REPORT OF THE
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

A STUDY OF VIRGINIA'S 1915c MEDICAID-FUNDED HOME AND COMMUNITY-BASED WAIVER FOR INTENSIVE ASSISTED LIVING SERVICES

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

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COMMONWEALTH of VIRGINIA

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TO: The General Assembly of Virginia

The report contained herein is provided pursuant to Item #335, #5c of the 1999 Appropriations Act which mandated the Department of Medical Assistance Services (DMAS) to review the current Medicaid assisted living waiver.

This study reflects a review of the Medicaid-funded home and community-based care waiver that provides intensive assisted living services to eligible residents in Adult Care Residences.

The Department spent 217 staff hours on this report, at a cost of approximately $6986.00.

Respectfully submitted,

Dennis G. Smith

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PREFACE

The 1999 General Assembly passed Item #335, #5c of the 1999 Appropriations Act which mandated the Department of Medical Assistance Services (DMAS) to review the current Medicaid assisted living waiver. The issues the General Assembly requested DMAS to review include:

I. The services covered by the assisted living payments and the extent to which payments reflect the services that need to be provided;
II. Whether additional nursing facility patients can be safely and appropriately served through assisted living;
III. The adequacy of reimbursement for assisted living care;
IV. The appropriateness of the current two-tiered structure for assisted living payments;
V. The extent to which Medicaid funds could be used in lieu of general funds to provide assisted living care;
VI. Best practices in other states; and
VII. The adequacy of the current regulatory structure, if heavier care patients were to be cared for in adult care residences.

This study reflects a review of the Medicaid-funded home and community-based care waiver that provides intensive assisted living services to eligible residents in Adult Care Residences. Additionally, the study includes options the Governor and the 2000 General Assembly Session can consider regarding the revision of the waiver.

We wish to extend our appreciation for the assistance and cooperation provided during this study by the staff of the Department of Social Services.

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EXECUTIVE SUMMARY

The 1999 General Assembly passed Item #335, #5c of the 1999 Appropriations Act which mandated the Department of Medical Assistance Services (DMAS) to review the current Medicaid assisted living waiver. The issues the General Assembly requested DMAS to review include:

I. The services covered by the assisted living payments and the extent to which payments reflect the services that need to be provided and the extent to which Medicaid funds could be used lieu of general funds to provide assisted living care;
II. Whether additional nursing facility patients can be safely and appropriately served through assisted living;
III. The adequacy of reimbursement for assisted living care and the appropriateness of the current two-tiered structure for assisted living payments;
IV. Best practices in other states; and
V. The adequacy of the current regulatory structure, if heavier care patients were to be cared for in adult care residences.

This report presents the options identified by the Department of Medical Assistance Services (DMAS) in relation to its review of the Medicaid home and community-based waiver that provides intensive assisted living services. The options outlined in this report are in no way intended to fully outline all the details which must be addressed in the revision of the Intensive Assisted Living (IAL) Waiver.

Options:

- DMAS could renew the waiver and not make any changes.

- DMAS could DMAS could renew the IAL Medicaid waiver for Fiscal Year 2001, eliminate the regular assisted living level and transfer the regular assisted living payment rate of $90 per month to the IAL waiver. "Grandfather" those individuals who are now eligible for regular assisted living as long as they continue to be eligible for the payments. Assess individuals for Intensive Assisted Living based on the number of personal care hours needed up to three hours per day and pay the ACR accordingly. For example, if one hour per day is needed, the ACR would be reimbursed $6.00 per day (up to $180 per month) for that resident; if two hours per day is needed, the ACR would be reimbursed $12.00 per day (up to $360 per month); and if three hours per day is needed, the ACR would be reimbursed $18.00 per day (up to $540 per month.)

- DMAS could renew the IAL Medicaid waiver for Fiscal Year 2001, eliminate the regular assisted living level and transfer the regular assisted living payment rate of $90 per month to the IAL waiver. The State would be able to maximize potential federal dollars in the Medicaid IAL waiver, thus increasing the service reimbursement amount in the waiver. Individuals could then be assessed based on the number of personal care hours needed up to three hours per day and pay the ACR accordingly. For example, if one hour per day is needed, the ACR would be reimbursed $6.00 per day (up to $180 per month) for that

resident; if two hours per day is needed, the ACR would be reimbursed $12.00 per day (up to $360 per month); and if three hours per day is needed, the ACR would be reimbursed $18.00 per day (up to $540 per month.)

- DMAS could renew the IAL Medicaid waiver for Fiscal Year 2001. Keep the regular assisted living payment the same as it is currently. Assess individuals for Intensive Assisted Living based on the number of personal care hours needed up to three hours per day and pay the ACR accordingly. For example, if one hour per day is needed, the ACR would be reimbursed $6.00 per day (up to $180 per month) for that resident; if two hours per day is needed, the ACR would be reimbursed $12.00 per day (up to $360 per month); and if three hours per day is needed, the ACR would be reimbursed $18.00 per day (up to $540 per month.)

- DMAS could (in conjunction with affected constituencies and other state agencies) study the feasibility of developing a Medicaid Alzheimer's/Dementia Waiver for individuals in their own homes or in ACRs. This 1915(b) Waiver would allow individuals who have Alzheimer's Disease or Dementia to receive services in a capitated environment similar to the Program for All Inclusive Care for the Elderly (PACE) Model. Services would be provided within an Adult Day Health Care setting by an interdisciplinary team of professionals. Services within the capitated rate would include: Adult Day Care, Primary Medical Care, Caregiver Counseling, Emergency Response Services (medication cueing, Wander Watch), personal care, respite care, prescription drugs, therapy services, nutritional supplements, durable medical equipment, and transportation. Exclusions to the capitation amount include physician visits and hospitalizations (covered under fee for service). Individuals who live in their own homes or in ACRs would be eligible for services from this waiver. By having a safe place for the family member during the day with "wrap around" services, the family may be able to cope longer before nursing facility admission is sought. Also, by making this service available to individuals in ACRs, individuals with Alzheimer's could be cared for at a little more than half the cost of nursing facility placement.

Additional Medicaid regulatory requirements for assisted living services providers would be needed with any reimbursement changes to ensure residents are receiving services appropriate to their care needs.

INTRODUCTION

Assisted living services are services supplied to an individual in a residential setting that provides or coordinates personal care services, 24-hour supervision, scheduled and unscheduled assistance, social activities, and some health-related services. The Department of Medical Assistance Services (DMAS) began its administration of the Intensive Assisted Living Program in 1996 and provides intensive assisted living (IAL) services through a Medicaid-funded home and community-based care waiver. The waiver provides additional funding to provide one hour of assisted living, or personal care services, per day to individuals who meet the IAL waiver criteria.

Adult care residence (ACR) that provide IAL services through the waiver have indicated that the current intensive assisted living reimbursement structure is not adequate to meet the needs of the intensive assisted living population. Providers feel the costs for providing quality care to individuals with higher acuity needs exceed the current intensive assisted living waiver rate of $6.00 per day. A 1998 study of the costs of ACR services to Auxiliary Grant recipients in Virginia by DMAS and the Department of Social Services (DSS) concluded that findings for the study did not demonstrate a need for an across-the board increase in the Auxiliary Grant rate (CHPS Consulting and Clifton Gunderson, P.L.L.C., 1998). The study also found that, while providers assert that costs vary with level of resident need for assisted living, there was a very weak correlation between the costs of care for residents and the various levels of care.

A review of 50 states in the 1998 Mollica study of assisted living revealed there is a variety of ways in which states set payment methodologies for assisted living services. There are four different types of reimbursement: case mix, flat rate, tiered rate, and a care plan rate. Virginia is one of thirteen states that sets a flat fee per level of care while other states vary in their methods. Some states, for example, reimburse according to the varying needs of the AL resident population rather than setting two levels of care.

While it is recognized that current reimbursement for assisted living services may need to be revised, results from recent DMAS utilization review findings suggest current assisted living providers need to improve their documentation of the provision of existing intensive assisted living services prior to any recommendation of a rate increase or change in payment methodology. In addition, further attention needs to be given on the needs of special populations, such as individuals with mental retardation, mental illness, or dementia who are receiving services through the IAL Waiver.

