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ASSISTED LIVING AT THE DAWN OF AMERICA'S "AGE WAVE": WHAT HAVE STATES ACHIEVED AND HOW IS THE FEDERAL ROLE EVOLVING?

ROUNDTABLE

BEFORE THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

ONE HUNDRED TWELFTH CONGRESS

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ASSISTED LIVING AT THE DAWN OF AMERICA'S "AGE WAVE": WHAT HAVE STATES ACHIEVED AND HOW IS THE FEDERAL ROLE EVOLVING?

TUESDAY, MARCH 15, 2011

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The roundtable was commenced at 1:01 p.m., in Room SH–216, Hart Senate Office Building.

Present: Senators Kohl and Corker.

Moderator: Susan Dentzer, editor-in-chief of Health Affairs

OPENING STATEMENT OF SENATOR BOB CORKER

Senator CORKER. My name is Bob Corker. I am a Senator from Tennessee and used to be involved heavily in State government as Commissioner of Finance.

I know Christy Allen is from Tennessee here, and I know that States all across our country have really been updating their State regulations as it relates to assisted living. All of you are here today to have a great roundtable.

Senator Kohl is the chairman of the committee, and he is on his way. And I know all we are doing is kicking this off. The brain trust of people around this table are going to talk about many of the issues dealing with assisted living.

But with 70 million folks coming along with the baby boom generation that I am a part of, and with all of the issues that I know we have to deal with, I am glad that you are here together. Assisted living has provided a great private-pay alternative for numbers of people. I know my parents have participated to a degree in that. Many of yours have done the same. Some of you may have done it yourself.

But the fact is that it is a great time for you all to be here. Obviously, our budgets here are under tremendous strain. I think you know that. And having an option like this that is more affordable, that in many ways is mostly private pay, is something that is very good. And I know that each of you is going to be heavily involved in a great discussion for 3 hours. I know a lot is going to be learned, and I welcome you here to the Capitol.

I think Chairman Kohl, I saw out of the corner of my eye, has just walked in. He is a great leader of the Aging Committee. I know he will have a few words of welcome. But I want to thank all of you who have come here to talk about this very important

issue at a very important time, and we certainly look forward to what you have to say.

Thank you very much.

Thank you, Susan for moderating.

The CHAIRMAN. Hello, Bob.

Senator CORKER. Hello, Chairman. I am going to step out and give you this seat. You will have much wiser things to say.

The CHAIRMAN. Well, Bob Corker, you know, is a very accomplished businessman from Tennessee, and I have done some work in my life in the area of business also. So we have a lot in common.

One way that I relate to people when they come to Washington from all different parts of the country is I ask them where they are from, and they say where they are from. And I say, "Well, do you shop at the Kohl's store in that city?"

[Laughter.]

And so, we start a beautiful relationship and a friendship. I am from that family. Our family started the Kohl's stores way back—well, we started them in 1962, we opened our first Kohl's department store.

That was, by coincidence, the same year that Wal-Mart opened their first store. They are much further ahead than we are. The family does not own the business anymore, but as matter of fact, my parents were immigrants from Europe. They came to the United States and met and married around the Great Depression. And in the late 1920s opened up a little grocery store on the south side of Milwaukee no bigger than a closet.

And that was the beginning of the Kohl's stores. We were first a supermarket business and then a department store business.

I worked at the Kohl's stores for many years, and I had a chance to be president for a while. And then the family decided they wanted to do something else with their lives. So the business got sold, and then I did one thing good, one thing bad.

The good thing I did was run for the Senate. The bad thing I did was buy a basketball team.

[Laughter.]

I bought the Milwaukee Bucks, and that has been a lot of fun, too. But most of all, I am a public servant now, and I very much appreciate what I am doing. I know how important it is.

And when we sold the business, I wondered what I would do with the rest of my life, but I certainly have found a calling that I like and enjoy. And I like serving people. I like dealing with problems and trying to find ways to improve the quality of lives of people in my State, but also around the country. So this has been a grand, grand experience for me.

And we are so happy that you are all here today because assisted living, as you know, is a huge, huge part of American life, and it is becoming bigger and bigger. I think that assisted living in the years and decades to come is going to become enormous in terms of the purpose it serves in our country and how many people will be engaged in assisted living.

And we will need all the expertise and the good ideas and thoughts that you have that we can possibly come up with in seeing to it that assisted living performs its function in our society in the best possible way, as it undoubtedly will have to be done in-

creasingly and can be done very well. As you know, it can be a really nice way for people to grow older and live lives that are fulfilling.

So it is well that you are here. And I know I have a Wisconsin guy, Kevin Coughlin, here, and we appreciate that you are here. We appreciate your role in assisted living in Wisconsin. You do a great job, and I am familiar with all the good things that you do in our State. Thank you so much for being here.

And we have a great moderator. Thank you so much for your work.

And I have a woman on my staff by the name of Anne Montgomery, who you probably know. She is as good as they come. When it comes to issues that are facing aging Americans, including assisted living issues, she is a very, very bright woman, works very hard, as you know, and she is always pushing me to do better. I am never doing good enough, which is what you want, I suppose. I suppose.

[Laughter.]

She is a good, good lady. And Deb Whitman is my head of the Aging Committee for me, and she has done an outstanding job also. So I am blessed that I work with them, and I am very blessed that you are here today. And I wish you well.

On Tuesday, both parties have their weekly lunch. Senator Corker has his, and I have mine. So I will be leaving. But again, I thank you all for being here, and I wish you well.

Ms. DENTZER. Thank you very much, Senator Kohl.

And thanks to Senator Corker, who has now moved on to his weekly luncheon.

Good afternoon, all of you. I am Susan Dentzer. I am the editor-in-chief of Health Affairs and happily was engaged by Anne and her colleagues to lead this roundtable discussion this afternoon.

This is a roundtable, notwithstanding the configuration of the table that you see is rectangular. But it is roundtable in every sense of the word in that we really hope to engage all of you actively in today's discussion.

As you see from the notes that we sent you on this meeting, we will be discussing three topics: the quality and oversight of assisted living, including, importantly, the area of consumer disclosure. We will range into affordability and reimbursement policies, including public financing through housing tax credits and subsidies and private payment supplementation. And then we will also spend some time on some access and discharge issues.

We will be going until 4:00 p.m., and we have, as we say in television, a "hard out" at 4:00 p.m. We have to leave the room promptly at that point. So we are going to try to keep each of these discussions on track at a little less than an hour.

We will take a 5-minute break after the second hour of conversation, and then we will resume for the last hour. And then, as I say, we will end promptly at 4:00 p.m.

Just a couple of housekeeping details. When you speak today, please use your microphones. You are going to have to press this little button in front of you and make sure the red light comes on. And then those who run the audio-visuals here have asked me to

make certain to tell you to log off at that point so that the mike can be passed to the next speaker.

We are going to begin. Many of you, I think, are known to many of you, but not all of you are known to all of you. So we are going to try to move very swiftly through a round of introductions so that we can rectify that.

What I would like to ask you to do is we will go around the room. We will start this way. And if you could just introduce yourself by name and title, and then maybe just a quick sentence about what in particular—what for you is the burning platform issue around assisted living that partly motivated you to be here today.

And I am going to start with the family reunion we have up here, the Allen twins. Actually, there is no relation, as I understand it.

Mr. JOSH ALLEN. Not that we know of.

Ms. DENTZER. Yes, right. None that you could trace, anyway. So, Josh, why don't you begin?

Mr. JOSH ALLEN. My name is Josh Allen. I am a registered nurse, and I am here to represent the American Assisted Living Nurses Association.

Having quite literally grown up in the industry, with the family business and working as a corporate nurse for many years, the quality of care within assisted living is near and dear to my heart. I know that it can represent a wonderful model of housing and care for many older adults.

Ms. DENTZER. Christy?

Ms. CHRISTY ALLEN. My name is Christy Allen. I am the Assistant Commissioner for the Tennessee Department of Health's Bureau of Health Licensure and Regulation. So I am one of those regulators.

Organized within my bureau are about 22 different licensing boards, one of which is the board that licenses healthcare facilities, such as assisted care living facilities. The issue, first and foremost, for that board is to remain consistent with the assisted care living philosophy of promoting independence and individuality and aging in place while balancing and ensuring proper compliance with quality of care and life safety standards.

Mr. CARLSON. My name is Eric Carlson. I am with the National Senior Citizens Law Center. I have worked in long-term care for 20 years.

My burning issue here is trying to articulate how a lot of these issues look from a consumer point of view. I have represented consumers for all of those times and have heard their real-life problems, and I want to be able to explain those to the best of my ability so that our public policy can better accommodate what folks need.

Ms. HUGHES. I am Krista Hughes, the director of the Arkansas Department of Human Services Division of Aging and Adult Services.

I am here today concerned about quality of care, quality of life, and affordability issues for assisted living going forward.

Mr. GROFF. I am Howie Groff, President of Tealwood Care Centers. I am here today representing the National Center for Assisted Living as its past chair. The burning issue I think people need to understand is that assisted living is a dynamic, cost-effective, and

resident-centered level of care that is very important to the entire long term care spectrum.

[The prepared statement of Howie Groff appears in the Appendix on page 205.]

Mr. CLAYPOOL. I am Henry Claypool, the director of the Office on Disability at the Department of Health and Human Services.

And I am here really today, hopefully, to learn something from you all, as we really grapple with some of the needs of younger people with disabilities and those that are older. The mix is something that can be quite complex. A lot of the wisdom in the room today can help inform some of our work at HHS.

Ms. STRAUSS. I am Julie Strauss. I am the interim administrator for the Office of Licensing and Quality of Care with the Seniors and People with Disabilities Division in Oregon.

And to reiterate from the other States, quality of care, quality of life issues continue to be where we are most interested, as well as sustainable models for ensuring independence and choice.

Ms. WILL. I am Patricia Will. I am the founder and CEO of Belmont Village Senior Living, which operates assisted living communities in six States. I am here as the immediate past chair of the American Seniors Housing Association.

We are principally interested in promoting quality, independence, and choice in our industry. But more than anything else, I am here today to collaborate with the various players at the table to find better answers. We call our industry "a work in progress," where the answers come from the people in this room.

Ms. EDWARDS. I am Barbara Edwards. I am the Director of the Disabled and Elderly Health Programs Group with the Federal Medicaid Program at CMS.

I am here because, obviously, Medicaid is an important funder of long-term services and supports for many of frail elderly, but also younger persons who live with disabilities in our communities. We are very interested in learning how we can best align Federal policy in the Medicaid program to help States offer the kinds of options for individuals that promote independence, choice, and assure that they have the opportunity to live in their communities and fully participate.

Thank you.

Mr. COUGHLIN. Hi. I am Kevin Coughlin. I am the director of the Bureau of Assisted Living in Wisconsin.

And I think what really I am interested in is really that whole quality discussion. I think there is a way that we can improve the quality in assisted living with a real collaborative approach. There needs to be a lot of people involved in this topic. So I am very interested to be here and to hear all the experts and what they have to say.

Mr. REED. My name is Charley Reed. I am from Washington State. I am a member of the AARP Board of Directors, and I used to be the director of the long-term care program in Washington State. I was involved in developing that program.

And I am here representing consumer interests about assisted living. We are very interested in developing a good, high-quality service in the array of services for people to choose from in the

community. And so, we are very interested in assisted living and whatever we can do to promote a high-quality service.

Mr. POLIVKA. My name is Larry Polivka. I am director of the Claude Pepper Center at Florida State University and a former director, like Charley, of the State Unit on Aging in Florida and have been long interested in assisted living and other community residential and alternatives in the long-term care system.

And there are many burning issues. In fact, most of them are very much interrelated. But two that I have had in mind for over 20 years is how do you make this option as available as possible to low-income people, especially through the Medicaid program and through the waivers and maybe other approaches within Medicaid, and maintain a regulatory framework that doesn't have the program blur into some kind of slightly less regulated or costly nursing home program?

And I think that is something that has become increasingly urgent as the program has expanded, including in the public sector.

Ms. COLLINS. I am Irene Collins. I am the Commissioner for the Alabama Department of Senior Services.

One of the things that I am very interested in hearing today is about this continuum of care, long-term care, and the role that assisted living actually plays in it and also a determination actually of what assisted living is.

Mr. JENKENS. That is helpful.

[Laughter.]

I am Robert Jenkens with NCB Capital Impact. We are a D.C.-based nonprofit who works with States and communities to develop innovations serving people with low incomes. I am the director of the Green House Project, which is working with many of the States that you represent here today to create a small home option for skilled nursing homes, as well as the former director for the Coming Home program, which worked with nine States to create affordable assisted living programs with the Medicaid agency, housing finance agency, and regulatory agencies.

My burning issue is creating more affordable assisted living to serve people with the lowest incomes.

Mr. VAUGHN. My name is Michael Vaughn. I am with the Department of Housing and Urban Development, the Office of Housing and, specifically, the Office of Healthcare Programs. I am the director of asset management for the Office of Residential Care Facilities.

[The prepared statement of Michael Vaughn appears in the Appendix on page 224.]

And I am here to give some examples of how HUD funding enables affordable assisted living solutions in many different types and also to learn what we can do to work with the people we have heard from, from Robert and Kevin and the State people, and work with Barbara's organization to provide more solutions to provide affordable assisted living. Thank you.

Ms. BACON. Thank you. I am Brenda Bacon. I am Vice Chairman of the Assisted Living Federation of America and the CEO of Brandywine Senior Living. We own and operate assisted living communities in five States, and I am also a former regulator. So a lot of what I hear you talking about in terms of wanting to work with

the assisted living communities and to provide access to seniors is something that very much resonates with me.

I think assisted living is an excellent opportunity for seniors to have choice about where to live when they can no longer live at home or no longer want to live with their families but want to still have the independence and the quality of life of being at home.

Ms. LYONS. I am Barbara Lyons, a senior vice president with the Kaiser Family Foundation and director of the Kaiser Commission on Medicaid and the Uninsured. The commission has tracked coverage and financing issues in the Medicaid program over the past two decades.

So I am here because assisted living is part of the long-term care continuum, and on the commission, we are interested in how delivery of long-term care services is changing over time and what that means for the people served by the program.

Ms. ROHERTY. Last, but not least. I am Martha Roherty, and I am the executive director of NASUAD, and that is the organization that represents the State agencies on aging and disabilities.

And I am here for a couple of reasons, one of which is that our agencies administer the Medicaid waiver program for the most part. All of our State agencies also help to provide options counseling for long-term services and supports for the consumers, both public and private pay. And so, obviously, assisted living is one of the most important options in that long-term services and supports array of services.

And also because our agencies help to administer the ombudsman program, and this is one of the confusing areas with the long-term care ombudsman program.

Ms. BACON. Susan.

Ms. DENTZER. Thank you, Brenda. And thanks to all of you. As you can see, we have a great group assembled to deal with these issues across various spectrums—from the consumer standpoint, from the provider standpoint, from the regulator standpoint, and those who also are looking at the big picture.

What we are going to do now is move into our first pod of questions to discuss, if you will. And this is the general area of quality and oversight. We are going to talk about what some of the leading State models are with respect to consumer disclosure standards.

We will talk a bit about what are—answering the question, "What is assisted living?" What are the essential services, the core philosophy, the other characteristics of assisted living that allow this combination of independence and privacy and autonomy and choice?

We are going to talk about ways that States have developed to balance the issue of quality of assisted living services under Medicaid in particular, while not treating it differently from other home and community-based services and the role of State oversight.

We want to talk about whether there are any key physical plant features that distinguish assisted living from institutional nursing facility models. We would like to bring up the topic of whether there should be a Federal floor in terms of services that are offered by Medicaid-participated assisted living facilities, and also should there be a Federal ceiling, a maximum level of care that would dis-

tinguish assisted living from independent living with home care services?

And then, finally, a topic we would like to get to, assuming there is time, is are there any minimum explicit or implicit Federal expectations or requirements for State oversight and monitoring of assisted living?

So, with that, what I would like to do now is turn to some of our colleagues who come from State government to begin to talk about some of this, starting with, for example, the essential services, the core philosophy, and so on, answering the question, "What is the definition of assisted living in your State?" And then moving on to some of these other issues—consumer disclosure standards, et cetera.

And so, Christy, Irene, Kevin, and Krista, as our representatives from the States, why don't you begin? And Christy, let us start with you.

Ms. CHRISTY ALLEN. Sure. I will. We were talking beforehand. In the State of Tennessee, our oversight of the long-term care system is shared among several different agencies. There is the Department of Health that is responsible for the licensure and the annual survey process.

So my piece of it is almost purely regulatory. We do work closely, though, with our Department of Finance and Administration's TennCare Bureau, which is the Medicaid administrator for the State.

Over the last couple of years, collectively, we have made some great strides in making assisted care more available to more people through the CHOICES program and then, last year, through the implementation of a new licensure law for adult care homes, which accept traumatic brain injury patients and ventilator-dependent patients.

That is a very, very new program. We have received one application. I think the idea is that over time it will grow, and I know that Oregon was a model for us in connection with that.

One critical area of the law that has helped get the board to start thinking differently about long-term care was the ability for a hospice patient to be admitted to and remain in assisted living so long as the facility could properly care for the resident's needs. And that sort of leads me into a discussion about what makes assisted living philosophically different from the other types of facilities that we regulate in my department?

One of the key examples is in staffing requirements, where, for nursing homes, there is a rigid staffing requirement set out in the law and then repeated in the rules. For assisted living, there need only be a responsible attendant, as defined by the law, and whatever staff is appropriate to all of the residents' level of need.

So that gives the facilities more flexibility in being able to develop individualized plans of care, the idea being that each resident will get the level of care that is appropriate to him or her and allow him or her to age in place in that facility. We have had a lot of discussions in the State about that, the overall idea being to retain as much independence as possible.

One thing that I looked at before I came up today was sort of a comparison between different facility types and enforcement.

Nursing home enforcement, nearly every—I will take that back. Many, many surveys result in several, several violations. We don't see that as much with assisted care living facilities.

I think during calendar year 2010, there were only a few substantiated complaints. And of those, they resulted in under $10,000 total civil penalties. So that tells me that the regulations are probably appropriate to the type of facility and that facilities are meeting those regulations.

I don't know if that is sort of what you were looking for, but I feel like that is a good balance. There are still applicable building and life safety standards. People still need to be able to get out in case of a fire. But they aren't as rigid as they are for some other facility types. So, you know, somebody who is in assisted living can have assistance to get out. They don't have to ambulate out on their own.

Ms. DENTZER. And do you want to take up some of the topics about floors on services or ceilings on services? Is any of that dealt with in State statute?

Ms. CHRISTY ALLEN. That is not within any of our regulatory piece of the statute. Ours is purely minimum standards for licensure and minimum standards for quality of care.

The payment aspect of it happens over with our TennCare oversight bureau. I am sorry, with our TennCare bureau, and it is primarily through the CHOICES program. And they do set that, I believe, in their rules every so often. They do look at that every year. But you will have to come back to me on that one.

Ms. DENTZER. And in terms of the requirements for State oversight and monitoring, are the inspections required? How often? What is the——

Ms. CHRISTY ALLEN. The inspections are required annually. There is an annual licensure requirement. So like every other facility that is licensed, an inspection will take place every 12 to 15 months. And any failure to comply with all of the standards that are adopted results in the facility being asked to submit a plan of correction within a certain period of time. And if they don't, then there are penalties that can potentially accrue.

What we find is that when notified prior to leaving the facility of the deficiencies, they correct them. And again, I think, you know, in nursing homes you find a lot of deficiencies related to staffing ratios. You don't find that in assisted living, so long as there is an appropriate level of care.

Similarly, there is a lot of emphasis in the Tennessee rules on the collaborative care plan. The physician working with the assisted care living facility, if appropriate, with the hospice provider, if that is involved as well. So that it is a personalized care plan with the oversight of the resident's physician.

Ms. DENTZER. Okay. And then just finally to clarify, you mentioned the adult care homes.

Ms. CHRISTY ALLEN. Yes.

Ms. DENTZER. That is a separate category, separate and distinct from assisted living, even though it is going to look and smell a lot like assisted living, it sounds like?

Ms. CHRISTY ALLEN. It will look like it, but it is very different. It is there are single-family residences in which 24-hour residential

care, including assistance with activities of daily living, is provided in a home-like environment to no more than five elderly or disabled adults.

So it is almost like it is a combination of the Green House model with an assisted living model, and it is a small home, single-family residence. And I think the intent is that people will care for people not related to them in a very small number and create as much of a home-like environment as possible.

Again, that is very new. We have one pending application. I look forward to seeing how that program grows over time.

Ms. DENTZER. Great. Okay. Well, thank you very much.

Let us move on to Krista, and give us a sense of the lay of the land in Arkansas, Krista, if you would?

Ms. HUGHES. In Arkansas, the licensure and regulatory agency for the assisted living industry is the Office of Long-Term Care, which is located within the Division of Medical Services, or the Medicaid agency.

We in the Division of Aging and Adult Services administer the Medicaid waiver, called Living Choices, and so we operate with an interagency agreement with Medicaid, and we have to stipulate how we ensure the quality of care, how we ensure qualified providers, the plan of care, the annual level of care determinations, and the financial accountability of the providers. That is pretty much our role.

One of the things that—and just correct me if I get off base from what you are wanting. When I started looking at the regulations, you know, I actually managed some assisted living properties in a former life. And so, you read them from different perspectives, depending on what hat you are wearing, and I had to brush up on this.

And what I noticed when I started looking at the regulations, we have a different set of regulations for residential care facilities, which were our 1970s version of boarding care homes and the preemptive entity for what is now assisted living. But we still have regulations governing residential care facilities. There is a moratorium on the development of any residential care facilities in Arkansas, going forward.

Then we also have two different levels of care for assisted living in our State. We have Assisted Living Level I. That has its own separate regulations. And then we have Assisted Living Level II, which does bring in nursing services into the assisted living facility. That has a separate set of regulations.

So I didn't bring my regulations. There are a lot of them. But what I did notice in reading them is that, philosophically, the assisted living regulations, it just has totally different language. It speaks to self-direction, the personal decision-making authority. It speaks to the configuration of the apartment being such that it maximizes one's choice and chance for independent living.

I mean just the entire set, throughout the entire set of the regulations, the wordage is just so utterly different. So that is the philosophy. I am trying to go through my notes. So that is the philosophy.

Ms. DENTZER. No, very helpful.

Ms. HUGHES. In terms of core services, we do have core services stipulated, and that includes 24-hour staff; assistance with obtaining emergency care; assistance with social, recreational, and other services; assistance with obtaining transportation; linen service; and three meals a day. So that is our base or the floor. In addition to that, facilities can provide other services on a negotiated basis with an individual and their families.

We, like Tennessee, have a flexible staffing pattern within the regulations, but we do have a floor on that as well. So, regardless, we do say "staff to meet your needs," but we also do have a floor for the staffing as well.

Arkansas does, by law, require a disclosure statement, and the disclosure statement has to speak to—is that me? I am going to try that.

Okay. The disclosure speaks to that you have to show that you are licensed. You have to show what services you provide. All of this is in advance to any level of move-in. The services have to stipulate, the ones that I just mentioned, the core services and any others that can be negotiated. It speaks to staffing, what is required in the regulations what you have in your facility.

It also stipulates that you have to tell whether or not your staff can sleep on the premise, which I found interesting. And it then speaks to physical plant features of your building, whether or not you are sprinkled. If so, to what degree. Do you have smoke detectors? Where are they? Do you have an emergency evacuation plan, and what is it?

So that is primarily for general facilities. And then on top of that, we have specialty care units, Alzheimer's specialty care units, and there is a separate disclosure statement for those. And it goes more, the very first one, in fact, stipulates you have to discuss your philosophy of care and the services, your therapeutic interventions, the level of training that your staff have. You know, just several different things in addition to the regular disclosure statement.

Ms. DENTZER. Let us move to Kevin. Sorry. Violating my own rule here. I think you heard that. So, Kevin, please take it away.

Mr. COUGHLIN. All right. Thanks, Susan.

You know, I think, starting out with the essentials of assisted living, in our State, we don't have the term "assisted living" in any of our regulations, but we have three models that sort of fall under that umbrella. I am mostly going to talk about the residential care apartment complex because that is one of our newest models that came more out of some of the new way of thinking of assisted living.

But I think some of the essentials are many things that Krista talked about with self-direction, independence, accessibility, homelike. The provisions of care need to include personal care, supportive care, and nursing care. And there is within the regulations the ability to age in place.

And I think with assisted living, it is important that we don't sort of force all assisted living to have to do certain things. I think the beauty of assisted living is communities can sort of define the type of care that they can provide and can become experts in that area. And then they don't get themselves into problems with not

being able to provide some of the provisions that do take place with aging.

So there is that ability to have both aging in place or to have certain things that could happen that could potentially lead to a discharge. And I think that is where that disclosure statement is very important, that when that does occur that we do have good disclosure statements.

Wisconsin does not have a regulation for disclosure statements, but it is captured in the admission agreements. A lot of that information does have to be disclosed in those admission agreements.

And I think one of the things I do want to talk about is sort of that quality oversight. And what we have really focused on in Wisconsin is that all agencies that are involved with assisted living have a role in quality, and it is not just the regulatory agency. But with regulations, we have tried to develop a new model that looks at both regulatory oversight, along with providing technical assistance.

What we have found is some of our surveyors are some of the best experts in this field, and they can offer a lot to the assisted living communities. So we have integrated technical assistance as part of our survey process, and we have also done a "one size does not fit all" in this setting. And we have had a less-intensive survey process for those communities that really have shown compliance, good compliance history with us. We go back on consecutive surveys and they are still in good compliance, they can reach sort of a less-restrictive oversight.

And what that has allowed us to do is really focus on some of the communities in our State that aren't doing as well, and we have been able to really shift those resources and also using very creative enforcement action sanctions that can help a facility fix their systems to sustain compliance or a very progressive enforcement action that could lead to these people not doing this business because if they continue to harm our citizens, they shouldn't be in this field.

And I think sort of with that process, we have also done a lot with collaboration, sharing our information with lots of different stakeholders. We have a very good relationship with the Medicaid program. They get all of our inspection reports. And what we have found is that has also built quality, where they are no longer publicly funding individuals in a facility that does not have good compliance history.

That, as well as our advocacy groups. We have a very strong relationship with our ombudsman program. Wisconsin ombudsmen have been in assisted living for a very long time, and working together with the ombudsman program, again, has allowed us to help improve the overall quality. The ombudsmen get in and do a lot of training, providing technical assistance to the industry.

And then also collaboration with our assisted living associations and the communities, sort of getting this all on the same page. I think as we have developed respectful relationships, we have been able to tackle some very difficult issues that have come down in this field. The whole thing about how much nursing should be in assisted living, how can we get better standards of practice implemented.

And I think the biggest part is really trying to get quality, the assisted living communities themselves to do real, internal quality assurance, quality improvement within their own organization because that is where it is going to really happen. And if we can, as a State regulatory agent, be a change agent in that area, we can help do that.

So that is kind of one of the big areas that I think has helped in Wisconsin is that collaboration across all spectrums. And I just want to kind of end with a statistic that we have had 31 consecutive years of growth in assisted living, and in the last 8 years, we have had a 50 percent increase in the number of beds in assisted living.

And at the same time, we have had a 40 percent decrease in the number of the incidents of complaints. And for that to sort of happen, actually, and it happened during a time where we introduced the 1–800 number and an online complaint number. So, for that to happen, I think it is showing that there is a real positive movement toward improved quality in our State.

Ms. COLLINS. I am left handed. There we go.

In Alabama, we have the regulatory agency is our State health department. These are their regulations, which they are currently in the process of updating. So we are excited about that. Our assisted living association is certainly working with them, along with others that are very interested in assisted living.

We do not have any of our Medicaid dollars paying for our assisted living beds. We have two types of assisted living, if you will. One is just a standard assisted living, which can be any array of situations, and that is all of these are licensed. But the SCALF assisted living, which is specialty care, is one that has to come through and be approved through our Certificate of Need Board to get beds in that. Both of those are under the purview of the health department.

The surveys that are conducted through these different assisted living groups are done by nurses through the health department. However, like Kevin and others have said, we also have in our agency the ombudsman program, which is a huge role in overseeing. They are in there at least twice a year, in all of the facilities that we have across the State.

We have about 10,000 assisted living beds in our State. They are, as I said earlier, different types of structures. So there are definite rules and regulations about the way the facility has to operate, about the staff that operates, the administration that takes place. And again, as has been mentioned earlier, we are very much concerned about the individual's rights and the ability to have a continuum of care in the manner in which they choose.

So this is going to be something that I think we will probably hear today quite a bit from all of the agencies that are represented.

Ms. DENTZER. Well, all of you have struck—I will get this right eventually here. All of you have struck some common themes about the independence focus, the quality of life focus that you want to preserve intact in assisted living. And what I would like to do is move to a discussion of how that squares with whether——

Oh, I am sorry. Julie, my apologies. Thank you. I have been prompted. I didn't mean to cut off representation from Oregon. So, please.

Ms. STRAUSS. That is okay. So, Oregon, we are very, very proud of the fact we had the first home- and community-based waiver. In Oregon, we currently serve 23,000 people in the waiver. Only 4,700 people in nursing facilities. So we have a very exciting community-based care system.

As far as you asked the characteristics of an assisted living facility versus another community-based setting, our assisted living facilities are required to be at least an economy apartment. They have to have their own bathroom. They have to have a kitchenette. We do have a floor of services that are required to be provided. We do not have a ceiling.

We have a uniform disclosure statement that we use. It is a standardized form by the agency, and then we have a specific set of criteria that must also be in the resident agreement, which includes the move-out protocols, the services that are available, as well as any fees, deposits, and it has to list the resident rights, as we have in our rules with regard to the bill of rights for residents.

That being said, right now in assisted living facilities in Oregon, 40 percent of the residents are Medicaid eligible. So we feel very strongly about the issue of access to independent and high-quality, high-choice facilities.

We do both a policy—in the area that I work, we do both the policy. We do the Medicaid contract. And we do the surveying. And so, we are in the facilities every 24 months, and we use a regular oversight process, as stipulated. And we work together with the industry and the advocates to come up with the guidelines and the principles for the monitoring of that facility.

Like Wisconsin, we see partnerships in the ombudsman's office, as well as in the Medicaid case managers at the local level. Everyone has a responsibility to have eyes and ears and everything else to help make sure that quality is happening.

In addition to that, I wanted to mention one of the reasons that we believe that Oregon is very, very successful with our community-based care is a progressive nurse delegation policy that we have that enables our facilities to better serve clients with lay staff who have oversight and delegation by a trained RN and the documentation as such.

Ms. DENTZER. Say a little bit more about what exactly that is and what it means.

Ms. STRAUSS. What nurse delegation is? Nurse delegation is by State law, we have stipulated what services that are regularly administered by a registered nurse, can be delegated to a non-RN. So the nurse explains the task and then monitors as an individual performs the task to ensure that a resident is safe. And then the nurse goes in and regularly checks to ensure that the delegation is appropriate and occurring and reviewing change of condition.

We do have other forms of what might be considered assisted living, but in Oregon, we stipulate in our rules what constitutes an assisted living facility different than our residential care facilities, which are a congregate living, that they exist under the same rules. And I think that is it.

Ms. DENTZER. Okay. Great. Well, thank you, again, all of you.

As I was saying, there are obviously some points of convergence here in terms of the desire to create choice and sense of autonomy, et cetera. There are also some differences among the various States in terms of who does the regulating, what the degree of regulation is, et cetera.

I want to just move to the question of how this intersects with Federal expectations or requirements. Are there any minimum explicit or implicit Federal expectations or requirements for State oversight and monitoring of assisted living? Should there be?

How does this—if we were to think about this going forward, how would this be structured, et cetera? And maybe Barbara and perhaps Henry would want to speak to some of that with respect to older populations as well as younger disabled populations?

Ms. EDWARDS. Well, here is where it starts to get even more complicated. We have already heard different approaches, and I don't know that we know that every State even licenses assisted living specifically. So lots of difference at the State level.

And one of the interesting elements now is that Medicaid is a fairly important funder of services for individuals in the community, doesn't have an assisted living service, doesn't define assisted living, doesn't define what an assisted living facility is, doesn't define a group home, doesn't define—that is not the way the Medicaid program is structured.

So from the Medicaid program perspective, what we have are services that can be made available to individuals by States through the State plan or through waiver programs that offer alternatives to institutions. So we have institutions that are defined, and those are the places where Medicaid services can be provided, including room and board. And then over the years, Congress has made more options for States to offer people with alternatives to institutional services for long-term services and supports, but there is not a definition of those settings and those issues.

What the law tends to refer to is home and community based or noninstitutional. And within that, then there are a very broad array of services that can be offered by States to individuals who meet certain need levels that are defined by the State, and those services can be provided.

So trying to think how to be helpful on this, the issue we tend to wrestle with in our policy tends to be more about what is home and community based? What are the characteristics of a home- and community-based housing and residential option versus what is institutional?

And there is one place in our guidance where we have specifically referenced assisted living services. That is in our 1915(c) waiver application and guidance. And in that case, what we are really describing there is a bundle of services that could be delivered to individuals who might be residing in a particular type of facility. And in the guidance, the facility is referred to as—actually isn't really described. It is more the bundle of services that are available to that individual in that setting.

We ask States that, if the settings are larger facilities, that they describe how they are going to assure home and community—that, in fact, there are home and community characteristics for that indi-

vidual's experience in that residence. So that makes this a difficult, to some extent, an issue or makes it flexible because States can define how they regulate their housing. And then the Medicaid services can fit into those settings in a fairly flexible set of ways.

So we have actually made more comment in guidance with regard to the characteristics of the setting than we have not by name, but just the characteristics of what is home and community based and what we are looking and what we perhaps would not be looking for. So if that is helpful, I can share some of that. But we don't come at it from the same perspective.

Ms. DENTZER. For all intents and purposes, assisted living is home or community based for——

Ms. EDWARDS. Services, there are some services in Medicaid that are to be delivered to individuals who are living in a home- and community-based setting. So I would put it this way. For assisted living to qualify as a place in which those services could be reimbursed by Medicaid, that assisted living facility would have to have the characteristics of home and community.

So that is what becomes important is what is the experience of care for the individual who is living there? Is it a home- and community-based setting, or is it more of an institutional setting? And for us, home and community based means person centered rather than provider centered. It means that it is home-like, and we have sometimes offered examples of what we think home-like means.

Access to privacy, a lockable apartment, access to facilities that are normally available in a home—a kitchen, bathroom, eating—that people have the ability to come and go, that they have the ability to participate in community activities in an unscheduled way. In other words, that the provider doesn't decide when individuals will go into the community, but individuals can have some choice in that, in those decisions, and that in an assisted living we would assume then there might be some assistance with those choices, but that individuals have a significant amount of ability to direct their own life and their experience of their community integration.

So we are interested in those characteristics of the home. And on the basis of that, Medicaid services to support that individual can be made available by the State.

Ms. DENTZER. Has there ever been an instance where an assisted living facility was judged to be institutional, and therefore, services to a person in that setting could not be provided, to your knowledge?

Ms. EDWARDS. I am not sure I can speak to that directly. Again, States identify the housing options that are made available to individuals, and we ask that they help us understand how they assure home and community nature of those settings.

There are certainly some cases where we might not think a setting looks like it is home and community based. But we, at this point, don't have regulation that defines what those look like, and it certainly isn't done by the name of the institution or the facility. Again, we don't define what an assisted living facility is, nor a group home specifically. So, instead, we are looking at the characteristics.

We are, and I want to sort of stress that we are in a regulatory development process at CMCS with regard to a variety of Affordable Care Act provisions that expand State options with regard to home- and community-based services. And so, I can't comment a lot about what we are thinking about in terms of guidance.

We have issued a new set of proposed regulations around community first choice. That at least begins to lay out some proposed regulations that might have some impact, and again, we are in the process of inviting comment from all interested parties. And so, again, I can't comment a lot on how we are developing policy. I can talk a little bit about the dialogue we have had with stakeholders in the past through advance notice of proposed rulemaking that was issued in 2009 and some of the comment and dialogue we have had around that.

So this is an area of great interest to us and great interest to stakeholders, to States, to individuals, to providers, and we really do welcome—we have had a rich dialogue with individuals about what it means to be home and community based. What we have learned is that there is not consensus about what that means, that sometimes preferences vary on the basis of age.

Sometimes preferences vary even from community to community within individuals with disability. We may hear sort of a strong view from individuals who represent or are people with cognitive or with developmental disabilities. We hear different things from people who represent those who are elderly. We hear different things from individuals who are younger adults with physical disabilities.

And the challenge for Medicaid is to develop policy that assures access to services across all of those populations in a way that is reasonable and we think reflects the intent of the law.

Ms. DENTZER. Great. Thank you.

Henry.

Mr. CLAYPOOL. Well, Barbara has covered quite a bit of ground there. So maybe I will pick a few points to underscore how we think about assisted living and the tensions that the Medicaid program confronts when it is asked to finance these services.

I offer a disability perspective. Home- and community-based services arguably came out of the need to have an alternative to an institutional setting for people, and many of them were people with disabilities. And perhaps most notable in that group is individuals with developmental disabilities and their need to move from large institutional settings to home- and community-based settings that serve people with developmental and intellectual disabilities.

And that movement, I think, has shown that the level of care, the types of needs that individuals have, and our ability to serve them in the community can vary, from individual's families choices and preferences. But we hear from individuals with developmental disabilities and their advocates that we should continue this movement toward smaller, more integrated settings to serve individuals with developmental and intellectual disabilities.

The same can be said for individuals with physical disabilities that, some unfortunately, may end up in an institutional setting like a nursing home when there is a lack of service or an unavailability of housing, which results in their institutionalization.

And we hear often from the advocates and some of the service providers that there is a need to move away from providing nursing home services, but that the home- and community-based services need to have specific characteristics. There is a strong preference for individualized community-based arrangement.

People with disabilities that are younger or on a different trajectory in their life's needs, and they do not want to be institutionalized, maximize their independence by living in a community-based setting where they will have full access to community supports, et cetera.

And then, on the other end, I see an aging population that is losing some function perhaps and interested in building a support system that will allow them to maintain their independence as long as possible and forestall what has been assumed in our society that one goes to a nursing home when your needs are such.

And these two are perhaps not in conflict, but they need to be reconciled. And the place that they end up being reconciled oftentimes is in Medicaid policy, and it creates a real challenge for the agency to align its policies in such a way that accommodates all the interests, preferences, and choices of these individuals.

It is interesting, though, when I hear the States going around and talking about the kind of the values that they hold around their assisted living systems that they articulate many of the things, obviously, that we hear from home- and community-based services advocates. But I would offer up the concept of a person-centered planning process. I don't know if it exists in many of the States already.

But this concept that Barb has mentioned does allow the individual to articulate their needs and talk about what their expectations are for the future. And it is, I think, a very empowering model that really does help move towards things like self-direction or greater independence on the part of the individual.

So there is much more that I think we can touch on, but I will let Susan get back to addressing some of the issues at hand.

Ms. DENTZER. Thank you, Henry, for that very helpful perspective.

Believe it or not, we have already exhausted our first hour. But I don't want to let this go without asking Barbara Lyons just perhaps to offer some comments from the perspective of the Kaiser Commission and your own expert perspective.

As you look across the States and think about Federal policy, Medicaid policy, obviously, a greater shift toward home- and community-based services overall, and particularly in the context of the Affordable Care Act, what rises to the surface for you as issues?

Ms. LYONS. Yes, thanks, Susan.

Let me just start by saying what I was struck by, as we were going around with the States, is again the variation that exists out there across the States and within the Medicaid program. There is always just a tremendous amount of variation.

As we have tracked long-term care services and supports, particularly over the past decade, I think it is important to at least acknowledge the really significant growth that we have seen in home- and community-based services. It has been, you know, pretty phenomenal over this past decade. That is one of the most fastest-

growing parts of the Medicaid program if we look over the last decade.

Whereas, on the institutional side, we have seen virtually no growth over the last decade. It has remained very flat. So I think that that kind of progress is important and moving in the direction that both folks under 65 and over 65 want to go in, in terms of where they are served and able to live and function. So that is pretty important.

When we look at the data and break it apart a little bit, we do see a difference between the under 65 population and the seniors in that, as Henry described, the under 65 population making that transition much more readily than what we see among seniors. And to some extent, that reflects the supports that are out there for the under 65 population, for seniors who are aging, and they often don't have the supports in the community.

And as we have looked at different home- and community-based waivers and programs that are out there, the two things that just really stick out for us in terms of enabling people to stay in the community are, number one, housing. Just couldn't be more critical for folks. As we looked at Money Follows the Person programs, that housing and ability to connect the Medicaid agency with the housing agencies at the local level is just absolutely pivotal.

And then the second factor that is really critical are the workers. And so, I was interested in Julie's comments about the nurse delegation because having the workers to assist people when they need it in the community is, again, just another really, really critical aspect for moving forward.

The ACA does present opportunities for States to continue to move in this direction. But I would be remiss if I didn't say that right now there is this huge budget crisis at the State level, which has, I would say, dampened some of the progress that we have seen moving forward over the past year, as States have wrestled with the economic impact of the recession.

Still, I think the goal is to move forward and keep moving in the direction of making more community-based services available going forward. And so, as States and the Federal Government deal with this crisis, we would hope not to lose ground in the interim.

So I will stop there. Thank you.

Ms. DENTZER. Well, thank you all, and you can begin to see how difficult it is to wade deeply into this topic in a short time frame.

We are going to move to the next area of discussion, though, now, which is essentially dealing with the question of the supply of assisted living in the sense that do we have any estimate of a national demand for affordable assisted living? Is there any Federal program that calculates this, or have we begun to even think through what the role of affordable assisted living broadly should be in the context of not just the move to home- and community-based services, but the aging of the baby boom, as has been mentioned.

What are the primary sources of Federal funding that can be used for the development of affordable assisted living? Grants, tax credits, et cetera. Does the Federal Government, in fact, have more plans to develop more assisted living for residents who are living in subsidized housing?

So those are the kinds of questions we have to verge into here. And then, of course, not just dealing with the Federal, how are the States approaching the challenge of developing affordable assisted living?

So, with that, Michael Vaughn, why don't you talk a bit about HUD's role in all of this?

Mr. VAUGHN. Well, HUD has two main areas where we intersect with this sector. The first is in our own inventory of public, Section 8, Section 202 affordable housing. And in that area, we have been working to expand the range of home and community services. We have been successful in broadening the options available under the Section 202 program.

And I said I would give some examples. I wanted to give one in that aspect. In Columbus, Ohio, we had a 202 project called InCare Suites. It was a $3.5 million award of a grant for a 39-unit independent living community. The residents, 69 percent of the residents were Medicaid eligible. And of the 39 households, some were active and independent. Ten percent had actually left a nursing home, and quite a few were receiving intensive Medicaid home- and community-based services.

So we are trying to broaden the newer aspects of assisted living, as Barbara mentioned and Henry mentioned, to our overall inventory.

The second main area where we are involved is more in the construction of traditional—and financing of traditional assisted living facilities that are affordable. And I think in introducing, you said, well, what is the Federal Government doing, and what are the States doing? It has all got to be together, it doesn't happen at all is, I think, what we have found.

We have low income tax credits, obviously, from the Department of the Treasury. They are an important aspect of all of these. Home grants from HUD that most of these go toward traditional affordable housing, family affordable housing. But also some of them are used for elderly, which can have these home- and community-based services, or for pure assisted living.

Our Section 202 program, again, is a program for the elderly. Section 811 for people with disabilities as well. Approximately $350 million annually from HUD. And of course, that program has faced budget pressures. These can be combined with other programs from the State.

The office I am in oversees the insurance, mortgage insurance under the Section 232 program. We have insured $17.1 billion in residential care facilities. Two-thirds of them are nursing homes. Approximately $5 billion of that is new facilities.

We have had a tremendous increase in demand for the program. We have gone from about 200 or so applications a year to over 700. We have had a lot of trouble keeping up with it, but we have recently made the decision to prioritize projects with tax credits associated.

I don't know if a lot of people know this, but HUD has a Section 542 risk-sharing program that is administered primarily by the State housing finance agencies. We partner with them, and we take a 50/50 risk. A number of the projects done under that program have been—37 of them—for affordable assisted living facilities.

Public housing authorities in HUD, they are our partners, and they are extremely creative in using the different sources—Medicaid waiver, the other home funds, et cetera—for either adapting their elderly projects or doing new from scratch assisted living projects. And there is even a program under the Federal Home Loan Bank Board, which I have seen. I was a HOPE VI grants manager, and I would see these lists of the sources.

