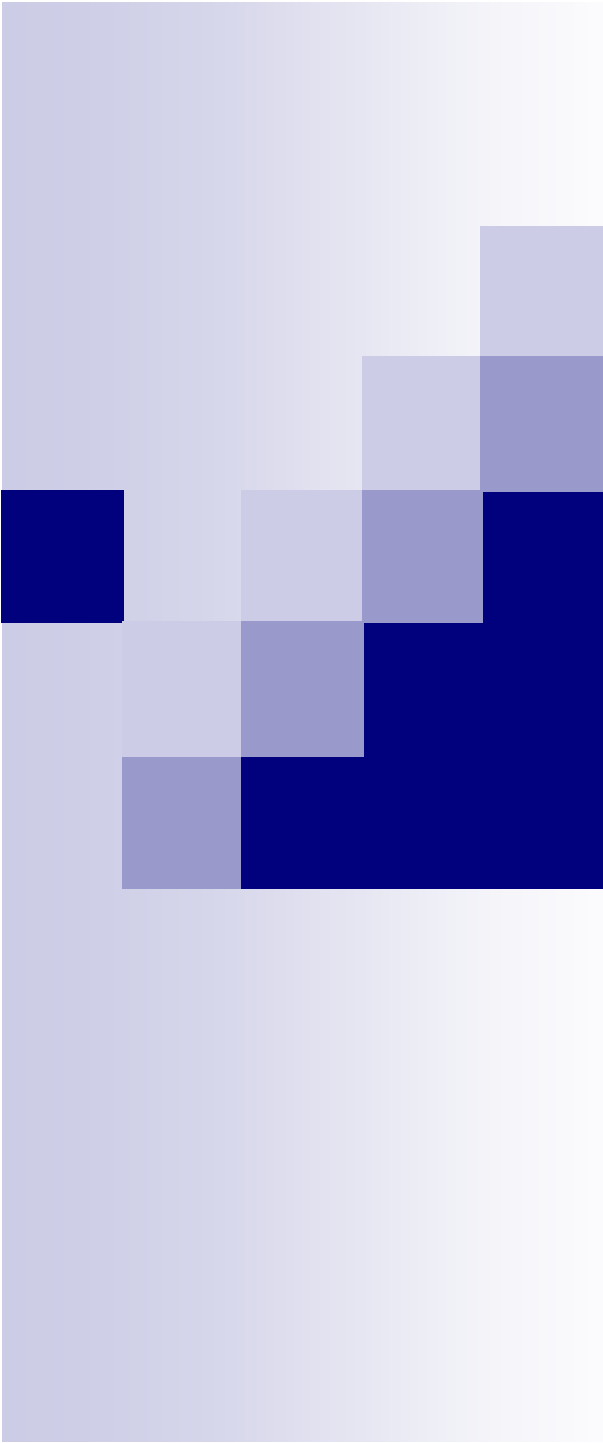




# Assisted Living

Policy and  
Advocacy Issues



# Introduction to Assisted Living Facilities



# Assisted Living Residences

Data from ALFA, ASHA, AAHSA, NCAL & NIC  
*2009 Overview of Assisted Living*

- Average years open = 13.3
- Properties have an average 54 units.
- Average monthly cost = \$3,022 or \$36,264 annual (single occupancy.)
- Average monthly cost dementia care unit = \$4,200.
- Ownership of operating units
  - 59% Private For Profit
  - 12.6% Publicly Held For Profit
  - 25.7% Non-profit
  - 1.3% Government sponsored
- 97% Sprinkled in common areas & 96% sprinkled in all rooms.
- 100% Smoke detectors in common areas & 99% in all rooms.



