturns and standardizing housing and health care facility credit delivery. Creating a government corporation would allow housing programs to respond to market needs rather as opposed to operating within strict programs defined by legislation.

The Corporation would be run by a CEO appointed by the President and confirmed by the Senate. An advisory board would be appointed to provide guidance on the operation of mortgage markets, housing credit needs of vulnerable populations and communities and changes need to carry the Corporation's public purpose mission. A maximum mortgage amount would be set as well as a five year aggregate new business limitation. Legislation implementing the new structure had not been submitted as of the publication date.

The reorganization proposal would create an Affordable Housing Fund (AHF) which consolidates the HOME program, the section 202 and 811 (services programs) for the elderly and people with disabilities, the National Homeownership Fund, Housing Counseling, HOPE grants and Lead Based Paint Hazard Reduction. Six existing programs for homeless people would be consolidated as a separate block grant and combined with the AHF in the year 2000. Funds from the AHF would be distributed 40% to states and 60% to localities as under the current HOME Program. supportive services, service coordinators and project based rental assistance and operating subsidies will remain as eligible activities. Thirty percent of the funds will be set aside for non-profit organizations to continue support for housing for the elderly and people with disabilities.

Since major revisions in HUD housing programs are not expected to pass Congress in 1995, the following descriptions, based on current law, are included. The material is taken largely from the 1992 version of the “Guide” with updates as appropriate.

Section 202 Supportive Housing for the Elderly

Formerly known as Housing for the Elderly and Handicapped, this HUD program has been in operation since the 1960s. The National Affordable Housing Act of 1990, however, made significant changes (effective October 1, 1991), including replacing the combination of mortgage loans and Section 8 rental subsidies with capital advances and "project rental assistance," and creating a separate program for housing for persons with disabilities (Section 811). In addition, provisions that address supportive service needs make it more feasible for 202 funds to be used for certain assisted living facilities. The program is open to private, nonprofit housing developers or consumer cooperatives proposing projects of up to 125 units, with a 40 unit minimum for projects in urban areas.

The capital advances are essentially grants which need not be paid back if the development meets very-low-income occupancy targets for 40 years. Advances are available to cover the costs of construction, rehabilitation and certain acquisitions.

The amount of the capital advance is determined by per-unit development cost limits established by HUD. As an example, a one bedroom unit in a building with an elevator would currently qualify for $33,816 in funds. An efficiency unit qualifies for $29,500. These cost limits will be revised periodically by HUD to reflect changes in construction and rehabilitation costs. In addition, Field Offices have the authority to adjust these limits where necessary by the "high cost factors" used in other HUD programs. The maximum adjustment is 240%.

In determining per-unit amounts, certain design elements and amenities (e.g. balconies, decks, dish washers, trash compactors, washers and dryers in the units and common space that exceeds 10% of the gross square footage) are ineligible for HUD funding. The maximum unit size is 415 square feet for efficiencies and 540 square feet for one-bedroom units. These design restrictions may, however, be waived if the owner can pay for the additional elements from other "non-federal" sources. If funds for these extra elements are borrowed, the sponsor must obtain HUD Field Office approval to ensure that the loan does not provide the lender with control of the property, or increase the need for HUD funds (e.g., the project rental assistance amount must not be used to repay the loan.)

Project rental assistance is based on operating cost standards, determined regionally, which are adjusted periodically by HUD to reflect changes in housing costs (using "appropriate indices such as the Consumer Price Index"). For example, the current standard for the Boston region for fiscal year 1994 is $4,485 per person per unit. No adjustments are made for the size of the unit. Since no projects currently operate under the revised 202 program, it is not clear whether the periodic adjustments will in fact keep pace with increases in operating costs.

Eligible residents for 202 buildings are households with at least one person age 62 or over and with a household income at or below 50% of the area median income, as established by HUD. Residents pay no more than 30% of their income for rent and may contribute up to 20% of their income for services.

Services and Eligibility

The program requires that services be provided, including but not limited to: meals (which must not be mandatory), housekeeping, personal assistance, transportation and health. No medical personnel are allowed on staff, however, and any health-related services must be based in the community rather than the project. The policy allows preventive health screening, wellness clinics, and care for episodic health problems. Residents may access services offered by the certified home health agency, for example, but the project itself cannot offer continuous medical services. Fifteen percent of the service costs, up to a maximum of $15 per unit, per month, is available through the Project Rental Assistance Contract for the service costs of qualifying 'frail' elderly tenants.

Frail elders are currently defined in the Program Handbook as persons with limitations in at least three Activities of Daily Living (ADLs) as established by HUD, which include eating, bathing, grooming, dressing and home management. Toileting, which is frequently included as an ADL in other state and federal programs, was specifically omitted. HUD's position is that incontinence is a health problem and not within the scope of HUD's housing programs.

The position of service coordinator may be covered through the operating budget if at least 25% of the residents in the development are frail or “at risk” (have limitations with at least one ADL and are in danger of premature institutionalization). Coordinators may serve the entire resident population regardless of their frailty.

Assisted Living Implications

The 202 revisions take a significant step in dealing with aging-in-place. Funding is limited and the tradition of funding conventional housing poses obstacles to a building in which all of the units were assisted living. HUD funding for community space is limited to 10% of the total square footage, yet the norm for assisted living is 30-40% of total square footage. These projects cannot be seen as institutions and the presence of residents with nursing needs creates a gray area in HUD policy. While owners and managers cannot employ a nurse to provide the care, nursing services can be provided by outside agencies to 202 residents. In addition the HUD guidelines do not include transferring or continence in its list of ADLs and presume that residents who need care with continence are not appropriate for these facilities.

Despite these limitations, 202 buildings could include a wing or a section of the building designed as assisted living. Designating portions of a building may enable a project to meet the 10% limitation for common space. 202 projects have a tremendous

advantage over other financing sources -- rent subsidies for low income tenants. The rent cap, 30% of income, leaves residents with additional discretionary income that can be applied to service costs, a particular advantage for residents who are not eligible for SSI. Very frail elders, who meet the criteria for placement in a nursing facility, and who have incomes under $1,374 a month ($16,488 annually) could be served if the state's Medicaid program elects the Special Income Level eligibility option. Cost sharing for services covered by Medicaid will have to be reconciled with Medicaid cost sharing policies.

Section 232 Mortgage Insurance

This HUD/FHA program was originally designed for nursing homes and intermediate care facilities. In 1985 the program was expanded to include board and care homes, defined as "a type of residential facility that provides room, board and continuous protective oversight" for "individuals who cannot live independently, but who do not require the more extensive care offered by intermediate care facilities or nursing homes." Recently revised HUD regulations now include assisted living as a qualified project type under the FHA 232 mortgage insurance program. The regulations, which went into effect December 29, 1994, define assisted living as:

> "a public facility, proprietary facility, or facility of a private, non-profit corporation that is used for the care of the frail elderly and that:
>
> (1) is licensed and regulated by the state or, if there is no state law providing for such licensing and regulation by the state, by the municipality or other political subdivision in which the facility is located;
> (2) makes available to residents supportive services to assist the residents in carrying out activities of daily living, such as bathing, dressing, eating, getting in and out of bed or chairs, walking, going outdoors, using the toilet, doing laundry, preparing meals, shopping for personal items, obtaining and taking medications, managing money, using the telephone or performing light or heavy housework and which make available to residents home health care services such as nursing and therapy;
> (3) provides separate dwelling units for residents, each of which may contain a full kitchen or bathroom, and includes common rooms and other facilities appropriate for the provision of supportive services to residents of the facility."[14]

An assisted living facility may be free standing, combined with a nursing home, intermediate care facility, and/or board and care home, or may be a separate part of such a facility, and may be owned by a for-profit or non-profit entity. The mortgage to be insured can cover new construction or substantial rehabilitation by a for-profit or a private non-profit mortgagor. Public entities (such as local housing authorities) are not eligible.

[14] 24 CFR Part 232.1 (m). Published November 29, 1994.

"Frailty" is defined as in the National Affordable Housing Act -- unable to perform at least three activities of daily living (including bathing, dressing, eating, getting in and out of bed/chairs, walking, going outdoors and using the toilet.

The same rule revision also fully implemented the refinancing provisions which were created in earlier legislation but up until now had only been made available by HUD for facilities already insured under FRA programs. Insurance is now available for the purchase and refinancing of non-FHA insured assisted living facilities, or additions to existing facilities. Fees apply at various stages of processing, from both FHA and the lender. The mortgage insurance premium rate is .5%. Mortgages insured under 232 have a maximum 40 year term and a 90% loan-to-value ratio (95% for non-profits).

Assisted living projects may have private or shared unit (with or without kitchens and baths) but projects which provide shared units must have the consent of each of the residents who share the unit. There are no income limits for residents set by the program, or limits on rents and charges. When reviewing applications, HUD looks at comparable facilities in the area to determine if the charges being suggested are marketable.

A new effort to reduce processing delays is currently being tested in Seattle and Portland. “Fast track processing” is done by local HUD offices (unlike delegated processing which may be done by approved lenders) but could improve processing time to 3-5 months. Time is saved in part through use of additional, detailed pre-application documentation, such as independent, third party appraisals.

Assisted Living Implications

This financing source is expressly directed toward assisted living facilities and board and care programs. It allows, but does not require, a developer to focus the subsidies derived from a lower mortgage rate on low and moderate income residents. Since the new provisions are quite recent, it is difficult to tell exactly what effect they will have on the financing of new assisted living facilities. According to one private mortgage lender in the northeast, the loans they have processed under the board and care provisions would still be viable using the new assisted living language. A key factor in this, as in other HUD programs, is the continued willingness on the part of HUD to maintain flexibility in processing individual deals. Local HUD offices currently have the ability to waive administrative (as opposed to statutory) guidelines on a case-by-case basis without prior approval from Washington. This flexibility has allowed a variety of projects to be financed using the board and mm option under 232, and could continue to do so under the assisted living option. The ability to do such waivers without submitting them to HUD headquarters is also an important time saver, since even standard FHA processing can take a minimum of 8-10 months.

Congregate Housing Services Program

The HUD Congregate Housing Services Program (CHSP) provides housing and supportive services to low income frail elders. Administered by HUD (and a portion of the funds will be made available through the Farmers' Home Administration), it bridges the housing and service systems by including funding for services. Final regulations were issued April 29, 1994. 7he Act recognizes that 20-30% of residents in federally assisted housing have some form of frailty and that “the effective provision of congregate services may require the redesign of units and buildings to meet the special physical needs of the frail elderly.” The 1990 amendments revised the program and may encourage developers/owners of existing projects to apply for the program. The Act lists eight general purposes of the amendments:

- Retrofit existing buildings to meet the special physical needs of residents.
- Create and rehab congregate space to accommodate supportive services.
- Improve the management capacity to assess service needs and coordinate supportive services.
- Provide services that prevent premature and inappropriate institutionalization.
- Provide readily available and efficient supportive services through an on-site coordinator.
- Improve the quality of life for residents.
- Preserve the viability of existing affordable housing for low income residents who are aging-in-place.
- Develop partnerships between the federal and state governments in providing services to frail elders.
- Utilize federal and state funds in a more cost-effective and humane way.

Eligible Applicants and Projects

States, local government agencies and local non-profit agencies are eligible to apply for five year grants (grants are renewable after five years) for service coordination and supportive services. The funds may used in Section 202, 236, 221(d), Section 8 and public housing projects. Approved sponsors may contract with other agencies to implement the service program.

Use of Funds

Funds may be used to retrofit an existing building by widening doorways, relocating light switches, outlets, thermostats, and other environmental controls, installing grab bars in bathrooms or reinforcing walls to allow later installation of grab bars, redesign of useable kitchens and bathrooms to permit use by people in wheelchairs and other adaptive designs that meet the needs of frail older people. Retrofit activities also include creating space to accommodate the delivery of supportive services.

Service Coordinators

These positions are responsible for chairing a professional assessment committee, working with service providers to meet resident needs, mobilizing public and private resources, and monitoring and evaluating the impact of services. Coordinators have to have training in the aging process, elder services, disability services, eligibility rules for federal programs and other areas.

The professional assessment committee consists of at least three people appointed by housing management and include medical and other health and social service professional competent to appraise the functional abilities of frail elders. The committee determines resident eligibility for services (three or more ADL impairments).

Services and Delivery

Grant funds can be used for transportation, personal care (which includes dressing, bathing, toileting), housekeeping, chore, non-medical counseling, group and socialization activities, assistance with medication (in accordance with state law), case management, personal emergency response and other services. Meal service must be offered to residents and coordination with the nutrition program under Title III of the Older Americans Act is encouraged. Title III nutrition providers receive preference for providing meal services in a congregate housing facility.

Services are intended for residents with three or more ADL impairments. However, the law allows other residents to receive services if the housing manager, service coordinator and professional assessment committee determine that their participation will not adversely affect the provision of services to residents with three ADLs. The definition of ADLs was intentionally broad in the types of activities considered ADLs though it has limitations in the level of impairment. The list includes eating, bathing, dressing, grooming, getting in an of beds and chairs, using the toilet, household management activities, grocery shopping, laundry, and getting to the doctor. However, tenants must be able to feed themselves but can need help cooking, preparing or serving food; they must be able to dress themselves but may need occasional assistance; they must be able to wash themselves but may need assistance getting in and out of the shower or tub.

Resident fees will cover 10% of the service costs. Fees for meals may be set between 10% and 20% of the person's adjusted gross income if they receive one meal a day. Residents receiving less than one meal a day pay 10% of their adjusted income. Contributions from food stamps can be counted toward the tenants fee.

Funding

The HUD funds for new projects will cover 50% of the cost of the program. The remaining 50% must come from resident fees (10%), in-kind contributions or state or other sources (40%). Fees may be waived for residents who cannot afford them. These conditions do not apply to existing programs. Housing owners, or states on behalf of owners, may apply for funds. The regulations allow funds from Medicaid, state and local sources, other third party contributions, OAA, Community Services Block Grants and excess residual funds from the management of the project to be used to meet the matching requirements. The imputed value of third party provided staff or services can be counted such as Medicare home health services. In addition, in-kind services can be included such as the market value of donated common or office space, utility costs, furniture, material, supplies, equipment and food used on the direct provision of services but funds from these sources are limited to 10% of the matching requirement.

Status

During recent funding rounds, fewer than expected applications were submitted. Only 28 applications were funded, accounting for about 25% of the available funds. In view of its limited used, the future of the program is uncertain even without major restructuring of HUD programs. The lack of applications has been attributed to the inability of developers to negotiate agreements to meet the matching requirements.

Assisted Living Implications

CHSP facilitates aging-in-place though it has many of the characteristics of assisted living -- individual units with baths and kitchens, and primarily as a housing program, it does not require licensing. Many residents with three ADL impairments are also likely to have health conditions that require skilled monitoring. HUD's concerns about delivering medical care are likely to limit the nursing services that can be delivered with project funds. The program mirrors many of the components of assisted living though the percentage of residents who meet the criteria for placement in a nursing facility will be higher in assisted living than in CHSP projects.

Farmers' Home Administration

The Farmers' Home Administration (FmHA) provides development loans and rental assistance for congregate housing and group homes for people 62 and older and people with disabilities. Loans may be made to a variety of organizations, state or local public agencies, consumer cooperatives, individuals, trusts and associations. Loans are

generally made in towns with populations of less than 10,000. Loans may be made in areas with populations between 10,000 and 20,000 if the area is not part of a standard metropolitan statistical area or adjacent to one. Funds are allocated by state and awarded by local FmHA offices. Loans under $1.5 million for less than 25 units can be approved at local offices. Loans above these limits must be approved by the central office. Loans may be made for up to 50 year terms. Public agencies and non-profit organizations may receive a loan for the entire cost of a project. Other borrowers must provide three percent equity. Applicants must provide initial operating capital equal to two percent of the total project cost which may be included in the loan for non-profit and government organizations. Project cost per unit is considered in relation to area costs. For example, the average cost per unit for New England projects is $55,000 to $60,000.

Projects include private apartments (about 550 square feet) with central dining rooms. Projects must be located as close to service providers and shopping as possible. Units must include bathrooms and a kitchen that includes a cooktop, stove, sink, refrigerator and food preparation surface. Units must be equipped with an emergency call system. The program encourages borrowers to work with architects experienced in adaptive design and congregate housing concepts. Loans may be used to build, purchase or renovate housing.

Tenants must not be totally dependent on others and must be able to vacate a unit in an emergency, and have the legal capacity to enter into a lease. Projects must provide at least one meal a day, seven days a week, transportation, routine housekeeping, personal care, recreation and social activities. Personal services are defined as nonmedical services which can include personal hygiene, nutrition counseling and general health screening. It does not include “recurring medical assistance such as dispensing medication or constant medical supervision.” Projects are encouraged to collaborate with state and area agencies on aging. Borrowers may also contract with home health agencies, hospitals, nursing homes and other organizations to provide services or they may hire staff directly. The service package must be affordable to low and moderate income tenants. Projects may not serve anyone who need continuous medical or institutional care.

All tenants must meet the income eligibility criteria which are related to area median income. Tenants pay 30% of their income for rent in projects participating in the rental assistance program.

Federal Funds Administered by States

Low Income Housing Tax Credits

The Tax Reform Act of 1986 created a new tax incentive program for investment in low-income housing. The Low Income Housing Tax Credit (LIRTC) allows owners/ developers of mixed-income rental housing to receive credit against tax liability. This program, administered by the U.S. Treasury Department, is intended to improve on past

forms of tax “shelters” (such as accelerated depreciation) by creating a more direct connection between the amount of tax benefit taken and the amount of low-income housing created and by increasing the targeting of the housing. The sale of credits to individual or institutional investors raises upfront cash for a project (equity which can be used to reduce the amount of debt financing required). It provides investors with credit against their own tax liabilities over a 10 year period. State credit allocating agencies (most frequently the state housing finance agency) establish additional restrictions, targeting goals and requirements for developments using tax credits, schedule competitive funding rounds and monitor compliance with both state and federal regulations. Some states have established targeting goals that include a variety of special needs housing.

An allocating agency may also set-aside a portion of the total allocation for certain types of housing projects. Ranking systems and set-asides may change from year to year to reflect shifting state priorities, practical experience (e.g., if no applications are received for set-aside allocations, they may be eliminated in ensuing years), or federal requirements.

The maximum amount of credit is calculated as a percentage of the funds spent on the “qualifying basis” -- the low-income portion of the housing development (low income living units), including construction, rehabilitation and/or acquisition costs. The percentage varies according to several factors, including type of development (new construction and substantial rehab receive a 9% credit while acquisition or projects that make use of other federal funds only receive 4%). The applicable percentage applied to the qualifying basis establishes the maximum amount of credit which may be allocated to a proposed development and that amount is then reduced by the allocating agency to the minimum amount required for financial feasibility. In 1991, the average allocation was $4,000 per unit, with investors paying roughly 45 cents to the dollar of credit.

The total volume of tax credits is controlled by Treasury in two ways. There are credits available under an annual state volume cap, administered by state allocating agencies and also credits available for projects financed through tax-exempt bonds, which are themselves subject to state volume caps.

Minimum occupancy requirements reserve 20% of the units for residents at or below 50% of the area median income, or 40% of the units for residents at or below 60% of the area median income. Rents on these units are capped at 30% of the qualifying income level rather than the resident's income.

These restrictions are “locked in” for a minimum of 15 years, with the program incentives encouraging even longer periods.

Service charges may come under the rent cap in certain situations. According to an ERS ruling, services which are mandatory are considered a condition of occupancy and therefore the cost could not be used to increase the resident's rent beyond the established level. Ile cost of a mandatory meals program, for example, would need to be

covered in the rent (30% of the qualifying income level of 50% or 60% of median) or would have to be covered by state programs or other sources. However, if the payment for a mandatory service package were made to the residence directly by the Medicaid program, rather than the tenant, it would comply with tax credit rules.

Assisted Living Implications

LIHTCs are more difficult to apply in assisted living than 202 or 232 programs. This program may be more suited to a project for less impaired residents or a mix of independent and less impaired residents. In this way services may be offered on a voluntary basis and the costs would not be covered by the rent. Yet rents, though capped, are higher for low income residents than in 202 buildings. Low income residents are, still likely to be able to afford a reasonably priced service package. On the other hand, an owner may have difficulty projecting staffing and food costs for a voluntary package.

An IRS “interpretation” complicates combining credits with bonds. According to the interpretation, if units include kitchens, the bonds cannot be used to finance common kitchens needed to prepare congregate meals. This requires a higher equity ratio which is difficult for non-profit organizations to meet. In addition, some states do not allow common space in projects financed by credits which makes housing with services or congregate housing models easier to finance than assisted living projects.

Tax credit financing addresses the needs of elders who qualify for SSI and Medicaid and those with incomes above the thresholds to be charged market rates. Elders between these levels could not afford to pay for the service package though owners may find them more attractive than a SSI recipient in a straight rental arrangement since the income base on which the rent is calculated is higher.

Elders with incomes under $1,374 a month ($16,488 annually) who meet the criteria for placement in a nursing facility could be served if the state's Medicaid program elects the Special Income Level eligibility option.