And Robert has been a consultant for putting these things together, and you usually have to have four or five before it works. But the Medicaid waiver is an important element going forward, as can be public housing operating subsidies, as can be Section 8 funds or the vouchers following the people, as Barbara mentioned.

So there is a panoply of things that can come from HUD, and creative people have put them together with a great deal of success.

Ms. DENTZER. To your knowledge, does HUD have an estimate of national need for affordable assisted living?

Mr. VAUGHN. Well, I was looking at some of the material from other people on this panel, people from AHFA, et cetera, and one of the statistics was that 25 percent of the present residents of nursing homes could be taken care of in a lower-acuity setting. And since there are about 1.5 million residents in skilled nursing facilities now, that would be 375,000 people. Or if you think of a traditional assisted living facility of about 100 units, that would be 375,000 people.

That actually ties in a little bit, if you want to extrapolate from the other end. I am one of these people that, if you work something statistically from two different directions and you come up with the same answer, it might be right.

Illinois has a program, a Medicaid waiver program where they have taken a lot of people out of nursing homes, and they have financed a total of 124 facilities. Well, if Illinois is 3 percent of the national population, which it is about, that would get you about to 3,700 facilities nationwide.

And there was one other estimate that we noted, the Center for Excellence in Assisted Living projected 67,000 units needed over the next 15 years. So that would be about double what we are talking about as immediate need. So those numbers aren't—you know, they kind of jive in a way.

So that is not an official estimate. That is looking at some statistics.

Ms. DENTZER. Well, from our industry members present, what is your sense about, first of all, that question in particular, your sense of estimated national need for affordable assisted living? And then what about the availability of funding and financing through various sources to actually build those facilities?

I know the current environment is, we hope, an anomalous environment. But it better be, going forward, right, if we are going to meet this national demand.

Brenda, do you have thoughts?

Ms. BACON. Well, there are approximately a million people in assisted living today, and about 120,000 of those are covered under the Medicaid waiver. Proudly in our Brandywine communities, we have 305 people that live there under the Medicaid waiver, and I

think that the numbers that Michael reviewed are really important numbers for us.

Certainly, for us as an economy, the American taxpayer to think about because nursing home care, as we all know, is far more expensive and a far less advantageous environment for the kind of individuality and care that we are talking about. And I was interested to hear Barbara say that preferences vary.

And in a nursing home, you don't have the ability to have your preferences vary. It is very expensive institutionalized care. But a lot of people need to be there, whether they need to be there or not for their needs, but because of the funding source. That is the only way they can access Medicaid if they can't afford to be a private payer.

So we believe that were there better access to community-based funding and other sorts of funding to help people afford assisted living, it would not only save the Medicaid program a lot of money and, therefore, the taxpayers a lot of money, but provide a better way of life for individual choices and people making decisions about how they want to spend their life.

Ms. DENTZER. So, in your view, what does that require then? More Federal investment in these affordable housing options or what precisely?

Ms. BACON. It does require more investment, something that I know we don't have a lot of these days. Certainly whether you are speaking of the elderly or the developmentally disabled communities, the access to that kind of care in the long run, as we all know, saves us money.

So the more we can invest in that, the better off we are going to be in the long run. I think the short run is our challenge, of how do you get those dollars where they need to be to help us out as we go forward? Particularly with the growing wave of elderly and particularly with the growing wave of Alzheimer's development, which is just an offshoot of the population aging.

If we can keep people with Alzheimer's in communities where they are receiving a lot of care and as well as care for their spirit and keeping them as active as they can be, rather than putting them in an institution, their lives, their families' lives are so much better, and we save a lot of money.

So the assisted living community would very much like to see access expanded for assisted living for all of our elderly and for disabled populations in the communities that can best meet their needs. We are not suggesting everybody can be just thrown into one community, and it all works. It really needs to be tailored to meet the needs of the population it is trying to serve.

Ms. DENTZER. How do you see this, Howie Groff?

Mr. GROFF. I want to preface this just so everybody understands. We operate in four States. We operate nursing homes and assisted livings. But the assisted living residences we operate go in communities from 500 to 500,000, and there are varying differences.

And as Michael talked about, there are a number of Federal programs that are available to us, but it is very difficult. Let me just start with HUD, wonderful program, under Section 232, but it is arguably an 18-month process. I understand they have been inundated because of the economy.

Fannie Mae and Freddie Mac are Federal lending institutions that we could utilize, but they don't finance new construction. So that is not even available to us. A lot of communities can use USDA financing, but they require a guarantee of some sort. And the question is with the state of the municipalities today, do they have the wherewithal to do that?

We could look at municipal bonds to develop affordable assisted living. Right now, as we see in the State of Illinois, they have been trying to finance their way out of their debt. It is kind of leading the people to say, wait a minute, this whole rating system needs to be put aside.

Tax increment financing is available. There are communities out there that are very cooperative with that, but there are also communities that refuse to do that.

Providers want to go to state housing authorities. Coming from Minnesota, we have the Minnesota Housing Finance Agency. They could be an FHA lending enabler, correct? They have chosen not to because they see that in conflict with other low-income housing. So they have never done elderly buildings. That is a choice they have made.

The last thing I would suggest is as we look at affordable assisted living, we also need to look at going back to what Barbara said. Right now, Medicaid pays for services only. So there is this whole housing component. "Where am I going to live? How am I going to get fed? Who is going to keep the lights on for me?"

And I think we need to address those needs in more creative ways. So the question is, could the elderly get access to housing vouchers that are under the HUD program right now that we are using for low income? What if we got real creative and looked at food stamps as a bucket of money to tap for the nourishment part of that component?

The point being, where we operate nursing homes, we have an all-inclusive rate which includes the housing and food component. We don't see that right now today in assisted living.

So I think there are some programs that exist out there, but right now, we are fragmented and disjointed. I think we are, quite honestly, more focused on trying to define assisted living rather than looking at, hey, we have got a whole bunch of these programs out here that are working. What can we do to take the best of the best and replicate those processes?

I think that, Michael, you were getting at that same point. There are some very creative things going on, and let us see what we can do to replicate those and also tap into that money that already exists. In this economy, we can't ask for more.

Ms. DENTZER. What about those of you, again coming back to those of you from State governments, do you see these issues of the existence of funding options, but so many constraints against using them that it is really not meeting the need? Christy.

Ms. CHRISTY ALLEN. I am constantly hearing from people who want more options for needs, and Tennessee has been able to do a lot in that regard through the home- and community-based waiver program. And we know that doesn't pay for room and board, and that remains an issue for families around the State.

We also—on the issue of availability, we are also a certificate of need State. So availability is determined largely by the group of people who sit on that particular board. So there are all manner of concerns and interests that go into talking about availability.

Ms. DENTZER. To clarify, so assisted living is subject to the certificate of need requirement?

Ms. CHRISTY ALLEN. Yes, every single healthcare facility type is. It is through the health services and development agency, which is maintained in a separate agency. So I do think that Tennessee has done a very, very good job of rolling out its CHOICES program statewide and getting as many people as possible to take advantage of it. But there is still an element of it that is private pay. And in a State where there are a lot of people with lower income and lesser means, that is a difficult challenge.

Ms. WILL. Susan, if I may?

Ms. DENTZER. Patricia.

Ms. WILL. We have talked a lot about and ought to talk a lot about gaining access for people who can't afford the product type. I think what many people don't realize or remember is that the average means of the people that we serve in market rate assisted living is decidedly middle class.

We have seen a number of studies that have come out, one very recently by Boston College, and the income, the mean income of a person living in assisted living is under $25,000 a year. We are fortunate in our industry in that our seniors of this generation were savers. We worry a lot about the explosion in the baby boom population and a different set of lifestyle habits.

And our seniors in the main were homeowners, very large penetration of home ownership. And even those with modest homes have been willing to sell their homes and use their equity, pay down effectively their equity to live in assisted living.

I think it is important to realize that because we recognize and all need to work together to find solutions for people who aren't in that position. But in the main, the industry is serving today people of relatively modest means.

Ms. DENTZER. Modest means at least in terms of income——

Ms. WILL. In terms of incomes and even assets. If you look at people who have sold homes, we are not talking about—we are talking about on average enough for someone to stay the average length of stay, which is about 2 years, 2 to 3 years in assisted living.

So I think that it is just important, yes, we need to explore all the means of access that we could find with all of the creativity of crossing programs, as Illinois has done. But we have a customer base today who, by choice, is using the resources that it has to be in our communities, and they are not necessarily affluent.

Ms. DENTZER. Just to recap, you said the mean income is under $20,000 a year?

Ms. WILL. Twenty-five.

Ms. DENTZER. Twenty-five. You are characterizing that as middle class. That doesn't sound so middle class in this day and age.

Ms. WILL. For a senior, it would be.

Ms. DENTZER. Okay.

Mr. POLIVKA. It is about the median for all people over 65, $24,000. But they are benefited from their housing equity.

Ms. WILL. Right. And that is a generation where we have very high penetration of home ownership and very high savings rates.

Ms. DENTZER. Well, I believe if Senator Corker were here, he would remind us that this is an environment of fiscal straits and not an environment in which we are likely to see a lot of new Federal funding come in.

So just to talk about ways where it might be possible to free up existing pools of Federal funding or work through existing programs and make those more accessible, less constrained, I would love to hear any perspectives from either our provider side or the State side about how it might be possible to free up a little bit more of this, to support the creation of more assisted living or affordable housing.

Larry.

Mr. POLIVKA. I have felt for 20 years that Medicaid was a tremendous potential resource for funding people living in assisted living. And I am a little surprised to hear that the number at this point is 125,000. I thought it would have been much higher than that by now.

I know that, in the case of Florida, it is somewhere in excess of 25,000 at this point. You have got an assisted living waiver with 5,500 people in it. You have got a diversion managed care program with about 10,000 in assisted living. You have got an assistive care services program with about 13,000 people in it that is funded through Medicaid with a match arrangement.

So it is over 25,000 people out of the 82,000 people in assisted living in Florida are Medicaid supported. I mean, that is really an explosion over about a 5- or 6-year period. And I know that, in the case at least, I think, of Oregon and Washington, that has been true for years.

So I am a little bit concerned about this apparent real serious unevenness in the use of the Medicaid waiver and other options like assistive services to maximize that resource in assisted living.

Ms. DENTZER. Do we even know how authoritative those numbers are, the 125,000?

Ms. BACON. I believe that the 120,000 are the people under the 1915(c) waiver. So those are the waivered slots for assisted living in each State, and there are 41 States that have that waiver program. I am not referring to those other programs that you might be talking about.

Mr. POLIVKA. Right.

Mr. JENKENS. So, Susan, I guess maybe partially in answer to Larry's comment. In working to help States create affordable assisted living programs for many years under the Coming Home program, there is a little bit of a cycle that we get into.

So States, like Arkansas, create a terrific assisted living Medicaid waiver benefit. They ask providers then to develop programs to participate in that. Providers, very few providers actually jumped in in Arkansas and other States because of a number of structural impediments to their doing that, including what Michael cited as the seven to eight layers of financing you might have to

put together to create an affordable unit for people with an SSI level of income.

So you don't get the full utilization of the slots that are available, which then limits the uptake that Larry mentioned. And so, I think it really gets back to what Howie said. We have to make it simpler or at least as simple to develop affordable assisted living as it is to provide nursing home services, and part of that is the payment source. It is complex.

Lenders are afraid of the risks that are involved in it. Providers are afraid of the risks that are involved in potentially capitated Medicaid waiver programs or capped Medicaid waiver programs.

So, in my experience, there are resources out there. There are more resources that could be directed or redirected from institutional sources, but we have to make it simpler if we want normal human beings to develop affordable assisted living.

Ms. DENTZER. Larry, to come back to what you were saying, you said you had long thought that Medicaid could take on a greater role.

Mr. POLIVKA. Oh, yes.

Ms. DENTZER. Did you mean in paying for the housing component?

Mr. POLIVKA. Yes. We created an extended congregate license in Florida in 1990 for the purpose of opening up assisted living to more impaired people, both coming in and remaining and aging in place. The whole notion was that the waiver would come right behind it to fund it.

And we were really drawing on the Oregon experience that had already been in place for 4 or 5 years funding assisted living and adult foster homes very extensively in that State. That was really the launching pad, as I understand it, for the transformation of the Oregon system in the mid 1980s was assisted living and foster care, Medicaid funded.

And my question in response to Robert is with this variance across the States. I am not so sure it is a matter of all these layers and complexity. I think it is a matter of State policy, in large measure. I think the Feds at CMS have been open to this for a long time, in part because of the kind of flexibility you describe, Barbara. I think it is a problem of State initiative, fundamentally.

Mr. REED. Yes, I agree with that. It is an issue of State policy and how they manage their system, how people access the system.

One of the things that I think we haven't talked about here yet is that most people who enter assisted living enter it in a traumatic event. You have to have a traumatic event to leave home. And while assisted living may be more attractive in many cases than nursing homes, it is still not home.

So something traumatic happens, and people have to access the long-term care system, and it is very complex in many States. And I also agree that Medicaid is the funder of many assisted living slots in Washington and Oregon and other States, but the Medicaid money does not build the buildings. They buy these slots from private providers, and I think it is important in Washington and Oregon to say that they have negotiated deals with the private providers, saying you can take some Medicaid clients, but not all Medicaid clients.

If you are a nursing home, you would take one Medicaid resident, you would take them all. In assisted living, you can take two or three or four. And what happens a lot with private providers is they have people who spend down. And instead of kicking that person out, they allow them to become Medicaid eligible and take a lower Medicaid rate for that person to stay there.

I want to just mention one other thing. I think we need to look at assisted living as not a continuum. It is part of the array of servcies. Continuum implies that you go there and move on. The assisted living concept is aging in place, and that works better in theory sometimes than it does in reality. But it is important to view assisted living as one of the array of services and that one size does not fit all.

Some people choose to live in that setting. Some people prefer to stay home. Some people even may prefer to go to a nursing home. But that should be a personal choice. And so, the importance of a good long-term care system is to provide options that are viable to consumers that they can choose where they want to be and where they feel most comfortable to meet their quality of life needs.

Mr. JENKENS. So I think there are really terrific examples across the States of individual programs that have addressed many of the concerns that we are listing. I think the challenge is to put them together consistently enough through reimbursement and financing programs to allow the development to take place.

So, just as an example, I think a real challenge that willing providers face when they want to develop an affordable assisted living program is that people have to be nursing home eligible. They go through a crisis, as Charley said, and they need a placement within 2 days. They have to be out of the hospital.

In nursing homes, there is a retroactive payment provision for people who are accepted in and then qualify for Medicaid. In most assisted living programs in States, there is not a retroactive provision. So people, by necessity, go to a nursing home. That is where the funding source is. And then they don't come out.

Michael talked about the 1.5 million people living in nursing homes. About 1 million of those are Medicaid funded. Less than 5 percent of Americans say they want to live in a nursing home. So I think you can kind of gauge the size of demand by those numbers and then understand, well, how do we get actually the supply to meet the demand?

And we know the demand is out there. So there is an issue with getting the supply on the table, and I think we can solve it. There are good examples. We just have to put our minds to it.

Ms. DENTZER. Michael.

Mr. VAUGHN. Yes, I said I wanted to give some examples, and I think an example here is helpful. It is an example both of the complexity and of the chances we have, the opportunities we have. It is when HUD recently did mortgage insurance for a 120-unit facility. Sixty percent of the units will be leased to Medicaid-eligible residents at Medicaid reimbursement rates, with the remaining 40 percent leased to private pay.

The financing of it was—had tax credits so that that same group basically had an income restriction as well. It pretty much went hand-in-hand. The funding for the project was a $12 million HUD

mortgage, Section 232; $11.2 million in low-income housing tax credit proceeds; $1.24 million from the Tax Credit Assistance Program under the American Recovery and Reinvestment Act; and $195,000 in Illinois tax credit funds. And again, based on the Medicaid waiver program.

And they have done a fair number of these around the country, but not in relation to the demand that is out there.

Mr. POLIVKA. I think that is proof the stimulus worked.

[Laughter.]

Mr. VAUGHN. It worked in this one.

Ms. DENTZER. Eric, let us take a comment from Eric, and then I think Barbara, as I understand, has—oh, this Barbara has new data. Okay. It is not clear which Barbara has the data, but we will go to Barbara Edwards.

Go ahead, Eric.

Mr. CARLSON. Thank you. First, I want to supplement my introduction. I am also here representing the Assisted Living Consumer Alliance, which is a national group of nonprofit organizations and individuals working together to improve standards in assisted living.

And I want to add something to this conversation, to say that it is important that we do identify what is assisted living. We are talking about what we need to do to increase access to assisted living. It is a good thing.

But I think it has come out from some of the discussions we have had over the last hour and a half, in practice, assisted living can be very different. It would be terrific if we were able to arrange for increased funding for a single occupancy model that provided an adequate level of services to folks. That would be fantastic. But if, instead, we are talking about increasing access to a model that is providing shared occupancy with staffing that may or may not be adequate, that is not such a good thing.

I would like to emphasize it is about more than just the money when we are talking about the programs so that we do have some understanding what exactly we are funding here. And when we have talked about the State models, I think we have understood that there are some differences.

From a consumer perspective, we are much more supportive of a model that has a little more structure and, say, the Arkansas and Alabamas that have a couple of different levels and that have standards that are more commensurate with the care needs of the individuals, as opposed to a one-size-fits-all licensing standard that may just require that there at least be someone awake and on duty and then, after that, leaves a lot of discretion up to the individual facility.

Because, in practice, you get bad results sometimes, and the flexibility that you have in the regulations allows, in the best-case scenario, a provider to do a tremendous job. But that is where you have the biggest problems, too, when you have people that aren't up to the challenge and, particularly with Medicaid funding, aren't up to the challenge of providing care for individuals who, by definition, have conditions that would warrant admission into a nursing facility.

So particularly in an environment where we want maybe not just to spend so much money, but to make sure that the money that we are spending is spent intelligently and well, it is important that we look at this. I am most familiar with Medicaid, but I think in all these programs when we are putting together these funding sources, we should make sure that the end product is something that is productive for folks.

And I do think, particularly when we are talking about Medicaid and dealing with folks who have a significant level of care, that we need to have some assurance that there are some standards there and that the care is appropriate for people's needs.

Ms. DENTZER. Reactions to that from—Larry.

Mr. POLIVKA. Eric, I am sensitive to your concerns, but—and this has been part of this debate for a long time, in terms of how we regulate and how specific do the standards become and how far do we get beyond what CMS is working with now in terms of HCBS definitions. Is there any evidence that this flexibility and wide range of approaches and definitions has really resulted in bad outcomes?

I mean, I have been looking at this for a long time, and I would certainly be interested in knowing if we have got substantial evidence. But I, frankly, have not yet seen it, and I have been looking for a long time.

Mr. CARLSON. My understanding is that the Inspector General for HHS is taking a look at this this year, to take a harder look at the Medicaid fund and home- and community-based services and assisted living and adult day health care. I can tell you from my own experience in California and in talking to folks from other States that we do see programs. I am in a State that inspects assisted living facilities once every 5 years, and I am well familiar personally with facilities that don't do a good job and with licensing agencies that aren't in a position to enforce standards upon those providers.

And I think it is a question of maybe it is a burden of proof question. I think the jury is out on the question in both directions, whether the care is adequate or whether the care is inadequate. And so, I do think that there is an issue. I think the providers would recognize that there are good facilities and bad facilities in their particular States. I think consumers recognize that there are good and bad facilities.

And I can look at a licensure system and see that, if it provides no standards, that is a real issue, particularly in an environment where many of the providers do not come from a healthcare background. And that is this issue here about the acuity of the residents increasing, which is a good thing that you have a system which doesn't force folks to go into nursing facilities and which allows people with greater care needs to stay, but you don't see the standards that match that.

And I defer to some of the State regulators, but I think that the Alabamas and the Arkansas, not to pick on them or to praise them, however that is perceived, they have reasons to try to develop particular levels of care with standards that match the needs of the people.

Mr. JENKENS. Can I expand a little bit on Eric's comment about Arkansas? Because I do think that is a terrific example of a regulatory system, especially one designed to help people at a nursing home level of care have additional options. And I want to compliment Charley for his pointing out that assisted living shouldn't be a stop on a continuum, that it is not—people are not widgets to be moved along a continuum of care.

They create homes, and they have harder and harder times creating homes as they are moved into higher levels of care. So assisted living should be an option within a set of community-based and facility-based long-term care options.

To do that, you have to have a regulatory structure like Arkansas's that really recognizes the significant level of acuity and services that will be required to provide, as Eric said, good quality care. And I would like to compliment Arkansas for doing that.

And I think we need to think about that, especially within the Medicaid spectrum. How do we create an option that is good quality, truly operationalizes person-directed care, and then create a system that allows that to be developed in large numbers so that it can be a meaningful choice in communities?

Ms. DENTZER. Barbara.

Ms. EDWARDS. Thank you.

I just wanted to offer a little bit of perspective on the issue of Medicaid and where Medicaid is serving. We serve almost a million people in HCBS 1915(c) waivers. So we don't have information at the Federal level as to what housing those individuals are in by type, but it has been a fairly robust program of providing those kinds of services to individuals in communities.

And we like to see programs that offer individuals choice of where they live so that they may choose to stay in their own home, and services come in. They may choose to live with a friend, and services can support them. They may choose an assisted living setting, and services can be funded there as well. And there may be an adult group home. There may be a foster care arrangement.

States make those decisions as to what options are going to be available. But I think from our perspective, we like to see that individuals have a choice. The fact that people have choice, though, is sometimes why it is difficult for Medicaid to be committed to the development of a new, say, an assisted living facility is that, again, the individual has the choice of where they want to live. At least that would be the ideal rather than the only place you can get that service is if you move into this building.

That is when I think we hear from advocates and others some concern that that may not be the way they would like to see the systems develop. They would like choices. And if the only choice is I must leave my home and move into a place where we are then funding, that becomes just the same problems folks have with nursing homes. If I have to move there because it is the only place that there is funding available, that can be the same challenge folks have if the only place they can get support is in an assisted living facility or a group home rather than also having the choice of staying in their own home.

So one of the challenges I think States have and one of the challenges of Federal policy is how to assure that people continue to

have reasonable choice while still helping to develop sufficient capacity where investments may be needed to develop that capacity.

Ms. DENTZER. Charley.

Mr. REED. Yes, I want to support that and support what Eric was saying before. I used to regulate the long-term care system in the State of Washington. And we were involved in developing assisted living early on. We regulated it.

I want to talk now from a consumer standpoint about regulation. Regulation is very important to consumers. I have already told you that people enter the system at the time of a traumatic event. We have to have regulation over the admission policies to assisted living, so it is clear what it is you are getting for what it is you are buying and about what happens if you get to another level of care and you are getting discharged. It has to be very clear from the facility. That needs to be regulated by somebody to be sure that they are not only clear, but they are implemented.

And then it has to be clear that your basic dignity is protected while you are in assisted living. I think that assisted living is a part of home and community services because of the privacy involved there. In general, you have got a key to the door. You have a private bathroom. You have your own cooking facility, and you get to decide when you want to have breakfast, what you want to have for breakfast. If you live in a nursing home, somebody decides that for you.

So I think assisted living meets the test in my mind of a community service. But it is important that there is good regulation and just as important that there is enforcement. There is some talk today about a plan of correction. That is a nice idea as long as they correct the problem.

I think the regulators have to be sure that they enforce what they find out. It doesn't do a lot of good just to find there is something wrong. Somebody needs to do something about that. And I assume that all the providers are well motivated, but sometimes they need to be reminded. There has to be a consequence for doing something wrong.

And as a consumer, I want to see the consequences applied. If I develop some horrible situation because the facility has not met my individual needs that they have contractually said they are going to do, I want a consequence. And so, regulators have to be there to provide that consequence.

And I agree that that is not very well done across the country, but it should be. And I think that regulation and enforcement is critical for States in all these settings, whether they are residential or assisted living or other community settings. It is important to the consumers.

Ms. DENTZER. We are going to have more discussion on regulation, per se, in the last bucket of this conversation.

Howie.

Mr. GROFF. I just want to make one comment. As we talk about it, and Charley just described your vision of assisted living, we need to remember that we do have many units where they are secured, where we take care of people with memory impairment.

And in those units, we oftentimes don't design full kitchens out of concern for the safety of the residents. So as we define home-

and community-based services, and as Brenda mentioned, we have over 120,000—I have got a number a little higher, but we will say it is north of 120,000—that are already being served in what we call assisted living.

Eric, you are right. We don't have one definition. I am not sure we will ever get there, quite honestly. But set that aside, we are already taking care of these folks with Medicaid services. And if we aren't careful with our definition, we might have to find new homes for these people not because it was done intentionally, but it could be an unintended consequence.

So I hope we work at that, Barbara, and look very hard at where are these folks being cared for today, and are they happy in those settings?

Ms. DENTZER. Robert.

Mr. JENKENS. Susan, one last comment from my side. Much of what we hear being discussed at the table, the need for simpler payment, the need for a definition, the need for good strong regulations, those are actually benefits from a lender's perspective. Lenders like something they can understand and analyze.

And it is very hard for them in the current setting when there is no certainty, there is no certainty about either revenue or, in some cases, cost to really make an assessment, especially one that will last the 15, 20, or 30, or 40 years that they are committing their funds to, especially when Medicaid waivers are renewed on, I guess, a 5- and a 3-year basis. So aligning those two pieces will be critical. But what we are talking about here won't hurt investment, may actually help.

Ms. DENTZER. Well, what would be the appropriate mechanism for alignment then? Is it regulations at the Federal level, or how does all of this come about?

Mr. POLIVKA. What are you aligning?

Mr. JENKENS. Payment sources, requirements, and lender and investor needs. So I think there is a terrific start to this, and I am not sure exactly where it is. Barbara, I don't know if you know, or perhaps Michael. But there has long been a hope for a very strong HUD and CMS workgroup around affordable assisted living and creating better alignment there.

I think that is a start. Then having some capacity to modify or realign programs or at least elements of the programs that I think we have, those of us working in this industry have long identified. The Center for Excellence on Assisted Living put together a white paper on affordable assisted living I think 3 years ago. It is a terrific paper. It really points out all of the different pieces that we are talking about.

And I think if we could get a workgroup together to actually look at those, some of it we may be able to solve quite easily within current programs and program rules. Some of it may be legislative. Some of it may be a new program.

Ms. DENTZER. What is the status of this rumored workgroup?

Mr. CLAYPOOL. HUD and HHS do have a working group that is focused primarily on the transition from institutional settings into the community. We haven't addressed assisted living as an issue.

However, our Assistant Secretary for Planning and Evaluation—you may be familiar with the work that they have done—has com-

missioned a couple of recent papers. And I am sorry, I don't have them here to cite from them. But I think that is a clear indication that the department is looking at the role assisted living plays in Medicaid long-term services and support.

Let me give you a broader perspective on where the HUD/HHS collaboration is. It came out of President Obama's year of community living. At the center of the initiative were 5,300 housing vouchers that HUD made available for disabled families, I believe is the term that HUD uses.

Of this 5,300 vouchers, 1,000 of those vouchers were set aside to coordinate with the CMS program Money Follows the Person, or a very similar State effort that was designed to provide the services that were needed by the individual when they moved into the community from an institution with the HUD voucher.

HUD has made the award of these vouchers. And CMS now is in the process of looking at to what extent was the Money Follows the Person program really instrumental in influencing the take-up of these vouchers?

There are a number of other issues that we are dealing with in this working group, and I could quickly give an overview on some of them. We are dealing with issues around civil rights. That is something that I think we should be mindful of when we talk about assisted living, particularly when the resources that Eric mentioned aren't in place.

If you develop a very congregated setting where people are going to be served and they don't have enough service, the Department of Justice may, indeed, come in and find that these individuals are not living in the most integrated setting appropriate to their need. We have seen that happen on the mental health services—there are Medicaid funds involved. But we are really talking about large congregate settings where services are provided to individuals without regard to their interest in living in scattered sties.

So I know that the industry around the table aspires to much better, but it is something that we have to be mindful of. And this working group is tackling some of those issues.

Our others are really focused on building partnership between the HUD programs, particularly the public housing authorities, and the Medicaid program and entities that are funded through the Medicaid program. There are a couple layers of complexity on the HUD side that I may get wrong. But the State housing finance entity has the ability to work with the Medicaid agency right now. And under the 811 program, it is supportive services for individuals with disabilities. Congress recently passed a law that now changes that program and really puts front and center this partnership between Medicaid and the housing State financing entity as the key objective.

There are a number of other ways that they want to bring financing arrangements to the table, which HUD can hopefully underscore. But the point being, when you really have a program like 811 moving away from just funding providers that are going to create living arrangements for people that rely on Medicaid toward a more strategic approach that is looking at how we can leverage the limited resources that HUD is making available through a program like 811 and using things like tax credits to make that possible. We

are beginning to, on the HHS side, really understand what it takes to build a strong partnership with the State housing entities, be they public housing authorities or at the financing level.

This will take a while to mature. We tried to do this in the late 1990s, and we didn't get too far in our partnership. But Secretary Sebelius and Secretary Donovan remain very committed to seeing the partnership blossom. And perhaps the information that is gathered here today will be forwarded to us so we can examine the assisted living issue through our collaboration.

Mr. VAUGHN. To add on a little bit to what Henry said, we are committed to that partnership, and our agencies are pursuing it. But we have other partners who need to be at the table, and I will say it before Barbara does. The CMS works through the States. So, in order for these things to work effectively, HUD is in many ways able to provide the funding for the housing itself. But the services have to come from HHS, and HHS doesn't administer directly, as HUD does, but it goes through the States. So the States have to be at the table to discuss the waiver programs and how they work.

Also, as you mentioned, the State housing finance agencies are the dispensers of the tax credit. So I think they have to be at the table, too, and our private sector partners, as well as our public housing authority partners. I think they need to be part of the discussion, as well as other people represented here at the table. So it shouldn't be a small group. It should be a larger one.

Ms. DENTZER. It is, believe it or not, already almost 3:00 p.m. It says it is on. There we go.

As I say, it is approaching 3:00 p.m. I propose that we take a 5-minute break now, stretch break, et cetera. Reconvene here in about 5 minutes, and then we will move on to our last set of discussions around regulatory issues and disclosure and so forth.

So see you back here in 5 minutes.

[Recess.]

Ms. DENTZER. If you all would go ahead and take your seats, we will get started in just a moment.

[Pause.]

Folks, if you would please go ahead and sit down, we will get started here momentarily.

Anne Montgomery just asked me to mention to all of you that the Aging Committee is going to be compiling all of the questions and the responses that all of you sent in to the questions that the committee asked and will be sending that out to everybody. It will take about 3 weeks for you to get that back, but you will have that.

And toward the end of our session today, let us try to devote perhaps the last 10 minutes or so to seeing if we can't surface a few points of consensus that came out of today's discussion as to how we keep the conversation moving forward on some of the issues that we have talked about.

We will move now to access and discharge issues that, again, impinge on many of the topics that we have been speaking about so far today. But, in general, what we want to discuss are issues along the following lines.

Do States generally require Medicaid-participating assisted living facilities to disclose what their policies are with regard to retaining residents who spend down their private funds—we discussed this

earlier—and become eligible for Medicaid? How does this work? Do States generally allow facilities to discharge individuals who start out as private pay and then spend down to Medicaid eligibility over time?

When the facility is in a position to replace a Medicaid beneficiary with a resident who can afford to pay a higher rate, does the facility, in fact, have that latitude? So that is one of the questions we want to explore.

Again, do all, many, some, no States have processes in place that permit Medicaid beneficiaries to appeal any discharge decisions by assisted living facilities? What is the legal position of facilities licensed to offer assisted living services with regard to discharging residents whose needs exceed State-licensed level of care requirements?

How does the facility have to comply with other statutes, antidiscrimination, Americans with Disabilities Act, Fair Housing Act, and so on in this regard? Is there merit at all in requiring assisted living facilities that ask a resident to leave because he or she develops the need for services that exceed that facility's care standards to help with the transfer of a resident to another setting in which higher-level services could be provided?

Or alternatively, could assisted living facilities, should they be asked to assist residents if they wish to age in place and bring in additional services?

And then, finally, are negotiated risk agreements, as are used in some States, a mechanism whereby living facilities and residents can attempt to negotiate additional services for residents whose care needs are found to exceed State licensing levels of care?

So this is kind of the body of the questioning that we would like to explore now. And I thought we would start off again with our providers on those perspectives to give a sense not only how they see things operating in their own State, what the legal environment is in their own State, but what ought to be the case.

So, Brenda Bacon, if we could begin with you?

Ms. BACON. Susan, I could talk about this all afternoon. So I am going to warn you. Just to hit on a couple of the subjects, I think that disclosure and commitment to that disclosure are crucial in every State for every provider.

I think that consumers have a right to know what your policy is, particularly since there is limited access to Medicaid waiver dollars. And you need to abide by that policy always. I think the State of New Jersey has taken steps, as other States have, but particularly in New Jersey, they require that 10 percent of the assisted living population have access to Medicare waivers. And I think that the communities in New Jersey proudly participate and actively participate in the Medicaid waiver program.

I think each State has developed its own approach to the Medicaid waiver, and 41 of those have, and some have not. But I think in every State, they have developed a very robust program around regulation and around access. And I think people are very, very involved in that process in each State.

There are two reasons I believe that people discharge from assisted living, which is their preferred setting. One is that their level of care is such that they need to be in skilled nursing. But,

most often, there is a discharge, unfortunately, because they can't access Medicaid, and they have to go to the skilled nursing center where they can access Medicaid dollars. And that is unfortunate, and we have talked a lot about that today.

So I think one of the main ways that we can increase the ability of people to choose the setting in which they want to live is to reduce the institutionalized hold on the dollars that they need. But in terms of policies of access and Medicaid acceptability, eligibility, commitment to stay, those need to be fully disclosed and honored, and I think everyone in the assisted living community certainly that I know of supports that.

Ms. DENTZER. So, then as a provider, what laws do you have to operate under within the State to discharge a person?

Ms. BACON. Well, in our State, we are required to make plans for discharge if we cannot take medical care. In other words, if someone absolutely requires 24-hour skilled care, and even though we have 24-hour nursing onsite, we certainly don't have the intensity of medical care that a skilled nursing facility has.

So everyone has an obligation in every State under every State regulation—to every 50 State set of regulations, they have to discharge if they can't care for them. I think beyond that, with the requirement for access to Medicaid funds, it is really what your State has developed in terms of its relationship and its State plan and its 1915 waiver in terms of how many waiver slots they have available so that people can stay in assisted living when they get there.

Ms. DENTZER. So is there any ability for individuals on Medicaid to appeal any discharge decision?

Ms. BACON. Oh, absolutely.

Ms. DENTZER. There is.

Ms. BACON. Absolutely. I have a person in one of my communities who has been there 11 years under a Medicaid waiver, and she will always be there. I have 305 people under Medicaid waiver, and they will be there as long as we can take care of them.

If there is a discharge, whether it is a health discharge or any other kind of discharge, there are always consumer rights and resident rights policies in every State that I know of that allows them to question that discharge.

Ms. DENTZER. Okay. Robert.

Mr. JENKENS. Susan, I would say that I think there are some very good examples of States that do have discharge controls and reviews. I think Oregon is one of them. Not all States do, and I would say there is a great deal of actual I would term it "tragedy" involved with some of the discharges that I have seen and heard about for people who either run out of funds or where providers decide that the Medicaid program is no longer sufficient to cover those costs.

I would say that discharge to me is one of the single-greatest issues facing assisted living and that for us to honor the values that assisted living was founded on—of home, of creating community, of integration in community, and aging in place—unless we address discharge issues and concerns, we won't get to what assisted living promised.

Ms. BACON. Can I just respond? There is one situation where one company very notoriously decided they were withdrawing from the Medicaid program, and New Jersey was kind of the epicenter of that. We understand that. I have seen all of the horror stories and the things that have gone on there.

The State of New Jersey has taken very aggressive action against that company, and I know of no other company in the assisted living industry that supports what happened there.

Ms. DENTZER. Larry and Martha, I want to ask you if this has perked up on your radar screen as well. But let us go to Larry first, and then we will——

Mr. POLIVKA. One of the reasons we created the license in Florida in 1990 to allow people to age in place was that 4,000 people a year were leaving assisted living against their wishes and going into nursing homes, most of them Medicaid placements.

You know, this is an inherently difficult issue. I think you have to give assisted living facilities the ability to make a decision about who can stay there, given the level of services that they can provide. And that sometimes is going to result in some really difficult, unfortunate decisions.

But if you can expand your Medicaid program to cover, to really accelerate the growth of it, you are going to be able to allow assisted living facilities to allow people to age in place under more, a wider range of circumstances than can now. But regulating discharge criteria is a really difficult issue. I think you really have to err on the sides of giving these facilities considerable autonomy in determining that as long as there are disclosure provisions that really do reflect the kinds of decisions that are made.

Ms. DENTZER. Robert, and then we will come over here to Josh, and then to Martha.

Mr. JENKENS. So I think Larry brings up a very important point. I think you want to set a minimum standard of what assisted living will attempt to provide, and then you want to create a great deal of flexibility for that provision of service either to be delivered or brought in safely and affordably.

But I do think there is a role for the State to challenge providers because many of the providers' business models don't involve people with high levels of need.

Mr. POLIVKA. Right.

Mr. JENKENS. As a matter of fact, they see that as a marketing issue or a cost issue.

I want to also say that it is not just providers, however. So, in my experience, regulators and regulations often are an equal impediment to people staying in place and expressing their choices and assuming some risks associated with staying in a lower level of care.

So I think there is an equally important piece of this that is really around what do regulations allow as far as civil rights, as far as people expressing their preferences and taking on some of those risks. And I know we will get to the issue of negotiated risk agreements later. That is one tool potentially for that, but there are many others.

Ms. DENTZER. Okay. Great. Josh.

Mr. JOSH ALLEN. You know, this topic has me chomping at the bit because nurses are often at the center of the conversation about whether or not someone needs to be discharged. And I think we should start with the term "discharge." I think it is highly inappropriate for the setting, given that we are encouraging it to be a home and home-like. You don't discharge out from your home. You move out of your home.

But Robert, I think, touched on a key point, which is, in my experience, it is actually not often the provider who is the challenge in this situation. It is the regulations that in some States are quite prescriptive in what can and cannot be done in assisted living.

I have had the opportunity to work in a number of different States as an assisted living nurse. One of them, my great home State of California, has a literal laundry list of seven or eight things that simply are not allowed in assisted living. You know, case closed.

You compare and contrast that to a State I have worked in, in Oregon, under the nurse delegation model that was brought up earlier. It is a good thing these mikes had off buttons, or we could have talked about delegation for hours.

Under that type of model, there is much greater flexibility. Whether it is using negotiated risk or a service plan or whatever system you want to use, there is a much greater flexibility for a healthcare provider—a nurse, probably a physician being involved as well—to sit down with that resident and their family and the provider and make some decisions about what is appropriate for this individual and how can we meet their needs.

So instead of just simply saying that if you have in the California example, if you have a G-tube, a gastrostomy tube, you cannot live in an assisted living community. Well, that is ridiculous. There are many individuals living with gastrostomy tubes in their homes, their true residential homes all the time.

So to say that simply because you are in this licensed building it is inappropriate is, I think, largely just a sign of how old California's regulations are. Whereas, under a model where we could say what is unique about this individual? Are they receiving food and fluids through that G-tube? Are they receiving medications through that G-tube?

Well, in some cases, the answer is no. So, for that individual, it could be perfectly appropriate for them to remain in that assisted living setting. In a State like Oregon and others that utilize nurse delegation, allow that professional nurse to use their judgment of how and when to train staff to provide assistance. I think these issues, they touch on everything we have been talking about today.

When you guys are getting into financing and banks, as a nurse, my eyes kind of glaze over a little bit. It is not my area. But the way that assisted living has really innovated over the last 20 years is, in many ways, what makes it affordable.

One of the reasons it is so expensive to live in a nursing home is because an overwhelming majority of the functions being provided for that resident have to be provided by a nurse. Medication management would be the classic and best example.

Why spend all that money to have a bunch of nurses running around passing pills when study after study has shown it can be

done very effectively by medication aides and medication technicians who have been trained or perhaps delegated to?

There is a tremendous amount of innovation out there regarding the actual provision of services to residents. And I think if more States would take the time to learn from one another rather than sort of working in silos and trying to figure it out for themselves, but see what has been done, what has been done effectively, it touches on everything we have been getting into—from access to affordability to discharge to quality of care.

At the end of the day, it goes back to the services being provided, and how can we provide them in a flexible way that can be tailored to the individual? Because if you want the opposite of that flexibility, quite frankly, you have a nursing home.

Mr. JENKENS. Josh, can I throw in lenders really hate it when you violate those regulations?

Mr. JOSH ALLEN. Yes. Larry, I actually didn't catch your question. I don't know if you were being rhetorical?

Mr. POLIVKA. Well, sort of, half and half. But they only inspect every 5 years in California. So who knows?

Mr. JOSH ALLEN. Well, the practical reality is—and I will speak from, I am obviously not a California regulator, but I do a lot of work in California. From a practical reality, they are in buildings much more than every 5 years. That is the minimum standard for regulatory inspections.

They are also in the buildings for complaints, new licensure, 90 days after licensure, and a host of other reasons. But nevertheless, any provider, I would hope, tries to practice to the letter what those regulations say. And unfortunately, in that example, there is a very prescriptive list of what is and isn't allowed.

Ms. DENTZER. Martha, I want to give you a chance to weigh in on this.

Ms. ROHERTY. I think we had an all-State call a couple of weeks ago on assisted living, and one of the things that came out is, if the States have an up-front disclosure that is really robust, it really can help out the consumer.

And so, we were kind of looking through what are some of the models for really a robust up-front disclosure? It would include like the preadmission process, the admissions process, what is going to trigger a discharge or a transfer, the plan of care, meaning the whole aging in place model and a consumer-directed vision for the consumer.

The staff training, the orientation of the staff, the CPR, if they have volunteers, that they are trained, what the physical environment looks like. The staffing patterns, the shift times, and then the residents' rights and who they can contact if there is a concern.

But on top of that, the States were talking about the need to really disclose the cost up front because a lot of the people, like one of the States said that some consumers go into a facility that is a Cadillac, and they can really only afford a Chevy.

Now who gets the burden of that transfer when that occurs? The State falls victim in a lot of cases because they are the bad guys that are not able to pay for the Cadillac, and the assisted living community is giving up that person's home. So if they knew more in advance what is included in the base rate and in the extra fees

and everything right up front, I think we would have some more informed consumers, too.

Ms. DENTZER. Eric, I want to bring you into this conversation. What is your perspective on this?

Mr. CARLSON. First, I would like to say that it is important to keep disclosure in perspective. It is a good thing, but not if it is in lieu of some solid base of standards. Not that everything needs to be standardized, obviously.

I think that there is a false choice that suggests that, by extending any kind of standards, you are turning an assisted living facility into a nursing facility or something that can't be saved. There is a middle ground here, and to the extent that we rely on disclosure, I think we have an unrealistic expectation of how that works in practice.

You are a consumer. There was a discussion here about a lot of these decisions being made in traumatic circumstances. You get a big stack of papers that describe how this facility is completely different from some other facility. Consumers aren't in a position to really process it.

They should be able to process and can be expected to process some differences around the edges, but not at the core. I think that consumers legitimately expect that there are some similarities between assisted living facilities, that they share some concepts. And when you buy into an assisted living facility, you know what that means at some basic level.

There may be differences. So I think that, myself and my constituents, the people I work with, really worry that there is too much of a focus on disclosure if we are ignoring standards because of that.

And then as applied to a couple of these issues—requiring that Medicaid be accepted, for example. In some States it is beyond disclosure that Medicaid, when a person becomes Medicaid eligible—and again, I am not from these States, but looking at the regs and the policy—Illinois, New Hampshire, Oregon, I believe. No, Illinois, New Hampshire in any case require that Medicaid be accepted.

What I see in Oregon is a statement saying that every bed has to be certified. I want to say that is an incredibly important thing for a consumer. That if you are in an assisted living facility, you enter as a private-pay individual, you spend your life's savings down to Medicaid eligibility, the facility is Medicaid eligible. You entered that facility knowing that it was Medicaid eligible, and then the facility says, "I am sorry. We don't want Medicaid from you." Just look at that from that person's perspective.

That is a hard, hard thing. And it strikes us as inappropriate to have a person pay their life's savings in such a way and then be told that they have to leave. There is something a little cold about that that I think is inappropriate from a policy perspective, from a human perspective.