BACKGROUND

Aging Population Needs and the Development of Assisted Living

Our society is aging. In the past twenty-five years, the United States (US) population as a whole increased by one-third, while the elderly population has nearly doubled, and the 85 and over population has nearly tripled (Ball, 1989). Ten million persons living in the community have disabilities, with thirty percent having significant functional or cognitive impairments requiring long-term care services. Slightly over one million individuals require assistance with three or more activities of daily living (ADLs). Much of the care provided to these individuals is through informal rather than formal supports (American Association of Retired Persons, 1994).

Although the need for assistance increases with age, elderly individuals still value their autonomy. When questioned, most older persons want to live in their own homes and remain as independent as possible. Many who require assistance cannot remain home, however, due to a loss of social supports and their inability to qualify for independent housing, residential living, or congregate care due to physical or cognitive impairments (that necessitate substantial service or supervision).

In response to consumers' difficulty and/or dissatisfaction with the residential and institutional options available and their demand for an alternative to nursing facility care, innovative providers developed the concept of assisted living over the past ten years. The philosophy of assisted living emphasizes personal dignity, autonomy, independence, and privacy. The focus of assisted living is to maintain or enhance the capabilities of frail older persons and persons with disabilities so they can remain as independent as possible in a home-like environment. The combination of residential housing and personal care services tailored to meet the needs of the individual help to promote the ability of residents to "age in place."

Assisted living meets the consumers' desires to:

- Remain in a home-like setting until substantially impaired;
- Enter a residential setting only when they develop substantial service needs;
- Remain in a residential environment that maximizes their autonomy, privacy, and dignity, even if they require a high level of services; and
- Avoid or delay placement in an institutional setting.

While definitions of assisted living vary throughout the country and are often given a variety of terms, the general definition includes a residential setting that provides or coordinates personal care services, 24-hour supervision, scheduled and unscheduled assistance, social activities, and some health-related services.

The development of assisted living as a long-term care service is the result of several factors, including the desire of individuals to "age in place," a growth in the population of older persons (especially 85 years and older), and changes in family structure that have produced an increase in the number of older persons living with less family and community supports. Individuals are now beginning to seek alternatives to institutional (nursing facility) care that provide more consumer autonomy and choice. In addition, state policymakers are also looking

for ways to slow Medicaid long-term care expenditures by utilizing home and community-based alternatives to institutionalization.

Assisted living is the fastest growing type of senior housing in the U.S., with an estimated 15-20% annual growth rate over the last few years. Assisted living facilities generally provide assistance with medications and arrange for intermittent skilled nursing care. Assisted living is not designed for persons requiring 24-hour skilled nursing care. According to the American Association of Retired Persons (AARP), the average length of residency in an assisted living facility in 1997 was approximately 26 months, with the most common reason for discharge being the need for a nursing home stay (1994).

Virginia's Long-Term Care Population

Projections for the growth of the elderly population for the Commonwealth indicate that older adults are the fastest growing segment of Virginia's population. The Virginia Employment Commission (1993) estimated that there are currently more than 950,000 Virginians age 60 and older, representing almost 15 percent of the Commonwealth's total population. From 1990 to 2010, the numbers of elderly will increase approximately 27 percent for persons age 65 to 74; 38 percent for persons age 75 to 84; and 97 percent for persons over 85 years of age. The demand for supportive services for people with disabilities will also increase.

Virginia's Ranking Among the States

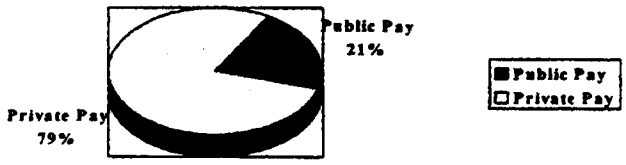
Measurement	Rank
Population	12th
Per-capita Income	15th
Number of Medicaid Recipients	16th
Number of Medicaid Recipients as a Percent of Population	39th

*Source: The Statistical Record of the Virginia Medicaid Program: Fiscal Year 1998

According to a national long-term care system study conducted by the University of Minnesota, Virginia is currently ranked 18th in the nation in terms of the growth rate of Virginians age 85+ from 1990-1996, with a growth rate of 26.96 percent. In addition, in 1996 Virginia was ranked 14th when comparing the ratio of Medicaid home and community-based care expenditures to all long-term care expenditures (Ladd, Kane, and Kane 1999).

Virginia's current LTC system is primarily financed through Medicaid (federal and state) dollars. One exception to this is the adult care residence (ACR) industry, which primarily serves private pay patients. Virginia does, however, reimburse for ACR & assisted living services for public pay clients. While this study will briefly explain the public pay system for residents in ACRs, the primary focus will be on Medicaid-funded assisted living services.

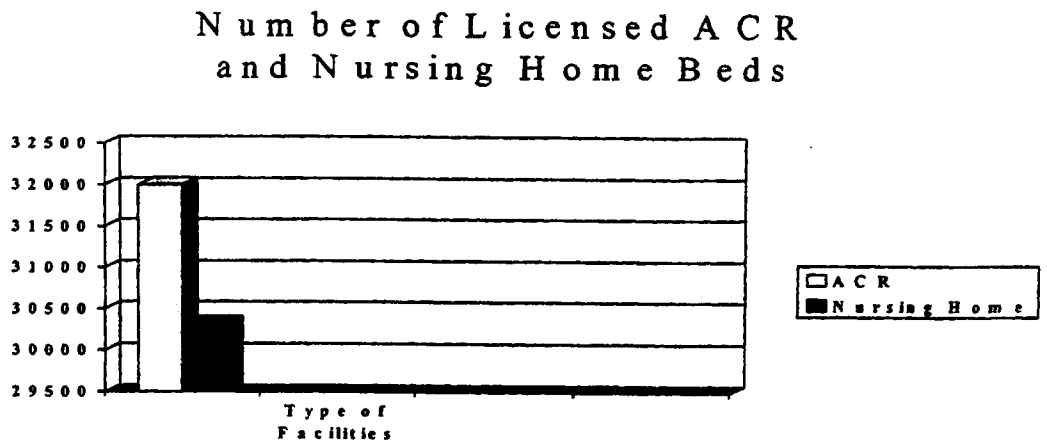
Number of ACR Private and
Public Pay Residents



Virginia's Publicly-Funded Adult Care Residence Service Programs

Adult Care Residences (ACRs) are a large component of Virginia's long-term care system. Formerly referred to as home for adults or domiciliary care, Section 63.1-172 of the *Code of Virginia* identifies an "Adult Care Residence" as "any place, establishment, or institution, public or private, operated or maintained for the maintenance or care of four or more adults who are aged, infirm or disabled and who are cared for in a primarily residential setting." Exceptions to this definition include group homes that are licensed by the Department of Mental Health, Mental Retardation and Substance Abuse Services, licensed educational facilities for adults who are 18 to 22 years of age, and homes that are caring for relatives. ACRs are also commonly called board and care or assisted living facilities and are licensed by the Virginia Department of Social Services (DSS).

Virginia has a booming ACR industry as the number of licensed ACR beds have increased dramatically between 1979 and 1999. The latest data from DSS shows there are 687 licensed facilities operating in Virginia. According to research conducted by the Joint Commission on Health Care in 1999, the total number of licensed ACR beds now outnumbers the total number of licensed nursing facility beds in Virginia.



Virginia's ACR population is also primarily private pay, although 21 percent (6,706) of the overall population of ACR residents are public pay residents.

In 1997, Virginia's ratio of residential care beds per 1,000 population aged 65 and over was 37.6, higher than the national ratio of 24.3 beds per 1,000 population (Harrington et al., 1999).

Virginia currently has three methods of payment for ACR services. The most basic payment for room and board is covered by an Auxiliary Grant. ACRs are also reimbursed for caring for residents who are increasingly impaired in their behavior, activities of daily living and medication management through assisted living levels of care.

The Auxiliary Grant

The Auxiliary Grant (AG) is a supplement to the income of recipients of SSI and certain other aged, blind, or disabled individuals residing in a licensed ACR or in adult family care. This assistance is available through local departments of social services to ensure that recipients maintain a standard of living that meets a basic level of need. The AG program is specifically for individuals who live in a licensed ACR or in an adult family care home approved by the local department of social services (Department of Social Services, 1998).

The AG program is a state (80%) and locally (20%) funded financial assistance program, which is administered by DSS. Its purpose is to provide supplemental income for a SSI recipient or an adult who would be eligible for SSI except for excess income, who resides in an ACR or in adult family care. The maximum rate is determined by the Virginia General Assembly and is adjusted annually. Effective July 1999, the monthly minimum rate was set at $775.00.