Tax-Exempt Bonds

Industrial Development Bonds (IDBs), or Industrial Revenue Bonds secure private investment and serve a public purpose. Under the authorization of the U.S. Treasury Department, states and certain other entities such as state housing finance agencies may issue bonds which fund construction and long term mortgage loans. Since the interest earned by individuals and corporations buying the bonds is exempt, from federal taxes, the interest rate is generally lower than that of similar investment instruments. The actual bond rate depends on many factors, including the strength and reputation of the issuing entity, the long term viability of the underlying project and overall bond market conditions. This lower bond rate results in a mortgage rate below prevailing commercial rates.

Under Treasury Regulations, housing developments financed with the proceeds of these bonds must reserve at least 20% of the units for residents at or below 50% of median income, or 40% at 60% of median income, for a minimum of 15 years. The housing must be permanent, rental housing (transition housing or resident ownership is not allowed) and apartments must include their own kitchens and baths. Certain requirements are waived if the bond proceeds are to be used by 501(c)(3) non-profit organizations. For example these bonds would not fall under the state's volume cap and proceeds could be used not only for new construction or substantial rehabilitation, but also for acquisition of properties which do not require substantial rehabilitation. Like tax credits, issuers frequently impose additional restrictions on bond-financed developments, including greater low-income targeting, or incentives for targeting certain geographic areas or certain special needs groups.

A bond may be issued specifically for one larger project, or several projects may be funded from a single bond. Generally, some level of mortgage loan processing has been completed before a bond will be issued and issuers may provide “bridge loans” to projects which are ready for construction before bond proceeds are available.

This model is attractive for several reasons, including flexibility designating the remaining 80% of the units as low, moderate or market rate housing. Some state policies also favor the individual apartment design for assisted living because it allows for maximum independence of residents (who may occasionally prepare meals in their units) and it competes with upscale facilities which provide maximum privacy and space for residents. If the bonds are used for loans to non-profit sponsors, the separate apartment rule does not apply. It can be restrictive, however, in the degree of “commercial” space allowed under the bond financing. Also, the tax-exempt bond alone, while it lowers the mortgage interest rate, is not sufficient to ensure the long term affordability of even 20% of the units. There are also caps on the volume of bonds issued by states.

Community Development Block Grant (CDBG) Program

HUD's CDBG Program has been used successfully for a number of years by states and cities. While its primary purpose is neighborhood revitalization and economic development, housing activities which benefit low and moderate income people or prevent or eliminate slum conditions are allowed. Approximately 70% of the national funds are allocated directly by HUD to metropolitan cities and urban counties and 30% of the funds are allocated to states for a small cities program. Program priorities are established (with public input) at the state and local levels, within federal guidelines, including targeting 70% of the funds for activities which benefit low and moderate income residents. Units of government receiving funds have the flexibility to provide grants or loans for a variety of purposes including property acquisition and rehabilitation of residential property. In the past, CDBG funds have been used in conjunction with several housing programs to provide the gap financing that projects need to assure affordability.

HOME

Title II of the National Affordable Housing Act of 1990 makes funds available to state or local governments which can be used to ensure the availability of affordable housing. The intent is to encourage community-based partnerships, using federal matching funds to leverage funds from other public and private sources. Funds are allocated annually by HUD on a formula basis and are placed in a “HOME Investment Trust Fund” which works as a line of credit, for participating jurisdictions. Monies drawn from the Trust Fund must be matched at rates equal to 25% for funds spent on rental assistance and housing rehabilitation, 33% for substantial rehabilitation and 50% for new construction.

Fifteen percent of the national program funds are set aside for Community Housing Development Organizations -- private, nonprofit organizations addressing low-income housing needs. HOME also provides a “model program” option through which HUD encourages state and local development of certain types of programs, including a rental housing production program. Under this option, jurisdictions use Trust Funds to advance up to 50% of the cost of certain housing options, including “projects which provide congregate facilities and supportive services” for frail elders. Advances are repayable and carry an interest rate of no more than 3%. Repayments go back into that jurisdiction's Trust Fund for continued use.

Program regulations contain multiple tests for low income affordability. In general:

- Ninety percent of funds spent on rental housing must go toward units occupied by residents at or below 60% of median income.

- A minimum of 20% of the units in projects constructed or rehabilitated must be occupied by residents at or below 50% of the median income and rents cannot exceed 30% of income.

- Rents on the remaining units must be the lower of the HUD fair market rent or 30% of 65% of median income.

- Housing must remain affordable for 20 years for newly constructed buildings and 5 to 15 years for rehabilitated structures, depending upon the amount of rehabilitation.

HUD will establish per unit limits for use of program funds, varying by market area and by the different eligible activities, which include: new construction, moderate or substantial rehabilitation, acquisition, site improvements, financing costs, or tenant-based rental assistance. The formula for new construction, for example, is 67% of the high cost limits under the HUD 221(d)(3) mortgage insurance program for multi-family rental housing, which in a high cost New England area would be about $50,000.

When HOME funds are used for rental assistance, the maximum assistance is set at the difference between 30% of income and the local Fair Market Rent, and rents must be between 80% and 100% of the Fair Market Rent. Eligible tenants are those at or below 60% of median income.

Financing Assisted Living -- State Practices

Changes Since 1992

State involvement in providing financing for assisted living has evolved significantly in the past several years. As recently as 1992 the majority of assisted living facilities being developed were financed through entrance fee-based equity and/or debt financing through commercial lenders, and were generally targeted at higher income elders. (One exception was the type of facility that grew out of the Board and Care model, developed and sponsored by non-profit entities with extensive financial resources.) A few states -- such as Oregon and New York -- had production programs for assisted living for lower-income elders, and a handful -- including Washington, Florida and New York -- were transforming existing housing into licensed or regulated facilities which provided more intensive services than independent living or congregate housing. Anecdotal reports from most states, however, showed one-of-a-kind deals that were difficult to replicate.

Issues remaining at the state level included: (1) combining sufficient housing and service subsidies to assure affordability for low- and moderate-income elders; (2) dealing with funding source requirements which conflicted with each other and with the characteristics of assisted living; (3) reconciling long-term mortgage financing with annual appropriations for service subsidies; and (4) mastering the unique underwriting expertise required of this hybrid of housing and personal care.

Federal housing programs designed to encourage production of affordable rental housing had begun expanding to address the integration of social, housekeeping, health and personal care services, but the fit was far from perfect. No “true” assisted living program had emerged on a national level.

Since that time, additional changes and innovations have taken place at both the federal and state levels. While it is clear that as of 1995, no comprehensive federal financing model yet exists that addresses both housing and services, and significant issues involving the use of existing housing and health/personal care programs remain, what has emerged from previous, anecdotal reports of particular projects is the beginning of distinct state models for financing affordable assisted living for the elderly. The information that follows is the result of interviews with state housing finance agencies responding to a recent Academy survey.

Current State Activity

Similarities among states

Among the different state models emerging from around the country, several similarities are apparent:

1. The need to combine funds from a variety of programs and funding sources, due not only to the unique combination of shelter and services, but also to the difficulties of achieving low-income affordability from any one source of housing funds. Most frequently used are tax-exempt or taxable bonds, housing finance agency funds, HOME money, Low Income Housing Tax Credits, and fund raising by non-profit sponsors. Also used are state appropriations, SSI, Medicaid,[15] and CDBG funds.

2. A significant commitment of state resources, which serve multiple purposes of increasing affordability, creating additional flexibility in financing mechanisms, and addressing various state priorities. Maryland, for example, uses state appropriated funds, while Alaska, Kentucky, Pennsylvania and Wisconsin use housing finance agency funds. Several states have targeted state Medicaid funds to these projects.

3. A flexible underwriting approach designed to put together the optimal financing package for each individual deal. While guidelines exist in every case, these are not "cookie cutter" programs -- each development requires intensive underwriting to determine the best possible approach. Kentucky, for example, loans at rates from two to five percent, while Pennsylvania will do debt financing where possible, and deferred loans in other cases.

4. An ongoing concern about the poor fit between the inherent characteristics of assisted living and the restraints of federal and state housing and service programs. Key among these are concerns about the reliability of annual funding appropriations, and about pending budget reforms and service cutbacks. Technical issues involving use of Low Income Housing Tax Credits include the cap placed on rents that may be charged to low-income residents. In certain circumstances, fees for services would be considered by the IRS to fall under the cap, essentially restricting the total amount charged for rent and services to 30% of the qualifying income (50% of area median). One issue with tax-exempt bonds is the requirement (with certain exceptions for nonprofit sponsors) that residential units include individual baths and cooking facilities, which runs contrary to some assisted living design models. A common difficulty faced by financing agencies is the different qualifying income levels and requirements for the different programs

[15] Although not technically used to pay for housing, the availability of Medicaid funds to pay for services of low-income residents provides assurance that these residents will be receiving not only shelter, but the personal care that defines assisted living.

which must be pieced together to make units affordable.[16] As state involvement in financing assisted living increases, issues with both Tax Credits and bonds continue to arise, frequently requiring IRS rulings on a project-by-project basis.

Differences among states

On the other hand, the differences among the state approaches make it clear that while these state models offer insights into how states may provide assisted living financing, they do not translate into one national program. Differences among the programs include:

1. The definition of assisted living in terms of the building characteristics, the service package, and the target resident population. All clearly fall into the broad category between independent living and institutionalization, but still vary from "beds" in semi-private rooms to complete apartment units. Some states -- depending on the variety and flexibility of their funding sources finance more than one type, as do Kentucky and Pennsylvania.

2. The type of financing mechanism used. While most states rely on an assortment of mechanisms for each project, the range of available mechanisms varies by state. Mechanisms include low-interest loans, deferred loans, grants, third party payments (from SSI and Medicaid), and equity from different sources (including syndication of Low Income Housing Tax Credits, fund raising by non-profit sponsors, and modest entrance fees.) The choice of mechanism is related to the source of funds. Using tax-exempt bonds, for example, results in low-interest loans, housing finance agency reserves are most likely to allow for deferred loans or additional interest rate write-downs, and federal HOME monies contributed by states or cities can be in the form of low-interest loans or grants.

3. The degree of low- and moderate-income target. All state models include provisions for low-income residents, but the percentage varies not only by state but sometimes by project within a state, as does the inclusion of units for moderate-income elderly. This appears to depend on the financing sources used, the regulatory/political climate, and perhaps the lead agency's overall approach to affordable rental housing production. Pennsylvania, which has loaned agency reserves at extremely low interest rates to non-profit sponsors capable of raising substantial cash equity, has projects up to 100% low income, while Alaska, Massachusetts and Oregon, which rely more on debt financing, achieve 20% low-income.

4. The reason for creating the program also varied by state, and reflected that state's resources and priorities, as well as the track record of conventionally

[16] Massachusetts, for example, is looking into using an Enhanced SSI State Supplement which would provide eligible individuals with up to $900 per month toward the costs of certified assisted living facilities. However, the rent/service charges (set at 75% of income) for these residents would exceed the rent limits established for units using Low Income Housing Tax Credits.

financed facilities. Some states were responding to the need to resolve Medicaid spending issues, while others were attempting to provide an alternative to the private, upscale development in their states. In several cases the programs evolved out of the desire of the development community to have a financing alternative.

State Examples

The state models described here illustrate how different states have been able to create financing programs for affordable assisted living. In most cases, these financing programs are still in an early stage of development, and will continue to evolve as the financing agencies gain experience.

Alaska

The Alaska Housing Finance Corporation has recently begun underwriting assisted living developments under its Special Needs Housing Program. Assisted living, as licensed by the State Division of Senior Services, is defined as residential facilities that provide residents with housing and food services, and provide or offer to provide one or more of the following: assistance with activities of daily living, personal assistance, or health related services. AHFC provides permanent loans only. One development currently in construction, with a commitment of AHFC funds, will provide 60 one-bedroom units, each with kitchen facilities and bath, a congregate dining space, and personal care services on site. The nonprofit sponsor contributed 31% of the total cost, with AHFC providing 35% through a 7% mortgage loan from tax-exempt bond proceeds, and 34% through a soft second loan at 1.5%. Funds for the soft second loan come from the Corporation's arbitrage earnings on bonds, and payments are deferred if there is insufficient cash flow from the project. Under this option, AHFC will underwrite soft seconds in the amount needed to make the deal work, up to 35% of the total development cost (not to exceed the amount of the first mortgage). At least 20% of the units will be for low-income residents, and payment of the monthly charges for those units is expected to come in part from Medicaid reimbursements under the Medicaid waiver program.

An additional project currently being processed would add an assisted living facility to a senior center and independent elder apartment building currently run by a non-profit sponsor. The 40 apartments will offer three meals, housekeeping services, 24-hour emergency response, and optional service coordination. Three units are subsidized with HOME money and intended for residents below 30% of median income, and five additional units are targeted for residents below 50% of median. The remainder are market units. Rents will range from $299-$550, with a monthly congregate services fee of $450 that is the same for all units but is not mandatory.[17] For this project, financing will include a first mortgage from tax-exempt bond funds, a second mortgage from the arbitrage fund, a HOME grant, and a grant from the AFHC's Senior Citizens Housing

[17] The AHFC points out that various federal and state programs for elderly residents of Alaska provide an income of at least $1,000 per month.

Development Program. This program is funded from Corporation reserves, and is used to assist non-profit sponsors with predevelopment costs.

Kentucky

The Kentucky Housing Corporation has offered two rounds of funding under its assisted living program -- first in 1993 and again in January of 1995. Ten million dollars from KHC reserves were made available each time to be used as permanent loans for projects which received conventional construction financing from other sources. Assisted living is not licensed in Kentucky, and the only prior development activity was a few upscale facilities in urban areas. The first round of KHC proposals included several small facilities in more rural areas. Several projects from that first round of proposals have commitments of construction financing, and will proceed as soon as the permanent loan commitment from KHC is available. The second round of proposals is currently being processed, and includes some conversions of independent rental housing to assisted living.

The facilities will range from 12-70 units and will include individual apartments, with baths and cooking facilities. The KHC generally requires one-bedroom units in addition to studios, a policy established because of vacancy rates for studio apartments across the state and waiting lists for one-bedroom units in elderly buildings. In addition there are a few two-bedroom units. One project is using a group home design instead of individual apartments. Services will be provided in-house or through existing community service programs.

Rates on KHC loans start at 2 points below prime, and may be lower if the project requires it. One project, for example, will be getting a 3% loan, while another will have a 2% rate for the first five years and a 5% rate thereafter. KHC has been pursuing HUD/FHA insurance for these loans, and hopes to be able to use the revised program, particularly on the larger projects. They are also working with FRA to finalize their participation in the Risk Sharing program, a new mortgage insurance option by which the lender and FHA share the risk (in this case KHC would assume 25%). Once FHA approves the underwriting plan that will be used by the lender for all mortgages using this insurance, processing of each insured loan is done by the lender, rather than HUD, resulting in a simpler and faster process than under standard FHA insurance programs. KHC also plans to use Low Income Housing Tax Credits in the future.

Maryland

The Maryland Community Development Administration offers of number of housing programs which use state appropriations to make below-market rate or deferred loans. These loans may be combined with other sources of financing, such as tax-exempt or taxable bonds, federal, state and local funds, and private loans. Among these programs is the Elderly Rental Housing Program (ERHP), which may be used for apartments, congregate housing, single room occupancy, and shared living. ERBP loans may be used toward acquisition, construction, rehabilitation or other development costs. Loan

proceeds may also be invested by CDA, and the interest used to subsidize a development's operating costs.

One project that recently used the EHRP program is a 32-unit development that also received a HOME loan through the county. During construction, CDA funds were lent at 0%, and the rate on the permanent loan is .57%. CDA applied low-income limits (60% of median income) to 16 units, and a limit of 80% of median on 7 others. The development is licensed by the Department of Health and Mental Hygiene, which provides funds toward service costs for eligible residents.

In addition, the CDA has provided financing for group homes, which are also licensed through the Department of Health and Mental Hygiene, and may include assisted living for the elderly. The Group Home Financing Program uses state appropriations in the form of deferred or low-interest loans for construction or for acquisition and rehabilitation. Fifty-one percent of the units or beds must be for residents at or below 60% of median income, and priority is given to projects which house residents with incomes below 30% of median. These homes are generally single family houses with private or semi-private bedrooms for up to 15 residents. Group Homes target several different special needs populations, most frequently developmentally disabled individuals, but are increasingly serving frail elders.

Massachusetts

Massachusetts Housing Finance Agency's Elder CHOICE program provides financing for assisted living which includes individual apartments with bath and kitchen facilities. In early 1995 legislation was passed which will require assisted living facilities to be certified by the Executive Office of Elder Affairs, but implementing regulations have not yet been finalized. Elder CHOICE guidelines specify that services should include up to three meals per day, assistance with personal care, 24 hour emergency response, service coordination, and housekeeping.

Elder CHOICE financing takes the form of construction and permanent loans, using tax-exempt or taxable bond funds. In addition, the commonwealth's Medical Assistance Division's Group Adult Foster Care program will provide reimbursement of $33.60 per resident per month toward service costs for each Medicaid eligible resident. Two loans have closed to date, and two more are in the final stages of loan closing. The loans for these developments come from tax-exempt bonds[18] and are up to 90% loan-to-value, with equity coming from cash contributions of the developers, and in some cases from syndication of Low Income Housing Tax Credits and Historic Rehabilitation Tax Credits. The loans are insured through the FHA Risk Sharing Program, which splits the risk 50-50 between FHA and MHFA. The developments range in size from 86-129 units and include studios, one-bedroom units and some two-bedroom units. A minimum of 20% of the units in each development will be for low-income residents, including those qualifying under the Group Adult Foster Care program.

[18] One development is also receiving funds from a taxable bond, to cover costs of commercial space for a preschool program run by a local non-profit.

Another development currently being proposed by a non-profit sponsor will use taxable bond proceeds for a mortgage loan covering 40% of project cost, Low Income Housing Tax Credits, HOME monies, land from the city at reduced cost, and funds raised by the sponsor. It will have 50% low-income units.

Oregon

An assisted living program was initiated in Oregon in the mid-1980s by the Senior and Disabled Services Division, using Medicaid waivers. The Oregon Housing and Community Services Department provides permanent financing for many of these licensed facilities through tax-exempt bonds. Loans are available to for-profit or non-profit sponsors and may be up to 85% of value, or cost, whichever is less. In addition to the mortgage loans, non-profit sponsors may apply for grants of up to $100,000, which are funded through state lottery monies and awarded in competitive funding rounds.

The developments financed to date range in size from 25-45 units, and all have a minimum of 20% low-income (50% of median) or 40% low-income (60% of median) units. Units are 0-1 bedrooms, and include meals, housekeeping, 24-hour response capability, and personal care.

Pennsylvania

Assisted living is licensed in Pennsylvania by the Department of Public Welfare as "Personal Care Homes" which provide food, shelter, personal care and supervision. The Pennsylvania Housing Finance Agency has created a program which can be used to finance Personal Care Homes, with guidelines that may exceed DPW requirements. According to PHFA guidelines, baths and kitchen facilities are "encouraged" in each unit, and baths are required for at least every two people.[19]

A PHFA financing package may take one of several forms. Of the three loans closed to date, one included a low-interest loan from tax-exempt bond funds and a soft second, deferred loan from PHFA reserves, which together totalled approximately 35% of project cost. The remaining funds were raised by the non-profit sponsor. The project was designed specifically for residents with Alzheimer's, and includes 36 units with private baths but no kitchens. There is a shared dining area and kitchenettes for groups of units. Half of the units are for low income residents (SSI or 50% of median) and half are market rate.

A second project included a loan from taxable bond proceeds, payment in advance of a $5,000 "entry fee" on half the units (with funds going toward construction costs), and cash and land donations from the non-profit sponsor. The fees are refundable to residents on a declining basis for five years. If a unit is re-rented from year 6 onward, the new entry fee will go toward reducing costs to low-income residents. Fees do not

[19] DPW guidelines allow up to 4 people per room, toilets shared by up to 6 people, and bathing facilities for up to 15 people.

provide residents with “ownership” rights. This project is made up of private or semi-private rooms with baths.

The most recently closed loan included deferred loans from both PHFA reserves and city CDBG funds for 42% of cost. Equity came from fund raising (33% of cost) and syndication of Low Income Housing Tax Credits (25%) by the non-profit sponsor. An additional amount of Tax Credit proceeds were set aside to assist with the rent and service packages. The 60 units are all affordable at 50% or 60% of median income, and all have kitchens and baths.

The PHFA deferred loans conic from $100 million in reserves set aside in 1987 for such purposes. They are written for a 25 year term but only begin to amortize in year 16, at a rate of 1%. Repayments come in years when there is a project surplus. In general, these deferred loans are used on projects which can't support debt in excess of $100,000. Early in the development of its programs, the PHFA made a policy decision to work solely with sponsors/developers with strong track records in the industry. To date all three projects have involved well-established non-profits which were able to carry out a significant amount of fund raising. Low-income units (SSI, 50% of median or 60% of median) range from 50 to 100% of the projects, and monthly charges range from approximately S400 to $2200.

Wisconsin

The Wisconsin Housing and Economic Development Authority has been financing group homes for special needs residents since the mid-1980's using WHEDA funds to make low-interest loans (average interest rate is 6.5%) of up to 90% of value. Other funds used include HOME money and cash equity from sponsors, who must be non-profit entities. There is also a grant program through which WHEDA has provided approximately $10 million over the last ten years for seed money to non-profits developing special needs housing. There is an annual competition for these grants, which are currently set at a maximum of $35,000.

