Legislative Budget and Finance Committee

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State Efforts to Fund Assisted Living Services

Prepared Pursuant to Act 2007-56

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Report Summary

Act 2007-56 directed the Legislative Budget and Finance Committee (LB&FC) to report on existing federal and state programs to provide financial assistance for assisted living services, including information on effectively administered model programs. The Act required the report be prepared for a select committee consisting of members of the Aging and Youth Committee of the Senate and the Aging and Older Adult Services Committee of the House of Representatives to develop a proposal to publicly fund assisted living in the Commonwealth.

States that fund "assisted living services" use the term broadly to refer to health, personal and supportive services for elderly and adult physically disabled persons in community residential settings. States (and the District of Columbia) fund assisted living services for elderly and adult physically disabled individuals in a variety of ways, including Medicaid, optional state SSI supplement, and other state programs. As shown in the Exhibit below, all but two states (Louisiana and Oklahoma) provided some public funding for assisted living services in 2008.

Medicaid Funding for Assisted Living Services

Medicaid is a federal and state financed program that is the primary source of public funding for long term care. It is also the main source of public funding for assisted living services, although assisted living services are for the most part privately financed.[1] Most states that fund assisted living services do so through one or more Medicaid program options, including:

- 29 states and the District of Columbia that use Medicaid waivers,
- 10 states that use Medicaid waivers and Medicaid State Plans, and
- 6 states that only use Medicaid State Plans.

In 2008, Pennsylvania was one of only six states (Alabama, Kentucky, Louisiana, Okalahoma, and West Virginia) that did not fund assisted living through Medicaid.

Fifteen of the 39 states that fund assisted living through Medicaid have waivers that, for the most part,[2] are limited to assisted living services. Such states include neighboring Delaware, New Jersey, and Ohio. In Maryland, assisted living services are provided as one of many services available through the state's home and community based waiver for elderly and adult physically disabled individuals.

[1]Nationally, Medicaid is the primary source of payment for about two-thirds of residents of nursing facilities and 12 percent of those in assisted living.

[2]Typically, such waivers include care management services delivered by Medicaid providers other than the assisted living service provider.

States Approaches to Funding Assisted Living Services

(First Quarter 2008)

State	Medicaid Waiver[a]	Medicaid State Plan	Optional State SSI Supplement	Other State Program
Alabama	No	No	Yes	
Alaska	Yes	No	Yes	Yes
Arizona	Yes	No	Yes[b]	
Arkansas	Yes[c]	Yes	No	
California	Yes[c]	No	Yes	
Colorado	Yes	No	Yes	Yes
Connecticut	Yes	No	No	Yes
Delaware	Yes[c]	No	Yes	
District of Columbia	Yes	No	Yes	
Florida	Yes[c]	Yes	Yes[b]	
Georgia	Yes	No	No	
Hawaii	Yes[c]	No	Yes	
Idaho	Yes	Yes	Yes[b]	
Illinois	Yes[c]	No	Yes	
Indiana	Yes[c]	No	Yes	Yes
Iowa	Yes	No	Yes	
Kansas	Yes	No	No	
Kentucky	No	No	Yes	
Louisiana	No	No	No	
Maine	Yes	Yes	Yes	
Maryland	Yes	No	Yes	Yes
Massachusetts	No	Yes	Yes	
Michigan	No	Yes	Yes	
Minnesota	Yes	Yes	Yes[b]	
Mississippi	Yes[c]	No	No	
Missouri	No	Yes	Yes	
Montana	Yes	Yes	Yes[b]	
Nebraska	Yes	No	Yes	
Nevada	Yes[c]	No	Yes	
New Hampshire	Yes	No	Yes	
New Jersey	Yes[c]	No	Yes	

State	Medicaid Waiver	Medicaid State Plan	2007 Optional State SSI Supplement	Other State Program
New Mexico	Yes	No	Yes	
New York	No	Yes	Yes	
North Carolina	No	Yes	Yes	
North Dakota	Yes	Yes	No[b]	Yes
Ohio	Yes[c]	No	Yes[b]	
Oklahoma	No	No	No	
Oregon	Yes	No	Yes	
Pennsylvania	No	No	Yes	
Rhode Island	Yes[c]	No	Yes	
South Carolina	No	Yes	Yes	
South Dakota	Yes	No	Yes	
Tennessee	Yes	No	No	
Texas	Yes	No	No	Yes
Utah	Yes	No	No	
Vermont	Yes	Yes	Yes[b]	
Virginia	Yes[c]	No	Yes	
Washington	Yes[c]	Yes	No	Yes
West Virginia	No	No	No	Yes
Wisconsin	Yes	Yes	Yes[b]	Yes
Wyoming	Yes[c]	No	No	

[a]Yes indicates a state with a Medicaid 1915 (c) or a Medicaid 1115 waiver providing assisted living services.
[b]Benefits may be reduced or eliminated for participants receiving assisted living services through Medicaid.
[c]State with a waiver limited to assisted living services.

Source: Developed by LB&FC staff.

New York is one of the six states that provide assisted living services through their Medicaid State Plans.

***Medicaid Waivers*:** With the exception of Arizona and Vermont, states that fund assisted living services through Medicaid waivers do so through Medicaid 1915 (c) home and community based waivers. Such waivers permit states to:

- Limit the number of consumers to be served,
- Make services available to people at risk of institutionalization without requiring waiver services to be available to all Medicaid participants, and
- Provide Medicaid services to persons who would not be financially eligible for Medicaid unless they were in an institution, such as individuals with monthly income up to 300 percent of the federal SSI benefit rate ($1,911 gross in 2008).

Since Medicaid waiver participants must require nursing facility level of care to qualify for the waiver, almost all states (at least 36 of 39) that pay for assisted living services through waivers have nursing service requirements. Such requirements are imposed by licensure and/or through Medicaid provider enrollment agreements, and vary from state to state. They include, for example, requirements for nurse development of individual care plans, nurse training and supervision of personal care aides or attendants, and provision of nursing services directly by program staff or through program contractors.

States that purchase assisted living services through Medicaid waivers typically provide such services in a variety of settings,[3] including: (1) "assisted living residences" as defined in Act 56,[4] (2) "other residential care settings" (e.g., adult foster care, personal care homes, etc.), and (3) "other assisted living programs" (e.g., home health care agencies). Of the 39 states providing assisted living services through waivers:

- 34 (including neighboring Delaware, Maryland, New Jersey, and Ohio) provide assisted living services in licensed residential care settings that are not limited to assisted living residences as defined in Act 56.

[3]Exhibits 3 and 4 on pages 12 through 15 provide information for each state.

[4]Act 56 limits provision of assisted living services to assisted living residences, which provide residents with a living unit that provides bathroom, living and bedroom space, and kitchen capacity (electrical outlets to have small appliances such as a microwave and refrigerator), closets and adequate space for storage and a door with a lock, except where a lock or appliance in a unit under special care designation would pose a risk or be unsafe. The Act permits two residents to voluntarily agree to share one unit under certain circumstances. As of mid-June 2008, proposed assisted living residence licensing regulations had not been published by the Department of Public Welfare.

- 15 provide assisted living services in assisted living residences as defined in Act 56, including three states (Arkansas,[5] Nevada, and New Mexico) which only provide assisted living waiver services in such residences.
- 7 (including New Jersey) provide assisted living services through other licensed assisted living programs in both licensed and unlicensed settings, including four states (California, Connecticut, New Hampshire and New Jersey) which fund assisted living programs to serve waiver participants in public housing.

When Medicaid waivers pay for assisted living services, they typically pay for a "bundled" package of health and health-related services. These services are identified by state in Exhibits 5 and 6 on pages 16 through 21 of the report. Of the 39 states with waivers:

- 37 have service packages that include personal care or attendant care, including health-related personal care requiring nursing supervision and/or delegation.
- 31 include medication management and/or administration.
- 25 include homemaker services.
- 24 include 24/7 monitoring and emergency response systems to meet planned and unplanned resident needs.
- 21 include nursing services.
- 10 include therapeutic and social recreational programming.

All neighboring states with waivers (Delaware, Maryland, New Jersey and Ohio) include nursing services, medication administration, and personal care in their assisted living service packages. Delaware's bundled services include all home health aide services not covered by Medicare; New Jersey's and Ohio's include skilled nursing service provision not covered through third party payors; and Maryland's and Ohio's include 24/7 monitoring and emergency response.

Since Act 56 appears to limit assisted living services to assisted living residences, LB&FC staff identified reimbursement methods for such services used by state Medicaid programs. Exhibits 8 and 9 on pages 25 through 28 of this report show the types of reimbursement and the maximum rates for the 15 states that provide assisted living services in assisted living residences through Medicaid waivers. About one-half of the 15 states that provide assisted living services in assisted living residences through waivers tailor payments to the assessed needs of the participant. They include:

[5]Arkansas also provides assisted living services through its state plan. Residential providers of assisted living services under the Arkansas state plan are not limited to assisted living residences, and those receiving state plan assisted living services are not limited to those who require nursing facility level of care.

- 5 (Arkansas, California, Nevada, Oregon, and Vermont) states with tiered rates based on the assessed needs of the participant.
- 2 (Hawaii and Washington) states with tiered rates based on the assessed needs of the participant, with such rates further adjusted to take into account regional differences in the cost of care.
- 1 (Texas) state with both a tiered and flat rate system, which also varies its rates to take into account single occupancy and shared occupancy. [6]

Five (New Jersey, Illinois, Kansas, New Mexico, and Utah) of the 15 states reimburse assisted living residences through flat payments that do not vary based on differences in waiver participants' assessed needs.[7] In Illinois, rates are flat, but vary by geographic region. In New Jersey, rates are flat, but vary by service setting. New Jersey has one flat rate for assisted living residences (maximum allowed rate of up to $70 per day), a second for services provided by other licensed residential care settings (up to $60 per day), and a third for services provided by other licensed assisted living programs in public housing (up to $50 per day).

Twelve of the 15 states where Medicaid waivers pay for assisted living services in assisted living residences also pay for such services when provided through other licensed residential care settings and other licensed programs. In New Jersey, Oregon, Vermont, Washington and Texas,[8] the assisted living service rates vary by setting. In California, Hawaii, Illinois, Kansas, and Utah,[9] however, the same maximum allowed rates are in place for assisted living residences and other residential care settings and programs.

Medicaid 1915 (c) waivers provide states with certain flexibility in their methods of establishing maximum allowed rates for assisted living services, and as a consequence, there is no single method states use to develop their rates. Thirteen of the 15 states that pay for assisted living services in assisted living residences[10] operate under 1915 (c) waivers. LB&FC staff were able to determine how nine of

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[6]Neighboring Delaware, Maryland, and Ohio have forms of tiered reimbursement. Delaware and Ohio have three tiered reimbursement systems based on individual resident need. In Delaware, the maximum allowed rates range from $34.38 to $51.41, and in Ohio, they range from $50 to $70 per day. Maryland's rates are based on the licensure level of the facility and whether the resident also receives day health programming. Maryland's maximum allowed rates range from $41.81 per day (with day programming) to $55.74 (without day programming) in a "Level II" facility and $52.73 to $70.31 in a "Level III" facility.

[7]The two remaining states –Arizona and Wisconsin—have locally negotiated per diems. In Arizona, the per diems are negotiated by managed care organizations and in Wisconsin by local governments.

[8]Such maximum allowed rates in other residential care settings typically are lower than the rates for an assisted living residence. In Texas, however, other residential care settings which are small and have high staff to client ratios (1:4) and mostly private bedrooms have maximum allowed rates ($66.43 per day) comparable to the highest rate in an assisted living residence ($67.30 per day).

[9]Arkansas restricts Medicaid waiver services to assisted living residences. It, however, permits the licensed residence or other assisted living program to enroll as the Medicaid provider responsible for the delivery of assisted living services. Arizona and Wisconsin have negotiated rates.

[10]Arizona and Vermont provide such services through 1115 waivers and, therefore, were not included in this analysis. Information on requirements for Medicaid 1115 waivers is provided with the body of the report.

the 13 states developed their maximum allowed rates for assisted living residences.[11] Of the nine states:

- Three (California, New Mexico, and Utah) estimated rates based on prior cost data available to the state (e.g., nursing facility and other program cost data, other waivers, etc.).
- Two (Texas and Washington) based their rates on annual cost reports providers are required to submit to the Medicaid program, and in the case of Washington a time study of the care required for each of its assessed need levels and labor wage rates for direct care providers.
- One (Illinois) linked rates to its nursing facility rates.
- One (Nevada) relied on prior waiver and market rates in an effort to attract providers.
- One (Kansas) relied on its existing fee schedule for attendant care services in the home.
- One (New Jersey) relied on prior demonstration programs and provided an additional allowance for capital outlays for improving existing buildings and new facilities.

We found wide variation among states in the rates they pay to assisted living residences as well as other key factors such as their state assisted living service packages, clinical criteria for admission to nursing facilities, provider enrollment requirements, availability of providers, and professional practice rules, in particular rules related to delegation of nursing services to unlicensed individuals. Of the states that fund assisted living services through Medicaid waivers, Nevada has the lowest maximum allowed rate ($20 per day). A waiver participant in Nevada that would qualify for such a rate would require supervision and cueing to monitor the quality and completion of basic self-care and activities of daily living, and may not be bedfast or immobile.

Washington has the highest allowed rate for state Medicaid waivers ($110.11 per day). In Washington, a waiver participant qualifying for the highest rate would reside in the Seattle area, in a facility with a 60 percent Medicaid occupancy, and would have an Activity of Daily Living (ADL) score of from 18 to 28 based on the state's needs assessment. To attain a minimum score of 18, an individual must be totally dependent in four of six ADL areas (i.e., personal hygiene, bed mobility, transfers, eating, toilet use, and dressing) and require limited assistance in a fifth area. An individual would attain a score of 19 if totally dependent in four ADL

[11]Current state agency staff were unable to provide information on how rates were developed in three (Arkansas, Hawaii, and Oregon) of the 13 states, and in one state (Wisconsin) counties negotiate individual provider rates. Oregon advised us that it is in the process of revising its rates and considering two methods. One method is based on a market survey of private assisted living rates, and a second based on the average number of hours of service provided to residents in assisted living residences. Under the later approach, the state would reimburse assisted living residences and other residential programs in the same way based on number of service hours provided in such settings.

areas and also totally dependent for locomotion in room, outside of the room, and walking in the room. Washington's maximum allowed payment rate includes the payment amount for room and board.

***Medicaid State Plan*:** Unlike waiver services, Medicaid State Plan Services are:

- Limited to elderly and adult physically disabled persons whose income and resources are low enough to qualify for Medicaid services outside of an institution, such as individuals who qualify for federal SSI benefits, and Optional State SSI Supplements.
- Available to all Medicaid enrolled participants who meet the requirements to receive the service.
- Not necessarily limited to those requiring nursing facility level of care.

Sixteen states permit residential care providers to enroll as Medicaid State Plan providers. In states that provide assisted living services through both Medicaid waivers and their state plans, state plan services are typically delivered to those who do not require nursing facility level of care and/or residential providers that do not participate in the waiver.

All six states without waivers (Massachusetts, Michigan, Missouri, New York, North Carolina, and South Carolina) that rely on their state plans to pay for assisted living services include personal care in the services they purchase. With one exception (Michigan), they also include some type of nursing service in their service package. Massachusetts, New York, and North Carolina have Medicaid payment rates that take into account differences in resident need. In North Carolina, the base payment rate is $17.50 per day but can increase to $51.25 for an individual requiring care in a special Alzheimer's Unit.

New York's Medicaid State Plan Assisted Living Program provides one of the most comprehensive set of assisted living services of any publicly funded assisted living service program. To participate in New York's program, an individual must require nursing home level of care,[12] and a provider must have obtained certificates of need and be licensed as residential and home health providers.[13] New York Assisted Living Program providers are reimbursed through capitated[14] per diems that include nursing services; physical, occupational and speech therapies; medical

[12]New York's State Plan also includes personal care services delivered by licensed home care agencies enrolled as Medicaid providers and under contract with a local social service district. Such services are not restricted to individuals who require nursing facility level of care.

[13]New York has specific regulations that govern this program. Program providers are not governed by New York's assisted living residence licensure requirements.

[14]Under such capitation, the Medicaid assisted living provider is financially responsible for the payment of all Medicaid services included in the assisted living service package that are required by the participant, even if such services are not delivered by the assisted living provider.

equipment and supplies that do not require prior authorization; adult day health; care management (including arranging transfer to a higher level of care); and personal emergency response services. New York's assisted living program rates are based on its nursing facility rates which take into account participant resource utilization (16 different groups) and vary by geographic region (16 regions). Since its rates are based on nursing facility rates, they take into account direct (e.g., nurses, aides) and indirect (e.g., allowable capital) components of care.

New York's Medicaid assisted living service rates in New York City range from $71.87 to $147.68 per day—the highest public rates for assisted living services paid for either through Medicaid waivers or State Plan Services. In addition to the Medicaid program per diem, the provider can receive up to $1,072 monthly for room and board for individuals who qualify for the federal SSI benefit and Optional State Supplement. Medicaid assisted living program participants with the Optional State Supplement have monthly incomes equivalent to 200 percent of SSI.

The New York program participant qualifying for the maximum allowed Medicaid payment of $147.68 per day would require daily restorative therapy (i.e., physical therapy and/or occupational therapy) for four or more consecutive weeks and have an ADL score of at least 5 based on New York's assessment. An individual with an ADL score of 5 in New York is, for example, one who requires continuous supervision and/or physical assistance with eating and is incontinent, and is taken to toilet on a regular schedule.

Optional SSI State Supplements

The Federal Supplemental Security Income (SSI) program is the primary source of public funding for room and board in assisted living residential settings. [15] The maximum federal SSI benefit rate ($637 monthly in 2008) is the same nationwide. Recognizing differences among states and the special needs of certain elderly and disabled persons, the federal program allows states to provide optional state supplemental payments for such individuals without jeopardizing the individual's eligibility for federal SSI benefits or reducing the federal benefit as a result of other maintenance and support. In addition, participants who qualify for the state supplement but do not qualify for the federal SSI monthly benefit qualify for full Medicaid benefits. Optional state supplement program benefits are available to those in need of supportive services and are not limited to those with nursing facility level of care needs.

Thirty-seven states (including Pennsylvania) provide financial support for assisted living services through optional SSI state supplement programs for elderly

[15]Outside of an institution, federal Medicaid funds cannot be used to pay for a participant's room and board. Under the federal SSI program, those in institutions are ineligible for the federal SSI monthly benefit, though there are provisions for a personal needs allowance.

and disabled adults in residential care. State supplements range from as low as $1.70 in Oregon to as high as $938 in North Carolina for an individual in a special care Alzheimer's Unit. (Exhibit 15 on pages 58 through 60 shows monthly optional SSI state supplement payments by state.)

Some states that provide assisted living services through Medicaid have elected to reduce or eliminate their Optional State Supplement benefits for those receiving such services. We identified at least eight states (including neighboring Ohio, Arizona, Florida, Idaho, Minnesota, Montana, Vermont, and Wisconsin) that provide no or reduced optional state SSI supplement benefits for those who qualify for the supplement but receive assisted living services through Medicaid. One other state (North Dakota) eliminated its optional state supplement program after the introduction of Medicaid assisted living funding.

One national consultant advises states to consider eliminating the Optional State Supplement for those who qualify for the Medicaid waiver so as to obtain federal matching funds for state dollars and help finance their Medicaid waivers. States that elect such an approach typically provide personal care services through their Medicaid State Plans whether in the home or in a licensed residential setting (e.g., Florida and Vermont).[16]

Other State Programs

As shown in the above exhibit, 10 states help fund assisted living services through other state programs. Typically, such programs are targeted to individuals who do not qualify for Medicaid services and/or federal SSI. The benefit levels and/or numbers of participants in such programs are limited. Maryland, for example, provides up to $650 per month for up to 600 participants who have financial resources just above the income and asset eligibility limits for SSI and the state's optional state supplement program. Washington provides assisted living services to 30 individuals that do not qualify for its Medicaid waiver and/or Medicaid State Plan Services.

West Virginia relies on its federal block grant funding (Title XX) to support care in certain adult residential care settings. Residents in such settings may qualify for up to $1,056.50 a month. West Virginia's Medicaid State Plan includes a personal care benefit for those who qualify in residential settings.[17] West Virginia Medicaid staff advised us that individuals in adult residential care settings typically do not receive Medicaid State Plan personal care.

[16]Pennsylvania's Medicaid State Plan does not offer personal care services in the home or in other community settings.

[17]West Virginia's Medicaid State Plan, however, does not permit residential care providers to enroll as State Plan providers.

Public Funding for Affordable Assisted Living Housing

In terms of housing financing, the federal government is the primary source of public subsidies for construction of assisted living to make such housing more affordable. The report provides information on two such programs and the role of the Pennsylvania Housing Finance Agency, in implementing the federal tax credit program.

Factors Influencing Public Funding Models for Assisted Living

All but six states fund assisted living services through their Medicaid programs and do so primarily through Medicaid 1915 (c) home and community-based waivers. There are, however, significant differences in state models for public funding of assisted living.

Several factors can influence the public funding models states select. While a complete list of such factors is beyond the scope of this report, several examples highlight important differences between the Commonwealth and other states, and why models in place in other states may or may not lend themselves to adoption for Pennsylvania. A model that may be efficient and effective for one state, moreover, may not be for another state because of their different situations and objectives for publicly funding assisted living services. Examples of such factors include:

Assisted Living Resident Retention Criteria: Of the 15 states that provide Medicaid assisted living services in assisted living residences as defined in Act 56, Vermont's retention criteria most closely mirror Pennsylvania's statute, which permits admission and retention of residents who are immobile and residents with skilled nursing needs, and authorizes the Secretary of Public Welfare to permit retention of residents who require continuous skilled nursing care. Vermont's criteria are consistent with its public funding model's emphasis on "aging in place" and its Medicaid waiver's provision of assisted living services as a substitute for nursing facility care. In particular, Vermont does not have discharge criteria such as those in place in Arkansas, California, Illinois, Kansas, Nevada, New Mexico, Utah, and Wisconsin, which require discharge of residents requiring continuous nursing care and/or residents who are bedfast or immobile, and which limit the ability of their public funding models to substitute assisted living services for nursing facility care for those with substantial needs.[18]

Nurse Delegation: Ten of the states that provide Medicaid assisted living services in assisted living residences permit nursing delegation of administration of oral medication in assisted living to unlicensed personnel, and several with less restrictive resident retention criteria (such as Hawaii, New Jersey, Oregon, Texas, Vermont, and Washington) permit delegation of oral medication administration and

[18]Appendix D provides a summary of the retention criteria by state.

multiple care tasks (e.g., sterile dressings, tube feeding). Pennsylvania's nurse practice statute, however, does not permit nurses in assisted living to delegate administration of oral medication or other nursing care tasks. (Nurse delegation tasks for all states may be found in Appendix E).

Nursing Facility and Resident Characteristics: Pennsylvania has been successful in achieving greater efficiency in its use of nursing facility beds by reducing the number of Medicare and Medicaid certified nursing beds, achieving high occupancy levels, and diverting those with lower intensity of need to home and community based waivers.[19] As a consequence, of the 15 states where Medicaid funds assisted living services in assisted living residences, only California, Hawaii, and Nevada, (which have bed availability rates substantially below the national rate) have higher average acuity levels than Pennsylvania, based on federal survey data. Minnesota researchers, in a study of eight states' efforts to rebalance their long term care systems, reported data showing Pennsylvania nursing facilities in 2004 had higher ADL scores than Arkansas, Florida, Minnesota, New Mexico, Texas, Vermont and Washington both at admission and three months post admission. This later indicator is viewed by researchers as the better nursing facility acuity indicator in view of the increased use of nursing facilities to provide subacute care for those leaving hospitals.[20] Kaiser Family Foundation researchers, based on analysis of Medicaid long-stay nursing home residents and their increasing disability, have noted further reduction in the Medicaid nursing home population will require levels of assistance and physical environments capable of meeting needs of more severely disabled older individuals.