And then the level of care issue as well, I think it is important to—I would suggest here that I think that facilities and consumers benefit from a little more specificity as to the level of care that the facility can and cannot provide. Because when the continuum is so broad that you have got some facilities that provide very little and

some that provide something close to a nursing facility level, it is difficult for consumers.

And when they are told that they have to leave, it seems much more like an ad hoc decision that a facility is saying to them we are deciding in your case we don't want to provide care anymore. And I agree with the statement that all the States say that a facility has grounds to discharge when the facility can no longer meet the person's needs.

But depending on what State you are in, it feels like an ad hoc decision because the facility in many of those States has the ability to provide care if it wanted to. The licensure standards allow for it, but the facility has self-defined itself as only providing a limited level of care.

And I will also mention that the difficulty for the provider at that point of view is that it really does raise some ADA and fair housing issues because, if it is the State that is setting those levels, it is the State that is at risk for violating the ADA. It is the State that is not making a reasonable accommodation to allow people to stay.

But if the State says we don't have any problem with you providing this level of care and the facility is saying we choose not to meet your needs—and I think it was mentioned earlier, there is a financial calculation about all of this and the type of level of care that you want to provide—the facility really has some issues.

And then as far as the process is concerned, there is a tiny, tiny minority of States that allow an administrative appeal in these circumstances. I agree that there may be regulations. And so, there are resident rights. There is probably in the vast majority of States, there is a listing of justifications for transfer and discharge, but they tend to be loose. They may refer to the contracts and if the contract-authorized discharge is okay, or it may allow discharge if the facility can no longer meet the person's needs.

So there is a lot of wiggle room there, and then there really is no administrative process. And it puts a consumer in a difficult position. California is one of those States. And in my experience, when consumers get a notice that says you have to leave, and there is no particular explanation of how it might be appealed—the law has changed in the last year or so—but they tend to just fold up their tent and say, "Well, I have been told what the situation is. That is it."

Ms. DENTZER. So I would like to hear from some of the State folks here and get a sense is this an issue in your State? Is there a mass movement among facilities to discharge individuals? Is there not? Is it a nonissue? And where along this spectrum do all of you fall?

Julie, maybe you could start by clarifying what is the situation in Oregon?

Ms. STRAUSS. So, in Oregon, we do have rules specifically around involuntary transfers, as we call them, or involuntary move-outs. And in our State, we have voluntary Medicaid participation. If you sign a Medicaid contract, you have agreed that Medicaid is a payer source. In our rules, you can ask someone to leave for nonpayment.

What we have said is, if Medicaid is a payer source and you have a Medicaid contract, you can't ask someone to leave if they become Medicaid eligible.

Ms. DENTZER. You cannot?

Ms. STRAUSS. You cannot. That is not a legitimate reason if you have a Medicaid contract. Of course, our uniform disclosures and our agreements require that you say up front, "Do you have a Medicaid contract?"

We have been very, very fortunate for providers who have decided that they no longer want to participate in Medicaid. They have gone through what we call a "gradual withdrawal contract." So they have said anyone who currently is living in our facility, we will go ahead and extend to them the courtesy if they spend down that they can continue to be in our facility and we will continue to accept Medicaid as a payer source until they leave.

What we are finding in the transfer rolls, quite honestly, what we are hearing, we don't see a lot of involuntary move-out notices going for level of care. We probably see much more having to do with behavior associated with a safety issue, either to themselves or to others, because we don't require the level of staffing in a lot of those facilities. A risk agreement is great when you are talking about negotiating with a family and an individual about their risk. It is another thing when there are other residents or staff being placed at risk by that individual.

And so, we are seeing a much higher occurrence of involuntary move-out notices for behavior rather than actually for medical service need, which seems to be the dominant topic here with regard to service level of need is more the behavior service than the medical service.

Ms. DENTZER. Irene.

Ms. COLLINS. Susan, in Alabama, again, we don't have Medicaid as a payee, or payer source. But we do have our bill of rights for our residents, and our ombudsmen are the voice out there for them if an issue does arise. And in addition, with the bill of rights, it is the same thing that Julie just said. In there, we are seeing more about behavior than we are about discharge for care. Same kind of thing.

Ms. DENTZER. Krista and Kevin, what is the situation?

Mr. COUGHLIN. In Wisconsin, two of our models, they are a little bit different. One model does allow for an appeal of a discharge, but that nonpayment issue is problematic sometimes because the person spent down, and then they don't—a facility doesn't have a contract for Medicaid.

And in our State, we have Family Care is the Medicaid program, which is working very well. Right now, it does reach about 80 percent of the population as an entitlement. So, in those places when we have spend-down, many times they are then eligible, and then they can remain.

We used to have a lot more discharges because of nonpayment because people had to go on a waiting list. So they went to nursing homes prematurely. But there is this issue does come up on occasion. I think disclosure is very important so people know ahead of time. But it is, when that happens, it is a very difficult situation.

When somebody does get an involuntary discharge because—for whatever reason.

I think what is nice about our regulations is we do have some flexibility. So, usually, if there is a barrier to the regulations, many times we can issue a variance, add some extra protection so that the person can stay so we don't have that move because transfer trauma can be very debilitating to an individual.

And I don't see it as—we do have some cases of that occurring, but I don't see it as a huge concern. I think communities, when they can, want to retain those people as long as possible.

Ms. DENTZER. And Krista.

Ms. HUGHES. In Arkansas, the Office of Long-Term Care, as I said, regulates and licenses the facilities. The ones that enroll in the Medicaid waiver enroll through my office with the Division of Aging and Adult Services. And actually, we don't even know how many units each facility—we don't ask them—we had not previously. We are now. We had not previously asked them to stipulate. So, really, you wouldn't know, even the long-term care surveyors would not know, going into a facility, which units were designated as Medicaid waiver units versus private-pay units.

The State does not get involved with if a particular previous resident was a Medicaid waiver client and discharged for whatever reason. They would not even be required to put another Medicaid waiver client into that particular unit. It is just not ever seen to that degree.

Ms. DENTZER. Okay. Let us move to the area of negotiated risk agreements. And Robert, I think you were starting to weigh in there?

Mr. JENKENS. Sure. I think that——

Ms. DENTZER. First of all, just so we are all on the same page, what are those?

Mr. JENKENS. Sure. So negotiated risk agreements mean different things to different people. But, in essence, the concept of a negotiated risk agreement is to allow an individual to assert that they are willing to take on some risk because either the provider doesn't offer a service that they may be judged to need or the setting itself may offer less protection in the way of life safety, in the way of services, or regulation than some might judge them to need as well.

So it is really a way to let a competent individual or the family make decisions the same way you or I do in our own home about what is good for us and what the balance is. So I don't know how many of you in this room have gone skydiving? Most nurses would not allow you to go skydiving if they were asked to weigh in on that. So it is really in that context.

I would say that, in this sort of three-party structure of good, strong, minimum regulations, additional flexibility allowed on top of those through good disclosure, and I would like to put in a plug for AHRQ's disclosure collaborative that is producing what I think will be a model of disclosure standards. And then consumer choice in the form of some way for the consumer, whether it is negotiated risk agreements or something else, to really be able to assert some piece, their piece in the conversation between providers and regulators.

And currently, in my opinion, consumers of assisted living don't have much of a voice in that conversation. So there is a paper funded by ASPE, of which I was an author, looking at negotiated risk agreements. This was about 5 years ago. The state of negotiated risk agreements, and then the pros and the cons around that.

Ms. DENTZER. Josh.

Mr. JOSH ALLEN. I think one of the practical realities of negotiated risk is often the question of who are you negotiating with? The resident, at the end of the day, is the person you are responsible for, and they are the consumer. But virtually every assisted living resident I have ever talked to has had a family member involved in some shape or form or another.

Sometimes it is a very clear legal relationship, you know, a power of attorney, for example, conservatorship. More often than not, I think it isn't. It is simply a relative who has helped mom or grandpa or whoever it is make their way into that assisted living community.

And I am speaking from many, many examples of personal experience where we know what the direction is for a resident, but we have conflicting direction from a family member. An example that sticks out in my mind I will never forget was in an assisted living community in Los Angeles I worked with where we had a resident who was to be receiving Aricept related to Alzheimer's disease, medication.

The family member who was the responsible party didn't have any real legal authority. But took it upon themselves to stop making the co-pays for that Aricept, and now as a provider we were sort of stuck in the middle of we know this resident needs it. The family, who is controlling the money—probably not entirely legally—doesn't want to pay for it.

And those sorts of examples happen time and again. Issues related to driving, issues related to wandering, issues related to following physician-prescribed diets. There are dozens of very practical examples where negotiated risk could perhaps play a role. But one of the practical realities, one of the challenges is it is not always as simple as the provider, the resident, and the regulations. It is usually a much more complex relationship with family members and perhaps legal representation for the resident.

That, at the end of the day, the care provider is stuck sort of wading through that somewhat tricky mess of figuring out at the end of the day who really should be making decisions for this resident. And this becomes even more tricky when we get into something we haven't talked about a lot today, but Julie started to bring it up, and that is the issue of memory care.

Persons with dementia, Alzheimer's disease, without question one of the fastest-growing segments of the population that are in need of assisted living services. Who is making the decisions for that person?

They rarely come to us with any sort of conservatorship. At most, there might be a financial power of attorney. And there are a number of logistical challenges to really successfully implementing anything that I would say resembles negotiated risk.

And then one last comment. I think what is important to take away from the ideas behind negotiated risk is the concept of com-

munication. Every State has different legal realities regarding negotiated risk.

In California, for example, we cannot use negotiated risk. In other States, they require you to have negotiated risk. And again, that is, I think, appropriate based on what fits the needs of the consumers in each State. But the running theme with negotiated risk is that it encourages communication.

Someone earlier brought up the service planning or the care planning process. That is really what needs to be happening is the provider, the resident, whoever else is involved in making these decisions, they need to sit down and they need to talk. It really is no more complicated than that.

You know, we could spend hours going in circles about the details, but it really is that simple. If all those interested parties sit down and have a conversation about what is needed, what is allowed, what is not allowed, how are we going to figure this out, in virtually every instance, you can come to some resolution.

And again, that starts to feed back into the discharge question. It starts to feed back into the level of care question. It is a very umbrella type of issue. When I worked in the corporate office for an assisted living provider as a nurse, one of my responsibilities was to get involved any time we were considering an eviction notice, an involuntary discharge, involuntary relocation.

And I can tell you, in 99.9 percent of cases, we were able to avoid ever writing that eviction notice. We didn't have to get the attorney on the phone to write a letter because we could sit down and we could talk. And sometimes the end of that conversation was the resident stayed, and we figured out a way to make that work, as in the case of the Aricept resident.

Other times the decision amongst all of the parties was, you know what, dad is wandering. We have found dad outside a few times in the last couple of weeks, and there are some very real safety concerns. And as painful as that decision is to move out, everyone, at the end of the day, was in agreement. It was the right decision.

Now it wasn't under the heading of negotiated risk, but I think the concept was there. To get people to sit down and talk and get all of the parties at the table. And you said what could we come to consensus to? I would certainly hope this group could come to consensus on that.

Mr. JENKENS. Susan, just a quick comment on Josh. I think he summarized the findings, actually, of our study quite beautifully, which really is the conversation that is important. And I think what we need, again, whether it is a negotiated risk agreement or some other framework, is the requirement that the conversation take place.

And I think in States that require a negotiated risk agreement, that provokes the conversation that says who should be included, including the consumer? I think in States where we don't have language around that, too often we get the eviction notice with no explanation, and the person is just, as we say, gives up and moves on.

Ms. DENTZER. So can you give us a sense how many States are like California—if I understood you, Josh—don't allow negotiated risk agreements at all? How many allow them?

Mr. JOSH ALLEN. For point of clarification, what California does have, though, are very clear standards regarding the development of a service plan, which I would argue—I am a nurse, not an attorney. I am sure there are lots of them in the room. There is a legal difference between disclose and a service plan, but I think the concept is very similar.

Mr. JENKENS. I am guessing Eric knows the number because I have forgotten.

Ms. DENTZER. True? You know?

Mr. CARLSON. Yes, 16 or 17 States have something in their regulations that look something like negotiated risk. They may call it something different. It may be managed risk. It may be informed consent. So I think it is confusing to say that, say, 16 States authorize it, and that is shown by this conversation. I think Robert started by saying, well, it is hard to say what negotiated risk is.

And this conversation illustrates it because we started talking about a waiver of liability, and we ended up talking about a conversation. And those are very different. And I can say I think the conversation is great. That is obviously important. I would hope that we could come to consensus on that.

But that is just light-years away from a consumer signing an agreement that says you, the service provider, will not be liable if certain bad things happen. It is hard to imagine any of us signing that in any other context—in a school context, in a service context. And again, we know how this happened. I would suggest that in the long-term care setting, it is usually the providers that present these agreements, and the consumers are not in a position to negotiate practically.

I have written a Law Review article on this in the Journal of Health Care Law and Policy that lists all the states. But I just want to mention from a legal perspective, if it is a waiver of liability, legally, it is unenforceable. The only, only arena in which from a consumer's perspective you can have a waiver of liability like this is in skydiving or bungee cord jumping or anything like skiing, downhill skiing.

But going to an assisted living facility is not like jumping out of an airplane. It can't be, and it isn't legally—there was a case in Delaware that the facility had what I think we would recognize as a negotiated risk agreement that stated that the agreement absolved the facility from "personal injuries or damages, even if resulting from negligence," and the contract said that this was in return for the resident having "independence, control, and choice" and "a higher quality of life."

This was negotiated risk, and the resident in this setting suffered a fall, had irreversible brain damage. In its defense, the facility put forward this agreement and said, well, these guys made a choice. They made a contract with us at the front end and said in return for living in this more home-like environment with a less institutional setting, they have released us from liability for these bad outcomes. And the trial court in this case said it would be un-

conscionable to enforce this type of waiver of liability in a consumer setting.

And so, my suggestion on negotiated risk is there needs to be some real clarity. I think all these States are playing a little fast and loose by putting these terms out there and being a little squishy about exactly what they mean. We need some real clarity.

And if we are talking about a conversation, we should talk about a conversation. And if we are talking about a waiver of liability, we should talk about a waiver of liability. But we shouldn't talk about them both simultaneously without extricating them from each other.

Mr. POLIVKA. Eric, I thought it was decided over 10 years ago that there was no waiver of liability? I thought, my assumption has been all along that you are talking about a continuing care planning instrument. You are not talking about a waiver of liability with a negotiated risk.

I mean, I thought that was decided long ago.

Mr. CARLSON. Well, I would like people to be clear about that. Because what I heard, I think Robert stated it accurately, which is that classically that is what these negotiated risk agreements contain. The Law Review article that I have written cites multiple statements by provider attorneys and by insurance companies and provider magazines recommending negotiated risk agreements for exactly this purpose.

And I agree in the public policy discussion when it comes up. I think people, in defending negotiated risk, say, well, it has nothing to do with waiver of liability. It is about negotiation and service planning, and that is why we have this confusion. We are talking about things without defining them adequately enough.

If everybody in this room agrees that there shouldn't be any liability waivers, I think we should write a document and say no liability waivers, and that would be tremendous.

Mr. POLIVKA. Well, it has never been found to hold in any litigation.

Mr. CARLSON. Pardon me?

Mr. JENKENS. I think where we are with this right now is I think there is a role for, as Eric points out, additional clarity, some standards, and a definition of what is in it and what is out. So Eric cited a pretty egregious case. I think we can probably find those cases for almost any subject we would choose to discuss.

I don't think that means that the concept of negotiating around risks from a consumer perspective so that they can make choices about what they are willing to risk or not risk is a bad one. I think we haven't found perhaps the right vehicle or at least the right middle ground in that vehicle to do that. It is a good area, I think, for further development.

Ms. DENTZER. Well, just on that point, as we have about 8 minutes left here, I gather there would be some consensus on having a conversation go forward on this topic in particular, whether it is a question of clarification at the Federal level, whether it is model legislation for the States. Something like that to do more to standardize these definitions or——

Mr. JENKENS. Well, I think—you know, I think the first question is, is this important enough? Is there enough of this going on in

the world to actually have that conversation? Eric and I could talk about this for the rest of our lives. We find it endlessly interesting.

Ms. DENTZER. Or might there someday be enough of this going on in the world?

Mr. POLIVKA. I think there are many other higher priorities.

Mr. JENKENS. That is what I was going to say. I am not sure this is a priority among affordable financing, regulatory issues, et cetera.

Ms. DENTZER. Okay. So in the interest of time, let me jump back then to the whole discharge area. Any sense of what this or another group like it could contribute there, or is that another one that is lower down on the list than, say, the financing or some of the other issues we talked about? Charley.

Mr. REED. Yes. One of the things that was touched on quite a bit, I think it begins with the admission criteria and how it is disclosed. I think that is the up-front place to start.

But the other thing we haven't touched on very much is the responsibility that State Medicaid programs and long-term care programs have in helping out with this. If people really do spend down and become Medicaid eligible, the State has a responsibility for that person to help them understand what their options are and to help them get to those options.

And so, it is no question that the assisted living facility has a responsibility, but so does the State. I think a lot of States haven't stepped up to that responsibility yet—that there is an obligation that States have to help people understand what their options are and how to actually take advantage of those options.

Ms. DENTZER. Okay. Well, moving on, let us jump back to our conversation about financing, sources of Federal funding. There seemed to be some consensus around having more discussions on bringing more people, more entities to the table, whether it is the States, whether it is the Feds, et cetera, to get a better sense of the sources of financing that could be tapped and how they can be best utilized.

Fair enough? Is that a fair summation of what there was clear agreement on? So that would be, if anything, a point of consensus this group, I think, would put forward.

Moving to the first part of our conversation, which was around the whole question of what is assisted living anyway? What are essential services? What is the core philosophy? We, in that context, began to talk a bit about the notion of a Federal floor or ceiling. I didn't detect necessarily any consensus points there on discussing that going forward. But if there were, that is another recommendation that probably is worth putting forward.

Any feedback there? Robert.

Mr. JENKENS. I think there is a lot of value in discussing what a floor should be for the Medicaid-funded programs and then whether or not there should be a ceiling. And I think there has been a lot of discussion around that over the years, the assisted living workgroup initiated by the Special Committee on Aging, and then the CO has continued that.

So I do think it is worth sorting out what is worth paying for and what truly brings the values of control and dignity and privacy to

someone who is receiving Medicaid funding. I would be a strong supporter of that.

Ms. DENTZER. Anyone violently opposed? Larry.

Mr. POLIVKA. I am sort of two minds about this. I think that what CMS has laid out has been functional. It has worked well for a long time for those States that are willing to pursue expanded funding through their waiver programs for assisted living.

The problem is, as I see it, and I may be overreacting, but in looking at long-term care trends, which I do fairly routinely now, it strikes me that States are really going to be moving towards managed long-term care designs because of the fiscal crisis and because the experience of States like Arizona and Wisconsin in developing their managed long-term care models. They seem to be cost effective. Some work better than others. I think Family Care is better than ALTCS.

But what you are going to get with that movement is what has happened in those States, including Florida to a lesser, but substantial extent, and that is massive use of assisted living. That is where the expansion is going to occur with managed long-term care development, I think, based on the experience of the States that have already done it in the last 10 years.

As that happens, I think there will be increasing pressure on State and Federal officials, legislators, and CMS people, and everybody else to begin to look at the issue of floors and ceilings from a different perspective than we have since 1990. And I have been a pretty laissez-faire, had taken a pretty laissez-faire approach to this for the last 20 years. I think it has worked well.

But that may be on the cusp of changing, as we see qualitative change in the design of long-term care systems and financing over the next 10 years.

Ms. DENTZER. Josh.

Mr. JOSH ALLEN. I would just sort of repeat what I commented earlier that I think you have to be very careful on the services side when you start talking about ceilings. Again, these sort of magical lists or criteria that say, no, this person is no longer appropriate, I think that flies in the face of the concept of consumer-directed and autonomy and choice and decision-making.

So I would just throw out a word of caution about the concept of putting a ceiling on what that setting may be for each person.

Ms. DENTZER. And you are the person who wouldn't let anybody go skydiving, right?

Mr. JOSH ALLEN. I would let Robert go skydiving.

[Laughter.]

Mr. POLIVKA. But the problem with that is that you are going to have a lot of pressure to move people out of nursing homes en masse, and then you run the risk of losing the thing that really distinguishes assisted living from nursing home care. You are going to blur the boundaries, and you are going to lose the quality of life focus that really defines and justifies the assisted living model.

So ceilings may not be the right way to talk about it, Josh. But you need to be concerned about at some point with these massive changes as they occur, what happens to the kinds of places where people live?

Mr. JOSH ALLEN. Well, but I would argue that many of the same types of nursing services and quality of nursing services are, in fact, provided in assisted living that just a short 10 years ago or 20 years ago would have thought to have been only appropriate in a nursing home. So I don't know that the sign outside the door necessarily dictates whether or not services can be provided.

I think what is different is the model on which they are provided. And the very simple example is you walk into typically any nursing home in the country, one of the first things you will see is a very large and expansive nurses station with hundreds and thousands of pieces of paper and people in nursing uniforms.

Most large assisted living communities have those same nurses stations. They are just not there for you to see. They are hidden behind a wall in a way that is much more comfortable for the consumer and feels more like a home. So the same services, many of the same services are being provided.

I don't think saying that just because assisted living would start to provide those services would make it no longer assisted living. I think it is how they are provided.

Mr. JENKENS. I think the line is already blurred, and I think the Green House Project is a good example of that. In skilled nursing, we learned from assisted living and we brought it back into skilled nursing. And I think that is a good model, and I think we should blur the lines as much as possible to give people choices.

Ms. DENTZER. And as we bring on remote monitoring and other technologies, things will change even further.

Irene, a quick last comment because we are at 4:00 p.m.

Ms. COLLINS. I was going to simply say that we have to remember the whole discussion is centered around the individual and personal choices.

Ms. DENTZER. An excellent note to end on, lest we think this is about something else.

Anyway, I want to thank all of you for a terrific discussion. I believe it is the case that this will not be the last of the roundtables or square tables the committee holds as it works its way through these issues.

But thank you very much. It has been a very good and vigorous discussion, a candid one. And I am sorry we have to end it here, but we hope to continue going forward, and we will look forward engaging you all in the future.

Thank you very much.

[Whereupon, at 4:00 p.m., the roundtable was concluded.]

APPENDIX

Senate Special Committee on Aging Roundtable

Assisted Living at the Dawn of America's 'Age Wave': What Have States Achieved and How is the Federal Role Evolving?

March 15, 2011

Senate Hart Office Building, Room 216, 1pm – 4pm

Moderator:

Susan Dentzer is editor-in-chief of *Health Affairs*, the nation's leading peer-reviewed journal of health care policy. She is an elected member of the Institute of Medicine and a frequent guest on National Public Radio and news shows. At *Health Affairs*, Ms. Dentzer oversees the journal's team of almost 30 editors and other staff to produce the monthly publication, called by the *Washington Post* the "Bible" of health policy.

Participants:

States

Christy Allen is the Assistant Commissioner for the Tennessee Department of Health's Bureau of Health Licensure and Regulation. In her current role, Ms. Allen oversees the Divisions of Health Related Boards, Health Care Facilities, Emergency Medical Services, and Animal Welfare. Previously Ms. Allen was Deputy General Counsel for the Tennessee Department of Commerce and Insurance.

Tennessee Bureau of Health Licensure and Regulation, Division of Health Care facilities
The Department of Health's Bureau of Health Licensure and Regulation is responsible for licensing and certifying health care professionals for 22 health related boards for the State of Tennessee. This division also investigates complaints pertaining to health care professionals and works closely with the Office of General Counsel to present cases before the various boards. The Health Care Facilities Division licenses and regulates health care facilities to ensure compliance with state minimum standards, federal standards of care, and conditions of participation for Medicaid and Medicare programs through facility surveys and incident investigations. The Emergency Medical Services Division provides quality assurance and oversight for pre-hospital emergency medical care and medical transportation systems in the state.

Irene B. Collins is the Commissioner of the Alabama Department of Senior Services. Commissioner Collins serves on the Governor's Workforce Development Council, the Medicaid Long Term Care Advisory Committee, member of the UAB Adult/Gerontology Geriatric Board, and several other advisory councils. Under the tutelage of Commissioner Collins, the Department of Senior Services received the 2007 Rosalynn Carter Leadership in Caregiving Award for the REACH Intervention Project.

Alabama Department of Senior Services

The Alabama Department of Senior Services (ADSS) is a cabinet-level state agency with 45 employees and serves the 907,000+ Alabamians who are 60 and older. As a planning, development, and advocacy agency for the aging, the employees include program specialists, administrators, attorneys, information technology specialists, accountants, auditors, nurses, nutritionists, case managers, grant special project personnel, as well as clerical support personnel. The State Ombudsman who acts as an advocate for residents in nursing homes and assisted living facilities is also housed in this agency. ADSS is the state agency responsible for coordinating state and federal programs for senior citizens from the Administration on Aging and Centers for Medicare and Medicaid Services. We administer statewide aging programs through nine regional planning commissions, 13 Area Agencies on Aging (AAAs), and over 2,000 direct service providers and volunteers.

Julie Strauss is the Interim Director for the Office of Licensing and Quality of Care, Seniors and People with Disabilities Division, in the Oregon Department of Human Services. The Office is responsible for policy for licensed settings for seniors and people with disabilities. Ms. Strauss has a background in community development, children and family services planning, finance and administration, and federal policy analysis.

Oregon Department of Health Services, Seniors and People with Disabilities

This group's main program areas include licensing and quality of care to that monitors & enforces standards of care & quality in long term care (LTC) settings. Activities include: quality assurance, Provider training & technical assistance, provider contract management, licensing & certification of LTC facilities & programs, policy development, protective services, community nursing, establishment of standards of care in adult foster homes, residential care facilities, assisted living & nursing facilities. In addition, the program provides senior and disability services through management & oversight of programs to seniors & people with disabilities, which include: in-home supports, Home Care Worker program, Oregon Project Independence (OPI), State Unit on Aging, Aged & Physically Disabled (APD) field services, case management, home care commission, rule & policy development, technical staff training. And lastly, the department provides oversight of Medicaid programs; program data & information; benefits to clients.

Krista Hughes is the Director of the Division of Aging and Adult Services in the Arkansas Department of Human Services. As Director, Ms. Hughes has focused on policy and programming initiatives to address the state's long-term care balancing efforts, including the Money Follows the Person grants. Ms. Hughes began her career in geriatric rehabilitation at the VA hospital in Little Rock, and has also worked in the for-profit senior retirement and assisted living industry.

Arkansas Department of Human Services, Division of Aging and Adult Services
The Arkansas Division of Aging and Adult Services (DAAS) is one of eleven divisions and four offices in the Department of Human Services (DHS). The Division of Aging and Adult Services is the agency of the state government designated by the governor and the state legislature as the focal point in all matters relating to the needs of older adults in Arkansas. The Division's mission is to promote the health, safety, and independence of the older Arkansas and adults with physical disabilities by working toward two primary goals: (1) to provide administrative support services for aging Arkansans and adults with physical disabilities; and (2) to enhance the quality of life for aging Arkansans and adults with physical disabilities that are authorized by both state and federal government. The Division also serves as an advocate for residents of nursing homes and provides protective services for individuals 18 years and older who are suffering from abuse, neglect, and/or exploitation.

Kevin Coughlin is the Director of the Bureau of Assisted Living at the Wisconsin Department of Health Services, Division of Quality Assurance. In this position Mr. Coughlin directs the licensing and certification of assisted living facilities, including community-based residential facilities, adult family homes, residential care apartment complexes, and adult day care programs. Mr. Coughlin was previously a Regional Field Operation Director in the Division of Quality Assurance and has also worked as a manager in an Assisted Living company.

Wisconsin Division of Quality Assurance
The Division of Quality Assurance (DQA) is responsible for assuring the safety, welfare and health of persons using health and community care provider services in Wisconsin. DQA regulates and licenses of over 40 different programs and facilities that provide health, long-term care, mental health/substance abuse services and caregiver background checks and investigations. Within DQA, the Bureau of Assisted Living (BAL) is responsible for licensing and surveying community based residential facilities, adult family homes, adult day care programs, and residential care apartment complexes.

Federal

Henry Claypool is the Director of the Office on Disability at the Department of Health and Human Services. Previously, Mr. Claypool served on Virginia's Health Reform Commission and as a Senior Advisor in the Social Security Administration's Office of Disability and Income Support Programs. Mr. Claypool has 25 years of professional and personal experience in the nation's health care system at the federal, state, and local level.

U.S. Department of Health and Human Services, Office of Disability
The Health and Human Services Office on Disability (OD) oversees the implementation and coordination of programs and policies that enhance the health and well-being of people with disabilities across all ages, races, and ethnicities. The Director of the Office advises the Secretary on disability policy issues. The mission of OD is to oversee the implementation and coordination of programs and policies that enhance the health and well being of people with disabilities. OD works directly with the agencies of the Department to facilitate policy development and to advance disability issues across agency and Departmental lines. Within its new mission, OD identifies opportunities to maximize and streamline processes that result in the elimination of inefficient or redundant efforts to serve Americans with disabilities. Efforts to fulfill OD's mission are organized around three themes: Improve Access to Community Living Services and Supports, Integrate Health Services and Social Supports, and Provide Strategic Support on Disability Matters.

Barbara Edwards is the Director of the Disabled and Elderly Health Programs Group in the Center for Medicaid, CHIP, and Survey & Certification at CMS. Ms. Edwards is a nationally recognized expert in Medicaid policy including managed care, cost containment, and long-term care. She served for eight years as the Ohio State Medicaid Director, where she led the implementation of Ohio's comprehensive strategy to promote access to home and community-based long-term services and supports.

U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Disabled and Elderly Health Programs Group
The Center for Medicaid, CHIP, and Survey & Certification is CMS' focal point for the formulation, implementation and evaluation of national program policies and operations relating to Medicaid, the Children's Health Insurance Program (CHIP), Survey & Certification, and the Clinical Laboratory Improvement Act (CLIA). The Center evaluates and assists State operations, develops and advances policy changes, assists in fraud prevention, and manages survey, certification, and enforcement programs for providers and suppliers. In addition, in conjunction with the Office of External Affairs and Beneficiary Services, the Center oversees CMS interactions and collaboration, relating to Medicaid and CHIP, with beneficiaries, States and key stakeholders (e.g., health care providers, other Federal government entities, local governments), and communication and dissemination of policies, guidance and materials to drive best practices for beneficiaries in States and throughout the health care industry.

Michael Vaughn is the Acting Director of Asset Management and Lender Relations for the Office of Residential Care Facilities at the Department of Housing and Urban Development. In this position, Mr. Vaughn has helped increase responsiveness, customer service and risk mitigation in Development (underwriting) and Servicing/Asset Management. Previously, Mr. Vaughn worked in finance in the private sector and as Chief Asset Officer of the Public Buildings Service at GSA.

U.S. Department of Housing and Urban Development, Office of Health Care Programs
The Office of Healthcare Programs (OHP), the successor to the Office of Insured Health Care Facilities, administers the Section 242 program (mortgage insurance for hospitals) and the Section 232 program (mortgage insurance for long-term care facilities). Since the Section 242 programs inception, nearly 400 mortgage insurance commitments (totaling $15.6 billion) have been issued for hospitals in 42 states and Puerto Rico. Since 1934, over 4,000 mortgage insurance commitments (totaling $16 billion) have been issued in all 50 states through the Section 232 program. The Office of Healthcare Programs is headed by the Deputy Assistant Secretary for Healthcare Programs. The Office of Residential Care Programs manages the Section 232 program. Staff members are located at Headquarters and out-stationed at a number of field locations. The office is comprised of three divisions: the Production Division, the Asset Management and Lender Relations Division, and the Policy and Risk Analysis Division.

Industry

Howie Groff is the President of Tealwood Care Centers, which operates more than 40 assisted living and nursing facilities across four states. As President, Mr. Groff is responsible for financial and operational issues as well as policy and business development. Mr. Groff is also the Immediate Past Chair of the National Center for Assisted Living (NCAL).

National Center for Assisted Living
The National Center for Assisted Living (NCAL) is the assisted living voice of the American Health Care Association (AHCA). NCAL is dedicated to serving the needs of the assisted living community through national advocacy, education, networking, professional development, and quality initiatives. NCAL's proactive, national focus on assisted living legislation is backed by the strongest and most influential long term care advocacy team in the country. NCAL members know that their voices will be heard by the national policymakers and regulators who continually seek to influence the future of assisted living. In addition to national advocacy, NCAL supports state-specific advocacy effort through its national federation of state affiliates. NCAL state affiliates work to create local education, advocate on behalf of assisted living providers, and provide the direct, ongoing support their assisted living members need to improve quality and grow their businesses.

Patricia Will is the Founder and CEO of Belmont Village Senior Living, a fully integrated developer and operator of Assisted Living communities with 19 facilities in six states. Before founding Belmont Village, Ms. Will worked in real estate and healthcare for more than 15 years. She is Chairman Emeritus of the American Seniors Housing Association (ASHA) and on the Board and Public Policy Committee of the California Assisted Living Association (CALA).

Belmont Village Senior Living
Belmont Village, L.P. is a fully integrated developer and operator of first-rate Assisted Living communities marketed under the name Belmont Village Senior Living. Headquartered in Houston, Texas, the Company operates 19 fully licensed communities (2,600 units) in California, Illinois, Texas, Georgia, Tennessee, and Kentucky. Belmont Village communities are designed for elder seniors who need assistance with daily living activities. The company's programs and services are supported by industry-leading best practices and research in the fields of gerontology, hospitality, architecture, and consumer preferences. Residents enjoy chef-prepared meals, housekeeping, transportation, social activities, and support from a well-trained staff including licensed nurses. Individuals with memory loss and Alzheimer's disease are supported by Belmont's proprietary programs, Circle of Friends® and Person-Centered Living®.

Brenda Bacon is President and CEO of Brandywine Senior Living, a company she co-founded in 1996 that currently serves 2,000 seniors in five states. Previously, Ms. Bacon was a senior advisor to New Jersey Governor Florio, and oversaw health care and human services reform efforts for the state. Ms. Bacon is Vice Chair of the Board of Directors of the Assisted Living Federation of America.

Brandywine Senior Living
Brandywine Senior Living is a premier provider of senior living services including independent, assisted living, and rehabilitation services throughout the East Coast. Located in 5 states (New Jersey, New York, Pennsylvania, Delaware and Connecticut), our company owns and operates 19 assisted living communities, and one small short-term skilled nursing unit within our Moorestown, New Jersey community. Our communities are branded as "Brandywine Assisted Living" or "Brandywine Senior Living", depending on whether the community is totally assisted living or offers additional senior living services such as independent living or skilled nursing care.

Advocates

Josh Allen is the President of the American Assisted Living Nurses Association (AALNA) and a Registered Nurse with over 15 years of industry experience. AALNA serves as a voice for Assisted Living nurses on issues related to resident care, nursing services, policy, and regulation. Mr. Allen also represents AALNA on the Coalition for Geriatric Nursing Organizations and as the chair of the Center for Excellence in Assisted Living.

American Assisted Living Nurses Association
The American Assisted Living Nurses Association (AALNA) is a professional nursing association representing assisted living registered nurses and licensed practical/vocational nurses. Our goal is to promote safe, effective, and dignified nursing practice in assisted living. With over one million older adults residing in assisted living communities and given the actual and potential increase in the nature and intensity of their health and personal care needs, the demand for licensed nurses in this domain is making assisted living one of the fastest growing segments in the nursing spectrum. AALNA was formed in June 2001 by a group of assisted living nurses and is still operated only by nurses currently practicing in the field. As a founding board member of the Center for Excellence in Assisted Living (CEAL), AALNA is a continuing voice for assisted living nursing.

Eric Carlson is Directing Attorney for the National Senior Citizens Law Center and has specialized in long-term care since 1990. In this position Mr. Carlson counsels other attorneys and co-counsels cases on behalf of consumers. Mr. Carlson is also the President of the Assisted Living Consumer Alliance, a national collaboration of groups and individuals who promote consumer rights and choices in assisted living.

National Senior Citizens Law Center
The National Senior Citizens Law Center is a non-profit organization whose principal mission is to protect the independence, well-being, and rights of low-income older adults and people with disabilities. NSCLC works for those without a voice in the nation's capital, in the states and in their communities. Through advocacy, litigation, and the education and counseling of local advocates, NSCLC seeks to ensure the health and economic security of those with limited income and resources, and access to the courts for all. Mr. Carlson also represents the Assisted Living Consumer Alliance, a national collaboration of groups and individuals working together to promote consumer safety, choice, and rights in assisted living. ALCA supports an improved quality of care, along with greater focus on consumers' needs and preferences.

Experts

Robert Jenkens is the Director of the Green House Project, an alternative to the institutional nursing home model that makes full use of Medicaid dollars and innovative designs to offer independence and dignity to residents. He is also Vice President at NCB Capital Impact, where he provides policy and development consulting to states and organizations interested in promoting quality assisted living. Prior to joining NCB Capital Impact, Jenkens was Real Estate Development Manager for Assisted Living Concepts, Inc.

NCB Capital Impact
NCB Capital Impact helps people and communities reach their highest potential at every stage of life. A national non-profit community development organization, NCB Capital Impact provides financial services and technical assistance to help make high quality health care, housing, and education more accessible and attainable, and eldercare more dignified and respectful. NCB Capital Impact partners with funders, policy makers, providers, and communities to deliver innovations that support an excellent quality of life for people with low-incomes through initiatives like The Coming Home Program for affordable assisted living and The Green House model of nursing home transformation.

Barbara Lyons is Senior Vice President of the Henry J. Kaiser Family Foundation and Director of the Kaiser Commission on Medicaid and the Uninsured, which serves as a policy institute and forum for analyzing health care access for low-income populations. Dr. Lyons previously served on the policy staff of the Commonwealth Fund Commission for Elderly People Living Alone. She also held a faculty appointment at the Johns Hopkins School of Hygiene and Public Health.

Kaiser Family Foundation
A leader in health policy and communications, the Kaiser Family Foundation is a non-profit, private operating foundation focusing on the major health care issues facing the U.S., as well as the U.S. role in global health policy. Unlike grant-making foundations, Kaiser develops and runs its own research and communications programs, sometimes in partnership with other non-profit research organizations or major media companies. We serve as a non-partisan source of facts, information, and analysis for policymakers, the media, the health care community, and the public. Our product is information, always provided free of charge — from the most sophisticated policy research, to basic facts and numbers, to information young people can use to improve their health or elderly people can use to understand their Medicare benefits.
The Kaiser Family Foundation is not associated with Kaiser Permanente or Kaiser Industries.

Martha Roherty is the Executive Director of the National Association of States United for Aging and Disabilities (NASUAD). She and her staff educate Congress, the Administration, advocacy groups, and the public on administrative, health, and social policy issues of concern to state officials. Prior to joining NASUAD, Ms. Roherty was director of the National Association of State Medicaid Directors.

National Association of States United for Aging and Disabilities

NASUAD represents the nation's 56 state and territorial agencies on aging and disabilities and supports visionary state leadership, the advancement of state systems innovation and the articulation of national policies that support home and community based services for older adults and individuals with disabilities. NASUAD's mission is to advance social, health and economic policies responsive to the needs of a diverse aging population and to enhance the capacity of its membership to promote the rights, dignity and independence of, and expand the opportunities and resources for, current and future generations of older persons, adults with disabilities and their families. NASUAD is the articulating force at the national level through which state agencies on aging join together to promote social policy in the public and private sectors responsive to the challenges and opportunities of an aging America.

Larry Polivka is the Executive Director of the Claude Pepper Center at Florida State University. Dr. Polivka served as Associate Director and Associate Professor at the School of Aging Studies at the University of South Florida, and was Director of the Florida Policy Center on Aging until 2009. Dr. Polivka's work compares costs and consumer outcomes of alternative long-term care services with a focus on in-home and assisted living programs, including analysis of managed care versus fee for service systems of financing and service delivery.

The Claude Pepper Center

The Claude Pepper Center is dedicated to preserving and enhancing the legacy of Senator Claude Pepper and his wife Mildred Pepper. Located on the main campus of Florida State University, the Center consists of the Pepper Library, Museum, State Data Center on Aging and the Center itself. In addition, the Pepper Institute on Aging and Public Policy is located within the Pepper Center building as are the offices of The Claude Pepper Foundation, Inc. Collectively, these organizations are focused on engaging in research and related activities which will improve the lives of Older Americans. Throughout his Congressional career, Senator Pepper tackled many significant public policy issues, but chief among them was improving the well being of Older Americans. The Pepper Center is devoted to the continued pursuit of this effort, chiefly through a team approach that brings to bear the critical resources of Florida State University and other organizations to the furtherance of this goal.

Charles Reed serves on the AARP board's Member and Social Impact Committee, and is chair of the AARP Insurance Trust. He is also a long-term care consultant with his firm, C.E. Reed and Associates. Previously Mr. Reed was the deputy secretary of the Washington State Department of Social and Health Services, the assistant secretary of Washington State Administration of Aging and Adult Services, the director of Washington State Bureau of Aging and Adult Services, and the director of Washington State Office on Aging.

AARP

AARP is a nonprofit, nonpartisan organization with a membership that helps people 50+ have independence, choice and control in ways that are beneficial and affordable to them and society as a whole. AARP does not endorse candidates for public office or make contributions to either political campaigns or candidates. We produce AARP The Magazine, the definitive voice for 50+ Americans and the world's largest-circulation magazine with over 35.1 million readers; AARP Bulletin, the go-to news source for AARP's millions of members and Americans 50+; AARP VIVA, the only bilingual U.S. publication dedicated exclusively to the 50+ Hispanic community; and our website, AARP.org. AARP Foundation is an affiliated charity that provides security, protection, and empowerment to older persons in need with support from thousands of volunteers, donors, and sponsors.

Questions from the Chairman

Quality and Oversight

1. **What are some of the leading state models with regard to consumer disclosure standards – e.g., of nursing staff availability and staff training, charges for services and for other (non-services) benefits, and protocols for individual assessment?**

***Christy Allen, Assistant Commissioner, Bureau of Health Licensure and Regulation, Tennessee Department of Health*:**

The Board's rules specifically require assisted care living facilities (ACLFs) to have a written statement of policies and procedures outlining the facility's responsibilities to its residents, any obligation residents have to the facility, and methods by which residents may file grievances and complaints. An ACLF must fully inform residents of their rights, of any policies and procedures governing resident conduct, of any services available in the ACLF and the schedule of all fees for any and all services. The ACLF must also ensure that each resident may participate in drawing up the terms of the admission agreement, including, but not limited to, providing for resident's preferences for physician care, hospitalization, nursing home care, acquisition of medication, emergency plans and funeral arrangements. Although each ACLF is required to have a responsible attendant at all times, a sufficient number of employees to meet the resident's needs, a licensed nurse available as needed, and a qualified dietitian (full-time, part-time, or consultant), there is no explicit requirement that this be disclosed to the resident. The ACLF is required to disclose whether it has liability insurance and the identity of the primary insurance carrier. If the ACLF is self-insured, its statement shall reflect that fact and indicate the corporate entity responsible for payment of any claims.

***Josh Allen, President, American Assisted Living Nurses Association*:**

Several states have implemented disclosure requirements with varying degrees of success. The Oregon Department of Human Services, for example, requires all assisted living communities to complete a Uniform Disclosure Statement. The document creates consistency in disclosure amongst providers, and addresses information regarding smoking, food services, assistance with activities of daily living, medications, health services, activities, transportation, housekeeping, deposits, fees, staffing, staff training, and discharge transfers.

A key element of the Oregon Uniform Disclosure Statement is that it recognizes that no disclosure document is perfect, and must be used as part of the process of evaluating and selecting an assisted living community. The second paragraph of the document states: "The Disclosure Statement is not intended to take the place of visiting the facility, talking with residents, or meeting one-on-one with facility staff. Please carefully review each facility's residency agreement/contract before making a decision."

***Brenda Bacon, President and CEO, Brandywine Senior Living*:**

Most Americans want to live in their homes as long as they are physically and mentally capable of doing so. When a senior can no longer or chooses to no longer live at home, there are many options available. To ensure a senior or family member is making the right decision, the Assisted Living Federation of America (ALFA) embraces "informed choice". This means that providers must fully disclose all information including services offered, pricing, limits of their services and other information that will help the individual make an informed choice about where they want to live.

There are a number of excellent state best practices in consumer disclosure. The best examples combine a disclosure form that is completed by every assisted living community and provided with a state-developed consumer education guide. The best disclosure forms clearly explain services, fees, conditions of move in and move out, the individualized assessment process, staffing patterns and training. The state developed consumer information guide explains how assisted living is licensed and regulated in that particular state, tips for choosing the right community, lists key resources for consumers such as the regulatory agency with oversight for assisted living, resident rights, and information on how to file complaints.