An effort is made is enhance affordability by holding the costs of this housing down through focusing on rehabilitation of existing buildings rather than new construction, and relying on non-profit sponsors who are not subject to the relatively high state property tax.

WHEDA has also provided tax-exempt bond financed mortgages for over 20 developments by non-profit sponsors of housing with social services. Units are generally 300-400 square feet and residents may share a bath. Low-income occupancy is 20% of units at 50% of median income or 40% at 60% of median income.

Summary of State Housing Financing Models									
	Alaska	**Kentucky**	**Maryland**		**Massachusetts**	**Oregon**	**Pennsylvania**	**Wisconsin**	
Type of unit	Apartments	Apartments	Semi private or private rooms	Apartment	Apartments	Apartments	Semi-private or private rooms, apartments	Semi-private or private rooms	Apartment
Project size	40-60 units	12-70 units	Up to 15 people	20-32 units	86-129 units	25-45 units	36-84 beds/ units	Up to 8 people	16-120 units
Eligible sponsor	Non-profit	Non-profit & profit	Non-profit & profit	Non-profit & profit	Non-profit & profit	Non-profit & profit	Non-profit & profit	Non-profit	Non-profit
Financing method	Permanent only: BMIR[1] or deferred loans, grants	Permanent only: BMIR loans	Construction & permanent: BMIR or deferred loans	Construction & permanent: BMIR or deferred loans	Construction & permanent: BMIR loans	Permanent only: BMIR loans, grants	Construction & permanent: BMIR or deferred loans	Construction & permanent: BMIR loans, grants	Construction & permanent: BMIR loans
Source of funds[2]	Tax exempt bonds. Agency funds, HOME	Agency funds, FHA insurance	State appropriations	State appropriations HOME	Tax exempt or taxable bonds, FHA insurance, LIHTC, HOME	Tax exempt bonds, state lottery revenues	Tax exempt or taxable bonds, Agency funds, LIHTC, CDBG	Agency funds, HOME, LIHTC	Tax exempt bonds
Income mix[3]	Minimum 20-40% low	40% low, 60% moderate	Minimum 51% low	100% low	Minimum 20% low	Minimum 20-40% low	50-100% low	Minimum 20% low	Minimum 20-40% low

1. BMIR: Below Market Interest Rates.
2. Indicates major sources of financing and credit enhancements used by the state agency. Most individual projects also include equity from the sponsor, and may use other local, state or private funds. Does not include funds used for services.
3. "Low" income is generally defined as SSI or Medicaid eligible, 30% of area median income, 50% of median or 60% of median, depending on the program used. Tax exempt bonds, for example, require 20% of the unit per project to be affordable at 50% of median income, or 40% of the units to be affordable at 60% of median. Kentucky figures are for the aggregate proposals; other states are by project.

Financing Services in Assisted Living

The capacity to provide home and community based services to frail elders has increased steadily through the ‘80s and ‘90s. As state systems emerged, they focused on the needs of elders who preferred to live independently and the systems necessary to effectively reach the appropriate market, to evaluate their functional ability and dependencies and to deliver services. Many states have developed extensive networks of case management agencies as the cornerstone of their community systems. During the ‘70s and ‘80s, states focused on the organization and delivery of services. In the '90s housing, which did not receive as much attention, has emerged as the central building block of long term care systems. As a result, traditional concepts of “home” and the regulatory approach to service delivery and quality care have been challenged.

The typical service package in assisted living includes meals, housekeeping, laundry, activities, 24 hour supervision, personal care with activities of daily living and varying levels of health services. Sources of financing for these services include state general revenue programs, Medicaid, the Older Americans Act, the Social Services Block Grant, and to a lesser extent the Community Development Block Grant and the Small Cities programs. Recently, long term care insurance policies have explicitly added coverage for assisted living or allow payment under Alternate Care Plan provisions.

Long Term Care Insurance

Long term care insurance policies were sold by 118 companies in 1993, down from 135 companies in 1992, and 3.4 million policies have been sold.[20] The study does not indicate how many policies are still in force. Policies are sold on an individual and group association basis, through employer sponsored plan and as a rider to life insurance policies. Premiums for policies sold by 13 companies comprising 80% of the market declined 8% from 1992.[21] In 1992, the average age of buyers in 1992 was 68 years old for individual and association plans, 42 for employer sponsored plans and 38 for riders to life policies. Since its emergence as a long term care setting, companies marketing long term care insurance have examined covering assisted living as a benefit. However, HIAA in its annual surveys of companies selling long term mm does not ask if policies provider coverage in assisted living settings. Most companies have approached coverage of assisted living cautiously. Questions facing state policy makers concerning its definition have also puzzled the industry. In addition to defining the benefit, companies have had to determine whether it will serve as a substitute for nursing home care or an option for in-home care. In setting rates and projecting utilization, actuaries have to determine who will use the benefit. Will assisted living be used by people who would otherwise seek admission to a nursing home? Or will utilization be higher for people who would not seek placement but would enter an assisted living residence rather than use services in their home? If a company assumes assisted living will replace nursing home utilization, the services will be covered based on the nursing

[20] Coronel, Susan. ***Long Term Care Insurance in 1993***. Health Insurance Association of America. March, 1995.

[21] Ibid.

home benefit and costs will decline. If a company assumes assisted living replaces home care benefits, services will be reimbursed according to the home care benefit (usually 50% of the nursing home benefit amount) and costs will increase since the rate will be paid 7 days a week rather than 3-5 times a week in the home. Companies must also determine what benefit triggers will used. If a company begins payments for people with impairments in 2 ADLs for home care and 3 ADLs for nursing home care, which trigger will be used in assisted living?

Companies are concerned about liability in both in-home and assisted living settings in the event that a person has been approved for benefit in a setting that is not capable of sustaining the claimant. One company representative believed that more companies would cover assisted living as a specified benefit if there was a standard definition.

Assisted living settings are not explicitly covered in policies offered by **Bankers' Life, Time Insurance Company and TIAA/CREFF**, however, these companies will pay for benefits in assisted living setting as Alternative Care Plans. **Bankers' Life** offers nursing home only policies as well as nursing home and in-home care. Company benefit managers are more cautious in approving care in assisted living settings under nursing home only policies and examine whether a nursing home admission is imminent. Under policies covering in-home care, assisted living is more readily approved since the person is likely to enter benefit anyway.

TIAA/CREFF policies cover assisted living under the Alternative Plan of Care if the person meets the eligibility requirements (impairments in 2 of 6 ADLs or cognitive impairment), the care plan has been done and the physician, care planner and company agree that assisted living is appropriate. The company is concerned about liability if the facility cannot provide the level of care needed. TIAA/CREFF policies cover in-home care from a certified home health agency or a home care agency meeting state licensure or certification requirements.

Time Insurance Company will cover care in assisted living settings that meet the Company's definition of a nursing home or assisted living settings that are licensed to provide nursing facility care. Few assisted living facilities would meet the definition of a nursing home but regulations in many states allow assisted living residences to provide a level of service that is provided in nursing homes and such residences could qualify under the definition. About 15% of the assisted living facilities are likely to meet the definition according to a company representative. The Company also covers assisted living under its alternative care benefit. Policy holders may be approved for alternative care benefits if they are eligible for nursing facility benefits, would otherwise require nursing facility care and the plan is agreed to by the company, the physician and the policy holder. In considering care in assisted living, the Company ensures that the person's condition has been assessed correctly, that appropriate care can be provided in the assisted living setting and provisions are made for monitoring by a Register Nurse. The RN need not be on the staff. The Company also checks to make sure that

the person's physician is involved and the assisted living setting meets state licensing requirements.

The alternative care benefit is more likely to be used to cover care in assisted living for people who have impairments in 2 or 5 ADLs, require continual assistance due to cognitive loss, or require assistance due to injury or illness though the policies do not specifically mention or define assisted living as this time.

Mutual of Omaha covers care in assisted living facilities, which are defined as "care in a facility licensed by the appropriate licensing agency to serve persons who require assistance with activities of daily living but do not require continuous medical or nursing care. Examples of assisted living facilities are licensed rest homes, custodial care facilities, personal care facilities and adult foster homes. The company has purposefully developed a broad definition since they do not expect policyholders will enter benefit for 10-15 years and the terms may change by the time benefits are used.

John Hancock Insurance Company, a market leader in policies sold to employees in major companies, covers assisted living in its newer group policies. However, the definition in group policies limits coverage to people with dementia. If a state does not license assisted living, facilities must meet standards that include:

- The primary function must be to provide residential care to persons with dementia, including but not limited to Alzheimer's Disease.

- The facility must have a consulting physician to review the medical condition of residents prior to admission and at least every 60 days.

- The facility must be a separate facility or a distinct part of another facility.

- The facility must have procedures for obtaining appropriate care in a medical emergency.

The company views assisted living as a covered service rather than a substitute for nursing homes and, while adding the service may increase the price, the company's products respond to design features sought by benefit managers of major employers who sponsor long term care insurance. **John Hancock's** individual policies do not limit coverage of assisted living to people with dementia.

AEGON USA, a large holding company for three American based insurance companies, **Banker's United, PFL Life Insurance and Life Investors**, defines an assisted living facility as "A facility that is engaged primarily in providing ongoing care and related service to at least 10 inpatients in one location and meets all of the following criteria:

- It provides 24 hour a day care and services sufficient to support needs resulting from inability to perform activities of daily living or cognitive impairment;
- Has an awake, trained and ready to respond employee on duty at all times to provide that care;
- Provides three meals a day and accommodates special dietary needs;
- Is licensed by the appropriate licensing agency, if any, to provide such care;
- Has formal arrangements for the services of a doctor or nurse to furnish medical care in case of emergency; and
- Has appropriate methods and procedures for handling and administering drugs and biologicals.

The policy contract states that free standing facilities or sections of CCRCs typically met the definition but individual residences and independent living units are generally not included.

CNA covers assisted living under two policy options. The first offers and alternative care facility benefit which includes assisted living residences. Customers may choose from two policy options. The first pays 80% of the cost of the ACF and an other pays 100% of the cost. These options are included in two of the newest policies marketed by CNA. In addition, all CNA policies include an alternate plan of care benefit for policy holders who qualify for placement in a nursing home. The plan will cover services provided in assisted living residences and other settings if the physician and the company agree and the setting is medically appropriate. CNA views assisted living as a facility providing ongoing care and services 24 hours a day to support needs resulting from the inability to perform activities of daily living. The facilities must provide 3 meals a day, special dietary services, as needed, and must be appropriately licensed. The facility must also have formal agreements with physicians and RNs to provide emergency care and they must have appropriate methods of handling medications.

Long Term Care Insurance Partnership Projects

Four National Long Term Care Insurance Partnership projects, funded by the Robert Wood Johnson Foundation, operate in **California, Connecticut, Indiana and New York**. The projects are coordinated through the RWJ National Program Office at the University of Maryland, Center on Aging. The projects each seek to combine Medicaid and private long term care insurance to create incentives for individuals to purchase private coverage. Policies that meet state standards can be purchased to help policy holders protect their assets. Once the insurance benefit has been exhausted, individuals would qualify for Medicaid if continued services were needed without meeting asset spend down requirements. The projects are based on the premise that individuals with private coverage will delay eligibility for Medicaid by using insurance benefits. Three projects**, California, Connecticut and Indiana**, allow people to offset $1 in assets for every $1 of benefits purchased. The **New York** model requires coverage for three years of nursing home care or six years of home health coverage.

Once benefits are exhausted, all assets are exempt. However, recipient income must be applied to the cost of care and Medicaid will pay the difference.

Policies have been available since October, 1994 in **California** from 7 commercial insurers and since mid-January, 1995 through CALPERs, the public employee benefit program. Nursing home and home care benefit policies are available and both cover care in assisted living. The policies use the definition included in the licensure category for Residential Care Facility as the definition for assisted living. Approximately, 1000 applications have been received, however, CALPERs is receiving over 500 a day since it began offering long term care policies.

Connecticut, another Partnership state, has contracts with 8 insurers. Five companies list assisted living as a covered benefit. One company covers the services in an assisted living setting and the other two cover the care regardless of the setting. Two other companies may cover care as an alternative care benefit if approved by a physician, the company and the policy holder. 'The policies were written prior to the adoption of assisted living regulations in **Connecticut** and officials expect that language will be added to the next generation of long term care insurance policies. By the end of 1994, 2,000 policies had been sold.

Assisted living is covered as residential care facilities in the **Indiana** program. Since its inception during the summer of 1993, 600 policies have been sold through 10 companies as of December, 1994. Interestingly, the term assisted living is used in regulations issued by the Department of Insurance: Residential care facility, also referred to as assisted living facility and alternative care facility. The definition is similar to that used by AEGON policies.

The state of **New York** currently operates a “Partnership for Long Term Care,” which has contracts with 19 insurers to sell policies under the partnership. The state has placed language in the contacts that requires that all companies must offer policies that cover care in assisted living settings. If benefits are exhausted under the policy, the policy holder is automatically eligible for Medicaid without spending their assets. By March 1995, nearly 6,000 policies had been sold.

The Finger Lakes Long Term Care Insurance Company sells two policies through the partnership: CareDirections IV and CareDirections VI. CareDirections IV policy holders select a daily benefit amount and the length of the benefit: 3 years, 5 years or a lifetime nursing home benefit with a maximum five year home care benefit. CareDirections VI policies cover 3 years of nursing home care, 6 years of home care or a combination of the two.

CareDirections VI policies covers benefits in all settings including nursing homes, a long term care unit of a hospital, assisted living facilities, adult day care centers and your own home (through a certified home health agency). The settings must be certified by Medicare or a state agency. Benefits are triggered by the need for “continual help with impairments in 2 of 5 ADLs or cognitive impairment resulting from organic brain

disorder which affects your ability to live independently." The CareDirections IV policy does not cover care in assisted living settings and the benefit trigger is assistance with two out of four ADLs or cognitive impairment. This policy does include an alternative plan of care option.

In 1993, Congress required that liens be placed on the estates of Medicaid recipients using nursing home benefits which conflicts with the asset protection components of the demonstrations. The four states were exempted from the asset recovery requirements. However, other states are pursuing similar partnership projects in order to protect assets from the spend down requirements. Assets remaining in the estate after the person dies would be subject to recovery.

State General Revenues

States have used general revenues to establish home and community care programs. The size and scope vary. Some states such as Connecticut, Illinois, Massachusetts, Washington and Wisconsin, have created substantial programs to provide services that were not covered under Medicaid and to serve frail elders, and often disabled adults, who may or may not have been eligible for Medicaid. Eligibility for state services vary by income level and functional status. Several states limit eligibility to elders who meet the criteria for placement in a nursing facility while others serve those who are defined as "at risk" or who have impairments that make independent living difficult, yet who do not require placement in a more service intense environment.

While states systems are well known and effective at serving frail elders in their homes, the complexity and limitations of programs for consumers and the housing system are also well known. Separate eligibility guidelines for housing and service programs create confusion and gaps in coverage. Service packages may be available for some elders in subsidized housing and not others. More recently as the supply of various housing and service options has failed to keep pace with the growing need, states have looked more creatively at modernizing their service programs to address the needs of elders as they age and become more frail. For example, states have traditionally limited services to elders in board and care or residential facilities. Residents received meals, housekeeping and limited other services in such licensed facilities. As residents have developed impairments in activities of daily living (bathing, dressing, eating, mobility, toileting), states have explored ways of providing personal care through community agencies to residents in these facilities. In addition, states are continuing to review their programs to provide the flexibility to adapt to changing models for meeting the housing and service needs of elders as they age.

Medicaid State Plan

The largest source of service funding for the poor is Medicaid. There are three sources of funds for community care: state plan services, home and community based waiver services and the relatively new optional community mm program. While major spending reductions are being considered in Medicaid by Congress, including a block

grant that would give states broad flexibility to set policy, the program will likely remain the primary source of funding long term care services for low income people. The descriptions below are based on current law. Congressional action during the remainder of the session could alter the financial and policy climate in which decisions relating to assisted living may be made.

Under current law, states are able to provide a range of services to all eligible recipients living in the community. The primary services include skilled nursing, home health aide and personal care with the latter being vital in an assisted living setting. Medicaid cannot reimburse for room and board services except in an institutional setting (hospitals and nursing facilities). Home health aide services can include tasks such as housekeeping, meal preparation and shopping, as long as they remain a subordinate part of the service plan. Personal care services include direct care such as assisting with administration of medications, assisting or supervising with basic personal hygiene, eating, grooming, and toileting. Personal care also includes tasks that maintain a safe and clean environment such as light house cleaning, changing linens and tasks that maintain nutritional needs such as meal preparation or shopping.

Until OBRA 93, personal care services must be approved by a physician and supervised by a registered nurse. OBRA 1993 made significant changes in the requirements for personal care as a state plan service. The law makes three changes in the personal care benefit. First, it gives states the option of allowing people other than physicians to authorize personal cue services. Second, it allows services to be provided by an individual who is qualified to provide such services with the qualifications to be determined by the state agency. Third, it allows services to be delivered in a person's “home or other location” such as a residential care facility.

The language reads:

> “personal care service furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the state) otherwise authorized (*emphasis added*) for the individual in accordance with a service plan approved by the state, (B) provided by an individual who is qualified to provide such service and who is not a member of the individual's family, and (C) furnished in a home or other location;”

The flexibility allows states to provide personal care more cost effectively and to deliver services through avenues developed through HCBS waivers in some states such as AAAs. While state plan services need not be targeted to nursing home eligible recipients, the entitlement nature of the service may affect the state's ability to limit spending. As the Guide was published, HCFA was finalizing proposed regulations to implement the new amendment.

Prior to the amendment, states developed approaches to providing personal mm in board and care and adult residential care facilities that are licensed by the state but are

not themselves able to provide such service under the state's licensing requirements. Arrangements with home health agencies and home care providers are made to deliver mm to frail residents. The practice met a growing need among residents in these facilities who did not require care in a nursing facility, though they may have met the level of care criteria, but whose care needs exceed the care allowed by older licensing standards. Concerns about standards of care, monitoring and licensing have been raised. Yet states have been pushed by a combination of consumer demand for options to nursing homes, a shortage of nursing facility beds, constraints on the growth of beds and budget driven efforts to develop more cost effective long term care resources for frail elders.

The OBRA amendments will allow states to develop more cost effective models of providing personal care in residential settings. Where state licensing provisions restrict the delivery of personal, revising the requirements to allow facilities to provide personal care directly will also contribute to more cost effective care.

1115 Demonstration Waivers

The Health Care Financing Administration has authority to grant extensive Medicaid waivers under Section 1115. Thus far, 10 states have received waiver to implement major reforms in state Medicaid programs. **Arizona, Florida, Hawaii, Kentucky, Massachusetts, Minnesota, Ohio, Oregon, Rhode Island, and Tennessee** have approved waivers and **South Carolina** has received approval in concept. At the present time, **Arizona** and **Minnesota** includes long term care in their waiver and **South Carolina** includes long term care in their proposed program. A major 1115 waiver to integrate Medicaid and Medicare acute and long term care services in **Minnesota** was approved the end of April, 1994. Applications are pending from 12 states and an additional 12 or more states are preparing proposals some of which will include long term care. **Oregon** began enrolling SSI recipients into its Oregon Health Plan, with the priority system for setting benefits, in February, 1995 for acute care services. Several other states will phase-in coverage of SSI populations in managed care networks. **New Hampshire** includes community based long term care pilot projects in its proposal.

While 1115 demonstration programs generally develop reforms that are broader than assisted living programs, they can be a vehicle for addressing eligibility and benefit limitations. Eligibility is typically set as a percentage of poverty (Hawaii, 300%; Oregon, 100%; Tennessee, 300%; Rhode Island, 250%; Kentucky 200%).

Demonstrations must be budget neutral over a five year period, that is they may not increase federal spending beyond what would have been incurred without the waiver. These demonstrations also give states flexibility to develop streamlined eligibility requirements and contracting provisions. They are not restricted to nursing home eligible recipients.

Home and Community Waiver Services Program

In 1981, Section 2176 of the Omnibus Budget and Reconciliation Act allowed states to receive waivers of plan requirements to provide home and community based services to recipients who met the criteria for admission to a hospital or nursing facility. The waiver offers states several advantages. It allows states to pay for services that are not covered under the state plan (e.g., homemaker, personal care, home delivered meals) and to limit the populations eligible for services. It allows states to define services, such as personal care, differently from the state plan.

Finally, states can provide other services such as case management, homemaker, respite care, home delivered meals, chore service, adult day care, transportation, and other services approved by the secretary. In 1986, case management was added as an optional state plan service.

States have used their waivers to serve specified numbers of frail elders, disabled adults and children and other groups. The waiver authority allows a state to limit its fiscal liability by specifying the number of slots that win be funded. The waiver programs must also meet a cost effectiveness test.

As assisted living has emerged as residential model, HCFA has developed a definition that states may adopt and include in their waivers (See appendix). **North Dakota, Minnesota and Texas** have created their assisted living programs through the waiver without a separate licensure category. **Ohio, Utah and Wisconsin** are planning to submit proposals to HCFA to create assisted living through waivers pending the passage of necessary funding.