Public Funding Objectives: States differ in their objectives for public funding of assisted living services, and such differences influence the public funding models they design.

- States seeking to substitute assisted living for skilled nursing facility care (e.g., New York, Texas, Washington, and Vermont) typically design funding models that include tiered reimbursement with Medicaid rates that increase as a participant's needs and resource use increase.

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[19]According to a 2006 report prepared by Medstat Research Division for the Centers for Medicare and Medicaid Services (*Profile of Pennsylvania: A Model for Assessing a State Long-Term Care System*, December 2006), Pennsylvania demographics set it apart from other states. The report notes the state has a high number of persons over age 65 and a higher proportion of those are over age 85—the group most likely to need long term care. Pennsylvania's nursing facility utilization rate is above the national average (40.8 residents per 1,000 persons 65 and older compared to 38.2 per 1,000 nationwide) when all residents, including private pay, Medicare, and Medicaid, are taken into account, but its Medicaid nursing facility days per thousand persons 65 and older is slightly below the national rate (10,139 compared with 10,394). The report also provides a detailed overview of Pennsylvania's long term care system for the elderly and physically disabled as well as the developmentally disabled and reviews efforts in recent years to rebalance the state's long term care system.

[20]*Rebalancing Long-Term Care Systems, Abbreviated Reports* for Arkansas, Florida, Minnesota, New Mexico, Pennsylvania, Texas, Vermont, and Washington prepared for the Centers for Medicare and Medicaid. Individual state reports are available at the University of Minnesota Principal Investigator's website (http://www.hpm.umn.edu/LTCResourceCenter/).

- States seeking to create incentives for development of assisted living to better balance availability of community and institutional care and provide a service model for low income persons who would not otherwise have access to assisted living (e.g., New Jersey and Illinois, which in 2007 had average monthly assisted living residence costs well above those nationally[21]) design their public models with flat rates that include amounts for capital costs. To help assure access, they also include in their models requirements for providers to reserve 10 to 25 percent of their units for Medicaid recipients.
- States concerned with differences in regional costs and seeking to assure access statewide (e.g., New York, Illinois, Hawaii, Washington) adjust their rates to account for regional cost differences.
- States seeking to meet the needs of special populations, such as those with dementia, limit their waivers to those requiring care in secure units (e.g., Virginia).
- States seeking to assure assisted living services are available for those with low and modest incomes take a variety of approaches, including:

    - Limiting Medicaid assisted living to those with relatively lower income (e.g., Illinois, Massachusetts, New York, North Carolina, South Carolina, Virginia),
    - Adding on to payments to providers with 60 percent or more Medicaid residents (e.g., Washington),
    - Designing public funding models to include residents in public housing (e.g., California, Connecticut, New Hampshire, and New Jersey),
    - Providing Medicaid assisted living services in more than one type of residential setting (e.g., 36 of the 39 states with waivers),
    - Permitting families and third parties to voluntarily supplement assisted living residence room and board for Medicaid participants (e.g., New Jersey, Florida, Washington) as long as the family assumes responsibility for the consequences of possible lost public benefits due to such supplementation.

States also vary in how they seek to foster provider participation through their public funding model design. Assisted living provider participation in public funding models is not assured with the introduction of public funding. Such participation is in part fostered through development of reasonable rates related to costs and resource use. The rates that can be derived from the data in the Fiscal Note accompanying Act 56 (i.e., an average of $86 per day for all Medicaid services) along with federal SSI and the Optional State Supplement would result in a total average rate of around $100 per day. While such waiver rates compare favorably to most surrounding and other states, and they compare favorably with reported costs

[21]$4,719 in New Jersey and $3,094 in Illinois compared to $2,714 nationally for a one-bedroom unit in an assisted living facility.

for assisted living units in Pennsylvania based on national surveys ($2,669 monthly for a one bedroom unit in 2007, or about $88 per day),[22] it is not possible to determine how the marketplace will respond to such rates. This is because, in part, the acuity of waiver residents will likely differ from that of general assisted living population in the national survey, and costs associated with possible regulatory requirements are unknown at this time.

Ease of administration is another way in which provider participation can be fostered. Some multi-state assisted living providers advised us they prefer less complex reimbursement systems, such as flat rate per diems, rather than flat rate fee-for-unit of service or complex tiered reimbursement systems.

Act 56 is a licensure statute. Consideration of all policy objectives related to the design of a public funding model would be outside of the scope of such a statute. Act 56, however, explicitly endorses the Commonwealth's funding of assisted living services through a Medicaid 1915 (c) waiver along with "aging in place," and providing for those who qualify for skilled nursing care with the highest level of need to continue to reside and receive care in licensed assisted living residences. As a licensure statute, it is silent on many factors that must be considered to develop an efficient public funding model tailored to work for Pennsylvania and meet the needs of its unique aging population.

This report provides detailed information on the public funding models in all 50 states and the District of Columbia, with particular emphasis on those states that publicly fund assisted living services in assisted living residences as defined in Act 56. The information in the report can by used by the Select Committee to craft a public funding model for Pennsylvania based on the Select Committee's consultation with policy makers and key stakeholders about factors such as those discussed above, and others, and consensus on Commonwealth objectives for public funding of assisted living.

[22]In Philadelphia the average monthly cost was $3,133 in 2007, which is above the national average, and 42 percent higher than the rest of the state, according to a national survey of long term care costs.

I. Introduction

Act 2007-56 directed the Legislative Budget and Finance Committee (LB&FC) to report on existing federal and other states' initiatives and programs to provide financial assistance for assisted living, including information on effectively administered model programs. The statute requires the LB&FC to submit the report to a select committee consisting of members of the Aging and Youth Committee of the Senate and the Aging and Older Adult Services Committee of the House of Representatives. It also directs the select committee comprise a Joint Legislative Task Force to be chaired by the Secretary of Aging for the purpose of developing a proposal to fund assisted living in the Commonwealth. (Appendix A provides the relevant section of the statute.)

Scope and Objectives

Specifically, the Act 2007-56 report is to:

1. Identify existing sources of public funding for assisted living as defined by the Act.

2. Identify existing sources of federal and state financial support for "supplemental health care services" and "cognitive support services."

3. Identify efficient public models for financing of assisted living residence services.

To identify existing public sources of funding for assisted living, including supplemental health care services and cognitive support services, we reviewed various national studies, spoke with national consultants, and met with staff of state agencies and associations. We also contacted state units on aging and agencies responsible for administration of the Medicaid program in the 50 states and the District of Columbia. Through such contacts, we learned that the federal Medicaid program is the major public source of funding for assisted living services.

To obtain specific information on each state's financing of assisted living services, we reviewed the state plan on aging, approved federal Medicaid plan, relevant state statutes and regulations, Medicaid provider manuals and contracts, federally approved Medicaid home and community-based waivers, and conducted additional follow-up with state program staff. Such reviews provided information for each state on requirements of providers for public payment for assisted living services, specific health and supportive services included in the term assisted living services, and the settings in which such services are reimbursed. The information we report is current as of first-quarter 2008. During our work, some states advised us they

were in the process of considering and implementing changes to their Medicaid assisted services.

To identify efficient models for public funding of assisted living, we reviewed the various approaches states use to fund assisted living services, their methods of reimbursement, and their assisted living service rates. Our report identifies some of the advantages and disadvantages of various approaches, and factors that influence states' public funding model designs.

The report also includes information on the federal Supplemental Security Income Program (SSI), which is the primary source of public funding for housing costs for the elderly and adults with physical disabilities; state-funded assisted living programs; and federal programs that assist with financing assisted living residences to help keep housing costs affordable. Such information is based on various federal sources, state laws and regulations, and state contacts.

Nationally, there is no standard definition of "assisted living" for purposes of licensure or public funding of assisted living services. All states use different terms and have different practices. Some states, for example, use the term assisted living to refer to programs that in Pennsylvania are known as domiciliary and licensed personal care homes. Other states use the term personal care home to refer to facilities that are more comparable to assisted living residences as defined in Act 2007-56.

To help consider the various state approaches to publicly fund assisted living services, we have chosen to standardize the language used in the report rather than use the specific labels used by individual states. Throughout the report, we have used the term "*assisted living services*" broadly to encompass all state practices for purchase of "assisted living services" for elderly and adult physically disabled persons. We have used the term "*assisted living residences*" to refer to assisted living services required by Act 2007-56. Such residences are required to be licensed and provide health services and individual resident living units (with a private bathroom, living and bedroom space and kitchen capacity) that may be shared by only one other resident based on mutual consent.

Many states do not limit their purchase of assisted living services to residential care settings that meet the definition of an assisted living residence as defined in Act 2007-56. They may purchase assisted living services in other licensed residential care settings (e.g., adult foster home, residential care settings with only private bedrooms, and other congregate residential settings). We, therefore, have used the term "*other residential care setting*" when referring to public purchase of assisted living service for residents in such licensed settings.

As noted in the report, several states that fund assisted living services in residential care settings do not restrict such services to licensed assisted living residences or other residential care settings. In such states, assisted living services may be provided by other community programs. Throughout the report, we have used the term "*other assisted living programs*" to refer to state programs in which licensed or publicly certified entities other than an assisted living residence or other residential care setting (e.g., home health agency, home care agency) are contractually responsible for providing "assisted living services" to those residing in assisted living residences or other residential care settings. When states fund *other assisted living programs* to provide services in unlicensed settings we have noted this in the report. (Appendix B provides a glossary of assisted living service terms we use in the report.)

Our report provides information in a format that allows comparison across states. We caution the reader when drawing conclusions from such comparisons. States vary widely in population, clinical criteria for admission to nursing facilities, availability of service providers, and professional practice rules, in particular rules related to delegation of nursing services to unlicensed individuals. Comprehensive analysis of such variation is beyond the scope of this report, though at times we have pointed out certain key differences between other states and Pennsylvania.

Acknowledgements

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Important Note

This report was developed by the Legislative Budget and Finance Committee staff. The release of this report should not be construed as an indication that the Committee or its individual members necessarily concur with the report's findings and recommendations.

Any questions or comments regarding the contents of this report should be directed to Philip R. Durgin, Executive Director, Legislative Budget and Finance Committee, P.O. Box 8737, Harrisburg, Pennsylvania 17105-8737.

II. Medicaid Programs: How They Fund Assisted Living Services, Their Covered Settings and Services

Assisted living is a combination of housing and supportive services that allow people to age in place, maintain their independence and exercise decision making and personal choice. Act 2007-56 specifically defined an "assisted living residence" as:

> Any premises in which food, shelter, personal care, assistance or supervision and supplemental health care services are provided for a period exceeding twenty-four hours for four or more adults who are not relatives of the operator and who require assistance or supervision in such matters as dressing, bathing, diet, financial management, evacuation from the residence in the event of an emergency or medication prescribed for self-administration.[1]

"Supplemental health care services," as defined in the Act, include the assisted living residence's provision (either directly or through contractors, subcontractors, agents, or designated providers) of any type of health care services, except for those services required to be provided by a health care facility.[2] The Act also permits licensed assisted living residences (or a distinct part of the residence) to obtain a "special care designation." Such designation allows the licensed residence to provide "cognitive support services"[3] to residents with severe cognitive impairments (e.g., dementia and Alzheimer's disease) in the least restrictive manner to ensure the safety of the resident and others in the residence while maintaining the resident's ability to age in place. The regulations required to license assisted living residences and implement the Act have been under development, but had not been published as proposed as of mid-June 2008.

Assisted living has become an increasingly important component of the long-term care system. With its philosophy which emphasizes greater resident control of his or her environment and privacy, market demand for assisted living has been growing as the population ages. Nationally, the average monthly cost for a one bedroom unit in an assisted living facility was $2,714 in 2007, or about $89 per day. While lower than the cost of nursing home care, such costs are more than twice the

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[1] 62 P.S. §1001.

[2] The Health Care Facilities Act, 35 P.S. §448.103, defines the following as health care facilities: general or specific hospitals including psychiatric hospitals, rehabilitation hospitals, ambulatory surgical facilities, long term-care nursing facilities, cancer treatment centers using radiation therapy on an ambulatory basis, inpatient drug and alcohol treatment facilities and hospice.

[3] "Cognitive support services" refer to services provided to an individual who has memory impairments and other cognitive problems which significantly interfere with their ability to carry out activities of daily living without assistance and who require that supervision, monitoring and programming be available on a 24 hour a day, seven day a week basis. Cognitive support services include assessment, health support services, and a full range of dementia programming and crisis management.

$1,025 national average monthly Social Security Pension and Disability Benefit for someone 65 or older in 2006. (Appendix C provides the average monthly cost in an assisted living facility, average daily nursing home rate, and average hourly rate for a home health aide for each state in 2007.)

Those residing in assisted living residences in 2000 typically needed assistance with an average of 2.3 activities of daily living (ADLs) (compared to 3.8 ADL for nursing facility residents), and half had some form of cognitive impairment, according to a 2004 analysis by the AARP Public Policy Institute. Residents typically remain at an assisted living residence from 2.5 to 3 years. Most residents who leave are transferred because they need more care. Typically, they are discharged to nursing facilities.

Act 2007-56: Act 56 authorized the Department of Public Welfare to develop regulations to license assisted living residences, and included several specific requirements for such regulations. In particular, the Act required assisted living residences to provide a resident with the resident's own living unit. Such units must contain a private bathroom, living and bedroom space, and kitchen capacity (electrical outlets to have small appliances such as a microwave and refrigerator), closets and adequate space for storage and a door with a lock, except where a lock or appliances in a unit under special care designation would pose a risk or be unsafe.[4] The Act permits two residents to voluntarily agree to share one unit under certain circumstances. A licensed assisted living residence, however, cannot require residents to share a unit.

In addition to defining assisted living residences and setting forth specific requirements for their licensure, the Act permits individuals who require nursing facility level of care to reside in licensed assisted living residences. Specifically, the Act states:

> Persons requiring the services of a licensed long-term care facility, including immobile persons, may reside in an assisted living residence, provided that appropriate supplemental health care services are provided such residents and the design, construction, staffing and operation of the assisted living residence allows for their safe emergency evacuation.[5, 6]

The Act also notes:

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[4] 62 P.S. §1021(a)(2).

[5] 62 P.S. §1057.3(b).

[6] The Act also authorizes assisted living residences to obtain waivers from the Secretary of Public Welfare to permit individuals who require services typically requiring daily skilled nursing care to remain at the residence with individual care plans able to meet the individual's health and social needs.

> Prospective or current residents for whom placement in a skilled nursing facility is imminent shall be given priority for assisted living residence services funded through a home- and community-based waiver.[7]

A *Fiscal Impact Summary* accompanying the legislation indicated the Department of Public Welfare (DPW) would apply to the federal Centers for Medicare and Medicaid Services for a new home and community-based waiver for assisted living as provided for in the Act. The *Summary* indicates the Department expected such a waiver would serve 1,688 consumers in the first operating year and increase to 5,063 consumers in the fifth year; with the total average costs for all services in the first year effectively equating to an average of $86 per day per consumer. The *Summary* further indicates: "the costs associated with providing assisted living services would be offset by savings in the nursing home program to the extent that utilization of nursing home care would be reduced."[8] [9]

In other words, the *Fiscal Impact Summary* estimates effectively assume about a one percent reduction in Medicaid nursing home bed days in the first partial year of an assisted living waiver from FY 2007-08 Medicaid nursing home bed day estimate levels. Such reductions would increase to three percent in the first full year of the waiver and seven percent by FY 2012-13.[10] In the last three years, Medicaid nursing bed days have declined three percent.

Medicaid State Plan: Medicaid is a program jointly financed by the federal and state governments to provide medical benefits to groups of low income people without medical insurance and those with inadequate medical insurance. Under Title XIX of the federal Social Security Act, no federal Medicaid funds are available to a state unless it submits and the Secretary of the Department of Health and Human Services approves the state's Medicaid plan (and any plan amendments) to serve eligible individuals. Such approvals are granted based on the plan meeting over 60 federal statutory requirements.

Medicaid Waivers and Demonstrations*:* Under the Social Security Act, the Secretary of Health and Human Services is permitted to waive certain federal

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[7]62 P.S. §1057.3(a)(3.1).

[8]House Committee on Appropriations 2007-08 Legislative Session, Senate Bill 704 *Fiscal Impact Summary,* July 6, 2007.

[9]Total state costs for a Medicaid assisted living waiver in the first partial year of the waiver are estimated to be $12 million (combined federal and state costs estimates are $26.2 million) with such costs offset by a projected $13.4 million in state costs for nursing facilities. The fiscal note anticipates a four percent increase in costs annually along with an expansion of the number to be served. With such increases, state costs of $31 million are projected for the first full year of the waiver and reach $77 million by 2012-13. According to the fiscal note, the Department of Public Welfare anticipates savings of $35 million in state costs in the first full year of the waiver and $86 million by 2012-13.

[10]These estimates rely on data reported in Department of Public Welfare budget documents. They assume a combined federal and state cost per day of $153.14 with state funds accounting for 45 percent of total costs and 19,257,406 long term care days for FY 2007-08 and the estimated state savings included in the *Fiscal Impact Summary*.

requirements to allow states greater flexibility in operating their Medicaid programs. Specifically, under Section 1915 (c) of the Social Security Act, the Secretary can waive Medicaid provisions in order to allow long term care services to be delivered in community settings rather than in institutional settings.[11] Section 1115 of the Act, moreover, provides the Secretary with broad authority to authorize research and demonstration projects to test policy innovations that further the objectives of the Medicaid program.[12]

Medicaid is the primary payer for residents in nursing facilities that have remained in the facility for more than 90 days, accounting for two-thirds of all long-stay residents.[13] Nationwide, the number of Medicaid long-stay residents in nursing facilities has declined, similar to the decline overall in nursing home long-term stay residents. While the number of Medicaid long-stay residents in nursing facilities has declined in recent years, their care needs have continued to increase.

Medicaid long-stay nursing home residents are severely disabled. In 2004, according to the Kaiser Family Foundation:

- 85 percent were 75 or older,
- 40 percent did not walk and moved about only by virtue of wheelchairs or similar devices,
- 54 percent needed supervision or help in five Activities of Daily Living (ADL), and another 25 percent with help in four ADLs,
- 61 percent had difficulty with bowel or bladder control,
- 68 percent had one or more physical conditions, and
- 62 percent had one or more mental/cognitive conditions.

In view of the characteristics of Medicaid long-stay residents, Kaiser Family Foundation researchers concluded further reductions in the Medicaid nursing home population will require levels of assistance and physical environments capable of meeting the needs of more severely disabled older individuals.

In an effort to serve more severely disabled older individuals outside of nursing facilities, most states now fund assisted living services through their Medicaid programs, typically through 1915 (c) home and community-based waivers rather than 1115 waivers or Medicaid State Plans. As reported below, Pennsylvania is one of six states (including Alabama, Kentucky, Louisiana, Oklahoma, West Virginia)

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[11]Section 1915 (c) Home and Community-Based Waivers permit states to choose the number of consumers to be served, make services available to people at risk of institutionalization without requiring the waiver service be available to all Medicaid participants, and/or provide Medicaid services to persons who would not otherwise be eligible for Medicaid unless they were in an institutional setting.

[12]Section 1115 research and demonstration projects permit states to expand eligibility to individuals not otherwise eligible under the Medicaid program, provide services not typically covered, or use innovative service delivery systems. Such demonstrations must be "budget neutral" meaning they cannot be expected to cost the federal government more that it would cost without the waiver.

[13]Medicare is the primary payer for persons recently admitted to nursing facilities.

that did not finance assisted living services for the elderly and adult physically disabled through its Medicaid program in the first-half of 2008.

A. State Approaches to Funding Assisted Living Services Through Medicaid

1915 (c) Home and Community-Based Waivers: As shown in Exhibit 1, 37 states and the District of Columbia, provide assisted living services through Medicaid home and community-based waivers for individuals who clinically quality for care in a nursing facility under the state's Medicaid program. Fifteen states fund assisted living services through home and community-based waivers that are limited to assisted living services.[14] The 15 states include four states (Florida, Indiana, Rhode Island, and Washington) that also include assisted living services in other 1915 (c) waivers which are not limited to assisted living services.

***1115 Waivers*:** Arizona and Vermont operate their entire Medicaid programs under 1115 waivers. Both states purchase assisted living services as a substitute for care in a nursing facility through their 1115 waivers.

Medicaid State Plan:[15] As shown in Exhibit 2, sixteen state Medicaid plans pay for assisted living services for eligible individuals. Six (Massachusetts, Michigan, Missouri, New York, North Carolina, and South Carolina) of the 16 states rely exclusively on their Medicaid state plans to fund assisted living services. In the 10 states where both the Medicaid state plan and waiver(s) are used to pay for assisted living services, state plan services are available to persons who are functionally impaired but may not require the level of care provided by nursing facilities, and/or services are delivered by residential providers that do not participate in the state's waiver.[16]

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[14]Such waivers, however, may include services for waiver participants that are delivered by providers who are not assisted living service providers. Typically, case management is a covered service for an assisted living waiver participant but it is not usually provided by the waiver assisted living service provider.

[15]The Deficit Reduction Act of 2005 provides for a Medicaid Program Home and Community-Based State Plan Service which allows states the option to provide home and community-based services through their regular State Medicaid Plan. Proposed regulations to implement this new option were published in April 2008, and not in place as of June 2008. Under the State Plan option, states would be able to provide one or more community waiver services (i.e., case management; homemaker; personal care; adult day health; habilitation; respite; and, subject to certain conditions for individuals with chronic mental illness, day treatment, psychosocial rehabilitation and clinic services) to individuals eligible for medical assistance under the State Plan, whose income does not exceed 150 percent of the federal poverty level, reside in the home or community, and meet needs-based criteria established by the state. State waiver and nursing facility needs-based criteria are required to be more stringent than the need-based criteria under the new State Plan option. States electing the option can limit the number of persons to be served, establish service waiting lists, and revise their needs-based criteria for benefit eligibility. "Other services" included in waivers (e.g., assisted living residences and other residential care settings) are not included in the community services included in the new State Plan option. The provision of "other services" continues to require a waiver.

[16]In some instances the provider may not qualify to participate in the approved waiver. In other instances, the provider may not elect to participate in the waiver.

Exhibit 1

States with Medicaid Home and Community-Based Service Waivers Providing Assisted Living Services (ALS) for Elderly and Adult Physically Disabled Individuals

(First Quarter 2008)

State	1915 (c) Waiver Provides for Assisted Living Services	1915 (c) Waiver Limited to Assisted Living Services	1915 (c) Waiver Not Limited to Assisted Living Services
Alabama	No	NA	NA
Alaska	Yes		✓
Arizona	No	NA	NA
Arkansas	Yes	✓	
California	Yes	✓	
Colorado	Yes		✓
Connecticut	Yes		✓
Delaware	Yes	✓	
District of Columbia	Yes		✓
Florida	Yes	✓	✓
Georgia	Yes		✓
Hawaii	Yes	✓	
Idaho	Yes		✓
Illinois	Yes	✓	
Indiana	Yes	✓	✓
Iowa	Yes		✓
Kansas	Yes		✓
Kentucky	No	NA	NA
Louisiana	No	NA	NA
Maine	Yes		✓
Maryland	Yes		✓
Massachusetts	No	NA	NA
Michigan	No	NA	NA
Minnesota	Yes		✓
Mississippi	Yes	✓	
Missouri	No	NA	NA
Montana	Yes		✓
Nebraska	Yes		✓
Nevada	Yes	✓	
New Hampshire	Yes		✓
New Jersey	Yes	✓	
New Mexico	Yes		✓
New York	No	NA	NA
North Carolina	No	NA	NA
North Dakota	Yes		✓
Ohio	Yes	✓	
Oklahoma	No	NA	NA
Oregon	Yes		✓
Pennsylvania	No	NA	NA
Rhode Island	Yes	✓	✓
South Carolina	No	NA	NA
South Dakota	Yes		✓
Tennessee	Yes		✓
Texas	Yes		✓
Utah	Yes		✓
Vermont	No	NA	NA
Virginia	Yes	✓	
Washington	Yes	✓	✓
West Virginia	No	NA	NA
Wisconsin	Yes		✓
Wyoming	Yes	✓	

Source: Developed by LB&FC staff.