AG recipients also receive a monthly personal allowance of $54.00, which is used by the resident for items such as personal toiletries, snacks, over the counter and non-prescription medications, medical co-payments, etc., and any activities outside of what is offered by the ACR provider. DSS regulations do not permit the personal allowance to be used for required recreational activities, administration of accounts, debts owed the ACR for basic services, or charges for laundry which exceed $10.00 per month.

Eligibility for the AG program is determined by the local department of social services in the locality where the individual resides. Residence for AG eligibility is determined by the city or county within the state where the person last lived outside of an institution or adult family care home. If residency cannot be determined, residency is where the individual is living at the time of the application. To be eligible for the AG Program, an individual must meet all of the following:

- Be 65 years of age or older or be blind or disabled;
- Reside in a licensed ACR or approved AFC home;
- Be a citizen of the United States or an alien who meets specified criteria;
- Have non-exempted resources less than $2,000 for one person or $3,000 for a couple; and
- Have been assessed and determined to need ACR care or adult family care placement.

The Auxiliary Grant covers room and board and maintenance and care. The AG rate includes:

- Provision of a furnished room in a facility that meets applicable building and fire safety codes;
- Housekeeping services based on the needs of the resident;
- Meals and snacks, including extra portions and special diets;
- Clean bed linens and towels as needed by the residents and at least once a week;
- Minimal assistance with personal hygiene (activities of daily living);
- Medication administration as required by licensing regulations including insulin injections;
- Provision of generic personal toiletries including soap and toilet paper;
- Minimal assistance with instrumental activities of daily living (IADLs);
- Securing health and transportation when needed for medical treatment;
- Providing social and recreational activities as required by licensing regulations; and
- General supervision for safety.

Based on a 1997 survey of approximately 400 licensed ACRs participating in the AG Program conducted by the DSS Division of Finance, 7,534 ACR residents received AG and/or assisted living public funding assistance. Of these residents, about 60 percent receive AG funds only, and 40 percent also received some form of assisted living assistance. In FY '98, approximately $20.2 million was expended in the AG Program (Department of Social Services, 1998).

There are two levels of care in an ACR: residential and assisted living. There are three levels of payment: residential, regular assisted living and intensive assisted living. Two levels of assisted living in Virginia, regular and intensive, are available to individuals eligible for an

AG who meet the criteria for these programs as defined in Virginia regulation 22 VAC 40-745-10 *et seq.*

III. SERVICES COVERED BY ASSISTED LIVING PAYMENTS AND THE EXTENT TO WHICH PAYMENT REFLECTS SERVICES THAT NEED TO BE PROVIDED

The 1994 Appropriations Act authorized DMAS to establish a program to provide payments for assisted living services. The Assisted Living Program is operated by the DMAS and provides reimbursement for assisted living services to residents who meet criteria for assisted living services. The intensive assisted living component of the program operates under a Medicaid home and community-based care waiver. Payment for assisted living is made directly to the ACR, and the ACR is responsible to provide or arrange for assisted living services.

The two programs combined (the Auxiliary Grant and Assisted Living) provide three levels of care to residents. Residential living represents the minimal level of service available under the Auxiliary Grant (AG) Program. To qualify for residential living, residents must have physical or mental impairments and meet the criteria for residential living. The criteria require dependency in only one activity of daily living or dependency in one or more of the instrumental activities of daily living, as documented on the Uniform Assessment Instrument (UAI). The AG rate is considered to cover the entire cost of residential living; DMAS does not reimburse for this level of care. Persons not meeting the criteria for residential living are not eligible for the AG. If they choose they may still purchase ACR services with their own resources.

Regular assisted living is provided to residents who are AG recipients and who are assessed as being dependent in two or more ADLs or who are dependent in behavior. DMAS pays the ACR $3.00 per day (up to $90 per month) per recipient for regular assisted living. Residents meeting the criteria for regular assisted living do not meet Medicaid criteria for nursing facility admission, so no federal funds can be used for this payment. These payments are made from state funds. In fiscal year 1998, DMAS paid regular assisted living claims for 2,586 residents.

Residents who receive intensive assisted living services under the Medicaid waiver must be at risk of nursing facility placement. That is, they must meet the criteria that DMAS applies to persons seeking nursing facility placement. DMAS pays the ACR $6.00 per day (up to $180 per month) per recipient for intensive assisted living services. Federal matching funds are available for intensive assisted living services.

ACRs licensed for assisted living services may choose to participate in the Assisted Living Program for AG recipients who meet the criteria. To be reimbursed for regular assisted and intensive assisted living, ACRs must have a provider agreement with the Department of Medical Assistance Services (DMAS) to provide these levels of care and must comply with DMAS' requirements for assisted living services. ACRs must also must be licensed by the Department of Social Services (DSS) to provide assisted living services before they can contract with DMAS.

Individuals seeking ACR services are assessed and placed into one of the two levels of care by a trained assessor who completes a Uniform Assessment Instrument (UAI) and authorizes admission to the adult care residence. An authorized assessor may be employed by a public human services agency or other qualified assessor who has a contract with DMAS to complete the assessment for public pay individuals. The qualified assessors may be staff from local departments of social services, local departments of health, area agencies on aging, centers for independent living, community service boards or independent physicians. The qualified assessor notifies DMAS and the eligibility worker at the local department of social services of the results of the assessment. Assessments are also completed by the qualified assessor whenever there is a change in the resident's condition that appears to warrant a change in the resident's approved level of care and/or at least annually.

The Adult Care Residence Industry – Licensing Changes

In 1993, the Virginia General Assembly passed significant legislation on reforming the ACR industry. The 1993 and 1995 General Assemblies amended §63.1-25.1 of the Code of Virginia requiring that Auxiliary Grant recipients be assessed by a qualified assessor to determine their need for residential care. The Code of Virginia (§63.1-173.3) was amended to require that a uniform assessment instrument (UAI) be completed upon admission and at subsequent intervals as determined by regulations of the Board of Social Services for each resident of an ACR.

The 1993 General Assembly amended §63.1-172 *et seq.* of the Code of Virginia, thereby establishing two-tier licensing for ACRs. The amendment defined requirements that the ACR must meet in order to be licensed as an ACR that will provide a level of service for individuals who may have physical or mental impairments and who require at least a moderate level of assistance with activities of daily living.

In order to reimburse ACRs for the additional cost imposed by the new ACR licensing requirements, a new system of reimbursement was developed. The new reimbursement method continued the AG Program and added two levels of payment for assisted living services: regular and intensive.

Virginia's Intensive Assisted Living Waiver

Virginia is one of 18 states to offer Assisted Living services through a Medicaid home and community-based care (HCBC) waiver. Medicaid HCBC waivers, established in 1981, afford States the flexibility to develop and implement creative alternatives to placing Medicaid-eligible individuals in medical facilities such as nursing homes. The HCBC waiver program recognizes that many individuals at imminent risk of being placed in an institutional setting can be cared for in their homes and communities, preserving their independence and ties to family and friends at a cost no higher than that of institutional care.

Under section §1915(c) of the Social Security Act (the Act), states may request waivers of certain federal requirements that impede the development of Medicaid-financed community-

based treatment alternatives. The requirements that may be waived are statewideness, comparability of services, community income and resource rules, and rules that require states to provide services to all persons in the state who are eligible on an equal basis. The requirements that may be waived are in section 1902 of the Act. States have the flexibility to design each waiver program and select the mix of waiver services that best meets the needs of the population they wish to serve.

To receive approval to implement HCBS waiver programs, State Medicaid agencies must assure the Health Care Financing Administration (HCFA) that the average cost of providing home and community-based services will not exceed the average cost of care for the identical population served in an institutional setting. The Medicaid agency must also document that there are safeguards in place to protect the health, safety and welfare of beneficiaries.

Services available under the HCBC waiver can include personal care services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under State law), and therapeutic social and recreational programming. The service includes 24-hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. Medicaid HCBC waiver services cannot include room and board costs. Other individuals or agencies may also furnish care directly, or under arrangement with the community care facility, but the care provided by these other entities supplements that provided by the community care facility and does not supplant it.