In addition to providing a flexible service package, the waiver also allows states to set higher income eligibility levels for people receiving waiver services who would not otherwise be eligible for Medicaid while living in the community. States may receive federal reimbursement for waiver and other Medicaid services to people with incomes up to 300% of the federal SSI payment standard, or $1,374 a month in 1995. States may also determine how much of a person's income may be kept to maintain a person in the community. Any income above the maintenance level is applied to the cost of waiver services. This would allow nursing home eligible elders to apply more of their income toward the monthly rent or room and board costs in an assisted living residence that does not have rent subsidies.

The waiver approach allows the state to control participation through enrollment caps. This will preclude every existing private residence from trying to enroll their eligible residents in the program though some added steps may still be necessary to focus available slots on real nursing home diversions.

While waivers can be used to serve residents in assisted living facilities, they may not convince a lender as to the long term viability of a new project. Initial waivers are

approved for a three year period and renewed for a five year period and cannot guarantee continuation during the full term of the mortgage.

Home and Community Based Services Waivers for the Elderly (1915d waivers)

The Omnibus Budget and Reconciliation Act of 1987 created a new waiver program for home and community based services to elders. The waivers apply only to Aged Medicaid recipients who are likely to enter a nursing facility in the absence of community services. States may receive waivers of income and resource limits, comparability and statewideness. In exchange, states must limit expenditures for long term care (nursing homes, home health, personal care, private duty nursing and community care services).

Rather than compare the amount of spending that would have occurred with and without a 2176 waiver, the 1915(d) waivers simply cap Medicaid spending for all long term care services. The limits are set based on projected increases in spending for institutional, community and in-home services and population growth (65+). FFP for state expenditures is tied to an Aggregate Projected Expenditure Limit (APEL). The APEL uses federal fiscal year 1989 as the base. Expenditures required by federal mandates, such as the OBRA nursing home reform amendments, may be added at state request. Base year expenditures are trended forward using the greater of 7% per year or the sum of adjusted expenditures for nursing facility and home and community based care. The formula steps include:

Base year nursing facility expenditures

- plus the market basket increase for such services;
- plus 2% per year;
- plus the percentage increase in the number of people 65 and older.

Base year home and community based care expenditures

- plus the market basket annual increase;
- plus 2%;
- plus the percentage increase in the number of people 65 and older.

The market basket increase for nursing home expenditures is based on the Medicare SNF Input Price Index and the inflator for community care is based on the Medicare Home Health Agency Input Price. The population 65 + in a state is based on a count of Medicare beneficiaries.

This waiver approach includes the same services as the 2176 waivers: case management, homemaker, personal care, adult day health care, and “other medical and social services that contribute to the well being of individuals and their ability to remain in the community.” The program's interim final regulations, published June 30, 1992, contain some suggested definitions though states are free to propose alternative definitions. The regulation do allow personal care to be provided by a family member, other than a spouse. The waiver must describe the conditions under which this is

allowed and states must have a mechanism to ensure that care is provided and it would not be furnished in the absence of payment, e.g. a relative leaves a job or moves to care for a family member.

Comparison of Medicaid Programs				
Official Name	**Home and Community Based Services Waiver Program**	**Home and Community Based Services Waivers for the Elderly**	**1115 Demonstration Programs**	**State Plan**
Common name	Section 2176; 1915 (c)	Section 1915 (d)	1115's	Same
Functional eligibility requirements	Nursing facility criteria	Nursing facility criteria	Determined by the state	Medical necessity or functional necessity under OBRA 1993
FFP limits	Based on formula that projects maximum expenditures under the waiver	Long term care expenditure cap	Must be budget neutral over the 5 year demonstration period	Federal matching rate for all expenditures
Formula	Cost effectiveness test based on nursing home capacity, and costs with/out the waiver	Aggregate projected expenditure limit (FY89 adjusted)[1]	NA	Relative per capita income
State liability	100% of costs for people served above approved limit	100% of expenditures above APEL	100% of expenditures above neutrality formula	NA
Special rules	Deeming waiver; special income level; post eligibility treatment of income	Deeming waiver, special income level; post eligibility treatment of income	Broad waiver authority	Regular rules apply

1. Adjusted each year based on the inflation rate for nursing facility and home health spending (Medicare indices), plus 2% per year, plus the percentage increase in the number of Medicare beneficiaries in the state.

These waivers also allow states to use the institutional deeming rules (e.g., income of the husband or wife is not counted toward the spouse's eligibility) and the special income level eligibility category.

Because of changes in the treatment of costs created legislation that passed following receipt of the waiver, Oregon, the only state that operated such a waiver, has dropped its waiver and combined participants into its 2176 waiver. In order to successfully use this waiver, states need:

- To control the supply of nursing facility beds;
- A case management system that screens recipients for entry into the long term care system;
- An expanding supply of appropriate community and residential services; and
- An effective nursing home reimbursement methodology.

Frail Elderly Community Care as an Optional Service (Section 4711)

Because of its limited use, funding for this option has not been included in President Clinton's FY 1996 budget. For a description of the program, see the 1992 edition of the “Guide.”

Older Americans Act

The Older Americans Act (OAA) provides relatively small grants to assist State Units on Aging and Area Agencies on Aging (AAAs) to develop and implement comprehensive and coordinated systems to serve elders. However, its flexibility readily supplements funds available from other sources. The Act's broad mandate and limited funding hinders its ability to serve as a funding source for large statewide initiatives although local projects may be successful at accessing funding through their local Area Agency on Aging. Services are targeted to those in greatest social and economic need with particular attention to low income minority elders. Funding for three broad areas receive priority: access, in-home and legal services. State Units on Aging administer the program through regional AAAs. Local AAAs have discretion to fund services that respond to local needs based on a needs assessment and an area plan. The most common services include health, transportation, housing assistance, community long term care (meals, homemaker, personal care, day care and others), legal assistance, health promotion and information and referral. Separate funding is allocated to states for congregate and home delivered meals. OAA funds are used to supplement services in states with large general revenue programs. In many states, the OAA and Medicaid waiver services, are the primary sources of funds for home and community based care.

APPENDIX A. DEFINITIONS

Associations

Assisted Living Facilities Association of America

A special combination of housing, supportive services, personalized assistance and health care designed to respond to the individual needs of those who need help with activities of daily living and instrumental activities of daily living. Supportive service are available 24 hours a day, to meet scheduled and unscheduled needs, in a way that promotes maximum dignity and independence for each resident and involves the resident's family, neighbors and friends.

American Association of Homes and Services for the Aging

Assisted living is a philosophy/program which combines and coordinates housing, personal and health-related services needed to help an individual maintain maximum independence and choice.

American Seniors Housing Association

A coordinated array of personal care, health services and other supportive services available 24 hours per day, to residents who have been assessed to need these services. Assisted living promotes resident self-direction and participation in decisions that emphasize independence, individuality, privacy, dignity and residential surroundings.

National Association of Residential Care Facilities

Residential care facility means a home or facility of any size, operated for profit or not for profit, which undertakes through its owner/s or management to provide food, housing and support with activities of daily living and/or protective care for two or more adult residents not related to the owner or administrator. Residential care homes are also know as assisted living facilities, foster homes, board and care homes, sheltered care homes, etc.

National Association of State Units on Aging

NASUA subscribes to a definition of assisted living which acknowledges the deep desire of America's elders to reside in their own homes or in a homelike environment. Accordingly, the Association views assisted living as referring to a homelike congregate residence providing individual living units where appropriate supportive services are provided through individualized service plans. Assisted living is first and foremost a home in which residents' independence and individuality are supported and in which their privacy and right to self-expression are respected. Contributing to its appeal is an

emphasis placed upon maximum autonomy, costs which appear to be lower than those for nursing home and a track record of a high degree of consumer satisfaction.

The position paper discusses several principles which include homelike environment, foster resident capabilities, honor the right of resident's to age in place, provide individualized supportive services which are developed with the full participation of informed residents, offer resident full disclosure and ensure that resident's rights are protected.

Federal

US Health Care Financing Administration (for Medicaid Home and Community Based Services Waivers).

HCFA developed a definition of assisted living for states to use in their Home and Community Based Services Waiver programs (2176 waivers). The definition states:

> Assisted Living. Personal care and services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under state law), therapeutic social and recreational programming, provided in a licensed community care facility, in connection with residing in the facility. This service includes 24 hours on site response staff to meet scheduled or unpredictable needs and to provide supervision of 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.
>
> 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 as well as bedrooms. Living units may be locked at the discretion of the client except when a physician or mental health professional has certified in writing that the client 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 the 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). Routines of care provision and service delivery must be client-driven to the maximum extent possible.
>
> Assisted living services may also include (check all that apply):
>
> - Home health care
> - Physical therapy
> - Occupational therapy
> - Speech therapy
> - Medication administration

- Intermittent skilled nursing services
- Transportation specified in the plan of care
- Other (specify)

However, nursing and skilled therapy services are incidental, rather than integral to the provision of assisted living services. Payment will not be made for 24 hour skilled nursing care or supervision. FFP is not available in the cost of room and board furnished in conjunction with residing in an assisted living facility.

HUD (232 Program).

Assisted living facility means a public facility, proprietary facility, or facility of a private nonprofit corporation that is used for the care of the frail elderly, and that:

1. Is licensed and regulated by the state or if there is no state law providing for such licensing and regulation by the state, by the municipality or other political subdivision in which the facility is located;

2. Makes available to residents supportive services to assist the residents in carrying out activities of daily living such as bathing, dressing, eating, getting in and out of bed or chairs, walking, going outdoors, using the toilet, doing laundry, preparing meals, shopping for personal items, obtaining and taking medications, managing money, using the telephone, or performing light or heavy housework, and which may make available to residents home health care services such as nursing and therapy.;

3. Provide separate dwelling units for residents, each of which may contain a full kitchen or bathroom, and includes common rooms and other facilities appropriate for the provision of supportive services to residents of the facility.

Long Term Care Insurance Policies

AMEX Life Assurance Company

Assisted care facility is a duly licensed facility with the primary purpose of providing continuous care and services to support needs resulting from inability to perform activities of daily living or cognitive impairment to at least ten resident inpatients. There must be a trained employee available at all times to provide that care; and the facility must have established procedures for overseeing the administration of medications. (The policy covers 80% of the daily maximum benefit for room and board and services in facilities that meet this definition).

UNUM

An assisted living facility is:

- an institution that is licensed by the appropriate licensing agency (if licensing is required) to primarily engage executive Director providing ongoing care and services to a minimum of 10 inpatients in one location and operates under state licensing laws and any other laws that apply; or

- any other institution that meets all of the following tests:
  - provides 24 hour a day care, custodial services and personal care assistance to support needs resulting from a loss of functional capacity or cognitive impairment; has an employee on duty at all times who is awake, trained and ready to provide care;
  - provides three meals day, including special dietary requirements;
  - operates nuder applicable state licensing laws and any other laws that apply;
  - has formal arrangements for the services of doctor or nurse to furnish medical care in the event of an emergency; is authorized to administer medication to patients on the order of a doctor; and;
  - is not, other than incidentally, a home for the mentally retarded, the mentally ill, the blind or deaf, a hotel or a home for alcoholics or drug abusers; or
  - a similar institution approved by UNUM.

John Hancock (Group Products)

A facility which is licensed to provide residential care specifically to persons with dementia, including but not limited to Alzheimer's Disease.

If the jurisdiction in which the facility operates does not license such facilities, then it must: be operated pursuant to law; and meet all of the following standards.

- Its primary function must be to provide residential care to persons with dementia.

- It must have a consulting physician to review the medical condition of residents. The physician must conduct an assessment of each resident prior to admission and ongoing assessment of each resident at least every 60 days to monitor problem behaviors and medical conditions.

- It must be a separate facility or a distinct part of another facility.

- It has established procedures for obtaining appropriate aid in the event of a medical emergency.

AEGON Insurance Group

A facility that is engaged primarily in priding ongoing care and related services to at least 10 inpatients in one location and meets all of the following criteria:

1. It provides 24 hours day care and service sufficient to support needs resulting from inability to perform activities of daily living or cognitive impairment;

2. Has an awake, trained and ready to respond employee on duty at all times to provide that care;

3. Provides three meals a day and accommodates special dietary needs;

4. Is licensed by the appropriate licensing agency (if any) to provide such care;

5. Has formal agreements for the services of a doctor or nurse to furnish medical care in case of emergency; and

6. Has appropriate methods and procedures for handling and administering drugs and biologicals.

States

Alaska

Residential facilities operated in the state that serve three or more adults who are not related to the owner of the facility by blood or marriage by providing housing and food service to its residents and providing or obtaining or offering to provide or obtain for its residents assistance with (a) activities of daily living, (b) personal assistance or a combination of services under (a) or (b).

Arizona

Supportive residential living center: a center that provides or coordinates supportive residential living services on a 24 hour basis in residential units. Facilities shall be capable of providing or coordinating home and community based services on a twenty four hour basis for support of resident independence in a residential setting.

Connecticut

Assisted living services means nursing services and assistance with activities of daily living provided to clients living within a managed residential community having supportive services that encourage clients primarily age 55 or older to maintain a maximum level of independence. Routine household services may be provided as assisted living services by the assisted living services agency or by the managed

residential community as defined in subsection (a) (13). These services provide an alternative for elderly persons who require some help or aid with activities of daily living as described in subsection (a) (4) or nursing service in order to remain in their private residential units within the managed residential community.

Hawaii

Assisted living facility means a combination of housing, health care services, and personalized supportive, services designed to respond to individual needs, to promote choice, responsibility, independence, privacy, dignity and individuality.

Iowa (Senate 454)

Assisted living means provision of housing and services which may include but are not limited to health related care, personal care and assistance with instrumental activities of daily living to six or more tenants in a physical structure which provides a homelike environment. Assisted living also includes encouragement of family involvement, resident self-direction, and resident participation in decisions that emphasize choice, dignity, privacy, individuality, shared risk and independence. Assisted living does not include the provision of housing and assistance with instrumental activities of daily living which does not include provision of personal care or health related care.

Kansas

A facility which includes apartments for residents and in which a range of services, including personal care or supervised nursing care, is provided or coordinated 24 hours a day, seven days a week for residents who may need such services for the support of resident independence.

Florida

Adult congregate living facility, hereinafter referred to as facility, means any building or buildings, section of a building, or distinct part of a building, residence, private home, boarding home, home for the aged, or other place, whether operated for profit or not, which undertakes through its ownership or management to provide, for a period exceeding 24 hours, housing, food service, and one or more personal services for four or more adults, not related to the owner or administrator by blood or marriage, who require such services; or to provide extended congregate care, limited nursing services, or limited mental health services for fewer than four adults is within the meaning of this definition if it formally or informally advertises to or solicits the public for residents or referrals and holds itself out to the public to be an establishment which regularly provides such services.

Massachusetts

Any entity… which provides room and board and provides, directly by employees Or through arrangements with another organization, assistance with activities of daily living for three or more adult residents who are not related….And collects payment or third party reimbursements from or on behalf of residents to pay for the provision of assistance with ADLs or arranges for same.

Maine

Assisted Living Services: personalized supportive services provided to functionally and/or mentally impaired adults that assist them in living in the residential environment of their choice and take into consideration their formal and informal support network.

Assisted living services provider: a provider of assisted living services certified by the Department as a Congregate Housing Services Program, a residential care facility or as a home health agency.

Maryland

Assisted living services include “a structured supportive environment in a home-like setting and personal care and chore services (help with IADLs, ADLs, routine housekeeping, menu planning, shopping, meal preparation, 24 hour supervision, assistance with medication administration, recreational and social activities of a non-therapeutic nature, assisting with transportation arrangements, and helping participants access medical care. The program also covers purchase of assistive equipment, environmental modifications, environmental assessment and behavior consultation.

Minnesota

Individualized home care aide tasks or home management tasks provided to a client of a residential center in their living units, and provided either by management of the residential center or by providers under contract with the management.

New Jersey

A coordinated array of supportive and health services, available 24 hours per day, to residents who have been assessed to need these services, including residents who require formal long term care. Assisted living promotes resident self direction and participation in decisions that emphasize independence, individuality, privacy, dignity and home-like surroundings.

Assisted living residence: a facility which is licensed by the department of health to provide apartment style housing and congregate dining and to assure that assisted living services are available when needed… Apartment units offer at a minimum one

unfurnished room, a private bathroom, a kitchenette and a lockable door on the unit entrance.

North Carolina

"Adult care home is an assisted living residence in which housing the management provides 24 hour scheduled and unscheduled personal care services to two or more residents, either directly or, for scheduled needs, through formal written agreement with licensed home care or hospice agencies. "Assisted living residence" means an group housing and services program for two or more adults, by whatever name it is called, which makes available, at a minimum, one meal per day and housekeeping services and provides personal care service directly or through a formal written agreement with one or more licensed home care agencies. Assisted living residences are to be distinguished from nursing homes subject to the provisions of G.S. 131E102. Effective October 1, 1995 there are two types of assisted living residences: adult care homes and group homes for developmentally disabled adults. Effective July 1, 1996, there is a third type, multi-unit assisted housing with services.

Ohio

A multiple unit residential facility that provides or arranges for skilled nursing care for one or more individuals who reside in the facility and are not related to the owner or operator …..

Must consist of assisted living units, each of which contains private cooking, bathing, washing and toilet facilities; has doors that can be locked and individual temperature controls; is equipped with automatic sprinkler equipment and is maintained for single occupancy except in cases in which two residents choose to share a unit.

Oregon

A program approach, within a physical structure, which provides or coordinates a range of services, available on a 24 hour basis, for support of resident independence in a residential setting. Assisted living promotes resident self direction and participation in decisions that emphasize choice, dignity, privacy, individuality and home-like surroundings.

Utah

A residential facility with a home like setting that provides an array of coordinated supportive personal and health care services, available 24 hours per day to residents who have been assessed under division rule to need any of these services. Each resident shall have a service based on the assessment which may include intermittent nursing care, administration of medications, support service promoting residents' independence and self-sufficiency.

Rhode Island

Residential care and assisted living facility. Publicly or privately operated residences that provide personal assistance lodging, and meals to two or more adults who are unrelated … Residential care facilities include sheltered care homes and board and care residences or any other entity by any other name providing the above services which meet the definition of residential care and assisted living facility.

Washington

(**Draft**) A combination of housing, health services and assistance with personal care,m provided by a licensed boarding home in accordance with the department's contract. The assisted living facility shall design and provide services in response to each resident's individual need, emphasizing and promoting the resident's independence and dignity. The assisted living facility shall develop and implement individualized service plans based upon the individual resident's needs and choices, and shall, whenever possible include the resident's family, friends and support system in the service planning process. To the extent possible the resident shall always be included in service negotiations.

(**Contract**) A coordinated array of personal care, health services and other supportive services available 24 hours per day to residents who have been assessed to need these services. Assisted living promotes resident self direction and participation in decisions that emphasize independence, individuality, privacy, choice and residential surroundings.

Wisconsin

A place where five or more adults reside that consists of independent apartments, each of which has an individual lockable entrance and exit, a separate kitchen, including a stove, and individual bathroom, sleeping and living areas, and that provides, to a person who resides in the place, not more than 28 hours per week of services that are supportive, personal and nursing services. Assisted living facility does not include a nursing home or a community-based residential facility, but may be physically part of a structure that is a nursing home or community based residential facility.

APPENDIX B. STATE SUMMARIES

This section contains summaries of policies and regulations in each state that response to our survey indicated that they operate an assisted living program. The summary begins with a general presentation of their policy and the context in which it has been developed. In addition, the regulations are summarized as they relate to the definition of assisted living, requirements for the living unit, admission policy, services provided, medication, and staffing.

ALABAMA

General Policy Approach

The state has a licensure category for assisted living but does not differentiate assisted living from board and care. In 1994, the state Commission on Aging organized a series of forums on long term care, held a statewide summit on long term care and formed a Policy Development Council to make recommendations for the reform of the state's long term care system. During the forums and the statewide summit, several nursing home administrators, consumers and others testified to the need for an assisted living program that expanded the range of services that could be provided in assisted living and changes the admission policy to allow people who meet the nursing home level of care criteria to be served in assisted living. However, a new administration and the announcement of a substantial Medicaid deficit are likely to effect the policy process and the environment for expanding services.

The regulations license three categories of facilities. Congregate assisted living facilities serve 17 or more adults, group assisted living facilities serve 4-16 adults and family assisted living facilities serve 2-3 adults.

Unit Requirements

The regulations do not require separate living and sleeping quarters. Private bedrooms without sitting areas must provide 80 square feet and double rooms 130 square feet. If sitting area are included, private rooms must be 160 square feet and double rooms 200 square feet. Bath rubs or showers must be available for every 8 beds, and lavatories and toilers for every six beds. Lockable doors are permitted.

Tenant Policy

The regulations provide that assisted living facilities may serve persons “who are not in need of hospital or nursing home care.” Facilities may not serve anyone with chronic health conditions requiring extensive nursing care and/or daily medication supervision, persons requiring daily professional observation or the exercise of professional judgement by staff. People who need assistance from more than one person to evacuate a building, show severe symptoms of senility, require restraint or treatment for addiction of alcohol or drugs may not be admitted or retained.

Services

Assisted living facilities must provide personal care for bathing, oral hygiene, hair care and nail care. Facilities may provide for general observation and may arrange or assist residents to obtain medical attention or nursing services when needed. Home health may be provided by a certified agency as long as residents receiving home health services do not require hospital or nursing home care.