# Assisted Living Residents

Data from ALFA, ASHA, AAHSA, NCAL & NIC  
*2009 Overview of Assisted Living*

- **Average Age = 86.9**
- **Average Age at Move-in = 84.6**
- **73.6% Female; 26.4% Male**
- **Average Income = \$27,260**
- **Average Assets (including home) = \$431,020**
- **Median Income = \$18,972**
- **Median Assets (including home) = \$205,000**



# Prior Residence

Data from ALFA, ASHA, AAHSA, NCAL & NIC  
*2009 Overview of Assisted Living*

- **Private home/apartment**                      **70%**
- **Nursing home**                                      **9%**
- **Retirement/IL**                                      **9%**
- **Family residence**                                      **7%**
- **Different ALF or group home**                      **5%**



# Assisted Living Residents

**Data from ALFA, ASHA, AAHSA, NCAL & NIC  
*2009 Overview of Assisted Living***

- **Average Length of Stay = 28.3 months**
- **Median Length of Stay = 21 months**
- **Average annual resident turnover = 42%**
- **62% within 10 miles of their previous residence.**
- **22% of residents made the decision to move independently; 49% partially involved; others made the decision for resident 25% of the time.**



# Health Conditions

Data from ALFA, ASHA, AAHSA, NCAL & NIC  
*2009 Overview of Assisted Living*

▪ Hypertension	66%
▪ Arthritis	42%
▪ Alzheimer's/Dementia	38%
▪ Coronary Heart Disease	33%
▪ Depression	30%
▪ Osteoporosis	27%
▪ Macular Deg./Glaucoma	19%
▪ Diabetes	17%
▪ Stroke	14%



# ADL Dependence

ALF Data from 2009 ALFA, ASHA, AAHSA, NCAL & NIC Survey

<u>ADL</u>	<u>ALF</u>	<u>NF</u>
■ Bathing	64%	96%
■ Dressing	39%	90%
■ Toileting	26%	84%
■ Transfer	19%	80%
■ Eating	12%	53%
■ <b>81% of ALF residents need help with meds.</b> (Average 9.9 meds daily – 7.6 prescriptions and 2.3 OTCs)		





# Other Care Issues

Data from ALFA, ASHA, AAHSA, NCAL & NIC  
*2009 Overview of Assisted Living*

- Residents need assistance with 4.5 IADLs on average with 4 out of 5 needing help with housework, laundry, medications, transportation and meal preparation
- 54% use a walking device (cane, walker, etc.) and 22% use a wheelchair
- 31% bladder incontinent; 14% bowel incontinent
- 92% of communities arrange for /provide hospice care



# Residents Moving Out

Data from ALFA, ASHA, AAHSA, NCAL & NIC  
*2009 Overview of Assisted Living*

- Nursing home 59%
- Home 9%
- Another ALF 11%
- Relative's home 5%
- Hospital (other than short term) 7%
- Independent living 4%
- Hospice 2%
- Other 4%

**One-third (33%) of residents die in the assisted living setting.**



# Three Federal Agencies Working on National Assisted Living Study

- **Largest examination of assisted living by the Federal Government**
  - Pilot Tested in 2009
  - National Field Survey in 2010
  - Findings Published in 2011
  
- **Agencies involved include:**
  - Office of the Assistant Secretary for Planning and Evaluation (ASPE)
  - National Center for Health Statistics (NCHS/CDC)
  - Agency for Healthcare Research & Quality (AHRQ)



# Consumer Advocacy Issues



# Issues for the Assisted Living Consumer Alliance (ALCA)

## 10 Principles for assisted living reform

- New laws, policies, and practices to protect residents
- Assisted living defined in a meaningful way
- Standards appropriate to the resident population
- Admissions contracts not taking unfair advantage of residents
- Assisted living facilities required to make reasonable accommodation to allow residents to remain



# Issues for ALCA (cont'd)

## 10 Principles for assisted living reform (cont'd)

- Medicaid-eligible applicants and residents treated fairly
- Vigorous enforcement of existing laws to protect residents from discrimination on the basis of disability
- State laws allowing private enforcement
- Strengthened state oversight of assisted living
- Strengthened federal oversight of assisted living