For example, Kentucky, Connecticut and New York among others have developed consumer information guides. The purpose of this information is to allow consumers to make an informed choice about the right community for themselves or a loved one.

The Agency for Health Care Research and Quality (AHRQ) is developing a common consumer disclosure document that when posted on line will be accessible to consumers to use when trying to select the right community for a loved one. ALFA has been part of the workgroup developing this tool.

As a service to the public, ALFA provides consumer-friendly materials and check lists to help guide consumers as they search for the right assisted living community to call home. We also offer a web-based community directory to assist seniors and families in locating and visiting communities. While these tools are excellent resources to help with the decision-making, they are only one piece of the process; consumers are always urged to visit a community, talk with residents and staff, and to be fully informed before making a decision – like anyone should when making a substantial and important investment or purchase.

***Eric Carlson, Directing Attorney, National Senior Citizen's Law Center*:**

A number of states have developed disclosure forms which provide consumers with a range of information. Two examples of forms are the forms used by Texas and Washington. *See* Texas Assisted Living Disclosure Statement, Form 3647, www.dads.state.tx.us/forms/3647/3647.pdf; Washington Disclosure of Services, DSHS 10-351, www.dshs.wa.gov/pdf/ms/forms/10_351.pdf. Each of these forms provides some helpful information, although each also has significant limitations.

Disclosure should include information such as the following:

- Overview of state requirements for levels of care and mandatory services.
- Assessment and care planning procedures.
- Detailed information on services provided in areas such as
    - Nursing care.
    - Personal care.
    - Dementia care.
    - Dietary services.
    - Medication administration and other assistance with medication.
    - Transportation.
    - Resident Activities.
- Staff training levels.
- Staffing patterns, including ratio of direct-care staff members to residents. (The last page of the Texas disclosure form contains a table of Shift Times and Staffing Patterns at the Facility.)
- Criteria for involuntary transfer or discharge, and any appeal rights that the resident may have.
- Certification for Medicaid, or lack thereof.
- Services included in the facility's base rate.
- Charges for any services not included in the facility's base rate.
- Room hold policies during hospitalizations.
- Deposits, and refund provisions related to deposits.

Although disclosure forms can be helpful to consumers searching for an assisted living facility, disclosure cannot substitute for legal standards. When looking for a long-term care facility, consumers generally are not prepared to distinguish between different facilities in this way, due to unfamiliarity with the relevant issues, and to the stress and time pressure that often accompany a search.

Of course, all disclosure items must be consistent with state licensure standards and any other legal standards.

***Kevin Coughlin, Director, Wisconsin Bureau of Assisted Living*:**

Wisconsin does not have a "consumer disclosure standard" that is used as a template for all licensed assisted living communities but does have similar requirements that must be disclosed in the admission agreement. Texas, Oregon, Maryland, Washington are states that currently have good disclosure agreements. Also there has been work done collaboratively with the Assisted Living Disclosure Collaborative (ALDC) which can be found at: http://www.ahrq.gov/research/aldc.htm.

However, Wisconsin statutes define a "right to know" that is granted to nursing home residents and prospective residents, including staffing information, identification of administrative leadership, and the facility's record of regulatory citations for these facilities. No similar requirement exists for assisted living facilities relating to staffing. Regulatory activity, including the facility's license, any statement of regulatory deficiency, any notice of revocation and any other notice of enforcement action must be posted within the facility in a prominent location. All regulated facilities in Wisconsin are required to disclose information relating to the schedule of

charges and services that are available at extra cost at the time of admission. Facilities are required to provide screening for communicable diseases that supplement a required clinical assessment done by a professional for the purpose of identifying active disease within a defined period after admission. Facilities are further required to use U.S. Centers for Disease Control and Prevention (CDC) protocols.

***Howard Groff, President, Tealwood Care Centers*:**

Almost all states require specified information in residency agreements. A 2007 report by the U.S. Department of Health and Human Services (HHS) noted the following state disclosure requirements within residency agreements:

- Services included in basic rates – required by 49 states.
- Cost of service package – 44 states.
- Rate changes – 30 states.
- Refund policy – 30 states.
- Cost of additional services – 28 states.
- Admission/discharge information – 28 states.

(See U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation, "Assisted Living and Residential Care Policy Compendium, 2007 Update," by Robert Mollica and Kristin Sims-Kastelein of the National Academy for State Health Policy.) States continue adding to disclosure requirements and are placing more information on their web sites concerning assisted living facilities.

Minnesota is a leader in providing information to consumers, which they can access prior to visiting any assisted living sites either on the Minnesota Department of Health web site at http://www.health.state.mn.us/divs/fpc/profinfo/lic/lichws.htm (Uniform Consumer Information Guide) or on MinnesotaHelp.org.

The U.S. Agency for HealthCare Research & Quality (AHRQ) is currently developing a tool designed to help consumers compare one assisted living community with another. Researchers and experts developing the tool consulted with a wide range of stakeholders and examined several state disclosure tools as models in developing this tool. AHRQ is field testing the disclosure tool this year. When finished, AHRQ will make the tool available to states and other entities for use.

The National Center for Assisted Living (NCAL) publishes *Assisted Living State Regulatory Review* on an annual basis. This report summarizes state regulations in several categories including the licensure term, definition, disclosure rules, facility scope of care, third party scope of care, move-in/move-out requirements, resident assessment, medication management, physical plant requirements, residents allowed per room, bathroom requirements, life safety, Alzheimer's unit requirements, staff training for Alzheimer's care, staffing requirements, administrator education/training requirements, staff education/training requirements, continuing education requirements, and Medicaid coverage. These rules have evolved steadily as have the many other aspects of assisted living that states regulate that are not within the scope of the report. Available

at www.ncal.org, NCAL's 2011 *Regulatory Review* provides a state-by-state comparison of staffing and staff training requirements. Each state's resident assessment requirements can be viewed in the *Regulatory Review.*

With regard to protocols for assessments in my home state, Minnesota last year implemented a uniform assessment tool for purposes of determining payment for "Customized Living."

***Krista Hughes, Director, Division of Aging and Adult Services, Arkansas Department of Health and Human Services*:**

Disclosure statements help consumers understand a range of issues that vary by facility within a State. Arkansas law requires disclosure to any person prior to signing an agreement for ALFs and RCFs. Ark. Code Ann. § 20-10-109 states:

Disclosure statement for Arkansas residential care and assisted living facilities.

(a) Each residential care and assisted living facility shall provide each prospective resident or prospective resident's representative with a comprehensive consumer disclosure statement before the prospective resident signs an admission agreement.

(b) The disclosure statement shall include, but not be limited to:

(1) Proof of current licensure through the Office of Long-Term Care;

(2) A list of services provided by the facility, including, but not limited to:

(A) Any medication administration, assistance taking medication, or reminders to take medication that the facility may by law or regulation provide;

(B) Any assistance the facility provides with activities of daily living, such as grooming, toileting, ambulation, and bathing;

(C) The availability of transportation; and

(D) Social activities inside and outside the facility;

(3) Staffing levels or ratios required by law, including, but not limited to, those concerning:

(A) Registered nurses;

(B) Licensed nurses;

(C) Certified nurse's aides or assistants; and

(D) Other staff;

(4) Whether staff members are required to be awake while on duty and, if not, the times when they may be asleep; and

(5) Information regarding the physical plant of the facility, including, but not limited to:

(A) Whether the facility has an emergency generator and, if so, the areas of the facility powered by a generator and the length of time the generator will provide power;

(B) Whether the facility has sprinklers and, if so, the areas of the facility that have sprinklers;

(C) Whether the facility has smoke detectors and, if so, the areas in which smoke detectors are located; and

(D) (i) Whether the facility has an emergency evacuation plan.

(ii) If the facility has an emergency evacuation plan, a copy of the plan shall be provided to each prospective resident or the prospective resident's representative before the signing of an admission agreement.

(c) The facility shall update its disclosure statement no less than annually.

Arkansas regulations for Assisted Living Level I, Section 806.a.2 require that "Prior to admission into the Alzheimer's Special Care Unit, the facility shall provide a copy of the disclosure statement and Residents' Rights policy to the applicant or the applicant's responsible party. A copy of the disclosure statement signed by the resident or the resident's responsible party shall be kept in the resident's file."

Arkansas regulations for Assisted Living Level I and II, Section 800.j, require the facility to have a Disclosure Statement. "A written statement prepared by the facility and provided to individuals or their responsible parties, and to individuals families, prior to admission to the unit, disclosing form of care, treatment, and related services especially applicable or suitable for the Alzheimer's Special Care Unit (ASCU). The disclosure statement shall be approved by the Department prior to use, and shall include, but not be limited to, the following information about the facility's ASCU:

1. The philosophy of how care and services are provided to the residents;
2. The pre-admission screening process;
3. The admission, discharge and transfer criteria and procedures;
4. Training topics, amount of training time spent on each topic, and the name and qualification of the individuals used to train the direct care staff;
5. The minimum number of direct care staff assigned to the unit each shift;
6. A copy of the Resident's Rights;
7. Assessment, Individual Support Plan & Implementation. The process used for assessment and establishment of the plan of care evolves and is responsive to changes in condition;
8. Planning and implementation of therapeutic activities and the methods used for monitoring; and

9. Identification of what stages of Alzheimer's or related dementia for which the unit will provide care."

***Larry Polivka, Executive Director, Claude Pepper Center*:**

There are minimum statutory requirements that must be addressed in the contract (i.e., license type, termination policies, fees, services provided, refund policies, bed hold policy, etc.) Each state has set minimum requirements and this should remain at the state level to maintain the flexibility to meet the needs of the seniors.

***Charley Reed, Member, Board of Directors, AARP*:**

Consumers and their families must have the information they need to make informed decisions about which assisted living residence may be right for them and best meet their needs. Texas requires assisted living facilities to provide prospective residents with a consumer disclosure statement in a standard format approved by the state. A 2006 report[1] notes that disclosure forms in New Hampshire, Oregon, and Texas include sections on staffing patterns.

Of note, the Assisted Living Disclosure Collaborative (ALDC) – a collaboration of the Agency for Healthcare Research and Quality (AHRQ), the Center for Excellence in Assisted Living (CEAL), and other stakeholders – is working through a voluntary consensus process to develop "uniform consensus information (data items and definitions) that can be used to describe the services and characteristics of individual AL residences."[2] The ALDC is working to develop uniform data items and definitions in the following areas: services and costs of care; staffing, staff training, and turnover; move-in/move-out criteria and resident rights; house rules; life safety; and dementia-specific services. The results of this work could serve as a model that states could adopt to provide consumers the information they need to compare assisted living residences and select the one that best meets their individual needs and preferences.

***Julie Strauss, Office of Licensing and Quality of Care, Seniors and People with Disabilities Division, Oregon Department of Human Services*:**

Oregon has well developed disclosure standards, including a universal disclosure statement used by all ALF/RCF facilities and additional requirements to be found in the resident agreement, such as occupancy requirements, payment agreement and resident rights (Oregon Administrative Rule [OAR] 411-054-0019(10)).

***Patricia Will, CEO, Belmont Village Senior Living*:**

There are several states, such as Florida, Kansas, Maine, Maryland, Massachusetts, New Hampshire, North Carolina, and Wisconsin that are leading models for consumer disclosure. These states among others require detailed disclosure regarding resident assessments, charges for services, grievance procedures, staffing, training, resident obligations, resident rights, etc. Maryland, for example, requires all assisted living providers to complete an Assisted Living

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[1] *Residential Care and Assisted Living: State Oversight Practices and State Information Available to Consumers*. AHRQ Publication No. 06-M051-EF, September 2006. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/research/residentcare/

[2] *Assisted Living Disclosure Collaborative (ALDC)*. November 2008. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/research/aldc.htm

Disclosure Form, which must be included with all marketing materials and made available to consumers upon request. Oregon, Texas, and Washington as well as other states also use standardized disclosure forms to describe their scope of services, rate structure, and staffing levels. Wisconsin requires that the qualifications of staff be included in the agreement as well as whether services are provided directly by the community's staff or under contract by an outside entity. Many states also have rules regarding the format of residency agreements specifically requiring that agreements be written in clear and precise language in 12 point type.

Importantly, all 50 states and the District of Columbia post links to their licensing regulations and statutes. States also post information to assist consumers and family members to determine whether residential care can meet their needs and compare service offerings at various communities.

In addition to standardized state consumer disclosure forms, there are a number of national and state trade associations that make available consumer checklist guides with detailed questions to ask when considering assisted living. Assisted living consumer checklists are posted on several national and state association websites (i.e. www.seniorshousing.org, www.ncal.org, www.alfa.org, www.leadingage.org) as well as consumer advocacy organization websites (i.e. www.aarp.org, www.ccal.org).

Finally, it is important to note that while consumer disclosure is very important in the decision-making process, there is no substitute for touring assisted living communities and getting a first-hand look at the overall operation. Observing personal interactions between staff and residents and talking directly to existing residents and staff about their level of satisfaction and candid thoughts about the community operation is invaluable in the overall decision-making process.

2. **What are the essential services, the core philosophy, and other key characteristics of assisted living that allow residents to have independence, privacy, autonomy and choice? Are there ways of defining assisted living in a way that meet the needs and preferences of all populations that are eligible for Medicaid home and community-based services (HCBS)?**

***Christy Allen, Assistant Commissioner, Bureau of Health Licensure and Regulation, Tennessee Department of Health*:**

The Board's adopted core philosophy of assisted living is to promote the availability of appropriate residential facilities for the elderly and adults with disabilities in the least restrictive and most homelike environment; promote assisted care living services to residents in facilities by meeting each individual's medical and other needs safely and effectively; and enhance the individual's ability to age in place while promoting personal individuality, respect, independence and privacy. The Board's rules set out a number of resident rights the ACLF must afford, all of which suggest resident independence to the greatest extent possible. Some of these rights include freedom to voice grievances and recommend change, participation in the development of the terms of the admission agreement, full management of his/her personal financial affairs (with stringent requirements imposed on the ACLF should the resident seek assistance in managing his/her personal financial affairs), to participate, or to refuse to participate, in any community

activities, and to have free access to the common areas of the ACLF and to and from the ACLF itself.

***Josh Allen, President, American Assisted Living Nurses Association*:**

Assisted living is a consumer-directed model of care. Rather than designing and delivering housing and services in a "cookie-cutter" approach that responds to a federal mandate, assisted living listens to and reacts to what the consumer is asking for. This can be seen in newer assisted living developments that are designed from the ground up with wireless Internet connections through the community, and existing communities that are adding "Internet" cafes to the common spaces. It is also seen in the delivery of care in a way that is more private and respectful of the wishes of the individual. For example, rather than pushing a large hospital-like medication cart into a dining room where the delivery of medications is on display for all to see, assisted living nurses instruct their staff to deliver medications in the privacy of the resident's room or apartment, or to discretely bring them to the dining room in an individual medication container if necessary or have them stop by the "Wellness Center" to pick up and take their medications in privacy.

Independence and choice are the watch words of most, if not all, of the training modules available in the assisted living industry. Policies, procedures, and training are based on the encouragement of the resident to continue to participate in their care the fullest extent physically and cognitively possible and to foster wellness at all times.

***Brenda Bacon, President and CEO, Brandywine Senior Living*:**

The guiding philosophy embraced by the members of the Assisted Living Federation of America is to ensure choice, independence, dignity and quality of life for all seniors. Virtually every state regulatory framework embodies this guiding philosophy.

Professionally-managed assisted living communities are either purpose-designed and built or modified from existing infrastructure to offer privacy, comfort, and home-inspired environments for seniors. The variety of settings, care offerings, and residences can range from convenient high-rise apartments near metropolitan centers to converted Victorian homes, to campus communities with all the charms of a small town. Most assisted living communities have between 25 and 120 rooms varying in size. Amenities in an assisted living community typically include:

- Three meals a day served in a common dining area
- Housekeeping services
- Transportation
- 24-hour security
- Exercise and wellness programs
- Personal laundry services
- Social and recreational activities

Care and access to wellness services at an assisted living community are typically based on an initial assessment of a resident upon move-in that results in an individualized service plan.

These plans are modified on a regularly scheduled basis to address any changes in the resident's individual needs and preferences. Care typically includes:

- Staff available to respond to both scheduled and unscheduled needs,
- Assistance with eating, bathing, dressing, toileting, walking and other activities of daily living
- Access to health and medical services, such as physical therapy and hospice,
- Emergency call systems for each resident's apartment,
- Medication management,
- Care for residents with cognitive impairments in a specially designed section of the community

Inherently, a one-size fits all definition of assisted living is inconsistent with the assisted living philosophy of care and service to seniors. Each individual senior has different needs and desires. While assisted living is a popular residential alternative to institutional care that has been embraced by elderly consumers, it is the consumer that defines assisted living. To try to identify assisted living in a way that would encompass other populations eligible for home and community based waivers such as OMRDD or younger disabled would compromise the quality of life and quality of care for all of these groups. Younger disabled consumers, OMRDD, and frail seniors may all need assistance with activities of daily living but there will be different needs for each population and for each individual within that population. (NOTE: Please see attached comments ALFA sent to CMS on this issue in 2009)

***Eric Carlson, Directing Attorney, National Senior Citizen's Law Center*:**

Private occupancy is the most important characteristic. Also, the unit or room should be a specific physical space owned or rented by the person receiving services, with this person having at a minimum the same protections from eviction that the state's tenants have under landlord/tenant law. Residents should have the freedom to furnish and decorate their own units.

Residents should have the freedom and support to control their own schedules and activities, and have access to food at any time. Residents also should be able to have visitors of their choosing at any time.

A facility should be responsible for making reasonable accommodations for a resident's needs. A facility's scheduling should be driven by residents' needs rather than by the convenience of the facility or its staff members.

A facility's services should facilitate residents' engagement with and participation in the community. Residents should be provided with necessary transportation to access services and activities in the community.

Currently the term "assisted living" is used in confusing ways to refer to everything from facilities that provide little more than room and board to those that provide around-the-clock nursing care. More definitional clarity and precision are needed, addressing both resident autonomy and care standards. For purposes of facilities that provide care under Medicaid HCBS waivers, assisted living should be defined to ensure care standards that will be adequate for residents whose care needs would warrant nursing facility care.

Definitions should be written with specificity as to resident rights and facility requirements. It is not enough to list a particular philosophy of care—the definition must be substantive and specific enough to ensure that a philosophy will be actualized and enforceable.

***Irene Collins, Commissioner, Alabama Department of Senior Services*:**

The resident should have the decision making control, with person centered services for the individual. The facility should offer quality services and activities. They should also be up front with all costs associated with basic and extended services. The rights for privacy and independence as well as a quality environment should be in place.

***Kevin Coughlin, Director, Wisconsin Bureau of Assisted Living*:**

Key characteristics in assisted living are that these communities must be a "home" with physical characteristics that are as home-like as possible, and fully accessible. They must be able to offer or arrange *supportive services* (meals, housekeeping, laundry service and arranging access to medical services); *personal services* (daily assistance with all activities of daily living which include dressing, eating, bathing, grooming, toileting, transferring and ambulation or mobility); and some *nursing services* (health monitoring, medication administration and medication management) that will be able to serve an elderly, frail, and disabled population that may have growing health concerns. Independence, privacy, autonomy and choice needs to be at the core of the state statutes and administrative codes and to have a robust resident rights section supporting these concepts in the regulations.

In general, Wisconsin law requires an assisted living facility to provide care and services in a manner designed to encourage the resident to move toward functional independence in daily living or to maintain independent functioning to the highest possible extent. These requirements require consideration of each resident's unique needs and preferences in order to achieve the individual's indentified goals.

***Howard Groff, President, Tealwood Care Centers*:**

About one million Americans reside in assisted living facilities, including about 131,000 receiving assistance under the Medicaid program. Assisted living is a growing and dynamic form of residential care, serving primarily elderly people and individuals with disabilities. Assisted living is more than a physical setting – it embraces a philosophy of care. Created in response to customer preferences and demand for individual-centered care, assisted living residences provide assistance with physical activities and health-related needs. They also strive to meet the social, emotional, cultural, intellectual, and spiritual well-being of residents.

Assisted living has evolved into a variety of models based on consumer preferences and regional differences. As a result, states take a variety of approaches in overseeing the industry and establishing standards. While assisted living is the most common term used in the nation both by the industry and state regulatory agencies, assisted living settings may be known by different names, including, but not limited to, residential care, personal care, adult congregate care, boarding homes, and domiciliary care. Regardless of what they are called, assisted living communities typically are:

- Congregate residential settings that provide or coordinate personal services, 24-hour supervision and assistance (scheduled and unscheduled), activities and health-related services, and include at least one awake staff member at all times;
- Designed to minimize the need to move;
- Designed to accommodate individual residents' changing needs and preferences;
- Designed to maximize residents' dignity, autonomy, privacy, socialization, independence, choice, and safety;
- Designed to encourage family and community involvement; and
- Settings that provide assistance in maintaining and enhancing the physical, emotional, intellectual, social, and spiritual well-being of residents based on their preferences.

Assisted living also encourages:

- The personal development of residents, on an individual basis;
- Physical activity that maintains and enhances fitness;
- Family and community involvement; and
- Development of positive relationships among residents, staff, families, and the community.

(See "NCAL's Guiding Principles for Assisted Living," available at http://www.ahcancal.org/ncal/about/Documents/GPAssistedLiving.pdf.)

While the resident-centered philosophy of assisted living is applicable to all types of residents, economic restraints present some limitations for low-income populations. For example, as discussed in greater detail below, the Medicaid program does not cover the cost of room and board, which is typically 40-50% of the cost of assisted living and Medicaid payment for services is typically below market rates. In part because of this economic constraint, 40 states allow units occupied by Medicaid beneficiaries to be shared. Since privacy is a key component of assisted living, most of these states require that residents receiving Medicaid services agree to share a unit and the person they share it with. While some argue that sharing a unit or room diminishes the assisted living philosophy, the economic reality of the way the system is currently structured and the scarce resources states have both demand that we remain flexible to keep the assisted living option available to Medicaid beneficiaries who choose that option.

***Krista Hughes, Director, Division of Aging and Adult Services, Arkansas Department of Health and Human Services*:**

Arkansas Assisted Living Level II Regulations, Section 200 - Purpose:

"The purpose of these rules and regulations is to establish standards for Level II assisted living facilities that provide services in a homelike environment for elderly and disabled persons. Level II assisted living facilities ensure that residents receive supportive health and social services as they are needed to enable them to maintain their individuality, privacy, dignity, and independence, in the highest degree possible in an apartment-style living unit. The assisted living environment actively encourages and supports these values through effective methods of service delivery and facility or program operation. The environment promotes resident self-direction and personal decision making while protecting resident's health and safety."

Assisted Living in Arkansas provides an apartment with an individual lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the

individual or the individual's family has domain and control. Choice is specifically referenced in the regulations and defined under Section 300 as, "viable options available to a resident that enables the resident to exercise greater control over his or her life. Choice is supported by resident's self-directed care (including methods and scheduling) established through the care planning process, and the provision of sufficient private and common space within the facility to provide opportunities for residents to select when and how to spend time, and when and how to receive personal and assisted living services."

Level II assisted living facilities provide private and semi-private (semi-private units are available for those who choose this arrangement) apartment style units that have separate bathroom and kitchenette areas. Residents are provided with keys to their apartment units; have unlimited access into and from the facility (residents are free to come and go as they please); have private mail boxes; have the right to have pets; have the right to eat meals at the facility dining room, eat meals prepared by the facility in their apartment, to prepare their own meals in their apartment, have meals delivered into the facility or to dine out; have the right to choose private health care providers if needed; and, have the right to unrestricted visitation.

Essential, or core, services that the assisted living facility shall provide include, but are not limited to:

a. 24-Hour Staff. The phrase 24-hour staff does not require continuous, uninterrupted visual monitoring, and does not place any responsibility with the facility for the conduct of a resident who is away from the facility. This definition does not mean, and is not intended to imply, that a facility is not responsible for any resident who has eloped, as that term is defined in the regulations;
b. Assistance in obtaining emergency care 24-hours a day;
c. Assistance with social, recreational and other activities;
d. Assistance with transportation (this does not include the provision of transportation);
e. Linen service;
f. 3 meals a day.

Robert Jenkens, Director – The Green House Project, NCB Capital Impact:

Assisted living's core philosophy – person-directed care – requires equal commitment by providers to transforming the environment and the operations typically found in long-term care. Too often, assisted living has been implemented as primarily an environmental upgrade (e.g., less institutional appearance, elimination of nurses' stations, private rooms or apartments). These physical changes form a necessary foundation for person-directed care and its capacity to deliver real and full independence, privacy, autonomy, and choice. This is especially true in regard to providing private rooms.

However, these physical upgrades are not sufficient. In fact, they are less than 50% of the effort required to operationalize person-directed care. The hardest work is redesigning service and organizational structures to enable support staff to get to know residents well and operate with significant flexibility in order to be truly able to respond to the person's needs and preferences. Many assisted living projects have achieved this physical and operational/organizational standard and many have not. Fortunately, we are learning how to do this effectively and consistently through evolving "culture change" practices and the work of organizations like the Center for

Excellence in Assisted Living (CEAL) who is documenting and distributing best practices in this area. Defining a set of person-center outcomes for assisted living and implementing an effective, stakeholder-led accountability system would be a significant contribution to consistently achieving the consumer, provider, and policy-maker goals that gave birth to the assisted living movement.

Barbara Lyons, Senior Vice President – Kaiser Family Foundation, Director – Kaiser Commission on Medicaid and the Uninsured:

Assisted living is a state regulated and monitored residential long-term care option that combines housing, health and other support services for seniors needing long-term services and supports. It offers many of the same protections available in nursing facilities at lower cost, with a more resident-centered service plan, and with less supervision. No single definition of assisted living exists, but the most common elements of assisted living include:

- Access to health care and medical services customized to specific needs,
- 24-hour emergency call systems for each resident,
- Housekeeping, laundry services, and three meals a day,
- Assistance with eating, bathing, dressing, toileting, and walking as needed,
- Staff available to provide 24-hour assistance to meet scheduled and unscheduled needs,
- Transportation available to residents.

The philosophy of assisted living rests heavily on principles of consumer direction which is a growing trend in Medicaid HCBS. Residents of assisted living facilities have the right to make choices and receive services in a way that promotes dignity, autonomy, independence, and quality of life. Services are disclosed and agreed to in the contract between the provider and the resident. On account of the independent living and disability rights movements and state efforts to rebalance Medicaid long-term care spending, these same principles of consumer direction are being utilized in Medicaid HCBS waivers today. Consumer direction was allowed or required in most waiver states, with 37 waiver states (76 percent) allowing or requiring consumer direction in at least some of their waivers in 2009.[i] Consumer direction in Medicaid includes initiatives such as consumer choice in the allocation of service budgets or the hiring and firing of service providers. Because of the unique health and support needs of Medicaid beneficiaries with disabilities, not all Medicaid beneficiaries choose to direct their own services but for those who do consider this option, consumer direction calls for a flexible approach to arranging health care and support services.

Larry Polivka, Executive Director, Claude Pepper Center:

The core philosophy of assisted living is independence, choice and dignity. Assisted living is just that – 'assistance' with activities of daily living. Residents are encouraged to be as independent as possible and 'assistance' is provided with some of the basic functions. Payment source should not be considered when providing resident care. However, we must be mindful that assisted living is a primarily private pay industry and to maintain their viability in the market HCBS reimbursement should be adequate to cover the services that are expected. The regulations should remain sufficiently flexible to allow the administrator to assess the resident and determine if the resident is appropriate for that ALF setting considering the above. Florida

has a health care assessment tool to use as guidance in determining appropriateness of placement in an ALF.

Charley Reed, Member, Board of Directors, AARP:

The philosophy of assisted living should maximize the ability to age in place, maximize autonomy, privacy, independence, choice, control, dignity, and quality of life, including providing private living units, as outlined below. A 2007 compendium on residential care and assisted living[3] noted that 29 states and the District of Columbia include provisions on assisted living concepts such as privacy, autonomy, and decision making in their regulations or Medicaid standards.

AARP believes states should define "assisted living" as supportive housing with:

- a residential setting that provides or coordinates flexible personal care services, 24-hour supervision, assistance (scheduled and unscheduled) with activities of daily living, and health-related services that meet individual needs and preferences;
- a services program and physical environment designed for aging in place (that is, the facilities minimize the need for residents to move within or from the setting to accommodate their changing needs and preferences);
- an organizational mission, a service program, and a physical environment designed to maximize residents' dignity, autonomy, privacy, and independence;
- a process for legitimate negotiated risk agreements between facilities and residents, allowing residents to enhance their autonomy and independence and providers to maintain a safe and appropriate environment; and
- private living units—with sleeping, living and food preparation areas, storage facilities, and a bathroom—shared only at the resident's request.

Another important definition of assisted living was developed by the Assisted Living Workgroup (ALW), which came out of the Senate Special Committee on Aging's work a decade ago. The ALW defined assisted living as follows:

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

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

[3] Residential Care and Assisted Living Compendium: 2007. Robert Mollica and Kristin Sims-Kastelein, National Academy for State Health Policy and Janet O'Keefe, RTI International. September, 30, 2007. U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. http://aspe.hhs.gov/daltcp/reports/2007/07alcom.htm.

- Recreational activities
- Transportation and social services

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

All individuals, including those who receive Medicaid home and community-based services, should have access to a full array of services, supports, and settings to meet their individual unique needs and preferences. A truly person and family centered approach to services and supports demands this. Assisted living is one of those settings that provides services and supports and should be available to individuals, including those receiving Medicaid HCBS. The most important service, support, or setting is the one that meets the very different needs and preferences of each individual consumer. No one size fits all, which is why having a full array of options available to meet individual needs and preferences is important.

***Martha Roherty, Executive Director, National Association of States United for Aging and Disabilities (NASUAD)*:**

There is tremendous variation among state assisted living definitions, therefore any federal definition must be broad enough to address the array of state models including housing with services, small assisted living facilities structured similarly to Adult Foster care, as well as larger settings. Components of the definition should address: autonomy, choice, privacy and dignity of residents. The Core Principles for Assisted Living included the April 2003 report to the U.S. Special Committee on Aging also would be useful components of a federal framework for a definition that states, in turn, could tailor to their unique service environments.

***Julie Strauss, Office of Licensing and Quality of Care, Seniors and People with Disabilities Division, Oregon Department of Human Services*:**

In Oregon, we have identified the essential services to include three daily nutritious meals, services to assist performing all activities of daily living on a 24 hour basis, medication administration, and others (OAR 411-054-0030). The core philosophy promotes resident self-direction and participation in decisions that emphasize choice, dignity, independence, and individuality in a safe and secure environment.

***Patricia Will, CEO, Belmont Village Senior Living*:**

The essence of assisted living is defined by a philosophy of care that supports "aging in place" through a broad array of health-related and supportive services that emphasize resident self-direction and participation in decisions that promote choice, dignity, privacy, and individuality. Residents of assisted living receive assistance with activities of daily living, (i.e. bathing, dressing, toileting) and, as permitted by state regulation, intermittent nursing level services. Additional services include three meals a day with a range of menu options and a complement of activity and community outreach programs.

For millions of frail seniors, assisted living has evolved into a highly supportive residential living environment that most have come to think of as "home." The evolution in assisted living has occurred over the course of many decades through ongoing collaboration with many stakeholders at the state and local level, including policymakers, providers and consumer advocacy groups. And through this collaborative process, assisted living regulations have developed into various models. And while these regulatory models may vary from state to state, they all share a common vision of assisted living—to provide a residential long term care model that, at its core, respects the privacy rights of seniors and their right to make choices that impact their daily lives.

Given the decades-long investment by state and local stakeholders across this country in helping to shape the future of assisted living, it would be a great disservice to the nation's seniors for the federal government to redefine assisted living in ways that could fundamentally alter highly successful state models of assisted living. Strong consumer demand for assisted living has emerged over the years, because state models of assisted living embrace the diverse needs of seniors who want to live in a highly dignified residential living environment that promotes aging in place and decision-making that emphasizes personal choice, dignity, autonomy, and privacy.

3. **Are there ways that states have developed to balance ensuring quality of assisted living services under Medicaid, while not treating it differently from other home and community-based services? What is the role of state oversight in this regard?**

***Christy Allen, Assistant Commissioner, Bureau of Health Licensure and Regulation, Tennessee Department of Health*:**

As a regulatory matter, there is no distinction made among residents receiving Medicaid, other home and community-based services, and private pay. The state's role is to ensure an ACLF's compliance with all applicable laws and rules in providing services to all of its residents.

***Brenda Bacon, President and CEO, Brandywine Senior Living*:**

Assisted living is regulated in all 50 states. While the consumers we serve are predominately private pay (83%) there is a small percentage (10%) of Medicaid residents, with the remainder utilizing long term care insurance. State regulators /regulations do not differentiate between private pay and Medicaid residents. The same quality of care, quality of life is required regardless of payment source. In fact, state regulators performing their annual inspections do not even know which residents are private pay and which are Medicaid. It does not make a difference and the same high standards are enforced for all residents.

***Eric Carlson, Directing Attorney, National Senior Citizen's Law Center*:**

We believe that Medicaid programs *should* treat assisted living facilities differently than the programs treat other providers of home and community-based services. Assisted living facilities provide around-the-clock care along with housing, meals, and other services. An assisted living facility is far different from (for example) a personal care provider who assists a Medicaid beneficiary for a few hours daily in the beneficiary's own home.

Currently, in most cases, certification of a facility for Medicaid participation under an HCBS waiver does not change the relevant quality of care standards for that facility in any significant

way. In the HCBS Waiver Application submitted by states, Appendix G lists participant safeguards and Appendix H lists the state's Quality Management Strategy. Appendix G concerns itself with only three limited areas: State Response to Critical Events or Incidents, Safeguards Concerning Restraints and Restrictive Interventions, and Medication Management and Administration. For these areas, a state generally refers to the state's existing licensure standards, without establishing any additional standards. Appendix H also does not include any quality standards, and instead has states lay out a system of data collection, analysis, and remediation.

By definition, HCBS waiver services are provided only to persons who have care needs that would qualify them for nursing facility admission. Given these increased care needs, and the significant amount of federal money spent on HCBS in assisted living facilities, it would be appropriate for CMS at a minimum to establish some limited standards for Medicaid-funded assisted living care.

***Kevin Coughlin, Director, Wisconsin Bureau of Assisted Living*:**

All assisted living facilities are licensed and regulated regardless of whether they are taking "private pay" or "Medicaid recipients." Wisconsin does not distinguish between different forms of payment for services in the regulatory treatment of service providers. A provider is examined for compliance with regulatory requirements based on its license category and not on its source of reimbursement. Additionally, clients who are receiving public funds have additional oversight by the state Medicaid program or the agency with which they contract. Wisconsin does a great job of collaborating between state agencies for regulation of assisted living and for Medicaid. For example, regulatory inspection reports are shared with the Medicaid program. The contract between the Wisconsin Division of Long Term Care for the Medicaid waiver program with CMS includes collaboration with the state regulatory agency to ensure that quality care is provided to Medicaid recipients. With this dual role of oversight, Wisconsin is experiencing significant improvement within the assisted living industry. Swift action is taken by both the regulatory agency and by the Medicaid agency when poor care is identified.

***Howard Groff, President, Tealwood Care Centers*:**

Over the years, the primary issues facing Medicaid coverage for assisted living have been economic, not regulatory. And this is even more the case today as many states facing huge budget shortfalls now contemplate deep and painful cuts in programs serving low-income Americans. Every day, the newspapers are filled with stories of states making more and more cuts.

Medicaid coverage in assisted living is much more limited than Medicaid coverage for nursing homes. While nursing home coverage is a mandated benefit under Medicaid, states have the option to cover assisted living services under the program. Furthermore, under Medicaid waivers, states can limit assisted living Medicaid coverage to a geographic area or to a certain number of slots. This is not the case for nursing homes. Under the Medicaid program, assisted living is considered a home and community-based (HBC) setting and consequently Medicaid does not pay the cost of room and board, utilities, and food. These gaps in Medicaid financing mean that states must consider a number of design decisions to finance costs that Medicaid does not cover. As a result, financing streams for assisted living receiving Medicaid tend be very

complex and funding for residents receiving Medicaid tends to be vastly lower than private-pay funding. As a result, private pay residents subsidize their fellow residents who rely on Medicaid by paying more each month to cover the Medicaid shortfalls.

The latest study detailing national and state-by-state Medicaid payment and policy for assisted living was prepared by independent researcher Robert Mollica in 2009. Titled "State Medicaid Reimbursement Policies and Practices in Assisted Living," the report was published by NCAL in late 2009 and updated previous research done by HHS. It details the wide variation in how states determine Medicaid payment levels for assisted living communities and other related policy issues. Among the findings is that the number of people receiving Medicaid coverage in assisted living communities grew significantly from 2007 to 2009 after virtually no growth over the previous three years. The report describes how states respond to the lack of Medicaid funding for room and board costs in determining a variety of policies including whether or how much states supplement payments for room and board; whether states allow families and individuals to supplement room and board payments for Medicaid beneficiaries; and whether states allow beneficiaries to share apartments, and under what conditions.

Among the major findings were the following:

- The number of people receiving Medicaid coverage for services in licensed assisted living settings increased 9.2% between 2007 and 2009, and 43.7% between 2002 and 2009.
- Nationwide, about 131,000 low-income frail elderly Americans received services in assisted living communities under the Medicaid program (about 134,500 if programs with state-only funding are included).
- Thirty-seven states provided coverage under §1915 (c) home and community based services waivers to cover services in residential settings; thirteen states provided coverage directly under their state Medicaid state plan; four included services in residential settings under §1115 demonstration program authority; and six used state general revenues. States may use more than one funding source.
- Tiered rates were the most common methodology for reimbursing assisted living providers (19 states) and flat rates were used in 17 states.
- Twenty-three states capped the amount that may be charged for room and board.
- Twenty-four states supplemented the beneficiary's federal Supplemental Security Income (SSI) payment, which states typically use as the basis for room and board payment. SSI payments combined with state supplements ranged from $722 to $1,350 a month depending on the state. Some states provide no supplement.
- Twenty-five states permitted family members or third parties to supplement room and board charges.
- Twenty-three states required apartment style units; 40 states allowed units to be shared; and 24 states allowed sharing by choice of the residents.
- Screening for mental health needs was performed by case managers and assisted living community staff in nine states; by case managers only, in 10 states; and by assisted living staff only, in nine states.

- Mental health services were arranged by assisted living communities in 16 states; case managers in 20 states; and may be provided directly by assisted living communities in three states.

While Medicaid does not pay for room and board in assisted living settings, payment rates for Medicaid services that are typically lower than private market rates. Gaps in the funding system drive many of the other problems facing Medicaid coverage in assisted living. Room and board typically comprises about 40-50% of the cost of assisted living and the SSI payment of $674 a month is often inadequate, even in instances where states supplement SSI, to match or come close to private-pay costs of a private room, food, and utilities.

Given the core economic issues described above, NCAL strongly opposes proposals to force providers to accept Medicaid coverage or to accept Medicaid-specified amounts as the entire payment. NCAL believes that families should be able to supplement room and board payments for residents receiving Medicaid coverage so that they can afford the housing component and have access to single-occupancy units.

Mandating providers to accept Medicaid coverage in a system where Medicaid typically pays far less than the cost of providing housing and services will end shrinking the supply of assisted living available to low-income seniors and may compromise the quality of care. Forbidding providers from controlling how many units are available for Medicaid coverage will expose them to great financial risk and put in jeopardy any future financing of affordable assisted living communities. Put simply, banks won't lend money to endeavors they know will probably fail and Medicaid beneficiaries simply don't cover costs. If you have too many Medicaid residents, your property will go under and lenders know that.

Mandating providers to provide Medicaid coverage in a system that often severely underpays for Medicaid also places a hidden tax on private-pay residents in the facility that will face higher payments as a result of the Medicaid underpayment. For many residents, ironically, this cost shifting will mean spending down their private assets faster and facing the prospect of going on Medicaid sooner than they otherwise would have done. The impact of any new Medicaid mandate needs to be carefully analyzed in terms of cost shifting onto privately-paying assisted living residents, many of whom have limited assets and income. According the latest national survey of assisted living residents and facilities, median assisted living resident income was $18,972 in 2009, about half the average cost of assisted living. This implies that most private-pay residents are spending down assets. (See "2009 Overview of Assisted Living," AAHSA, ASHA, ALFA, NCAL & NIC, Washington, D.C., 2009.) Adding more mandates or an additional overlay of federal regulation would be especially detrimental in the current economic environment in which many states already are cutting Medicaid rates and coverage.

Providing quality Medicaid coverage will become even more difficult in 2014 when assisted living providers, like other employers, will have to comply with the new coverage expansion mandates in the Affordable Care Act. Because industries with high percentages of low-wage workers, including long term care, tend to have relatively high percentages of uninsured and underinsured workers, complying with the law's health insurance coverage expansion requirements will cause their labor costs to increase significantly. While NCAL supports efforts to expand health coverage, Medicaid rates will need to be adjusted to account for these added costs.

Despite these concerns, and even though public money is currently scarce, it is imperative for policymakers to consider ways to help states cover the gaps in Medicaid funding. Policies that could be considered include: making housing vouchers available to low-income assisted living residents including Medicaid beneficiaries; providing increased public financing for construction of affordable assisted living; and, expanding incentives and mechanisms for families to save for future long term care costs.

Despite the economic challenges facing Medicaid coverage in assisted living communities, states generally have done a good job of overseeing quality of care of this population. And I believe providers have stepped up to the plate to try and serve the Medicaid population, even though it may not always be in their best business interests. While many providers participate in the Medicaid program, they must be careful to limit their exposure to sub-market payment levels if they want to keep their doors open.

***Krista Hughes, Director, Division of Aging and Adult Services, Arkansas Department of Health and Human Services*:**

Assisted Living, while considered a HCBS program, is a facility based model of care, and therefore subject to more rigorous licensing, regulatory and oversight functions by the state. Additional measures, above those required by other HCBS apply:

a. Permit of Approval (POA): Initial licensure requires that the applicant for licensure possess a current, valid Permit of Approval issued by the Arkansas Health Services Permit Commission or Health Services Permit Agency. The Permit of Approval process is also commonly referred to in other states as the Certificate of Need. In both cases, it is a process used by states to control growth by determining whether a geographical region has the need for additional beds and services before a facility may be constructed or licensed.
b. Life safety code survey and compliance requirement, and all other applicable building codes including state and local codes.
c. Physical plant management; dietary; public health & infectious disease compliance, such as reporting communicable disease, safe water supplies, drainage and sewer and related matters;
d. Medication management: Depending on the type of assisted living facility (Arkansas has two levels), this can range from storage of medication to prompting or reminding to take medication, to administration of medication. Above all, however, it requires that storage meet relatively strict requirements to ensure and preserve the efficacy of medication, the safety and security of dangerous medications, and the delivery of the correct medication to residents.
e. Inspections: By having separate health and life safety surveys, it allows survey teams to concentrate on just one aspect of services to residents – care issues and physical plant requirements. This allows for more in-depth and comprehensive surveys.

***Barbara Lyons, Senior Vice President – Kaiser Family Foundation, Director – Kaiser Commission on Medicaid and the Uninsured*:**

The primary mechanism states use to ensure quality in assisted living facilities is the licensure process. Like many other home and community based services, most states provide assisted

living benefits through waivers. As part of the waiver application process, CMS requires that a state assure the quality of the waiver-funded services. The state's assurance generally relies heavily on the existence of the licensure regulations.[ii] All states now license or regulate residential care facilities, although the standards, inspections, and enforcement vary greatly. As a result, little is known about quality of care and quality of life in residential care facilities for people with disabilities, including compliance with state regulations, staffing patterns, or resident outcomes.

This stands in contrast to nursing homes, where there are multiple mechanisms at both the state and federal level to ensure quality. Current nursing home quality standards are predominantly the result of the Omnibus Budget Reconciliation Act of 1987 (OBRA '87). OBRA 87 changed the previous federal system of regulating nursing in several significant ways. It established new, higher standards that were much more resident focused than previous standards. The law established an enforcement system for noncompliant nursing homes that incorporated a range of enforcement sanctions.[iii] And the law merged Medicaid and Medicare standards and survey and certification into a single system.[iv]

***Larry Polivka, Executive Director, Claude Pepper Center*:**

In Florida, all assisted living facilities must meet the same minimum standards in law and rule. Residents are not singled out as Medicaid recipients and receive the same standard of care that private pay residents receive. States should not require reporting of Medicaid residents individually for this express purpose. The payment source should not be considered when providing resident care.