Financing

Other gm SSI, no public financing is available for assisted living.

Medication

Assistance is limited to reminders, reading container labels to the resident, checking the dosage, opening containers. Registered nurses are allowed to administer medications for residents who do not require acute, continuous or extensive medical or nursing care.

Staffing

The regulations require at least 1 staff member per 6 residents 24 hours a day and personal care staff to meet the needs of residents.

ALASKA

General Policy Approach

In 1994 the Alaska legislature passed a law to encourage the development of assisted living homes to provide a homelike environment for older and persons with a mental or physical disability needing assistance with activities of daily living. The law promotes resident participation in the community, recognizes the resident's right and responsibility to evaluate and make choices concerning the services to be provided. The law provides for licensing assisted living homes for elders, people with dementia, and people with physical, mental or developmental disabilities. The Department of Health and Social Services win license homes for people with mental or developmental disabilities and the Department of Administration will license homes for older people, people with dementia and people with physical disabilities. The agencies are allowed to issue regulations setting additional requirements or standards.

The law is effective January 1, 1995. Draft regulations have been prepared and were issued for comment in February. The regulations set minimal requirements which will be defined in more detail in policies and procedures which will be developed and issued during the first year of the program as experience during the transition is gained. State officials expect that most providers will be small and personal care, RN assessment and oversight win be arranged or contracted from other organizations.

Fees are charged for a license. A base fee of $100 is charged for facilities of 3-5 residents and $250 for 6 and larger. In addition, applicants must pay $50 per resident for each resident over 2. Holders of residential care facility and adult foster care licenses may convert to an assisted living license.

Definition

The law creates “Chapter 33. Assisted Living Homes” to emphasize that assisted living serves as the resident's home. The statute applies to residential facilities serving three or more adults who are not related to the owner of the residence by blood or marriage that provide housing, food service, and provide, obtain or offer to provide assistance with activities of daily living, personal assistance (help with IADLs, obtaining supportive services [recreational, leisure, transportation, social, legal, et.al.], being aware of the resident's whereabouts when traveling in the community, and monitoring activities) or a combination of ADL assistance and personal assistance.

Unit Requirements

No requirements are specified for the type of unit. Shared rooms are allowed. Facilities must meet life safety code requirements applicable for buildings its size.

Tenant Policy

The home and each resident must sign a residential service contract that describes the services and accommodations to be provided, rates, the rights, duties and obligations of the resident, and the policies and procedures for terminating the contract. Residents who have exceeded the 45 consecutive day limit for receiving 24 hour skilled nursing (see below) may continue to live at the home if the home and the resident or resident's representative have consulted with the resident's physician, discussed the consequences and risks and a revised plan without 24 hour nursing has been reviewed by a registered nurse. Terminally ill residents may continue to reside in the residence if a physician certifies that the person's needs are being met.

Services

Each resident must have a plan of care developed within 30 days of move-in that identifies strengths and weaknesses performing ADLs, physical disabilities and impairments, preferences for roommates, living environment, food, recreation, religious affiliation and other factors. The plan also, identifies the ADLs with which the resident needs help, how help will be provided by the home or other agencies, and health needs and how they win be addressed. The plan must also identify the resident's reasonable wants and how those will be addressed. If health related services are provided or arranged, the evaluation must be done quarterly. If no health services are provided, an annual evaluation is required. Assisted living homes may provide intermittent nursing services to residents who do not require 24 hour care and supervision. Intermittent nursing tasks may be delegated to staff who are not licensed as a nurse for tasks designated by the board of nursing. 24 hour skilled care may be provided for not more than 45 consecutive days.

Financing

When the regulations are finalized, rates will be adjusted to reflect the level of care and regional variations across the state. Rates will be comparable to current rates for residential care I and II which in the Anchorage area are 38.44 a day for Level I and $48.44 for Level II. The level II rate in the Northwest region is $80.64 a day.

Medications

“Home staff persons” may provide medication reminders, reading labels, observing a resident while taking medication, checking self-administered dosage against the label, reassuring the resident that the dosage is correct, and directing/guiding the hand of a resident at the resident’s request.

Staffing

Homes must have the type and number of staff needed to operate the home and must develop a staffing plan that is appropriate to provide services required by resident care plans.

ARIZONA

General Policy Approach

Chapter 163 (1993) authorized the Director of Health Services to certify centers for the delivery of home and community based services. The law views supportive residential living services as in-home services. Participation is capped at 100 “members” at any point in time until September 30, 1995. An additional 100 members may be served after October 1, 1995. The pilot supportive residential living (assisted living) project operates in Maricopa County. Although the statute and regulations do not use the term assisted living, the pilot operates according to the principles of assisted living. Providers submit a statement that demonstrates their knowledge and commitment to the philosophy of supportive residential living.

Three facilities have been certified with 18, 28 and 54 units.

Data concerning resident satisfaction, number of residents, length of stay, level of care, emergency room utilization, urgent care visits, days of hospitalization, average days and cost, average daily cost of supportive residential living, service levels, demographic information, functional information, and medical information must be reported by sites. A one year report on resident satisfaction will be issued in March 1995. An evaluation will be submitted to the Governor's Long Term Care Committee by December 1995 and a full report is due to the legislature in 1996 when a decision will be made to expand the program statewide or terminate the demonstration.

The residence must meet local building and fire codes based on construction and occupancy.

Unit Requirements

Each unit must be constructed as a private apartment with living and sleeping space, kitchen area, bathroom and storage areas, with a minimum of 220 square feet, excluding the bathroom. Units must have individually keyed locks and resident temperature controls. Kitchen areas must have a sink, refrigerator, cooking appliance that can be disconnected or removed, space for food preparation and storage space for utensils and supplies.

Tenant Policy

Projects cannot serve anyone who needs continuous nursing services, cannot direct care, needs continuous therapeutic intervention to sustain life and is violent toward self or others. In addition, non-Medicaid (ALTCS) residents cannot require more than one person to assist with ambulation, transfer from bed, chair or toilet or other ADLs, is unable to self-propel a wheelchair or cannot get out of bed more than three hours a day.

Resident agreements include the terms of occupancy, a statement of the services provided, services that are available for an additional cost, monthly fees and expenses, deposit and refund policies, termination procedures, copies of the rules and resident rights.

Services

Prior to move in, an interdisciplinary team conducts an assessment and develops a plan with the resident or their representative that identifies the services needed, the person responsible for providing the service, method and frequency of services, measurable resident goals and the person responsible for assisting the resident in an emergency.

The statute allows intermittent home health (nursing, aide, medical supplies, equipment or appliances and therapies), homemaker, personal care, medically necessary transportation and meals.

Financing

Rates have been negotiated with each project within guidelines specified in the waiver. Program administrators used rates set for adult foster care, nursing facilities, the Oregon assisted living program and the Arizona HCBS program as guidelines in working with centers. Administrators also consider the package of services provided and ask each residence to propose a unit rate. Three classes of rates are negotiated based on the level of care: intermediate, low skill and high skilled. Ile SSI payment rate is $446 a month of which $391.10 is paid to the residence to cover room and board charges and $66.90 is retained by the resident.

Arizona Payment Rates		
Class I	**Class II**	**Class III**
44.00 - 45.51	49.00 - 50.76	55.00 - 63.51

Medications

Facilities must have policies and procedures governing the procurement, administration, storing and disposal of medications. Staff may supervise self-administration by opening bottle caps, reading labels, checking the dosage and observing the resident taking the medication. Medications which cannot be self-administered must be administered by an RN or “as otherwise permitted.” The phrase as otherwise permitted was included to accommodate any future statutory changes in the state's nurse practice act. Medication organizers can be prepared a month in advance by an RN or family members.

Staffing

The center manager may employ or contract with staff for supportive services, supervision, food service, housekeeping and maintenance, social and activity programs

and general supervision. At least one staff must be awake and on-duty. An RN must be available to provide nursing service specified in each plan of care. No staff ratios are included in the regulations and centers are required to have sufficient personnel available to provide services identified in resident care plans.

Managers must receive 20 hours of continuing education credit each year. Staff are required to receive an orientation from the center and complete a 16 hour training program, approved by the county within 60 days of their employment as well as 20 hours of in-service training a year.

CONNECTICUT

General Policy Approach

Assisted living regulations were issued by the Health Department and approved by the Legislative Review Committee in December, 1994. The regulations take a unique approach by allowing “managed residential communities” (MRCs) to offer assisted living services through assisted living services agencies (ALSAs). MRCs may obtain a license to also serve as an ALSA.

The regulations focus on the licensing of agencies to provide services rather than the building and services as an entity. MRCs have to notify the health department of their intention to provide assisted living services. The ALSA, either the MRC or another agency, must be licensed by the Department of Public Health and Addiction Services to provide services. The MRC is not licensed by the Department of Public Health and Addiction services. MRCs must show evidence of compliance with local zoning ordinances and building codes.

Definition

Assisted living services: nursing services and assistance with ADLs provided to clients living within a managed group living environment having supportive services that encourage clients primarily age 55 or older to maintain a maximum level of independence. Routine household services may be provided as assisted living services or by the managed residential community. These services provide an alternative for elderly persons who require some help or aid with ADLs and/or nursing services

Unit Requirements

To qualify as a managed residential community and a setting in which assisted living services may be provided, units are defined as a living environment belonging to a tenant(s) that includes a full bathroom within the unit including water closet, lavatory, tub or shower bathing unit and access to facilities and equipment for the preparation, and storage of food.

Tenant Policy

Each agency will develop its own admission criteria but the regulations do not allow the agencies to impose unreasonable restrictions and screen out people whose needs may be met by the agency. Assisted living services may be provided to residents with chronic and stable health, mental health and cognitive conditions as determined by a physician or health care practitioner.

Services

Services may only be provided by organizations licensed as an assisted living services agency. Nursing services are listed in the regulations and include client teaching, wellness counseling, health promotion and disease prevention, medication administration and delegation of supervision of self-administered medications and provision of care and services to clients whose conditions are chronic and stable.

Registered nurses may also perform quarterly assessments, coordination, orientation, training and supervision of aides.

Financing

The Health and Education Facilities Authority provides loans for the development of assisted living settings. As yet, no specific program has been developed to subsidize services for low income residents of assisted living.

Medications

The regulations allow for administration of medications by licensed staff. Assisted living aides may supervise the self-administration of medications which includes reminding, verifying, and opening the package.

Staffing

ALSAs must have at least 1 RN and an on-site supervisor 20 hours a week for every 10 or fewer RNs and aides and a full time supervisor for every 20 RNs and aides. A sufficient number of aides must be available to meet residents' needs. All aides must be certified Nurses Aides or Home Health Aides and complete 10 hours of orientation and one hour of in-service training every 2 months.

Twenty four awake staff are not required since the needs will vary among managed residential communities. However, 24 hour staffing could be required if indicated by resident plans of care. An RN must be available on-call. 24 hours a day.

FLORIDA

General Approach

Legislation was passed in 1991 that authorized the delivery of Extended Congregate Care (ECC) in Adult Congregate Living Facilities (ACLFs) to promote the availability of appropriate services for elderly and disabled persons in the least restrictive and most home-like environment to encourage the development of facilities which promote dignity, individuality, privacy and decision-making ability. The law specifies that regulations governing these facilities shall be sufficiently flexible to allow facilities to adopt policies which enable residents to age in place when resources are available to meet their needs and accommodate their preferences. ACLFs may provide extended congregate care to residents.

Providers must receive ACLF and ECC licenses. The ECC license sets higher requirements for units and services than the ACLF license alone.

Both the authorizing statute and the regulations include a philosophy that emphasizes resident autonomy. Facilities with both licenses must provide opportunities for residents to make personal decisions and choices, and to participate in developing a care plan. The residence must also develop policies which allow residents to age-in-place, maximize independence, dignity, choice and decision-making.

Legislation changing the name of the ACLF program to assisted living is pending before the state legislature. A number of other legislative proposals are pending that would extend the range of allowable services, require a test for administrators, set requirements for specialized Alzheimers' programs, and increase fire safety requirements (require sprinklers). Amendments to the regulations, which were initially promulgated in 1992, were published January 31, 1995. The revised regulations are expected to be effective by May 1995.

Approximately 1800 facilities are licensed as ACLFs of which 120 have an ECC or limited nursing service license and are eligible to participate in the state's assisted living Medicaid waiver program.

Definition

“Adult congregate care facility means any building or buildings, section of a building or distinct part of a building, residence, private home, boarding home, home for the aged or other place, whether operated for profit or not, which undertakes to provide through its ownership or management, for a period exceeding 24 hours, housing, food service, and one or more personal services for four or more adults, not related to the owner or administrator by blood or marriage, who require such services; or to provide extended congregate care, limited nursing services, or limited mental health services.”

"Extended congregate care license: a specialized license which is issued to facilities which have met the basic licensure provisions of (ACLFs).

Unit Requirements

ACLFs providing extended congregate care must provide private rooms or apartments, or semi-private room or apartment shared with a roommate of choice, with a lockable entry door. Facilities that provide shared bathrooms must have one bathroom shared by no more than four residents.

Tenant Policy

Admission The regulations for "admissions" are very detailed. New residents must be able to perform ADLs with supervision or assistance; do not require 24 hour nursing supervision; are capable of taking their own medication or may require administration of medication and the facility has licensed staff to provide the service; do not have bed sores or stage 2, 3, or 4 pressure ulcers, are able to participate in social activities; capable of self-preservation; is not bedridden; non-violent; and does not require 24 hour mental health care.

Continued residency Additional criteria affect continued residency. Residents may not be retained if they develop a need for 24 hour supervision; become bedridden for more than 14 days, become totally dependent in 4 or more ADLs (exceptions for quadraplegics, paraplegics and victims of muscular dystrophy, multiple sclerosis and other neuro-muscular diseases if the resident is able to communicate their needs and do not require assistance with complex medical problems). Residents may stay if they develop stage 2 pressure sores but must be relocated for stage 3 and 4 pressure sores. Residents who are medically unstable, become a danger to self or others or experience cognitive decline to prevent simple decision making may not be retained.

This lengthy list of resident conditions which may and may not be treated may be replaced by using the Medicare skilled nursing definition to establish the admission and retention policy.

The original law emphasized aging-in-place and the regulations included a requirement that residents must reside in the facility 90 days prior to the need for ECC services. This prevented people from moving in to an ACLF who needed the services upon move in. Modifications to the requirement are pending in the legislature.

To receive services under the Medicaid waiver, tenants must be 60 years of ago or older and meet one of the following criteria:

- Require assistance with 4 or more ADLs or three ADLs plus supervision or administration of medications;
- Require total help with I or more ADLs;

- Have a diagnosis of Alzheimer's Disease or another type of dementia and require assistance with 2 or more ADLs;
- Have a diagnosed degenerative or chronic medical condition requiring nursing services that cannot be provided in a standard ACLF;
- Are Medicaid eligible, awaiting discharge from a nursing home but cannot return to a private residence because of a need for supervision, personal care, periodic nursing services or a combination of the three.

Services

The facility must describe the personal, supportive and nursing services to be made available. Facilities may provide limited nursing services (eg., medication administration and supervision of self-administration, applying heat, passive range of motion exercises, ice caps, urine tests, routine dressings that do not require packing or irrigation and others), intermittent nursing services (eg., change of colostomy bag and related care, catheter care, administration of oxygen, routine care of an amputation or fracture, prophylactic and palliative skin care); counseling emotional support, networking, assistance securing social and leisure services, shopping, escort, companionship, family support, information and referral, transportation assistance developing and implementing self-directed activities. In addition, facilities are to provide ongoing medical and social evaluation, dietary management, and medication administration.

Facilities **may not** provide oral or nasopharyngeal auctioning, assistance with tube feeding, monitoring of blood gasses, intermittent positive pressure breathing therapy, intensive rehabilitation services for a stroke or fracture or treatment of surgical incisions which are not clean and free from infection and any treatment requiring 24 hour nursing supervision.

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

Financing

A total of $2.3 million was approved in 1994 for 220 Medicaid Home and Community Based Services Waiver slots as a pilot program. The SSI benefit is $586 a month. The program reimburses providers $750 a month for services for a total payment of $1336 less the personal needs allowance. An evaluation of the program will be done to examine levels of need and developed a tiered rating system as appropriate.

To be eligible for the program, recipients must be an SSI recipient, have income under 300% of the federal SSI benefit or, for aged and disabled applicants, have income under 90% of the federal poverty level.

Medications

Medications may be administered by staff within the scope of their license.

Staffing

Facilities are allowed to establish their own staffing plan based on the amount and type of services needed by residents and reflected in resident plans of care. Certified nursing assistants and certified home health aides must receive training in the concepts and requirements of extended congregate care.

HAWAII

General Approach

A multi-member task force was created by House Concurrent Resolution 377 to make recommendations and assisted living and to explore the use of Medicaid waivers to support low income residents in assisted living. The report was issued in December 1994 and legislation authorizing the development of assisted living regulations was passed in April, 1995. Members of the task force made site visits to facilities in Oregon and Washington. The report recommended that the Department of Health be authorized to develop regulations to establish an assisted living program.

Definition

The report recommended that assisted living be defined as a special combination of housing, personalized supportive services, and health care designed to respond to individual needs. Assisted living promotes choice, responsibility, independence, privacy, dignity and individuality and encourages the involvement of a resident's family and friends. The setting within an assisted living facility is usually a private studio apartment and bath.

Unit

The definition emphasizes but would not require that units be configured as apartments.

Services

Not described.

Financing

The report suggested that land policies should be reviewed and modification of zoning requirements made to allow existing housing stock to be used. State loans and bonds would be made available to at favorable interest rates to stimulate development. The report recommended consideration of providing a higher level of service in residential mm facilities as a means of maximizing existing buildings to meet new needs. A resolution passed the legislature directing the Medicaid Agency to study the feasibility of using a Medicaid Home and Community Based Services Waiver to finance services.

Medication

The nurse practice act should be modified to allow medication management by designated staff. A task force is working with the Department of Health to revise the NPA to allow delegation.

Staffing

Not addressed.

IDAHO

General Approach

A concept paper has been prepared by the Idaho Residential Care Council that outlines a policy for assisted living. The draft paper states that assisted living serves people who need assistance with ADLs but not skilled nursing care. Assisted living promotes independence and dignity for each resident in a home like atmosphere rather than a medical atmosphere.

The paper envisions misted living as providing care that is less intensive than nursing home care and more services than are available in independent housing. Licensing would be done in a manner that does not remove independence and choice from the resident.

Definition

Not developed yet.

Unit

Not addressed.

Services

The concept paper calls for providing assistance with eating, bathing, dressing, toileting and walking; three meals a day in a common dining room; housekeeping services; transportation; emergency call system for each resident; medication management by licensed CNAs; social and recreational activities; and personal laundry services.

The paper recommends development of a point system to charge for services in addition to the monthly rent which charges residents only for the services they use.

Financing

Not addressed.

Medication

Not addressed.

Staffing

Not addressed.

INDIANA

General Approach

The state legislature called for a study of assisted living during the summer of 1994. The Interim Study Committee on Health Care and Licensure Issues held five meetings and received public testimony. The Committee report, issued November 1994, included a proposed definition for insisted living. A motion to file legislation authorizing creation of a program based on Oregon and draft regulations in Ohio received a 5-4 vote but required 7 affirmative votes to be adopted as a recommendation of the Committee.

Definition

Proposed: a program approach, within a physical structure, which provides or coordinates a range of social and health care services for five or more individuals, available on a 24 hour basis, for support of resident independence in a residential setting. Assisted living promotes resident self-direction and participation in decisions that emphasize choice, dignity, privacy, individuality, independence and home-like surroundings. (Approved 9-0).

Unit Requirements

Not addressed.

Tenant Policy

Not addressed.

Services

Not addressed.

Financing

Not addressed.

Medications

Not addressed.

Staffing

Not addressed.

IOWA

General Approach

SF 454 contains findings and a description of provisions that must be defined by regulation. The bill, which provides for a certification process for assisted living facilities, passed the Senate and was amended by a House Committee. The bill did not come to the floor prior to the end of the 1995 session and was held over until the 1996 session. State agencies continue to work with legislators and plan to develop draft regulations based on SF 454 that would be issued after passage. The bill anticipates that funding will be included in budget submitted next year to subsidize assisted living as a Medicaid waiver service. The regulations and certification process would be developed by the Department of Elder Affairs.

Definition

Assisted living means provision of housing and services which may include but are not limited to health related care, personal care, and assistance with instrumental activities of daily living to six or more residents in a physical structure which provides a homelike environment. Assisted living also includes encouragement of family involvement, resident self-direction, and resident participation in decisions that emphasize choice, dignity, privacy, individuality, shared risk and independence. Assisted living does not include the provision of housing and assistance with instrumental activities of daily living which does not also include provision of personal care or health related care.

Units

The bill requires a minimum of private space for sleeping and dressing. The requirements will be developed through regulations.

Tenant Policy

Tenants needing skilled services may be served. Rules must be drafted which provide for contracts between the assisted living facility and the resident regarding shared risk.

Services

The bill allows for the provision of health related care by an RN, LPN or other licensed health care professionals on a part time or intermittent basis. Facilities are not required to provide health related services but must provide personal care or health related service to offer themselves as assisted living. Part time or intermittent is defined as up to 35 hours a week on less than a daily basis of personal care and health related services, or temporary daily care defined as up to 8 hours a day for not more than 21 days.