Targeted ACR Case Management

In some cases, Intensive Assisted Living (IAL) Waiver recipients are also eligible to receive targeted case management services. These services are available to residents who:

1) Require coordination of multiple services and/or have some problem which must be addressed to ensure the resident's health and welfare; and
2) Are not able or do not have other supports available to assist with the needed coordination and access to services or problem resolution; and
3) Who need a level of coordination beyond what the ACR can reasonably be expected to provide. The residents also have a plan of care developed by the case manager, which complements the ACR provider's Individual Service Plan (ISP) and addresses service needs that are beyond the capability of the assisted living provider. The case manager also monitors the resident's ISP on at least a quarterly basis.

The two types of Medicaid-funded case management services available to the Intensive Assisted Living Waiver recipients are a twelve-month reevaluation only, or ongoing targeted case-management services, which includes the twelve-month reevaluation.

The case manager for ongoing targeted ACR case management is responsible for: completing the assessment; any change in level of care; developing a plan of care that addresses needs assessed through the UAI; implementing and monitoring the plan of care; monitoring the

individual's ISP; conducting quarterly visits with the resident; serving as the contact for the ACR, family and other service providers; and assisting with discharge. Case managers are reimbursed $75.00 for each quarterly visit with the resident. In Fiscal Year 1998, ACR targeted case management services cost $114,605.

Eligibility

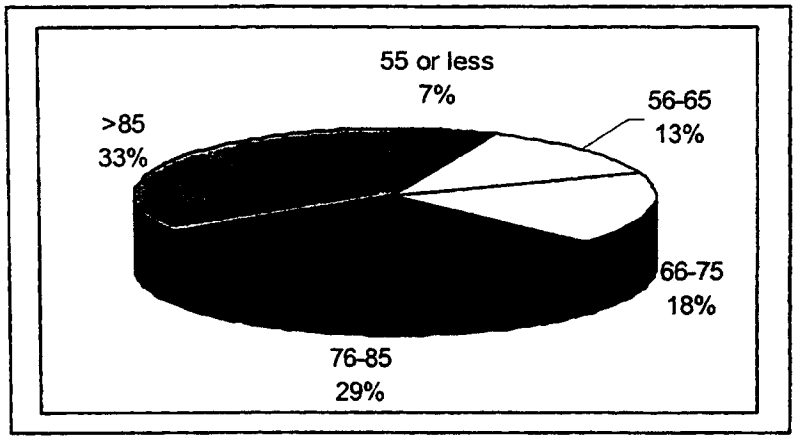
Intensive assisted living services are defined as services provided under the home and community-based waiver program. Individuals who are categorically needy as either aged, blind or disabled who receive an AG payment and reside in an ACR are eligible for intensive assisted living services. In addition, the individual must be determined to be at-risk of nursing facility placement in the absence of a home and community-based waiver service, such as those provided in an assisted living facility and the individual's functional capacity as described below:

- Persons who have dependencies in at least four ADLs, or
- Persons who are dependent in two or more ADLs and have dependencies or semi-dependencies in a combination of behavior pattern and orientation; or
- Persons who are semi-dependent in two or more ADLs and have dependencies in a combination of behavior pattern and orientation.

The IAL waiver was developed to provide an additional payment mechanism for assisted living providers for personal care services provided to waiver recipients. The IAL waiver was developed as a way to allow residents to "age in place" and avoid institutionalization, and serves as a way for the Commonwealth to combine Federal dollars with State funds to provide additional funding to ACR residents. Virginia received approval in August 1996 to offer intensive assisted living services under the Medicaid waiver. In Fiscal Year 1998, approximately 1,259 individuals received services under the waiver at a total cost of $4,944,292, with the cost for assisted living expenditures being $1,716,872, and acute care costs totaling $3,227,420. The average annual cost per IAL waiver recipient in 1998 was $6,646.

Current Population Served

DMAS selected a sample of the IAL Waiver recipients that were served in Fiscal Year 1998 and examined the population's overall degree of dependency in ADLs and IADLs. To obtain this information, DMAS reviewed the recipients' most recent assessment, as documented in the Medicaid Long-Term Care Information System (LTCIS). The sample showed 67 percent of residents were female and 33 percent of residents were male. Age ranges indicate that a majority (62 percent) of the IAL waiver recipients were over 76 years of age.



A majority of residents were dependent in several ADLs:

Activity of Daily Living	Percentage of Residents With Dependency	Most Frequently Cited Dependency
Bathing	95%	Human Help – Physical Assistance (47%)
Dressing	86%	Human Help – Physical Assistance (53%)
Toileting	76%	Human Help – Physical Assistance (31%)
Transferring	57%	Human Help – Physical Assistance (24%)
Eating	48%	Human Help – Physical Assistance (30%)
Bowel	52%	Incontinent – Weekly or More (42%)
Bladder	61%	Incontinent – Weekly or More (56%)

In addition, approximately 94 percent of IAL Waiver recipients were also dependent in instrumental activities of daily living (IADL). IADLs are social tasks such as meal preparation, housekeeping, laundry, money management. An individual's degree of independence in performing these activities is also a part of determining appropriate level of care and service needs, as is one's ability to manage medication and his or her behavior pattern and orientation.

IV. WHETHER ADDITIONAL NURSING FACILITY PATIENTS CAN BE SAFELY AND APPROPRIATELY SERVED THROUGH ASSISTED LIVING

The General Assembly requested DMAS to examine Virginia's current nursing facility population of Medicaid beneficiaries and determine how many of these beneficiaries could be served in an assisted living setting.

Virginia's Nursing Facility Population

DMAS conducted a data analysis and determined there were 27,863 Medicaid beneficiaries who received services in a nursing facility during Fiscal Year 1998. Seventy-two percent of the population (20,234) consisted of female residents and the remaining twenty-six percent (7,629) were males. Eighty-eight percent of all nursing facility recipients were 65 years of age and older. The annual cost for nursing facility care was $394,228,369 with an average annual (institutional) cost of $14,149 per individual. Residents received care in a nursing facility an average of 250 days per year.

In order to determine if any of the 27,863 recipients served could potentially be served in an assisted living facility, DMAS looked at the recipient's level of dependencies in the nursing facilities using the Patient Intensity Rating System and crossed these with the ADL requirements for assisted and intensive assisted living services. A description of the Patient Intensity Rating System is provided.

Patient Intensity Rating System (PIRS)

The basic component of the PIRS three patient class system is an ADL score variable. This score is a composite measure of patient function in six ADL areas: bathing, dressing, transferring, ambulation, eating, and continency. Individual residents are assigned a score between zero and two for each of these six areas based on data collected from the recipient's most recent assessment that authorized nursing facility placement.

A zero designates that a resident needs no staff assistance in an ADL area, whereas a value of two indicates a total dependence on staff. The score on each ADL is summed to derive the composite ADL score. Thus, the ADL score ranges in value from 0 to 12. A low scores indicates fewer ADL deficiencies, and high scores imply more extensive deficits. Scores are used to identify patients in one of the following classes: Class A (Routine I), Class B (Routine II), and Class C (Heavy Care).

Class A and B patients are classified by their functioning status as measured by the ADL composite score and do not have heavy care requirements. Patients with scores of zero to six have the lowest nursing resource needs and will fall into Class A; those with scores of seven to twelve fall into Class B. Class C or Heavy Care patients have an ADL composite score of nine or above and have at least one heavy care condition.

According to the most recent PIRS quarterly assessment in April 1999, Class A, the lightest care group, contained 5248 (or 21.7%) recipients. Class B contained the most individuals, with 13,934 (57.5%) Class C, the heaviest care patients, had 5,030 (20.8%) recipients.

For the purposes of this waiver study, the data reviewed identified the number of individuals currently in the nursing facilities who meet the criteria for intensive assisted living services. Initially, 5,522 individuals in Class A (5,064) and Class B (458) were identified as

meeting the eligibility criteria to receive services in an intensive assisted living setting. This included the number of:

1) Individuals with 4 or more ADL dependencies: Class A (4319) and Class B (217);

2) Individuals with 2 or more ADL dependencies & are dependent or semi-dependent in a combination of behavior and orientation: Class A (729) and Class B (234); and

3) Individuals who are semi-dependent in two or more ADLs and have dependencies in a combination of behavior and orientation: Class A (16), Class B (7).

The data reveal that the majority of individuals who met these criteria can be found in the Class A category. The decreasing numbers show in the subsequent category (Class B) that individuals who reside in nursing facilities tend to be more functionally and cognitively impaired and would not be appropriate for an assisted living setting.