Exhibit 2

States With Medicaid State Plans Providing Assisted Living Services through Residential Providers

State	Medicaid State Plan Covers Residential Provider Provision of Assisted Living Services	State Also Covers Assisted Living Services Through 1915 (c) or 1115 Waivers
Arkansas	X	Yes
Florida	X	Yes
Idaho	X	Yes
Maine	X	Yes
Massachusetts	X	No
Michigan	X	No
Minnesota	X	Yes
Missouri	X	No
Montana	X	Yes
New York	X	No
North Carolina	X	No
North Dakota	X	Yes
South Carolina	X	No
Vermont	X	Yes
Washington	X	Yes
Wisconsin	X	Yes

Source: Developed by LB&FC staff.

B. Settings in Which Medicaid Pays for Assisted Living Services

States that purchase assisted living services through Medicaid do so in a variety of settings, including assisted living residences as defined in Act 2007-56; other residential care settings; and at times, through assisted living programs providing care in unlicensed settings. Appendix B provides operational definitions for each of these terms.

Medicaid 1915 (c) and 1115 Waivers: As shown in Exhibits 3 and 4, states providing assisted living services through Medicaid waivers typically elect to cover such waiver services in more than one type of residential setting or program.

- Fifteen[17] of the 39 states and the District of Columbia provide assisted living services in assisted living residences (as defined in Act 2007-56), including three (Arkansas, Nevada, and New Mexico) which limit their waiver service coverage to assisted living residences.

[17]Arizona, Arkansas, California, Hawaii, Illinois, Kansas, Nevada, New Jersey, New Mexico, Oregon, Texas, Utah, Vermont, Washington, and Wisconsin.

- Thirty-four[18] of the 39 provide assisted living service in other residential care settings.
- Seven (California, Connecticut, Indiana, Maine, New Hampshire, New Jersey, and Oregon) of the 39 provide services through assisted living programs in unlicensed residences such as public housing.[19]

As shown in Exhibits 3 and 4, typically Medicaid assisted living services include a requirement for some type of nursing service. Such requirements may be part of licensure requirements that are adopted by Medicaid for its assisted living service providers, or they may be part of Medicaid regulations or provider agreements and contracts. Such nursing service requirements vary from state to state, and include requirements such as nurse development of individual care plans, nurse training and supervision of personal care aides or attendants providing direct care, and provision of nursing services by provider staff or through a provider's contractor(s).

[18]Arizona, Alaska, Colorado, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Maine, Maryland, Minnesota, Mississippi, Montana, Nebraska, New Hampshire, New Jersey, North Dakota, Ohio, Oregon, Rhode Island, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, Wisconsin, and Wyoming.

[19]Illinois was not included as unlicensed because although these residences do not have specific licensure requirements they must be certified as meeting Medicaid regulations.

Exhibit 3

Types of Settings in Which Assisted Living Services for Elderly and Adult Physically Disabled Individuals Are Provided in State Medicaid 1915 (C) Waivers

(First Quarter 2008)

State	1915 (c) Waiver Limited to Assisted Living Services	1915 (c) Waiver Not Limited to Assisted Living Services	Assisted Living Services Setting(s)
Alaska		X	-Other residential care setting with nursing service
Arkansas	X		-Assisted living residence with nursing service -Other assisted living program (home health agency in ALR)
California	X		-Assisted living residence with nursing service -Other assisted living program with nursing service in assisted living residence -Other assisted living program with nursing service in unlicensed setting (public housing)
Colorado		X	-Other residential care setting
Connecticut		X	-Other assisted living program with nursing service in other residential care setting -Other assisted living program with nursing service in unlicensed setting (public housing)
Delaware	X		-Other residential care setting with nursing service
District of Columbia		X	-Other residential care setting
Florida[a]	X	X	-Other residential care setting with nursing service
Georgia		X	-Other residential care setting with nursing service
Hawaii	X		-Assisted living residence with nursing service -Other residential care setting with nursing service
Idaho		X	-Other residential care setting with nursing service -Other residential care setting
Illinois	X		-Unlicensed (certified) assisted living residence with nursing service -Unlicensed (certified) other residential care setting with nursing service
Indiana[a]	X	X	-Other residential care setting with nursing service -Other assisted living program with nursing service in unlicensed setting (housing with service establishments)

Exhibit 3 (Continued)

State	1915 (c) Waiver Limited to Assisted Living Services	1915 (c) Waiver Not Limited to Assisted Living Services	Assisted Living Services Setting(s)
Iowa		X	-Other residential care setting with nursing service
Kansas		X	-Assisted living residence with nursing service -Other residential care setting with nursing service -Other residential care setting
Maine		X[b]	-Other residential care setting with nursing service -Other assisted living program with nursing service in unlicensed setting (private apartments)
Maryland		X	-Other residential care setting with nursing service
Minnesota		X	-Other residential care setting with nursing service -Other residential care setting -Other assisted living program with nursing service
Mississippi	X		-Other residential care setting
Montana		X	-Other residential care setting with nursing service -Other licensed health care facility (residential hospice)
Nebraska		X	-Other residential care setting with nursing service
Nevada[a]	X		-Assisted living residence with medical professional
New Hampshire		X	-Other residential care setting with nursing service -Other assisted living program with nursing (i.e., supported residential health care) in licensed and unlicensed settings (e.g. public housing)
New Jersey	X		-Assisted living residence with nursing service -Other residential care setting with nursing service -Other residential care setting -Other assisted living program with nursing service in licensed (ALR and other residential care settings) and unlicensed (public housing) settings
New Mexico		X	-Assisted living residence with nursing service
North Dakota		X	-Other residential care settings with nursing service

Exhibit 3 (Continued)

State	1915 (c) Waiver Limited to Assisted Living Services	1915 (c) Waiver Not Limited to Assisted Living Services	Assisted Living Services Setting(s)
Ohio	X		-Other residential care setting with nursing service
Oregon		X	-Assisted living residence with nursing service -Other residential care setting with nursing service -Other unlicensed assisted living services (i.e., Specialized Living Services) in unlicensed setting (i.e., private apartments)
Rhode Island[a]	X	X	-Other residential care setting with nursing service
South Dakota		X	-Other residential care setting with nursing service
Tennessee		X	-Other residential setting with nursing service
Texas		X	-Assisted living residence with nursing service -Other residential care setting with nursing service
Utah[a]		X	-Assisted living residence with nursing service -Other residential care setting with nursing service -Other unlicensed residential setting (i.e., host home) with nursing service
Virginia	X		-Other residential care setting with nursing service
Washington[a]	X	X	-Assisted living residence with nursing service -Other residential care setting with nursing service
Wisconsin[a]		X	-Assisted living residence (certified) with nursing service -Other residential care setting with nursing service
Wyoming	X		-Other residential care setting with nursing service

[a]State with more than one 1915 (c) Medicaid waiver with assisted living services.
[b]Participants may reside in licensed residential care settings or take part in other assisted living programs paid for through the Medicaid waiver. They may receive State Plan and waiver services, however, the annual costs for Medicaid State Plan and waiver services cannot exceed the allowed waiver cap.

Source: Developed by LB&FC staff from Medicaid regulations and provider manuals and state licensure and certification requirements.

Exhibit 4

Types of Settings in Which Assisted Living Services for Elderly and Adult Physically Disabled Individuals Are Provided in State Medicaid 1115 Waivers
(First Quarter 2008)

State	Assisted Living Services Setting(s)
Arizona	-Assisted living residence with nursing service -Other residential care setting with nursing -Other residential care setting
Vermont	-Assisted living residence with nursing -Other residential care setting with nursing

Source: Developed by LB&FC staff.

Medicaid State Plans: States that fund assisted living services through their Medicaid state plans also provide such services in a variety of settings. Of the 10 states shown in Exhibit 2 that fund assisted living services through both Medicaid plans and waivers, six (Arkansas, Florida, Idaho, Maine, North Dakota, Washington) permit residential providers other than those participating in their waivers to provide state plan assisted living services. All six states that fund assisted living exclusively through their state plans (Massachusetts, Michigan, Missouri, New York, North Carolina, South Carolina) purchase such services in assisted living residences and other residential settings. To participate in the New York Medicaid assisted living program, however, a provider must obtain a certificate of need and be licensed as a residential and home care agency or contract with a certified home health agency (or multiple agencies) to provide Medicaid assisted living services.

C. Medicaid Covered Assisted Living Services

Medicaid 1915 (c) and 1115 Waivers: Exhibits 5 and 6 list the Medicaid assisted living service packages purchased through Medicaid waivers. As shown in Exhibits 5 and 6, of the 39 states purchasing assisted living service packages through waivers, at least:

- 37 purchase personal care or attendant care, including health-related personal care requiring nursing supervision and/or delegation,
- 31 purchase medication management and/or administration,
- 25 purchase homemaker services,
- 24 purchase 24/7 monitoring and emergency response systems to meet both planned and unplanned resident needs,
- 21 purchase nursing services, and
- 10 purchase therapeutic social and recreational programming.

Exhibit 5

Assisted Living Services Required of Assisted Living Residences and Other Residential Care Providers Participating in State Medicaid 1915 (c) Home and Community-Based Service Waivers (ALS) for Elderly and Adult Physically Disabled Individuals (First Quarter 2008)

State	Assisted Living Services in Medicaid 1915 (c) Waivers
Alaska	Personal care assistant; Chore services; and Meal services
Arkansas	Medication oversight; Medication administration; Periodic nursing evaluations; Limited nursing services; Attendant care (i.e., assistance with activities of daily living, mobility and transferring, assistance with toileting or incontinence care, assistance with eating & drinking, etc.); Therapeutic social and recreational activities; and Non-medical transportation.
California	Intermittent skilled nursing care; Assistance with self-administration of medication; Medication administration as necessary; Personal care and assistance to meet scheduled and unscheduled needs; Washing, drying and folding all laundry; Performing all necessary housekeeping tasks; Facility maintenance; Three meals per day plus snacks, including accommodation for special diets; Providing or coordinating transportation; Daily social and recreational activities; Emergency response systems to summon immediate assistance from personal care provider; and Service plan development.
Colorado	Personal care (i.e., bathing, skin care, hair care, nail care, mouth care, shaving, dressing, feeding, ambulation, exercises, transfers, positioning, bladder care, bowel care, medication reminding, accompanying); Homemaking services (routine light housekeeping, meal preparation, dishwashing, bedmaking, laundry, shopping); and Protective oversight 24 hrs/365 days.
Connecticut	Nursing visits; Home health services not covered by Medicare; and Personal services (i.e., hands on assistance with daily living activities, such as medication management, dressing, grooming, bathing, using the toilet, transferring, walking, and eating, personal laundry, changing bed linens in conjunction with incontinence care or other needs which necessitate such assistance more than once per week).
Delaware	Nursing services, including assistance with medication administration, insulin/other injections, blood sugar monitoring, and nursing assessment; Home health aide services not covered by Medicare; Personal services/assistance with ambulating, transferring, grooming, bathing, dressing, eating and toileting; Meal services, including three meals per day and consultation with a dietitian and/or nurse for special diets; Social/emotional services for persons with dementia or other cognitive impairments and assistance with laundry, cleaning, shopping, etc.
District of Columbia	Intermittent skilled nursing; Medication administration; Attendant care; Personal care aide; Homemaker; Chore aide; Therapeutic social and recreational services; and Transportation.
Florida	Intermittent nursing; Medication administration; Physical therapy; Occupational therapy; Speech therapy; Specialized medical equipment and supplies; Attendant call system; Attendant care; Personal care; Homemaker; Chore Companion services; Behavior management; and Therapeutic social and recreational services.

Exhibit 5 (Continued)

State	Assisted Living Services in Medicaid 1915 (c) Waivers
Georgia	Personal care services supervised by an RN; Monitoring self-administration of medication; Meals and snacks, including modified or special diets and assistance with feeding and monitoring nutritional intake and status; Household services essential to a members health; Transportation for medical appointments; Obtaining prescriptions and medications; and Laundry services as part of personal care.
Hawaii	Personal care; Homemaking; and Transportation.
Idaho	Medication management; Personal care; Meals to include special diets; Housekeeping; Laundry; Transportation; Socialization and recreation; and Assistance with personal finances.
Illinois	Intermittent nursing; Medication oversight and assistance with self-administration; Personal care; Housekeeping; Maintenance; Laundry; Health promotion and exercise programming; Social and recreational programming; Transportation to community activities, shopping, and arranging outside services; Emergency call system; and 24 hour response/security staff.
Indiana	Medication oversight; Attendant care; Personal care and services; Homemaker; Chore; Companion services; Therapeutic social and recreational programming; and 24-hour onsite response staff to meet scheduled and unpredicted needs.
Iowa	Consumer directed attendant care, including assistance with *skilled services* (tube feeding, intravenous therapy, parenteral injections, catheterizations, respiratory care, care of decubiti & other ulcerated areas, rehabilitative services, colostomy care, care of medical conditions out of control, postsurgical nursing care, monitoring medications, preparing and monitoring responses to therapeutic diets, and recording and reporting of changes in vital signs) and *non-skilled* services (i.e., dressing, hygiene, grooming, bathing supports, wheelchair transfer, ambulation and mobility, toileting assistance, meal preparation, cooking, eating and feeding, housekeeping, medications ordinarily self-administered, minor wound care, employment support, cognitive assistance, transportation) under the direction of an RN or licensed therapist.
Kansas	Attendant care services to include *health maintenance activities* (medication administration and assistance, monitoring vital signs, supervision and/or training of nursing procedures, ostomy care, catheter care, enteral nutrition, wound care, range of motion, reporting of changes in functioning or condition) and *physical assistance or total support for ADLs* (i.e., bathing, grooming, dressing toileting, transferring, walking/mobility, eating, accompanying to obtain medical services and health); and Homemaker service (home management of IADLs and supervision of ADLs).
Maine	Coordination/and or oversight by a registered nurse of all covered services performed by unlicensed health care and assistive personnel; Assistance with activities of daily living, including transfers, changing positions in bed, bladder and bowel requirements, routine catheter care and routine colostomy care; Incidental household tasks (meal preparation, laundry, bedmaking, dusting and vacuuming) essential to maintain health and safety; Supervision of, or assistance with obtaining, storing and administering prescribed medication; Personal supervision; Care management services; and Diversional or motivational activities.

Exhibit 5 (Continued)

State	Assisted Living Services in Medicaid 1915 (c) Waivers
Maryland	Nurse oversight; Medication management; Personal care and chore services; Health care and social services; Daily monitoring of resident service plan; Meals, including special diets; Laundry and housekeeping services; Social and spiritual activities; Basic personal hygiene supplies; and 24-hour supervision.
Minnesota	Incidental nursing services (medication setups, insulin draws); Home health aide-like tasks (administration of medications, performing routine delegated medical or nursing or assigned therapy procedures, assisting with body positioning or transfers of consumers who are not ambulatory, feeding of individuals who are at risk of choking, assisting with bowel and bladder control, devices, and training programs, assisting with therapeutic or passive range of motion exercises, providing skin care, including full or partial bathing and foot soaks, during episodes of serious disease or acute illness providing services performed for or to assist the consumer with hygiene of their body and immediate environment); Home care aide-like tasks (preparing modified diets, reminding to take regular scheduled medication or perform exercises, perform household chores in the presence of technically sophisticated medical equipment or episodes of acute illness or infectious disease, perform household chores when required to prevent exposure to infectious disease or containment of infectious disease, assist in dressing, oral hygiene, hair care, grooming and bathing if the consumer is ambulatory and has no serious acute illness or infectious disease.); Central storage of medications; Home management (snack and/or meal preparation, personal laundry, housekeeping/cleaning, shopping); Supportive services (assistance in setting up appointments, managing funds, setting up medical and social services, arranging or providing transportation, socialization); Supervision of services (includes ongoing awareness of a person's needs and activities, and recognition of the need for assistance, and provision of the assistance required or the summoning of appropriate assistance); Provide each consumer a means to effectively summon assistance; and Supervision 24/7, if necessary and authorized.
Mississippi	Intermittent skilled nursing services; Medication oversight/medication administration; Attendant care services; Personal care services; Homemaker services; Chore services; Transportation; Therapeutic social and recreational programming; Attendant call system; and 24-hour on-site response staff to meet scheduled and unpredictable needs.
Montana	Medication oversight; Personal care services; Homemaking; Assistance in arranging transportation for medical care; Social activities; Recreational activities; and 24 hour on site response staff to meet scheduled and unscheduled needs.
Nebraska	Medication assistance; Health maintenance (e.g., recording height and weight, monitoring blood pressure, monitoring blood sugar, providing insulin injections to stable diabetics); Personal care services (including feeding a resident unable to eat independently or assuring other arrangements are made for such care); Adult day care/socialization activities; Escort services; Essential shopping; Housekeeping activities; Laundry services; Meal service; and Transportation services.
Nevada	Medication oversight; Augmented personal care; Homemaker; Chore; Companion services; Transportation; Therapeutic social and recreational programming; and 24-hour on-site response staff to meet scheduled or unpredicted needs.

Exhibit 5 (Continued)

State	Assisted Living Services in Medicaid 1915 (c) Waivers
New Hampshire	*Assisted living services*: Required: Medication management, attendant care, personal care, homemaker, chore, companion services, therapeutic social and recreational programming, meal preparation and serving. Optional: nursing services, personal emergency response systems, intermittent skilled nursing, 24-hour availability of on-site response staff to meet scheduled or unpredictable needs. *Congregate care:* Required: Case management, personal assistance, homemaker, meals, and transportation. Optional: adult group day care, health maintenance, personal emergency response system. *Residential care*: Required: Nursing services, periodic evaluations, home health aide services, homemaker services, environmental accessibility modifications, 24-hour supervision, and transportation.
New Jersey	Skilled nursing; Health monitoring; On-going assessment; Medication administration; Attendant care; Homemaker; Chore; Transportation; and Social activities.
New Mexico	Medication management; Medication oversight; Homemaker; Companion services; Social and recreational programming; and 24-hour on-site response capability to meet scheduled and unpredictable needs.
North Dakota	*Adult Foster Care*: Personal attendant care, non-medical transportation *Residential care (for persons with dementia or brain injury)*: Personal care, therapeutic social and recreational programming, 24-hour on-site response staff to meet scheduled and unpredictable needs.
Ohio	Nursing services (i.e., health assessments and monitoring, medication oversight, incidental skilled nursing when not available through a third-party payor); Skilled nursing care on a part-time intermittent basis, supervision of special diets, administration of medication, and application of dressings; Personal care; Supportive services (e.g., housekeeping, laundry and maintenance); 24-hour on-site response capability to meet scheduled and unscheduled needs; Co-ordination of the provision of meals; Non-medical scheduled transportation; Social and recreational programming; and Community transition services.
Oregon	Supervision and assistance 24-hours a day to support individual health, activities of daily living and instrumental activities of daily living.
Rhode Island	Medication oversight; Medication administration; Attendant care; Personal care; Homemaker; Chore; Companion services; Transportation; Therapeutic social and recreational programming; and 24 hour on-site response staff to meet scheduled and unpredictable needs.
South Dakota	Medication administration; Special diets; Supplemental oxygen (These services are only available to those requiring 24-hour supervision and cognitively or physically unable to perform the required service).
Texas	Personal care (includes medication administration, injections; transferring/ambulating 24-hour supervision, and meal services [including dietary counseling and nutrition education, modifying food texture, and assistance with eating]); Home management (i.e., changing bed linens, housecleaning, laundering, shopping, storing purchased items, such as medical supplies, in the client's living unit); Transportation and escort to the nearest available medical provider and local community and recreational activities; Social and recreational activities (at least 4 hours per week); and Participation in client assessment.

Exhibit 5 (Continued)

State	Assisted Living Services in Medicaid 1915 (c) Waivers
Tennessee	Medication oversight; Personal care and homemaker services.
Utah	General nursing care; Medication assistance; Assistance with activities of daily living; Assistance for physical transfers; Assistance to evacuate the building, if necessary; Housekeeping services, including personal laundry; Three meals per day; Planned social and recreational activities; 24/7 general monitoring and emergency response services; Participation in care plan development and interaction with designated Case Management Agency; and Coordination of third party services.
Virginia	Nursing evaluations; Skilled nursing services to complete resident assessments, administer medications, and provide training, consultation, and oversight of direct care staff; Medication administration; Attendant care; Personal care; Homemaker; Chore; Companion services; Therapeutic social and recreational programming appropriate for residents with dementia (19 hours of planned group programming each week not to include activities of daily living with each resident having at least one hour of one-on-one activity per week, not to include activities of daily living); and 24-hour on-site response staff to meet scheduled and unpredictable needs.
Washington	*Adult Residential Care*: Personal care. *Assisted Living and Enhanced Adult Residential Care:* Intermittent nursing services; Medication administration; Personal care services; Supportive services. *Enhanced adult residential care Specialized Dementia Care*: Must provide the Enhanced Adult Residential Care Services in a specialized dementia care program and maintain awake staff 24/7.
Wisconsin	*Adult Family Homes and Community-based residential care facilities:* Several hours of nursing care per week, Health care; Personal care; Supervision; Behavioral and social supports; Daily living skills training; and Certain transportation. *Residential care apartment complexes*: Nursing services; Personal assistance; Supportive services; and Assistance in the event of an emergency.
Wyoming	Any necessary medication assistance; Personal care; and 24-hour supervision.

Source: Developed by LB&FC staff.

The states with waivers that border Pennsylvania (Delaware, Maryland, New Jersey, and Ohio) include nursing services in the assisted living service package they purchase. Delaware (like Connecticut) specifies that all home health aide service not covered by Medicare is included within the waiver's assisted living service package.

Exhibit 6

Assisted Living Services Required of Assisted Living Residences and Other Residential Care Providers Participating in State Medicaid 1115 Waivers
(First Quarter 2008)

State	Assisted Living Services in Medicaid 1115 Waivers
Arizona	Personal care, Homemaker
Vermont	Nursing overview (assessment, health monitoring, routine nursing care provided or supervised by an RN, available one hour per resident per week), Medication management (includes administrating medication), Personal care services, Household services, Laundry, Recreation activities, 24-hour on site supervision.

Source: Developed by LB&FC staff.

Medicaid State Plans: Of the 16 states providing assisted living services through Medicaid state plans, most are purchasing health-related personal care service.[20] As shown in Exhibit 7, five (Maine, Massachusetts, New York, Vermont, Washington) of the 16 also include nursing service or treatment in the assisted living service package they purchase.