Facilities just provide a core service which at a minimum includes 24 hour response capability to meet unscheduled or unpredictable needs, the ability to create individualized service plans and to coordinate services. Services may be provided through contracts with certified home health agencies, hospitals, licensed health care professionals, home care aides or relatives.

Financing

SF 454 directs the Department of Human Services to seek a Medicaid waiver to cover assisted living for Medicaid recipients.

Medication

Not addressed in SF 454.

Staffing

Providers will have to develop a core service capacity which will be defined by regulations.

MAINE

General Approach

Chapter 661 of the Acts 1994 directed that state agencies develop a definition of assisted living that includes a range of services from in-home assistance to facility based care but that excludes supported living program operated by the Department of Mental Health and Mental Retardation; recognizes different levels of care with appropriate levels of regulation and provides necessary protection for consumers without unduly restricting choice. The Bureau of Elder and Adult Services (BEAS) has published a proposed policy with an effective date of April 1, 1995. The service based approach will license providers of service and limits which organizations may be licensed to provide assisted living services. Any organization offering assisted living services must be licensed under one of three categories identified in the regulations. The new policy does not make changes in current programs or licensure categories and simply alter the terms that can be applied to current programs as well as introduce a set of principles.

The five principles described in the regulations are:

- Assisted living services are personalized and based on the needs and values of the consumer. This means the consumer is involved in decision-making, is informed of risks and has the right to fail.

- Assisted living services foster independence.

- Assisted living services recognize and respect the dignity and rights of the consumer.

- Assisted living services offer the consumer a choice of services and lifestyle.

- Assisted living services respect the privacy of the consumer.

Further regulations are to be developed by the Department of Human Services to implement consumer protection standards related to provider fitness, service contracts and leases, promotion of consumer rights and a grievance process, scope of practice and minimum safeguards for life safety, food service and sanitation and the minimum standards for accommodations and the environment.

Definition

Assisted Living Services: personalized supportive services provided to functionally and/or mentally impaired adults that assist them in living in the residential environment of their choice and take into consideration their formal and informal support network.

Assisted living services provider: a provider of assisted living services certified by the Department as a Congregate Housing Services Program, a residential care facility or as a home health agency.

Unit Requirements

Not specified. May be the subject of further regulations.

Tenant Policy

Not specified.

Services

The regulations do not revise the scope of services vided by residential care pro facilities, congregate housing services programs and home health agencies. Each provider category provides a different set of services.

Congregate housing services: care management services, housekeeping services, personal care assistance, transportation and at least one meal a day available to consumers in a multi-unit residential building.

Residential care services: personal supervision, protection from environmental hazards,assistance with activities of daily living, administration of medications, diversional or motivational activities, diet care and nursing services.

Home health services: in-home provision of professional nursing services, physical and/or occupational therapy speech pathology, medical social work, nutritionist services and the supervised services of licensed practical nurses, home health aides and/or certified nurse assistants providing treatment and rehabilitation for illness or disability, aimed at restoring or maintaining independent functioning.

Financing

Assisted living would be financed through existing program. No new sources of funding are provided.

Medications

No changes are made from current practice.

Staffing

No changes are made from current practice.

MARYLAND

General Approach

There are several housing with supportive services programs that operate in the state. In 1976, the Office on Aging began the Sheltered Housing program, a support services program for frail elderly residents in HUD subsidized senior apartment buildings. In 1986, Sheltered Housing (now known as Senior Assisted Housing) was expanded to group homes for the elderly which provides services to 4-15 residents in a group setting. In 1993, the Office on Aging was approved for Medicaid Home and Community Based Services Waiver to serve resident in Group Senior Assisted Housing (GSAH) facilities.

The Department of Health and Hygiene regulates large facilities serving 16 or more residents in non-apartment settings. While this category is regulated as domiciliary care, some facilities advertize themselves as assisted living. Some private market apartment models that offer support services operate without state regulation. State agencies are currently reviewing the array of models to determine how assisted living should be defined and regulated.

Definition

Senior Assisted Housing is a residential program that combines housing and support services for seniors, who are at least 62 years old, who need daily help with activities of daily living in order to remain in the community.

Units

The multi-family SAH program operates in 43 senior apartment buildings throughout the state, serving over 900 people. There are over 1400 residents living in 175 certified GSAH facilities. Group facilities offer private or semi-private bedrooms and residents share common areas of the home. Many group home residents (about half) have some form of dementia. Although some group facilities have been developed in former convents, school buildings or newly constructed buildings, most facilities are developed using existing housing stock. The conditions of participation require that buildings meet all state and local laws governing the physical plant, including fire accessibility and safety standards. To offer assisted living services, providers must be certified annually by the Maryland Office on aging.

Services

Required services include daily meals, housekeeping, laundry and assistance with personal care. The group home model also requires 24-hour on site supervision. Optional services include assistance with medication administration, recreational and social activities of a non-therapeutic nature, assisting with transportation arrangements, and helping participants access medical care. Under the Medicaid waiver, services in

group homes have been augmented to include environmental modifications, assistive equipment and behavior consultation services, and Senior Center Plus, a social day care program.

The Medicaid waiver component of the program is unique in that it provides support for environmental modifications. The program will pay two thirds of the modification costs and the assisted living provider pays the remaining third. Reimbursement for assistive equipment must be pre-authorized by the Area Agency on Aging case manager and approved by the state Office on Aging. Reimbursement for assistive equipment is limited to $1000 per participant during a 12 month period and reimbursement for environmental modifications is limited to $3000 per participant over a lifetime. Assistive equipment and environmental modifications reimbursements are divided among the participants affected.

Financing

In both models, eligible low income residents may be subsidized through state general funds. Subsidies are provided on a sliding scale based on income. In the group home program, services for nursing home eligible residents may also be covered under the Office on Aging's Medicaid waiver.

Service providers determine the cost of care in both models. In the multi-family model, the average monthly fee for services is $474, with an average monthly subsidy of $151 per resident. Rates for group homes range from $1000 to $2500 a month. The state subsidy is capped at $550 a month in non-waiver group homes. Participants pay the difference between the state subsidy and the monthly fee. The monthly fee is capped at $1200 for residents determined eligible under the GSAH Medicaid waiver. Waiver eligible residents pay 20% of the monthly fee for room and board.

Medication Assistance

The Medicaid waiver allows approved providers, under the supervision of a registered nurse, to administer medications to waiver clients. Only persons who have successfully completed medication management training provided by the Office on Aging may administer medications. A registered nurse, under contract with the Area Agency on Aging, is required to monitor Medicaid approved homes at least every 45 days to assure that medications are administered property.

Staffing

In both SAH models staff must be adequate to provide the required services. Under the Medicaid waiver at least I staff person must be on duty at all times for every 8 residents. Providers may be a physician, nurse or persons with three years of applicable experience.

MASSACHUSETTS

General Approach

Chapter 354 (Acts of 1994) was signed into law in early January 1995 and creates a process for the **certification** of assisted living facilities by the Executive Office of Elder Affairs. The law provides that the regulations “shall be sufficiently flexible to allow assisted living residences to adopt policies and methods of operation which enable residents to age-in-place.” To be certified, residences must submit information such as the number of units and number of residents per unit, location of units, common spaces and egress by floor; base fees to be charged; services to be offered and arrangement for delivering care; number of staff to be employed and other information required by the Executive Office of Elder Affairs. The process does not require licensing or review of the building which must comply with state and local building codes. The buildings are considered residential use for applying codes.

Throughout the state, 42 assisted living residences (1636 units) are operating, 24 residences (1321 units) are under development. All 66 residences expect to become certified under the new legislation. The Massachusetts Housing Finance Agency (MHFA) and the Massachusetts Industrial Finance Agency (MIFA) provide loans for assisted living. The MHFA “Elder CHOICE program is designed to support development of appropriate housing and ADL assistance for frail elders. The agency's RFP says that assisted living offers a supportive residential environments which maximizes the ability of elders to live independently and reduces the need for costly institutionalization. The Medicaid Group Adult Foster Care program has certified 7 programs and 8 more applications are expected to be approved.

Definition

Assisted living residence, any entity, however organized, whether conducted for profit or not for profit, which meets all of the following criteria:

> Provides room and board; provides, directly by employees of the entity or through arrangements with another organization which the entity may or may not control or own, assistance with activities of daily living for three or more adults residents who are not related by consanguinity of affinity to their care provider and; collects payments or third party reimbursements from or on behalf of residents to pay for the provision of assistance with the activities of daily living.

Unit Requirements

Units must be single or double occupancy with lockable doors. New construction must provide for private baths. Existing buildings may qualify if they provide private half baths and one bathing facility for every three units. All residences must provide a kitchenette in each unit or access to cooking capacity. The Secretary of Elder Affairs is authorized to waive the requirements for bathrooms and bathing facilities when determined to meet public necessity and to prevent undue economic hardship as long

as the residence provides a homelike environment and promotes privacy, dignity, choice, individuality and independence.

Tenant Policy

The statute does not allow people needing 24 hour skilled nursing supervision to be admitted or retained in an assisted living residence. To qualify for reimbursement under the Medicaid Group Adult Foster Care program, tenants must require daily assistance with at least one ADL and assistance with managing medications as documented by a physician and a nursing assessment; be at risk of requiring nursing home placement; have been discharged from a nursing home; be chronically disabled; and require 24 hour supervision.

Services

Chapter 354 requires that residences all provide or arrange for opportunities for socialization and access to community resources; assistance with ADLs identified in a plan of care (at a minimum residences must offer support for bathing, dressing and ambulation); up to three meals daily; housekeeping; self-administered medication management; laundry; and the ability to respond to urgent or emergency needs.

Twenty four hour nursing services are not allowed. Skilled services may only be provided by a certified home health agency on a part time or intermittent basis not to exceed 90 days in a one year period. Medical conditions requiring services on a periodic, scheduled basis are also allowed. In addition, residents may “engage or contract with any licensed health care professional and providers to obtain necessary health care services .... to the same extent available to persons residing in private homes.”

The MHFA Elder CHOICE program requires, at a minimum, personal care (assistance wit bathing, dressing, continence, ambulation, toileting, eating and transfers); housekeeping and maintenance, laundry, medical monitoring and transportation, up to 3 meals a day, 24 emergency response and service coordination and case management.

Financing

The Massachusetts Housing Finance Agency and the Massachusetts Industrial Finance Agency provide loans for the construction of assisted living projects.

Services for low income tenants are subsidized through Medicaid and the Executive Office of Elder Affairs. The Medicaid Group Adult Foster Care provides an average of $33.70 per day for services and administrative costs. The Elder Affairs program provides $817 a month.

Chapter 354 suspends approval of further SSI applications for the higher payment standard for assisted living residents pending a study of the economic affect of the program. The study has been completed and submitted to the legislature for further consideration. The study concluded that Medicaid saves $2,398 (average savings weighted by income) a year per recipient through the GAFC program and the SSI assisted living payment compared to nursing home costs. Based on terminations in the GAFC program, the study estimated that nursing home admission would be delayed an average of 8 months for 29% of the participants, avoided entirely for 31% of the participants who would die and another 39% who may return to another community option.

The state had received approval from the Social Security Administration for a separate payment standard of $920 a month for single individuals in assisted living. The regular community payment standard for an aged person living alone is approximately $550 a month. The higher standard was approved to provide a more realistic level of support for room and board which cannot be reimbursed by Medicaid for low income recipients.

Medications

Residence staff are allowed to remind residents to take medications, open containers, open prepackaged medications, reading the label, observe, check dosage against the label and reassure residents that the proper dosage has been taken.

Staffing

No staffing specific guidelines are included concerning the type and number of staff. However, the residence must maintain an ability to provide timely assistance to residents and to respond to urgent or emergency needs through on site staffing, personal emergency response or other means. Under draft regulations, all staff and contracted providers must receive a 6 hour orientation which includes the philosophy of independent living, resident bill of rights, abuse, safety and emergency measures, communicable diseases, communication skills, the aging process and resident health and related problems. Staff providing personal must complete an additional 54 hour training course that includes 20 hours of personal care and 34 hours of general training. The personal care component must be taught by an RN. Personal care staff will be reviewed twice a year by a qualified nurse.

MINNESOTA

General Policy Approach

The Minnesota statute covers home care services which include nursing, personal care, therapies, nutritional services, home management and others which are delivered in a place of residence. The state has implemented an assisted living program through its state funded Alternative Care (AC) program and the Medicaid Home and Community Based Services Waiver program. Licensing is provided through regulations governing home care providers.

The Alternative Care Program serves nursing home eligible residents whose income exceeds Medicaid eligibility levels but who would spend down to Medicaid levels within six months if admitted to a nursing home. The HCBS waiver covers aged and disabled Medicaid recipients who meet the nursing home criteria.

Definition

Assisted living services are defined in the home care regulations as individualized home care aide tasks or home management tasks provided to clients of a residential center in their living units, and provided either by the management of the residential center or by providers under contract with the management. Individualized means chosen and designed specifically for each client's needs, rather than provided or offered to all clients regardless of their illness, disability or physical condition. Residential centers are defined as a building or complex of buildings in which clients rent or own distinct living units. Five classes of home care may be licensed including class E, assisted living license which covers the provision of “assisted living services to residents of a residential center.”

The state's Medicaid waiver defines assisted living services as “up to 24 hour oversight and supervision, supportive services, home care aide tasks and individualized home management tasks provided to residents of a residential center living in their own units/apartments with a full kitchen and bathroom. A full kitchen includes a conventional stove with an oven, refrigerator, food preparation counter space and a kitchen utensil storage compartment. Supportive services include socialization (when socialization is part of the plan of care, has specific goals and outcomes established and is not diversional or recreational in nature), assisting clients in setting up meetings and appointments, and providing transportation (when provided by the residential center only). Individuals receiving assisted living services will not receive both homemaking and personal care services and assisted living services. Individualized means that services are chosen and designed specifically for each resident's need, rather than provided or offered to all residents regardless of their illness, disabilities or physical conditions.

Unit Requirements

The assisted living policies under the waiver require full apartments with kitchens.

Tenant Policy

Participants for the AC and Medicaid waiver programs must be screened by the county preadmission screening team and must meet the nursing home level of care criteria. Most residents fall into case mix categories A through D (see table).

Services

The regulations allow the provision of assisted living services which include home care aide and home management tasks provided to clients of a residential center within living units and provided by management or by providers under contract with the center. Home care aide tasks are differentiated from home health aide and include assisting with dressing, oral hygiene, hair care, grooming and bathing, if the client is ambulatory and has no serious illness or infectious disease, preparing modified diets, medication reminders, household chores in the presence of technically sophisticated medical equipment or episodes of acute illness of infectious disease.

The Medicaid waiver defines services as “supportive services include socialization (when socialization is part of the plan of care, has specific goals and outcomes established and is not diversional or recreational in nature), assisting clients in setting up meetings and appointments, and providing transportation (when provided by the residential center only). Individuals receiving assisted living services will not receive both homemaking and personal care and assisted living services. Individualized means that services are chosen and designed specifically for each resident's needs, rather than provided or offered to all residents regardless of their illness, disabilities or physical conditions.

Under the AC and Waiver programs, residents may also receive home health and skilled nursing which are reimbursed separately from the payment for assisted living services.

Financing

Rates are negotiated between the client and the provider with limits based on the client's case mix classification. Service rates under the AC program cannot exceed the state's share of the average monthly nursing home payment. The client pays for room and board (raw food costs only -- meal preparation is covered as a service). The cost of services in addition to assisted living services may not exceed 75% of the average nursing home payment for the case mix classification. Under the HCBS waiver, rates for assisted living services are also capped at the state share of the average nursing home payment and the total costs, including skilled nursing and home health aide, cannot exceed 100% of the average cost for the client's case mix classification.

Statewide maximum FY 94 rates for elderly recipients ranged from $565 a month to $1330 a month depending upon the case mix classification. Rates in a particular county could be higher or lower than the averages. Rates for participants with physical disabilities ranged from $597 to $1361. These rates are in effect in 1995 (see table).

Medications

Assistance with self-administration is allowed.

Staffing

The Department of Health's standards for home care services licenses do not apply to the building itself.

Minnesota Case Mix Categories and Average Rate Limits

Category	Rate		Description
	Elderly	Disabled	
A	$565	$597	Up to 3 ADL dependencies[1]
B	$638	$671	3 ADLs + behavior
C	$722	$755	3 ADLs + special nursing care
D	$798	$831	4-6 ADLs
E	$876	$9090	4-6 ADLs + behavior
F	$881	$914	4-6 ADLs + special nursing care
G	$948	$980	7-8 ADLs
H	$1073	$1105	7-8 ADLs + behavior
I	$1117	$1150	7-8 = needs total or partial help eating (observation for choking, tube or IV feeding and inappropriate behavior)
J	$1186	$1218	7-8 + total help eating (as above) or severe neuro-muscular diagnosis or behavior problems
K	$1330	$1363	7-8 + special nursing

1. ADLs include bathing, dressing, grooming, eating, bed mobility, transferring, walking and toileting.

NEW JERSEY

General Policy Approach

Regulations took effect in December 1993 governing the provision of assisted living services in assisted living residences and comprehensive personal care homes. The regulations are intended to promote aging in place in homelike, apartment style settings for frail elders. The purpose section of the regulations describes the goals of assisted living to "maintain independence, individuality, privacy, dignity" in an environment that "promotes resident self direction and personal decision making while protecting health and safety."

State policy makers intended to allow the provision of assisted living in a range of settings, including conventional elderly housing projects. Because of conflicts between HUD policy and state licensure, the regulations do not apply to conventional housing. Any facility requiring a license is considered a medical facility under HUD rules and therefore ineligible for HUD subsidies. New Jersey has received a demonstration grant from the Administration on Aging to implement an assisted living service model from which appropriate standards can be developed.

As of February, 1995, 3 facilities have been licensed and 15 proposal were pending.

Definition

Assisted living "means a coordinated array of supportive personal and health services, available 24 hours per day to residents who have been assessed to need these services, including residents who require formal long term care. Assisted living promotes resident self direction and participation in decisions that emphasize independence, individuality, privacy, dignity and homelike surroundings."

Unit Requirements

The regulations define an assisted living residence as "a facility which is licensed by the Department of Health to provide apartment-style housing and congregate dining and to assure that assisted living services are available when needed, for four or more adult persons unrelated to the proprietor." Each unit must offer one unfurnished room (minimum 150 square feet of clear and useable floor area), private bathroom, a kitchenette and a lockable door on the unit entrance. The kitchenette must include a small refrigerator, cabinet for food storage, sink, and space with outlets suitable for cooking appliances such as a microwave, cook top or toaster oven." An additional 80 square feet of floor space must be provided in for each additional person occupying a unit.

Tenant Policy

Assisted living is not appropriate for people who are not capable of responding to their environment, expressing volition, interacting or demonstrating independent activity. Each resident receives an assessment and a care plan by a registered nurse. The residence may, but is not required to, care for people who require 24 hours, seven day a week nursing supervision, are bedridden longer than 14 days, consistently and totally dependent in four or more ADLs, have cognitive decline that interferes with simple decisions, require treatment of stage three or four pressure sores or multiple stage two sores, are a danger to self or others or has a medically unstable condition and/or special health problems. The admission agreement has to specify if the facility will retain residents with one or more of these characteristics and the additional costs which may be charged.

Services

The residence must provide or coordinate services. The minimum service capacity must include personal care, nursing, pharmacy, dining, activities, recreation, and social work services to meet the individual needs of residents.

Financing

State officials are examining options for financing assisted living for low income residents.

Medications

Residences are allowed to provide supervision of and assistance with self-administration of medications and administration by trained and supervised personnel.

Staffing

The regulations require at least one awake staff member and one additional staff at night and sufficient staffing to provide the services indicated by the assessments of resident needs. A registered nurse must be available on staff or on call 24 hours a day. Administrators must either be licensed as a nursing home administrator or complete an assisted living training course approved by the Department of Human Service or equivalent training approved by the Department of Health within one year of their employment as an administrator. In addition they must complete 10 hours of continuing education a year. Personal care assistants must complete a nurses aide training course, a homemaker-home health aide training program or equivalent training approved by the Department of Health.

NEW YORK

General Approach

In 1991, the state legislature created an assisted living program (ALP) and authorized contracting for 4200 units. Since the program substitutes for nursing home beds, the nursing home bed need formula was reduced by an equivalent amount. By 1994, 63 projects totalling 3500 units had been approved through a state contracting process. Fourteen sites are operational. An RFP process has been implemented for 700 units in New York City. The budget submitted by Governor Pataki would repeal the program as part of a proposed Medicaid savings plan.

The state approaches assisted living as a service option in existing housing. Assisted living programs must hold a licensed as an adult home or enriched housing program (which address housing) and a license as a licensed home care services agency or a certified home health agency or a long term home health care agency (which address service delivery).

Oversight is spread among a number of state agencies. The Department of Health reviews licenses for licensed home care agencies and the Department of Social Services licenses adult homes and enriched housing.

Adult homes and enriched housing programs are both licensed under the state's adult care facility regulations. Both models serve five or more people and provide long term residential care, room, board, housekeeping, personal care and supervision. Adult homes represent the state's board and care model while enriched housing programs operate in community integrated settings resembling independent housing units.