It must be noted, however, that although 5,522 recipients were initially identified as having met the criteria for intensive assisted living services there are a variety of issues that need to be taken into consideration before the recipients could return to the community. One important issue involves nursing facility residents who are semi-dependent or dependent in behavior and orientation. Approximately 2,701, or 49 percent of the recipients identified were appropriate in behavior and orientation. The remaining 51 percent of the population was semi-dependent or dependent in behavior and orientation. It is uncertain that these individuals could be cared for in a less structured (lower level of care) setting that may place these individuals or other residents residing in assisted living at risk of harm.

Other issues include:

- The recipient's (or his or her family's) choice to live in a nursing facility. Some residents or their families prefer that the individual live in a nursing facility rather than in an assisted living environment;

- The degree of community support available to the recipient. Although the ACR provides services to meet their most basic needs, the recipient may require additional services or assistance not covered by the ACR;

- The assisted living industry is not as regulated as the nursing home industry. Although ACR regulations are in place to ensure patient protections, there are only minimal requirements to ensure staff training and levels appropriate to provide care for residents with special needs. DSS also does not have as much authority to enforce patient protections and quality services as the licensing and survey agency for nursing homes (Virginia Department of Health) does; and

- The number of available providers is critical, as one of the most important barriers to returning to the community is housing. In a 1997 national assisted living study, researchers Mandard and Cameron noted that providers responded that there were large numbers of

inappropriately placed nursing facility residents. It is estimated, however, that of the 25 percent of nursing home residents who might be better served in assisted living, 75 percent could not afford the monthly rent. The transitioning of individuals into assisted living settings would not be able to occur until it could be assured there were enough public pay providers available to accept the residents and provide appropriate care for their needs. Currently, 25 percent of all providers accept public pay residents; however, there are severe shortages of these providers in some areas of the state, such as Northern Virginia. This issue needs to be considered when exploring the option of transitioning individuals from a nursing facility setting into the community where the room and board rate is no longer included in the Medicaid payment.

In conclusion, there is the possibility that some individuals currently being served in Medicaid-certified nursing facilities could return to the community. These individuals could enjoy a more independent lifestyle in a home-like environment and would be more cost-effective to the State. However, the issues involving consumer choice, regulatory requirements and compliance, the availability of AL public pay providers, and the degree of community supports available must be addressed before a nursing facility resident could be transitioned into the IAL Waiver.

Additional Population Expansion

The study requested DMAS to explore the feasibility of widening eligibility requirements for the waiver to include eligible individuals who are not AG recipients. Although many states link their Medicaid AL Waiver services with the state supplemental rates, some states do not require individuals to be eligible for state supplemental rates in order to qualify for the Medicaid waiver. Florida, for example, sets functional and financial eligibility requirements but does not mandate that recipients be eligible for the state supplemental payment.

If eligibility requirements for the IAL Waiver were expanded, DMAS is unsure how many individuals would be eligible for waiver services should waiver requirements be extended to include individuals who only meet the Medicaid functional and financial requirements. It is believed that there are individuals in the community living with family or who live alone who may opt into this waiver. For those private pay individuals currently in ACRs, a study conducted in 1993 by Virginia Tech's Center for Gerontology estimated that 18 percent of the private pay ACR population met the criteria for the IAL Waiver. This means 4,734 individuals currently being served in assisted living settings may be potentially eligible for the IAL Waiver. If these individuals were added into the waiver, the annual cost for these individuals at the current IAL rate would be an additional $31,462,164. In addition, the same issues apply to this population in terms of the availability of providers and approval from HCFA.

One additional issue concerns the "conversion" of nursing home beds into assisted living beds. If profits for Medicaid services in the IAL setting increase and/or the assisted living population is expanded, nursing homes may see the ACR industry as more profitable and could thus convert nursing home beds into assisted living beds. The ACR industry is also not as heavily regulated as the nursing home industry, and this can be an attractive incentive for nursing facilities to convert their beds into assisted living beds. The main problem with this is that

quality care services cannot be monitored or enforced as effectively as in the nursing home industry, and could consequently reduce resident protections and care. This could thus create a level of care for individuals who are nursing facility eligible that would not be required to meet existing nursing home survey regulations. This is happening nationally in areas where the assisted living payments are relatively high and regulatory requirements are minimal.

Re-Creating the IAL Waiver

The IAL Waiver's available services and payment does not appear to provide an optimal opportunity to assist frail elderly residents with aging-in-place. The IAL waiver currently only pays for one hour per day of assistance for recipients who are at risk of nursing home placement. This was determined in 1993 when DMAS conducted an analysis of personal care hours incurred by community-based care recipients with low Activities of Daily Living (ADL) scores. That is, individuals needed assistance with 0-6 ADLs. This analysis estimated that, on average, assisted living recipients would require approximately one hour per day of personal care services, or 30 hours per month. However, for "Level A" individuals, the maximum number of hours of care is expected to be no more than 25 hours per week and one hour per day of care may not be enough to provide for the needs of individuals at the IAL level. This is especially true for individuals who require the 24-hour supervision provided residents in ACRs for whom the alternate institutional placement must be a nursing facility. A better approach may be to assess individuals based on the number of hours needed up to three hours per day and pay the ACR accordingly. For example, if one hour per day is needed, the ACR would be reimbursed $6.00 per day for that resident; if two hours per day is needed, the ACR would be reimbursed $12.00 per day; and if three hours per day is needed, the ACR would be reimbursed $18.00 per day. It must be assumed that if the individuals needs more than three hours of personal care per day through the waiver, he or she will not meet the criteria for residence in an ACR.

In order to obtain additional funding to provide increased assistance to individuals (with higher care needs) at this level, Virginia could eliminate the regular assisted living level and take the regular assisted living payment rate of $90 per month and transfer it to the IAL waiver. The State would be able to maximize potential federal dollars in the Medicaid IAL waiver, thus increasing the service reimbursement amount in the waiver. This increase in Medicaid funding would not constitute an increase in general funds, as this amount has already been appropriated. Additional Medicaid regulatory requirements for providers would be needed to ensure the provision of quality services for individuals with higher care needs under the IAL waiver, such as persons with Alzheimer's Disease or dementia.

The current eligibility requirements for entry into regular assisted living include being dependent in two or more activities of daily living or being dependent in behavior and orientation. These individuals are not nursing-home eligible, and according to Richard Ladd, a national assisted living consultant hired by DMAS to examine the IAL Waiver, most states do not provide (publicly funded) services for individuals at this level of care. He suggested eliminating this level of service provision and maximizing state funds under the IAL waiver.

Currently, ACRs that provide services to individuals with mental retardation and/or mental illness are enrolling as ACR providers for regular and intensive assisted living service

reimbursement. According to a recent JCHC study (1998), many individuals with mental illness/mental retardation are being discharged from state hospitals to ACRs. While providers are receiving regular assisted and IAL waiver payments to provide personal care to the recipients, the recipients' active treatment needs are often not being met. The $90.00 monthly rate is not sufficient to meet the specialized needs of these residents. It has been demonstrated that the mentally ill population cannot be served cost-effectively through Medicaid waivers. Two states, Oregon and Vermont, received initial approval from the Health Care Financing Administration (HCFA) to offer HCBC waiver services for persons with mental illness; however, they were not renewed because this populations' care under Medicaid was not cost-effective. This is because Medicaid does not pay for individuals in institutions for mental disease (IMD) between the ages of 21 and 65, unless they are in facilities of 16 beds or less.

III. THE ADEQUACY OF REIMBURSEMENT FOR ASSISTED LIVING CARE AND THE APPROPRIATENESS OF THE CURRENT STRUCTURE FOR ASSISTED LIVING PAYMENTS

Currently, the Commonwealth makes a monthly AG payment through the local departments of social services to the resident for the purpose of paying for room and board in the ACR. The services covered by the rate are described earlier in this report.

DMAS pays the ACR a per diem fee for each recipient authorized to receive assisted living services, based on whether the recipient is authorized for regular or intensive assisted living. Payment of the per diem fee is limited to the days in which the recipient is physically present in the facility. These payments are an add-on payment to the base Auxiliary Grant payment, which the ACR receives directly from the resident.

The regular assisted living payment is $3.00 per day, not to exceed $90.00 per month. This amount comes from General Funds, but is administered by DMAS. In order to qualify for the regular assisted living payment, individuals must meet the criteria for regular assisted living.