New York's state plan assisted living service package is the most comprehensive of any of the states. In addition to personal care and nursing service, New York's assisted living service package includes physical, occupational and speech therapy, certain medical equipment and supplies, home health aide services, adult day care, care management (including transfer to a higher level of care), and personal emergency response services. Such differences in covered services are important when considering maximum allowable payment rates available through Medicaid. As discussed below, New York's Assisted Living Program rates are among the highest in the nation.

[20]Personal care Medicaid State Plan services mean services 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 authorized for the individual by a physician as part of a plan of treatment or in accordance with a service plan approved by the state. Personal care services are provided in the home by individuals qualified to provide the services and who are not members of the individual's family (i.e., legally responsible relative). The federal Medicaid program does not require states to provide personal care services in their state Medicaid plans. States that elect to provide personal care services in the home may also elect to provide such services in other locations. Pennsylvania's Medicaid State Plan does not include personal care service.

Exhibit 7

Medicaid State Plans Funding Assisted Living Services Provided by Assisted Living Residences (ALRs) and/or Other Residential Care (ORC) Settings Enrolled as Medicaid Providers

State	State Plan Assisted Living Services
Arkansas	*Personal care*
Florida	*Assistive Care Services*: an integrated set of services on a 24-hour per day basis that include health support, assistance with daily living activities, assistance with instrumental activities of daily living, and assistance with self-administration of medication
Idaho	*Personal assistant services*: including assistance with medication and nursing supervision. Limited to a maximum of 16 hours of service per week.
Maine	*Assisted living services:* includes administration of prescribed medications; ADLs; personal care, including routine colostomy care; and care management *Adult Family Care*: includes personal care such as routine colostomy care and supervision and assistance with administration of prescribed medication *Private Non-Medical Institution Services* includes food, shelter, and treatment
Massachusetts[a]	*Group Adult Foster Care:* includes medication management, personal care, nursing care management and 24-hour access to services *Adult foster care:* includes nursing services and oversight, direct care, care management, 24/7 assistance with scheduled and unscheduled needs
Michigan[a]	*Personal care in adult foster care or home for the aged*
Minnesota	*Personal care:* includes health related functions that can be delegated or assigned under state law by licensed health care professionals to be performed by a personal care attendant under the direction of a qualified professional in a foster care setting with no more than four residents
Missouri[a]	*Basic personal care:* "medically-oriented, maintenance services to assist with activities of daily living when this assistance does not require devices and procedures related to altered body functions." *Advanced Personal Care*: routine personal care with ostomies, care of external, indwelling and suprapubic catheters, administration of prescribed bowel programs, manual assistance with noninjectable medications set up by a nurse, use of assistive device for transfer, etc. in licensed residential care facilities.
Montana	*Personal care*: includes medically necessary in-home services not including skilled services that require professional medical training unless otherwise permitted in state law provided by adult foster home or group home. Up to 40 hours a week may be prior authorized.
New York[a]	*Assisted Living Program:*[b] provides nursing services; physical, occupational, and speech therapy; medical equipment and supplies that do not require prior authorization; home health aide services; personal care services; adult day health; case management (including arranging transfer to a higher level of care); and personal emergency response services.

Exhibit 7 (Continued)

State	State Plan Assisted Living Services
North Carolina[a]	*Adult Care Home Personal Care*: includes medication administration and, for example, care for pressure ulcers, feeding for residents with swallowing problems, colostomy care, oral suctioning, gastrostomy tube feeding, etc. with nursing assessment, monitoring, and supervision of selected personal care tasks.
North Dakota	*Basic Care Assistance Provider*: delivers personal care, including medication assistance, general maintenance catheter and ostomy care, etc..
South Carolina[a]	*Integrated Personal Care*: includes assistance with bathing, dressing, toileting and maintenance of continence, eating, transferring, ambulating, incontinence care, observing and monitoring overall condition to include temperature, pulse rate, respiratory rate, and blood pressure, reporting changes in condition under plans of care developed by a nurse and nurse training and determination of competence and monitoring of unlicensed attendants.
Vermont	*Assistive Community Care Service*: includes nursing assessment and routine nursing tasks, medication assistance, personal care services, case management, 24-hour on-site assistive therapy.
Washington	*Adult Residential Care*: provides personal care services including medication management, body care with the application of certain dressings and ointments performed by a licensed nurse or through nurse delegation, assistance with bathing, bed mobility, eating, locomotion in room, immediate indoor and outdoor environment, toilet use, transfer, and personal hygiene.
Wisconsin	*Personal care*: includes medically oriented activities (e.g., home health aide) related to assisting an individual with activities of daily living to remain in their residence where such activities are supervised by a nurse. Services limited to 250 hours per calendar year unless additional service is prior authorized. Residential provider participation limited to providers with no more than 20 beds.

[a]State without waiver funding for assisted living services.
[b]To apply to participate as a qualified provider in the New York Medicaid Assisted Living Program, a residential or congregate care provider must be licensed and have obtained a certificate of need (CON) to provide assisted living services. In addition, such providers must be licensed home care providers or contract with a certified home health agency or approved long term home health program (in New York hospitals and health care facilities qualify to operate such programs). Other Medicaid provider requirements also apply.

Source: Developed by LB&FC staff.

D. Medicaid Reimbursement Methods and Maximum Allowable Payments for Assisted Living Services in Assisted Living Residences

States vary in their Medicaid reimbursement methods and maximum allowed payments for waiver services provided by assisted living residences. They also vary in their methods and maximum allowed payments for state plan assisted living services.

1915 (c) and 1115 Waivers: As shown in Exhibits 8 and 9, of the 15 states with waivers that purchase services of assisted living residences:

- Five states (Arkansas, California, Nevada, Oregon, and Vermont) have tiered payments based on the assessed needs of the waiver participant.
- Four states have flat payments (Kansas, New Jersey, New Mexico, and Utah) that do not vary based on the differences in assessed needs of waiver participants.
- Two states (Hawaii and Washington) have tiered payments based on the assessed needs of waiver participants and regional differences in cost of care.
- Two states (Wisconsin, Arizona) negotiate rates with individual providers for individual waiver participants.
- One state (Texas) has both a tiered and flat rate payment system.
- One state (Illinois) has a flat payment system that varies by region.

About half (6 of 13) of the states in Exhibits 8 and 9 with waivers that do not negotiate rates and purchase assisted living services in assisted living residences and other residential care settings (and/or programs) have the same maximum allowed rates for assisted living residences and their other assisted living service providers. Such states include Arkansas, California, Hawaii, Kansas, Illinois, and Utah. Notable exceptions include New Jersey.

New Jersey has a flat rate for assisted living residence services that does not vary based on differences in individual care needs. Its maximum allowed per diem payment for assisted living services in an assisted living residence, however, is $10 higher than for services in other residential care settings, and $20 higher than for services through other assisted living programs (i.e., an assisted living program providing care in public housing).

Exhibit 8

Type of Reimbursement and Maximum Allowable Reimbursement Levels for Assisted Living Services Provided by Assisted Living Residences in State Medicaid 1915 (c) Home and Community-Based Service Waivers for Elderly and Adult Physically Disabled Individuals*

State	Type of Reimbursement Method	Maximum Allowable Participant Rate[a]	Monthly Room and Board Rate
Arkansas	Tiered rates (4) based on assessed need	$44.49 $48.22 $53.43 $56.25	$566[b]
California	Tiered rates (4) based on assessed need	$52 $62 $71 $82	$444[b]
Hawaii	Tiered rates (2) based on assessed need adjusted for region and receipt of SSI	*SSI recipient*: $24.98 - $29.98 $41.06 - $46.06 *Cost Share*: $51.14 - $56.13 $67.22 - $72.22	$1,228.90 $418
Illinois	Flat rates based on geo-graphic region (7)	$56.23 - $71.98	$547
Kansas	Fee-for-service for atten-dant care prior authorized in individual care plan	$3.31 - $3.66 per unit of service (15 minutes) up to a maximum of 8 hours per day.	Not Applicable
Nevada	Tiered rates (3) based on assessed need	$20 $45 $60	$912
New Jersey[c]	Flat rate	$70	$692.55
New Mexico	Flat rate	$51.49[b]	Not Reported.

Exhibit 8 (Continued)

State	Type of Reimbursement Method	Maximum Allowable Participant Rate[a]	Monthly Room and Board Rate
Oregon[c]	Tiered rates (5) based on assessed need	$727 monthly (i.e., about $24 daily) $962 monthly $1,271 monthly $1,662 monthly $2,052 monthly (i.e., about $68 daily)	$494.70
Texas[c]	Tiered rates (6) based on level of provider effort to provide appropriate services based on individual medical need for providers participating in an Attendant Care Rate Enhancement Program (ACRE) and apartment occupancy	*Single Occupancy Apartment ACRE Participant*:[d] $50.22 $51.94 $58.17 $55.58 $62.34 $67.30 *Double Occupancy Apartment ACRE Participant*:[d] $43.23 $44.96 $51.18 $48.59 $55.35 $60.30 *Single Occupancy non ACRE*: $42.08	$552
	Flat rate for providers that do not participate in the ACRE based on apartment occupancy	*Double Occupancy non ACRE*: $33.03	
Utah	Flat rate	$69.75	

Exhibit 8 (Continued)

State	Type of Reimbursement Method	Maximum Allowable Participant Rate[a]	Monthly Room and Board Rate
Washington[c]	Tiered rates (12) based on assessed need and regions which vary by region (3) and the percent of Medicaid occupancy (less than 60 percent Medicaid, 60 percent or more Medicaid)	Region 1: •$74.63 - $110.11 with 60 percent or more Medicaid occupancy •$69.22 - $104.70 with less than 60 percent Medicaid occupancy Region 2: •$68.41 - $106.17 with 60 percent or more Medicaid occupancy •$63.49 - $101.25 with less than 60 percent Medicaid occupancy. Region 3: •$67.60 - $106.49 with 60 percent or more Medicaid occupancy •$62.36 - $101.25 with less than 60 percent Medicaid occupancy	Room and board is included in the maximum allowable per diem rate, but federal matching funds are not requested for the room and board payment amount ($576.22)
Wisconsin		Rates are negotiated with the county responsible for administering the waiver. Under the waiver, an individual waiver participant's total service costs (including administration, case management, transportation, state plan services etc.) cannot exceed $88.22, and counties are required to ensure that the average cost of waiver services for all waiver participants does not exceed 48 percent (about $42) of the individual waiver participant maximum allowed amount.	

*2008 information unless otherwise footnoted.

[a]Daily unless otherwise specified.

[b]2007 information.

[c]Rates differ for assisted living residences, other residential care settings, and/or other assisted living programs participating in the waivers.

[d]Opportunity for rates to increase from $0.05 to $9.95 based on level of participation in ACRE.

Source: Developed by LB&FC staff.

Exhibit 9

Type of Reimbursement and Maximum Allowed Reimbursement for Assisted Living Residences in Medicaid 1115 Waivers

State	Type of Reimbursement Method	Maximum Allowable Participant Daily Rate	Monthly Room and Board Rate
Arizona	Managed Care Organization (8) negotiated rates based on levels of care (3) for which the facility is licensed.	*Supervisory care services*: $56.84 - $75.89 *Personal care services*: $62.50 - $95.15 *Directed care services*: $79.00 - $114.73 (2007)	$512.55 (2007)
Vermont	Tier (3) rates based on need + flat fee for Medicaid state plan personal care ($34.25).	$53.95 $60.69 $67.44 (2007)	$627.72 (2008)

Source: Developed by LB&FC staff.

Another notable exception is Texas. Texas has different rates for assisted living residences and assisted living service provided in other residential care settings (which are not shown in Exhibit 8). In Texas, however, certain small other residential care settings with high staff to client ratios (1:4) and mostly private bedrooms have one of the highest allowed assisted living service reimbursement rates. Such residential settings have maximum allowable payment rates of $66.43 per day compared with $67.30 per day for the highest tier of assisted living residence services. Texas rates also differ from other states in that they vary by unit or room occupancy, and they include certain financial incentives for providers to pass on rate increases to direct care staff.

Exhibits 8 and 9 also display the maximum allowable payment rates under Medicaid waivers for assisted living residences. The exhibits show that for the 13 states with defined maximum allowed per diem rates[21]

- Nine states (Arkansas, California, Hawaii, Illinois, Nevada, New Mexico, Oregon, Texas, and Vermont) have their lowest allowable rates set below $60, and

- Ten states (California, Hawaii, Illinois, Nevada, New Jersey, Oregon, Texas, Utah, Washington, and Vermont) have their highest allowable rates set at or above $60.

[21]Arizona, Kansas and Wisconsin are excluded from the analysis as their rates are provider specific negotiated rates or based on the Medicaid program's established fee schedule for units of authorized service.

Of the 13 states, Nevada has the lowest maximum allowable rate ($20 for the first level of care tier), and Washington and Vermont have some of the highest rates ($110.11 in the Seattle area of Washington for a participant with the highest level of assessed need in an assisted living residence with more than 60 percent of its occupancy accounted for by Medicaid and $101.69 in Vermont for a participant receiving both waiver services and Medicaid state plan Assistive Community Care Service described in Exhibit 7.)

A Nevada waiver participant who qualifies for the maximum allowable rate of $20 per day requires "supervision and cueing to monitor the quality and completion of basic self-care and activities of daily living." Such a participant, moreover, may only require minimal hands on assistance and their ability to swallow must be intact—thus precluding individuals with more advanced stages of dementia. Nevada licensure regulations typically do not allow residential care facilities to admit or retain any person who is bedfast (i.e., unable to change position in bed without assistance of another person) or immobile, requires confinement in locked quarters, or requires skilled nursing or other medical supervision on a 24-hour basis.

The state of Washington licensure regulations allow a facility to retain any ambulatory adult[22] it can safely serve, except for individuals who require the frequent presence and evaluation of a registered nurse unless the individual is receiving hospice care or has a short-term illness that is expected to be resolved within 14 days and the facility is able to provide the necessary care. In order for a Washington waiver participant to qualify for the maximum allowable rate of $110.11, the participant would need to have an Activity of Daily Living (ADL) score of 18-28 on Washington's needs assessment instrument. To attain a minimum score of 18, an individual must be totally dependent in four of six ADL areas (i.e., personal hygiene, bed mobility, transfers, eating, toilet use, and dressing) and require limited assistance in a fifth area. An individual would attain an ADL score of 19 if totally dependent in four ADL areas and also totally dependent for locomotion in room, outside of the room, and walking in the room. Washington's maximum allowed payment rate, moreover, includes the total payment for room and board.

State Plan Services: State Medicaid Plan rates for assisted living services do not lend themselves to comparison as state plan services do not require an individual be in need of nursing facility level of care to qualify for state plan services. Exhibit 10, however, provides information on the reimbursement methods and maximum allowed payments in the 16 states providing assisted living services through their state Medicaid plans. The exhibit shows that five (Maine, Massachusetts, Missouri, New York and Washington) of the 16 states have a type of tiered payments. North Carolina has a flat fee schedule, however, it provides for need-related payment enhancements.

[22]Facilities that meet additional state standards and are approved by the state director of fire protection to care for semi-ambulatory or non-ambulatory residents may admit and retain such residents.

Exhibit 10

Medicaid State Plans Funding Assisted Living Services Provided by Assisted Living Residences (ALRs) and/or Other Residential Care (ORC) Settings Enrolled as Medicaid Providers

State	Reimbursement Method(s)	Maximum Allowed Payment(s)
Arkansas	Flat fee-for-service	$3.46 per unit of service (15-minute) in 2008
Florida	Flat fee-for-service	$9.28 per day in 2008
Idaho	Flat fee-for-service	$3.77 per unit of service (15 minutes) in 2008
Maine	Tiered fee-for-service rate Tiered fee-for-service rate Facility peer group and case mix adjusted rates based on allowable costs that exclude room and board and regionally adjusted for inflation	$36.59-$83.24 per day based on individual assessed need $23.84-$71.68 per day based on individual assessed need Vary by facility
Massachusetts[a]	Flat fee-for-service Tiered fee-for-service	$37.75 per day in 2008 Level I--$37.75 per day Level II $82.02 per day
Michigan[a]	Flat fee-for-service	$184 per month in 2008[b]
Minnesota	Flat fee-for-service based on ratio of participating residents to attendants in the group setting	$2.63 per unit of service (15 minutes) with a 1:1 attendant to resident ratio, $2.99 for a shared 1:2 ratio, and $2.63 for a 1:3 ratio in 2008
Missouri[a]	Tiered fee-for-service	$3.88 per unit of service (15-minutes) for Basic Personal Care provided by a facility, and $4.39 for a unit of Advanced Personal Care in 2008
Montana	Flat fee-for-service	$2.64 per unit of service (15 minutes) in 2008
New York[a]	Capitated per diem rates that vary by region (16) and participant resource utilization groups (16) Residents may not be discharged because their service costs exceed the capitated payment rate	$43.84 -$85.14 in the region with the lowest rates, and from $71.87 to $147.68 in the region with the highest rates in 2008

Exhibit 10 (Continued)

State	Reimbursement Method	Maximum Allowed Payment
North Carolina[a, c]	Flat-fee-for service basic rate base on facility size with "add on" or enhanced payments for "heavy care" residents and	$17.50 per day in facilities with less than 31 licensed bed $19.17 per day in facilities with 31 or more beds in 2008 Enhanced payments for "heavy care" residents: $10.80 per day for eating, $3.86 for toileting, $14.66 for eating and toileting, and $2.78 for ambulation/ locomotion
	Separate flat-fee-for service rates for Special Alzheimer's Units based on facility size and with no enhanced payments	$45.76 per day in facilities with a Special Alzheimer's Unit and less than 31 licensed beds $51.25 in facilities with Special Alzheimer's Units and 31 or more beds in 2008
North Dakota	Facility specific rates	$18 per day to $49.33 per day in 2008
South Carolina[a, d]	Flat fee-for-service rate	$16 for a unit of service (1 hour per day) in 2008
Vermont	Flat fee-for-service	$34.25 per day in 2008
Washington	Tiered rates (12) based on individual assessed need that vary by region (3) and which include room and board payments	$48.95 to $83.04 per day in non-metropolitan areas and $48.95 to $92.94 per day in the state's major metropolitan area in 2008
Wisconsin	Flat fee-for-service	$3.96 for a unit of service (15 minutes) in 2008

[a]State without waiver funding for assisted living services.
[b]The federal Center for Medicare and Medicaid Services (CMS) is now requiring Michigan to change its reimbursement methodologies for personal care services in adult foster care and community mental health facilities. CMS has indicated that payments must go directly to personal care providers, rather than the facility, and payments must be based on the individual and his/her activity of daily living needs and the actual services delivered. As of late February 2008, Michigan was in negotiations with CMS.
[c]Program under discussion with CMS.
[d]Facility resident must qualify for the Optional State SSI Supplement to qualify for the program.

Source: Developed by LB&FC staff.

Eight states (Florida, Maine, Massachusetts, New York, North Carolina, North Dakota, Vermont, and Washington) reimburse for a day of service. Their maximum allowable per diems range from $9.28 per day in Florida for an individual who would not require the level of care provided in a nursing facility to as high as $147.68 per day in New York City for an individual who must require nursing facility level of care to be eligible for New York's program.

The New York Assisted Living Program participant qualifying for the maximum allowable payment of $147.68 per day would require daily restorative therapy (i.e., physical therapy and/or occupational therapy) for four or more consecutive weeks and have an ADL score of at least 5 based on New York's assessment. An example of a participant with an ADL score of 5 under New York's assessment system is one who requires continuous supervision and/or physical assistance with eating and is incontinent, taken to toilet on a regular schedule.

The New York program permits providers to care for individuals who require nursing facility level care unless they require continual nursing or medical care, are chronically bedfast and require lifting equipment to transfer or the assistance of two persons to transfer, or are cognitively, physically or medically impaired to a degree which endangers the safety of the resident or other residents. Residents such as these, however, may be retained in the program if a physician certifies such residents' needs will be met, and the assisted living program provider agrees to retain the residents. When residents can no longer be retained in the program, the provider is responsible for assisting them to secure alternative placement and must routinely notify the appropriate state office of applications that have been completed, are pending, or have been rejected for transfer to an appropriate facility.

The New York Assisted Living Program's maximum allowable payment of $147.68 per day in New York City is the highest Medicaid assisted living service rate of any state providing assisted living services either through a waiver or state plan services. New York providers, moreover, can receive up to $1,072 monthly for room and board in 2008. New York's Medicaid rate, however, is a capitated rate for a bundled package of service. As a consequence the assisted living program provider is responsible for the cost of all assisted living services included in the bundled service package and required by the resident even if the assisted living provider does not provide the service. Assisted living program providers, for example, are responsible for Medicaid payment for Medicaid covered medical equipment and supplies even when such supplies are delivered by other Medicaid providers.

E. Approaches Used by State Medicaid Programs to Develop Their Assisted Living Residences Rates

State Medicaid programs face challenges in designing rate setting methodologies for assisted living residences. They need to set their Medicaid reimbursement rates at a level high enough to promote provider participation and quality care for their clients. States must also be concerned that those methodologies meet both state budget constraints and federal Medicaid requirements.

States that provide assisted living services in assisted living residences and other residential care settings under a Medicaid 1915 (c) home and community-based (HCBC) waiver use various methods to establish their reimbursement rates. According to instructions for the HCBS waiver application issued by Centers for Medicare & Medicaid Services (CMS) in February of 2008, waiver payment rates may be determined in a number of ways, and they are allowed to vary based on the type of service being offered. Rates can include factors to provide for serving individuals with different levels of need or to adjust for geographic differences in providing services in different parts of the state. Rates may also reflect a state-established fee-for-service schedule. CMS, however, requires states to have consistent rate determination methods or standards that they apply to each waiver service and all jurisdictions. The state, moreover, must clearly identify the methods used to determine the rates in the state's waiver application.

LB&FC staff attempted to identify how the states that fund assisted living services in assisted living residences established their rates for such services. In order to determine how the reimbursement rate was set, we reviewed documentation and spoke with program staff for each of the 13 states with 1915 (c) home and community-based waivers. Exhibit 11 identifies the rate setting methods used. As shown in the Exhibit, in some cases more than one factor was used in the state's rate determination method.

- Seven of the thirteen states provided for tiered rates based on the assessed needs of the client.
- Three states, Hawaii, Illinois, and Washington, varied their rates based on geographic location.
- California, Illinois, and Utah used the state's rate for skilled nursing facilities as a base when establishing the rate for assisted living services.
- Kansas used its Medicaid state plan fee-for-service schedule for attendant care services and pays assisted living residences for the authorized units of such services in an individual care plan that are delivered to the resident.
- Wisconsin negotiated the reimbursement rate with each county that is responsible for administering the waiver (and the counties in turn negotiate rates with providers).

- California, New Mexico, and Texas based their rates on costs as reported by providers.
- Washington based its rates on a time study conducted to determine resource use associated with the assessed level of care need,[23] wages from the state department of labor, and administrative costs reported by nursing homes.
- New Jersey and Utah used a pilot program to establish base rates for similar services which were adjusted to reflect assisted living services.
- We were unable to determine how rates were initially established in Arkansas, Hawaii, and Oregon.

Although Oregon was unable to provide information on how its tiered rates were originally established, its rate setting unit is considering two methods to revamp Oregon's existing Medicaid rates. In the first scenario, Oregon would conduct a market survey of private assisted living facility rates. Such private market rates would be indexed at some percentage (perhaps 85%) for the Medicaid waiver rates. Under the second scenario, Oregon would take the average number of hours of service provided to clients at private assisted living facilities in a month and use an hourly rate to determine Medicaid's reimbursement amount. All assisted living service providers regardless of the service setting would be similarly reimbursed based on their hours of client service. According to Oregon program staff, preliminary estimates for either of these methods would result in a rate close to the current rates.