***Charley Reed, Member, Board of Directors, AARP*:**

Quality is important across all home and community-based settings. States vary greatly in their regulation and enforcement efforts to ensure quality in assisted living and other settings. Many elements and principles of quality are relevant and consistent across settings, such as promoting autonomy, choice, privacy, dignity, and independence. However, assisted living is also different from other home and community-based settings in essential ways, so certain elements of quality are different in assisted living. For example, assisted living providers have greater responsibilities for oversight than in home care. Assisted living residences must meet a variety of state licensure standards that do not apply to other settings of care. States should have appropriate standards, regulations, and licensing requirements coupled with their effective enforcement to help promote common goals of home and community-based services, such as resident autonomy and decision making, and to ensure quality in assisted living.

***Martha Roherty, Executive Director, National Association of States United for Aging and Disabilities (NASUAD)*:**

In Section 1915(c) Home and Community-Based Services (HCBS) waivers, states are required to develop quality improvement strategies for all services delivered under the waiver, including assisted living. Additionally, virtually all states license, or in some instances certify, either the assisted living setting or the assisted living provider. Typically, at least two entities are involved in oversight of Medicaid-financed assisted living – the state agency operating the Medicaid-financed assisted living service is responsible for Medicaid waiver quality improvement efforts

and related Centers for Medicare and Medicaid Services (CMS) reporting and the state licensure and certification agency is responsible for licensing or certifying either the assisted living setting or the assisted living provider for both Medicaid and private pay assisted living.

Typically such state licensure and certification agencies license or certify other HCBS residential providers participating in the Medicaid program. In affordable assisted living arrangements that involve housing financing, state housing agencies and/or public housing authorities often have oversight authority.

***Julie Strauss, Office of Licensing and Quality of Care, Seniors and People with Disabilities Division, Oregon Department of Human Services*:**

In Oregon, Medicaid services are not distinguished from private pay services. Each resident, regardless of payer source is guaranteed the minimum service floor.

***Patricia Will, CEO, Belmont Village Senior Living*:**

States are responsible for ensuring quality for all persons receiving home and community-based services, regardless of setting or resident payment source. Typically, state regulatory agencies have a system of periodic on-site inspections of assisted living communities. Most state inspections are required on annual basis and are usually unannounced, unscheduled visits. The inspection process in most states is intended to determine whether deficiencies (i.e. violations of regulatory requirements) exist in the primary areas of a community's operation (i.e. staffing standards, medication administration, residency agreements, life safety, resident rights, food service, plans of care, etc.)

Typically, notes are shared during the inspection process and deficiencies of a minor nature can often be corrected at the time of the survey. Most deficiencies are generally not of a serious nature. As necessary, a community will submit a plan of correction following the survey to correct any deficiencies that require additional follow-up to remedy the problem and avoid future reoccurrence. In cases where a very serious deficiency is found or where deficiencies are repeat violations, states can and do impose financial penalties. Likewise, severe and persistent violations can lead to temporary suspension or revocation of a community's license.

In addition to routine periodic inspections, state regulatory agencies are obligated to investigate any and all complaints they receive, even if the complaint appears to be frivolous. If it is determined that there is merit to the complaint, the community is required to submit a plan of correction.

4. **Are there key physical plant features that generally distinguish assisted living from an institutional nursing facility model, and which are common between states, or is there great variation? From a board and care model?**

***Christy Allen, Assistant Commissioner, Bureau of Health Licensure and Regulation, Tennessee Department of Health*:**

The Board has adopted similar (if not identical) building and life safety codes that are applicable to all Tennessee-licensed health care facility types; in this instance, the codes are the 2006

International Building Code and the 2006 National Fire Protection Code (NFPA Life Safety Code). The fire safety standards should afford reasonable protection to ACLF residents without unduly disturbing the residential atmosphere to which they are accustomed. When submitting plans and specifications for construction, the ACLF is required to specify the evacuation capabilities of the residents in order to determine the design and construction requirements for the facility; in other words, the design and construction requirements are determined by the residents' ability to self-evacuate or "defend in place" in case of fire. For a resident who meet medical eligibility (level of care requirements for nursing facility purposes) and whose physician has certified that the needs of the resident can be safely and effectively met by the ACLF, the ACLF must provide assurance of timely evacuation in case of fire or emergency.

***Josh Allen, President, American Assisted Living Nurses Association*:**

Assisted living has a look and feel that is distinctly different from the physical plan in institutional nursing facilities. The assisted living environment emphasis the creation of a homelike atmosphere, and while health services are often provided or directed onsite, they are carried out in a manner that encourages privacy. For example, most institutional nursing facilities feature a large "nurses station" that houses charts, medical equipment, and personnel. While many assisted living communities have a similar space, it is usually held behind closed doors so as not to dominate the environment.

With that said, there is great variation in the physical design of assisted living communities. There is an old adage that goes, "if you have seen one assisted living community, you have seen *one* assisted living community." The physical plant is typically designed to cater to the needs and preferences of the target population and to fit in with a typical residential design in the region.

***Brenda Bacon, President and CEO, Brandywine Senior Living*:**

Most importantly, assisted living must adhere to the life safety building codes of every state. International Building Code and/or the National Fire Protection Act govern life safety requirements of every assisted living community. But within the life safety code requirements there is still the opportunity to have a residential community that differs significantly from institutional nursing facilities.

The early pioneers of assisted living were focused on an alternative to institutional care where there was a lack of privacy, choice and independence. Assisted living was intended to create a residential home like environment. The first assisted living communities, for example, removed the fluorescent lights, linoleum, nurse's stations, and medication carts. Long, wide corridors with guardrails disappeared. Comfortable furniture replaced hospital -like chairs and residents were encouraged to bring their own furniture from home. Assisted living apartments have doors that lock for privacy. Pets are common in most assisted living communities today.

Again because assisted living is consumer driven, the physical surroundings continue to evolve as the desires of residents and family members change. Computers, Wii games and flat screen TVs are commonplace now. Perhaps the most important philosophy of assisted living that differentiates it from other long term care settings is the message that anyone working in assisted living learns and that is "We work where our residents live; they do not live where we work."

Purpose-built assisted living differs from the board and care model mainly through the ability to build a residential model and provide a greater element of safety than can be provided in a board and care home. All professionally managed assisted living communities are sprinkled and have smoke detectors. Following required life safety building codes, professionally managed assisted living communities are able to care for residents incapable of self-preservation, something that smaller board and care homes are unable to do.

Eric Carlson, Directing Attorney, National Senior Citizen's Law Center:

Originally, one of the biggest distinctions between the nursing facility model and the assisted living model was the private occupancy to be offered by assisted living facilities. This is still largely true in the private-pay market: private occupancy is the norm for residents paying privately for their care, as they prefer private occupancy and can pay for it.

By and large, however, state assisted living laws do not require private occupancy, and neither do Medicaid laws and policies. For Medicaid payment for assisted living services, many Medicaid HCBS waivers state that a resident in that state is entitled to a private unit, unless two residents agree to share a unit. Nonetheless, in practice, shared occupancy is the norm under such waivers. The facilities are set up to provide shared occupancy to Medicaid-eligible residents, and the residents "agree" to shared occupancy because they effectively do not have an available alternative.

It is difficult to generalize regarding the size of an assisted living facility's physical plant. Some assisted living facilities house over one hundred residents. Others may house six or seven residents in a converted house in a residential neighborhood.

Irene Collins, Commissioner, Alabama Department of Senior Services:

There are great variations within the states.

Kevin Coughlin, Director, Wisconsin Bureau of Assisted Living:

In Wisconsin, there are three models that fall under the umbrella term for "assisted living". The Residential Care Apartment Complex (RCAC) is the model that most closely mirrors the national discussion for assisted living. Within this model facilities must meet classification of R-4 or I-1 occupancy within the International Building Code which assures proper life safety for vulnerable residents but also allows for apartment style living that closely mirrors the living arrangement and communities that they were used to living in. Wisconsin assisted living communities have been able to provide safe, accessible, environments that incorporate the key values of independence, privacy, autonomy and choice. Pets are allowed, furnishings are non-institutional and the entire feel is home-like. Compliance with the international building code raises the bar for safety and allows for aging in place for a much more vulnerable resident.

The broad category of assisted living encompasses the "board and care model" as used elsewhere in the nation. In a phrase, the distinctive feature of assisted living is the "homelike environment" afforded to residents who live in the facility. This includes, generally, a living space more reminiscent of an apartment than a hospital room, and a greater degree of mobility from one part of the facility to another and extending beyond the campus to the surrounding community.

***Howard Groff, President, Tealwood Care Centers*:**

Assisted living emerged as a more consumer-focused alternative to nursing homes over the past several decades. Historically, Medicaid drove the design of older nursing facilities and mandated that rooms be shared often 240-square-foot semi-private designs and most were built in the 1960s and 1970s. As the number of patients coming to nursing facilities for short-term rehabilitative care has increased, designs have changed and often include more private suites today and therapy areas where physical, speech and occupational therapy are delivered.

The building of assisted living communities took off in the 1990s in the private-sector marketplace, not under a government program such as Medicaid, and consumer preferences directly drove the look and design of assisted living communities. Assisted living community design has its roots in a Scandinavian model of care. Most assisted living communities offer private studio, one-bedroom, or two-bedroom apartments. Dining rooms and indoor and outdoor activity areas are common. Some assisted living communities were designed specifically for residents with dementia and have designs that reduce agitation and support safe wandering behaviors. Virtually all assisted living communities are fully sprinkled. Typical board and care homes tend to be residential homes with bedrooms that have been converted to house residents.

A wide variety of housing types are licensed as assisted living/residential care. Depending on state licensure rules, assisted living licensure can include group homes, purpose-built apartments, and campuses including multiple levels of care.

Below are some key differences between assisted living and the traditional nursing facility model:

Assisted Living	*Nursing Facility*
Full apartments – studios, 1 & 2 bedrooms	Prescribed rooms – 240 sq ft; often semi private
Private baths	Shared baths
Units have kitchen appliances, frequently washers/dryers	Rooms are bedroom model with minimal storage
Focus on wellness, possibly including workout area with exercise equipment	Focus on rehabilitation and skilled care; therapy areas
Stays of more than two years on average	Median length of stay less than 30 days
Restaurant-style open dining	Meals are therapeutic
Residential care fire safety standards assuming unit doors closed and staffing level lower than institutional care	Institutional fire-safety standards assuming room doors open at night and higher staffing level

Variations in assisted living physical plant include:

- Units design ranging from 250 square-foot studios to 1,200 square-foot apartments with multiple bedrooms and baths;

- Common space amenities ranging from having only a serving kitchen to inclusion of chapels, libraries, workout areas, commercial kitchens, mail rooms, bistros, spas, barber/beauty facilities, craft areas, and workshops;
- Models ranging from 4-5 bedroom homes converted to care for residents in their own bedroom to multi-story campuses with full apartments; and
- Service levels ranging from providing meals and housekeeping services to memory support, care suites.

***Krista Hughes, Director, Division of Aging and Adult Services, Arkansas Department of Health and Human Services*:**

In Arkansas, the key physical plant characteristics that distinguish ALFs from nursing facilities are that ALFs generally are single occupancy rooms that have private bathrooms and kitchenettes. Additionally, there are different requirements. Below are excerpts from the regulations that further demonstrate differences:

In Nursing Homes: Standard patient rooms shall not have more than five (5) beds. Single standard patient rooms shall measure at least one-hundred (100) square feet. Multi-patient rooms shall provide a minimum of seventy-two (72) square feet per bed. Patient beds shall be located in rooms and placed at least three (3) feet apart in all directions and so located as to avoid contamination (respiratory droplets), drafts, excessive heat, or other discomfort to patients, to provide adequate room for nursing procedures and to minimize the transmission of disease. Each standard patient room shall be equipped with or conveniently located near adequate toilet and bathing facilities; at least four (4) patients' toilet facilities and three bathing units shall be provided for each thirty-five (35) beds. Each toilet facility shall be in a separate stall.

Residential Care facility (RCF, or board and care home) regulations require a minimum of 100 square feet, exclusive of entrance way and closet space, for single rooms and 80 square feet per resident in shared rooms. A minimum of one toilet/lavatory is required for every six residents and one tub/shower for every 10 residents. Minimum requirements include 20 square feet of living room and activities space per licensed bed. The larger the facility, requirements for additional space for activities increase.

Assisted living facility requires all units to be separate apartments of adequate size and configuration to permit residents to carry out, with or without assistance, all the functions necessary for independent living. Separate bathroom and kitchen area are required. Single occupancy apartments must be at least 150 square feet excluding entryway, bathroom and closets, and 230 square feet for 2 persons. Minimum requirements include 20 square feet of living room and activities space. Dining areas are separate from living and activities areas.

***Robert Jenkens, Director – The Green House Project, NCB Capital Impact*:**

The key physical features associated with the assisted living model are private apartments (or private rooms and bathrooms in small house implementations), and residentially detailed common areas that include common living, dining, and support areas. There is great regulatory and practice variation between what states and providers call assisted living. Legislatively mandated minimum standards that establish the environmental elements necessary to meet

assisted living's stated values of independence, privacy, autonomy, and choice as well as person-directed care would assist policy makers, providers, and the financial community develop effective programs to support the capital expenditures required for construction.

Larry Polivka, Executive Director, Claude Pepper Center:

Assisted living is a residential setting. Typically you will find more social areas such as libraries, sitting rooms, game rooms, and other gathering spots. Resident rooms look like apartments; residents are encouraged to bring their personal furnishings and belongings. In Florida, 67% of ALFs are under 10 beds and many times are a home that has been converted to meet necessary physical plant requirements under law.

Charley Reed, Member, Board of Directors, AARP:

AARP believes that private accommodations should be the norm for all types of long-term services and supports. Industry leaders, such as the Green House Project funded by the Robert Wood Johnson Foundation, are developing skilled nursing facilities with residential design features, including private bedrooms and bathrooms. Other countries, such as Denmark, already require such private accommodations for all types of long-term services and supports.

As noted above, AARP believes that a defining characteristic of assisted living residences is that they provide "private living units—with sleeping, living and food preparation areas, storage facilities, and a bathroom—shared only at the resident's request." This characteristic, much more than the number of units in a building, is the most notable difference between assisted living and institutional or board and care facilities where shared accommodations are more the norm, especially for those who must rely on public programs like Medicaid to pay for the services. AARP believes that assisted living residents should share rooms only by choice, even if they must rely on Medicaid for payment. Principles such as privacy, dignity and autonomy should also always be a guide within any physical plant features, including where there are shared accommodations.

Regarding private rooms, it is important to note that:

- A research report published by AARP's Public Policy Institute found that private accommodations were important factors in "better psychological, social, and even physical outcomes."[4]
- A survey of assisted living residences sponsored by several industry groups in 2009 found that only 3 percent of units were shared by two unrelated individuals, though this was more common (15 percent) in dementia care units.[5] The findings of private accommodations are somewhat higher than other surveys that use more inclusive definitions of assisted living, but they indicate the strong preference of consumers in this largely private pay market.
- More than two-thirds of the member organizations of the Assisted Living

[4] *Consumer Perspectives on Private versus Shared Accommodations in Assisted Living Settings,* Rosalie Kane, Mary Olsen Baker, Jennifer Salmon, and Wendy Veazie, AARP Public Policy Report, 1998.
[5] *2009 Overview of Assisted Living*, American Association of Homes and Services for the Aging, American Seniors Housing Association, Assisted Living Federation of America, National Center for Assisted Living, and National Investment Center, 2009.

Workgroup, formed at the request of the Senate Aging Committee, supported a recommendation that "Assisted living units are private occupancy and shared only by the choice of residents (for example, by spouses, partners, or friends)." [6]

- States vary greatly regarding requirements that assisted living provide private accommodations. As a 2008 report by Robert Mollica noted, "Some states have simply amended their statutes to rename board and care homes as assisted living and continue to permit dual occupancy. Others have allowed dual occupancy standards in grandfathered buildings but require new buildings to offer single occupancy units. Some states maintain separate licensing categories, allowing dual occupancy in some settings and requiring single occupancy in others. Several states have multiple licensing categories and the two-person limit may apply to only one of the categories." In all, 35 states have some licensure category that permits shared accommodations in at least some types of facilities. [7]

Martha Roherty, Executive Director, National Association of States United for Aging and Disabilities (NASUAD):

There is tremendous variation among the states in terms of physical plant features thus the need for a very broad assisted living definition or key set of components that must be addressed when state develop a definition. However, states generally agree that the Assisted Living Core Principles and any related components should be crafted in such a way to make clear how assisted living should differ from nursing facilities both visually and service philosophy. Board and care homes typically have more restrictions on what services and levels of care may be served in such settings. Assisted living services, following its aging in place model, typically allow people with higher level needs to move in and/or stay longer.

Julie Strauss, Office of Licensing and Quality of Care, Seniors and People with Disabilities Division, Oregon Department of Human Services:

Physical plant requirements for ALF facilities are outlined in OAR 411-054-0300. Distinguishing characteristics of ALF are an individual living unit, private bath and kitchen area.

Patricia Will, CEO, Belmont Village Senior Living:

There are many physical plant features that distinguish assisted living from skilled nursing homes. Most purpose-built assisted living communities throughout the United States include private, lockable apartment-style living units that include separate sleeping and living areas, an individual bathroom, and kitchenette with a microwave and/or mini-refrigerator; fully carpeted living and dining spaces; attractive artwork; residential furnishings; and special purpose rooms such as computer work station, a library, and exercise room.

5. Are there any minimum (explicit or implicit) federal expectations or requirements for state oversight and monitoring of assisted living?

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[6] *Assisted Living Workgroup Report to the Senate Aging Committee,* 2003.
[7] *Residential Care and Assisted Living Compendium,* op cit.

***Christy Allen, Assistant Commissioner, Bureau of Health Licensure and Regulation, Tennessee Department of Health*:**

In Tennessee, oversight of ACLF standards is performed exclusively by state staff on behalf of the Board for Licensing Health Care Facilities.

***Josh Allen, President, American Assisted Living Nurses Association*:**

The licensure, regulation, and oversight of assisted living are handled primarily at the state level. There are, however, some federal laws and regulations that apply to all businesses, including assisted living. Examples would include U.S. Department of Labor standards related to fair employment practices; Occupational Safety and Health Administration standards related to safe working conditions; CDC standards on infection control; and Centers for Medicaid and Medicare Services requirements, when applicable.

***Brenda Bacon, President and CEO, Brandywine Senior Living*:**

Assisted living is regulated in all 50 states. Whether it is the Department on Aging, or Department of Health or Social Services, or a similar agency, there is a state regulatory agency responsible for monitoring and enforcing the state regulations related to assisted living. In addition to the state agencies that have oversight of assisted living, there are other state and local agencies that impact assisted living. These include construction and fire codes, food safety, etc.

There are also many federal laws that impact assisted living. OSHA, ADA, Fair Housing, Workers compensation, and EPA all have requirements that in some way impact assisted living providers and residents. The Older Americans Act disseminates funds to every state including money for the long-term care ombudsman program; a program that is increasingly playing a larger role in assisted living.

***Eric Carlson, Directing Attorney, National Senior Citizen's Law Center*:**

In most states, Medicaid money for assisted living is provided through a Home and Community-Based Services (HCBS) waiver. Because HCBS waivers are not exclusively for assisted living—most HCBS waivers cover services provided in a beneficiary's home—HCBS waivers for assisted living in general do not set standards for oversight and monitoring of assisted living. Instead, the HCBS waiver defers to the state assisted living licensure standards, with the federal government accepting the existence of state licensure standards as adequate consumer protection, regardless of the quality of those licensure standards or their actual enforcement.

In the HCBS Waiver Application submitted by states, Appendix G lists participant safeguards and Appendix H lists the state's Quality Management Strategy. Appendix G concerns itself with only three limited areas: State Response to Critical Events or Incidents, Safeguards Concerning Restraints and Restrictive Interventions, and Medication Management and Administration. Appendix H does not include any quality standards, and instead asks states to lay out a system of data collection, analysis, and remediation.

Irene Collins, Commissioner, Alabama Department of Senior Services:

We are noted as having some of the most strict requirements for our Assisted Living facilities.

Kevin Coughlin, Director, Wisconsin Bureau of Assisted Living:

In Wisconsin, the Division of Long Term Care (DLTC) operates the Medicaid waiver program. The contract between DLTC and CMS has language on how Wisconsin assures quality with all Medicaid recipients whether they live in their own home or in assisted living. The collaboration between the Division of Quality Assurance (DQA) (regulators) and DLTC enhances the oversight and monitoring of Medicaid recipients residing in assisted living facilities. DLTC's contract with CMS for the Medicaid waiver program includes language outlining the collaboration between DLTC and DQA for ensuring quality. This is not an explicit requirement, but CMS has acknowledged that the agency is pleased to see a strong collaboration between the funding agency and the regulatory agency.

Howard Groff, President, Tealwood Care Centers:

Because it combines housing with services for a frail, elderly population, assisted living is impacted by a multiple federal and state regulations and policies, including those related to civil rights, environment, labor practices, and care standards. Some cities and counties also have additional requirements. The states have primary responsibility for regulating the core functions of assisted living communities. In approving a state plan or waiver including Medicaid coverage in an assisted living setting, CMS implicitly delegates to the states the responsibility for overseeing the quality of care, typically though state licensure and inspection of residences. In addition and under federal law, state Medicaid Fraud Control Units (MFCUs) have authority to investigate cases of fraud, abuse, and neglect in both Medicaid and non-Medicaid assisted living and residential care settings.

Krista Hughes, Director, Division of Aging and Adult Services, Arkansas Department of Health and Human Services:

While there are no federal regulations specific to ALFs, there are Section 1915(c) waivers that contain some component requirement of state oversight and monitoring, understanding the waiver reflects a small percentage of the overall ALF industry. In Arkansas, an Interagency Agreement exists between the Division of Medical Services (DMS) and the Division of Aging and Adult Services (DAAS) to define each agency's responsibilities in administering the Living Choices waiver program. This agreement is renewed annually and updated as needed. DMS monitors the agreement to assure that the specified provisions are executed.

The Quality Assurance Protocol is part of the Interagency Agreement. The Division of Medical Services requires DAAS to demonstrate how the agency will meet the following criteria:

- Assuring the health and welfare of waiver participants
- Assuring the adequacy of plans of care for waiver participants
- Assuring that all waiver services are provided by qualified providers
- Implementing the processes and instruments for evaluating/re-evaluating level of care need

- Assuring that an adequate system of assuring financial accountability is in place

In the larger scope, the Arkansas Office of Long Term Care is the designated entity to provide regulatory and quality oversight to the ALF industry, including both care and life safety issues.

Barbara Lyons, Senior Vice President – Kaiser Family Foundation, Director – Kaiser Commission on Medicaid and the Uninsured:

There is no federal regulation of residential care facilities except under Medicaid home and community-based services waivers.[v] Medicaid does not explicitly define assisted living; rather the Medicaid program defines specific services that qualify as home and community-based. The federal government requires state Medicaid programs to explain how they will assure the quality of waiver-funded services, including home and community based services provided in assisted living settings. The federal government can weigh in on Medicaid beneficiary rights and protections and make certain requirements of the state as conditions for the approval of the waiver but there are no explicit federal requirements for state oversight or monitoring of assisted living, beyond the overall requirements of beneficiary rights and protections. [vi] In 2004, 37 states had Medicaid home and community-based services waivers covering services in residential care facilities. Twenty-nine states and the District of Columbia reported in 2004 that they include provisions regarding assisted living concepts such as privacy, autonomy, and decision making in their residential care regulations or Medicaid standards.[vii]

Services that are required by state law and regulation to be provided or coordinated must include but are not limited to[viii]:

- 24-hour awake staff to provide oversight and meet scheduled and unscheduled needs
- Provision and oversight of personal and supportive services (assistance with activities of daily living and instrumental activities of daily living)
- Health related services (e.g. medication management services)
- Social services
- Recreational activities
- Meals
- Housekeeping and laundry
- Transportation

For nursing homes, CMS manages a database that allows consumers to obtain information about nursing homes around the country, but comparable information is not available for assisted living facilities. The Nursing Home Compare Website provides consumers with quality information about nursing homes based data from the Minimum Data Set (MDS) resident assessment and information collected from state inspections. Consumers can compare nursing facilities on 15 different outcomes measures. Similar data collection efforts in assisted living facilities could help improve quality monitoring and help consumers to better understand their choices when deciding upon long-term care options.

***Larry Polivka, Executive Director, Claude Pepper Center*:**

There should be no federal requirements. Assisted living should remain regulated at the state level.

***Charley Reed, Member, Board of Directors, AARP*:**

No, there are not really formal federal expectations or requirements for state oversight and monitoring of assisted living.

***Martha Roherty, Executive Director, National Association of States United for Aging and Disabilities (NASUAD)*:**

Federal requirements only exist in the context of Section 1915(c) HCBS waivers and under the new Section 1915(i) and related quality assurance requirements. Version 3.5 of the (c) waiver application goes into more detail about quality improvement. No federal guidance exists for oversight and monitoring for private pay assisted living. It's here that NASUAD thinks a federal framework might be explored – federal framework for a disclosure statement, federal framework for a bill of rights, federal frame work for a licensure process. Each framework should allow flexibility for states to tailor such structures to their unique service systems.

***Julie Strauss, Office of Licensing and Quality of Care, Seniors and People with Disabilities Division, Oregon Department of Human Services*:**

Oregon's Home and Community based waiver specifically outlines the regulation and oversight of these facilities as an expectation of our agreement.

***Patricia Will, CEO, Belmont Village Senior Living*:**

There are federal laws that impact assisted living; however the primary responsibility for regulating assisted living rests with the states. With regard to the federal role in assisted living, federal laws and regulations direct CMS to ensure that states with HCBS waivers are adequately protecting the health and welfare of waiver beneficiaries. CMS includes a suggested definition of assisted living on the application form that states submit for a waiver; however, states are free to submit a different definition, subject to CMS approval. The CMS definition emphasizes the assisted living philosophy of privacy, independence, and services to meet residents' scheduled and unscheduled needs.

As part of the CMS approval process, a state must document that necessary safeguards are in place to protect the health and welfare of waiver beneficiaries. States must also submit annual reports on the health and welfare of waiver recipients. CMS regional offices are responsible for ongoing monitoring of waivers and the quality of beneficiary care.

With regard to the state role in regulating and monitoring assisted living, virtually all states in recent years have updated their regulations to meet the changing needs and preferences of residents in areas such as consumer disclosure, quality assurance, staffing, and training requirements. Between 2004 and 2007, 21 states revised their regulations and 12 states reported

current activity to revised regulations.[8] In 2009, at least 22 states reported making statutory, regulatory or policy changes impacting assisted living or Medicaid coverage and at least eight states made major statutory or regulatory changes or overhauled their rules; in 2010, 14 states made substantive revisions to their regulations; in 2011, 18 states made changes to policies, regulations, and statutes and six states (i.e. Idaho, Kentucky, Oregon, Pennsylvania, South Carolina, and Texas) reported making major changes to their regulations.[9] A year-by-year state summary of state regulatory changes can be found on the American Seniors Housing Association website (www.seniorshousing.org).

Affordability, Supplementation and Reimbursement

6. **What are the primary sources of federal funding (e.g., grants, tax credits) that are or can be used for development of affordable assisted living? Does the federal government, and do states, define "affordable" assisted living in specific ways? Or does the definition of "affordable" vary by program?**

***Brenda Bacon, President and CEO, Brandywine Senior Living*:**

The U.S. Department of Housing and Urban Development's Federal Housing Administration operates the Section 232 program to provide capital access for long-term care, assisted living and skilled nursing facilities through mortgage insurance. Section 232 provides assisted living communities with better loan terms and dramatically reduced interest rates when borrowing money to build, replace or modernize assisted living properties than do many traditional lending sources. Presently, loans via the Section 232 program are the only avenue for financing for thousands of assisted living communities. Section 232 loans reduce Medicare and Medicaid costs by providing for lower interest rates, which is an eligible reimbursable expense.

The Section 202 Program provides capital advances to finance the construction, rehabilitation, or acquisition with or without rehabilitation of structures that will serve as supportive housing for very low-income elderly people, including the frail elderly, and provides rent subsidies for the projects to help make them affordable.

To our knowledge there is no one definition of affordable assisted living. Some people do define affordable assisted living as assisted living paid for by Medicaid but it is important to remember that Medicaid only pays for services on behalf of people who meet the income requirements. Medicaid will not pay for either the housing or food costs of these individuals.

Perhaps one of the biggest myths about assisted living is that it is only for the wealthy. The average monthly cost of assisted living in Wisconsin is $3,375 while the average monthly cost of skilled nursing care is $7,440. The monthly comparison in Tennessee is $3,216 for assisted living versus $5,890 for skilled nursing care. At 83 percent private pay, certainly many consumers are finding assisted living an affordable option.

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[8] *Residential Care and Assisted Living Compendium:2007*, National Academy for State Health Policy, Robert Mollica and Kristin Sims-Kastelein; Research Triangle Institute, Janet O'Keeffe

[9] National Center for Assisted Living State Regulatory Review: 2010, 2011; American Seniors Housing Association Assisted Living and CCRC State Regulatory Handbook 2010

The median annual income of an assisted living resident is $19,000, asset value excluding home equity is $125,000, and asset value including home equity is $205,000. Assisted living does not require a large down payment or "buying "the apartment that is common in the continuing care retirement community model. The average length of stay in assisted living is 28 months and approximately 6 % have to move for financial reasons. And of course as a market-driven business, pricing of assisted living can be very competitive.

Perhaps the more important public policy issues are how to educate consumers so they know that Medicare and Medicaid do not pay for assisted living and how-to make sure that consumers take the necessary steps to plan for their long term care needs. Today's consumers sell their mortgage-free homes and use the equity to pay for assisted living. Some do supplement this equity with other sources such as investments, savings, insurance, loans and monthly income benefits. Will future generations be mortgage-free and have that resource available to finance their long-term care?

***Irene Collins, Commissioner, Alabama Department of Senior Services*:**

We do not have federal funds for our facilities; they are all private pay except for a few who are Veterans assisted. Therefore, Assisted Living may not be affordable for many of our state's seniors.

***Kevin Coughlin, Director, Wisconsin Bureau of Assisted Living*:**

In 2002, Wisconsin was one of eight states selected to participate in the Robert Wood Johnson Foundation's "Coming Home: Affordable Assisted Living" grant program. The Wisconsin Housing and Economic Development Authority (WHEDA ,,) and the Wisconsin Department of Health and Family Services (DHFS) lead the initiative. Directional and technical assistance for the grant was provided by NCB Development Services. For the purposes of the initiative, the goal was to create assisted living that is affordable to low-income seniors by reducing housing costs and accessing the Medicaid program to pay for services. To be affordable in this context, a Residential Care Apartment Complex (RCAC) in Wisconsin would need to offer rates in the following range:

- Service charges that can be paid with the funding available from the Medicaid Waiver program. For 2004, this would mean service charges averaging up to $1,273/month. The maximum charge for any individual resident may not exceed $2,366/month. Service charges should reflcct the resident's level of need.
- Housing and food charges at a level that Medicaid Waiver recipients can pay out-of-pocket. For 2004, this would be from $499 to $1,627/month. A typical MA Waiver resident would have $679 per month available for room and board. Rents for housing must comply with the income and rent requirements of any housing finance program(s) used to reduce the cost of shelter in the RCAC. More information on this initiative can be found at: http://www.wiaffordableassistedliving.org/

However, currently in Wisconsin there is not a uniform definition of "affordable assisted living." It is a matter of consideration for the persons or entities proposing to construct and operate an assisted living facility in the context of their anticipated return on investment. Aside from federal sources available through HUD and HHS, Wisconsin has financing available through the

state's Wisconsin Housing and Economic Development (WHEDA). DLTC does not directly facilitate development of assisted living, so many of the business decisions related to market analysis and need for housing is done outside the scope of DLTC's role.

To the extent that the affordability of assisted living is essential to access for people the programs serve, DLTC does work with managed care organizations to establish policies that take the cost of housing into account. Affordability is defined in DLTC programs as within the typical funding of SS/SSI beneficiaries for room and board expenses.

***Howard Groff, President, Tealwood Care Centers*:**

There is no single benchmark of "affordable" assisted living. When applying the HUD/FHA definition to an affordable unit, most times about 50% of the tenant population will qualify; many of those are private-paying tenants.

Federal funding options include:

- HUD/FHA non-recourse financing, which can finance start-up developments (20% equity requirements; application and processing period of 12-18 months; and does not provide grants);
- USDA recourse financing based on ownership structure, which can finance start-up developments (as low as 20% equity requirements; application and processing period of 6 months; will provide grants to certain municipal entities; not all associated development costs are eligible for the loan; limited to $10,000,000);
- Municipal bonds non-recourse financing after meeting stabilization covenants, which can finance start-up developments (20-30% equity requirements; application and processing period of 6 months; does not provide grants; at present given the financial status of municipalities extremely difficult to obtain financing and obtain rating status);
- Fannie Mae/Freddie Mac non-recourse financing, which will not finance start-up developments (20% equity requirements; application and processing period of 6-10 months; does not provide grants);
- SBA recourse financing, which will participate in financing start-up developments (20% equity requirements; application and processing period of 6-10 months; limited to $2,000,000); and
- Tax Increment Financing, which is supplemental financing related to limited forgiveness of real estate tax payments (requires 20% of units be affordable).

There is often a lack of coordination with state funding programs. For example, Minnesota's Housing Finance Agency has never extended loans to long term care facilities. The agency's mission statement is as follows: *As the State's affordable housing bank, we offer products and services to help Minnesotans buy and fix up homes and we support the development and preservation of affordable rental housing by offering financing and on-going asset management of affordable rental housing developments.*

***Krista Hughes, Director, Division of Aging and Adult Services, Arkansas Department of Health and Human Services*:**

In Arkansas, the primary sources have been the federal and state LIHTC (Low Income Housing Tax Credit), HOME Program, federal Home Loan Bank grants, USDA Rural Development Foundation grants, and the Assisted Living Incentive Fund, created by the State of Arkansas and funded with ARRA funds. Rural Development has participated in one (1) assisted living development.

Yes, in AR the definition of affordable assisted living would mirror the definitions found in the LIHTC, HOME, and Rural Development Programs.

***Robert Jenkens, Director – The Green House Project, NCB Capital Impact*:**

For state Medicaid programs, affordable assisted living is typically defined as assisted living that will accept the established state Medicaid payment for assisted living services and the person's SSI payment (less a small personal needs allowance) as full payment for "room and board" required by the individual and state programmatic guidelines (unlike in a nursing home, Medicaid does not pay for room and board in assisted living).

For state and federal housing programs that may be used in assisted living, affordable assisted living is most often not specifically addressed. Rather, an assisted living program eligible to participate in the financing or grant program needs to meet the general housing affordability criteria used by the program – usually based on federal poverty guidelines or a percentage of area median income. The federal/national housing programs most frequently used to fund the construction of assisted living that is affordable to Medicaid-eligible individuals are: Low-Income Housing Tax Credits (LIHTC), HUD's Federal Housing Administration's (FHA) 232 Mortgage Guarantee Program, HUD's HOME program, HUD's Assisted Living Conversion Program (ALCP) Program, USDA's Community Facilities Grant/Loan/Guarantee Program, the Federal Home Loan Bank's Affordable Housing Program (AHP), and tax-exempt bonds. Combining one or more of these programs, when allowed, is often necessary to deliver a project whose rent is affordable to Medicaid-eligible individuals.

***Barbara Lyons, Senior Vice President – Kaiser Family Foundation, Director – Kaiser Commission on Medicaid and the Uninsured*:**

To develop affordable assisted living options developers must raise enough capital upfront, such that they are able to offer units at prices that will be affordable for middle- and low-income individuals. According to a report from the Center for Excellence in Assisted Living, one of the most important sources of financing for developers of affordable assisted living is the low-income housing tax credits (LIHTC), a real estate development program. Non-profit developers of affordable housing apply for LIHTCs through a competitive process and those credits, once received, are then purchased by corporate investors. This provides more capital for the developers and reduces the debt/equity requirements on developers which in turn enable developers to charge a lower rental rate.[ix]

Other public sources of financing may include HUD funds, through either the HUD 202 program or traveling section 8 vouchers, and Veterans' Affairs Aid and Attendance pension. Through the HUD 202 supportive housing for the elderly program HUD provides interest-free capital

advances to private, nonprofit sponsors to finance the development of supportive housing for the elderly. The capital advance does not have to be repaid as long as the project serves very low-income elderly persons for 40 years. In addition to the capital advance, project rental assistance funds are provided to cover the difference between the HUD-approved operating cost for the project and the tenants' contribution towards rent. Project rental assistance contracts are approved initially for 3 years and are renewable based on the availability of funds.[x]

In many cases tax credits account for more than half of total development costs, with the remaining costs subsidized by state and local sources. Three to five equity sources are often required to fund one affordable assisted living project, making these projects challenging to undertake.[xi]

***Larry Polivka, Executive Director, Claude Pepper Center*:**

ALFs have not traditionally been federally funded. However, there is an increasing amount of Medicaid funding in ALFS that is being provided through waiver programs in Florida and in other states, and there are also opportunities for federal grants or tax credits.

***Charley Reed, Member, Board of Directors, AARP*:**

Other participants can better address this question.

***Martha Roherty, Executive Director, National Association of States United for Aging and Disabilities (NASUAD)*:**

The primary sources are Medicaid (waiver and state plan) and housing financing tools. Housing financing tools include low-income tax credits and housing vouchers. There is no standard definition for affordable assisted living; however, some states operationalize the definition at Medicaid while others consider affordable assisted living as low-income tax credit and Medicaid.

***Michael Vaughn, Acting Director, Asset Management and Lender Relations, Office of Residential Care Facilities, Office of Healthcare Programs, HUD*:**

The primary federal sources are:

- Low Income Housing Tax Credits – approximately $8 billion per year in investment of which a small portion is allocated to assisted living projects.
- HOME – approximately $1.5 to 2 billion in grants/soft loans administered by local/state governments but a similarly small portion is allocated to assisted living projects.
- Section 202 – approximately $350 million administered by HUD but generally does not go to assisted living with exception of HUD's Section 202 Assisted Living Conversion program (Sec. 202 Example - Columbus)
- HUD's section 232 Program: HUD insures $17.1 billion in mortgages on 2,580 Skilled Nursing Facilities (SNF), Assisted Living Facilities (ALF) and Board and Care Facilities (B&C) ($12.1 billion for 1,800 SNFs and $5.0 billion for 780 ALF/B&C), with 500 to 600 new commitments for FY 2011 (415 SNFs and 125 ALF/B&C (expected)). Approximately 15% is new construction and affordable communities are eligible for the program. Since October 2000, 18 ALF properties representing 1,818 units with mortgages of $156 million have been insured with Tax Credit affordability restrictions, and others have had affordability

restrictions not related to tax credits. (SECTION 232 EXAMPLE: Victory Center of Vernon Hills)

- HUD's Section 542 Risk Sharing Program for which State Housing finance authorities and GSE's are eligible has insured 37 mortgages for $248 Million Dollars for affordable assisted living facilities.
- Projects funded by Public Housing Authorities (PHA's) using HUD allocated Capital and Operating Funds, and in some cases Section 8 Rental Assistance contracts. (PHA Example- Lapham Park)
- Funds provided under the Federal Home Loan Bank Board Affordable Housing Program

These federal funds are often most effectively combined with each other and with State funding, especially under Medicaid waiver programs.

Affordability requirements vary by program and by state. However, generally tax Credits must be 60% of AMI or lower; however some states require some number of units to be at lower levels. HUD funds must be 80% of AMI or lower; however they generally serve an ELI (30% of AMI or lower) population. However, developers can use allocate funds for certain units and not others allowing for mixed-income communities.

HUD's Section 542 Risk Sharing program defines "affordable" as a project in which 20 percent or more of the units are both rent-restricted and occupied by families whose income is 50 percent or less of the AMI as determined by HUD, with adjustments for household size, OR --a project in which 40 percent (25 percent in New York City) or more of the units are both rent-restricted and occupied by families whose income is 60 percent or less of the AMI as determined by HUD, with adjustments for household size.

Rent-restricted means that gross rent for a unit does not exceed 30 percent of the imputed limitation applicable to such unit. HFAs are responsible for determining gross rent and/or income limitations including a determination of personal benefits expenditures (e.g., utilities).

***Patricia Will, CEO, Belmont Village Senior Living*:**

The primary sources of federal funding for development of "affordable assisted living" ("AAL") include Low Income Housing Tax credits, FHLB grants, HOME loans, and HUD 232 loans. AAL is typically defined by the fact that it is attached to a Medicaid waiver. There have been a few AAL buildings built with tax credits but not a Medicaid waiver.

7. **Is there estimated national demand for affordable assisted living, or any federal program that calculates this? How many affordable assisted living units exist today? Are there any public or private-sector projections for how many affordable assisted living units are needed in the next 5, 10 and 20 years?**

***Brenda Bacon, President and CEO, Brandywine Senior Living*:**

We are not aware of any data is this area. However the U.S. Center for Disease Control and Prevention is currently completing the first national survey of residential care communities (assisted living) this year and that data may shed some light on this issue.

***Irene Collins, Commissioner, Alabama Department of Senior Services*:**

By virtue of the population age 65 and over increasing dramatically we can assume that the demands will be greater.

***Kevin Coughlin, Director, Wisconsin Bureau of Assisted Living*:**

We are not aware of a calculated "national demand" for assisted living services. In Wisconsin, there are approximately 41,940 assisted living units in three distinct regulated categories: Adult Family Homes, Residential Care Apartment Complexes, and Community-Based Residential Facilities. This is compared to 37,345 skilled nursing facility beds.

Wisconsin recently celebrated its 31st consecutive year of growth in assisted living communities. In 2008, assisted living beds surpassed nursing homes beds. Assisted living beds have increased with the roll-out of Wisconsin's Family Care and I Respect, I Self-Direct (IRIS) programs which are entitlement programs that offer different choices for Medicaid beneficiaries.

To date, there have only been a handful of successful "affordable assisted living" projects in Wisconsin where tax credits or subsidies on the housing side, plus Medicaid funding for assisted living services, have been combined to allow a majority of residents in the facility to be low income. Most assisted living communities will serve only a certain percent of low-income residents, so that in total, they have an adequate case mix of "private pay" vs. "publicly funded." This can vary from 5% to 75% depending on the assisted living community. Overall assisted living in Wisconsin is expanding by at least 5% a year and does not appear to be slowing down, even in the current economy.

***Howard Groff, President, Tealwood Care Centers*:**

NCAL is not aware of any projections of demand for affordable assisted living but it is likely to be far greater than what is available in today's market. Today, on a national basis, about 13% of assisted living residents receive care under the Medicaid program compared with more than 60% of nursing home residents. There are many barriers to the expansion of Medicaid coverage in assisted living. For example, two states don't cover Medicaid services in assisted living at all. Most of the rest cover assisted living services under waivers in which they can limit the number of available slots. While assisted living Medicaid coverage is extensive in some states, programs in many states are very small and/or limited to geographic areas. Also, as noted above, lack of payment for room and board and sub-market payment for Medicaid services limits provider participation. Speaking hypothetically, if assisted living services were an entitlement under Medicaid and room and board costs were adequately covered, the percentage of assisted living residents receiving Medicaid assistance would not be as high as in nursing homes but would likely be far above 13% nationally.

***Krista Hughes, Director, Division of Aging and Adult Services, Arkansas Department of Health and Human Services*:**

Specific to Arkansas, the Arkansas Health Services Permit Agency (AHSPA), with direction from a nine member Health Services Permit Commission, is responsible for issuing Permits of Approval (POAs) for Nursing Homes, Residential Care Facilities, Assisted Living Facilities, Home Health and Hospice Agencies, Psychiatric Residential Care Facilities and Intermediate

Care Facilities for the Mentally Retarded. The Commission/Agency's mission is to ensure appropriate distribution of health care providers through the regulation of new services, protection of quality care and negotiation of competing interests so that community needs are appropriately met without unnecessary duplication and expense. The AHSPA methodology projects the need for Assisted Living beds at 30 beds per 1000 persons who are 65 years old and older. The need will consider the number of proposed and existing ALF beds and the number of proposed and existing RCF beds in a county. Need is projected five years forward using the most recent census data available from the UALR Institute for Economic Advancement. An exception to the population based formula exists when occupied beds in all facilities in a county are 75% occupied by residents who are documented to be under the age of 65 years old. In this instance, beds in those facilities will not be counted in the county bed need. January 2011 Need Report, completed by the AHSPA, shows a total of 4,917 assisted living units either built or in some stage of construction, and 2,950 residential care facility (RCF) beds (note: Arkansas has a moratorium of POA for RCF) for a total of 7,867 units. The forecasted need for 2015 is 13,620, thus, showing a net need of 5,753 units in the next 4 years.