# Issues for ALCA

- Fairness for Medicaid residents in assisted living
  - Position Paper #1 calls for federal legislation to protect residents whose facility terminates its Medicaid participation
- Mandatory arbitration
  - Position Paper #2 opposes mandatory arbitration agreements



# Medicaid Payment for Assisted Living






# Medicaid Eligibility

- No-Share-of-Cost
  - SSI
  - SSI & State Supplement (optional)
- Special Income Group
  - Generally income  $\leq$  300% of federal SSI.
  - Post-eligibility payment for health care.
- Medically-Needy
  - Extra income paid towards health care



# Special Income Limit

- \$2,022 for 2009
- Over-income persons can obtain eligibility through qualified income trusts.
  - Qualified income trusts authorized statutorily for nursing facility care.
  - Generally allowed in waivers also.



## Post-Eligibility Calculations Often Linked to SSI rate

- 2008 date: SSI of \$637 per month
- Illinois - \$547, \$90 PNA
- Texas - \$552, \$85 PNA
- Washington - \$574.21, \$62.79 PNA
- Arkansas - \$579, \$58 PNA
- Ohio - \$587, \$50 PNA



# Some States Higher

- Minnesota - \$865, \$89 PNA
- Vermont - \$685.38, \$60 PNA
  - With more income, resident has 15% of available income.
    - Resident with \$800 retains \$120 and pays \$680.
    - Resident with \$950 (maximum allowed under both post-eligibility calculations and medically-needy spend-down) retains \$142.50 and pays \$807.50.



# Wisconsin Varies with Room and Board Costs

- Income allowance was \$817 but could be increased to the extent that housing costs exceeded \$350.
  - “Housing” costs are only part of facility’s room and board charge.



# Medically-Needy Eligibility

- Too much income to be categorically eligible, but can become eligible by paying extra income.
- Income standards tend to be low, tied down by relationship to 133 % of 1996 AFDC level.
  - Often less than SSI.



# Income Deductions Available Since 2001

- State may not limit deductions only to waiver beneficiaries, or only to persons in institutions.
- Targeting can only be based on eligibility groups such as the medically-needy aged.
- State then faces significant financial ramifications.



# Deductions May Be Limited In Practice

- State can employ deduction that necessarily will apply exclusively (or almost exclusively) to specific waiver settings.
  - Disregard specific kinds of income.
  - Disregard income used for a particular purpose.
    - CMS examples:
      - Medical savings account.
      - Maintain or repair home.






# Few States With Medically-Needy Eligibility

- Some states with no deductions:
  - Wisconsin - \$591.67 monthly (since at least 2001)
  - Minnesota - 75% of the federal poverty level; \$650 in 2008
  - Montana - \$545, including \$100 PNA



# Some States Offer Income Deductions

- Washington - \$467, but with income deduction to raise effective level to SSI rate.
- Vermont - \$950, due to
  - Grandfathering from previous demonstration waiver.
  - Income deduction to factor in cost of living increases since 1996.



# Protections Against Spousal Impoverishment

- Concept comes from nursing facility eligibility standards.
  - Resources: At-home spouse can keep minimum of \$21,912 to \$109,560, depending on state, or one-half of total, up to \$109,560.
  - Income: At-home spouse can keep \$1,822 to \$2,739, depending on state, or up to \$2,739 if necessary to cover excess housing costs.



# Most Waivers Included Spousal Impoverishment Protections

- States tended to protect both income and resources, but with the allocations set at the low end of the federally-set range.
- Allocations generally were consistent with the allocations offered by the state for nursing facility care.




# Why Spousal Impoverishment Protections Are Less Effective

- Resident has to spend towards room and board.
  - Resident has less money to allocate to at-home spouse, because it must be spent towards room and board.
  - NF resident might have income allocation of \$50, while assisted living resident is more likely to have \$637 or more.