[23]The Washington study found that the median amount of one-on-one time received was 44 minutes per day for Boarding Home [i.e., assisted living residences and other residential care settings] residents and 85 minutes per day for Adult Family Home residents. Data on residents' activities of daily living, Cognitive Performance Score, and whether they were classified as clinically complex or having a behavior problem accounted for 47 percent of the variation in direct care time for boarding home residents and 30 percent of direct care time for adult family home residents. In the time study, the amount of direct care time residents received also varied dramatically. In boarding homes, 10 percent of the residents received less than 9 minutes of direct care each day and another 10 percent received over 2 hours of direct care time. Among the Adult Family Home residents, 10 percent received less than 24 minutes and another 10 percent received over 3 hours of direct care time.

Exhibit 11

How Rates Were Determined in Select States

State	Rate	Rate Determined
Arkansas	Tiered per diem	NOT AVAILABLE
California	Tiered per diem	Rates are based on estimated costs as reported for skilled nursing facilities and for other state waivers to cover the included services and stay within Medicaid guidelines. The average midrange rate for AL mirrors the average midrange rate for Residential Care Facilities for the Elderly.
Hawaii	Tiered per diem	NOT AVAILABLE
Illinois	Flat rate by region	Rate calculated at 60 percent of the weighted average of nursing facility rates by geographic region.
Kansas	Fee for service	Fee for service schedule rate for attendant care authorized in individual care plan not to exceed 8 hours per day.
Nevada	Tiered per diem	Rates based on prior waiver programs with similar services. These are not cost based but rather market rates intended to attract providers to the program.
New Jersey	Flat per diem	Rate based on Adult Family Care demo program rate (1995) plus an allowance based on the type of facility (Residential Health Care Facility or Assisted Living Residence). The add-on provides for capital outlay costs for improving existing or building new facilities.
New Mexico	Flat per diem	Based on a rate study using cost info from a cost survey to providers. Includes wage proxies, estimates of staffing levels for provided services, and other estimated costs to provide services.
Oregon	Tiered monthly	NOT AVAILABLE for old rates. Currently revamping rates based on one of two methods: a) Average of private ALF rates from a market survey, indexed using 85%. b) Use average number of hours to provide services to clients (235 hrs/mo for levels 4-5) times the service rate used for residential care facilities and adult foster homes ($11.00/hr)
Texas	Tiered per diem	Rates are calculated using the median cost for each level of service based on 4 cost areas as reported annually by personal care homes including: attendant costs; direct care costs; facility & operations costs; and admin and transportation costs.
Utah	Flat per diem	Rate based on a pilot program run under a previous 1915 (a/b) waiver which established a capitated rate for managed care in skilled nursing facilities. This rate included room and board costs which were deducted to meet CMS requirements for AL services.
Washington	Tiered per diem	Levels of service tiers based on time study to determine need levels. Rates for each tier is in part cost based using: wages based on data for care providers from WA Dept Labor Statistics and benchmarked to reflect lower wage rate for residential care workers, and admin costs based on annual reported cost data from nursing homes. Rate setting also considered state budget constraints and the need to set rates to ensure provider participation.
Wisconsin		Negotiated with administering county

F. Factors Influencing the Design of Public Funding Models for Assisted Living

When considering public financing models for assisted living, it is important to consider factors that differentiate states and influence the models they select. A comprehensive list of such factors is outside of the scope of this report. Some examples, however, highlight some important differences between the Commonwealth and other states and why models in place in other states may or may not lend themselves for adoption in Pennsylvania, and why models that one state may view as efficient and effective may not be viewed as such by states with different public funding objectives. Examples of such factors include: criteria for assisted living resident retention, state nurse practice acts, nursing facility and resident characteristics, and the state's objectives in public funding of assisted living.

Assisted Living Resident Retention Criteria: Most states explicitly prohibit admission or retention of persons who are a danger to themselves or others and those whose needs cannot be met by the residence. They also permit discharge of residents for failure to pay room and board and other agreed on charges. There are, however, substantial differences in state licensure criteria for retention of residents in assisted living. Exhibit 12 provides certain assisted living retention criteria for the 15 states where Medicaid pays for assisted living residence services.

Exhibit 12

Selected Assisted Living Resident Retention Criteria for States Where Medicaid Pays for Assisted Living Service in Assisted Living Residences

State	Retention Criteria
Arizona	May not retain those unable to direct their own care; who are bed bound; have stage III or IV pressure sores, or require continuous nursing services unless provided by a licensed hospice service agency or a private duty nurse.
Arkansas	May not retain those who need 24-hour nursing services, are bedridden, or have mobility needs the facility cannot meet. If resident is terminal, services may be provided if a physician or nurse certifies that their needs can be met.
California	May not retain those that require 24 hour skilled nursing or intermediate care, oxygen, catheter or colostomy care, have contractures or diabetes, need enemas or suppositories, are incontinent, need injections or intermittent positive pressure breathing machines, have stage I and II dermal ulcers, or need wound care, unless 24-hour skilled nursing or care is available.
Hawaii	May not retain those whose need for services cannot be met.
Illinois	May not retain those who need nursing care or require total assistance with two ADLs.
Kansas	May not retain those with unmanageable incontinence; who are immobile; have a condition requiring two-person transfer; or require ongoing skilled nursing intervention that is needed 24-hours per day, unless the service agreement includes 24-hour hospice or family support services.
Nevada	May not retain those who are bedfast; require 24-hour skilled nursing or other medical supervision; need gastrostomy care; suffer from a staphylococcus infection or other serious infection or medical condition. A resident unable to self-manage their medical conditions must be discharged.
New Jersey	May not retain those who require specialized long term care, such as respirators, ventilators, or severe behavior management. Facilities may specify other discharge requirements, such as 24-hour nursing supervision, for retention of residents with nursing, ADL and mobility needs.
New Mexico	May not retain those if they require continuous nursing care, which may include ventilator dependency; or stage III or IV pressure sores.
Oregon	May not retain those whose needs exceed the level of ADL services available; who have a medical or nursing condition that is complex, unstable, or unpredictable; or if the facility is unable to evacuate the resident.
Texas	May not retain those whose needs cannot be met. Residents may contract with a home health agency to provide needed services or they must be discharged.
Utah	May not retain those who are immobile; require inpatient nursing care; do not have stable health; require more than limited assistance with ADLs; or require regular or intermittent care in the facility from a licensed health professional. Those unable to take life-saving action in an emergency without assistance must be discharged.
Vermont	May not retain those whose needs cannot be met. Those needing 24-hour nursing care; who are bedridden; dependent in four or more ADLs; have severe cognitive decline; stage III or IV pressure sores; or have an unstable medical condition may be retained if the facility can care for them. Those needing skilled nursing care may arrange for that care to be provided.
Washington	May not retain those requiring the frequent assistance of a registered nurse, except those residents receiving hospice care, or who have a short-term illness or are nonambulatory.
Wisconsin	May not retain those whose needs cannot be met; or who require more than 28 hours of supportive [e.g., housekeeping}, personal [i.e., assistance with ADLs], and nursing services per week; or who require the immediate availability of a nurse 24-hours per day.

Source: Developed by LBFC staff from *Assisted Living State Regulatory Review, March 2008,* prepared by the National Center for Assisted Living.

As shown in Exhibit 12:

- 9 states (Arizona, Arkansas, California, Illinois, Kansas, Nevada, New Mexico, Utah and Wisconsin) have specific criteria prohibiting retention of residents requiring continuous nursing care. Three (Arizona, Arkansas, and Kansas) of the nine states provide exceptions for residents receiving hospice care.
- 6 states (Arizona, Arkansas, Kansas, Nevada, Utah, and Washington) have explicit criteria prohibiting retention of residents who are bedfast or immobile or require more than two persons for transfer.
- 3 states (Illinois, Utah, and Wisconsin) have explicit criteria related to Activity of Daily Living (ADL) need requirements.
- 2 states (New Jersey and Oregon) permit assisted living residences to establish their own criteria for retention of residents with nursing, ADL, and mobility needs. New Jersey, however, requires mandatory discharge of residents in need of specialized long term care, such as respirators and ventilators.
- 1 state (Texas) requires discharge of residents whose needs cannot be met by the residence, but provides an exception if such need's can be met by the resident's home health agency.
- 1 state (Arizona) prohibits retention of residents unable to direct their own care.

Of the states in Exhibit 12, Vermont's criteria most closely mirror the retention criteria in Pennsylvania's assisted living statute. Pennsylvania's statute permits admission and retention of residents who are immobile and residents with skilled nursing needs. It also authorizes the Secretary of Public Welfare to permit retention of individuals with continuous skilled nursing needs if the Secretary determines the resident's needs can be met by the licensed residence.

Vermont licensure regulations[24] do not allow assisted living facilities to accept or retain any individual if the individual has a serious, acute illness requiring the medical, surgical or nursing care provided by a general or special hospital. Such facilities are also prohibited from admitting individuals with the following equipment or care needs: ventilator; respirator; stage III or IV decubitus ulcer; nasopharangeal, oral or trachial suctioning; or two-person assistance to transfer from bed or chair or to ambulate. Licensed facilities, however, are permitted to retain current residents who develop a need for such equipment or treatment or who develop a terminal illness while in the residence as long as the provider can safely meet the resident's needs. In addition, the Medicaid program permits providers to retain residents requiring more complex services (e.g., daily catheters, feeding tubes, Stage III or IV decubitus ulcers, suctioning and sterile dressing) with specific approval for the resident's care from the licensing agency.

[24]As of June 2008, regulations had not been promulgated to implement assisted living residence licensure in Pennsylvania.

Vermont's assisted living discharge criteria are consistent with its assisted living public funding model's emphasis on "aging in place" and its Medicaid waiver's provision of assisted living services as a substitute for nursing facility care. Discharge criteria such as those in place in Arkansas, California, Illinois, Kansas, Nevada, New Mexico, Utah, and Wisconsin limit the ability of their public funding models to provide assisted living services as a substitute for nursing facility care for those with substantial needs. (Appendix D provides information on the retention criteria for all of the states.)

Nurse Delegation: Nurse delegation of care tasks to unlicensed personnel in assisted living programs is another example of how states differ. Exhibit 13 provides information on care tasks nurses may delegate in assisted living residences for the states that purchase assisted living services in assisted living residences through Medicaid waivers. As shown in Exhibit 13, 10 of the 14 reporting states permit nursing delegation of administration of oral medication in assisted living. Several of the states with less restrictive criteria for discharge from assisted living (such as Hawaii, New Jersey, Oregon, Texas, Vermont, and Washington) permit delegation of medication administration and multiple care tasks. Pennsylvania differs from such states as its nursing practice act does not permit nurses in assisted living to delegate administration of oral medication or other nursing care tasks listed in the exhibit. (Appendix E provides information on nurse delegation in assisted living programs for all of the states.)

Exhibit 13

Delegation of Nursing Care Tasks in Assisted Living*

	Arizona	Arkansas	California	Hawaii	Kansas	Nevada	New Jersey	New Mexico	Oregon	Texas	Utah	Vermont	Washington	Wisconsin
Administration of oral medication		✓		✓	✓		✓		✓	✓	✓	✓	✓	✓
Administration of pre-drawn insulin				✓			✓		✓	✓	✓	✓		✓
Administration of other injectable medications				✓					✓		✓			✓
Administration of PRN medication				✓			✓		✓	✓	✓		✓	✓
Applying unsterile dressings	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Applying sterile dressings	✓			✓			✓		✓	✓	✓	✓		✓
Tube feedings		✓		✓			✓		✓	✓	✓	✓		✓
Bladder catheters		✓		✓			✓		✓	✓	✓	✓	✓	✓
Bowel treatments	✓			✓		✓	✓		✓	✓	✓	✓	✓	✓

*Check mark indicates a task that registered nurses are sometimes permitted to delegate to unlicensed assistive personnel.
Note: Illinois elected not to participate in the study survey.

Source: Susan C. Reinhard, RN, PhD, FAAN et al, *Nurse Delegation of Medication Administration for Elders in Assisted Living*, Rutgers Center for State Health Policy, The State University of New Jersey - Rutgers, June 2003.

Nursing Facility and Resident Characteristics. States vary in bed availability and resident acuity in their nursing facilities. Such variations have implications for the types of persons to be served through Medicaid waivers.

Medicare and Medicaid Certified Bed Availability. As shown in Table 1, 10 of the 15 states have rates of nursing facility bed availability per thousand persons 65 and older below the national rate. Most (5 of 7) of the states that have seen increases in their number of Medicare and Medicaid certified beds from 1999 through 2005 have rates of nursing home bed availability per thousand 65 and older below the national rate. Such states include New Jersey.

As shown in Table 1, Pennsylvania's bed availability rate mirrored the national rate in 2005, although its total number of certified beds declined from 1999 through 2005 while nationwide there was a slight increase. At least 1,500 of Pennsylvania's bed decline occurred through a program introduced by the Department of Public Welfare and the County Commissioners Association of Pennsylvania known as the Program for Alternative Community Care. The program provided incentives for counties to downsize their existing bed capacity and convert space to other uses, such as expanded physical therapy departments, adult day care centers, and independent housing units. From 1998 through 2005, counties participating in the program received an additional 2,322 home and community-based services waiver slots to provide additional home and community-based services for the elderly.

Occupancy of Medicare and Medicaid Certified Beds. The eight states (Hawaii, Illinois, Kansas, New Mexico, Oregon, Vermont, Washington, and Wisconsin) in Table 1 that reduced their certified bed capacity from 1999 through 2005 may be doing so to achieve more efficient use of their existing capacity. As shown in Table 2, nine of the 15 states have occupancy rates for their Medicare and Medicaid certified beds below the national rate. Pennsylvania's high occupancy rate is surpassed only by Hawaii and Vermont (which have lower bed availability rates than Pennsylvania) and Wisconsin (which has a higher bed availability rate than Pennsylvania).

Proportion of Medicaid Residents. Table 2 shows Medicaid is the major payer for long term care. With the exception of Kansas and Utah, Medicaid was the primary payer for 60 percent or more of residents in certified beds in 2005. The percent of residents with Medicaid as the primary payer, however, was below the national average in 9 of the 15 states, and also in Pennsylvania.

Such data for Pennsylvania are consistent with a 2006 Medstat Research Division finding that Pennsylvania's nursing facility utilization rate is above the national average (40.8 residents per 1,000 persons 65 and older compared to 38.2 per 1,000 nationwide) when all residents (i.e., private pay, Medicare, and Medicaid) are taken into account. Its Medicaid nursing facility days per thousand 65 and older, however, are slightly below the national rate (10,139 compared with 10,394).

Table 1

Total Number of Certified Nursing Facility Beds in the U.S. and Selected States
(Calendar Years 1999 and 2005)

	1999	2005	2005 Bed Availability Rate
Arizona	8,728	11,018	16.5
Arkansas	20,397	24,109	64.5
California	103,735	116,339	32.4
Hawaii	3,488	3,126	19.5
Illinois	97,896	90,507	60.3
Kansas	24,698	23,113	64.9
Nevada	4,675	5,200	23.8
New Jersey	28,260	47,966	43.1
New Mexico	6,921	6,232	29.4
Oregon	12,053	11,454	26.1
Texas	104,337	111,407	53.8
Utah	5,482	6,441	33.9
Vermont	3,399	3,118	40.2
Washington	23,659	22,189	33.5
Wisconsin	44,658	36,080	51.4
Total U.S.	1,509,848	1,567,024	44.8
Pennsylvania	91,250	86,224	44.9

Source: Charlene Harrington, Ph.D. et al, *Nursing Facilities, Staffing, Residents and Facility Deficiencies, 1999 Through 2005*, Department of Social and Behavioral Sciences, University of California, September 2006. LB&FC staff calculated the 2005 Bed Availability Rates using 2000 U.S. Census data.

Table 2

Characteristics of Nursing Facilities in Selected States and the U.S.

(2005)

	Arizona	Arkansas	California	Hawaii	Illinois	Kansas	Nevada	New Jersey	New Mexico	Oregon	Texas	Utah	Vermont	Washington	Wisconsin	Total U.S.	Pennsylvania
Facility Occupancy Rates for Certified Nursing Facilities	77.8	71.5	85.2	91.4	75.8	77.1	80.7	87.6	87.3	64.7	72.4	71.2	91.6	85.8	88.4	85.4	90.0
Percent of Certified Nursing Facility Residents With Medicaid as the Primary Payer	63.5	70.8	66.4	74.7	62.8	54.0	62.0	64.8	66.5	60.5	67.9	54.6	65.7	61.1	63.7	65.4	63.4
Average Summary Score for Resident Acuity	101.5	101.2	111.2	111.9	86.8	87.7	110.1	95.0	102.2	98.4	100.8	93.9	101.6	96.4	83.8	102.2	105.6

Source: Charlene Harrington, Ph.D. et al, *Nursing Facilities, Staffing, Residents and Facility Deficiencies, 1999 Through 2005*, Department of Social and Behavioral Sciences, University of California, September 2006.

Resident Acuity. Table 2 also shows that most (12 of the 15) states in which Medicaid purchases assisted living services in assisted living residences have average resident acuity levels below the national average. Only California, Hawaii, and Nevada (which have bed availability rates substantially below the national rate) have higher resident acuity than Pennsylvania, which has average resident acuity above the national average.

High acuity levels for Pennsylvania nursing facility residents have been identified in other national studies. Researchers from the University of Minnesota analyzed nursing home resident acuity using MDS ADL[25] data at admission and three months post admission in case studies of eight states' efforts to rebalance their long term care systems. Because many nursing facilities are now used to provide subacute care for those leaving hospitals, researchers view acuity data three months post admission as a better long term care acuity indicator for nursing facilities. As shown below in Table 3, Pennsylvania nursing facilities in 2004 had higher ADL scores than all other states in the study both at admission and three months post admission.

Table 3

Nursing Home Acuity for Selected States in 2004

State	Mean ADL at Admission	Mean ADL at 3 Months Post Admission
Arkansas	14.99	12.30
Florida	15.29	14.41
Minnesota	13.74	12.21
New Mexico	13.71	11.99
Pennsylvania.....	16.16	15.60
Texas	14.56	13.28
Vermont	14.63	13.48
Washington	15.26	14.32

Source: *Rebalancing Long-Term Care Systems, Abbreviated Reports* for Arkansas, Florida, Minnesota, New Mexico, Pennsylvania, Texas, Vermont, and Washington prepared for the Centers for Medicare and Medicaid. Individual state reports are available at the University of Minnesota Principal Investigator's website (http://www.hpm.umn.edu/LTCResourceCenter/)

Based on analysis of data from prior years (2002, 2003, and 2004) showing that Pennsylvania's nursing facility resident acuity had continually increased, the University of Minnesota researchers concluded Pennsylvania's home and community-based waivers appear to have been successful in providing care for those needing nursing facility level of care with lower acuity needs.

[25]All certified Medicare and Medicaid nursing facilities are required to complete, record, encode, and transmit MDS (Minimum Data Set) data for all facility residents as a condition of participation in these public programs. MDS includes extensive resident data, including information on each resident's ADL abilities (e.g., bed mobility, transfer, locomotion on the unit, dressing, eating, toilet use, and personal hygiene).

Act 56 indicates public funding should be targeted to those who would otherwise require placement in a nursing facility, and it provides for collection of the same information for waiver and nursing facility participants. The Act, however, does not specify the acuity levels of consumers to be served by Medicaid at home, in licensed assisted living residences, and in nursing facilities. Some nursing facility provider representatives advised LB&FC staff that Pennsylvania's assisted living model should be designed to serve a population different than those currently receiving care in nursing facilities, and should not be funded with funds available for those served in nursing facilities. The assisted living public funding model selected for Pennsylvania may target those who are not as impaired as Medicaid residents in nursing facilities, however, based on the Commonwealth's success in achieving greater efficiency in use of nursing facilities (through a decline in the number of certified Medicare and Medicaid beds, higher bed occupancy levels, and increasingly acuity levels in nursing facilities), individuals to be served through a Medicaid assisted living waiver can be expected to have relatively high levels of service need.

Public Funding Objectives: States differ in the objectives they seek to achieve through public funding of assisted living services. Such differences influence the public funding models and reimbursement methods they develop. States, for example, differ in the extent to which they seek to:

- Promote "aging in place."
- Provide assisted living services as an alternative to skilled nursing facility care.
- Create incentives for development of assisted living for Medicaid participants to better balance their long term care systems.
- Assure access to assisted living in all areas of the state and promote other state objectives, such as care for special populations.
- Assure access to assisted living services for those with low and modest incomes.
- Foster provider participation.

"*Aging in Place."* Act 56 seeks to promote the ability of consumers to "age in place." Less than one-fourth of the states with Medicaid waivers providing assisted living services, however, reference "aging in place" in their regulations.[26]

Substituting for Skilled Nursing Facility Care. Act 56 appears to promote assisted living as a substitute for skilled nursing facility care. States that have similar objectives (e.g., New York, Oregon, Texas, Washington, and Vermont,) typically use some form of tiered reimbursement with rates that increase as the participant's

[26]The guiding principles of the National Center for Assisted Living note the phrase "aging in place" was once used to describe a commitment to minimize the need to move, but has evolved to mean different things to different people. To prevent consumer confusion and misunderstanding, the Center discourages use of the phrase unless accompanied by an explanation of any health-related occupancy restrictions mandated by the residence and/or state regulations.

needs and resource use increase in their public funding models. Such practices provide incentives for care of those with higher level of needs, and address the increasing resource use and costs faced by providers as they care for those with greater intensity of need.

Incentives for Development of Assisted Living to Better Balance Availability of Community and Institutional Long Term Care Services. While tiered reimbursement systems help promote aging in place and use of assisted living as a substitute for skilled nursing facility care, flat rate systems tend to promote other state objectives. Flat rate reimbursement systems, for example, can be used to provide incentives for providers to develop new assisted living services and make them accessible to Medicaid consumers who might not otherwise have access to such care.

New Jersey, for example, has an average monthly assisted living cost well above the national average ($4,718.55 compared to $2,714 in 2007). It uses a flat rate system that varies by setting and reimburses Medicaid waiver assisted living residences a higher rate than other assisted living service providers in recognition of the added costs involved in developing new assisted living residences. In New Jersey, assisted living residences must obtain a certificate of need to operate. In awarding a certificate of need, the state takes into account a provider's planned participation in the Medicaid waiver program, and requires facilities to reserve 10 percent of total beds for use by Medicaid-eligible persons. The 10 percent Medicaid utilization is expected to be achieved within three years and maintained thereafter, though facilities can obtain an exception to the requirements.

Illinois also has a flat rate reimbursement system. Its Medicaid assisted living waiver rates are tied directly to the state's nursing facility rates, which cover provider direct and indirect costs and take into account regional cost differences. Linking the assisted living rates with the nursing facility rates provides an incentive for development of new assisted living programs for low and moderate income individuals in a state with an average monthly cost for assisted living well above the national average ($3,094.29 compared to $2,714). Illinois officials told us they view the state's Medicaid assisted living services as providing opportunity for low income individuals to access a service model not otherwise available to them. To promote this objective, the Illinois Medicaid waiver assisted living program requires its contractors to reserve at least 25 percent of their assisted living residence units for Medicaid residents. [27] Illinois, however, does not view its program as a substitute for skilled nursing facility care, and the Medicaid assisted living program does not provide exceptions for continued stay when higher levels of care are needed.

[27]The Illinois Medicaid assisted living program establishes the room and board rate and personal needs allowance for program participants and provides for low income participants to receive food stamp benefits. In 2008, Medicaid participants generate program revenue from Medicaid, room and board and food stamps equivalent to $77.70 per day in the area of the state with the lowest Medicaid waiver rate and $93.46 in Chicago.