The average number of beds is 62. (Note: The largest ALF is an ALF I – 118 beds; the smallest is an ALF II – 20 beds). Currently, there are 19 ALF I and 43 ALF II licensed in Arkansas. Currently, there are 211 affordable assisted living units, according to the Arkansas Development Finance Authority. Additionally, the Arkansas Assisted Living Waiver (Living Choices) currently serves 636 people. The waiver cap is currently set at 800 slots.

***Barbara Lyons, Senior Vice President – Kaiser Family Foundation, Director – Kaiser Commission on Medicaid and the Uninsured*:**

Over 10 million people need long-term services and supports because their ability to care for themselves has been reduced by a chronic illness or disability.[xii] Long-term care affects the old and the young; people may need care over a lifetime, or care needs may be limited to a relatively brief period of several months or years. Needs for care are also wide ranging. People with long-term services needs may require only some supportive services around the home, help with everyday tasks such as bathing or preparing meals, or they may have complex medical needs requiring around-the-clock care supervision. Only a small fraction of those who need long-term care reside in nursing homes or other institutions; most live in their own homes, and assisted living has rapidly emerged as a community-based housing and long-term care option for older Americans.[xiii, xiv]

The number of persons with long-term care needs is projected to grow due to the aging of baby boomers and increased life expectancy, especially for individuals with disabilities under age 65, thereby increasing the demand and need for long-term services and supports. As demand grows, poor and low-income people will continue to turn to Medicaid to pay for their long-term care needs. While no specific federal program calculates consumer demand for assisted living services, we do know that consumer demand for Medicaid HCBS is increasing as witnessed by the over 365,000 individuals on waiting lists for services in 2009.[xv]

The median annual rate for an assisted living facility was $38,220 in 2010 (compared to about $70,000 for a nursing home).[xvi] According to a recent study, in 2007 there were 11,276 assisted living facilities nationwide, with 839,745 units. This represents approximately 23 assisted living

units per 1,000 elderly U.S. residents, though there is widespread variation in assisted living penetration across states.[xvii]

***Larry Polivka, Executive Director, Claude Pepper Center*:**

In Florida there are 11 ALFs that are designated affordable assisted living facilities. Six serve low income elderly. More details are available at Florida's Department of Elder Affairs (DOEA).

***Charley Reed, Member, Board of Directors, AARP*:**

Other participants can better address this question.

***Martha Roherty, Executive Director, National Association of States United for Aging and Disabilities (NASUAD)*:**

To date, there is no national estimate for affordable assisted living demand. The best benchmarks include waiver waiting lists and the National Investment Center for the Seniors Housing & Care Industry (NIC) research. NASUAD members report that: a) rates are not keeping pace with increases in acuity as people age in place; b) more out-of- residence days due to hospitalizations or post-acute care placement cause challenges; and c) because little is available to help potential residents choose affordable settings, more people may need affordable assisted living due to higher than expected rates of spend-down to Medicaid.

***Michael Vaughn, Acting Director, Asset Management and Lender Relations, Office of Residential Care Facilities, Office of Healthcare Programs, HUD*:**

Industry sources have estimated that approximately 10% of the 1 million residents in 38,000 existing Assisted Living facilities are recipients of Medicaid waiver funding. It has also been estimated that 25% of the approximately 1.5 million existing Skilled Nursing Facility residents could be have their needs met in Assisted Living facilities, creating large savings for the States. To house those 375,000 residents would require an additional capital investment of over $50 billion in new facilities. The savings to the states in Medicaid costs, as well as to the Federal government in reduced Medicare expenses for healthier residents could well justify such a capital expenditure. Illinois presently has 124 affordable AL facilities developed under these programs, and claims to realize savings of $35 million per year. Extrapolating on a population basis to the entire country confirms the estimate above. Additionally the estimate by the Center for Excellence in Assisted Living of 67,000 units needed over the next 15 years is consistent as well.

***Patricia Will, CEO, Belmont Village Senior Living*:**

We are not aware of a national demand estimate for AAL, but would estimate that there is tremendous unmet need for affordable assisted living across the United States given that lenders and investors are often reluctant to finance affordable housing due to inadequate reimbursement rates and the lack of guarantee that Medicaid waiver funding will continue to be available.

8. Does the federal government have plans to develop more assisted living services for residents living in subsidized residences, including Sections 202, Section 811, and

public housing programs, in order to assist residents who wish to "age in place"? What is the status and role of the Section 232 program?

***Brenda Bacon, President and CEO, Brandywine Senior Living*:**

The biggest obstacle with the Section 232 program is having sufficient staff to process applications. We understand that there may be over 300 projects in queue waiting for the application process to begin. Appropriations to fund additional staff to address the backlog are critical as many projects will forfeit financing approval due to the long waiting time for HUD to process applications.

***Kevin Coughlin, Director, Wisconsin Bureau of Assisted Living*:**

We are unaware of any such national formalized plan.

However, in Wisconsin, when these projects -- tax credits or subsidies for housing, plus Medicaid services -- come together, they are extremely effective. The provider is able to operate successfully with the Medicaid rates, the housing entity can operate profitably with the tax credits or subsidies, and the community at large benefits, because there is a place for low income seniors or persons with disabilities with high level-of-service needs to live without having to go to a nursing home.

***Howard Groff, President, Tealwood Care Centers*:**

We defer to HUD's expertise on this question.

***Charley Reed, Member, Board of Directors, AARP*:**

Other participants can better address this question.

***Martha Roherty, Executive Director, National Association of States United for Aging and Disabilities (NASUAD)*:**

The current fiscal environment creates uncertainty for housing and supportive services for seniors and people with disabilities. In Fiscal Year (FY) 2011, funding for the Department of Housing and Urban Development (HUD) has continued under a series of short-term continuing resolutions (CR). To date, each CR has continued funding at the FY2010 level for all of the accounts in HUD's budget, including Section 202 Housing for the Elderly Program and Section 811 Supportive Housing for Persons with Disabilities. However, on February 18, 2011, the House approved H.R.1, a CR to fund the federal government through the end of FY2011. H.R. 1 would reduce funding for Sections 202 and 811 to $238 and $90 million, respectively. As compared to FY2010 appropriated amounts, the H.R.1 proposes to reduce funding to Section 202 by $537 and Section 811 by $110 million. H.R. 1 was considered, but not approved, by the Senate on March 9, 2011. On the same day, the Senate also considered, but did not approve, a Senate amendment to H.R.1, S.Amdt. 149. S.Amdt. 149 included FY2010 funding levels for Sections 202 and 811. In addition, in February, 2011, the President released his budget request for FY2012. The President's Budget reduces funding in Section 202 Programs from the $825 million to $757, a reduction of $68 million from the CR for FY2011. Also, the President's

budget proposes to reduce funding for Section 811 to $196 million, which represents a decrease of $104 million from CR for FY2011 funding levels. Decreases in funding for housing and supportive services could negatively impact the stock of affordable assisted living units.

However, in 2010, two legislative Acts were enacted that could support seniors and individuals with disabilities age-in-place. First, Section 202 Supportive Housing for the Elderly Act of 2010 (P.L. 111-372) attempts to strengthen the program by making several programmatic changes. For instance, the Act makes it easier for owners to make health and supportive services available to residents by creating a new category of housing, "service enriched housing," eligible for grants under the Assisted Living Conversion Program (ALCP). Second, the Frank Melville Supportive Housing Act of 2010 (P.L. 111-374) authorizes and incentivizes more integrated models of supportive housing units by funding small set-asides of Section 811 units within affordable housing developments. The Melville Act – for the first time in federal housing policy – authorizes a separate Section 811 Project Based Rental Assistance approach to promote the creation of integrated supportive housing units.

Section 232 Residential Care Facilities Program is important to developing accessible housing options. The Section 232 program provides mortgage insurance for loans supporting the construction, renovation, equipping, and/or refinancing of nursing homes, assisted living facilities, and board & care homes through HUD's Federal Housing Administration (FHA). The program maintains a negative credit subsidy rate.

***Julie Strauss, Office of Licensing and Quality of Care, Seniors and People with Disabilities Division, Oregon Department of Human Services*:**

Housing vouchers are not currently used in ALF settings.

***Michael Vaughn, Acting Director, Asset Management and Lender Relations, Office of Residential Care Facilities, Office of Healthcare Programs, HUD*:**

HUD is working administratively to prioritize new Section 202 and new Section 811 programs that make more explicit connections to services to ensure that residents (whether elderly or non-elderly disabled) have the resources they need to live independently in the community for as long as possible. In addition, the President's budget request for FY 2012 includes $40 million for HUD's Assisted Living Conversion Program, a long-standing program that helps existing owners of Section 202s retrofit their properties to better accommodate frail elderly and licensure.

The recently enacted bi-partisan S. 118, the "Section 202 Supportive Housing Act" included Title 3 which specifically amends the Assisted Living Conversion Program (ALCP) to authorize use of those funds for projects that do not propose to license the entire building but rather propose to connect residents with community-based licensed services delivered directly to the individual's apartment, such as those provided through Medicaid Home and Community Based waivers or the PACE program. This legislative change in the context of ALCP offers a possible roadmap forward for how Section 202 property owners, public housing authorities, and elderly-restricted LIHTC owners could more generally facilitate aging in place through larger changes on a state by state basis to the Medicaid program that are facilitating delivery of services directly to the community rather than requiring institutionalization.

Also, HUD has been working closely with HHS to develop the "Money Follows the Person (MFP)" model. The MFP Demonstration Program reflects a growing consensus that long-term supports must be transformed from being institutionally-based and provider-driven to "person-centered" consumer directed and community-based.

In support of this initiative, HUD is encouraging PHAs to utilize local preferences and use public housing units and housing choice vouchers to join with state Medicaid offices and aging and disability agencies administering Medicaid programs in promoting the Money Follows the Person Rebalancing Initiative. Through funding made available in this initiative, states participating in the MFP program may receive the resources necessary to hire a transition coordinator. The transition coordinator could then assist the public housing tenant or voucher participant access needed services within his or her home.

The Section 232 Program has seen an explosion in demand, with applications rising from an annual rate of 225 to over 700 over the past three years. This year, HUD expects to approve about 125 applications for FHA mortgage insurance on ALF/B&Cs and is seeking to increase the number of affordable ALFs it insures. It has been hampered by the lack of staff resources to process applications, forcing affordable assisted living developers to wait in a lengthy queue and jeopardizing project funding from other sources including tax credit allocations.

***Patricia Will, CEO, Belmont Village Senior Living*:**

The HUD 232 Section program is a great source of permanent and construction financing for licensed AAL. In fact, if a HUD 232 application is made on a new construction AAL with tax credits, it is pulled out of the regular queue and put on a fast track. This is primarily because of IRS deadlines attached to tax credit financed projects. The HUD processing queue is now so long it would be virtually impossible to do a regular tax credit deal without being fast-tracked.

9. **How are HUD and HHS collaborating to better connect housing and services for persons with disabilities and older adults, including the recent provision of funding for 1,000 housing vouchers to serve non-elderly disabled individuals transitioning from institutions? Will these vouchers be used for subsidization of rent only, and if so, how will the services be paid for?**

***Brenda Bacon, President and CEO, Brandywine Senior Living*:**

We do not have any information on this initiative.

***Eric Carlson, Directing Attorney, National Senior Citizen's Law Center*:**

HUD and HHS have created the Community Living Initiative to assist people with disabilities in moving out of institutions and integrating into the community. Information about the initiative is available at www.hhs.gov/od/topics/community/olmstead.html.

HUD on April 7, 2010, announced the availability of 5,300 vouchers to be used by public housing agencies to provide housing for non-elderly persons with disabilities. The Notice of Funding Availability divided the vouchers between approximately 4,300 Category 1 vouchers

and 1,000 Category 2 vouchers. To obtain Category 1 vouchers, the public housing agency must demonstrate that tenants will have access to adequate support services. The standards for obtaining Category 2 vouchers are higher: the public housing agency must identify a partnering agency, and that agency must be a state-level agency responsible for transferring persons out of nursing facilities and like institutions. In most cases, this partnering agency will be the agency responsible for transferring persons from nursing facilities under the state's Money Follows the Person (MFP) program.

Vouchers can be used for housing but not services. MFP programs help pay for transition expenses. Medicaid HCBS programs often are used to pay for ongoing personal care expenses.

***Howard Groff, President, Tealwood Care Centers*:**

The recent dialogue and increased coordination between HHS and the U.S. Department of Housing and Urban Development (HUD) is a welcome development and holds great promise for expanding housing-with-services options available to low-income seniors and people with disabilities. However, while HUD recently made a number of housing vouchers available for non-elderly, low-income people to help them transition from institutional settings or remain in community settings, so far such vouchers have not been made available to elderly individuals. Lack of funding for housing also continues to be a major barrier to the transitioning individuals to community-based settings under the Money Follows the Person grant program.

***Krista Hughes, Director, Division of Aging and Adult Services, Arkansas Department of Health and Human Services*:**

In AR, most housing vouchers are allocated to and administered by Public Housing Authorities (PHAs), which have very long waiting lists. To date, no AR PHAs have developed affordable assisted living housing in AR, so the vouchers have not been available to tenants in assisted living.

***Barbara Lyons, Senior Vice President – Kaiser Family Foundation, Director – Kaiser Commission on Medicaid and the Uninsured*:**

The lack of affordable, accessible housing remains the toughest challenge for states attempting to transition Medicaid individuals from institutions back to the community.[xviii] Through the Money Follows the Person (MFP) rebalancing demonstration program, 30 states have transitioned nearly 9,000 Medicaid beneficiaries living in institutions back to the community and another 4,000 transitions are currently in progress. Furthermore, as of January 2011 fourteen additional states applied for MFP grants following the announcement of additional federal funding for the program through the Affordable Care Act.[xix] However, states are still far behind their original goals of transitioning over 35,000 individuals back to the community. Obstacles to transition include lack of affordable, accessible housing and lack of community workforce supply.

To address these barriers, HUD and HHS have joined forces to explore ways of combining housing subsidies with Medicaid services. This translates into state Medicaid agencies working with state and local housing authorities to fund specific initiatives under MFP to help successfully transition individuals back to the community. For example, the Ohio Medicaid agency has partnered with the Ohio Housing Finance Agency to fund and develop a web-based

Permanent Supportive Housing (PSH) Medicaid Toolkit (http://www.pshmedicaidtoolkit.ohio.gov/default.htm).[xx]

PSH is permanent, community-based housing targeted to low-income individuals with serious and long-term disabilities. PSH tenants are provided access to a comprehensive array of services and supports designed to meet their needs and maintain housing stability. Ohio also received national recognition from HUD in July 2010 for its partnerships with public housing authorities resulting in the ability to connect vouchers to MFP participants. In addition, Georgia MFP has partnered with the State Housing Finance Authority (the Department of Community Affairs-DCA, Rental Assistance Division) by developing a Housing Choice Voucher (HCV) program. DCA has provided 100 HCVs for use by MFP participants. The DCA/MFP partnership has now expanded to include six Public Housing Authorities (PHAs) in metro areas in the state. Partnerships like this are an integral part of the MFP program as they help increase safe, affordable, and accessible housing options for persons with disabilities looking to return to the community.

***Charley Reed, Member, Board of Directors, AARP*:**

Other participants can better address this question.

***Martha Roherty, Executive Director, National Association of States United for Aging and Disabilities (NASUAD)*:**

NASUAD respectfully defers to its federal partners at DHHS and HUD.

***Julie Strauss, Office of Licensing and Quality of Care, Seniors and People with Disabilities Division, Oregon Department of Human Services*:**

Oregon's Housing and Community Development Agency makes available to facilities willing to serve underserved and low income populations state-bond-backed loans.

***Michael Vaughn, Acting Director, Asset Management and Lender Relations, Office of Residential Care Facilities, Office of Healthcare Programs, HUD*:**

HUD has developed a close partnership with the Department of Health and Human Services (DHHS) to better align housing programs with health and social service programs for individuals with disabilities.

Over the past year HUD has released 5,300 Housing Choice Vouchers for Non-Elderly Disabled persons (NED vouchers).

- 1,000 of these NED vouchers were released in connection with the HHS/CMS "Money Follows the Person" Program, targeting disabled individuals wishing to transition from institutional settings to the community. HUD and HHS worked closely in the development of the HUD NED Notice of Funding Availability (NOFA) to ensure the NED and MFP programs were linked as closely as possible.

- In addition HUD and HHS are partnering on a Capacity Building effort, funded through the MFP program that will promote collaboration between health and human service

housing agencies at the federal, state and local levels to improve the support of persons with disabilities. The capacity building initiative will support such efforts in five states (15 sites), including both NED-MFP sites and others.

Related to the capacity building effort is the support of Housing Resource Coordinators to facilitate the linkages between Medicaid services and the resources available through Public Housing Agencies. In addition, consideration is being given to supporting the creation of a cadre of local level coordinators to ensure that transition of persons from institutions is accomplished as seamlessly as possible within the health and housing systems.

HUD and HHS are also engaged in a joint research effort focused on identifying optimal models of housing and service provision for seniors. The goal is to use the research to design a demonstration of targeted, coordinated housing, health and long-term services and supports for older adults. A component of this joint research effort is the testing of the feasibility of data sharing as a tool for better understanding the needs of older adults being served by HUD and HHS, and to better target resources.

***Patricia Will, CEO, Belmont Village Senior Living*:**

We have no specific knowledge regarding HUD and HHS collaboration, however; when HUD was made aware of the tax credit timing issues, they allowed a waiver from standard HUD Section 232 processing procedures to deal with the IRS timing issues discussed above. With regard to HUD housing vouchers, it only pays for rent, not for assisted living services.

10. How have states approached the challenge of developing affordable assisted living, and what sources of federal funding do they use? What barriers have states encountered in accessing federal funding? What types of state funding and private funding sources have typically been involved in putting together affordable assisted living projects? Can any of the federal financing programs for affordable housing be streamlined, and if so, how?

***Brenda Bacon, President and CEO, Brandywine Senior Living*:**

States have utilized, in varying degrees, the home and community based services waiver for assisted living. However as mentioned earlier, the Medicaid waivers pay for services, but not housing or food. State funding for affordable assisted living projects have been virtually non-existent. We do not anticipate in these troubling economic times a reasonable scenario where states will set aside finances for affordable assisted living development programs. We do feel states will continue to invest in Medicaid state plan amendment and waiver programs as they realize savings for utilizing home and community-based alternatives to nursing homes. However it is critical that the waiver reimbursement rate be adequate to pay for quality care.

The main resources for the development of affordable assisted living projects remain the Sections 232 and 202 programs. While we have no recommendations on how to streamline the federal financing programs at this time, a simple way to speed development of affordable assisted living is to address the backlog of applications in queue for the Section 232 program.

***Kevin Coughlin, Director, Wisconsin Bureau of Assisted Living*:**

Wisconsin has an entitlement program known as Family Care and IRIS using Medicaid waivers that now serve approximately 80% of the population. Wisconsin has a handful of successful "affordable assisted living" projects financed with tax credits plus Family Care, with the majority of residents being low income. In talking to people involved with the housing tax credits or subsidies, such projects appear to be very limited in how many there are, and they are very complex to establish. There needs to be better education for assisted living developers on how to apply for these and how to navigate the process. Streamlining would be very helpful.

***Howard Groff, President, Tealwood Care Centers*:**

See answer to question #6. Barriers include:

- The HUD/FHA loan process (application to loan closing takes 18 months);
- USDA requires both equity and debt guarantees;
- Given the financial status of municipalities, it is currently extremely difficult to obtain financing and rating status for Municipal Bonds;
- Equity requirements usually favor a structure involving local economic development agencies or churches where they can contribute land as equity.

Also, as noted above, there is often a lack of coordination with state funding programs. For example, Minnesota's Housing Finance Agency has never extended loans to long term care facilities.

***Krista Hughes, Director, Division of Aging and Adult Services, Arkansas Department of Health and Human Services*:**

Arkansas developers can utilize the State Assisted Living Incentive Fund (funded by ARRA funds), LIHTC (Low Income Housing Tax Credit), HOME (block grant), RD (Rural Development), and CDBG (Community Development Block Grant) as funding sources. Barriers have included access to funds for infrastructure, access to grant or non-loan funds to make the developments cash-flow, and position of funds used for development (each funder wants to be in first position, but since the federal funds available to AR are required to be "gap" financing, they must be in the highest positions to protect the federal investment). If streamlining occurs, and Public Housing Authorities, Rural Development, and HUD requirements are adopted, those organizations could consume all federal resources to maintain those federal agency's respective housing inventories, thus making development of affordable housing (primarily by for-profit and non-profit developers) unlikely or impossible.

***Robert Jenkens, Director – The Green House Project, NCB Capital Impact*:**

States have typically used Medicaid waiver or state plan funding to make assisted living services affordable to people with low incomes, combined with subsidized housing and finance programs to make the rent portion of assisted living fees affordable. Meals are generally paid from residents' personal or SSI income.

Federal financing programs can be significantly streamlined and aligned to support the rapid growth of affordable assisted living. The best way to accomplish this is for Congress to convene a workgroup to identify legislative and program modifications to allow the easy and rapid combination of existing federal housing and healthcare financing programs. In addition to existing programs, the workgroup could recommend any new financing or grant programs required to meet the demand for assisted living services and support CMS's work to shift the balance of Medicaid payments from institutional care to community-based options.

***Barbara Lyons, Senior Vice President – Kaiser Family Foundation, Director – Kaiser Commission on Medicaid and the Uninsured*:**

Affordable assisted living typically refers to licensed residential settings that provide apartment-style housing together with supportive services (e.g., help with personal care, meals, housekeeping and medication management) to older residents, at least a portion of whom are low-income.[xxi] As of 2010, there were 37 states that paid for assisted living services through Medicaid waivers and 16 states that paid through a state plan. And some states that paid through both. However, states have the ability to limit the number of slots for assisted living in their HCBS waivers, and this creates some uncertainty for developers and investors because they cannot reliably calculate demand. The challenges associated with developing affordable assisted living highlight the difficulty of finding affordable, safe housing options in the community.

***Larry Polivka, Executive Director, Claude Pepper Center*:**

DOEA would have this information.

***Charley Reed, Member, Board of Directors, AARP*:**

The primary way that states have used to provide affordable assisted living is through the Medicaid program. A few states also provide state funded subsidies for eligible residents who are unable to afford the cost of assisted living and might otherwise be in nursing facilities. A 2009 report[10] by Robert Mollica found that 134,345 people were being served in assisted living under various state programs:

- Medicaid 1915 (c) waivers – 37 states
- Medicaid state plans – 13 states
- Medicaid 1115 waivers – 4 states
- State revenues – 6 states

States and providers committed to serving people with low and moderate incomes have faced a host of challenges in expanding affordable assisted living. A report from the Center for Excellence in Assisted Living (CEAL) identified the following as the top five main obstacles to creating affordable assisted living:

- Inadequate funding for housing and services;

[10] *State Medicaid Reimbursement Policies and Practices in Assisted Living.* Robert L. Mollica, Ed.D. September, 2009. Prepared for the National Center for Assisted Living, American Health Care Association. http://www.ahcancal.org/ncal/resources/Documents/MedicaidAssistedLivingReport.pdf

- Recognition of the need to blend housing and services to provide consumer choice;
- Lack of information on the comparative costs and benefits of affordable assisted living;
- Lack of standardization to allow stable real estate funding and risk evaluation; and
- Lack of technical assistance to address knowledge gaps between consumers, funders, providers, and policy makers.

A pilot program funded by the Robert Wood Johnson Foundation, the Coming Home Program, worked with nine states to develop the kinds of technical assistance tools needed to bring together the relevant state agencies so that the housing and services financing streams could be used to develop affordable assisted living, especially in underserved rural areas. That program led to the development of more than 3,000 units of affordable assisted living. The lessons of that program could serve more states in order to develop affordable assisted living at a scale commensurate with the growing demand.

Martha Roherty, Executive Director, National Association of States United for Aging and Disabilities (NASUAD):

Affordable assisted living is developed using a combination of housing financing and Medicaid as well as public housing developments and Medicaid-financed supportive services. Beneficiaries typically contribute to costs through cost of care payments to the providers and room and board payments to the provider or housing owner (e.g., Medicaid rates may not include room and board). States report challenges with coordinating HUD and DHHS requirements. Any steps that the federal government could undertake to streamline requirements and reporting for states would be extremely helpful. While many states have developed working groups to address the "layer cake" effect (e.g., licensure, Medicaid waiver requirements, life safety, and housing requirements), coordinating all of these sometimes competing requirements is a challenge particularly in tight budget times. The topic of competing interests is particularly of concern – e.g., licensure medical model of survey versus HCBS Wavier/person centered expectations.

Michael Vaughn, Acting Director, Asset Management and Lender Relations, Office of Residential Care Facilities, Office of Healthcare Programs, HUD:

States have successfully used a combination of LIHTC and debt financing for the development of the facility, with income from residents provided or supplemented by payments under Medicaid waiver programs. There has been success with this model, especially in certain states – 13 of 18 LIHTC deals done by Section 232 have been in Illinois. Other states have struggled to find the right format for Medicaid waiver programs to provide the necessary income to support development of facilities with provision for the appropriate level of care.

Patricia Will, CEO, Belmont Village Senior Living:

Most states have not used the tax credit program to finance AAL. Most often, this is because their Medicaid waiver won't accommodate this kind of financing, because the waiver acts more like a voucher that travels with the resident versus a project-based contract. In short, the problem

is not that the states lack access to federal funding, but rather that the state's waiver is inadequate to cover the level of assisted living services often required. Additionally, it is not apparent to the state Tax Credit Agency that tax credits can be used for developing AAL. What is needed is a stated IRS rule or opinion that you can use tax credits with AAL provided you meet certain requirements.

11. Today, developers trying to develop affordable assisted living typically must navigate multiple layers of financing. Does this present challenges for developers that are typically too difficult to navigate, and if so, why?

***Brenda Bacon, President and CEO, Brandywine Senior Living*:**

Anytime developers utilize multiple sources of financing it is complicated. In a typical "for-profit" project, you will experience one or maybe two sources of financing. Today, most developers of affordable assisted living more than likely have one avenue for financing and that rests with HUD. Because of the backlog of processing HUD Section 232 housing applications for example, other financing contingent on HUD financing will be dropped because the loans are not processed in a timely manner.

***Irene Collins, Commissioner, Alabama Department of Senior Services*:**

The growth of assisted living in our state is definitely affected by the financial market today. We have approximately the same number of licensed beds as we did in 2000.

***Kevin Coughlin, Director, Wisconsin Bureau of Assisted Living*:**

In Wisconsin it can be very difficult to navigate the process and to meet the paperwork requirements.

***Howard Groff, President, Tealwood Care Centers*:**

Yes, this presents serious challenges for developers. Below are two examples.

In the Twin Cities area, there are very few assisted living communities in Minneapolis and St. Paul proper. Developers have chosen to develop in the suburbs and third-ring market. Tealwood operates a large (200-bed) nursing facility (NF) immediately south of downtown Minneapolis. We have a Transitional Care Unit in the NF and found that, after completing rehabilitation, a large number of residents had to go to assisted living communities in the suburbs to convalesce. We saw a need to develop an assisted living community in Minneapolis that would serve a large number of Elderly Waiver (Medicaid) clients when complete (probably 40% of its capacity). In order to get the "deal done" using HUD/FHA financing, we needed to obtain incentive funds through the City of Minneapolis. We were ultimately able to obtain this financial help, but it took numerous meetings with the planning agency in addition to two City Council meetings to accomplish.

In another situation, we are developing an assisted living community in Edina, which is one of the wealthiest cities in Minnesota, if not the wealthiest. We are developing it in conjunction with a church adjacent to the site. (Note: the church sold us the land and will own part of the project.)

We wanted to make a portion of the building affordable (20 of 139 units) and sought approval from the City Council to grant us Tax Increment Financing (TIF). The city denied our request even though the necessary TIF district existed.

In regards to this same project with the church, the city is invoking park dedication fees of $5,000 per unit, or some $695,000. There are two questions begging to be asked here: First, how frequently will our elderly clientele utilize the park system or baseball fields? Second, how could an affordable project ever be able to afford the $5,000 per unit park fee?

***Krista Hughes, Director, Division of Aging and Adult Services, Arkansas Department of Health and Human Services*:**

If the developer has any affordable housing development experience, the financing is not too challenging to undertake successfully. If not, assisted living is a difficult project to finance and implement on a first time basis.

***Robert Jenkens, Director – The Green House Project, NCB Capital Impact*:**

Assembling multiple layers of financing to reduce rent costs to an affordable level for Medicaid-eligible individuals is a significant challenge. Generally, state Medicaid programs' income and asset limits are more restrictive than the applicable housing programs. The programmatic variability in income guidelines between Medicaid and housing programs, as well as between housing programs that need to be combined, lead to gaps in necessary capital due to differing subsidy requirement assumptions, complex structures that limit development and increase costs, and a reduced pool of investors and lenders with the risk tolerance to take on assisted living projects when far simpler independent housing projects exist with the same returns.

***Larry Polivka, Executive Director, Claude Pepper Center*:**

We believe so. One example would be Quiet Waters in Belle Glade. It took Mr. Glucksman approximately 10 years to get the project started.

***Charley Reed, Member, Board of Directors, AARP*:**

Other participants can better address this question.

***Martha Roherty, Executive Director, National Association of States United for Aging and Disabilities (NASUAD)*:**

NASUAD respectfully defers to industry representatives.

***Julie Strauss, Office of Licensing and Quality of Care, Seniors and People with Disabilities Division, Oregon Department of Human Services*:**

Currently, in Oregon, ALF and RCF census figures are approximately 80 percent, suggesting that when the economy improves and the population continues aging the demand may outpace the available units. However, Nursing Facilities are currently at about 60 percent occupancy. Many of these units could be modified or razed to accommodate new construction.

***Michael Vaughn, Acting Director, Asset Management and Lender Relations, Office of Residential Care Facilities, Office of Healthcare Programs, HUD*:**

There are a number of sophisticated affordable assisted living developers who have become adept at combining the different funding sources in order to produce successful properties. Illinois' and other states' success in encouraging development of these facilities shows that with properly designed programs, these challenges can be overcome.

***Patricia Will, CEO, Belmont Village Senior Living*:**

If a developer plans to use tax credits and other affordable financing tools to develop an AAL, they will have to plan on dealing with multiple layers of financing. This is pretty typical in the affordable housing development business and not likely to change specifically for developing AAL.

12. What level (federal and state) and type of government funding, for capital and for services, is needed to deliver sufficient new units to meet projected needs for new (or converted) affordable assisted living units, while maximizing savings?

***Brenda Bacon, President and CEO, Brandywine Senior Living*:**

We do not have the expertise to answer this question.

***Kevin Coughlin, Director, Wisconsin Bureau of Assisted Living*:**

In Wisconsin, assisted living would benefit significantly with more federal funding for capital in the form of tax credits or subsidies. In the few cases where there are tax credits or other government funding that helps the capital or housing component, matched with Wisconsin's Family Care or IRIS programs for services, then the assisted living community is able to successfully operate a facility that is serving all low income elderly or disabled residents.

***Howard Groff, President, Tealwood Care Centers*:**

Even though public money is currently scarce, it is imperative for policymakers to consider ways to expand the availability of affordable assisted living and to help states cover the gaps in Medicaid funding for assisted living. Broadly speaking from a national perspective, policies that could be considered include making housing vouchers available to low-income assisted living residents including Medicaid beneficiaries; providing increased public financing or loan supports for construction of affordable assisted living; building a housing financing component into or alongside Medicaid services payments for beneficiaries living in community-based settings, including assisted living; and expanding incentives and financial vehicles for individuals and families to save for future long term care costs.

In Minnesota, the number of Medicaid recipients under the state Elderly Waiver grew from 9,772 in FY 2000 to 26,313 in FY 2008 with the number in Customized Living/24-Hour Customized Living recipients growing from 684 to 9,210 over the same eight-year period.

There needs to be a greater level of HUD funding and a loosening up of the restrictions tied to that program. HUD money is very inflexible in terms of the characteristics of the residents, and it has an uncertainty in terms of longer-range budgeting. Providing options for low- or no-interest borrowing would help bring down the rental costs. In Minnesota, we have a Housing Finance Agency (MHFA) that is really a "bank" to lend out money at reduced interest rates. Unfortunately, senior housing is in direct competition with projects for homeless families for these limited dollars. As a result, the priority has been to finance projects that reduce homelessness for women and children. Since seniors aren't viewed as being homeless, they are not in the first tier of financing. Further, should the MHFA choose to, it could actually shorten the HUD/FHA back log through its ability to originate FHA-secured loans through its HUD public program.

***Robert Jenkens, Director – The Green House Project, NCB Capital Impact*:**

Current federal and state affordable housing programs are oversubscribed and cannot fully support the demand they are designed to serve. Given competing needs and resulting rationing, it has been my experience that states are lucky if they can assist one to three assisted living projects (serving 40 to 200 people). With the 85+ population growing rapidly, these best case production levels will not be sufficient to handle current or future demands for less costly nursing home alternatives preferred by consumers. One or all of the following will be necessary (individually or, most likely together) if Congress wants appropriate assisted living options to be widely available for people eligible for the Medicaid nursing home benefit:

- Increased rent subsidy supports to individuals
- Modifications to existing loan and grant programs
- A new financing program designed to pair with Medicaid funded assisted living.
- Higher levels of Medicaid reimbursement that include room and board payments sufficient to support conventional debt (room and board payments are currently not allowed in waiver programs).

***Larry Polivka, Executive Director, Claude Pepper Center*:**

AHCA and Florida's Department of Elder Affairs (DOEA).

***Charley Reed, Member, Board of Directors, AARP*:**

While other participants have more expertise on issues related to capital financing, we would note that much, if not most, of the debt financing currently available for assisted living and other types of care facilities comes from the government sponsored enterprises (GSEs), Fannie Mae and Freddie Mac. Moreover, the Federal Housing Administration's (FHA) Section 232 program is one of the few remaining sources of credit enhancement, especially for not-for-profit sponsors. As Congress addresses reforms to the GSEs and FHA, it is important to consider the implications for the future of facilities providing long-term services and supports. At a time when the average nursing home is over 30 years old, the country needs a forward-looking strategy to capitalize the innovative and more person-centered residences that we all hope will characterize the future of long-term services and supports. To that end, AARP supported a bill introduced by Senators Casey (D-PA) and Wicker (R-MS) in the last Congress to build the infrastructure for funding

small cottage-type facilities. Similar or other approaches on a larger scale are needed to promote both the affordability and the livability of the next generation of long-term care facilities.

While resources are limited, there are some ways that the federal government currently meets some of the funding needs. HUD's Assisted Living Conversion Program provides funding for owners of subsidized housing to retrofit their properties to meet state assisted living licensing requirements. Through the establishment of partnerships with service providers and with financial assistance for building retrofits from the Assisted Living Conversion Program, the owners of a small number of affordable housing developments have taken steps to ensure that residents can age in place and access needed supportive services. Funding for this conversion program is very limited, but even if all existing subsidized developments could be retrofitted to provide common services for older adults, the current supply would still fall short of growing demand. Since its creation in 2000, the program's reach has been limited and funding has not been sufficient to enable participation on a widespread basis. (The Assisted Living Conversion Program received $25 million annually in fiscal years 2008 and 2009 and $30 million in FY2010.)

State Housing Finance Agencies (HFAs) can also play a significant role in financing affordable assisted living through their roles in allocating federal low-income housing tax credits (LIHTC) as well as their ability to float bonds to support affordable assisted living. State HFAs have the flexibility necessary to develop financing programs that would support assisted living, but relatively few of them have made affordable assisted living a major goal – reflecting both the competition from other demands for housing finance as well as the lack of technical competence in this very specialized area of finance. Arkansas is an example of a state that has identified affordable assisted living as a priority, and the state housing finance agency has reserved a portion of its LIHTC allocation to finance such projects. The state also allocated $5 million from stimulus funding to invest in affordable assisted living, based on its experience that making assisted living affordable is very difficult without significant equity financing. Projects that must rely on debt financing have found that the ongoing need to service those debts make the housing portion unaffordable to most people with low incomes.

Martha Roherty, Executive Director, National Association of States United for Aging and Disabilities (NASUAD):

NASUAD respectfully defers to industry representatives.

Julie Strauss, Office of Licensing and Quality of Care, Seniors and People with Disabilities Division, Oregon Department of Human Services:

Oregon has one of the lowest per capita nursing facility populations (Medicaid is about 4700 residents). However, with appropriate community supports there are still residents that are perceived to be able to be served in other community-based facilities.

Michael Vaughn, Acting Director, Asset Management and Lender Relations, Office of Residential Care Facilities, Office of Healthcare Programs, HUD:

The Section 232 and 542 programs are subject to Congressional approval of FHA Commitment authority, but since both programs are subsidy negative (make money for the government), they

should theoretically be able to be expanded to meet demand. Tax Credit authority is allocated to the States, and because of market conditions, has produced less capital for development than in the past. Also, State funding of Medicaid waiver programs is hampered by budget pressures, and in some cases the statutory need to allocate Medicaid funds to SNF's results in inadequate compensation levels for affordable assisted living waiver programs.

***Patricia Will, CEO, Belmont Village Senior Living*:**

In terms of what level and type of funding is needed to deliver sufficient new units is yet to be determined, however; if the IRS can make this an acceptable type of affordable housing financed with tax credits that AAL developers nationwide will have access to the fairly large tax credit equity market.

13. Are there estimates of how many Medicaid beneficiaries who are served in nursing homes today could be served in assisted living residences instead? What would be the cost savings to states and the federal government if more affordable assisted living was available?

***Brenda Bacon, President and CEO, Brandywine Senior Living*:**

Estimates show that at a minimum, 25 percent of nursing home residents do not need to be in a skilled nursing setting and could be served in assisted living. Because assisted living is 33 to 50 percent less costly than skilled nursing care, assisted living saves state and federal government money in two ways. One, consumers financial assets last twice as long if someone is living in assisted living vs. skilled nursing care. In many cases this means an individual will never "spend down" and need Medicaid. If someone should spend down and become Medicaid eligible and lives in assisted living vs. skilled nursing home, again because reimbursements are lower than skilled care, federal and state governments save money.

***Eric Carlson, Directing Attorney, National Senior Citizen's Law Center*:**

Making such an estimate is complicated by the fact that assisted living facilities can vary greatly from each other, both from state to state and within a single state.

***Irene Collins, Commissioner, Alabama Department of Senior Services*:**

There should be information available in those states who have Money Follows the Person grants who allow for transition into Assisted Living.

***Kevin Coughlin, Director, Wisconsin Bureau of Assisted Living*:**

The Family Care program in Wisconsin is designed to eliminate this inequality in access to appropriate resources, through creating an entitlement program incentivizing managed care organizations to serve each enrollee in the most appropriate setting, using the full spectrum of community and institutional services.

***Howard Groff, President, Tealwood Care Centers*:**

As noted in the answer to question #7, if affordable assisted living were an entitlement under Medicaid (as nursing home care currently is) and the cost of room and board were adequately financed, many more low-income individuals could live in an assisted living setting in many states. This is especially the case in states that have limited non-institutional options for long term care. Another factor would be how each state currently defines "nursing home eligible" from a clinical perspective. Those with a higher clinical floor would not be able to move as many residents out of nursing facility settings. However, it is important to note that if Medicaid participation levels were to rise for assisted living, that would mean that government spending for room and board and the number of assisted living slots would have to rise, thereby reducing some of the savings of generated by less use of institutional settings. Therefore, the overall savings generating by expanding home and community-based options are often hard to estimate.

***Krista Hughes, Director, Division of Aging and Adult Services, Arkansas Department of Health and Human Services*:**

According to the article "Prospects for Transferring Nursing Home Residents to the Community", published in Health Affairs in 2007, Arkansas has a higher than average prevalence rate of low care nursing home residents. Arkansas used the low care definitions outlined in this article and analyzed calendar year 2007 Arkansas Medicaid nursing home resident assessments from the Centers for Medicare & Medicaid Services Minimum Data Set (MDS) national data repository. The analysis showed that during calendar year 2007, an estimated 10.7% of Medicaid per-diem residents were classified as low-care. During this calendar year, $560 million was spent on behalf of Medicaid beneficiaries treated in the nursing home. Projecting the percentage of low-care Medicaid residents to actual calendar year 2007 expenditures, it is estimated that as much as $59 million could have been spent on low-care residents at the nursing facility. In Arkansas, the tiered per diem rate for ALF ranges from $61.15 to $73.62; the SFY '09 weighted average per diem for nursing homes was $143.59; so, the cost savings to the state and federal government of treating the low care population in alternative settings would be substantial.

***Barbara Lyons, Senior Vice President – Kaiser Family Foundation, Director – Kaiser Commission on Medicaid and the Uninsured*:**

The nursing home resident population consists mainly of elderly, long-stay residents (over 90 days) and both their number of conditions and needs for assistance in functioning have increased in recent years. Today's nursing home population consists of over one million individuals, and most are over age 85, female and widowed.[xxii] Disease prevalence is higher, and multiple conditions are more common, among nursing home residents today, indicating an increasingly sicker population. These individuals largely rely on a combination of personal finances and Medicaid to pay the costs of their care; in 2004, 69 percent of long-stay (a stay of 90 days or longer) nursing home residents reported Medicaid as the primary payer for their care.[xxiii] Sustaining further reductions in the nursing home population by caring for more of these severely disabled older individuals in community-based settings will require levels of assistance, and physical environments, capable of meeting these needs. This will be especially important for people with cognitive disabilities, whose unique needs can present challenges for finding appropriate home and community-based supports.

***Charley Reed, Member, Board of Directors, AARP*:**

If adequate staffing and services are made available, many, if not most, nursing home residents may be able to be to have their needs met in assisted living, which costs less than nursing home care. To be eligible for Medicaid waiver funding, potential assisted living residents and other home and community-based services recipients must meet nursing home eligibility criteria, so enabling people to live in other settings can promote savings. To maximize the likelihood of realizing such savings, states should institute effective programs to divert consumers who can be adequately served in non-institutional settings to less expensive alternatives that consumers generally prefer. Similarly, the most direct way to realize such savings is to enable current nursing home residents to transfer to home and community-based settings, including assisted living, that meet their needs and preferences. Importantly, regardless of whether individuals are residents of assisted living or nursing homes, they should have homelike settings, choice and control, privacy, autonomy, dignity, and be able to control their own schedules.

***Martha Roherty, Executive Director, National Association of States United for Aging and Disabilities (NASUAD)*:**

The number of potential residents will vary from state to state because states have different requirements for admission to nursing homes and different requirement for admission and discharge from assisted living including prohibited conditions, etc. Savings also would be very state specific and program specific (e.g., NH payments compared to assisted living and level of assisted living).

***Julie Strauss, Office of Licensing and Quality of Care, Seniors and People with Disabilities Division, Oregon Department of Human Services*:**

Oregon does not have a hard enrollment cap in its home and community based waiver.

***Patricia Will, CEO, Belmont Village Senior Living*:**

While we do not have national estimates, an AAL provider in Illinois estimates that over 20% of its AAL residents came directly from nursing homes and approximately two-thirds of his residents resided in nursing homes at some point in time. In Illinois, an affordable assisted living resident's costs are approximately $1,000 per month per resident less than a Medicaid nursing home resident.

14. Are there changes in Medicaid that the federal government and states could make that would make it more feasible to finance and develop affordable assisted living? For example, if states work to develop significant home and community-based state Medicaid options that are not subject to hard enrollment caps, might this enhance interest in expanding assisted living among developers and advocates?

***Brenda Bacon, President and CEO, Brandywine Senior Living*:**

Medicaid pays for services but it does not pay for housing or non-service related amenities such as food. Therefore Medicaid reimbursement for assisted living will not incentivize a developer

unless the Medicaid slots are somehow tied to development incentives such as tax credits. Furthermore, it is not the caps that are a disincentive but the reimbursement levels. Care is expensive and assisted living providers cannot provide quality care at some of the minimal reimbursement rates that states have established across the country. The other problem is many states never adjust their rates to even cover cost of living adjustments. This is a further disincentive for providers to care for publicly financed residents.

***Eric Carlson, Directing Attorney, National Senior Citizen's Law Center*:**

Eliminating enrollment caps clearly would be one way to make affordable assisted living a more viable option for residents, providers, and developers. A state's care system is improperly skewed towards nursing facility care if nursing facility care is an entitlement but Home and Community-Based Services (HCBS) in an assisted living facility are subject to an enrollment cap.