# Washington Response to Problem

- State-only money pays facility for room and board, leaving more for the resident to allocate to at-home spouse.
- Resident must request “exception to rule” from state.
  - Exception process evidently is used so as not to tie state’s hands in event of budgetary problems.



# Is Facility Required to Accept Designated Amount?

- Colorado, Indiana, Vermont, require that room and board allocation be accepted as payment in full.



# Limited Exceptions

## ■ Texas

- Extra charge only for item or service not covered by Medicaid.
- Item or service must be authorized in writing.
  - Examples: private telephone, personal reading material, or alternative food.





## Other States Argue Requirements Are Unnecessary

- Arkansas, Wisconsin, and others argue that residents' limited incomes put practical cap on amount that facilities can charge.



# National Assisted Living Medicaid Payment and Policy Study

**“State Medicaid Reimbursement Policies  
and Practices in Assisted Living,”  
September, 2009, by Robert Mollica.**

Available at [www.NCAL.org](http://www.NCAL.org).



# NCAL Medicaid Payment & Policy Study

## Key Findings:

- **AL Medicaid coverage is growing again (9% between '07 and '09) after drop between '04 and '07 -- now about 131,000 nationally.**
- **37 states use 1915(c) HCBS waivers; 13 provide coverage directly under state Medicaid state plan; 4 include it 1115 demonstration programs; and 6 use state general revenues. States may use more than one funding source.**



# NCAL Medicaid Payment & Policy Study

- Tiered rates the most common methodology for reimbursing assisted living providers (19 states). Flat rates are used in 17 states.
- 23 states cap the amount that may be charged for room and board.
- 24 states supplement the beneficiary's federal Supplemental Security Income (SSI) payment of \$674, which states typically use as the basis for room and board payment. SSI combined with state supplements ranges from \$722 to \$1,350 a month depending on the state. Some states provide no supplement.



# NCAL Medicaid Payment & Policy Study

- **25 states permit family members or third parties to supplement room and board charges.**
- **23 states require apartment style units; 40 allow units to be shared; and 24 allow sharing by choice of the residents.**
- **Screening for mental health needs is performed by case managers and assisted living community staff in 9 states; by case managers only, in 10 states; and by assisted living staff only, in 9 states.**
- **Mental health services are arranged by assisted living communities in 16 states; case managers in 20 states; and may be provided directly by assisted living communities in 3 states.**



# Level of Care



# “Assisted Living Level of Care” Can Be Elusive Concept

Two problems:

- Law varies from state to state.
- Definitions tend to be written in general language.



# What Can Be Provided versus What Must Be Provided

- Level of care ceilings generally have been raised.
- But regulations generally do not require facilities to provide services up to the regulatory ceiling.





# Can Contracts Provide the Answers?

- Illinois says “yes”:
  - “Assisted living, which promotes resident choice, autonomy, and decision-making, should be based on a contract model designed to result in a negotiated agreement . . . . This model assumes that residents are able to direct services provided for them and will designate a representative to direct these services if they themselves are unable to do so. This model supports the principle that **there is an acceptable balance between consumer protection and resident willingness to accept risk and that most consumers are competent to make their own judgments about the services they are obtaining.**”



# Disclosure Requirements Are Common

- Texas, Washington, & others have state-developed forms.
- Most commonly, format of disclosure is within facility's discretion.
- Alzheimer's Ass'n has emphasized disclosure of facilities' dementia care.



# Levels of Care

16 states recognize more than one level.

- Two or three levels
- Higher levels reflect greater health care capabilities




# The Case in Favor of Multi-Level Systems

- Different types of facilities require different types of standards.
- When licensing standards are drawn in a one-size-fits-all model, standards tend to drop to the lower common denominator.
- A facility can retain residents by licensing at the highest level.



# The Case Against Multi-Level Systems

- By pigeonholing residents into specific regulatory boxes, multi-level systems force residents to move multiple times.
- Flexible licensing standards allow assisted living facilities to adjust services as necessary.