One provider with whom we spoke who provides Medicaid assisted living services in New Jersey (which has a flat rate reimbursement system) and New York (which has a tiered system) reported a preference for New Jersey's flat rate system, even though its maximum payment rate was lower than New York's. According to the provider, New Jersey's flat rate was easier for providers to administer than New York's more refined and complex tiered payment system. New York's payment system, with higher payments based on increased resident resource use, however, helps providers with the financial costs of serving Medicaid residents with dementia, according to the provider.

A founder of Illinois' Medicaid assisted living program advised LB&FC staff that if he could "redesign the state's program," he would have a separate payment tier for those with dementia who require greater direct care resources. Representatives of national associations that advocate for those with Alzheimer's disease and related dementia advised us they prefer tiered reimbursement systems to provide incentives for care of such individuals. They also appreciate systems that provide incentives for retention of direct care staff.

Statewide Access and Other State Objectives. Some states have designed their public funding models to promote a variety of other public objectives. Illinois (with a flat rate system) and Hawaii, New York, and Washington (with tiered rate systems), for example, adjust their rates to take into account regional cost differences to help assure statewide access to assisted living services in both low and high cost areas of the state.

Texas uses a tiered rate system as an incentive for providers to pass along payment increases to direct care staff and promote quality of care through their retention. Assisted living residences that do not agree to participate in the incentive program are reimbursed through a flat (and lower) rate. Texas also has established differing Medicaid rates for single and double occupancy. Such an approach promotes resident privacy and comparable services for Medicaid and private consumers.

Ohio helps assure its assisted living waiver fills a niche in its continuum of long term care by limiting assisted living waiver enrollment to those who previously participated in a home and community-based waiver or resided in a nursing facility. Recently, Ohio expanded its eligibility criteria to include those who required nursing facility level of care and who have received assisted living for at least six months prior to applying for the waiver.

Virginia has designed its program to focus on low income persons with severe dementia. Its Alzheimer's and Related Dementias Assisted Living Waiver is available only to individuals who qualify for the state's SSI Optional State Supplement

program and are residing in or seeking admission to a secure dementia unit in a licensed assisted living facility.

Washington's adjusted tiered rates include a "capital add-on" for assisted living residences. We were advised that at one point Washington had a "true" "capital add-on," but the term now refers to the additional payment available to assisted living residences that serve at least 60 percent Medicaid residents. In Washington, such residences qualify for higher Medicaid payment rates.

Access for Very Low Income Residents. Medicaid funding of assisted living services does not guarantee low income Medicaid recipients, in particular those with a very high level of need, will be able to gain access to licensed assisted living residences. To help promote such access, states take various approaches. As noted above, Washington provides financial incentives through its rate structure. States such as Illinois, Massachusetts, New York, North Carolina, South Carolina, and Virginia have chosen to promote such access through their eligibility criteria, which effectively limit their programs to those who financially qualify for federal SSI benefits and their optional state supplements.

California, Connecticut, New Hampshire, and New Jersey have chosen to assure access for those with low incomes by providing Medicaid assisted living services through specific programs to serve residents in public housing. Connecticut and New Jersey license other assisted living programs that are permitted to provide assisted living service in public housing (and in certain other residential settings). In Connecticut and New Jersey, the agencies responsible for licensure of assisted living are also responsible for licensure of home health and home care programs.

The New Hampshire Medicaid waiver provides assisted living services in a variety of both licensed and unlicensed settings, including "congregate care" in public housing units. "Congregate care" waiver providers are responsible for provision of personal care services, supervision, medication reminders, and other supportive activities specified in the care plan to support health and wellness. They are, however, not required to provide nursing and home health services as are other licensed residential care providers participating in the Medicaid waiver. This suggests a different type and/or lower intensity of care is provided by New Hampshire's different Medicaid assisted living service providers.

California in its relatively new assisted living demonstration program addresses the problem of public housing residents potentially receiving a lower level of care than other waiver participants by requiring providers enrolled in its demonstration and serving those in public housing to provide the same Medicaid assisted living services to waiver participants in public housing units as they do in an assisted living residences. In California, such services must be provided in the public

housing unit by a licensed home health agency participating in the Medicaid waiver program.

California, moreover, has similar admission and discharge requirements for all assisted living waiver participants,[28] with one additional requirement for participants in public housing. Assisted living programs in public housing units cannot admit and must discharge individuals who (1) are not able to mobilize to a chair or wheelchair without the assistance of more than one attendant or (2) require transfer or mobility assistance from more than one person in the event of an emergency requiring evaluation.

Most states attempt to address the issue of access to assisted living services by designing their Medicaid waivers to purchase assisted living waiver services in a variety of residential settings, including licensed adult foster care and personal care homes that meet Medicaid requirements for assisted living service delivery. Such an approach expands access to services for Medicaid participants, but has the possible disadvantage of allowing two different assisted living housing standards—one for those who can access assisted living privately and one of those who rely on public financing for such services. States may address such possible disparities through development of provider contracts which address resident room requirements to provide for resident privacy and access to essential amenities, and which may exceed state licensure requirements.

Another approach used in some states to promote access by low income persons to assisted living residence services is to allow family members to voluntarily supplement room and board charges of assisted living residents receiving Medicaid assisted living services. Some providers view the flexibility to permit family supplementation of Medicaid waiver residents in assisted living as providing an incentive for assisted living residences to participate in the Medicaid program, and view Medicaid room and board rates that are based on federal SSI benefit levels as a disincentive for provider participation. One national report indicates that more than twenty states allow families to voluntarily supplement room and board charges.

LB&FC staff contacted several states that reportedly allow family supplementation of assisted living residence room and board. Illinois, New York, and Texas advised us that, contrary to the information in the national report, they do not permit families to voluntarily reimburse for room and board payments above the SSI and Optional State Supplement level.

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[28]The program prohibits admission and requires transfer of residents with prohibited health conditions—active communicable tuberculosis, Bi-Pap dependency without the ability to self-administer at all times, chemotherapy, coma, continuous IV/TPN (i.e., Total Parental Nutrition—an intravenous form of complete nutritional sustenance) therapy, nasogastric tubes, Wound Vac therapy; restraints except as permitted by the licensing agency, stage 3 or 4 pressure ulcers, and ventilator dependency.

Texas specifically addresses unit or room type and unit sharing in its Medicaid rate structure and advised us that its assisted living provider contract requires the provider to accept the rate as payment in full for the services specified in the contract and "to make no additional charge to the individual, any member of his/her family or to any other source for any supplementation for such services, unless specifically allowed by Department directives." Ohio advised us that it prohibits such practices as they jeopardize a waiver participant's eligibility for a variety of public benefits including SSI, Food Stamps, and Medicaid itself, and can result in reduced, or lost, benefits to the individual.

We confirmed that Florida and New Jersey allow families to voluntarily supplement Medicaid resident room and board in assisted living residences. Such states, however, have policies to advise family members that the family, not the state, is responsible for costs associated with lost or reduced public benefits should this occur as a result of such supplementation. They also require the reporting of such supplementation to relevant federal agencies and, in the case of New Jersey, the waiver program. New Jersey advised LB&FC staff that about 15 percent of its assisted living providers have policies providing for voluntary family supplementation of assisted living room and board for those participating in the Medicaid waiver.

Washington has regulations that in certain instances permit third parties to make supplemental payments to the Medicaid contracted assisted living residence, and permit its contractors to require Medicaid residents to move from the facility when third parties do not pay voluntary supplements the facility is permitted to charge. Washington's regulations, however, explicitly prohibit its assisted living service contractors with one type of unit or all private bedrooms from requesting supplementation "unless the unit or private bedroom has an amenity that all or other units or private bedrooms lack e.g., a bathroom in private bedroom, a view unit, etc."

The National Senior Citizen's Law Center is in the process of initiating a review of state supplementation policies related to Medicaid residents in assisted living. The Center's position is that Medicaid participating facilities should be prohibited from soliciting supplemental payments from residents' family members and friends. To assure that low-income Medicaid beneficiaries are treated fairly, it recommends the same non-discrimination rules that govern nursing facilities apply to waiver participants. In Pennsylvania, licensure regulations for personal care homes explicitly prohibit family supplementation of room and board for SSI residents in personal care homes because of the adverse impact such practices could have on resident benefits.

Fostering Provider Participation. Enlisting substantial provider participation in a Medicaid assisted living waiver program is not assured simply by the

introduction of public funding. California and Ohio advised LB&FC staff that fewer providers initially enrolled in their programs than had been anticipated. While most states fund assisted living services through their Medicaid programs, nationally only 12 percent of assisted living residence consumers receive assisted living services paid for through Medicaid. A 2001 study of Kansas' assisted living facilities sponsored by the Kansas Departments on Aging and Social and Rehabilitation Services found that although over 75 percent of the facilities in the study were enrolled as Medicaid waiver providers, only 11 percent of the residents in the study received assisted living services through Medicaid.[29]

Reasonable public rates are important to encourage provider participation and promote quality of care. The Fiscal Note accompanying Act 56 in the first waiver year projected costs that equate to an average cost of $86 per day per consumer for all services (i.e., not limited to those of the assisted living service provider). With federal SSI and the optional state supplement providing an additional $33.88 per day, the total estimated assisted living per diem for a Medicaid consumer could approach about $100 per day for Medicaid assisted living services and room and board (excluding the personal needs allowance of $60 per month, the value of federal Food Stamps, and the cost of other Medicaid services such as case management).[30]

According to a national survey, the average monthly cost for assisted living in Pennsylvania in 2007 was $2,669.21 statewide (i.e., about $88 per day) and $3,133.12 in Philadelphia (i.e., about $103 per day).[31] Available national survey data do not allow us to determine if the Medicaid waiver participant's acuity and resource use are similar to those of residents in the national survey. In the Kansas study noted above, however, Medicaid residents were found on average to be more functionally and cognitively impaired on admission than the study's residents as a whole, and were more often admitted from a higher level of care (e.g., nursing facilities and acute and rehabilitation hospitals).[32]

A total per diem of about $100 would approach Washington's per diem for the highest level of need in the Seattle area for an assisted living residence with more than 60 percent Medicaid occupancy. Washington, however, may have lower overall costs because it permits significant nurse delegation to unlicensed personnel, which Pennsylvania's nurse license law does not allow.

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[29]Dobbs-Kepper, et al. *Resident and Facility Factors Related to Residents' Length of Stay in Assisted Living and Residential Health Care Facilities: A Longitudinal Analysis*, The University of Kansas, 2001.

[30]The Department of Public Welfare's proposed FY 2008-09 budget anticipates long-term care facility expenditures (including hospital days) averaging $153 per day, excluding client cost sharing. In 2007, the average daily cost of a nursing home bed in a private room was $232.33 in Pennsylvania, and $251.93 in Philadelphia, according to a national survey.

[31]The average cost in the United States in 2007 was $2,714 per month for a one-bedroom unit in an assisted living facility.

[32]In the study, more than half of the Medicaid residents were private pay on admission.

A total per diem of about $100 would also be as high or higher than the highest per diems for Pennsylvania's surrounding states with Medicaid waivers. (Appendix F provides information for Pennsylvania's surrounding states.) Nonetheless, it would be substantially lower than in New York, which has a combined Medicaid service and room and board rate of over $180 per day in New York City for the highest level of care resource group, and lower than New York's lowest area rates ($120 per day combined service and room and board for the highest level of care).

New York's average daily nursing home bed costs in 2007 were much higher than Pennsylvania's ($303.35 per day compared to $232.33), and its average monthly costs for assisted living were also higher ($3,120.54 compared to $2669.21). New York's Medicaid Assisted Living Program, moreover, is effectively limited to those with monthly income at 200 percent of the SSI level. Typically, Medicaid waivers in Pennsylvania include those with incomes up to 300 percent of the SSI level.[33]

While a $100 Medicaid service and room and board rate on its face appears reasonable in comparison to most surrounding and other states, the adequacy of such a rate cannot be determined. Such a determination would require information, which is not available, on the acuity levels of those to be served as well as other cost drivers (such as regulatory requirements).

Substantially involving providers in publicly funded assisted living may also be challenging for reasons unrelated to rates. Existing providers with high demand for their services may elect not to revise their current business models which address consumer preferences for settings that do not remind them of nursing facilities.[34] Providers interested in revising their current business models to participate in state efforts to rebalance the state's long term care system, moreover, may face challenges in changing their staffing patterns and recruiting staff, in particular nursing staff, to provide more intensive programming to serve residents with high levels of need.

Providers interested in securing assisted living licensure and participating in a Medicaid waiver (or State Plan) program may also be challenged by federal Medicaid regulatory and administrative requirements for enrolled providers. Some states advised us that small private providers are not prepared to participate as Medicaid providers because of federal Medicaid administrative and billing requirements for enrolled providers. Assisted living corporations that operate in multiple states typically are better positioned to address such requirements; however, at

[33]In 2008, Pennsylvania's total federal SSI and Optional State SSI Supplement benefit for an individual ($637 in federal SSI benefits +$439.30 Optional State Supplement with a personal needs allowance = $1,076.30) is equivalent to 169 percent of federal SSI. In 2006, the average Old Age Survivor and Dependent benefit was $1,048.09 per beneficiary in Pennsylvania and $1,014.59 nationally.

[34]Chapin, R and D. Dobbs-Kepper, Aging in Place in Assisted Living: Philosophy Versus Policy, *The Gerontologist*, Vol 41, No. 1, 43-50.

least one advised us that fee-for-service billing (such as in Kansas) is particularly difficult.

Even some major multi-state assisted living providers, however, are now terminating their contracts with Medicaid programs. This has occurred even in states that have been successful in achieving high participation of assisted living providers and have been in the forefront in offering assisted living services as an alternative to institutional care.

In the mid-1980s, Oregon became the first state in the nation to obtain a home and community-based waiver and provide assisted living services as an alternative to institutional care. The state also promoted the development of assisted living and other residential care facilities, in particular in rural areas, through a state loan program. To obtain such loans, facilities had to agree to set aside at least 20 percent of their units for Medicaid residents.[35] Oregon also provided much higher rates for assisted living residences (tied to nursing home rates[36]) than to its other assisted living service providers.[37]

In the late 1990s, however, payment rates for Oregon adult foster homes and residential care facilities were substantially modified in response to the increased frailty levels of those receiving assisted living services in adult foster care and other residential care settings, and changes in the regulatory requirements for such settings.[38] In early 2003, in response to state budget constraints, Oregon eliminated services for over 3,500 individuals with lower level of care needs.[39] In 2007, Oregon's residential care and assisted living licensure requirements were further modified to require such programs to provide health services and have systems in place

[35]As of 2004, there were 57 loans for 46 assisted living facilities and residential care facilities that financed 2,182 units worth $118 million. In 2001, the state imposed a moratorium on construction of assisted living facilities, which the Oregon legislature has extended to 2009.

[36]In the early 1990s, the highest assisted living rate was set at 75 percent of the lowest nursing facility rate.

[37]In 2006, 41 percent of Oregon's long term care clients were served in-home, 18 percent in nursing facilities, 15 percent in adult foster care, 14 percent in assisted living residences, 4 percent in residential care, 4 percent in contracted residential care (typically Alzheimer's care units), 2 percent in PACE, and 2 percent in other service sites, according to the Office of Oregon Health Policy and Research's latest report to the state legislature.

[38]Generally, assisted living residents in Oregon are more ambulatory than residents in Oregon residential care facilities and Alzheimer's care units, and less likely to require transfer assistance, meal assist, or have incontinence managed by the facility, according to a February 2008 report of the Office for Oregon Health Policy and Research. The 2008 report does not account for the differences in resident acuity. It, however, provides data indicating that Oregon residential care facilities are more likely to have Alzheimer's Care Units, with few assisted living facilities having such units. Oregon also provides assisted living services through adult foster care providers. In Oregon, adult foster care providers at times care for individuals with complex health conditions (e.g. AIDs, brain trauma, ventilator dependent, etc.).

[39]Oregon has 17 level of care criteria to receive Medicaid coverage of nursing facility care. In 2003, those at levels 14 (i.e., needs assistance with eating) through 17 (i.e., needs assistance in bathing or dressing) no longer qualified for coverage.

to respond to the 24-hour care needs of residents and to have licensed nurses regularly scheduled in the facility and available by phone for consultation.[40]

As a result of Oregon's efforts to provide assisted living as an alternative to institutional care, Medicaid residents accounted for 39 percent of those in assisted living residences as of December 2005. By June 2007, however, this had dropped to 33 percent. Since that time, a national assisted living provider, which operates in 17 states, stopped accepting new Medicaid residents. The Oregon Medicaid program and the national assisted living provider have entered into gradual withdrawal contracts to terminate services for all current Medicaid residents as of January 31, 2009.

Act 56 is a licensure statute. It explicitly provides for the Commonwealth's funding of assisted living services through a Medicaid 1915 (c) home and community-based waiver. It also endorses the concept of "aging in place," and provides for those who qualify for skilled nursing care to continue to reside and receive care in licensed assisted living residences.

As a licensure statute, the Act could not be expected to address all of the many factors that influence public funding models. The Select Committee created by Act 56 to develop and recommend a public funding model for assisted living in the Commonwealth may wish to consider factors such as those illustrated above and others in consultation with policy makers and key stakeholders as it identifies Commonwealth objectives for public funding of assisted living and crafts a public funding model that efficiently accomplishes such objectives.

[40]In Oregon, nursing facilities are primarily providers of sub-acute care. In 2005, 66 percent of those in Oregon nursing facilities stayed less than one month and 85 percent less than three months, according to the Office for Oregon Health Policy and Research's most recent report to the Oregon legislature.

III. State Supported Assisted Living Services Programs

Ten states fund assisted living services with public funds other than Medicaid. They include: Alaska, Colorado, Connecticut, Indiana, Maryland, North Dakota, Texas, Washington, West Virginia, and Wisconsin. With the exception of West Virginia, all of the states provide assisted living services through Medicaid 1915 (c) waivers. Three (North Dakota, Washington, and Wisconsin) provide assisted living services through their Medicaid State Plans. Five (Alaska, Colorado, Indiana, Maryland, and Wisconsin) states also have optional state SSI supplement programs (discussed in Section IV).

Typically, states rely on state or local general fund dollars to support their programs. Exhibit 14 describes the services provided through the state programs and identifies the types of setting in which they are delivered.

In general, assisted living services that rely on state funds are targeted to individuals who do not qualify for Medicaid services and/or federal Supplemental Security Income. Colorado, Connecticut, Maryland, North Dakota, Texas, and Washington operate state programs for those that have income or resources just above Medicaid financial eligibility or do not meet federal disability requirements. In Indiana, the state-funded program provides certain cash assistance for housing and supervision for individuals who reside in government-operated residential facilities and are, therefore, ineligible for federal Supplemental Security Income (SSI) assistance.

Most of the state programs are very limited in scope. For example,

- Alaska's program serves only two Alaska Native rural communities,
- Colorado's program serves seven individuals,
- Maryland's program provides up to $650 per month for support and is limited to 600 participants,
- Texas' program provides average benefits of about $600 monthly, and includes about 650 participants, and
- Washington has about 30 participants receiving state-funded assisted living services.

West Virginia's program relies on federal block grant funding (Title XX) to support room and board and care in residential care settings. Residents can qualify to receive up to $1,056.50 monthly. West Virginia's Medicaid State Plan includes a personal care benefit for those who qualify in residential settings. West Virginia's Medicaid Plan, however, does not permit residential care providers to enroll as personal care providers, and West Virginia Medicaid staff advised us that adults in residential settings are not receiving Medicaid State Plan personal care services.

Exhibit 14

State Supported Assisted Living Services

State	Type of Service(s) Provided	Service Setting(s)
Alaska	Assistance with activities of daily living, medication management, skilled nursing care, personal care and housekeeping	-Other residential care settings serving Alaskan Natives in two rural communities
Colorado	Assistance with basic personal tasks, supervision of self-administration of medications, room and board, housekeeping, laundry services, 24 hour residential care, and opportunities for recreational activities	-Other residential care settings (i.e., certified to provide Adult Foster Care Services)
Connecticut	Assistance with activities of daily living, housekeeping, laundry services, meals, service coordination, and nursing supervision	-Other assisted living program in "Registered Managed Residential Communities"
Indiana	Cash assistance for room and board, housekeeping, laundry, and minimal supervision	-Other residential care settings operated by a county or other public entity
Maryland	Cash assistance for meals, assistance with activities of daily living, housekeeping, medication management, and 24-hour supervision	-Other residential care setting serving 4 to 16 residents
North Dakota	Personal care; therapeutic, social and recreational programming provided in conjunction with residence in the facility; 24-hour on-site response staff to meet scheduled and unpredictable needs and provide supervision, safety, and security	-Other residential care settings
Texas	Assistance with activities of daily living that are essential to daily self-care, housekeeping, and meal preparation	-Assisted living residences -Other residential care settings
Washington	Physical or verbal assistance with activities of daily living and instrumental activities of daily living due to functional limitations	- Assisted living residences - Other residential care settings
West Virginia	Room and board and assistance with activities of daily living, housekeeping, laundry services, meals, and other services required to maintain independence	-Assisted living residences -Other residential care settings
Wisconsin	Room and board, personal care services, assistance with medications, health monitoring, and leisure time services	- Assisted living residences -Other residential care settings

Source: Developed by LBFC staff.

IV. Other Federal and State Funding for Assisted Living Services

A. Federal Supplemental Security Income (SSI) and Optional State Assistance Programs for SSI Recipients

The federal Supplemental Security Income Program (SSI) is the primary source of assistance to cover basic living expenses of low income elderly and disabled adults. Persons eligible for SSI also qualify to receive other benefits, most notably health care benefits through Medicaid. Medicaid funds, however, cannot be used to pay for room and board.[1] Federal SSI, therefore, is the primary source of public funding for room and board in assisted living residential settings. As of January 2008, the maximum federal SSI benefit is $637 monthly.

The maximum federal SSI monthly benefit is the same no matter where the eligible individual resides. The federal program, however, allows states to provide optional state assistance to take into account differences across states and individuals with special needs, such as elderly and disabled adults who cannot live independently and reside in certain special care settings. Under the federal SSI program, receipt of such optional state assistance does not jeopardize the individual's eligibility for federal SSI benefits or reduce the individual's federal benefits as a result of other maintenance and support. As shown in Exhibit 15, 37 states provided optional state assistance to SSI recipients in such settings in 2007.[2, 3]

There is considerable variation in state benefits in their optional state supplement programs. For those states with benefits, they range from $1.70 in Oregon per month to as high as $938 monthly for an individual in a secure Alzheimer's Unit in North Carolina. Seventeen (California, District of Columbia, Hawaii, Idaho, Illinois, Indiana, Kentucky, Maryland, Massachusetts, Nebraska, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Dakota, and Virginia) have state supplements that can be as high as $400 or more monthly.

As shown in Exhibit 15, from 2000 through 2007, 13 states maintained their maximum monthly optional state supplement benefit amount at the same level. One state (Alaska) started an Optional State Supplement program; 14 states,

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[1]Individuals who reside in nursing facilities and other institutions are not eligible to receive the federal SSI basic benefit. As a consequence, the federal Medicaid program includes basic subsistence costs as allowable cost in rate setting for nursing facilities and other institutions whose residents are ineligible for federal SSI.

[2]The LB&FC's April 2005 report on Long Term Care for the Elderly in Pennsylvania, prepared pursuant to House Resolution 618 of 2004 provides additional information on the federal SSI program, its requirements for states, and state optional programs.