Also, protections against spousal impoverishment should be made mandatory in HCBS programs as soon as possible. Under 2010's health care reform law, the protections against spousal impoverishment are scheduled to become mandatory for HCBS programs in 2014, but that does not help those at-home spouses who are becoming impoverished now, or those Medicaid beneficiaries who are staying in a nursing facility rather than a Medicaid-certified assisted living facility in order to protect the at-home spouse from impoverishment.

Finally, state Medicaid programs should establish realistic room and board allocations for beneficiaries living in assisted living facilities. Currently, room and board allocations too often are based on Supplemental Security Income (SSI) levels, rather than on the cost of providing room and board. Adequate room and board standards would allow the resident to retain additional income, and authorize the facility to charge the resident a higher amount consistent with the income retained by the resident. This issue is discussed in somewhat more detail in question (and answer) #15, immediately below.

***Kevin Coughlin, Director, Wisconsin Bureau of Assisted Living*:**

As Wisconsin has moved from limited Medicaid slots to a Medicaid entitlement program with Family Care and IRIS, assisted living has expanded. In 2010, Wisconsin experienced its 31st consecutive year of growth in assisted living communities. More information regarding Wisconsin's Family Care and IRIS programs can be found at:

http://www.dhs.wisconsin.gov/LTCare/

http://www.dhs.wisconsin.gov/bdds/IRIS/index.htm

It may be axiomatic that increased availability of funding to support assisted living for middle and lower economic class residents would create an incentive for developers to increase their participation in this arena. It would, however, require a certain bit of caution to assure that investors are truly committed to the assisted living concept more than they are committed to the potential fiscal benefits for this to become a stable model for providing needed care and services.

***Howard Groff, President, Tealwood Care Centers*:**

See answers to questions #3, #7, and #13.

***Robert Jenkens, Director – The Green House Project, NCB Capital Impact*:**

There are several straightforward modifications to the Medicaid program that the Federal and state governments could make to facilitate financing for assisted living and, by building additional diversion capacity, save nursing home costs. Giving assisted living and other community-based care options the same status as the nursing home benefit would level the playing field and turn the focus of a large long-term care financing industry squarely on to creating alternatives.

Specifically, assisted living services would need to be made an entitlement (e.g., no enrollment caps), reimbursements would need to be resized to include room and board (creating a much simpler one-stop payment to remove complexity and perceived risks), and retroactive payments would need to be available when assisted living providers serve a new resident before the resident's Medicaid eligibility is approved. Making the assisted living benefit comparable to that received by institutional providers will alleviate misaligned incentives and address concerns that affordable assisted living projects will suffer low occupancy induced by Medicaid waiver services waiting lists and easier/faster admission to a nursing home.

A final financing obstacle that states could address if they want to recruit more providers to develop affordable assisted living is the fear expressed by many underwriters about the reliability of optional waiver programs over the 15-40 year term of their financing. An innovative approach to addressing this obstacle could be a federal/state partnership to guarantee loans negatively impacted by changes to the federal or state Medicaid waiver program. The benefit of this type of limited guarantee is that the risks (payment triggers) are entirely controlled by the guarantors.

Including room and board, an automatic inflation index, and or a guarantee program would allow underwriters to gain confidence that overall cost will be covered and loan covenants maintained. This risk mitigation would provide additional access to capital at lower costs. Until these industry concerns are addressed, only relatively small numbers of viable affordable assisted living projects will move forward – each relying on an exceptional circumstances to mitigate Medicaid risks (e.g., large endowments, minority status in a larger and financially stable operating entity).

For more information on developing and financing affordable assisted living, see the CEAL White Paper on Affordable Assisted Living (www.theceal.org) and "The Coming Home Program: Creating a State Road Map for Affordable Assisted Living Policy, Programs, and Demonstrations." Journal of Housing for the Elderly (2004).

***Barbara Lyons, Senior Vice President – Kaiser Family Foundation, Director – Kaiser Commission on Medicaid and the Uninsured*:**

With the passage of health reform, states were given the opportunity to expand access to Medicaid HCBS through a number of new initiatives that could enhance interest in affordable, community-living options. For example, The State Balancing Incentive Program provides

enhanced federal matching funds to states to increase the proportion of their Medicaid long-term care dollars that go towards HCBS. Eligible states can receive the increased match on all Medicaid HCBS programs including waivers and the personal care benefit—the two primary avenues through which most states pay for assisted living—in addition to PACE programs, and home health programs. To qualify for the enhanced federal funding states are required to implement a number of delivery system reforms including a single entry point system, conflict-free case management, and standardized assessment instruments for determining eligibility. These delivery system reforms in combination with enhanced federal support will expand access to Medicaid HCBS and may help broaden community-living options. Another ACA option that a number of states are pursuing is the Money Follows the Person demonstration program. A total of 43 states are currently receiving funding in order to transition individuals living in institutions back to the community. Early research into the MFP program found that housing remains the biggest barrier to transition so additional consideration exploring the use of Medicaid funds for affordable community-housing options is warranted. Lastly, the Community First Choice option includes a new Medicaid state plan option to assist Medicaid beneficiaries with long-term services needs. The new option defines permissible supports including help with rent, utility deposits and household furnishings. These added supports are designed to increase independence and to help seniors and persons with disabilities remain in the community.

***Charley Reed, Member, Board of Directors, AARP*:**

Vermont's unique Section 1115 Medicaid waiver provides some information regarding the effects of removing the institutional bias associated with Medicaid funding for long-term services and supports in most states. The state has embarked on a comprehensive change in priorities to allow consumer choice to determine the types of long-term services and supports they receive under the Medicaid program. While most of the growth in services has been among those receiving home care, affordable assisted living has also grown substantially.

***Martha Roherty, Executive Director, National Association of States United for Aging and Disabilities (NASUAD)*:**

First, already such options exist , Section 1915(i) and conceivably Section 1915(k), the Community First Choice Option. Second, volume only is half of the equation; providers also must feel comfortable with Medicaid rates and the stability of rates. The addition of new Medicaid state plan options and rate stability both are questionable in these difficult budget times.

***Julie Strauss, Office of Licensing and Quality of Care, Seniors and People with Disabilities Division, Oregon Department of Human Services*:**

Oregon does add inflation during their biennial budget process for all provider rates. Room and Board are not considered or covered in the Medicaid payment.

***Patricia Will, CEO, Belmont Village Senior Living*:**

Establishing a viable and reliable reimbursement rate structure would be very helpful. Reimbursement rates in many states are so inadequate that it is very challenging to deliver quality care. Hard enrollment caps make it difficult to develop new AAL unless you can reserve those units for your development.

15. Are there states that set their Medicaid rates for assisted living to factor in an annual measure of inflation? Are there states that have examined Medicaid reimbursement levels in the context of what providers' costs are for room and board and services?

***Brenda Bacon, President and CEO, Brandywine Senior Living*:**

We are not aware of any states that factor in an annual inflation measure for Medicaid waiver rates. North Carolina does require cost reports from its providers and does make adjustments to reimbursement based on these reports. The reverse is more likely the case as it is quite common for states to have the same reimbursement rate for 10 or more years. Even New Jersey, which has one of the best reimbursement rates in the country at $70 per day, had the same rate from 1997 to 2006 until there was a $10 increase in 2007.

***Eric Carlson, Directing Attorney, National Senior Citizen's Law Center*:**

We defer to other roundtable participants as to the Medicaid service rates used by specific states. We note that a Medicaid-certified assisted living facility receives two types of payments: one for room and board, and the other for services. Because the Medicaid program does not pay for room and board in an assisted living setting, the room and board payment is made by the resident from the resident's available income, at an amount set by the state. Payment for services is made by the Medicaid program and also by the resident, if the resident's income exceeds a minimum set by the state.

In sum, the resident pays the room and board charge, and may also contribute towards assisted living services, if the resident's income is high enough. The resident's payments for room and board and for services are calculated to leave the resident with a small monthly personal needs allowance, generally in the range of $60 to $100 monthly.

In general, the room and board rates used by state Medicaid programs are unrealistically low. They often are based on SSI payment levels rather than on the facility's cost of providing room and board.

***Kevin Coughlin, Director, Wisconsin Bureau of Assisted Living*:**

In Wisconsin, DHS/ DLTC currently is working on development of a statewide residential rate method factoring in acuity, facility type, provider cost and available income into a standardized rate method.

Currently, Wisconsin adjusts its Medical Assistance rates (through the Family Care and Community Options programs) periodically based on inflation and other indices.

***Howard Groff, President, Tealwood Care Centers*:**

Keeping Medicaid rates updated for inflation is typically a political and policy issue that states face. In the current economic climate, while a few states may grant small increases in rates, most are either level-funding or cutting rates, sometimes substantially.

As noted in the answer to question #3, the lack of Medicaid funding for assisted living room and board costs causes states to make a series of design decisions to try to cover those costs. These design features include whether or how much states supplement payments for room and board; whether states allow families to supplement room and board payments for Medicaid beneficiaries; and whether states allow beneficiaries to share apartments, and under what conditions.

States also must set personal needs allowance levels for Medicaid beneficiaries from funds available for room and board. In recent years, some states have increased personal needs allowances to help residents pay for the additional expense of medication co-payments required for non-institutional dual eligibles under the Medicare Part D program since 2006.

***Krista Hughes, Director, Division of Aging and Adult Services, Arkansas Department of Health and Human Services*:**

The Arkansas Living Choices Section 1915 (c) waiver for Assisted Living includes an annual 3% rate increase.

***Robert Jenkens, Director – The Green House Project, NCB Capital Impact*:**

Arkansas is a good example of a state that uses a heath care cost index to adjust their assisted living (AL) rate. This has proven to be a very valuable state provision in the eyes of low-income housing tax credit (LIHTC) syndicators. Arkansas also reviewed projected cost information during their rate setting work and used it to develop a fair rate structure.

***Larry Polivka, Executive Director, Claude Pepper Center*:**

Florida does not.

***Charley Reed, Member, Board of Directors, AARP*:**

Yes. Some states set their Medicaid rates for assisted living facilities to factor in an annual measure of inflation. According to a report by Robert Mollica,[11] some states regularly adjust their rates.

For example, "(t)he Arizona Medicaid agency, AHCCCS, in some years has contract language that directs its managed care organizations to pass on the inflationary amount assumed for HCBS in the capitation rate adjustment. Arizona indicated that a 4.6% increase was assumed in 2009; However, according to the Arizona Health Care Association, rates may decrease by 5% in 2010. Rates are negotiated between managed care contractors and providers. Illinois links its rates to 60% of the weighted average regional nursing home rate, which is adjusted every two years. Idaho's statute ties payment for state plan personal care services to the prevailing hourly wage for similar nursing facility staff. The rates include a 55% supplement for travel, administration, training, and all payroll taxes and fringe benefits. Annual adjustments are typical in Missouri and Nebraska, whereas other states increase rates when funding is approved by the legislature".[12]

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[11] *Ibid.*
[12] *Ibid.*

States use five primary ways to set rates: flat, tiered, case mix, care plan, and negotiated. These mechanisms are not mutually exclusive. The report cited above[13] contains a good description of each state's rate setting mechanisms. Many states take into account providers' costs by including differentials based on type of setting, geographic regions, or services provided.

With respect to room and board, federal regulations do not allow Medicaid reimbursement for room and board except in an institution and for respite care that is furnished in a state-approved facility. However, states may limit the amount charged for room and board. State policies on room and board charges vary considerably. Some states limit the amount that can be charged for room and board by setting a combined "rate" for Medicaid beneficiaries that includes service costs and room and board costs paid by the resident. Other states tie the amount that facilities can charge Medicaid beneficiaries for room and board to the state's Supplemental Security Income (SSI) payment plus a state supplement, if any, and minus a personal needs allowance.[14]

Martha Roherty, Executive Director, National Association of States United for Aging and Disabilities (NASUAD):

NASUAD offers two responses:

a. Yes – states vary their reimbursement models. Examples include tiers based on level of need, flat rate, and case mix. Some states increase by some level annually but such increases are unlikely in the current budgetary environment.
b. No – Medicaid may not pay for room and board. Additionally, CMS examines state rate setting methodologies to ensure that states are not "padding" service rates to help cover room and board. In fact the Section 1915(c) waiver application includes a section in which states must describe how room and board is excluded from the rate and how room and board will be covered. Families can supplement room and board payments for Medicaid beneficiaries but such family supplementation payment has implications for Supplemental Security Income (SSI) payment amounts or even SSI eligibility.

Julie Strauss, Office of Licensing and Quality of Care, Seniors and People with Disabilities Division, Oregon Department of Human Services:

Oregon does not allow supplementation. Because Oregon's rate is "all inclusive" any additional funds paid for services or supplies on the residents behalf become income and may, during Medicaid eligibility review, cause eligibility issues for residents.

Patricia Will, CEO, Belmont Village Senior Living:

We are not aware of states that use a COLA increase on rates. In Illinois, a state known for fostering development of AAL, the state collects annual cost reports, however; the state does not seem to use the cost data for rate adjustments. In fact, most states set reimbursement rates so low that it makes it very difficult to reasonably cover the cost of providing quality affordable assisted living.

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[13] *Ibid.*
[14] *Ibid.*

16. How common is the practice of Medicaid-participating facilities seeking additional (supplemental) funding from a beneficiary's family? What is the extent of private supplementation currently?

***Brenda Bacon, President and CEO, Brandywine Senior Living*:**

Approximately 25 states allow family supplementation for waiver residents in assisted living. The family supplementation is used mainly to allow residents to have a single room. It is important to note that 11 percent of families supplement the cost of assisted living for private pay residents. Family supplementation should be encouraged and allowed in all 50 states.

***Eric Carlson, Directing Attorney, National Senior Citizen's Law Center*:**

Based on our conversations with consumer representatives from across the country, this type of supplementation is not uncommon. We are not aware, however, of any good empirical measure of the extent of supplementation. The state and federal governments do not compile that information, to our knowledge. Even if there were an attempt to gather such data, the results might not be accurate: "supplemental" payments are often made surreptitiously, in an effort to keep that payment from reducing or eliminating the resident's eligibility for Supplemental Security Income (SSI) or Medicaid.

The federal and state governments should prohibit assisted living facilities from soliciting or accepting supplemental payments from the family or friends of a resident eligible for SSI or Medicaid, unless the supplemental payment truly is for an "extra" item or service not covered under the facility's basic services or the Medicaid service package. By definition, residents eligible for SSI and/or Medicaid have few savings and very limited income, and a facility should accept the state-authorized amount as payment in full.

If a facility has chosen to be certified as a Medicaid provider, it has agreed to accept Medicaid-authorized amounts as payment in full for Medicaid-covered services. *See* Section 447.15 of Title 42 of the Code of Federal Regulations. It is unfair to Medicaid beneficiaries, and a violation of federal Medicaid law, for a facility to solicit or accept supplemental payments from the family members or friends of a Medicaid-covered resident.

The National Senior Citizens Law Center recently published a white paper on this issue, entitled *Medicaid Payment for Assisted Living: How Supplemental Payments Affect an Assisted Living Resident's Eligibility for Medicaid and SSI*. A copy of this white paper is submitted with these answers.

***Irene Collins, Commissioner, Alabama Department of Senior Services*:**

All of our beds in Alabama are private pay with the exception of very few through VA.

***Kevin Coughlin, Director, Wisconsin Bureau of Assisted Living*:**

In Wisconsin, DLTC has developed policy protections for use by managed care organizations to restrict the instances of any 'balance billing' to enrollees or families for services, while still

allowing families and others to supplement for additional amenities that is based on informed choice, voluntary agreement and assurance of non-duplication of services.

Seeking supplemental payments happens, but we cannot be certain how frequently or how much of a supplement is demanded.

***Howard Groff, President, Tealwood Care Centers*:**

As noted in question #3, according to research done by Robert Mollica in 2009, 24 states supplemented the beneficiary's federal Supplemental Security Income (SSI) payment, which states typically use as the basis for room and board payment. SSI payments combined with state supplements ranged from $722 to $1,350 a month depending on the state. Some states provide no supplement.

Twenty-five states permitted family members or third parties to supplement room and board charges.

***Larry Polivka, Executive Director, Claude Pepper Center*:**

While there is no data available we feel that certain that this is occurring due to the inadequate funding available to meet current financial obligations.

***Charley Reed, Member, Board of Directors, AARP*:**

According to a 2009 report,[15] 25 states allow family supplementation, 14 states do not, and the rest of the states do not have a policy or did not answer the question. A recent paper by the National Senior Citizens Law Center[16] notes that "Seventeen states allow supplementation, sixteen prohibit the practice (sometimes with exception, as noted below), and four have no policy." States vary in their supplementation policies, and these policies can impact an individual's eligibility for Medicaid and SSI.

Assisted living residences should make clear in their contract and other documents what is covered. Coverage should include a private living unit. Prohibitions of federal and state requirements that the children or grandchildren of Medicaid beneficiaries receiving long-term services and supports (LTSS) assume financial responsibility for their parents' or grandparents' care should continue. However, families should not be prevented from paying for services that Medicaid does not cover, including additional payments for private rooms where they are not covered by Medicaid reimbursements.

***Martha Roherty, Executive Director, National Association of States United for Aging and Disabilities (NASUAD)*:**

In a 2007 study commissioned by the DHHS Assistant Secretary for Planning and Evaluation, researchers found that 25 states make provision for family supplementation of room and board,

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[15] *Ibid.*

[16] *Medicaid Payment for Assisted Living How Supplemental Payments Affect Assisted Living Resident's Eligibility for Medicaid and SSI: A Resource for Advocacy and Policy Development.* National Senior Citizens Law Center. January, 2011. http://www.nsclc.org/areas/long-term-care/Assisted%20Living/Medicaid-Payment-for-Assisted-Living/White%20Paper%20-%20Supplemental%20Payments%20Jan%202011%20FINAL.pdf

twelve states prohibited such payments, and eight states had no policy. NASUAD has no more recent information. It is important to point out, however, that families may not supplement the Medicaid payment to the assisted living provider for assisted living services.

***Julie Strauss, Office of Licensing and Quality of Care, Seniors and People with Disabilities Division, Oregon Department of Human Services*:**

Yes, the OAR (411-054-0019) requires disclosure of facility's Medicaid participation. If the facility has a DHS Medicaid contract they may not provide notice of involuntary move-out for non-payment if a resident becomes Medicaid eligible. If a facility is a non-participating entity, when a resident becomes Medicaid eligible they can be issued notice of involuntary move out.

***Patricia Will, CEO, Belmont Village Senior Living*:**

There are no national statistics regarding the extent to which family supplementation is widely practiced. It should be noted, however; that family supplementation is not permitted in all states. In fact, only about half the states reported that they allow family supplementation.[17] Moreover, there are financial implications for families that choose to supplement a beneficiary's care because a family contribution paid directly to an SSI beneficiary is considered as unearned income and this can lead to a reduction in the SSI payment or the loss of SSI altogether, and with it, potentially Medicaid as well.

Access and Discharge Issues

17. Do states generally require Medicaid-participating assisted living facilities to disclose what their policies are with regard to retaining residents who spend down their private funds and become eligible for Medicaid? Do states generally allow facilities to discharge individuals who start out as private-pay clients and spend down to Medicaid eligibility over time, e.g., when the facility is in a position to replace a Medicaid beneficiary with a resident who can afford to pay a higher rate?

***Brenda Bacon, President and CEO, Brandywine Senior Living*:**

Every state regulatory framework requires the assisted living provider to have a lease/ residency agreement with the resident. Every residency agreement includes reasons a resident may need to move out of the community. When a resident begins to deplete his or her resources assisted living providers will make a sustained effort to help someone who is starting to deplete their assets. For example, they may suggest they move to a smaller room or perhaps share a room. Many companies have a benevolent fund that will help residents who have depleted their resources. However, if in fact all of the above have been tried, and the resident becomes impoverished, the community will help the resident find a Medicaid bed either in assisted living, if available in that state, or in a skilled nursing facility.

[17] Residential Care and Assisted Living Compendium: 2007

***Eric Carlson, Directing Attorney, National Senior Citizen's Law Center*:**

Protections in this area are vitally important. A resident is placed in a serious predicament if she spends her life savings for assisted living care, only to be told, after savings have been spent, that the Medicaid-certified facility has decided to not accept Medicaid for her care.

Federal law should offer protection to residents, but neither CMS nor the state Medicaid agencies seem to be applying the federal law to assisted living facilities. The relevant authority is section 447.15 of Title 42 of the Code of Federal Regulations, which broadly requires a Medicaid-certified provider to accept Medicaid reimbursement from a Medicaid-covered patient. For example, if a Medicaid-certified hospital provides services to a Medicaid-covered patient, the hospital must accept Medicaid reimbursement (plus any authorized patient contribution) for that patient's care. The hospital is not allowed to bill the resident on a private pay basis.

This federal requirement, unfortunately, often does not seem to be enforced in the case of Medicaid-certified assisted living facilities. For example, over the past two years the Assisted Living Concepts (ALC) chain has implemented a national strategy of refusing to accept Medicaid from residents in Medicaid-certified facilities, in order to drastically reduce the percentage of ALC's residents under Medicaid coverage. *See, e.g.*, N.J. Dep't of the Public Advocate, Aging in Place, Promises to Keep, An Investigation into Assisted Living Concepts, Inc. and Lessons for Protecting Seniors in Assisted Living Facilities (2009), at www.state.nj.us/publicadvocate/seniors/pdf/alc_report.pdf .

Thus, disclosure of policies is not an adequate protection for residents, if the disclosure gives a Medicaid-certified facility the option to refuse Medicaid reimbursement from a Medicaid-covered resident in the future. Potential residents instead deserve a clear message when looking for and then choosing an assisted living facility – a message that either the facility is not certified for Medicaid and will not be able to accept Medicaid reimbursement if and when the resident becomes Medicaid-eligible, or the facility is certified for Medicaid and will be able to accept Medicaid.

Most state Medicaid programs do not have a clear position on this issue, and that lack of clarity as a practical matter allows a facility to refuse Medicaid from a resident as the facility chooses. Disclosure is required in a limited number of states including New Jersey and Oregon.[18] As mentioned, disclosure alone is inadequate protection for consumers. In 2008, the National Senior Citizens Law Center obtained assisted living disclosure statements through New Jersey's Open Public Records Act. According to the disclosure statements, the state's facilities imposed onerous requirements for acceptance of Medicaid: forty-five percent of the facilities would not accept Medicaid unless the resident had already paid on a private-pay basis, and, of those facilities, a full 82 percent required private payment of at least ten months.

The National Senior Citizens Law Center recently published a white paper on this issue, entitled *Medicaid Payment for Assisted Living: Preventing Discrimination against Medicaid-Eligible Residents*. A copy of this white paper is submitted with these answers.

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[18] N.J. Dep't of Health & Sen. Servs., Div. of Aging & Community Servs., Policy Memorandum # 2004-5, VIII-1, Disclosure of Assisted Living Facilities' Medicaid Policies (July 30, 2004); Or. Dep't Hum. Servs., Div. of Seniors & People with Disabilities, Uniform Disclosure Statement: Assisted Living/Residential Care Facility, Form SDS 9098A (Feb. 2008); *see also* Or. Admin. R. 411-054-0025(7).

***Kevin Coughlin, Director, Wisconsin Bureau of Assisted Living*:**

Wisconsin does require disclosure for any kind of discharge, including "spend down," as part of an admission agreement. In general, as long as there has been proper disclosure, an assisted living community can involuntarily discharge when spend down occurs. Most assisted living communities that have a contract for Medicaid-eligible residents will allow them to stay when "spend down" occurs, unless the resident mix is heavy on Medicaid and the rates are not sustainable for overall operations.

***Howard Groff, President, Tealwood Care Centers*:**

The vast majority of states allow providers that choose to participate in the Medicaid program to choose their level of participation.

More states are requiring assisted living communities to disclose policy with regard to accepting Medicaid as a source of financing. For example, the state of Washington began requiring boarding homes (its licensure term for assisted living) to fully disclose to residents, orally and in writing prior to admission, the facility's policy on accepting Medicaid as a payment source, effective July 26, 2009. The law requires that the facility policy state, in a language the resident or resident's representative understands, the circumstances under which the facility will provide care to Medicaid eligible residents.

In New Jersey, a law enacted in 2009 requires the Department of Health and Senior Services and the Division of Medical Assistance and Health Services to distribute to all licensed assisted living facilities an information sheet explaining clinical and financial eligibility in the Medicaid waiver program for assisted living and maintain it on a web site. Assisted living facilities are required to provide this information sheet to all prospective private pay residents and/or the financially responsible party.

As explained above, NCAL opposes government mandates to participate in Medicaid because of the underfunding for services and gap in funding for room and board. However, despite these economic realities, there is a need for protecting beneficiaries from unfair market practices. NCAL believes that assisted living providers that promised private-pay residents they would provide Medicaid coverage should the residents exhaust their ability to pay, should honor those promises.

After the abrupt withdrawal of one assisted living company from the Medicaid market, several states have responded to consumer concerns. Two years ago, for example, the state of Washington enacted a law requiring boarding homes withdrawing from the Medicaid program to continue to provide Medicaid services to existing Medicaid residents and to residents who have been paying privately for at least two years and who become eligible for Medicaid within 180 days of the withdrawal. As noted above, Washington also requires that boarding homes fully disclose to residents a facility's policy on accepting Medicaid as a payment source. Last year, New Jersey passed legislation requiring an assisted living residence or comprehensive personal care home that surrenders its license and promised not to discharge Medicaid residents to escrow funds to pay for care in an alternate facility.

One of the important economic realities when talking about an assisted living provider's ability to control its level of Medicaid participation is that Medicaid pays assisted living communities

less than the cost per day to deliver Medicaid services in most cases. Coupled with the shortfall resulting from what SSI pays for room and board expenses, sub-market Medicaid rates for services result in private-pay residents paying more each month to cover Medicaid residents. By underfunding the cost of care for Medicaid, society in effect is asking each private pay-resident to subsidize each Medicaid resident by paying extra to cover the Medicaid shortfall. Asking private-pay residents to subsidize a few Medicaid residents is usually manageable. But without the ability to control the number of Medicaid-covered residents, it is feasible that some communities would need to raise their private pay rates substantially. It is worth noting that the median income of all assisted living residents was under $19,000 in 2009. The typical assisted living resident is a middle-class, widowed 87-year-old woman on a fixed income. This means the typical resident has limited means and cannot afford to subsidize an unlimited number of Medicaid residents. In such cases, it would be conceivable that private pay-residents could get priced out of their assisted living community or, ironically, be caused to spend down to Medicaid more rapidly. If financial exposure to Medicaid is too great, an assisted living community might no longer be competitive in the marketplace.

***Barbara Lyons, Senior Vice President – Kaiser Family Foundation, Director – Kaiser Commission on Medicaid and the Uninsured*:**

Most states do not require Medicaid participating assisted living facilities to disclose what their policies are with regard to retaining residents who spend down their private funds and become eligible for Medicaid. One recent study found that among 37 states who pay for assisted living through a Medicaid waiver, only three (IL, NH, and OR) reported requiring certified facilities to retain private pay residents who spend down to Medicaid eligibility while living in the facility.[xxiv] Additionally, when an assisted living facility withdraws from the Medicaid program, existing facility residents lose any ability to use Medicaid eligibility in that facility.[xxv] Most states have made efforts to improve consumer education around long-term care options, including information on assisted living, through the use of Aging and Disability Resource Centers and case managers.[xxvi, xxvii] However few states maintain comprehensive information on the discharge policies of assisted living facilities in the state.

***Larry Polivka, Executive Director, Claude Pepper Center*:**

Florida does not address. This is left up to the assisted living community to make the determination.

***Charley Reed, Member, Board of Directors, AARP*:**

Providers should be clear about their policies for when residents are unable to pay. Furthermore, it is unconscionable for providers to evict residents receiving Medicaid in order to maximize returns as one major provider has recently done on a nationwide basis. But even assisted living facilities that participate in the Medicaid program generally have limited Medicaid slots to offer residents who spend down to Medicaid eligibility. A concern for residents who spend down to Medicaid eligibility is that providers may evict them because they cannot pay. The frequency of this is not clear but a 2009 industry survey of assisted living found that only six percent of discharges were due to "financial reasons".[19] Some evictions may occur because assisted living

[19] *2009 Overview of Assisted Living*, op cit.

providers do not have the ability to extend Medicaid assistance because of the limited nature of such assistance. States should show more responsibility in making Medicaid assistance available to assisted living residents who spend down their resources. Allowing such residents to remain in place rather than forcing them into higher cost nursing homes is both more humane and more economically responsible.

Martha Roherty, Executive Director, National Association of States United for Aging and Disabilities (NASUAD):

In the 2007 study commissioned by the DHHS Assistant Secretary for Planning and Evaluation, researchers found that about 21 states have requirements for Resident's Rights. Requirements for Disclosure Statements are included in virtually all states but the content requirements vary considerably. NASUAD suggests that: a) federal guidance on standard requirements for disclosure statements is needed; and b) increased federal funding for options counseling including such counseling services delivered by I&R staff and ADRCs in order to educate potential residents about the marketplace for both public and private assisted living settings would be extremely helpful. Decisions regarding moves often are made in the absence of detailed information. The help of an objective third party, such as an ADRC options counselor could help a potential resident and/or family understand which provider is the best option (i.e., presence of specialty care, add-on costs, etc.). In terms of move out due to conversion to Medicaid, at least one state requires assisted living facilities to maintain 10 percent Medicaid census.

In terms of move out, NASUAD suggests building on the 2003 Senate Special Committee on Aging Assisted Living Work Group, to develop federal guidance on a framework for a resident bill of rights and disclosure statement. NASUAD also suggested increased federal funding for state programs that provide resident advocacy services (e.g., Adult Protective Services and State Long-Term Care Ombudsman) regardless of payment source and federal tools for data collection on abuse and neglect in the assisted living setting.

Julie Strauss, Office of Licensing and Quality of Care, Seniors and People with Disabilities Division, Oregon Department of Human Services:

OAR 411-054-0080 provides information on involuntary move-outs. Included in these rules is the availability of administrative hearing for anyone issued an involuntary move-out, for both Medicaid and private pay residents.

Patricia Will, CEO, Belmont Village Senior Living:

States typically require communities to disclose conditions under which the residency agreement may be terminated, including a detailed description of billing and payment policies and procedures and nonpayment of the stated rate. With the possible exception of New Jersey which requires assisted living providers to set aside 10 percent of their units to serve Medicaid residents within three years after licensing, other state regulations provide the flexibility necessary to allow assisted living providers to choose whether or not to participate in state Medicaid programs (i.e. Home and Community-Based Service (HCBS) waivers, state-plan services or demonstration waivers).

Given the increasing cutbacks in state budgets, the real threat of frozen reimbursement levels over time, and the fact that Medicaid waiver services are optional and not an entitlement, many assisted living communities have opted to either not participate in the Medicaid program or to limit the number of units for certification. A key problem with the Medicaid HCBS waiver program is that states can limit the size and number of people served in the HCBS programs. In fact, states have a great deal of discretion in determining the size and scope of their HCBS waiver programs. States can limit services to specific counties or regions of the state; they can decide which groups of people will be covered by the waiver; they can select which services to cover under the waiver; and they set a limit on the number of budgeted waiver "slots." Moreover, because Medicaid does not pay for room and board in residential care settings, the cost of caring for Medicaid beneficiaries puts assisted living communities at increased financial risk. To offset Medicaid losses, the burden would likely fall on private-pay residents in the form of higher rate increases.

If an assisted living community chooses to participate in the state's Medicaid program and has set aside a specific number of certified units to care for residents who become Medicaid-eligible, then the community should be required to uphold its obligation and honor its Medicaid commitment. It can be noted that New Jersey recently passed legislation that requires assisted living companies to put funds in an escrow account if they have promised to care for Medicaid-eligible residents, even in cases where the community surrenders its assisted living license or ceases to operate.

18. Is it common for states to have processes in place that permit Medicaid beneficiaries to appeal discharge decisions by assisted living facilities?

***Josh Allen, President, American Assisted Living Nurses Association*:**

It is our understanding that most states have an appeals process in place to address disagreements between a resident and a provider. This process may be through the state licensing agency and/or via the Ombudsman program. These processes are available to all residents in states where these practices exist, not just those receiving Medicaid funding.

***Brenda Bacon, President and CEO, Brandywine Senior Living*:**

All residents (private pay and Medicaid) have the right to file complaints and appeal involuntary discharges that will be investigated by the state. Providers of assisted living must disclose in their residency agreements reasons why someone may need to move out of the community. The Home and Community Based Waiver program only serves 10 percent of the assisted living population. Therefore, most Medicaid recipients cannot move into or remain in assisted living.

***Eric Carlson, Directing Attorney, National Senior Citizen's Law Center*:**

No, it is not common. In the HCBS waiver application, the state must list its appeal processes in Appendix F, but those appeal processes apply to a resident's appeal of the state's decision whether or not to grant waiver eligibility. Those appeal processes do not apply to an assisted living facility's decision to discharge a resident.

***Kevin Coughlin, Director, Wisconsin Bureau of Assisted Living*:**

In Wisconsin, one of the three types of facilities that fall under the umbrella term "assisted living" are required to offer appeals when there is an involuntary discharge – Community Based Residential Facilities (CBRF).

***Howard Groff, President, Tealwood Care Centers*:**

NCAL believes that states should designate an agency or agencies for hearing appeals of transfer or move-out notices regardless of whether the resident is private-pay or served by Medicaid. These processes should provide for an in-person hearing accessible to the resident. States should preserve the resident's and the assisted living community's right to present evidence and arguments and to refute evidence and arguments presented by other parties. In addition, NCAL recognizes that some communities also have internal appeal processes that can be used to appeal decisions. However, NCAL does not believe that residents should be required to exhaust internal procedures before appealing the assisted living community's decision to the state. In states that don't have appeal systems, we recommend that an assisted living community create an appeals process that utilizes neutral outside mediation.

***Krista Hughes, Director, Division of Aging and Adult Services, Arkansas Department of Health and Human Services*:**

Section 602 of the assisted living regulations addresses involuntary transfer or discharge of residents. It states that a thirty (30) day written notice of transfer or discharge, unless an immediate discharge is required to ensure the welfare of the resident or the welfare of other residents, shall be provided. The written notice shall contain a statement explaining the resident's right to appeal, and that the appeal must be made to the Office of Long Term Care within seven (7) calendar days of the written notice of transfer or discharge to the resident. In the event an immediate transfer or discharge is required, the facility shall advise the resident or his or her responsible party, and immediate arrangements shall be made based on the written occupancy admission agreement to transfer or discharge such resident to an appropriate facility.

For applicants and/or clients in the Medicaid Section 1915 (c) Assisted Living waiver (called Living Choices in Arkansas), appeals are the responsibility of the Department of Human Services Appeals and Hearings section. Waiver applicants are advised on the DCO-700 (Notice of Action) or the system-generated Notice of Action by the Division of County Operations of their right to request a fair hearing when adverse action is taken to deny, suspend or terminate eligibility for Living Choices.

***Larry Polivka, Executive Director, Claude Pepper Center*:**

Florida does not have an appeal process for Medicaid or private pay. To our knowledge the only time a resident is terminated is because the ALF can no longer provide the services that the resident requires or breach of contract.

***Charley Reed, Member, Board of Directors, AARP*:**

If the Medicaid reimbursed services requested are provided at the assisted living facility, it is a matter of state law what the obligations for the assisted living provider will be. For example, if

eligibility for the services is determined by the state, then the due process requirements identified above are exclusively the responsibility of the state. If, on the other hand, a state delegates eligibility determinations and determinations about the scope of services to be provided to the assisted living provider, then the provider might have some role in the due process procedures, but the ultimate responsibility for ensuring that beneficiaries' due process rights are protected still falls on the state.

Federal law requires that a Medicaid beneficiary receive notice and opportunity for a hearing for any adverse decision, including a denial of services. Each state is obligated to ensure that beneficiaries are not denied services (including a reduction in amount, duration or scope) on the basis of their medical diagnosis, illness or condition. 42 CFR 440.230(c). Further, beneficiaries are entitled to a hearing if services are not provided in a reasonably prompt manner.

Notice must contain a statement of what action the State or Medicaid-certified provider intends to take, the reasons for the action, the regulations or change in law that support or require the action, an explanation of the individual's right to request an evidentiary hearing if available, the circumstances under which a hearing will be granted, and an explanation of the circumstances under which Medicaid is continued if a hearing is requested. 42 C.F.R. § 431.210.

Martha Roherty, Executive Director, National Association of States United for Aging and Disabilities (NASUAD):

Such requirements vary by state licensure regulations.

Julie Strauss, Office of Licensing and Quality of Care, Seniors and People with Disabilities Division, Oregon Department of Human Services:

Reasons allowed for facility notice of move out include: resident needs exceeding ADL services outlined in the facility's disclosure information, behaviors or actions that put the resident or other in danger, and a medical or nursing condition that is complex or unstable that exceeds the level of health services outlined in the facility's disclosure information.

Patricia Will, CEO, Belmont Village Senior Living:

Assisted living residents, regardless of pay or source, always have the right to appeal a discharge decision.

19. What is the legal position of facilities licensed to offer assisted living services with regard to discharging residents who say they do not wish to leave, but whose needs exceed state-licensed "level of care" requirements, under federal anti-discrimination statutes, including the Americans with Disabilities Act, the Fair Housing Act and Fair Housing Amendments?

Josh Allen, President, American Assisted Living Nurses Association:

The American Assisted Living Nurses Association is not in a position to give a legal interpretation of this potential issue. However, assisted living nurses overwhelmingly support allowing residents to remain in the assisted living community for as long as safely possible—so

called, "aging in place." We believe that by working with the resident, healthcare professionals, state regulators, and other key stakeholders, an effective solution can often be developed that allows a resident to safety remain in the assisted living community, despite changing care needs. With that said, there are some instances whereby a resident cannot be safely cared for in an assisted living environment due to medical instability or other factors.

***Brenda Bacon, President and CEO, Brandywine Senior Living*:**

ALFA completely supports "informed choice" for residents of assisted living. This means that the decision of whether or not to move in, or move out of an assisted living community should be the collaborative decision of the resident, his or her family, his or her physician, and the assisted living provider. If they all agree the resident's needs can be met in the assisted living community, the resident should be allowed to stay. However, in states that have retention standards in their regulations, providers have no choice but to require a resident to move out knowing that the only option will be for the resident to leave the place they call "home" to a more expensive institutional skilled nursing facility against their wishes. ALFA is actively working to change the statutes in states to allow full aging in place when all these other conditions are met.

***Eric Carlson, Directing Attorney, National Senior Citizen's Law Center*:**

In such a situation, the facility will be expected to comply with the licensing level of care requirements. If the resident contends that the level of care requirements violate federal law, the burden will be on the resident to file suit against the state under the federal law in order to invalidate the improper level of care requirements. The facility likely would be named also in such a suit, but as a practical matter there likely would be no obligation placed against the facility unless and until the state were ordered to reform its level of care requirements.

If state law authorized a facility to seek a waiver of the level of care requirements, the federal anti-discrimination laws likely would require the facility to seek waiver of those requirements for a resident seeking to remain in the facility.

We emphasize that this answer applies only to those situations in which a resident's needs truly exceed what a facility can provide under the state's level of care requirements. Sometimes a facility scapegoats state law for the facility's refusal to admit or retain a person, even though state law actually does not prevent the facility from caring for the person.

***Kevin Coughlin, Director, Wisconsin Bureau of Assisted Living*:**

In Wisconsin, if an assisted living community has disclosed reasons for discharge during the admission process, and a resident exceeds the state licensed "level of care," the community can initiate an involuntary discharge. However, the community is responsible for assisting the resident with relocation, and cannot just discharge to the street. We are not aware of a case where this has been challenged based on the ADA or Fair Housing Act. In many cases the opposite occurs. Wisconsin regulations allow a resident to exceed the level of care if additional services are arranged for by the resident, or if there is a waiver or variance obtained through the regulatory agency.

***Howard Groff, President, Tealwood Care Centers*:**

Viewed from a 30,000-foot perspective, the assisted living profession operates in the eye of a potential legal storm, as providers often find themselves between unresolved, and often contradictory, bodies of law reflecting what are often opposing political and social trends and pressures. On one hand, as assisted living has accommodated an increasingly disabled population, there has been pressure to increase the level of state regulation. According to the HHS report by Robert Mollica and colleagues published in 2007, while only a few states do not allow individuals who meet the state's minimum nursing level of care criteria to receive care in assisted living settings, no states allow persons needing a skilled level of care to be served in an assisted living setting for an extended period of time (needing 24-hour-a-day skilled nursing oversight or daily skilled nursing services). States take different approaches for setting admission/retention policies, and typically impose upper limits on the type and/or duration of care that can be rendered in assisted living communities. As residents' needs near or exceed allowable limits, residents often express a desire to stay and arrange to bring in services. "Aging in place" thus raises several regulatory and resident safety issues. While facing provider capacity limits and limits imposed by state rules, communities also face a number of civil right laws requiring them to make reasonable accommodations as residents' conditions become more complex. Navigating these conflicting forces is often difficult and requires negotiation and common sense approaches to individual circumstances.

A key issue in this regard is when communities can perform resident assessments, which are necessary for developing care plans and typically mandated under state law. Being able to assess residents is critical for providers and residents. A few years ago in one Midwestern state, a state official proposed a prohibition of all pre-move-in assessments, stating that such assessments violate the Fair Housing Act. The argument was that providers should not be allowed to determine whether an individual could be eligible to move in based on whether they could serve their clinical needs. Had this proposal survived, the net effect would have been families would have moved their loved ones into assisted living communities only to discover that their clinical needs could not be met or that the state prohibited the kind of care their loved ones needed in assisted living settings. This example drives home the need for a common sense approach that allows residents to make informed choices based on assessments of their needs.

***Krista Hughes, Director, Division of Aging and Adult Services, Arkansas Department of Health and Human Services*:**

Assisted Living Facilities are subject to license restrictions on the level of care the facility may provide. Discrimination occurs if a facility refuses to serve a resident that it has the ability to serve under its license, if the reason for non-service is race, gender, age, disability, etc. It is not discrimination to refuse to provide services that the facility may not legally provide.

***Larry Polivka, Executive Director, Claude Pepper Center*:**

ADA and the Fair Housing Act should not be considered when addressing appropriateness of placement in Florida. If an ALF is out of compliance with the state requirements these federal statues do not shield or protect them from administrative sanctions.

***Charley Reed, Member, Board of Directors, AARP*:**

It is fair to say that the law is evolving in this area, which can place the state's "level of care" licensure standards that require the discharge of residents with certain types or acuity of conditions at odds with civil rights protections designed to allow consumers to live and receive services in places they choose. The Fair Housing Amendments Act of 1988 extended FHA protections to persons with disabilities, prohibiting a variety of discriminatory housing practices including eviction because of a disability.

Some "level of care" requirements may be subject to challenge as discriminatory. State regulatory schemes requiring the discharge of someone with a particular diagnosis or impairment are inherently suspect and open to challenge. For example, requiring the discharge of any resident who has a diagnosis of Alzheimer's disease would likely be discriminatory, since many people with this illness are able to meet the requirements of residency in assisted living.

But even level of care requirements not held to be inherently discriminatory may nonetheless be subject to challenge if there is no process by which the individual can request a "reasonable accommodation" as required by the civil rights statutes cited in the question. Thus even if a particular restriction that certain skilled nursing procedures exceed the licensure of assisted living to provide is not discriminatory, the resident who needs such services can request a reasonable accommodation to have those needs met by a third party provider licensed to provide the service.

Either way, decisions made about a person's continued ability to remain in assisted living must be made based upon individual assessments of the person's ability to remain in place, with or without an accommodation, and not on the basis of the type of disability or condition. Providers are not required to make accommodations where to do so would result in an undue financial and administrative burden or would fundamentally alter the nature of the provider's operations. But providers and state licensing agencies are required to make reasonable accommodations to enable people to remain in the homes that they choose if the accommodations meet those tests. A number of states have enacted interactive processes to provide appeals and individual determinations of the ability to remain, even if their continued residency represents a violation of the level of care requirements.

***Martha Roherty, Executive Director, National Association of States United for Aging and Disabilities (NASUAD)*:**

Typically, licensure regulations determine which residents may remain in facility. Some use numbers of support hours while others have certain prohibited conditions.

***Julie Strauss, Office of Licensing and Quality of Care, Seniors and People with Disabilities Division, Oregon Department of Human Services*:**

Yes, there is merit in asking a facility which has identified a resident's need for services has exceeded the level the facility can provide to assist in finding a more suitable location.