# In Reality, All Systems Are Multi-Level

- Two options:
  - Levels Set By State
  - Levels Set By Individual Facility



## Exception for Care Provided by Home Health Agency

- Twenty-one states have such an exception.
  - This underestimates the prevalence of home health services, which often are provided without an exception.
- Exception may or may not be limited to specific procedures.
- **Q:** Does facility have health care expertise itself?



## Exception for Care Provided by Hospice Agency

- Twenty-two states have an exception for terminally-ill residents receiving hospice services.
- Two justifications:
  - Fairness to dying person
  - Extensive array of services provided by hospice agency





## “Private” Exceptions: State Is Not Involved

- Fourteen states have private exceptions of one sort or another.
- Private exceptions usually apply to retention but not admission.
- Consent of physician may or may not be required.



# Private Exceptions: Pros & Cons

- Pro: State should not stand in the way of an arrangement that is acceptable to the parties involved.
- Con: State standards are beneficial to all concerned. Routine use of private exceptions undermines the effectiveness of state quality-of-care standards.



# Facility Consent Required: Pros & Cons

- Pro: Resident is at risk if facility can't provide adequate care.
- Con: Facility could provide adequate care, but has chosen to not make the effort. Facility might be trying to get rid of residents who are less appealing physically, or whose care is more time-consuming.



# ADA Requires Facilities to Meet Care Needs

- In 1980's and 1990's, gov'ts were defendants in cases alleging that persons with disabilities were excluded from facilities.
- Now, gov'ts have ceded discretion to facilities, so facilities are potentially liable.



# Potential Facility Defenses to ADA Claim

- Medical decisions are not subject to ADA second-guessing.
  - **But** admission/discharge decisions are administrative, not medical.
- Facilities should be able to choose a specialization, and not be required to undergo a “fundamental alteration.”
  - **But** character of facility is set by license, rather than by facility’s supposed specialization.



# Negotiated Risk

- Meaning of term is hopelessly confused.
  - Allowing resident to stay although facility cannot meet resident's needs?, or
  - Documenting resident's decision to act against facility advice (e.g., diabetic eating chocolate cake)?
    - See Eric Carlson, *Protecting Rights or Waiving Them? Why 'Negotiated Risk' Should Be Removed From Assisted Living Law*, 20 J. Health Care L. & Pol'y 287.

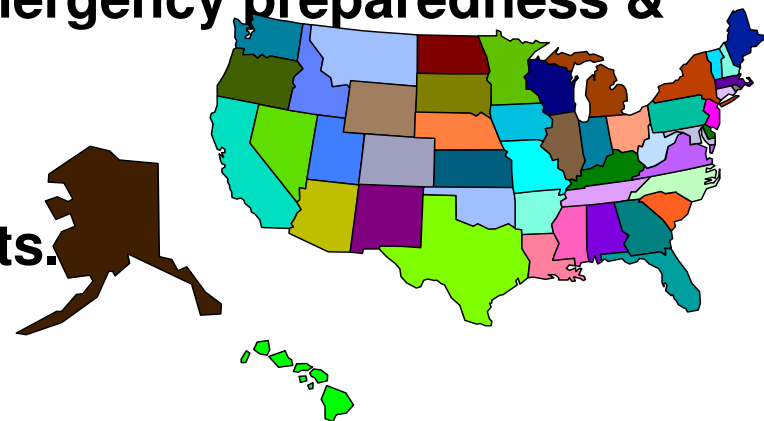


# Assisted Living Regulatory Trends

**“Assisted Living State Regulatory Review 2009,” National Center for Assisted Living**

# State Regulatory Trends

- State regulation of assisted living continues to evolve.
- Changes to accommodate more intense resident health and chronic care needs.
- Higher standards for Alzheimer's/dementia care.
- Multi-level licensure systems.
- Fire safety, disease control, emergency preparedness & incident reporting.
- Disclosure requirements.
- Staff training and resident rights.