[3]States provide their Optional State Supplement benefits to individuals in a variety of licensed residential settings. None of the states with Optional State Supplement programs, restrict such benefits to income eligible individuals residing in assisted living residences as defined in Act 56.

Exhibit 15

Optional State Supplementation of Federal SSI Benefits in Residential Care Settings

Monthly Payment Amounts in 2000 and 2007[a]

State and Setting	2000 State Supplementation for an Individual	2007 State Supplementation for an Individual
Alabama		
Personal Care Home	$56-$60	$56-$60
Foster Home	$110	$110
Alaska		
Assisted Living Home	None	$100
Arizona		
Licensed Supervisory Care Home	$50	$70[b]
Adult Foster Care Home	$50	$70[b]
Arkansas	None	None
California		
Nonmedical Out-of-Home Care	$335	$412
Colorado		
Adult Foster Care	$230	$295
Connecticut	None	None
Delaware		
Adult Residential Care Facility	$140	$140
District of Columbia		
Adult Foster Care Home (50 beds or less)	$307	$485
Adult Foster Care Home (over 50 beds)	$417	$595
Florida		
Adult Family Care Home	$228	$78.40[c]
Assisted Living Facility	$228	$78.40[c]
Georgia	None	None
Hawaii		
Domiciliary Care Facility (1 to 5 residents)	$521.90	$621.90
Domiciliary Care Facility (6 or more residents)	$629.90	$729.90
Idaho		
Assisted Living Facility	$340 - $475	$319 - $453[d]
Illinois		
Sheltered Care Facility	$345.55	$437.00[e]
Indiana		
Licensed Residential Facility	$836.79	$593.90[f]
Iowa		
Residential Care	$313.06	$286.50[g]
Kansas	None	None

Exhibit 15 (Continued)

State and Setting	2000 State Supplementation for an Individual	2007 State Supplementation for an Individual
Kentucky		
Personal Care Facility	$394	$520
Family Care Home	$139	$172
Louisiana	None	None
Maine		
Foster Home	$49	$49
Flat Rate Boarding Home	$217	$217
Cost Reimbursement Boarding Home	$219	$234
Maryland		
Care Home	$66 - $666	$66 - $666
Assisted Living Facility	$184	$184
Massachusetts		
Licensed Rest Home	$293	$293
Assisted Living Facility	$454	$454
Michigan		
Domiciliary Care	$87	$87
Personal Care	$157.50	$157.50
Home for the Aged	$179.30	$179.30
Minnesota		
Nonmedical, Group Residential Facility	$709.89	$130[h]
Mississippi	None	None
Missouri		
Licensed Residential Care Facility	$154 - $288	$156 - $292
Montana		
Assisted Living Facility	$94	$94[i]
Adult Foster Care	$52.75	$52.75
Nebraska		
Adult Family Home	$145	$138
Assisted Living Facility	$270	$438[j]
Nevada		
Domiciliary Care	$350	$391
New Hampshire		
Residential Care Facility for Adults	$207	$207
Enhanced Family Care Facility	$207	$207
New Jersey		
Congregate Care Facility	$150.05	$150.05
New Mexico		
Licensed Adult Residential Care Home	$100	$100
New York		
Congregate Care Facility Level I	$228.48 - $266.48	$228.48 - $266.48
Congregate Care Facility Level II	$405.00 - $435.00	$405.00 - $435.00
Congregate Care Facility Level III	$458.96 - $482.96	$641.00

Exhibit 15 (Continued)

State and Setting	2000 State Supplementation for an Individual	2007 State Supplementation for an Individual
North Carolina		
Basic Adult Care Home	$470	$571
Special Care Unit	-	$938
North Dakota		
Licensed Basic Care Facility	$1,116.40	None[k]
Ohio		
Adult Family/Foster Home	$456	$506
Adult Group Home	$556	$606
Adult Residential Care Facility[l]	$456	$506
Oklahoma	None	None
Oregon		
Adult Foster/Residential Care	$1.70	$1.70
Pennsylvania		
Domiciliary Care Facility for Adults	$329.30	$389.30
Personal Care Home	$334.30	$439.30
Rhode Island		
Residential Care/Assisted Living	$582	$575[m]
South Carolina		
Licensed Residential Care Facility	$348	$348
South Dakota		
Assisted Living Facility	$434	$589
Adult Foster Care	$230	$296
Tennessee	None	None
Texas	None	None
Utah	None	None
Vermont		
Assistive Community Care Services	$48.38	$48.38
Residential Care Home	$223.94	$223.94
Virginia		
Assisted Living Facility	$330 - $448	$513 - $672
Washington	None	None
West Virginia	None	None
Wisconsin		
Private Nonmedical Group Home or Natural Residential Setting	$179.77	$179.77[n]
Wyoming	None	None

Footnotes for this exhibit are found in Appendix G.

Source: Developed by the LB&FC staff from the Social Security Administration reports (*State Assistance Programs for SSI Recipients* for 2000 and 2007), state regulations, and information provided by selected states.

including Pennsylvania, increased their benefits; and six reduced benefits. Three states had benefits that were unchanged for some, and increased or reduced for others.

At least nine of the states that provide assisted living services through Medicaid reduced or eliminated their Optional State Supplement Program for individuals who qualify for Medicaid State Plan and/or Medicaid waiver assisted living services.

- One state (North Dakota) eliminated its optional state SSI assistance program following the introduction of Medicaid funding for assisted living.

- Four states (Arizona, Idaho, Montana, and Ohio) eliminated the optional state SSI supplement for elderly and adult disabled Medicaid waiver participants, and

- Four states (Florida, Minnesota, Vermont, and Wisconsin) reduced their state SSI supplement as Medicaid state plan personal care and/or waiver service become available for Medicaid recipients in residential care settings.

Vermont reduced its optional state supplement for elderly and physically disabled individuals in residential care when it introduced its Medicaid State Plan Assistive Community Care Services (i.e., its Medicaid State Plan Assisted Living Services) for such individuals. Vermont, however, maintained a higher optional state supplement amount for individuals in residential programs that do not meet the requirements for Assistive Community Care Services, such as those with developmental disabilities.[4]

While several states reduced their SSI optional state supplements for those in residential care as Medicaid services were made available to provide assisted living services in such settings, others did not. From 2000 to 2007, North Carolina and New York, for example, which provide assisted living services through their Medicaid State Plans, expanded their optional state supplement benefits for those receiving Medicaid assisted living services.

In 2005, North Carolina created a new supplement for those in adult care home special care units for those with Alzheimer's Disease and related disorders. An individual residing in such a unit may qualify to receive up to $1,561 for room and board and personal needs (i.e., $46) under the state's optional state supplement, and in addition may qualify to receive Medicaid payment for care in such a

[4]Federal financial participation for Medicaid State Plan personal care services, is not available for services to individuals in residential programs primarily designed to serve persons with developmental disabilities and behavioral health care needs such as intermediate care facilities for the mentally retarded or institutions for mental disease.

unit of $45.76- $51.25 per day (See Exhibit 10). New York added facilities that qualify to participate in its Medicaid State Plan Assisted Living Program to the residential care category qualifying for the highest optional state supplement. It also increased the amount of the highest supplement and provided for a combined federal and state monthly SSI benefit of $1,264 (including a $164 personal needs allowance) in 2007.

B. Federal Housing Programs for Assisted Living Services

The federal government has primary responsibility for public housing policy and programs in the United States. Such federal programs provide tax credits, low interest loans, mortgage insurance, loan guarantees, and in some instances direct subsidies to make housing more affordable. They are administered by several federal agencies, including the United States Treasury, Department of Housing and Urban Development (HUD), United States Department of Agriculture (USDA), and Federal Home Loan Bank System (FHLBS). For the most part, such programs serve broad public policy goals and are not targeted to assisted living services.[5] Two federal programs, however, have played a role in support of assisted living.

- The Assisted Living Conversion Program.
- The Low Income Housing Tax Credit Program.

***The Assisted Living Conversion Program*:** This program is the only federal housing program specifically targeted to "assisted living" service settings. It is a federal grant program authorized under Section 202 (b) of the federal Housing Act of 1959 and directly administered by the federal Department of Housing and Urban Development (HUD).

Only private non-profit owners of eligible properties can apply for Assisted Living Conversion Program grants. Eligible properties include those designated for the elderly, occupied for at least five years, and participating in one of several HUD housing programs.

The Assisted Living Conversion Grant Program supports the conversion of some or all dwelling units in an eligible property to provide assisted living for the frail elderly. Grant funds can be used to reconfigure units and create common spaces for supportive services. Such common spaces include central kitchen or dining areas, lounges, and recreation and office spaces. HUD requires residents in properties that qualify for the Assisted Living Conversion Grant Program to be able

[5]A comprehensive review of all federal housing programs is outside the scope of this report. The GAO's *Elderly Housing: Federal Housing Programs That Offer Assistance for the Elderly*, February 2005 (GAO-05-174) provides an excellent overview of federal housing programs targeted to making housing more affordable for the elderly and disabled, and is available at the GAO's website (www.gao.gov).

to live independently, though they may be frail and need some assistance with activities of daily living.[6]

One of the federal program's requirements is that supportive services[7] required by residents must be made available in some way by the property's owner. Such services may be provided directly by the property owner or through a third party.

Since 2000, HUD approved three Assisted Living Conversion Program grants in Pennsylvania. HUD awarded:

- $2.8 million to the Ann Thomas Presbyterian Apartment in Philadelphia to convert 28 units in 2002.[8]
- $1.9 million to the Guild House West (property of The Friends Rehabilitation Program) in Philadelphia in 2005.[9]
- $2 million to Mercy Douglas Residences in Philadelphia in 2007.

As of February 2008, Pennsylvania had no grant applications pending, according to HUD.

The Low Income Tax Credit Program: The United States Treasury Low Income Tax Credit Program is the major public program available to help keep housing affordable, including housing in assisted living. Low-income housing tax credits are the most common source of equity financing for low-income housing in the United States, accounting for 50 percent or more of such project costs, according to the Robert Wood Johnson Foundation's *Coming Home* project[10]

Under the Low Income Tax Credit Program, the United States Treasury's Internal Revenue Service (IRS) annually allocates tax credit authority to State Housing Finance Agencies. Such allocations rely on a statutory formula that includes a credit ceiling. The State Housing Finance Agencies in turn award tax credits to developers for acquisition, rehabilitation, or new construction of affordable housing.

The IRS requires State Housing Finance Agencies to annually submit Qualified Allocation Plans (QAPs) that prioritize the state's housing needs and identify the criteria the state will use to award tax credit allocations to developers. In their

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[6]Residents must also meet relevant income requirements.
[7] Examples of such services include meals, housekeeping, laundry, transportation, and personal care.
[8]This project was completed, according with HUD officials with whom we spoke.
[9]This project was not completed by the grantee, and federal grant funds were returned to HUD.
[10]Over a 13 year period, the Robert Wood Johnson Foundation supported NCB Capital Impact to provide technical assistance to develop affordable models of assisted living, in particular in small and rural communities and for low-income seniors. NCB Capital Impact is the non-profit affiliate of NCB. It provides financial services and technical assistance to create more affordable cooperative home ownership, assisted living, housing and services for the frail elderly, health care facilities, and charter schools.

plans, states can establish preferences and set-asides to guide project selection, including set asides for supportive housing projects for the mentally or physically disabled, elderly, homeless, minorities, and large families.[11]

Based on the QAP, the State Housing Finance Agency awards tax credits to developers, who in turn offer the credits to investors. Investors then obtain reductions in their federal tax liability (over a 10 year period) in exchange for providing capital to finance qualified, affordable rental housing.

To qualify for the federal tax credits, developers are required to rent 20 percent of their units to those with income equal to or less than 50 percent of HUD's estimated area median income (i.e., approximately $2,167 monthly for an individual in Philadelphia County, which is equivalent to 341 percent of federal SSI in 2008; and $1,504 monthly in Sullivan County, which is equivalent to 237 percent of federal SSI.), or to rent 40 percent of their units to those with incomes equal to or less than 60 percent of HUD's estimated area median income (i.e., approximately $2,600 monthly for an individual in Philadelphia County, which is equivalent to over 400 percent of federal SSI in 2008; and $1,805 monthly in Sullivan County, which is equivalent to 284 percent of SSI[12]).[13] Such requirements must be met for at least 30 years.

The Pennsylvania Housing Finance Agency (PHFA) is the state agency responsible for development of the IRS required Qualified Allocation Plan for the Commonwealth. Pennsylvania's 2008 Qualified Allocation Plan includes a five percent set aside for supportive housing. To qualify for such a set-aside a developer must:

- Provide at least 25 percent of total units to eligible populations that are homeless; or non-homeless households that require supportive services, including those with mental, physical, sensory, or developmental disabilities; persons with substance abuse disorders; persons diagnosed with AIDs and related diseases, and other special populations.

- Document the need for housing for the target population.

[11]QAPs also provide for regional, non-profit, and preservation set asides.

[12]HUD reports estimated area median income for households to qualify for certain HUD programs. HUD reported its 2008 estimated area median income for counties in Pennsylvania, including one person households at 50 percent of the HUD estimated area median income. LB&FC staff derived the estimates for 60 percent based on HUD reported estimates for one person households at 50 percent of the estimated area median in the reported counties since HUD did not report information for one person households at 60 percent of the estimated median income.

[13]Federal housing income eligibility thresholds differ from those in other federal programs such as Medicaid program. Those with income above 300 percent of SSI would be ineligible to participate in a Medicaid home and community-based waiver.

- Provide appropriate services for the target population that are not a condition of residency.

- Be located within two blocks of a public transit stop or include transportation in the site plan for services.

- Have funding in place or identify a viable plan for funding of appropriate services for the duration of the compliance period.

- Provide a rental subsidy so that rents in the Supportive Housing Units do not exceed 30 percent of household income.

- Comply with other relevant federal multifamily housing requirements.

PHFA officials advised us that assisted living residences in Pennsylvania have participated in the federal tax credit program. The agency, however, does not maintain a list of such participants.

A few states (e.g., Oregon) have operated state low interest loan programs to foster the development of assisted living residences. Such states, however, are the exception rather than the rule.

In the past (starting in 1975), Pennsylvania operated a Nursing Home Loan Agency to make safety improvements to nursing facilities and personal care homes to come into compliance with State and Federal licensure standards. Subsequently, the Commonwealth established a moratorium on new nursing home loans; and in 1994, a Governor's Executive Order (1994-5) authorized the sale of the Agency's nursing home loan portfolio. Proceeds from the sale of the portfolio were assigned to the Pennsylvania Housing Finance Agency to make low-cost bridge loans to encourage construction of low income housing in the Commonwealth. Act 1997-10 repealed the statute creating the Nursing Home Loan Agency and authorizing loans to nursing and personal care homes; and in 1997, regulations governing such loans were repealed.

V. Appendices

APPENDIX A

Act 2007-56

Section 9. Within nine months after the effective date of this section, the Legislative Budget and Finance Committee shall report to the General Assembly on existing Federal and other states' initiatives and programs that provide financial assistance for assisted living. This study shall include information on other Federal or state assisted living programs that are effectively administered and may be considered a model. Within six months after receipt of the report, a joint legislative task force consisting of selected members of the Aging and Youth Committee of the Senate and the Aging and Older Adult Services Committee of the House of Representatives shall review the report and any recommendations contained therein and shall report back to the full committees with a proposal for a funding mechanism for assisted living in this Commonwealth. The chairman of the Aging and Youth Committee of the Senate and the chairman of the Aging and Older Adult Services Committee of the House of Representatives shall select three members from the majority party and three members from the minority party and the Secretary of Aging shall serve as chairperson of the task force.

APPENDIX B

Glossary of Assisted Living Services

Assisted living residence: includes licensed settings which provide assisted living services to residents in a resident living unit which includes a private bathroom, living and bedroom space and kitchen capacity, and which may be shared with no more than one resident based on mutual consent. Act 2007-56 provides for the licensure of assisted living residences in Pennsylvania based on licensure standards to be promulgated by the Department of Public Welfare.

Assisted living services: includes health, personal, and supportive services for persons who may clinically quality for nursing facility care. Such services are delivered in "home-like" settings including licensed assisted living residences, other residential care settings, and through other assisted living programs in licensed and unlicensed settings.

Other assisted living program: includes provision of assisted living services by a licensed or certified program such as a home health agency or home care agency in an assisted living residence, an other residential care setting, or an unlicensed setting and where the other assisted living program is responsible for responding to the planned and unplanned health and safety needs of program participants on a 24/7 basis.

Other residential care setting: includes assisted living services provided in licensed settings such as adult foster homes, residential settings with private or semi-private bedrooms and private bathrooms, residential settings with private or semi-private bedrooms and without private bathrooms, residential settings with more than two residents sharing a bedroom and without private bathrooms, and other licensed residential settings.

Unlicensed setting: a setting in which assisted living services are provided that is not licensed or certified by a state or designated local agency (e.g., county) responsible for public health and safety.

APPENDIX C

Cost of Long-Term Care in 2007, by State

State	Average Daily Nursing Home Rate (Private Room)	Average Monthly Cost in Assisted Living Facility (One Bedroom Unit)	Home Health Aide Average Hourly Rate
Alabama	$ 148	$ 2,265	$ 37
Alaska	539	3,633	49
Arizona	194	2,631	21
Arkansas	128	1,758	26
California	241	2,909	31
Colorado	204	2,669	24
Connecticut	328	3,853	26
Delaware	206	2,337	22
Dist. of Col.	214	2,934	19
Florida	206	2,588	19
Georgia	145	2,169	31
Hawaii	296	2,264	22
Idaho	185	2,272	21
Illinois	159	3,094	28
Indiana	177	2,539	25
Iowa	139	2,226	23
Kansas	125	2,612	18
Kentucky	180	2,697	28
Louisiana	119	2,257	34
Maine	226	3,374	29
Maryland	200	2,410	23
Massachusetts	287	4,272	22
Michigan	199	2,180	19
Minnesota	177	2,924	27
Mississippi	162	1,957	30
Missouri	138	2,378	25
Montana	168	2,458	22
Nebraska	146	2,411	30
Nevada	208	2,296	32
New Hampshire	274	3,270	24
New Jersey	256	4,719	21
New Mexico	177	2,560	21
New York	303	3,121	23
North Carolina	167	2,721	22
North Dakota	143	1,609	26
Ohio	184	2,478	19
Oklahoma	132	2,182	38
Oregon	201	2,710	38
Pennsylvania	232	2,669	23
Rhode Island	241	2,815	22
South Carolina	160	2,973	29

Appendix C (Continued)

State	Average Daily Nursing Home Rate (Private Room)	Average Monthly Cost in Assisted Living Facility (One Bedroom Unit)	Home Health Aide Average Hourly Rate
South Dakota	147	2,179	19
Tennessee	161	2,232	27
Texas	167	2,622	22
Utah	167	2,152	25
Vermont	235	2,978	26
Virginia	174	2,205	18
Washington	225	2,996	32
West Virginia	192	2,186	27
Wisconsin	204	2,637	29
Wyoming	164	2,352	20
National Average[a]	$205	$2,714	$25

[a]In 2008, the reported comparable rate for a nursing home was $209, for an assisted living facility $3,008, and for a home health aide $29.

Source: National Clearinghouse for Long-Term Care Information website (www.longtermcare.gov) accessed January 2008 and May 2008.

APPENDIX D

Selected Assisted Living Resident Retention Criteria, by State

State	Retention Criteria
Alabama	May not retain residents who require medical care, skilled nursing care, are severely cognitively impaired, require restraints or confinement; require limitations on egress from the facility; are unable, because of dementia, to understand a facility's unit dose medication system; have chronic health conditions requiring extensive nursing care, daily professional observation, or the exercise of professional judgment from facility staff; or require any care beyond assistance with ADLs. However, residents who require medical care, administration of oral medications, or skilled nursing care for no longer than 90 days may remain in the facility if such care can be delivered by properly licensed individuals. There are also certain exceptions for persons in hospice care.
Alaska	May not retain residents in need of 24-hour skilled nursing care for more than 45 consecutive days. Certain exceptions may be made for terminally ill residents.
Arizona	May not retain residents unable to direct their own care; who are bed bound; have stage III or IV pressure sores, or require continuous nursing services unless provided by a licensed hospice service agency or a private duty nurse.
Arkansas	May not retain residents who need 24-hour nursing services, are bedridden, or have mobility needs the facility cannot meet. If residents are terminally ill, services may be provided if a physician or nurse certifies the residents' needs can be met.
California	May not retain residents that require 24 hour skilled nursing or intermediate care; or individuals who require oxygen, catheter or colostomy care, have contractures or diabetes, need enemas or suppositories, are incontinent, need injections or intermittent positive pressure breathing machines, have stage I and II dermal ulcers, or need wound care, unless such care is provided by a licensed skilled professional.
Colorado	May not retain residents who are consistently uncontrollably incontinent unless the resident or staff are capable of preventing such incontinence from becoming a health hazard; are totally bedridden with limited potential for improvement; need medical or nursing services on a 24-hour basis; have a communicable disease or infection unless such residents are receiving a medical or drug treatment for the condition and the admission is approved by a physician; or have a substance abuse problem unless it is no longer acute and a physician determines it is manageable. A facility may retain residents who become bedridden if there is documented evidence of an order from a physician describing the services required to meet the resident's health needs; ongoing assessment and monitoring by a licensed or certified home health agency or hospice; and adequate staffing by individuals trained in the provision of care for bedridden residents.
Connecticut	Each facility must develop written policies for the discharge of clients. The policies must address changes in residents' conditions, and what constitutes routine, emergency, financial, and premature discharge.

Appendix D (Continued)

State	Retention Criteria
Delaware	May not retain residents who require care by a nurse that is more than intermittent or for more than a limited period of time; who require skilled monitoring, testing, and aggressive adjustment of medications and treatments where there is the presence of, or reasonable potential of, an acute episode unless there is a registered nurse to provide appropriate care; require monitoring of a chronic condition that is not essentially stabilized through available medications and treatments; are bedridden for more than 14 days; have stage III or IV skin ulcers; require a ventilator; require treatment for a disease or condition that requires more than contact isolation; have an unstable tracheotomy or a stable tracheotomy of less than six months duration; have an unstable PEG tube; require an intravenous or central line with an exception for a completely covered subcutaneously implanted venous port; or wander such that the assisted living facility would be unable to provide adequate supervision or security arrangements. There are exceptions for hospice residents.
District of Columbia	May not retain residents if they need professional nursing care; are non-ambulatory; are unable to perform ADLs with minimal assistance; are incapable of proper judgment; are disoriented to person or place; require treatment of stage III or IV skin ulcers, require ventilator services, or require treatment for an active, infectious, and reportable disease or a disease or condition that requires more than contact isolation.
Florida	May not retain residents who are incapable of performing ADLs with supervision or assistance; require 24-hour nursing supervision; have stage II, III, or IV pressure sores; are unable to participate in social and leisure activities; or are non-ambulatory, or bedridden for more than seven days.
Georgia	May not retain residents who are bedridden or require continuous medical or nursing care.
Hawaii	May not retain residents whose need for services cannot be met.
Idaho	May not retain residents who require ongoing skilled nursing or care not within the legally licensed authority of the facility. Such residents include those who: have a gastrostomy tube, arterial-venous shunts, or supra-pubic catheter inserted within the previous 21 days; are receiving continuous total parenteral nutrition or intravenous therapy; require physical restraints, including bed rails; are comatose, except for a resident whose death is imminent; are on a mechanically supported breathing system; have a tracheotomy and are unable to care for the tracheotomy independently; are being fed by a syringe; have open, draining wounds for which the drainage can not be contained; have a stage III or IV pressure ulcer; have a pressure ulcer or open wound that is not improving bi-weekly; or have an unstable condition and need nursing assessment and observation because they have methiccillin-resistant staphylococcus aureus in an active stage. Residents not capable of self evacuation may not be retained.
Illinois	May not retain residents who need nursing care or require total assistance with two ADLs.
Indiana	May not retain residents who require 24-hour, comprehensive nursing care or comprehensive nursing oversight; who require less than 24-hour, comprehensive nursing care or comprehensive nursing oversight or rehabilitative therapies and have not entered into a contract with an appropriately licensed provider of the resident's choice to provide such services; or are not medically stable and require total assistance with two of the following criteria: eating, toileting, and transferring.