The intensive assisted living payment for recipients is $6.00 per day, not to exceed $180.00 per month. This amount comes from a combination of Federal and State funds. To qualify for the intensive assisted living payments individuals must meet the intensive assisted living service criteria.

History- Reimbursement Rates

The 1990 Joint Legislative and Audit Review Commission (JLARC) report, which studied the adult home care industry, recommended designing the funding system to be linked to the licensed level of care provided. In order for the state to set a reimbursement amount that would reflect each level of care, the system must be able to differentiate financial assistance for eligible individuals based on the level of care they receive from the ACR. Residents who required more intensive levels of care could receive additional funding. JLARC recommended using the median cost of care for each level as the maximum established Auxiliary Grant rate for homes licensed under each level of care.

Based on the 1990 JLARC report, a Secretarial Task force was established which also proposed a tiered system of care. The General Assembly then passed House Bill 2280 in the Spring of 1993, which required the establishment of a two-tiered system by June 1994. Level I care was referred to as Residential Living and Level II was referred to as Assisted Living.

In 1993, in order to determine the reimbursement rates for assisted living and intensive assisted living services, DMAS conducted an analysis of personal care hours incurred by community-based care recipients with low Activities of Daily Living (ADL) scores (needed assistance with 0-6 ADLs). This analysis estimated that, on average, assisted living recipients would require approximately one hour per day of personal care services, or 30 hours per month. Assisted living services focus on the assistance needed with activities of daily living. Traditional personal care services provided in the home include 50% of the time spent on instrumental

activities of daily living (IADLS) like light housekeeping, meal preparation and money management. The cost for IADLs is not included in the assisted living rate because it was assumed the basic AG rate covered this cost.

In addition, since assisted living services are offered in congregate living settings by staff employed in that setting, there was no need to reimburse for travel time to the site of care for either the aide or the supervising health care professional. Only the actual time spent in "hands-on" care was included in the assisted living payment. Because the staff delivering assisted living services are employees of the home, fringe benefits and basic supervision are already included in the Auxiliary Grant payment. Thus, the rate for assisted living services was set at $3.00 per hour with a maximum of $90.00 per month.

As impairment levels increased with the intensive assisted living population, so did the regulatory requirements for providers. According to 1993 cost report data from the Virginia Department of Social Services, assisted living facility staff were paid at or close to minimum wage which is currently $5.15 per hour. The payment of $6.00 per hour was thus considered to be sufficient to cover the cost of wages and benefits and the cost of licensed health care professional supervision. With 30 hours of intensive assisted living allowed per waiver client per month, the maximum payment per month was established at $180.00.

Adequacy of Reimbursement for Assisted Living and Intensive Assisted Living Care

In 1998, DMAS and DSS conducted a study which examined the costs of ACRs service Auxiliary Grant recipients in Virginia. The data did not demonstrate a need for an across-the board increase in the Auxiliary Grant rate. The study recommended that the state consider basing future annual increases on meeting federal maintenance of effort requirements. The study also found, that while providers assert that costs vary with level of resident need for assisted living, there was a very weak correlation between the costs of care for residents and the various levels of care (CHPS Consulting and Clifton Gunderson, 1998).

Providers have questioned this finding and maintain that the current assisted living reimbursement structure does not appear to be adequate to meet the needs of the intensive assisted living population. Virginia ACR providers feel the costs for providing quality care to individuals with higher acuity needs far exceeds the current IAL daily rate of $6.00 per hour.

Some assisted living provider representatives suggested eliminating the current flat rate structure and looking at what other states do in terms of reimbursement. For example, some providers reimburse according to the care needs of the individual (similar to a case-mix system) rather that having the designation of residential living, assisted living, or intensive assisted living. Others, such as consumer advocates, argued the current system of care is inadequate and strongly cautioned against paying additional dollars for services unless quality care indicators are used to monitor the care provided.

Quality Care Concerns: Utilization Review Results of Assisted Living Services

Preliminary results from utilization reviews conducted by DMAS conclude current assisted living providers need to improve the provision of existing assisted living and IAL services. In order to ensure to HCFA that waiver services are appropriate and recipients meet waiver criteria, DMAS has been conducting utilization reviews of assisted living providers. Between May and September 1999, DMAS staff conducted random utilization reviews of 12 ACRs in Southwest and Central Virginia that are enrolled to provide regular and intensive assisted living services. The results concluded 11 of the 12 facilities reviewed were found to be noncompliant with program (provider) requirements. The noncompliance issues involved 108 residents. Some of the issues of noncompliance include:

1) There were no completed resident assessments (UAIs) and/or authorizations available for 36 residents;
2) Facilities did not have ISPs for 104 residents that appropriately or adequately addressed the residents' needs;
3) Facilities did not have ISPs that were updated at least annually or when the resident's needs changed for 54 residents;
4) Facilities did not have documentation to support that 47 residents met Intensive Assisted Living Services Criteria;
5) There were 18 residents living in the facilities that were documented to have a prohibited condition; and
6) One hundred and three medical records did not have medications administration documented as ordered.

In addition, facilities did not have patient logs for 62 residents which documented the resident's presence in the facility, as required by DMAS. Rather, the information for the review had to be obtained by reviewing nurse aide summaries and medication logs (if available).

ACRs in other areas of the state will be reviewed for compliance as well. The initial findings of these reviews, however, strongly suggest that current assisted living providers are not maintaining the necessary documentation to show the (level of care) needs of the resident, how the facility plans to care for the residents (through ISPs), and what care has been provided to residents.

IV. BEST PRACTICES IN OTHER STATES

While there is no one national model of assisted living reimbursement to utilize, states are currently utilizing four approaches for reimbursement of assisted living services. They include flat rates, flat rates that vary by type and setting, tiered rates, case mix rate systems, and care-plan or fee-for-service rates (Mollica, 1998). It should be noted that assisted living services are defined in different ways by different status; there is no national standard. As such, comparisons must be made carefully.

Flat Rate

There are thirteen states that currently pay in this mechanism. Among these, Virginia, Colorado, Nevada, South Dakota, and Georgia all cover services in licensed board and care facilities that are often referred to as assisted living services.

Flat rates are often seen as incentives for facilities to admit residents who need lighter care. Facilities receive the same monthly payment regardless of the level of care needed or staffing requirements. Facilities may also tend not to admit residents with higher acuity needs. The following chart lists the reimbursement amounts paid through Medicaid for assisted living services by states using flat rates:

State	Rate
Colorado	Bundled rate - $29.88 per day (includes services other than personal care)
Florida	Bundled rate – $30.71 per day (includes personal care, intermittant nursing, therapies, etc.)
Georgia	Rate – Group homes, $24.66 per day; Family homes, $23.49 per day
Maine	Unavailable
Maryland	Rate - $1,200 per month
Massachusetts	Rate (adult foster care) - $33.70 per day
Nevada	Rate (for personal care) - $277.20 per month
New Mexico	Bundled rate - $47.50 per day
North Carolina	Basic rate of $8.07 per hour; amount increases as ADL needs increase
Rhode Island	Rate - $1400 per month (including room and board covered by SSI)
South Dakota	Rate (for medication administration) - $150 per month
Virginia	Rate - not to exceed $180 per month
Vermont	Unavailable

Because of the variation in the services offered, a state by state comparison cannot be made.

Florida

Florida offers a bundled rate to Extended Congregate Care providers. The bundled rate, $30.71 per day, encompasses a variety of assisted living services, including: an attendant call

system, attendant care, behavior management, chore, companion services, homemaker, incontinence supplies, intermittent nursing, medication administration/management, occupational therapy, personal care, physical therapy, specialized medical equipment, speech therapy, and therapeutic social and recreational programming. In addition, recipients are mandated to receive case management services to oversee their individualized service plans and help to connect recipients with needed services. This type of care also has a spousal impoverishment piece. Florida offers the Medicaid bundled rate to qualified individuals in addition to the state supplemental payment of up to $665 per month ($43 personal needs allowance), which is similar to the Auxiliary Grant in Virginia. But, recipients do not have to be eligible for the optional state supplementation in order to qualify for the Medicaid waiver. Florida has three levels of care similar to Virginia's levels of care, which are: standard, limited nursing service, and extended congregate care. Florida is currently looking at developing a payment based on the level of care required by residents (tiered level).

South Dakota

South Dakota allows up to $910 per month (SSI and State Supplemental Payment) for assisted living facilities. Residents keep a personal needs allowance of $30 per month. If a qualified individuals needs medication administration, the Medicaid HCBC waiver will pay the provider $150 per month. The total payment averages $1,030 per month.