Definition

Assisted Living Program (ALP): An entity which is approved to operate pursuant to section 485.6(n) of this Title, and which is established and operated for the purpose of providing long term residential care, room, board, housekeeping, personal care, supervision, and providing or arranging for home health services to five or more eligible adults unrelated to the operator.

Unit

Adult homes provide single or double occupancy bedrooms and have I toilet and lavatory for every six residents and 1 tub/shower for every 10 residents.

Enriched housing programs must provide single occupancy units, unless shared by agreement, and each unit must include a full bathroom, living and dining space, sleeping area and equipment for storing and preparing food. Shared units must provide for toilets, lavatory, shower or tub shared by not more than 3 residents.

Tenant Policy

To receive state reimbursement, tenants must be assessed by a physician to need nursing home care. Participants must have stable medical conditions and are able to assure self-preservation in an emergency. Operators may not serve anyone requiring continual nursing or medical care; is chronically bedfast or chairfast and requires lifting equipment or two person assist for transfer; or is cognitively, physically or medically impaired to a degree which endangers the safety of the resident or other residents.

Services

Adult homes and enriched housing programs can provide supervision, personal care, case management, activities and food service under their adult care facilities license. To operate as an assisted living program, additional services and licenses are needed. The facility may seek a license to provide nursing care and therapies or they may contract with a home health agency or a long term home health care program.

The capitation rate covers personal care, home health aide, personal emergency response, nursing services, physical therapy, occupational therapy, speech therapy, medical supplies that do not require prior authorization and adult day health care, if needed.

A care plan is jointly developed by the ALP and the CHAA/LTHHP which reflects physician's orders and the assessment process.

Financing

Subsidies are available for Medicaid recipients. The service reimbursement is set at 50% of the resident's Resource Utilization Group (RUG) which would have been paid in a nursing home. The state has created RUG rates for 16 geographic areas of the state. There are two groups of RUGs, one for health related services and another for skilled services. Payments based on RUGs for ALP residents (50% of the amount paid in a nursing home) for the four health related categories range from $51.04 to $66.54 a day in New York City to $31.07 to $39.53 in northern rural areas of the state. The rate for skilled nursing RUGs range from$ 74.57 to $104.88 a day in New York City to $43.85 to $60.35 in northern rural areas.

The reimbursement category is determined through a joint assessment by the Assisted Living Program and the designated home health agency or long term home health care program. The assessment and the RUG category are reviewed by the Department of Social Services district office. The residential services (room, board and some personal care) is covered by SSI which also varies by region. In 1994, the SSI rates were $881 in New York City, Nassau, Suffolk and Westchester counties and $851 in the rest of the state.

Medication

Assistance with self-administration is allowed including prompting, identifying the medication for the resident, bringing the medication to the resident, opening containers, positioning the resident, disposing of used supplies and storing the medication.

Staffing

Adult homes must have a case manager and staffing that is sufficient to provide the care needed by residents. Staff providing personal care must complete a home health aide training course or other examination approved by the Department of Health. Adult home staff must provide 3.5 hours of service staff time per resident per week for personal care, 1 hour per resident per week for housekeeping and 2 hours of food service time per resident per week.

Enriched housing programs must staff to provide a total of 6 hours per resident per week for housekeeping, personal care and food service which can be allocated based on aggregate resident needs.

NORTH CAROLINA

General Approach

Legislation (Chapter 535) was passed the end of July, 1995 that converts domiciliary care or rest homes to adult care homes which are called assisted living residences. The law also adds a category of assisted living residence called multi-unit assisted housing with services. The multi-unit assisted housing with services category takes effect July 1, 1996. Emergency regulations are now being drafted. Funding for personal care has been approved effective August 1, 1995.

The legislation was based in part on the work of a 31 member “Steering Team” which made recommendations to the Secretary of the Department of Human Resources. The recommendations would establish assisted living as an umbrella concept that includes a variety of models in two basic categories -- multi-unit independent housing and adult care homes, including family care homes. The Team included state and county agencies, advocacy groups, nursing home, housing and adult care home providers, legislators and others. The group met 9 times between August 1993 and January 1995 and five subcommittees were formed that met regularly between meetings. The Team established four goals for the model:

- assure that adults of all ages and adults with disabilities receive high quality care and services;
- protect individuals' safety and well-being;
- reserve individual rights and dignity; and
- allows diversity in service delivery models.

Quality of care would be assured through the development of outcome measures rather than rules that rely on structure and process.

Definition

“Adult care home” is an assisted living residence in which the housing management provides 24 hour scheduled and unscheduled personal care services to two or more residents, either directly or, for scheduled needs, through formal written agreement with licensed home care or hospice agencies. “Assisted living residence” means a group housing and services program for two or more adults, by whatever name it is called, which makes available, at a minimum, one meal per day and housekeeping services and provides personal care services directly or through a formal written agreement with one or more licensed home care agencies. Assisted living residences are to be distinguished from nursing homes subject to the provisions of G.S. 131E-102. Effective October 1, 1995 there are two types of assisted living residences: adult care homes and group homes for developmentally disabled adults. Effective July 1, 1996, there is a third type, multi-unit assisted housing with services.

Multi-unit assisted housing with services means an assisted living residence in which hands on personal care services and nursing services which are arranged by housing management are provided by a licensed home care or hospice agency, through an individualized written plan of care. Multi-unit assisted housing with service programs are required to register with the Division of Facility Services and to provide a disclosure statement. The disclosure statement is required to be part of the rental greement and covers the emergency response system, charges for services, limitations of tenancy, limitations of services, resident repsonsibilities, the finanacial and legal relationships between the housing management and home care or hospice agencies, an appeals procedure and procedures for initial and annual resident screening and referrals for services.

Unit Requirements

Settings in which services are delivered may include self-contained apartment units or single or shared room units with private or area baths. Residential building codes would apply to adult care homes serving 6 or fewer residents and institutional codes to adult care homes service more than 6 residents.

Tenant Policy

Adult care homes may not care for people who are ventilator dependent, require continuous licensed nursing care, individuals whose physician certifies that that placement is no longer appropriate, individuals whose health needs cannot be met in the specific adult care home as determined by the residence and people with such other medical and functional care needs as the Social Services Commission determines cannot be properly met.

Multi-unit assisted housing with services may not care for people who are ventilator dependent, have dermal ulcers III and IV, except stage III ulvcers that are healing, take psychotropic medications without appropriate diagnosis and treatment plans, have nasogastric tubes except when the individual is capable of independently feeding themself or is managed by a home care or hospice agency, individuals requiring continuous nursing care, and individuals who meet the nursing home level of care criteria, unless the individual's physician determines otherwise.

Services

At a minimum residences must provide one meal a day and housekeeping services. Personal care may be provided directly or through contracts. Nursing services may be provided by the residence on a case by case exception basis apporoved by the Department. However, nursing services can be provided through licensed home care agencies.

Financing

The state budget included funds to pay residences for personal care services (1 hour per day). Residents with impairments on 4 or more ADLs and residents with dementia can receive case management services and up to 50 hours per month in additional personal care services.

Medication

Medications may be administered in adult care homes by designated and trained staff.

Staffing

Not addressed.

NORTH DAKOTA

General Approach

Assisted living is viewed as a service in an apartment setting. The state reimburses assisted living through its Medicaid Home and Community Based Services Waiver and state funded service programs. Licensing is not required however, the public welfare statute contains a definition of assisted living. While only one provider participates in the programs, state officials note that interest from other potential providers has increased. The current site is a mixed population site funded by HUD for people with mobility impairments. The state assisted living programs provides services to residents in fifteen of the twenty apartments.

Definition

An environment where a person lives in an apartment like unit and receives services on a twenty four hour basis to accommodate the person's needs and abilities and maintain as much independence as possible.

Unit Requirements

An apartment setting is required.

Tenant Policy

Participants in the service programs must have needs that can be met through the program. To qualify for services, residents must have impairments in 4 ADLs or impairments in 5 IADLs totalling 8 points (see below) or 6 points if the person lives alone.

Services

The program provides environmental and personal services to participants.

Financing

The state has four sources of financing: an HCBS waiver for the aged, blind and disabled, an HCBS waiver for people with traumatic brain injuries, and two state funded programs -- service payment for elderly and disabled and the exceptional service payment for the elderly and disabled. The programs pay providers a rate based on the care needs of the resident. The maximum rate is $50 a day. A point system is used to convert unmet service functional needs to a rate (see table). The total points are multiplied by a factor of 8 to obtain a monthly payment rate.

Medications

The state's nurse practice act allows assistance with self-administration but not the direct administration except by licensed staff. No separate requirement outside the nurse practice act are included.

Staffing

Must be able to deliver the necessary services required by plans of care.

North Dakota Point System			
Activity		**Value**	
Taking Medication	1	Foot Care	10
Temp\Pulse\Resp\BP	1	Nail Care	10
Managing Money	1	Change Dressings	10
Communication	1	Apply Elastic Bandage	10
Shopping	6	Care of Prosthetic	10
Housework	6	Medical Gases	10
Laundry	6	Meal Preparation	20
Mobility	6	Exercise	20
Transportation	6	Water Bath/Heat	20
Bathing	15	Ostomy Care	20
Teeth/mouth care	15	Bowel Program	20
Dress/undress	15	Indwelling Catheter	20
Toileting	15	Bronchial Drainage	20
Transfer	10	Feeding/eating	20
Continence	15	Supervision Level I	15
Eye Care	10	Supervision Level II	30
Skin Care	10		

OHIO

General Approach

In July 1993, chapter 3726 was signed that created an assisted living program. In April 1994 the Department of Health issued draft regulations and a Medicaid Home and Community Based Services Waiver proposal was submitted to HCFA. Implementation of the program was planned for July 1, 1994. As the process for developing the regulations proceeded, segments of the assisted living and nursing home industries expressed concerns about the model and the direction of the regulations. An amendment was passed that delayed the effective date of regulations pending a review by a special committee consisting of 6 legislators, 4 state agencies 4 provider groups (3 nursing home and 1 assisted living), the Area Agency on Aging Association, the Ombudsman Association, AARP and a taxpayer group.

The task force was created to address opposition to Chapter 3726 and the proposed regulations dealing with the unit requirements, the level of services provided in assisted living and the medical conditions of tenants. While a formal consensus report was not submitted, the governor's budget included several proposals contained in the draft report. The budget bill would repeal the assisted living statute and create a new category of residential care facility to replace the current rest home classification. Residential care facilities would be able to provide up to 120 days of skilled nursing services with exceptions for special diets, medication administration and dressing changes.

The current statute describes a licensing role for the Department of Health to regulate the services provided, and general requirements for the living unit. The policy focuses on the services rather than the setting which must comply with local building codes.

Definition

Chapter 3726 defines an assisted living facility as “a multiple unit residential facility, other than ... that provides or arranges for skilled nursing care for one or more individuals who reside in the facility and are not related to the owner or operator of the facility or his spouse as a parent, grandparent, child, sibling, niece, nephew or child of an aunt or uncle.”

Unit Requirements

The current law specifies that the facility must consist of single occupancy units (unless shared by choice) containing private cooking, bathing, washing, and toilet facilities, has doors that can be locked and individual temperature controls, is equipped with automatic sprinkler equipment. Ile facility must be approved by the local building department rather than the Health Department.

Tenant Policy

Assisted living facilities may not admit anyone who requires skilled nursing care on a 24 hour a day basis or retain a resident for a period longer than is necessary to complete an appropriate transfer. Residents requiring 24 hours of care for more than 30 days, or have medically complex needs requiring constant nursing supervision, assessment, planning or intervention or require direct supervision of licensed nursing personnel may not be served.

The statute allows facilities to serve residents requiring skilled care for up to 120 days. Exceptions to the 120 day Emit allow residents receive dressing changes, special diets and medication administration.

Services

The law provides that an assisted living facility must provide or arrange for services needed or requested be the resident such as skilled nursing care, supervision, personal care services including assistance with self-administration of medications, homemaker services, therapies and other services specified by the Director of the Department of Health. A home and community based services waiver application was submitted, and later withdrawn, to HCFA to finance services for Medicaid recipients. The governor's budget includes funding for waiver services. A new waiver will be submitted following adoption of the budget recommendation.

Financing

The budget proposal includes $4.4 million for the Department of Aging to develop an assisted living program through a Medicaid Home and Community Based Services waiver and to subsidize room and board payments. The Department of Aging has developed a five tiered system for determining the level of reimbursement (see table). Rates will range from $200 to $1400 a month. A residential State Supplement of $700 a month will be paid to cover room and board costs.

Medications

Non-licensed staff may assist with self-administration. Activities include reminders, ob serving, handing medications to the resident, verifying the resident's name on the label, removing oral or topical medications from containers, applying medication upon request, placing containers with medication to the mouth of the resident.

Staffing

At least 1 staff member must be on-site at all times. In addition, sufficient staff time must be available to meeting a timely manner the residents' care, supervisory and emotional needs and reasonable requests for service, including ongoing supervision of residents with increased emotional needs or presenting behaviors that cause problems

for the resident or other residents and to properly provide dietary, housekeeping, laundry and facility maintenance services and recreational activities. An RN, LPN or physician must be on duty when medications are being administered. Staff may be shared with other licensed facilities in the same building or in the same lot as long as staffing requirements for all facilities are met.

Ohio Assisted Living Waiver Service Levels	
Service Level	**Minimum Waiver Service Needs**
One	• Assistance with 2 secondary ADLs
Two	• Assist with 1 primary ADL & 1 secondary ADL; or • Level one + medication administration; or • Level one + behavior management; or • Level one + plus unstable medical condition; or • Level one + daily skilled nursing services not covered under the state Medicaid Plan
Three	• Assist with 4 ADLs (any type); or • Assist with 3 ADLs (including 1 primary ADL) plus medication administration; or • Level two plus behavior management; or • Level two plus unstable medical condition; or • Assist with 3 ADLs (including one primary ADL) plus daily skilled nursing services not covered under the state Medicaid Plan.
Four	• Assist with 5 ADLs (any); or • Assist with 4 ADLs (any) plus medication administration; or • Level three plus behavior management; or • Level three plus unstable medical condition; or • Assist with 4 ADLs (any) plus daily skilled nursing services not covered under the state Medicaid Plan.
Five	• Assist with 5 ADLs plus medication administration AND daily skilled nursing services not covered under the state Medicaid Plan; or • Level four plus behavior management; or • Level four plus unstable medical condition.

OREGON

General Approach

The state has adopted assisted living regulations and policies which encourage the use of the arrangement to substitute for nursing homes and to offer home-like environments which enhance dignity, independence, individuality, privacy, choice and decision making. Facilities are required to have written policies and procedures winch describe how they will operationalize these principles.

Definition

“Assisted living means a program approach, within a physical structure, which provides or coordinates a range of services, available on a 24 hour basis, for support of resident independence in a residential setting. Assisted living promotes resident self-direction and participation in decisions that emphasize choice, dignity, privacy, individuality, independence and home-like surroundings.”

Unit Requirements

Each unit must provide 220 square feet of space, not including a private bathroom. Units in pre-existing structures may provide 180 square feet. Units must have kitchen with a sink, refrigerator, cooking appliance and space for food preparation and storage, individual heat controls, lockable doors and a phone jack. Buildings must meet applicable zoning and building codes.

Tenant Policy

The regulations specify “move out” criteria that allow residents to choose to remain their living environment despite functional decline. Facilities may ask residents to leave if the resident's behavior poses an imminent danger to self or others, if the facility cannot meet the resident's needs or services are not available, non-payment or the resident has a documented pattern of noncompliance with agreements necessary for assisted living.

Services

An interdisciplinary team conducts an assessment with each resident and develop a plan that responds to their needs. Services include assistance with ADLs, nursing assessment, health monitoring, routine nursing tasks, medication assistance, housekeeping, dim meals a day, laundry, and opportunities for socialization that utilizes community resources.

Each facility must also have the capability to provide or arrange for medical and social transportation, ancillary services for medically related care, barber/beauty

services, social/recreational, hospice, home health and maintenance of a personal financial account for residents.

Financing

The state provides five levels of payment for Medicaid recipients residing in assisted living settings. Residents must meet the nursing home level of care criteria. The levels are assigned based on a service priority score determined through an assessment (see table below). ADLs include eating/nutrition, dressing/grooming, bathing/personal hygiene, mobility, bowel and bladder control and behavior.

Service priority ratings are assigned based on the number and type of impairments in ADLs. Service priority A is assigned to people who are dependent in 3-6 ADLs; priority B dependent in 1-2 ADLs (see table).

Oregon Service Priority Categories and Payment Rates		
Impairment Level	**Service Priority**	**Rate**
Level V	Service priority A or priority B and dependent in the behavior ADL.	$1586
Level IV	Service priority B or priority C with assistance required in the behavior ADL.	$1283
Level III	Service priority C or priority D with assistance required in the behavior ADL.	$978
Level II	Service priority D or priority E with assistance required in the behavior ADL.	$736
Level I	Service priority E or F or priority G with assistance required in the behavior ADL.	$553

Medications

The regulations allow residents to keep medications in their unit if they are capable of self-administration. Facilities are allowed to administer medications and they must have policies and procedures which assure all administered medications are reviewed every 90 days.

Staffing

The regulations do not specify staffing requirements. Each facility must have sufficient staff to deliver the services specified in resident plans of care.

Service Priority Categories	
Category	**Impairments**
A	Dependent in 3-6 ADLs
B	Dependent in 1-2 ADLs
C	Requires assistance in 4-6 ADLs
D	Requires assistance in 3 critical ADLs
E	Requires assistance in 2 critical ADLs
F	Requires assistance in 3 ADLs
G	Requires assistance with 1 critical ADL and meets conditions of at least 1 other essential factor or requires assistance with 1 critical ADL and 1 less critical ADL.
NOTE: critical ADLs are bowel and bladder control, eating/nutrition, behavior/cognition; less critical ADLs are dressing/grooming, bathing/personal hygiene, mobility.	

RHODE ISLAND

General Approach

The state's regulations use the term “residential care and assisted living facilities.” Only 45 homes are licensed and about half were previously licensed as ICFs. The program is equivalent to board and care.

Definition

Rhode Island regulations define “residential care and assisted living facility means a publicly or privately operated residence that provides personal assistance lodging and meals to two or more adults who are unrelated to the licensee or administrator, excluding however, any privately operated establishment or facility licensed pursuant to” other statutes.

Unit Requirements

The regulations allow double occupancy. Older homes have shared baths while newer buildings provide private baths in each unit.

Tenant Policy

Two levels of licensing are allowed. Level I cares for residents who are capable of self-preservation, take their own medications and are ambulatory. Level II residents are not capable of self-preservation, need nursing assistance to take medications and require assistance with personal hygiene. Residents needing skilled care cannot be served.

Services

The regulations define personal assistance as 24 hour adult staffing of the home, and of one or more of the following services, as required by the resident or as reasonably requested by the resident, including: assisting the resident with personal needs; self administration of medication, or administration of medications by appropriately licensed staff, assisting in arranging for supportive services, monitoring activities, reasonable recreational, social and personal services. Homes cannot provide skilled care.

Medication

RNs must administer medications and monitor health conditions. Unlicensed staff may only remind residents to take their medications and observe, Staff must have 4 hours of turning by an RN regarding policies and procedures and have passed an exam based on the training.

Staffing

Must be sufficient to provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychological well-being of the residents, according to appropriate level of licensing.

TEXAS

General Approach

Assisted living services are included in the state's Medicaid Home and Community Based Services waiver program.

Definition

Assisted fiving/residential care services provide a 24 hour living arrangement for persons who, because of a physical or mental limitation, are unable to continue independent functioning in their homes. Services are provided in personal care facilities licensed by the Texas Department of Human Services (DHS). In effect the rules recognize 3 types of units provided in licensed personal mm facilities. Nursing facility waiver participants are responsible or their room and board costs and, if applicable, copayment for assisted living/residential care services.

Unit Requirements

The program guidelines differentiate between assisted living apartments, residential care apartments and residential care non-apartments. Assisted living apartments must provide each participant a separate living unit to guarantee their privacy, dignity and independence. Units must include individual living and sleeping areas, a kitchen, bathroom and adequate storage. Units must provide 220 square feet, excluding bath, but units in remodeled buildings may provide 160 square feet. Double occupancy units may be provided if requested.

Residential care apartments must be double occupancy with a connected bedroom, kitchen, and bathroom area providing a minimum of 350 square per client. Indoor common space used by residents may be counted in the square footage requirement. Kitchens must be equipped with a sink, refrigerator, cooking appliance (stove, microwave, built-in surface unit) that can be removed or disconnected and space for food preparation.

Residential care non-apartments is a licensed personal care facility which do not meet either of the above definitions. These units may be double occupancy units in free standing buildings that have 16 or less beds.

Tenant Policy

Not stated.

Services

Services that must be available provided include personal care, administration of home management (housekeeping), escort, 24 hour supervision, social and recreational activities and transportation.

Financing

The Medicaid waiver provides $29.39 a day for services in single occupancy assisted living apartments, $22.96 a day for double occupancy residential cue apartments and $18.99 a day for residential care non-apartments. The SSI payment for room and board is $11.88 a day.

Medications

The waiver rules allow the direct administration of all medications or the assistance with or supervision of medication.