Appendix D (Continued)

State	Retention Criteria
Iowa	May not retain residents who require more than part-time or intermittent health-related care; are bed-bound; require routine two-person assistance to stand, transfer, or evacuate; have unmanageable incontinence on a routine basis; or are in an acute stage of alcoholism, drug addiction, or mental illness. Part-time or intermittent means licensed nursing services and professional therapies that are provided no more than five days per week; or licensed nursing services and professional therapies that are provided six or seven days per week for temporary periods of time with a predictable end within 21 days; or licensed nursing services and professional therapies in combination with nurse-delegated assistance with medication or ADLs that do not exceed 28 hours per week.
Kansas	May not retain residents with unmanageable incontinence; who are immobile; have a condition requiring two-person transfer; or who require ongoing skilled nursing intervention that is needed 24-hours per day, unless the service agreement includes 24-hour hospice or family support services.
Kentucky	May not retain residents if they are non-ambulatory, unless due to a temporary health condition for which health services are being provided, and if they are not a danger to themselves or others.
Louisiana	May not retain residents in need of additional care beyond routine personal care unless such residents can provide or arrange for their own care and care can be provided through appropriate private-duty personnel. Such care cannot amount to continuous nursing care, which is defined as 90 days or more of care.
Maine	May not retain residents if the services required cannot be met by the facility, or the residents' intentional behavior results in substantial physical damage to the property.
Maryland	May not retain residents if they require more than intermittent nursing care; require treatment of stage III or IV skin ulcers; require ventilator services; require skilled monitoring, testing, and aggressive adjustment of medications and treatments where there is the presence of, or risk for, a fluctuating acute condition; require monitoring of a chronic medical condition that is not controllable through readily available medications and treatments; require treatment for an active, reportable communicable disease; or treatment for a disease or condition that requires more than contact isolation. Individuals may also be discharged if they are at a high risk for health and safety complications that cannot be adequately managed.
Massachusetts	May not retain residents in need of skilled nursing care unless the care will be provided by a certified provider of ancillary health services or by a licensed hospice.
Michigan	May not retain residents who become ill, injured, or disabled following admission, and require intensive nursing care or nursing care on a 24-hour basis. Residents may remain, however, if their family, physician, and the facility consent to continued stay and agree to cooperate in providing the needed level of care and the necessary additional services. Residents may be transferred or discharged only for medical reasons, or for his or her welfare or that of other residents.
Minnesota	Not specified.
Mississippi	May not retain residents who are not ambulatory; require nasopharyngeal and/or tracheotomy suctioning; require gastric feedings; require intravenous fluids, medications, or feedings; require an indwelling urinary catheter; require sterile wound care; or require treatment of decubitus ulcer or exfoliative dermatitis.

Appendix D (Continued)

State	Retention Criteria
Missouri	May not retain residents if necessary services cannot be obtained in or by the facility; they require hospitalization or skilled nursing placement; they require skilled nursing services for which the facility is not licensed or able to provide; they require more than one person to simultaneously assist the resident with any ADL with the exception of bathing and transferring; they are bed bound or similarly immobilized due to a debilitating or chronic condition. Residents must be physically and mentally capable of negotiating a normal path to safety unassisted or with the use of assistive devices. Some exceptions for hospice care.
Montana	Category A facilities may not retain residents who have stage III or stage IV pressure ulcers; have a gastrostomy or jejunostomy tube; require skilled nursing care or other skilled services on a continuing basis except for the administration of medications; or are not able to accomplish ADLs with supervision and assistance. Residents may not be consistently and totally dependent in four or more ADLs as a result of a cognitive or physical impairment, nor may the resident have severe cognitive impairment that prevents expression of needs or the ability to make basic care decisions. Category B facilities may not retain residents who require skilled nursing care or other services for more than 30 days for an incident and for more than 120 days a year; are consistently and totally dependent in more than four ADLs; do not have a practitioner's written orders for moving in and for care; or do not have a signed health care assessment that is renewed quarterly by a licensed health care professional who has visited the facility. Category C facilities may not retain residents if they have a severe cognitive impairment that renders them incapable of expressing needs or of making basic care decisions; or if they are at risk for leaving the facility without regard for personal safety.
Nebraska	May not retain residents if they require complex nursing interventions; or their conditions are not stable or predictable, unless such residents have sufficient mental ability to understand the situation and assume responsibility for arranging for care from a third party; or have care needs that do not compromise the facility operations.
Nevada	May not retain residents who are bedfast; require 24-hour skilled nursing or other medical supervision; need gastrostomy care; suffer from a staphylococcus infection or other serious infection or medical condition. A resident unable to self-manage medical conditions must be discharged.
New Hampshire	May not retain residents if their needs cannot be met by the facility and they cannot evacuate in accordance with the state fire code. If a resident's health status changes so the resident requires ongoing medical or nursing care, the resident must be transferred to a facility that is licensed to provide these services.
New Jersey	May not retain residents who require specialized long term care, such as respirators, or ventilators. Facilities may specify other discharge requirements, for residents with nursing, ADL and mobility needs.
New Mexico	May not retain residents if they require continuous nursing care, which may include ventilator dependency; or stage III or IV pressure sores.

Appendix D (Continued)

State	Retention Criteria
New York	In adult homes and enriched housing, residents may not be retained if they need continuous nursing care; are chronically bedfast or chair fast; or are cognitively, physically, or mentally impaired to the point that the resident's safety or safety of others is compromised. Enhanced assisted living residences may not admit residents in need of 24-hour skilled nursing care. However, residents in need of 24-hour skilled care may continue to stay if they hire appropriate nursing, medical, or hospice staff to meet their needs; the resident's physician and home care services agency determines and documents that the residents can be safely cared for in the residence; the assisted living provider agrees to retain the resident and coordinate the care for all providers and, the resident is otherwise eligible to reside at the residence. Enhanced assisted living facilities may also retain individuals who are chronically chair fast and unable to transfer, or chronically require the physical assistance of one other person to transfer.
North Carolina	A multi-unit assisted housing with services facility may not retain residents who are ventilator dependent; have dermal ulcers III or IV, except when a physician has determined that stage III ulcers are healing; need intravenous therapy or injections directly into the vein, except for intermittent intravenous therapy managed by a home care or hospice agency licensed by the state; have airborne infectious disease in a communicable state that requires isolation or requires special precautions by the caretaker to prevent transmission of the disease; are taking psychotropic medications without appropriate diagnosis and treatment plans; are using nasogastric tubes; are using gastric tubes except when they are capable of independently feeding and caring for the tube, or are managed by a state licensed home care or hospice agency; require continuous licensed nursing care; have physician certifying that placement is no longer appropriate; are totally dependent in four or more activities of daily living as documented on a uniform assessment instrument unless an independent physician determines otherwise; or have health needs and other medical and functional care that cannot be met by the residential facility. In adult care homes, residents may not be retained when they need continuous medical supervision; are ventilator dependent; a physician certifies placement is no longer appropriate; or health needs cannot be met as determined by the residence.
North Dakota	May not retain residents incapable of self-preservation or who have a condition requiring 24-hour-a-day onsite availability of nursing or medical care. Other discharge criteria are developed independently by each facility.
Ohio	May not retain residents who require skilled nursing care beyond the supervision of special diets, application of dressings, or administration of medication unless the care is on a part-time/intermittent basis for not more than a total of 120 days in any 12-month period. There are exceptions for hospice residents.
Oklahoma	May not retain residents needing care in excess of the level that the facility is licensed to provide or capable of providing.
Oregon	May not retain residents whose needs exceed the level of ADL services available; who have a medical or nursing condition that is complex, unstable, or unpredictable; or who are unable to be evacuated by the facility.
Pennsylvania	Not specified.
Rhode Island	May not retain residents who do not possess the physical mobility and judgmental ability to take appropriate action in emergency situations, except in special dementia care units; or who do not meet the requirements for residency stated in the residency agreement or state or local laws and regulations. Residents requiring any more than temporary nursing services must move to a nursing facility.

Appendix D (Continued)

State	Retention Criteria
South Carolina	May not retain residents who need nursing services, or require hospital or nursing care.
South Dakota	May not retain residents who require more than intermittent nursing care or rehabilitation services. Residents covered by Medicaid cannot be involuntarily transferred or discharged unless their needs and welfare cannot be met by the facility.
Tennessee	May not retain residents who are in the latter stages of Alzheimer's disease; require nasopharyngeal and tracheotomy aspiration; require initial phases of a regimen involving administration of medical gases; require a nasogastric tube; require arterial blood gas monitoring; cannot communicate their needs; require gastrostomy feedings; require intravenous or daily intramuscular injections or intravenous feedings; require insertion, sterile irrigation, and replacement of catheters; require sterile wound care; or, require treatment of extensive stage III or IV decubitis ulcer or exfoliative dermatitis. A self-care exception exists in the regulations for individuals who are able to care for their own medical conditions. If residents are no longer able to care for their condition, they must be transferred immediately to a licensed nursing home or hospital. A facility may allow residents to remain in the facility for no longer than 21 days, if they require intravenous or daily intramuscular injections or intravenous feedings; require insertion, sterile irrigation, and replacement of catheters, or require sterile wound care.
Texas	May not retain residents whose needs cannot be met. Residents may contract with a home health agency to provide services or they must be discharged.
Utah	May not retain residents who are immobile; require inpatient nursing care; do not have stable health; require more than limited assistance with ADLs; or require regular or intermittent care in the facility from a licensed health professional. Residents unable to take life-saving action in an emergency without assistance must be discharged.
Vermont	May not retain residents if their needs cannot be met. Residents needing 24-hour nursing care; who are bedridden; dependent in four or more ADLs; have severe cognitive decline; stage III or IV pressure sores; or have an unstable medical condition may be retained if the facility can care for them. Residents needing skilled nursing care may arrange for that care to be provided.
Virginia	May not retain residents if they are ventilator dependent; have some stage III and all stage IV dermal ulcers; have nasogastric tubes; need continuous licensed nursing care; or have physical or mental health care needs that cannot be met by a facility.
Washington	May not retain residents who require the frequent assistance of a registered nurse, except those residents receiving hospice care, or who have a short-term illness; or who are nonambulatory.
West Virginia	May not retain residents in need of extensive or ongoing nursing care or with needs that cannot be met by the facility.
Wisconsin	May not retain residents if their needs cannot be met; the time required to provide services exceeds 28 hours per week; or their condition requires the immediate availability of a nurse 24-hours per day.
Wyoming	May not retain residents if their needs cannot be met with available support services or such services are not available. Residents of secure dementia units may not be retained when they score less than 10 on the Mini-Mental State Exam; when they need ongoing intermittent nursing care; or when they require more than limited assistance to evacuate the building.

Source: Developed by LBFC staff from *Assisted Living State Regulatory Review (March 2008),* prepared by the National Center for Assisted Living.

APPENDIX E

Delegation of Nursing Care Tasks in Assisted Living*

State	Administration of oral medication	Administration of pre-drawn insulin	Administration of other injectable medications	Administration of PRN medication	Applying unsterile dressings	Applying sterile dressings	Tube feedings	Bladder catheters	Bowel treatments
Alabama					✓				
Alaska[a]									
Arizona					✓	✓			✓
Arkansas	✓						✓	✓	
California					✓				
Colorado	✓	✓	✓	✓	✓	✓	✓	✓	✓
Connecticut						✓	✓		
Delaware					✓		✓	✓	✓
Florida					✓	✓	✓	✓	✓
Georgia[a]									
Hawaii	✓	✓	✓	✓	✓	✓	✓	✓	✓
Idaho							✓	✓	✓
Illinois[a]									
Indiana									
Iowa	✓				✓	✓		✓	✓
Kansas	✓				✓				
Kentucky							✓	✓	✓
Louisiana							✓	✓	✓
Maine									
Maryland	✓	✓	✓	✓	✓	✓	✓	✓	✓
Massachusetts									
Michigan[a]									
Minnesota	✓	✓			✓	✓	✓	✓	✓
Mississippi								✓	
Missouri[a]									

Appendix E (Continued)

State	Administration of oral medication	Administration of pre-drawn insulin	Administration of other injectable medications	Administration of PRN medication	Applying unsterile dressings	Applying sterile dressings	Tube feedings	Bladder catheters	Bowel treatments
Montana	✓			✓	✓				✓
Nebraska									
Nevada					✓				✓
New Hampshire	✓			✓	✓	✓	✓	✓	✓
New Jersey	✓	✓		✓	✓	✓	✓		✓
New Mexico					✓				
New York									
North Carolina	✓	✓			✓	✓	✓	✓	✓
North Dakota	✓	✓							
Ohio					✓	✓	✓	✓	✓
Oklahoma	✓	✓							
Oregon	✓	✓	✓	✓	✓	✓	✓	✓	✓
Pennsylvania									
Rhode Island					✓				
South Carolina	✓	✓	✓	✓	✓	✓	✓	✓	✓
South Dakota	✓			✓	✓			✓	✓
Tennessee					✓				
Texas	✓	✓		✓	✓	✓	✓	✓	✓
Utah	✓	✓	✓	✓	✓	✓	✓	✓	✓
Vermont	✓	✓			✓	✓	✓	✓	✓
Virginia									
Washington	✓			✓	✓			✓	✓
West Virginia	✓				✓				
Wisconsin	✓	✓	✓	✓	✓	✓	✓	✓	✓
Wyoming					✓				✓

*Check mark indicates a task that registered nurses are sometimes permitted to delegate to unlicensed assistive personnel.

[a]State Board of Nursing elected not to participate in the study survey.

Source: Susan C. Reinhard, RN, PhD, FAAN et al, *Nurse Delegation of Medication Administration for Elders in Assisted Living*, Rutgers Center for State Health Policy, The State University of New Jersey - Rutgers, June 2003.

APPENDIX F

Pennsylvania's Surrounding States

Five of Pennsylvania's surrounding states publicly fund assisted living services through their Medicaid programs for those with needs that would qualify to receive care in a nursing facility. Delaware, Maryland, New Jersey and Ohio fund assisted living services for such individuals through Medicaid waivers. New York funds its assisted living program for such individuals through its Medicaid State Plan. Delaware, Ohio, and New Jersey's waivers are limited to assisted living services. In Maryland, assisted living services are one of many services available through its home and community based waiver for elderly and adult physically disabled individuals.

The five surrounding states that publicly fund assisted living services through Medicaid do not limit funding of such services to assisted living residences as defined by Act 2007-56. They all, however, include nursing services in the assisted living service package paid for by Medicaid.

With respect to reimbursement under Medicaid waivers, Delaware and Ohio have three tiered reimbursement systems based on resident assessed need. Maximum allowed Medicaid payments in Delaware range from $34.38 to $51.41 per day. In Ohio, they range from $50 to $70 per day.

To apply for the Ohio assisted living waiver, an individual must meet additional criteria that are not in place in other surrounding state waivers. Prior to applying for assisted living waiver services, an individual must have participated in one of Ohio's Medicaid waiver programs and would move to a nursing facility if not for the assisted living program, be a nursing facility resident who would remain in the nursing facility if not for admission to a residential care facility, or be a current resident of a residential care facility and have resided at the facility for at least six months before the date of the assisted living waiver application.

In Maryland's waiver, assisted living rates are tied to a program's level of licensure and whether or not the resident also participates in adult day programming. In 2008, Maryland's maximum allowed per diem rates were $41.81 for an assisted living resident in a "Level II" facility who participated in adult day programming and $55.74 for such a resident not participating in adult day programming. "Level II" licensure requires staff with the ability to provide substantial support for some, but not all, activities of daily living and the ability to provide or ensure assistance with taking medication and the administration of medication. For those in "Level III" facilities, the maximum allowed rates were $52.73 and $70.31. Such facilities must have staff and the ability to provide or ensure provision of comprehensive support as frequently as needed to address any number of activities of daily living needs.

New Jersey does not vary its Medicaid payments based on resident needs. It reimburses providers through flat rates which are setting specific. New Jersey's maximum allowed Medicaid payment in an assisted living residence is $70 per day in 2008. New Jersey's Certificate of Need (CON) program takes into account a proposed assisted living residence's plans to participate in the state's Medicaid waiver, and requires those that receive CONs to plan to serve a specific proportion of Medicaid residents.

New Jersey also reimburses for assisted living services provided in other residential care settings, which are licensed. The maximum allowed reimbursement for such settings is $60 per day, and it is $50 per day for services delivered by licensed providers in public housing settings.

New York's Assisted Living Program reimburses using a case mix system which takes into account 16 different resident acuity levels and 16 different regions. In the region with the lowest rates, the maximum allowable rates range from $43.84 to $85.14 per day. In the region with the highest maximum per diems (New York City), the program's maximum allowed rates range from $71.87 to $147.68. New York's Assisted Living Program rates, moreover, are capitated payments that include nursing services; physical, occupational, and speech therapies; medical equipment and supplies that do not require prior

Appendix F (Continued)

Authorization; home health aide services; personal care services; adult day health; case management; and personal emergency response services. New York's program also differs from those in surrounding states in that it requires its Assisted Living Program providers to obtain Certificates of Need and to be dually licensed as residential providers and as home care providers or contract with home health agencies.

With the exception of West Virginia, all of Pennsylvania's surrounding states make available Optional State Supplementation of Federal SSI payments for low income residents in selected residential care programs. In Ohio, however, the full optional state supplement is not available to those participating in the state's assisted living waiver.

Maryland provides an Optional State Supplement program. It also operates a small state program that mirror the Optional State Supplement program for a limited number of individuals in residential care whose income and resources are slightly above the federal SSI program's eligibility and asset levels.

West Virginia does not operate an Optional State Supplementation program. It does, however, offer a state program using federal Title XX dollars to support room and board and care in certain residential care settings. Residents in such settings may also qualify for the state's Medicaid State Plan personal care services; however, residential providers are not permitted to enroll as Medicaid State Plan personal care providers in West Virginia. According to West Virginia Medicaid staff, despite such eligibility, adults in residential settings are not receiving Medicaid State Plan personal care services.

Source: Developed by LB&FC staff.

APPENDIX G

Footnotes for Exhibit 15

[a]The maximum federal SSI monthly benefit in 2000 was $512, and in 2007, $623—an increase of $111 for the period.

[b]Arizona has a room and board program for certain qualified individuals and provides $70 per month payment for housekeeping services for those receiving SSI in certain types of residences. Arizona Long Term Care Services recipients, however, are not eligible for the Supplemental Payment Program.

[c]In 2000, Florida provided a $228 optional state supplement (OSS) to SSI recipients living in Adult Family Care Homes (AFCH) and Assisted Living Facilities (ALF) and to recipients who met all SSI criteria except for income if their income did not exceed $697 monthly. As of January 2002, the SSA reported that the optional state supplement for persons living in these facilities was $78.40 a month, a decrease of $149.60 a month. The reason for the decrease is that in 2001, Florida implemented the Medicaid Assistive Care Services (ACS) Program—an optional Medicaid State Plan service--in order to increase payments for eligible recipients requiring an integrated set of services on a 24-hour per day basis, who live in AFCH's and ALF's. To implement Florida's Medicaid State Plan Assisted Living Program (i.e., the ACS Program), state OSS funds were transferred from the Department of Children and Families to Medicaid to draw down federal Medicaid matching funds, and Florida's optional state supplement amount was reduced from $228 to $78.40 (except for a group that was "grandfathered" following a legal challenge). Such benefit effectively reduced the income eligibility thresholds for the program, thus reducing the OSS caseload by about 10 percent. Florida estimates that providers who elected to participate as Medicaid providers for the ACS Program and continued to serve OSS recipients received about 16 percent more in revenues for caring for such residents.

[d]Idaho eliminated its Optional State Supplement for participants in its Medicaid 1915(c) home and community waiver providing assisted living services for the elderly and adult physically disabled. The 2007 reported benefit is only available to participants in the Idaho Medicaid waiver for the developmentally disabled.

[e]Illinois' sheltered care allowance amount is based on a point count assessment of the client's needs and the county where the facility is located. The point count is the total of all points allowed for the services required and received by the resident from staff of the facility. The total point count for a client receiving sheltered care services cannot exceed 11 points. Counties are grouped based on economic variation for the purpose of determining sheltered care rates. The dollar amount listed in the exhibit ($437.00) represents the highest optional supplement amount a client can receive if they qualified for the highest number of points based on their service needs and the facility is located in one of the five counties with the highest allowed rates. Illinois' average Optional State Supplement payment was $410.00 in 2007.

[f]Indiana modified its rate setting method under the program changing to a flat rate system from a facility specific cost based system. Such a change accounts for the modified state supplement upper limit.

[g]Iowa did not respond to our request for information about the reasons for its reported benefit reduction.

Appendix G (Continued)

[h]Minnesota's reported 2007 state supplement excludes the service component amount included in the reported 2000 benefit. Those eligible for the optional state supplement who receive personal care or nursing services through the State Medicaid Plan or through a Medicaid waiver are not eligible to receive the service component of the state supplement. Counties may, however, negotiate a service component payment rate for those individuals in certain licensed residences who are not receiving Medicaid State Plan or Medicaid waiver assisted living services.

[i]Montana Medicaid waiver participants in assisted living do not qualify for the optional state supplement.

[j]In 2000, Nebraska provided an Optional State Supplement to aged, blind and disabled recipients, who resided in Certified Adult Family Homes (AFH) and Licensed Assisted Living Facilities (ALF) . The amount of the supplement was $145 for persons living in AFH's and $270 for persons living in ALF's. The amount of supplementation provided to residents of Adult Family Homes did not measurably change between 2000 and 2007. In 2007, the amount of the supplement was $138, a reduction of $7 a month. The supplement for eligible residents of Assisted Living Facilities increased to $438 a month by 2007, an increase of $168. According to a state official, in 2001, the state allocated an additional $2 million dollars in state general fund monies to increase the level of state supplementation for eligible residents in licensed Assisted Living Facilities.

[k]In 2000, North Dakota provided an optional state supplement to persons in Licensed Basic Care Facilities. The amount of the supplement was $1,116.40. The supplement dropped to $299.16 in 2005. In 2006, the state discontinued the Optional State Supplement program. North Dakota changed its program to a state-only funded program for individuals who qualify for Medicaid and have certain assessed needs, but do not qualify for its Medicaid State Plan personal care services or its Medicaid waiver. The state program provides providers with approved per diem payments; however, the approved payments may be reduced if the appropriation for the program does not include sufficient funds to cover costs statewide.

[l]Ohio's state supplement is not available to Medicaid waiver participants.

[m]Rhode Island's state supplement was modified in statute effective January 1, 2003 when the state elected to reduce the state supplement by the amount of the federal benefit increase in 2003.

[n]Wisconsin's supplement is limited to individuals with an assessed need for at least 40 hours per month of supportive home care, daily living skills training, or community support services. Wisconsin Medicaid waiver recipients have facility service costs covered by the waiver excluded from the calculation to determine eligibility for the additional supplement.

Source: Developed by LB&FC staff from information provided by the Social Security Administration reports, *"State Assistance Programs for SSI Recipients"* for 2000 and 2007 and information provided by selected states and state regulations.