North Carolina

North Carolina uses a modified flat rate and pays additional amounts according to increasing ADL impairments. The state/county special assistance payment (which includes the federal SSI payment) covers up to $893 per month of room and board and basic personal care services. Residents receive a needs allowance of $43 per month. For residents who qualify for Medicaid funded services, the basic payment is $8.07 per day for one hour of personal care assistance. As impairments in ADLs increase, so does the daily payment. Residents who have extensive or total impairments can receive $10.87, $16.00 or $18.80 per day, depending on the degree of impairment. The rates include the rate of $8.07 per day. Costs are beginning to skyrocket in North Carolina; therefore, North Carolina is beginning to look at case-mix as an alternate way to reimburse providers more accurately based on residents' level of care needs.

Flat rates that vary by Type and setting

Only three states (Alaska, New Jersey, and Texas) reimburse according to the type of assisted living and the setting in which people reside. One state, Texas, reimburses according to the type of residence rather than acuity. For example, Texas reimburses separately for single occupancy assisted living apartments, residential care units, and non-apartment, double occupancy models.

New Jersey

New Jersey reimburses according to the setting. The base room and board rate consists of $572.00 for assisted living residences and personal care homes, but the Medicaid rate varies. For example, assisted living residences receive $1,800 per month for services. Assisted living programs receive $1,200 per month, and personal care homes receive $1,500 per month for providing Medicaid services. New Jersey is currently reviewing this methodology.

Tiered rates

Seven states (Arizona, Delaware, Florida, Oregon, Washington, Wisconsin, and Vermont) reimburse providers through tiered rates. The system can have up to five levels of reimbursement based on the type, number and severity of ADL or cognitive impairments.

Oregon

One state that is nationally recognized for its assisted living services is Oregon. Oregon currently reimburses using a five-tier level that is based on the degree and type of resident impairment. The room and board rate ($420.70) is separate from the service rate, which varies according to level. Service costs range from the lightest level of care, Level 1 ($579.00) to the heaviest level of care, Level V ($1643.00). Most Medicaid recipients are located on Level IV with a monthly service cost of ($1330.00).

Case mix rate systems

Four states are currently developing or utilizing a case-mix methodology that is based on the nursing home case mix methodology. One state, New York, sets service reimbursement at 50 percent of the resident's Resource Utilization Group (RUG) which would have been paid for the resident in a nursing facility. This payment is in addition to the state supplemental payment (up to $857 per month), that covers room, board and basic assistance with ADLs.

Minnesota

Minnesota also utilizes a case mix system. Under the Medicaid waiver, the total costs of all services may not exceed 75 percent of the average nursing home payment for the resident's case-mix classification. The absolute cap is 100 percent of the average cost for the resident's case-mix classification. There are 11 levels that vary according to the individuals' ADL dependency and special needs. Medicaid-funded assisted living rates range from $1429 a month for Category A individuals to $3333 a month for Category K individuals. Several states (such as North Carolina and Maine) are currently exploring this methodology. This method is considered to be a more accurate method of reimbursement for facilities.

Care plan or fee-for-services based rate

Six states currently use a methodology that involves three mechanisms: an assessment, a care plan and a form of payment. A qualified assessor conducts a comprehensive assessment of the individual . Rather than receiving one monthly payment, providers are reimbursed via a fee-for-service in accordance with the resident's approved plan of care. This payment methodology is considered to be more cumbersome because the billing process is time consuming and many providers are accustomed to receiving an all-inclusive fee for services provided.

V. ADEQUACY OF THE CURRENT REGULATORY STRUCTURE

Policy regarding ACR regulation and reimbursement vary widely among the states. This is because the federal government has assumed no significant role in developing or guiding policy with respect to ACR services. If there is an increase in federal funding this may eventually lead to the development of federal standards, but until then, the primary regulator will be the states.

The rapid growth of the assisted living industry is raising concern about the quality of care and consumer protection provided to residents. In its recently released report on assisted living, the General Accounting Office (1999) identified two issues that will need to be addressed by states. One involved ensuring that prospective consumers are adequately informed of the services provided in the ACR prior to their decision for admission. Another issue concerns the increasing numbers of residents that are encountering problems with quality of care and consumer protections. The GAO report cautioned state regulators to be attentive to these issues and be prepared to take steps necessary to ensure consumer protections and adequate care are in place.

Virginia's assisted living providers indicated that they did not feel that concern about the quality of care provided was an issue of regulatory compliance. Rather, they felt there was a strong need for additional funding to provide services needed by residents. While the providers recognize the importance of regulations, they suggested creating a quality assurance system for assisted living services under the existing regulatory process that focuses on customer satisfaction and maintains actual outcomes. They believe such a system would better serve the interests of the assisted living resident by providing him or her with powerful input into the quality evaluation process and the delivery of services. Many stakeholders fear that additional regulation of the assisted living industry will result in prescriptive standards that will limit assisted living's innovation and consumer orientation.

ACR resident advocates argue this point, however, and feel with higher levels of reimbursement come higher levels of accountability for the care provided. Consumer advocates believe that standards for assisted living are essential to protect consumers, and that regulations are a vital component of quality assurance. Some question the adequacy of the existing DSS licensure requirements to sufficiently protect the rights of residents, and would like to see "tougher" standards enacted with sanctions to enforce the standards.

The adequacy of the existing ACR regulatory structure in Virginia has already been the subject of study. The Joint Legislative Audit Review Commission's (JLARC) 1998 study of services for mentally disabled ACR residents made several recommendations that pertain to issues being explored in this study. In one recommendation, JLARC suggested that consideration be given to establishing a priority list of basic standards pertaining to resident health and safety. Another recommendation was that DSS should establish a stronger enforcement process with clear timelines for enforcement action to be taken. In response to this recommendation, DSS is currently taking steps to strengthen the enforcement process and is

already beginning to impose civil money penalties on assisted living facilities that are noncompliant with licensing standards.

Some groups, such as AARP, concur with recommendations similar to JLARC and suggest developing an "escalating" enforcement system (Cirtro and Hermanson, 1999). This system would allow varying degrees of regulatory intervention based on the severity of the problem uncovered during monitoring and the provider's capacity or willingness to improve. AARP feels that regulators, providers and consumers benefit by a progressive system that first focuses on cooperative efforts between providers and regulators to correct deficiencies (a cooperation that could spawn an innovative and efficient solution). The effort would only move to prescriptive phases when providers cannot or will not correct deficiencies or a recipient is at imminent risk of harm (Wilson, 1996).

The 1998 JLARC Report additionally suggested tying DMAS' assisted living payments to licensure status to help strengthen enforcement. JLARC suggested modifying the DMAS regulations to include measures of quality in consumer-oriented areas and be coupled with a system to improve providers' performance when quality measures are failed. Currently, the DMAS regulations for assisted living services (12-VAC-30-120-Part VII) require assisted living participating providers to meet DSS licensing regulations regarding facility participation standards. If providers are noncompliant with DSS licensure standards or are found to be fraudulently billing Medicaid for assisted living services, DMAS can retrieve the money paid to the facility or, under severe circumstances, revoke the facility's provider agreement. DMAS regulations are only effective in the review of whether services were provided and whether the resident meets criteria for services. DMAS does not review the quality of services being provided because this responsibility falls under the DSS licensure regulations. More severe penalties for poor care, such as civil money penalties, are implemented under the DSS regulations.

Specialized Populations

JLARC's study of mentally disabled residents of ACRs in 1998 estimated that, in 1996, 57 percent of Virginia's ACR residents receiving Auxiliary Grants needed only residential living services, while 29 percent needed regular assisted living and 14 percent needed intensive assisted living. Nearly half (47 percent) of AG recipients had a behavioral health diagnosis, 20 percent had a mental illness, 14 percent had a developmental disability or dementia, and 13 percent had some other behavioral health diagnosis. Over half (53 percent) of residents did not have an identified diagnosis, but live independently.

Some providers feel the current regulatory structure needs to be revised to more accurately reflect the varying populations that are currently being served in AL facilities. For example, the DSS licensure regulations address minimal requirements for individuals with serious cognitive deficits. Virginia licensure currently requires 8 hours of annual continuing education training for residential living staff; 12 hours are required for assisted living staff. The requirements additionally specify that the training shall be relevant to the population in care, and if individuals with mental impairments reside in the ACR, at least two of the required hours of training should focus on residents with mental impairment. Virginia's licensure requirements, however, are not as specific as other states' requirements for similar populations.