Staffing

Not described.

UTAH

General Approach

The state's regulations establish assisted living as a place of residence where elderly and disabled persons can receive 24 hour individualized personal and health related services to help maintain maximum independence, choice, dignity, privacy, and individuality in a home-like environment. The rules provide for 3 levels of license: large facilities, 15 or more residents; small facilities 6-16 residents; and limited capacity facilities, up to 5 residents.

Program rules have been approved and rules for construction of assisted living facilities were approved March 17th and were expected to be effective by July, 1995.

Definition

HB 201, which was passed during the 1994 legislative session, defines assisted living as “a residential facility with a home-like setting that provides an array of coordinated supportive personal and health care service, available 24 hours per day, to residents who have been assessed under division rule to need any of these services. Each resident shall have a service plan based on the assessment, which may include: specified services of intermittent nursing care, administration of medication, and supportive services promoting residents' independence and self-sufficiency.”

Unit Requirements

A residential living unit means a one or two bedroom unit which may also include a bathroom and additional living space. A maximum of two residents may occupy a resident living unit. Additional living space means a living room, dining space and kitchen facilities, or a combination of these facilities, in a resident living unit. Units must have lockable doors and tenants must have a key.

Facilities providing only bedrooms must provide a toilet and lavatory for every four residents and a bathtub or shower for every 10 residents. Occupancy-units without additional living space must be a minimum of 120 square feet for single occupancy units and 200 square feet for double occupancy units. Bedrooms in units that do provide additional living space must be at least 100 square feet for single units and 160 square feet for double units.

Tenant Policy

Facilities may not serve anyone who requires inpatient hospital care or 24 hour continual nursing care that will last more than 15 calendar days or people who cannot evacuate without physical assistance of one person. Written acceptance, retention and transfer policies are required of each facility. Facilities may not accept anyone who is suicidal, assaultive or a danger to self or others, has active tuberculosis or other

communicable disease that cannot be adequately treated at the facility or on an outpatient basis or may be transmitted to other residents through general daily living.

Physician's statements are required that document the resident’s ability to function in the facility and describing the following information: whether the resident's health condition is stable, free from communicable disease, allergies, diets, current prescribed medications with dose, route, time of administration and assistance required, physical or mental limitations and activity restrictions.

The rules allow pets to be kept if permitted by local ordinances.

Services

Facilities must provide personal care, food service, housekeeping, laundry, maintenance, activity programs, medication administration and assistance with self-administration and arrange for necessary medical and dental care.

Financing

The state plans to amend its Medicaid Home and Community Based Services Waiver in May to add assisted living as a service. Rates for the program have not been developed.

Medications

Facilities are allowed to provide medication administration by licensed staff and assistance with self-medication by unlicensed staff (opening containers, reading instructions, checking dosage against the label, reassuring the resident that the correct dosage was taken and reminding residents that a prescription needs to be refilled.

Staffing

Direct care staff are required on-site 24 hours a day to meet resident needs as determined by assessments and service plans.

VIRGINIA

General Approach

The state is revising its adult care residence (ACR) regulations to include assisted living which is described as a service in ACRs rather than a setting or a building. The summary is based on the draft regulations dated 6/94. The regulations are expected to be finalized and implemented by July, 1995. A Medicaid HCBS waiver win be sought to provide funding for Medicaid recipients when the regulations are finalized.

Definition

Assisted living means a level of service provided by an adult care residence for adults who may physical or mental impairment, and require at least a moderate level of assistance with activities of daily living. Moderate level of assistance means dependency in two or more ADLs.

Unit Requirements

The regulations do not change the unit requirements. ACRs may offer single rooms (minimum 100 square feet for newer buildings) or multiple occupancy rooms (80 square feet per occupant). Facilities must provide one toilet and wash basin for every seven people and one bath tub for every ten people.

Tenant Policy

ACRs cannot admit or retain residents with the following conditions or needs:

- Ventilator dependent
- Dermal ulcers (III or IV)
- Intravenous therapy or injections directly into the vein.
- Airborne infectious disease in a communicable state.
- Psychotropic medications without an appropriate diagnosis and treatment plan.
- Nasogastric tubes/gastric tubes.
- Individuals who present a danger to themselves or others.
- Individuals requiring continuous nursing care.
- Individuals whose physician certifies that placement is no longer appropriate.
- Individuals who require maximum physical assistance as documented by an assessment.
- Individuals whose health care needs cannot be met in the specific ACR.

Public residents must have an assessment completed by a case manager. Assessments for private pay residents may be completed by a case manager, an independent private physician, or an employee of the facility who meets the

qualifications of a case manager and assessments by facility workers must be signed by an independent physician.

Services

The policy offers ACRs the flexibility to develop a program and service plan that meets the following criteria:

- Meet physical, mental, emotional and psycho-social needs,
- Provide protection guidance and supervision;
- Promote a sense of security and self worth; and
- Meet the objectives of the service plan.

Each facility develops a written program description for prospective residents that describes the population to be served and the program components and services available. Facilities are permitted but are not required to offer all services as long as they have services that are appropriate for the needs of residents.

Financing

A service rate of $180 a month to cover personal care services is anticipated. Nursing care would not be covered in the rate.

Medications

Self-administration of medications is allowed although assistance with self-administration is not described in the regulations. Medication administration is permitted when licensed staff are available or a medication training program approved by the board of nursing has been completed.

Staffing

Staffing patterns must be appropriate to deliver the services required by the residents as described in the plans of care.

WASHINGTON

General Approach

The state initiated its assisted living program as a pilot effort in 1 site in 1989. A larger demonstration began in July, 1991. Thirty five facilities, representing 1200 units had signed contracts as of January 1995 and contracts with 14 facilities, with approximately 800 units, were pending. Of the 1200 units, 300 are occupied by Medicaid recipients. The Department of Aging and Adult Services has budgetary authorization to contract for 1030 state funded units. Contracting for new units for Medicaid recipients requires adding capacity through new construction or contracting with existing facilities whose availability varies with resident turn over rates. State policy limits the percentage of units that they will contract for in a facility.

Based on demonstration experience, the Department of Aging and Adult Services has developed draft regulations codifying its contract requirements. Proposed regulations win establish contract requirements. Until regulations are issued, the program requirements are contained in “Assisted Living Facility and Service Contract” between the state agency and facilities which must be licensed under the boarding home rules. The regulations are expected to be finalized by June, 1995.

Definition

“Assisted living means a coordinated array of personal care, health services and other supportive services available 24 hours per day to residents who have been assessed to need these services. Assisted living promotes resident self-direction and participation in decisions that emphasize independence, individuality, privacy, dignity, choice and residential surroundings.”

Unit Requirements

The **contract** requires that facilities provide a home-like environment enhancing the dignity, independence, individuality, privacy, choice and decision-making ability of residents. In addition to meeting boarding homes rules, the **contract** requires that units are private, personally furnished apartments with an accessible shower, kitchen area, lockable door and mail box. Units must be at least 220 square feet and include an interactive communication unit or an emergency response system monitored 24 hours a day. Kitchens must have a refrigerator and a microwave oven or a two burner stove. Each unit must be wired for television and telephone service. Homes built and occupied prior to July 1, 1993 may provide a community kitchen rather than kitchens within each unit. Existing facilities must provide a minimum of 180 square feet.

Tenant Policy

Residents may be required to move when their needs exceeds the services provided through the contract with the state agency; the resident places themself or

others at an unreasonable risk; the resident has failed to make proper payments for services; or the resident requires a level of nursing care that is exceeds what is allowed by the boarding home license.

Services

Facilities must develop a negotiated service plan. Services include personal care, nursing services, social services, consultation (dietician, pharmacist), social/recreational activities, 3 meals, housekeeping and laundry. Nursing services are differentiated by licensure category. RNs or LPNs may provide insertion of catheters, nursing assessments, and glucometer readings. Unlicensed staff may provide the following under supervision of an RN or LPN: stage one skin care, routine ostomy care, enema, catheter care, and wound care. Unlicensed staff may provide assistance with transfer, mobility, hygiene and incontinence.

Financing

Currently, the reimbursement rate for Medicaid recipients who meet the nursing home level of care criteria is $47.37 a day that includes the SSI payment for room and board of $20.31 a day and a Medicaid payment of $27.06 for services. The Aging and Adult Services Division is considering a tiered rate structure with three levels for light, moderate and heavy care. The levels will reflect number and type of ADL impairments and the extent to which mental health and dementia issues affect the intensity of service delivery.

Medications

Medication administration is covered under the boarding homes rules. The boarding home rules allow for reminders, assistance with self-administration and administration of medications by licensed staff. Changes in the nurse practice act to allow nurse delegation is pending in the legislature.

Staffing

RNs or LPNs are required to be available on site 5 hours a day, 7 days a week and on call 24 hours a day to provide services listed in the negotiated service agreements. Other staff must be sufficient to deliver services identified in service agreements. New staff must receive 5 hours of training and monthly in-service on assisted living values and principles.

WISCONSIN

General Approach

An Assisted Living Advisory Committee developed a draft report in 1994 which described an assisted living model for Wisconsin. The legislature amended and passed a proposal submitted by the governor as part of the budget proposal to permit development of assisted living facilities in the state. The legislation provides for the certification of assisted living facilities under rules to be submitted by December 1, 1995 to the Department of Administration and to the joint legislative council by January 1, 1996. The program would be effective in July 1996.

The draft report emphasized a philosophy that is the basis of the long term care system called RESPECT (relationships, empowerment to make choice, services to meet individual needs, physical and mental health services, enhancement of participant reputation, community and family participation and tools for independence).

Definition

A place where five or more adults reside that consists of independent apartments, each of which has an individual lockable entrance and exit, a separate kitchen, including a stove, and individual bathroom, sleeping and living areas, and that provides, to a person who resides in the place, not more than 28 hours per week of services that are supportive, personal and nursing services. Assisted living facility does not include a nursing home or a community-based residential facility, but may be physically part of a structure that is a nursing home or community based residential facility.

Unit Requirements

As stated in the definition, the proposal will require individual apartments.

Tenant Policy

The legislation requires the development of a mutually agreed upon service agreement and signing of a negotiated risk agreement that identifies situations which could put the resident at risk and for which the resident understands and accepts responsibility.

State funding would be provided to Medicaid recipients who meet the nursing home level of care criteria through the Medicaid Community Options Program Waiver (COP-W) and the Community Integration Program (CIP). CIP funding is only available when nursing home beds are closed and funding is transferred to provide community care to replace the closed capacity. The legislation addresses the type of resident who may be served through the 28 hour per week cap on services. Tenants needing more care could not be supported in assisted living. The regulations that will be developed

may address the types of residents who may be served as opposed to the amount of reimbursement that will be provided for Medicaid tenants.

The advisory committee report set the 28 hour threshold as the minimum service need before a facility could discharge a resident although facilities choose to serve residents requiring more than 28 hours of service.

The draft report from the advisory committee recommended that facilities be allowed, but not required to, deny admission to people with chronically unstable medical conditions which require the availability of a nurse 24 hours a day; residents who are unable to recognize danger; residents who require hands on assistance with eating or swallowing; require two person transfer; are incontinent and cannot self-manage or control their incontinence through a reasonable schedule of reminders and/or toileting assistance; ventilator dependent; and other conditions. Facilities may care for people with such conditions if they are adequately staffed to do so.

Services

The budget legislation sets a limit of 28 hours a week for supportive nursing and personal care services. However, the advisory committee concluded that assisted living residents may require more care than people in the community and the threshold was devised to prevent facilities from discharging residents prematurely. The threshold was developed based on an analysis of the amount of care required by participants in the state's Community Options (Medicaid Waiver) program and the Community Integration Program and reflects a higher level of care than the average community client. Rules defining supportive services and nursing services will be developed for purposes of reimbursement.

The draft report recommended the following as required services: housekeeping, laundry, three meals a day, personal care, assistance with transferring, mobility assistance, provide or arrange of transportation, nursing assessment, evaluation and supervision, medical administration and monitoring, nursing care sufficient to meet resident needs within parameters of discharge criteria, social and recreational services, psycho-social support/intervention, behavior symptom management, opportunities for community activities, personal emergency response, information and referral and arrangement of other services (financial management, therapy, counseling).

Financing

The bill limits state reimbursement to 85% of the average statewide Medicaid nursing home rate excluding room and board. The statewide average rate for services in 1993-1994 was $1215 to $1308. Rates would be established each year by July 1st. The Department of Health and Social Services would be responsible for developing the rates which have to be approved by the Department of Administration. State officials are planning to develop a tiered rate structure that reflects varying service needs. Facilities would be reimbursed as waiver slots are available.

Medications

The draft report would have allowed assistance with self-administration and administration of medications by appropriate staff.

Staffing

The draft report would require that providers submit staffing plans which would be approved by the Department of Health and Social Services. Minimum standards would require 24 awake staff, full time administrator/manager, sufficient staff to meet resident needs as identified in plans of care, licensed or certified staff to provide or arrange for nursing, dietary evaluation and services and pharmaceutical services. Cross training of staff to provide personal care, basic nursing care, cooking, laundry, housekeeping and other services would be encouraged.

WYOMING

General Approach

In 1992, the Director of the Department of Health formed a task force to determine bow board and care homes can be established as low cost options in the continuum of care for the elderly. The task force reviewed who qualifies, current and future needs, existing and potential resources and cost reimbursement options. The task force included state agencies including the housing agency, ombudsman, consumer advocacy (AARP), home health agencies, not-for-profit nursing homes, board and care homes, and domiciliary care homes. The group's report was issued in October, 1992. In 1993, the legislature passed a definition of assisted living that allowed limited nursing care to be provided. Regulations were effective in October 1994 that re-name and modify the board and care licensure category. Board and care facilities can also be licensed as an assisted living facility in order to provide limited skilled nursing services and medication administration.

Definition

The statute defines assisted living as “a dwelling operated by any person, firm or corporation engaged in providing limited nursing care, personal care and boarding home care, but not habilitative care, for persons not related to the owner of the facility.” Boarding home care means a dwelling or rooming house operated by any person, firm or corporation engaged in the business of operating a home for the purpose of letting rooms for rent and providing meals and personal daily living care, but not habilitative or nursing care, or personal not related to the owner.

Unit Requirements

A maximum of 2 people may share a bedroom. Bedrooms include toilets and sinks. One tub and shower rooms are required for every 10 residents.

Tenant Policy

The regulations now allow residents who need limited nursing to be served. Previously, residents needing skilled nursing had to transfer to a nursing facility. However, residents who wander or need wound care, stage II skin care, are incontinent or need total assistance with bathing and dressing, continuous assistance with transfer and mobility may not be served.

Services

The facility must describe the services provided and the charges for services. Facilities must provide meals, housekeeping, personal and other laundry service, assistance with transportation, assistance obtaining medical, dental and optometric care and social services, partial assistance with personal care, limited assistance with

dressing, minor non-sterile dressing changes, stage I skin care, infrequent assistance with mobility, cuing for ADLs with visually impaired residents and intermittently confused and/or agitated residents requiring occasional reminders to time, place and person, care for residents who care for their own catheter/ostomy without assistance, care for residents who are incontinent but care for themselves, RN assessments and medication review, and 24 hour supervision.

Services that may not be provided in assisted living include continuous assistance with transfer and mobility, care for residents who cannot feed themselves independently, total assistance with bathing or dressing, provision of catheter or ostomy care, care of residents who is on continuous oxygen if monitoring is required, residents whose medical condition requires more than 7 days bedrest, residents who wander, stage II skin care and beyond, wound care, incontinence care.

Financing

The task force report recommended that the Wyoming Department of Commerce be authorized to make loans to finance the development, remodeling and construction of board and care and/or assisted living facilities in underserved communities. No subsidies are available for low income residents.

Medications

The new regulations allow assistance with self-administration which includes but is not limited to reminders, removing from containers, assistance with removing caps, and observing the resident take the medication.

NATIONAL STUDY OF ASSISTED LIVING FOR THE FRAIL ELDERLY

Reports Available

A National Study of Assisted Living for the Frail Elderly: Discharged Residents Telephone Survey Data Collection and Sampling Report

HTML	http://aspe.hhs.gov/daltcp/reports/drtelesy.htm
PDF	http://aspe.hhs.gov/daltcp/reports/drtelesy.pdf

A National Study of Assisted Living for the Frail Elderly: Final Sampling and Weighting Report

HTML	http://aspe.hhs.gov/daltcp/reports/sampweig.htm
PDF	http://aspe.hhs.gov/daltcp/reports/sampweig.pdf

A National Study of Assisted Living for the Frail Elderly: Final Summary Report

HTML	http://aspe.hhs.gov/daltcp/reports/finales.htm
PDF	http://aspe.hhs.gov/daltcp/reports/finales.pdf

A National Study of Assisted Living for the Frail Elderly: Report on In-Depth Interviews with Developers

Executive Summary	http://aspe.hhs.gov/daltcp/reports/indpthes.htm
HTML	http://aspe.hhs.gov/daltcp/reports/indepth.htm
PDF	http://aspe.hhs.gov/daltcp/reports/indepth.pdf

A National Study of Assisted Living for the Frail Elderly: Results of a National Study of Facilities

Executive Summary	http://aspe.hhs.gov/daltcp/reports/facreses.htm
HTML	http://aspe.hhs.gov/daltcp/reports/facres.htm
PDF	http://aspe.hhs.gov/daltcp/reports/facres.pdf

Assisted Living Policy and Regulation: State Survey

HTML	http://aspe.hhs.gov/daltcp/reports/stasvyes.htm
PDF	http://aspe.hhs.gov/daltcp/reports/stasvyes.pdf

Differences Among Services and Policies in High Privacy or High Service Assisted Living Facilities

HTML	http://aspe.hhs.gov/daltcp/reports/2000/alfdiff.htm
PDF	http://aspe.hhs.gov/daltcp/reports/2000/alfdiff.pdf

Family Members' Views: What is Quality in Assisted Living Facilities Providing Care to People with Dementia?

Executive Summary	http://aspe.hhs.gov/daltcp/reports/1997/fmviewses.htm
HTML	http://aspe.hhs.gov/daltcp/reports/1997/fmviews.htm
PDF	http://aspe.hhs.gov/daltcp/reports/1997/fmviews.pdf

Guide to Assisted Living and State Policy

Executive Summary	http://aspe.hhs.gov/daltcp/reports/1995/alspguidees.htm
HTML	http://aspe.hhs.gov/daltcp/reports/1995/alspguide.htm
PDF	http://aspe.hhs.gov/daltcp/reports/1995/alspguide.pdf

High Service or High Privacy Assisted Living Facilities, Their Residents and Staff: Results from a National Survey

Executive Summary	http://aspe.hhs.gov/daltcp/reports/hshpes.htm
HTML	http://aspe.hhs.gov/daltcp/reports/hshp.htm
PDF	http://aspe.hhs.gov/daltcp/reports/hshp.pdf

National Study of Assisted Living for the Frail Elderly: Literature Review Update

Abstract HTML	http://aspe.hhs.gov/daltcp/reports/ablitrev.htm
Abstract PDF	http://aspe.hhs.gov/daltcp/reports/ablitrev.pdf
HTML	http://aspe.hhs.gov/daltcp/reports/litrev.htm
PDF	http://aspe.hhs.gov/daltcp/reports/litrev.pdf

Residents Leaving Assisted Living: Descriptive and Analytic Results from a National Survey

Executive Summary	http://aspe.hhs.gov/daltcp/reports/2000/alresdes.htm
HTML	http://aspe.hhs.gov/daltcp/reports/2000/alresid.htm
PDF	http://aspe.hhs.gov/daltcp/reports/2000/alresid.pdf

State Assisted Living Policy: 1996

Executive Summary	http://aspe.hhs.gov/daltcp/reports/96states.htm
HTML	http://aspe.hhs.gov/daltcp/reports/96state.htm
PDF	http://aspe.hhs.gov/daltcp/reports/96state.pdf

State Assisted Living Policy: 1998

Executive Summary	http://aspe.hhs.gov/daltcp/reports/1998/98states.htm
HTML	http://aspe.hhs.gov/daltcp/reports/1998/98state.htm
PDF	http://aspe.hhs.gov/daltcp/reports/1998/98state.pdf

Instruments Available

Assisted Living Discharged Resident Telephone Interview

HTML	http://aspe.hhs.gov/daltcp/instruments/ALDRTI.htm
PDF	http://aspe.hhs.gov/daltcp/instruments/ALDRTI.pdf

Assisted Living Discharged Resident Proxy Respondent Telephone Interview

HTML	http://aspe.hhs.gov/daltcp/instruments/ALDRPRTI.htm
PDF	http://aspe.hhs.gov/daltcp/instruments/ALDRPRTI.pdf

Facility Screening Questionnaire

HTML	http://aspe.hhs.gov/daltcp/instruments/FacScQ.htm
PDF	http://aspe.hhs.gov/daltcp/instruments/FacScQ.pdf

To obtain a printed copy of this report, send the full report title and your mailing information to:

U.S. Department of Health and Human Services
Office of Disability, Aging and Long-Term Care Policy
Room 424E, H.H. Humphrey Building
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Washington, D.C. 20201
FAX: 202-401-7733
Email: webmaster.DALTCP@hhs.gov

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Assistant Secretary for Planning and Evaluation (ASPE) Home
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