# 2009 NCAL Regulatory Review

## ■ 2008 trends include:

- **Changes to emergency/disaster preparedness and fire safety standards (including CA, CO, MD, MO, MS, OK, VA);**
- **Increased staff training requirements (including CO, CT, MD, VA, WA);**
- **Increased or modified medication management standards (including MD, NJ, RI, VA);**
- **Added or changed background check requirements (including GA, MD, MS, WA);**
- **Added disclosure standards (incl. CA, CO, MD);**
- **Added staffing requirements (including MD, MO).**



# 2009 NCAL Regulatory Review

- **In the state of Washington, new law requires boarding homes withdrawing from the Medicaid program to continue to provide Medicaid services to existing Medicaid residents and to residents who have been paying privately for at least two years and who become eligible for Medicaid within 180 days of the withdrawal.**
  - **However, a federal district court ruled Jan. 14, 2009 that the law's provisions were unconstitutional under the Contract Clause of the U.S. Constitution for provider agreements in effect March 28, 2008, when the law was passed; the law remains in effect for provider agreements entered into after March 28 2008**



# Proposed Rulemaking By HHS



# Medicaid Home and Community-Based Waivers

- Advance Notice of Proposed Rulemaking, 74 Federal Register 29,453 (June 22, 2009)
  - Combine or eliminate three permitted waiver categories (aged or disabled, or both; mentally retarded or developmentally disabled, or both; mentally ill)
  - Most effective way to define home and community



# Staffing



# Mandatory Topics

- 37 states require that initial training include certain topics.



# List of Topics Tend to Be Long and General

- *e.g.*, Colorado
- Initial training:
  - Orientation,
  - Training specific to the particular needs of the populations served,
  - Resident rights,
  - First aid and injury response,
  - Care and services for the current residents,
  - Facility's medication administration program.
- Within one month of hire:
  - Assessment skills,
  - Infection control,
  - Identifying and dealing with difficult situations and behaviors,
  - Resident rights, and
  - Health emergency response.



# Some States Require Minimum Number of Hours for Initial Training

- 12 or fewer hours – 5 states
- 13 to 24 hours – 4 states
- 25 or more hours – 10 states





## Facility Generally Has Great Discretion in Conducting Training

- 9 states require certain qualifications of person conducting training.
- 6 states have some control over curriculum content.
- 5 states require passage of competency examination.



# Nurse Participation

- 26 states require that facilities employ or contract with nurses.
  - Generally nurse is not required to be present at facility on a regular basis.



# Nurse Delegation Is Increasingly Common

- 21 states allow non-nurses to administer medication in assisted living.
- 6 states have authorizations beyond medication administration for care provided by non-nurses.



# Medication Administration Presents Difficulties in Assisted Living

- Two general approaches:
  - Allow non-nurses to “assist with self-administration of medication,” and use broad definition of “assistance with self-administration”
  - Nurse delegation (medication aides, med techs, etc.)



# Nurse Delegation: Pros & Cons

- Pro: The use of nurses is cost-prohibitive for assisted living. If non-nurses are to administer medication, it should be done honestly, with reasonable standards. Studies have shown good results for nurse delegation.
- Con: Non-nurses can't do an adequate job. Why should nurse practice acts be relaxed only for assisted living residents? This is a slippery slope towards substandard care.



# Staffing Levels

- 43 states require that staffing levels be adequate.
- 18 states set minimum staffing ratios.
  - The approximate middle ground is a ratio of 1 to 15 during the day, and 1 to 25 at night.
  - Staffing levels may be less than they initially appear, since direct-care staff often is involved in laundry, housekeeping, etc.



# Questions?

- Eric Carlson

- National Senior Citizens Law Center

- Toby Edelman

- Center for Medicare Advocacy

- Karl Polzer

- National Center for Assisted Living