In examining how other states provide training for specialized populations, fifteen states were identified that require training on Alzheimer's disease and 15 states require training on mental health and emotional needs. Maine, for example, requires pre-service training for staff providing care in Alzheimer's/Dementia Care Units. The standards are a minimum of 8 hours of classroom orientation and a minimum of 8 hours of clinical orientation to all new employees. Topics covered include resident rights, facility philosophy related to Alzheimer's disease/dementia care, wandering/egress control, etc.

Other individuals that may be served effectively through Medicaid waivers includes individuals with Alzheimer's or dementia. These individuals may not be served appropriately through the IAL waiver due to behavioral issues. Therefore, an additional Medicaid waiver could be developed specifically for this population that would serve individuals who are in their homes or in ACRs. Because of the unique needs of this population, an adult day care model has been found to be effective by other states. DMAS could develop a model waiver for the first year and would serve no more than 200 individuals. In this way, a determination could be made about the effectiveness of this type of service delivery. This 1915(b) Model Waiver will allow up to 200 individuals who have Alzheimer's Disease or Dementia to receive services in a capitated environment similar to the PACE Model. Services will be provided within an Adult Day Health Care setting by an interdisciplinary team of professionals. Services within the capitated rate would include: Adult Day Care, Primary Medical Care, Caregiver Counseling, Emergency Response Services (medication cueing, Wander Watch), personal care, respite care, prescription drugs, therapy services, nutritional supplements, durable medical equipment, and transportation. Exclusions to the capitation amount include physician visits and hospitalizations (covered under fee for service). Individuals who live in their own homes or in ACRs would be eligible for services from this waiver. By having a safe place for the family member during the day with "wrap around" services, the family may be able to cope longer before nursing facility admission is sought. Also, by making this service available to individuals in ACRs, individuals with Alzheimer's could be cared for at a little more than half the cost of nursing facility placement.

Research indicates that 17.7% of individuals in nursing facilities under age 65 suffer from Alzheimer's disease or related conditions; 39.1% of individuals ages 65-74; 50.2% of individuals ages 75-84 and 53.6% of individuals 85 and older. (U.S. Department of Health and Human Services, 1998). Seven out of ten Alzheimer's patients live at home and are cared for by their families. Because of the nature of the disease, many families provide care 24 hours per day. (VDA, 1999). By having a day care program where the individual can stay while family members are at work, or to provide respite from caregiving burdens, individuals may be able to remain at home longer. In addition, if other services are available at the day care center, family members who work will not have to take additional time off from work to attend to these medical appointments. This would help decrease the caregiving burden. Medication management in an important component of a program of this kind. People over age 65 constitute 13 percent of the U.S. population, but take 25-30 percent of all prescribed medications. The risk of an adverse drug reaction rises exponentially with the number of drugs used. Adverse reactions, which are less well tolerated in older persons, account for 10 to 17 percent of the medical reasons for their acute hospital admissions. About 40 percent of older persons do not

take their medications are directed, and up to 35 percent of noncompliant older persons may suffer health problems as a result. (O'Keefe, 1999). Proper medication management could reduce hospital stays and, along with the other services mentioned above, help delay institutional placement.

Some states, such as Arizona and Florida, require a minimum amount of training in addition to "competency" to ensure the staff can demonstrate their skills and knowledge of the specialized populations. An example includes Florida's requirement of 12 hours training or the amount of time needed to verify a person demonstrates skills and knowledge of Alzheimer's disease and related dementia. Others, such as Georgia and Idaho, specify the populations that the staff must receive annual training on but do not require "competency" tests.

If payments are set according to the varying populations served and their needs, service and/or staffing requirements beyond existing DSS licensure regulations will need to be added to ensure ACR staff provide services appropriate to the unique needs of the assisted living population. Additional requirements should include specific staff training and/or certification, required activities and/or services specific to the needs of the individual, etc. Florida, for example, mandates stringent eligibility requirements for providers of assisted living services to recipients who have high rates of functional disability, severe cognitive impairment, and incontinence. This could be accomplished by adding additional requirements in the DMAS assisted living regulations and tying the requirements to the payment methodology, or by strengthening existing DSS licensure requirements. If DMAS becomes the payment mechanism for higher levels of care, the additional requirements will need to be within DMAS regulations.

The impact that increased staffing requirements would have on the provider community, however, would need to be taken into account. Currently, approximately 100 licensed ACRs provide services to public pay clients. It is possible that, although the Medicaid funding would be increased with additional regulatory requirements, some providers would not be able to afford program compliance. This could result in fewer providers who would participate in the Medicaid program and may even put some smaller providers who cannot compete with larger corporations out of business.

CONCLUSION

This report presents the options identified by the DMAS in relation to the revision of the Medicaid home and community-based waiver that provides Intensive Assisted Living services.

Providers of Assisted Living and Intensive Assisted Living Services will need to be more accountable for the services they provide, as recent utilization reviews of existing providers indicate noncompliance with IAL and AL program requirements. Provider documentation of resident care assessments, individualized service plans, and services provided need to be improved before DMAS can be assured that individuals are receiving the appropriate services.

Options:

- DMAS could renew the waiver and not make any changes.

- DMAS could DMAS could renew the IAL Medicaid waiver for Fiscal Year 2001, eliminate the regular assisted living level and transfer the regular assisted living payment rate of $90 per month to the IAL waiver. "Grandfather" those individuals who are now eligible for regular assisted living as long as they continue to be eligible for the payments. Assess individuals for Intensive Assisted Living based on the number of personal care hours needed up to three hours per day and pay the ACR accordingly. . For example, if one hour per day is needed, the ACR would be reimbursed $6.00 per day (up to $180 per month) for that resident; if two hours per day is needed, the ACR would be reimbursed $12.00 per day (up to $360 per month); and if three hours per day is needed, the ACR would be reimbursed $18.00 per day (up to $540 per month.)

- DMAS could renew the IAL Medicaid waiver for Fiscal Year 2001, eliminate the regular assisted living level and transfer the regular assisted living payment rate of $90 per month to the IAL waiver. The State would be able to maximize potential federal dollars in the Medicaid IAL waiver, thus increasing the service reimbursement amount in the waiver. Individuals could then be assessed based on the number of personal care hours needed up to three hours per day and pay the ACR accordingly. For example, if one hour per day is needed, the ACR would be reimbursed $6.00 per day (up to $180 per month) for that resident; if two hours per day is needed, the ACR would be reimbursed $12.00 per day (up to $360 per month); and if three hours per day is needed, the ACR would be reimbursed $18.00 per day (up to $540 per month.)

- DMAS could renew the IAL Medicaid waiver for Fiscal Year 2001. Keep the regular assisted living payment the same as it is currently. Assess individuals for Intensive Assisted Living based on the number of personal care hours needed up to three hours per day and pay the ACR accordingly. For example, if one hour per day is needed, the ACR would be reimbursed $6.00 per day (up to $180 per month) for that resident; if two hours per day is needed, the ACR would be reimbursed $12.00 per day (up to $360 per month); and if three hours per day is needed, the ACR would be reimbursed $18.00 per day (up to $540 per month.)

- DMAS could (in conjunction with affected constituencies and other state agencies) study the feasibility of developing a Medicaid Alzheimer's/Dementia Waiver for individuals in their own homes or in ACRs. This 1915(b) Waiver would allow individuals who have Alzheimer's Disease or Dementia to receive services in a capitated environment similar to the Program for All Inclusive Care for the Elderly (PACE) Model. Services would be provided within an Adult Day Health Care setting by an interdisciplinary team of professionals. Services within the capitated rate would include: Adult Day Care, Primary Medical Care, Caregiver Counseling, Emergency Response Services (medication cueing, Wander Watch), personal care, respite care, prescription drugs, therapy services, nutritional supplements, durable medical equipment, and transportation. Exclusions to the capitation amount include physician visits and hospitalizations (covered under fee for service). Individuals who live in their own homes or in ACRs would be eligible for services from this waiver. By having a safe place for the family member during the day with "wrap around" services, the family may be able to cope longer before nursing facility admission is sought. Also, by making this service available to individuals in ACRs, individuals with Alzheimer's could be cared for at a little more than half the cost of nursing facility placement.

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