***Patricia Will, CEO, Belmont Village Senior Living*:**

All licensed communities are legally responsible for ensuring full compliance with state regulations. Accordingly, communities cannot pick and choose which state regulations to comply with. A community that knowingly retains a resident who exceeds state licensure "level of care" requirements could be subjected to fines and penalties, or worse, risk having its license suspended or revoked.

20. Is there merit in requiring assisted living facilities that ask a resident to leave because s/he develops needs for services that exceed the facility's level of care standards, to help with the transfer of the resident to another setting in which higher-level services can be provided? Alternatively, could assisted living facilities be asked to assist residents if they wish to "age in place" and bring in additional services?

***Christy Allen, Assistant Commissioner, Bureau of Health Licensure and Regulation, Tennessee Department of Health*:**

The most common ACLF violation in Tennessee is an inappropriately placed resident, which is defined, generally, as one for whom the ACLF can no longer safely and effectively meet his/her medical needs or a resident whose verbal or physical aggressive behavior poses an imminent threat to him/herself or others. The ACLF is required to regularly assess each resident to ensure the resident's needs for services are consistent with the Board's rules and to determine those residents who should be transferred to a higher level of care. The written admission agreement must include a procedure for handling the transfer or discharge of residents that does not violate the resident's rights under the law or the Board's rules. The ACLF is required to provide thirty (30) days written notice prior to transfer or discharge, except where any physician orders the transfer because the resident requires a higher level of care.

Please also refer to Question 30.

***Josh Allen, President, American Assisted Living Nurses Association*:**

Assisted living nurses, the professionals who frequently hold the responsibility of overseeing the care of assisted living residents, overwhelmingly support the concept of "aging in place." This is rooted in the fundamental concept that an assisted living community is the resident's home; it is not a "facility." Assisted living nurses believe in working with their residents, the residents' families, providers, medical professionals, and state regulators, to find a way to allow a resident to remain in the assisted living community throughout their lifespan, or as long as the resident so desires. By developing resident-centered service plans that tailor care and services to the unique needs of the individual, this goal is often achievable.

Should a transfer to a higher level of care be required or ordered by a physician, the assisted living community has a responsibility assist the resident and/or family to find the most appropriate setting for the resident, in accordance with their needs and preferences.

***Brenda Bacon, President and CEO, Brandywine Senior Living*:**

Virtually every state regulatory framework requires the assisted living provider to help the resident find another setting when the state requires they move out of assisted living. Many times a resident and their family will wish to evaluate potential new settings without the assistance of the assisted living provider.

Assisted living providers would welcome the opportunity to help residents age in place with additional services. If the assisted living provider is not equipped to handle the higher acuity needs, the community could help the resident find additional services to be brought in, provided of course that the resident is willing to accept the additional care.

***Eric Carlson, Directing Attorney, National Senior Citizen's Law Center*:**

In this scenario, assistance with transition to another setting is the very least that a facility should be expected to do.

We recommend that licensure or certification standards be clear as to what services must be provided by an assisted living facility, and set meaningful quality of care standards for provision of those services. As appropriate, licensing standards could offer different levels of licensure—Levels I, II, and III, for example—depending on the types of care needs that were to be accommodated. Medicaid HCBS certification standards, on the other hand, should be uniform, since by definition all Medicaid HCBS beneficiaries have care needs that would warrant nursing facility admission.

A resident's ability to remain in an assisted living facility generally should not depend on the resident bringing in additional services. Instead, the facility should have the capacity to provide necessary services or to arrange for those services. Services should be coordinated and the facility must be responsible for those services. It can be a recipe for disaster if, instead, the facility were to provide a lesser level of care, with the resident attempting to fill in gaps by arranging for supplemental services by others.

There may be times for a resident's hiring of additional caregivers, but such hiring should be kept to a minimum. In general, facility staff should be responsible for ensuring that a resident's care needs are met.

***Irene Collins, Commissioner, Alabama Department of Senior Services*:**

Each state has a different protocol but in Alabama our clients have a Bill of Rights they are presented with when they are entering into an agreement with the assisted living facility. This provides an opportunity for discussion of the subject up front.

***Kevin Coughlin, Director, Wisconsin Bureau of Assisted Living*:**

In Wisconsin, regulations require the assisted living community to assist a resident in finding an appropriate living arrangement prior to transfer or discharge. When looking at aging in place, it is important to make sure the community is able to meet all the service requirements needed, including those that may be episodic. In some cases a community might help a resident arrange for more services independent of the services offered by the community, but what happens when

those additional services do not materialize? Is the community responsible? The resident's needs must be met and it is important not to create a situation where the resident may be at great risk.

Most definitely. Facilities are, and should be, required to provide assistance in locating and evaluating the appropriateness of alternative living arrangements in this situation. Aging in place is an admirable concept, but it should not be seen as a requirement that facilities are forced to change their model and level of care and services when an individual's needs change beyond the ability of the facility to safely and effectively be a home for the resident.

Howard Groff, President, Tealwood Care Centers:

Assisted living communities generally do try to promote aging in place. However, not every resident's needs can be accommodated in every instance. In addition, not all residents can afford to hire private duty nurses or aides to meet their needs. Assisted living communities must staff to meet residents' needs. While assisted living residences typically have a full-time nurse and nurses on call at other times, most assisted living communities don't have round the clock nurses. It can easily cost $100,000 or more a year to hire a nurse per shift. Spread over the typical assisted living resident community population, this translates to about $2,000 more per year per resident.

As part of assisted living's person-centered focus, each resident needs to be evaluated based on his or her individual needs. These individual needs are then evaluated in aggregate and community-wide staffing decisions are made based on the aggregate need. It is not uncommon for residents' health needs to ebb and flow with time and community administrators typically know how to accommodate these changing resident needs in their communities. The addition of hospice care in assisted living through outside hospice providers has enabled an ever-growing number of assisted living residents to remain in the assisted living setting in their final days.

Attached is a generic copy of Tealwood's assisted living lease. At the very end of this lease, we state very clearly the company's continued stay requirements. As you can readily see, to continue providing services to some residents based on their needs, we would need to go beyond the boundaries of our licensure (Class F) in Minnesota.

Tealwood is currently piloting a "Continuity of Care" program whereby we coordinate with a certified (Medicare) Home Health Agency to provide higher level nursing services to home bound residents under the Medicare Part A and B programs. Here is where a campus setting can be very beneficial. If the assisted living community is on the same campus as a nursing facility, our assisted living clients have access to full therapy services seven days per week through Medicare Part B.

We are currently working with a physician group and evaluating the benefits of having them do clinical visits in our assisted living buildings. Through this program, they could become the primary care physicians for our clients and provide them appropriate care without having to leave their home.

***Larry Polivka, Executive Director, Claude Pepper Center*:**

It is not a requirement for an ALF to assist with the termination or relocation of a resident however many do work with the family and resident to find alternate placement. ALFs should be asked to do anything outside of state regulations.

***Charley Reed, Member, Board of Directors, AARP*:**

In addition to the reasonable accommodation of permitting a resident to bring in additional services under certain circumstances if a person's needs for services exceeds the facility's level of care standards, as described in our response to Question 19, there may also be some circumstances where the facility would be required to provide additional services to retain the resident, subject to a reasonable accommodations analysis (including undue financial and administrative burdens and fundamental alterations). As noted above, a number of states have enacted legislation to spell out the rights of the assisted living resident to negotiate for such accommodations. If such accommodations are not possible or the resident wants to leave to receive care elsewhere, AARP believes that assisted living providers have an obligation to assist the resident in finding alternatives that better meet their needs. This should include linking the resident to an independent options counselor.

***Martha Roherty, Executive Director, National Association of States United for Aging and Disabilities (NASUAD)*:**

NASUAD offer two responses:

a. A federal Assisted Living Residents' Bill of Rights should include such requirements which would mirror similar requirements in the Nursing Home Residents Bill of Rights. State services such as options counselors and State Long-Term Care Ombudsman also could be helpful; and
b. Facilities may be asked to allow additional assistance to be delivered if state licensure allows for it and the assisted living provider allows third parties to deliver services (e.g., liability issues).

***Julie Strauss, Office of Licensing and Quality of Care, Seniors and People with Disabilities Division, Oregon Department of Human Services*:**

OAR outlines service plan requirements (OAR 411-054-0036) and provides a description of managed risk agreements and requirements.

***Patricia Will, CEO, Belmont Village Senior Living*:**

In most cases, the need for a resident discharge is not unexpected and preparations are made in advance so that all care options can be thoughtfully considered. As part of the resident assessment process, the community staff routinely works with residents and family members to assist in facilitating a smooth transfer to a higher level setting. Some states, (i.e. Tennessee and Virginia) limit the provision of skilled nursing services in assisted living by restricting the types of medical treatments that can and cannot be provided, such as gastronomy feedings and intravenous therapy. Other states, such as Massachusetts, prohibit communities from providing skilled nursing directly, but allow residents, under certain conditions, to arrange for the provision

of skilled services through a home health agency. Some states, such as California, have an "exceptions" process that permits communities to apply for an exception to care for a resident with a prohibited condition, thereby making it possible for residents to age in place if the exception is granted.

In cases where a resident wishes to remain in the community but the skilled service(s) required by the resident are either prohibited by regulation or the community does not provide skilled nursing services, a resident's desire to age in place can sometimes be accommodated by arranging for services with a home health agency, provided that such arrangements comply with state regulatory requirements concerning the provision of skilled care. For example, Massachusetts will permit residents to make arrangements for skilled care services provided that "the skilled services are only provided by a certified home health agency on a part-time or intermittent basis to persons whose medical conditions require services periodically or on a scheduled basis."

21. Are negotiated risk agreements, as used in some states, a mechanism whereby assisted living facilities and residents (or in specified circumstances, residents' surrogates) can attempt to negotiate additional services for residents whose care needs are found to exceed state licensing levels of care?

***Christy Allen, Assistant Commissioner, Bureau of Health Licensure and Regulation, Tennessee Department of Health*:**

Because of the flexibility the Board's rules afford ACLFs in providing care appropriate to the needs of the resident, and in light of the required admission agreement, the Board's rules could provide some opportunity to address additional services in such an agreement.

***Josh Allen, President, American Assisted Living Nurses Association*:**

Although we are not in a position to comment on their legal merits, assisted living nurses recognize that when used in the manner described, negotiated risk agreements—and other documents, such as a written service plan—can serve as vehicle for communication between the resident and the provider. While this does not negate state regulatory limits on levels of care, it does encourage active dialogue between the resident and provider, who can then work together to find a mutually beneficial solution to the level of care issue at hand, thereby allowing the resident to remain in place. The negotiation of additional services is frequently the first step in any negotiated risk discussion.

***Brenda Bacon, President and CEO, Brandywine Senior Living*:**

Negotiated risk agreements have many great uses and assisted living providers do use them but they may not be used to exceed statutory requirements. Assisted living is highly regulated and monitored at the state level. Providers may not under any circumstances circumvent state regulations. Such action could result in fines, provisional licenses, bans on admissions or even revocation of a license.

Eric Carlson, Directing Attorney, National Senior Citizen's Law Center:

In a negotiated risk agreement, the resident agrees to stay in a facility even though the facility's level of care is inadequate. The agreement includes a waiver that releases the facility from liability for the inadequate care. For example, an immobile resident might agree to remain in an assisted living facility even though the facility lacks the staff to regularly reposition the resident, and in a negotiated risk agreement would release the facility from liability from any pressure sores that the resident might develop.

Negotiated risk agreements are unenforceable under consumer contract law—a consumer health care contract violates public policy if it releases the health care provider from liability. For example, a consent to surgery must not release the hospital or surgeon from responsibility for negligence. *See, e.g., Tunkl v. Regents of Univ. of California*, 383 P.2d 441 (Cal. 1963).

To this point, only one court has addressed the validity of negotiated risk agreements in assisted living. A resident's fall in an assisted living facility had caused the resident to suffer irreversible brain damage and permanent physical impairments. In its defense, the facility pointed to provisions of the admission agreement that exempted the facility from liability "for personal injuries or damage to property, even if resulting from the negligence of [the facility] or its employees." Citing this language, the facility argued that the resident had waived the facility's liability in return for having "independence, control and choice," and "a higher quality of life." *Storm v. NSL Rockland Place, LLC*, 898 A.2d 874, 878-79 (Del Super. Ct. 2005). The judge, however, emphatically rejected this argument, concluding that it would be "unconscionable" to allow the facility to use the agreement as a defense. *Storm*, 898 A.2d at 884.

Because negotiated risk agreements violate consumer contract law, and because liability waivers are difficult to defend in public policy discussions, proponents of negotiated risk recently have been muddying the waters in their defense of negotiated risk. When defending the concept of negotiated risk, they cite examples such as a diabetic resident wishing to eat a dessert, or an unsteady resident desiring to wear high heels for a special occasion. These examples confuse matters, because they involve situations in which the facility's level of care is irrelevant. Such examples involving diabetic residents or high heels are simply situations in which a resident is choosing to act against a facility's recommendations. There is no need for an "agreement" in such situations; nursing homes and assisted living facilities routinely address those situations under current law by documenting that the resident is acting against medical advice.

I have written a law review article on this topic: Eric M. Carlson, *Protecting Rights or Waiving Them? Why 'Negotiated Risk' Should Be Removed from Assisted Living Law*, 10 J. Health Care L. & Pol'y 287 (2007). A copy of the article is submitted along with these answers.

Kevin Coughlin, Director, Wisconsin Bureau of Assisted Living:

These sorts of agreements are used with some degree of success in one of Wisconsin's three types of assisted facility licensed providers. Residential Care Apartment Complexes operate under a licensure statute which specifies that the facility may negotiate a risk agreement with any tenant. The remaining forms of assisted living licenses, Adult Family Homes and Community Based Residential Facilities do not have this provision included in their enabling laws.

A risk agreement is used for any situation or condition which is or should be known to the AL community that involves a course of action taken or desired to be taken by the resident, and which is contrary to the practice or advice of the community and could put the resident at risk of harm or injury. Risk agreements concern a resident's preference concerning how a situation is to be handled and the possible consequences of acting on that preference, and what the assisted living community will and will not do to meet these needs and preferences. Alternatives may be offered to reduce risk or mitigate consequences relating to the situation or condition. The agreed-upon course of action, of both the resident and the community, incorporates the resident's understanding and acceptance of responsibility for the outcome from the agreed-upon course of action. A risk agreement may not waive any requirement or right of a resident. Neither the resident nor the community can refuse to accept reasonable risk, or insist that the other party accept unreasonable risk. Wisconsin participated in the 2006 study by the U.S. Dept. of Health and Human Services, "Study of Negotiated Risk Agreements in Assisted Living: Final Report,"

http://aspe.hhs.gov/daltcp/reports/2006/negriskes.htm

***Howard Groff, President, Tealwood Care Centers*:**

Negotiated risk agreements can be useful tools for residents and communities to negotiate how additional services can be rendered and for delineating the related risks. However, a study sponsored by the federal government found that negotiated risk agreements are not widely used and are inappropriate in some circumstances. For example, they cannot be used to waive government requirements. While some states promote the use of negotiated risk agreements to encourage resident choice and independence, such risk agreements are most commonly used as formal communication tools for informing residents and families about particular behaviors or resident decisions that may not be in the resident's best interests, and acknowledging that there could be negative consequences to those resident choices, decisions, or behaviors.

***Robert Jenkens, Director – The Green House Project, NCB Capital Impact*:**

Negotiated risk agreements operate a little differently in each state where they are allowed. In my opinion, their best use is to provide a state sanctioned means for residents to decline unwanted services or transfers based on a provider or regulator's determination of what is best for him or her. Implemented with appropriate safeguards, negotiated risk agreements offer residents or their formally appointed surrogates the best defense against the penchant of the long-term care community and, often, families for "excess safety." When provider, regulator, or family members' well intentioned desire for maximum safety is allowed to dominate a resident's preferences, the resident loses the independence, autonomy, and choice that assisted living was conceived to deliver.

***Larry Polivka, Executive Director, Claude Pepper Center*:**

Florida does not recognize negotiated risk agreements therefore if a facility exceeds their state licensing level of care they are out of compliance and subject to administrative sanctions.

***Charley Reed, Member, Board of Directors, AARP*:**

There is no one definition of a "negotiated risk agreement." The terms negotiated risk or shared decision making are used by service providers to resolve differences between a consumer's

preferences and a provider's recommendations in the service plan. Such agreements may be intended to increase resident choice and autonomy, rather than deferring to the provider's decision in all cases. Areas that are often subject to negotiated risk are such things are dietary restrictions or falls prevention measures that may restrict resident choices. Such agreements should be documented in the services plan, with the risks identified, potential alternative ways to mitigate the risks offered, and the resolution documented. A negotiated risk agreement is not appropriate when instead of increasing resident choice it serves to reduce or avoid regulatory or legal liability.

In circumstances where a resident needs services beyond what an assisted living facility is licensed to provide, the resident may have the right to remain in the facility and to receive additional services (either by the resident obtaining and paying for them, or through an arrangement whereby the ALF provides them and payment by the resident or others is made) under protections of the Fair Housing Act and other federal and state civil rights laws (see Questions 19 and 20). An agreement related to rights under FHAA and other civil rights legislation are more properly called a "reasonable accommodation" since it addresses making exceptions to licensure rules not a negotiation between the resident and provider over service plans.

***Julie Strauss, Office of Licensing and Quality of Care, Seniors and People with Disabilities Division, Oregon Department of Human Services*:**

In Oregon we recognize the best practice is to maintain minimum services, well-defined resident rights, and clear disclosure statements.

***Patricia Will, CEO, Belmont Village Senior Living*:**

Negotiated risk agreements are not used to negotiate additional services for residents whose needs exceed state licensing requirements. Rather, risk agreements are intended to allow residents the right to make lifestyle choices that may have adverse health consequences, such as a diabetic who chooses to eat desserts after every meal.

Questions from the Ranking Member

Quality and Oversight

22. Are there any industry-recognized best practices in assisted living? If so, what are they?

***Josh Allen, President, American Assisted Living Nurses Association*:**

Although assisted living continues to evolve in response to the needs and preferences of an aging U.S. population, there is information available on recognized standards and best practices.

In 2001, the Assisted Living Workgroup—a national initiative of nearly 50 national organizations representing assisted living providers, consumers, long term care professionals, health care professionals, state regulators, and other stakeholders—began work on a report to the U.S. Senate Special Committee on Aging. The completed report includes 110 recommendations related to core principles; accountability and oversight; affordability; direct care services; medication management; operations; resident rights; and staffing. Although not perfect, the recommendations were developed through a consensus process so that all points of view were represented in the final report.

The National Center for Assisted Living has released data from a national survey on performance measures in assisted living. The survey revealed information about improving the quality of care and life for assisted living residents, including common industry practices related to criminal background checks; resident and family satisfaction surveys; availability of licensed nursing staff; review of incident reports; and measurement of employee satisfaction.

The Center for Excellence in Assisted Living operates an online clearinghouse that serves as a national resource for the collection and dissemination of information about assisted living. The clearinghouse include information on research findings and outcomes related to assisted living; exemplary assisted living practices, measures, and public policies; consumer materials; links to relevant websites; international documents/abstracts; media articles; and training and education materials.

***Brenda Bacon, President and CEO, Brandywine Senior Living*:**

A vital role of the Assisted Living Federation of America is to work with our members to continuously "raise the bar" for excellence throughout the industry. To this end, ALFA identifies best practices inside and outside the industry and shares these best practices among and with senior living professionals through Assisted Living Executive magazine, the ALFA Annual Conference, a Best of the Best Awards program, Executive Roundtables, ALFA Exchange (a social media networking site), and a variety of other programs, products and services—all intended to improve operational excellence.

In 2011, for example, ALFA received 140 nominations for our Best of the Best Awards program. A few of the innovations identified to receive recognition include:

MBK Senior Living, an Irvine, Calif. based senior living provider, developed a new infection prevention program that was developed with input from every department – from nursing to dining services. While every good operator has infection prevention programs in place, MBK's goal was to build a grassroots movement around it in all of their communities. A thorough and thoroughly understood program can prevent and better control outbreaks of germs. Results include a 70 percent reduction of outbreaks in communities and no building closures.

Sonata Senior Living, an Orlando, Florida based provider, is developing a new memory care community with resident-directed rather than program-centered scheduling in mind. Amber lighting in bathrooms will help cue residents who get up at night to use the bathroom. Residents will have unimpeded access to secure outdoor areas, a wireless call system and door and window contacts will alert staff to resident emergencies. These and other features are helping Sonata create the next generation of assisted living communities.

Silverado Senior Living, an Irvine, Calif. based provider of memory care communities is expanding and deepening its worker safety initiatives. Among the new initiatives are Shoes for Crews, a companywide slip-resistant footwear initiatives for staff in communities; a real-time workers' compensation dashboard allowing managers to monitor trends in injuries; new policies and training targeting frequent causes of injuries including lifting and transferring residents.

AgeSong, an Oakland, Calif. based provider of senior living, recently became the first certified Green Restaurant in a senior living setting. The community uses fresh local (sometimes community grown) produce as available; engages in composting, recycling and using biodegradable products. It also continually seeks ways to reduce energy and cook foods that are healthier for the environment and residents. Since the program began, AgeSong has reduced its energy costs by 3-5 percent and increased composting and recycling by 20 percent.

In addition to ALFA's work, The Center for Excellence in Assisted Living (CEAL) of which ALFA is a founding member, has as its primary goal to manage a clearinghouse with information on best practices and quality assisted living models.

Finally at the state level, one example is Wisconsin's Coalition of Collaborative Excellence in Assisted Living that is focused on identifying and sharing successful best practices.

***Eric Carlson, Directing Attorney, National Senior Citizen's Law Center*:**

A best practice is to hire adequate numbers of direct-care staff members, and to give them training comparable at least to the training provided to certified nurse aides in nursing homes. A related best practice is to hire persons with adequate health care expertise (including but not limited to nurses) in order to meet residents' needs and allow residents to remain living longer in an assisted living setting.

***Kevin Coughlin, Director, Wisconsin Bureau of Assisted Living*:**

In the regulatory environment, the Wisconsin Assisted Living Regulatory Model can be described as a best practice in regulating the assisted living industry. The model utilizes a survey process with more scrutiny of communities that have regulatory non-compliance and an abbreviated survey for those who have achieved and sustained compliance over time. It also incorporates technical assistance in the survey process, takes aggressive and progressive

enforcement action against assisted living communities that harm Wisconsin citizens, and encourages collaboration across the assisted living spectrum in order to help improve the overall industry. There have been at least 10 states that have incorporated aspects of the Wisconsin model into their own state programs. A PowerPoint presentation previously submitted to the U.S. Senate Committee on Aging summarizes the success of Wisconsin's program.

***Howard Groff, President, Tealwood Care Centers*:**

NCAL is pleased to report that the assisted living industry has been indentifying best practices and key resources for providers nationwide for many years. At its last meeting, in April of 2003, the Assisted Living Workgroup provided the Senate Special Committee on Aging with a comprehensive compendium of more than 100 recommendations designed for consistent quality in assisted living communities. These recommendations spanned seven different areas and were agreed upon through a consensus process.

Since 2003, the assisted living profession has continued collaborative efforts of identifying and developing best practices through a variety of organizations. NCAL have been part of many of those efforts. NCAL participated on a national task force organized by the National Multiple Sclerosis Society (NMSS) in 2004. From this effort, the NMSS published a 46-page document for assisted living providers to better serve those residents with Multiple Sclerosis (MS) residing in assisted living. The guidelines outline what MS is, its set of clinical conditions, and how to maximize the quality of life for those living with MS. These guidelines may be found on the NMSS web site at http://www.nationalmssociety.org/search-results/index.aspx?q=assisted+living&start=0&num=20.

In 2006, NCAL was part of a collaborative effort sponsored by the Alzheimer's Association that developed Dementia Care Practice Recommendations for Assisted Living Residences and Nursing Homes. These guidelines provide providers of long term care strategies for improving the quality of care provided to and quality of life experienced by the residents of assisted living. The guidelines cover six areas of care including food and fluid consumption, pain management, social engagement, wandering, falls, and physical restraints. NCAL provided copies of these guidelines to its entire membership for reference and adoption. The guidelines may be found at http://www.alz.org/national/documents/brochure_DCPRphases1n2.pdf.

In 2009, NCAL was invited to review the work of the American Medical Directors Association on Caregiver Communication, Medication Management, and Diabetes Management. All three tools were developed for assisted living providers as resources to provide quality care for their residents. These resources may be accessed at http://www.amda.com/resources/alproducts.cfm#ALDIAB.

As a result of the Assisted Living Workgroup, the Center for Excellence in Assisted Living (CEAL) was formed in 2004 and is a national non-profit collaborative organization of 11 organizations. One of CEAL's major objectives is to foster high quality care through creating resources and acting as an objective source of information to facilitate quality improvement in assisted living; increasing the availability of research on quality practices in assisted living; establishing and maintaining a national clearinghouse of information on assisted living; and providing resources and technical expertise to facilitate the development and operations of high-quality, affordable assisted living programs to serve low- and moderate-income individuals.

Additionally, CEAL has published two white papers on topics including person-centered caring and medication management. In 2010, CEAL partnered with Med-Pass to create a Medication Administration Pocket Guide for Medication Technicians. More information may be found at www.theceal.org. In 2009, CEAL became a collaborative partner with the Agency for Healthcare Research and Quality to assist in the development of a Consumer Disclosure Tool to assist consumers in their search for the best community for their loved one.

NCAL's state affiliate in New Jersey, the Health Care Association of New Jersey, has a best-practices site which list best practices for Medication Management, Fall Management, Pain Management and Performance Improvement. These resources may be found at http://www.hcanj.org/bestpractices.htm.

NCAL developed its Advocating Care Excellence (ACE) in 2009 to demonstrate its commitment to quality and performance excellence in assisted living. NCAL believes that successful quality initiatives raise the bar for resident satisfaction, quality of life, and improved operational performance. NCAL's ACE houses all of NCAL's current quality resources and tools. All of NCAL's work towards quality care is based on NCAL's series of Guiding Principles:

- Guiding Principles for Assisted Living
- Guiding Principles for Consumer Information
- Guiding Principles for Dementia Care in Assisted Living
- Guiding Principles for Leadership in Assisted Living
- Guiding Principles for Quality in Assisted Living

These five documents serve as the foundation for all of NCAL's Inservice Training Tools and Quality Resources that it develops for its membership.

In 2010, NCAL launched its Performance Measures Initiative aimed at identifying and collecting data on areas that lend themselves to high quality care and quality of life for the residents and staff living and working in assisted living communities. In 2010, NCAL collected data on its Tier I Performance Measures, those elements that contribute to increased quality of life for residents residing in assisted living. Copies of the 2010 NCAL Performance Measure Report can be obtained by contacting NCAL's director of workforce and quality improvement. This survey report was based on a 16 % response rate of the NCAL membership. Of those responding, some of the key findings include:

- 91 % of the communities measured resident and family satisfaction;
- 94 % of the communities reviewed incident reports for residents;
- 95 % of the communities reviewed incident reports for staff;
- 94 % of the communities had a licensed nurse available to the staff and residents 24 hours a day (through various means); and
- 98 % of the communities conducted criminal background checks on all new employees.

NCAL is currently in the development phase of its Tier II Performance Measures, or those elements that contribute to an increased level of quality care. These measures include collecting data on falls, pain management, weight change, pressure ulcers, infection control, medication management, hospitalizations, elopements, depression, and advanced care planning. These areas will be incorporated into future surveys of the NCAL membership beginning in 2012.

Krista Hughes, Director, Division of Aging and Adult Services, Arkansas Department of Health and Human Services:

Not to the knowledge of the Arkansas Office of Long Term Care. This question would perhaps best be put to national organizations that represent assisted living facilities, such as the Assisted Living Federation of America (ALFA) or the National Center for Assisted Living.

Robert Jenkens, Director – The Green House Project, NCB Capital Impact:

There are many recognized exemplary practices in assisted living policy, regulation, design, and services. The Center for Excellence in Assisted Living (CEAL) was formed as a result of a Senate Special Committee on Aging hearing on assisted living quality in 2001 and the recommendations of the subsequent Assisted Living Workgroup (ALW). One of CEAL's main goals is to bridge research, policy, and practice by bringing providers, advocates, and experts together to vet and disseminate assisted living resources. See www.theceal.org for a compendium of exemplary practices.

Larry Polivka, Executive Director, Claude Pepper Center:

There are and they are continually being developed and updated as needed due to social and economic changes.

Charley Reed, Member, Board of Directors, AARP:

Other participants can better address this question.

Julie Strauss, Office of Licensing and Quality of Care, Seniors and People with Disabilities Division, Oregon Department of Human Services:

Oregon licenses each assisted living facility. Licensing visits are conducted every 24 months. Additionally, the Long-Term Care Ombudsman (LTCO), case managers, and facility complaint investigators are in facilities and report any concerns for follow up by the licensors. Failure to maintain minimum standards may result in penalties, licensing conditions, or license revocation.

Patricia Will, CEO, Belmont Village Senior Living:

The assisted living industry recognizes that maintaining the quality of its services is important to the overall well-being of residents. Best practices are promoted and dissemination of information about evolving standards is a priority of assisted living trade associations. Best practices cover a wide range of services, including dementia care, medication administration, dietary service, resident assessments, activities, hospice care, etc.

Many organizations to which residential owners and operators and staff belong promote excellence in the provision of assisted living services. For example, The Center for Excellence in Assisted Living (www.theceal.org) was formed in 2004 with the primary goal to maintain a national clearinghouse for information on quality and effective practices in assisted living. Other organizations that promote best practices in assisted living include the American Seniors Housing Association (www.seniorshousing.org) Assisted Living Federation of America (www.alfa.org); the National Center for Assisted Living (www.ncal.org); Leading Age (www.leadingage.org) and the Alzheimer's Association (www.alz.org).

23. What is the state role in regulating assisted living?

***Christy Allen, Assistant Commissioner, Bureau of Health Licensure and Regulation, Tennessee Department of Health*:**

As indicated in the introductory paragraphs, ACLFs are licensed by the Board for Licensing Health Care Facilities. ACLFs are inspected at least once every fifteen (15) months and in response to complaints filed by the public for compliance with applicable state law and Board rules.

***Josh Allen, President, American Assisted Living Nurses Association*:**

States are actively involved in regulating both the initial licensure and ongoing operation of assisted living communities. A 2011 report from the National Center for Assisted Living found that many states continue to evolve their assisted living regulations, despite economic challenges:

"At least 18 states reported making statutory, regulatory, or policy changes in 2010 and January 2011 impacting assisted living/residential care communities. At least six states made major changes including Idaho, Kentucky, Oregon, Pennsylvania, South Carolina, and Texas.

"Focal points of state assisted living policy development include life safety, disclosure of information, Alzheimer's/dementia standards, medication management, background checks, and regulatory enforcement. Other areas of change include move-in/move-out requirements, resident assessment, protection from exploitation, staff training, and tuberculosis testing standards."

***Brenda Bacon, President and CEO, Brandywine Senior Living*:**

Assisted living is regulated in all 50 states. Their role is to ensure that the state's seniors who may live in assisted living communities are safe and live a good quality of life. States license providers after they show they can meet rigorous requirements. The state statutory and regulatory framework determines such requirements as the structure of the building, life safety requirements, square footage of rooms and even wattage in the light fixtures. All require that policies and procedures are submitted to the state for review and approval, including staff requirements, training, activities, and dining services. Virtually every component of the community is regulated. After receiving a license, assisted living communities are monitored by the state regulatory agency and receive unannounced inspections to make sure they are complying with the state requirements. Deficiency reports are issued, and providers must submit corrective action plans. State regulatory agencies have the authority to fine communities, place a ban on admissions, allow only a provisional license or completely revoke a license of a provider that they believe may be endangering the health, safety and welfare of the residents.

***Eric Carlson, Directing Attorney, National Senior Citizen's Law Center*:**

States set standards, conduct inspections, investigate complaints, enforce relevant laws, and issue licenses. The specifics of a state's actions differ greatly from state to state. Many states are relatively lax in their standard-setting and enforcement. The better states set quality of care standards that are consistent with the care needs of the persons who can be admitted as residents.

The less conscientious states rely heavily on the facility's disclosure of its care practices and/or on the terms of the admission agreements signed by residents.

***Irene Collins, Commissioner, Alabama Department of Senior Services*:**

In Alabama the Department of Public Health regulates the assisted living facilities. They are in the process of updating this approximately 60 page document. Also, the facilities are visited by the State Ombudsman program at least twice a year.

***Kevin Coughlin, Director, Wisconsin Bureau of Assisted Living*:**

The states have a very important role in licensing and regulating assisted living communities. In Wisconsin, the Bureau of Assisted Living licenses and regulates over 3,200 communities with over 40,000 beds. Wisconsin has strong and effective regulations that govern the operations of assisted living. State surveyors are also responsible for investigating complaints, conducting periodic inspections, verifying compliance when enforcement action has been taken and licensing new facilities. This is a role that states do very well and that has led to development of unique processes that have been efficient and effective.

***Howard Groff, President, Tealwood Care Centers*:**

Although many federal laws impact assisted living, regulation of assisted living occurs primarily at the state level. Though state licensure terms vary, there is much commonality in the range of services that assisted living communities provide across the country. Assisted living communities provide housing with services, including assistance with activities of daily living, such as dressing and bathing, and help with medication administration. Many assisted living communities provide specialized services for people with Alzheimer's diseases or other dementias. (See attachment listing state and federal agencies with oversight of Housing with Services in Minnesota.)

Since the Assisted Living Work Group issued its report to this Committee in 2003, the body of state laws and regulations relating to assisted living has grown steadily. All 50 states and the District of Columbia regulate assisted living/residential care facilities. The continuing development of the body of state law and regulations governing assisted living is described in several reports including the Department of Health and Human Services' (HHS') "Assisted Living and Residential Care Policy Compendium, 2007 Update," (which is updated every few years) and NCAL's annual *Assisted Living State Regulatory Review*. Research conducted for the just-released 2011 edition of NCAL's *Regulatory Review* shows that more than a third of states change their assisted living/residential care laws or regulations over the past year, a rate of change similar to what has been happening since 2003. States have responded as assisted living has grown and as some communities serve residents with more complex health and chronic care needs. While state assisted living regulation remains a work in progress and is not perfect, states generally have responded to issues that have arisen and adjusted their regulatory systems appropriately.

In 2010 and January 2011, even though the pace of regulatory change slowed somewhat as states faced enormous fiscal pressures, at least 18 states reported making statutory, regulatory, or policy changes impacting assisted living/residential care communities, according to data collected for the 2011 edition of *Assisted Living State Regulatory Review*. At least six states

made major changes including Idaho, Kentucky, Oregon, Pennsylvania, South Carolina, and Texas. Focal points of state assisted living policy development in 2010 include life safety, Medicaid policy, disclosure of information, Alzheimer's/dementia standards, medication management, background checks, and regulatory enforcement. Other areas of change include move-in/move-out requirements, resident assessment, protection from exploitation, staff training, and TB testing standards.

Pennsylvania is the most recent of many states that have implemented multi-tiered regulatory systems, in part to accommodate the expanded role that assisted living is playing within the spectrum of long term care housing and services. Pursuant to legislation enacted in 2007, Pennsylvania implemented new assisted living regulations on January 18, 2011, thereby creating a second level of licensure alongside personal care homes. Oregon developed new rules for the endorsement of Memory Care Communities, thereby enhancing its regulations for Alzheimer's care. Oregon's endorsement rules focus on person-centered care, consumer protection, staff training specific to caring for people with dementia, and enhanced physical plant and environmental requirements. Rhode Island passed legislation that, once implemented, will expand the types of assisted living residents that may receive skilled nursing care or therapy and the length of time they may receive such services.

Washington state clarified that boarding homes must fully disclose to residents a facility's policy on accepting Medicaid as a payment source. New Jersey passed legislation requiring an assisted living residence or comprehensive personal care home that surrenders its license and promised not to discharge Medicaid residents to escrow funds to pay for care in an alternate facility.

In 2009, 22 states reported making statutory, regulatory, or policy changes impacting assisted living/residential care communities or assisted living Medicaid coverage, and at least eight of these states made major statutory or regulatory changes or overhauled sections of their rules. In 2008, at least 18 states made regulatory changes impacting assisted living/residential care communities with at least six of these states making major modifications to their regulations. (Source: Data collected for *NCAL Assisted Living State Regulatory Review*, 2010 and 2009 editions.)

As assisted living has evolved, states have acted to protect vulnerable populations. According to HHS' "Assisted Living and Residential Care Policy Compendium," in 2007 45 states had requirements for residential care facilities serving residents with Alzheimer's disease and other dementias (up from 44 states in 2004, 36 in 2002, and 28 in 2000)." The number of states with rules specifically geared for the care of Alzheimer's patients in assisted living has grown since then. In 2009, for example, Georgia, New Mexico, and Iowa created or added to protections for residents with Alzheimer's disease or other dementias, according the NCAL's *Regulatory Review.*

Almost all states require specified information in residency agreements. The 2007 HHS report noted the following state disclosure requirements within residency agreements:

- Services included in basic rates – required by 49 states.
- Cost of service package – 44 states.
- Rate changes – 30 states.

- Refund policy – 30 states.
- Cost of additional services – 28 states.
- Admission/discharge information – 28 states.

States continue adding to disclosure requirements and are placing more information on their web sites concerning assisted living facilities.

According to the HHS report, while only a few states do not allow individuals who meet the state's minimum nursing level of care criteria to receive care in assisted living settings, no states allow persons needing a skilled level of care to be served in an assisted living setting for an extended period of time (needing 24-hour-a-day skilled nursing oversight or daily skilled nursing services). States take different approaches for setting admission/retention policies and can be grouped into three categories (or combinations thereof):

- Full continuum (e.g., OR, HI, WA, ME). These states allow assisted living facilities to serve a wide range of needs.
- Discharge triggers. These states specify a list of medical needs or treatments that cannot be provided in assisted living and that will result in discharge (e.g., TN, VA).
- Levels of licensure (e.g., AZ, AR, FL, UT). Facilities are licensed based on needs of residents. In recent years, more states have moved to different levels of licensure.

NCAL's *Assisted Living State Regulatory Review* tracks and summarizes state regulations in several categories including the licensure term, definition, disclosure rules, facility scope of care, third party scope of care, move-in/move-out requirements, resident assessment, medication management, physical plant requirements, residents allowed per room, bathroom requirements, life safety, Alzheimer's unit requirements, staff training for Alzheimer's care, staffing requirements, administrator education/training requirements, staff education/training requirements, continuing education requirements, and Medicaid coverage. These rules have evolved steadily as have the many other aspects of assisted living that states regulate that are not included within the scope of the report.

NCAL strongly supports regulation of assisted living at the state level. NCAL believes that all assisted living/residential care communities should be licensed or certified by the states and surveyed by the states at reasonable regular intervals. States should provide adequate funding to perform periodic surveys at least every two years and to do timely surveys in response to complaints or issues of a serious nature as they arise. NCAL also believes that providers that have historically demonstrated a high level of customer satisfaction and excellence should be rewarded. For example, providers demonstrating excellence could be recognized for excellent performance on a public web site or surveyed less frequently.

While some argue that the federal government should extend its system of regulation for nursing facilities to encompass assisted living/residential care communities, NCAL opposes this for many reasons. For one thing, federal government regulation of nursing homes has not been an unblemished success story. It is punitive in nature and gives providers little, if any, incentive for quality improvement. Federal regulation of nursing homes, along with sub-market Medicaid reimbursement levels, has played a key role in creating and rigidifying a medical model of housing with services and making it difficult for the nursing home industry to update physical

plant and improve quality. (Despite this, the nursing home industry has documented quality improvements in recent years.)

In order to meet the needs of different types of consumers, assisted living communities come in many models and designs. Assisted living can be provided in a high-rise building housing several hundred individuals, in a small home with just a few, or within a campus offering many levels of care. The key to assisted living is providing resident-centered care in a secure setting that respects individual lifestyle choices, dignity, and privacy. Living accommodations can include a full size apartment, a single room, or living with another person. In some facilities, services are limited to meal preparation, housekeeping, medication reminders, and minimal assistance. In others, more intensive services, including help with administering medications, on-site nurses, and regular assistance with daily activities such as bathing and dressing are available. Assisted living also can be a very good place to live for many people with Alzheimer's disease or other dementias. There is no need to impose uniformity in senior housing, including assisted living. People seeking assisted living services should have a wide array of choices, unlike the current situation with highly regulated nursing homes. States are best positioned to regulate assisted living, especially since there is wide variation among states on the types of housing available, availability and support for community-based settings, and definitions of what is considered an institutional level of care under the Medicaid program.

An important difference between assisted living and nursing homes is the primary source of financing. Federal regulation of nursing homes arose in part because the federal government paid for much of the physical plant (including through the Hill-Burton Act) and continues to pay for most nursing home care through the Medicare and Medicaid programs. While federal/state Medicaid programs finance care for more than 60% of nursing home residents, Medicaid finances care of only about 13% of assisted living residents. Assisted living is primarily financed with private-sector dollars. Because of this, market forces can exert more influence on the level of quality in assisted living facilities than nursing homes: private-pay residents unhappy with the care they receive are more likely to be able to move to another facility than those relying on government programs with limited choices.

States continue developing oversight of assisted living/residential care, even though some are now facing major budget constraints. According to a 2006 report by the U.S. Agency for Healthcare Research and Quality (AHRQ), all states reported that they receive and investigate complaints in assisted living settings. (See U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, "Residential Care and Assisted Living: State Oversight Practices and State Information Available to Consumers," Robert Mollica, September 2006.) Oversight and monitoring of assisted living facilities vary by state; much like nursing home inspections, assisted living surveyors follow protocols to enforce licensing requirements and standards. According to the report, the typical survey process includes an annual unannounced inspection of the facility. While a few states do not provide enough funding to perform surveys required under their statutes, most are doing at least an adequate job of inspecting assisted living facilities.

The AHRQ report also mentions a few states that have begun using collaborative approaches toward assisted living oversight. Rather than moving assisted living to the federal regulatory approach that has been taken for nursing homes, policymakers should follow the lead of states such as Wisconsin that have taken a more collaborative approach with assisted living regulation

and oversight. (*Governing* magazine, "Public Officials of the Year: 2007 Winner: Kevin Coughlin: Common-Sense Compliance," by Penelope Lemov, http://www.governing.com/poy/2007/coughlin.htm.)

***Krista Hughes, Director, Division of Aging and Adult Services, Arkansas Department of Health and Human Services*:**

In Arkansas, the role is to develop standards and criteria, promulgate regulations accordingly, review facility performance under those regulations, and impose remedies for violations of those standards.

***Robert Jenkens, Director – The Green House Project, NCB Capital Impact*:**

The federal government is not directly involved in quality assurance for assisted living services reimbursed by the Medicaid program; this is in contrast to its role in nursing homes. States create their own regulatory and program rules and provide the bulk of regulatory oversight for Medicaid-funded assisted living services. While many federal laws impact assisted living, federal oversight is limited to reviews of existing or proposed state quality assurance systems during the waiver application process, and periodic reviews of those systems.

***Barbara Lyons, Senior Vice President – Kaiser Family Foundation, Director – Kaiser Commission on Medicaid and the Uninsured*:**

The regulation of assisted living facilities is almost exclusively within the purview of the state. States regulate assisted living primarily through the licensure process and standards for licensure vary widely. State licensing and oversight agencies do not generally collect outcomes data for licensed assisted living facilities, making quality comparisons challenging. Unlike nursing homes, states set their own policies on the characteristics of who may be served and what services must be provided in assisted living facilities. At least two states (Alabama and Maine) have developed systems for rating assisted living facilities.[xxviii]

***Larry Polivka, Executive Director, Claude Pepper Center*:**

We believe that regulation should remain at the state level. The state has oversight to assure that ALFs are operating in compliance with state law and rule and are involved in the development of those laws and rules.

***Charley Reed, Member, Board of Directors, AARP*:**

In contrast to nursing homes, no federal quality standards exist for assisted living. The state role is paramount in regulating assisted living facilities within their borders. States vary significantly in their licensing requirements, quality standards, monitoring and enforcement activities. Assisted living monitoring and survey tools track each State's own regulatory requirements and are not standardized across states.

***Martha Roherty, Executive Director, National Association of States United for Aging and Disabilities (NASUAD)*:**

See responses above. State agencies provide Medicaid payment for services, State Supplementation Payments for room and board, and provide oversight through Section 1915(c)

HCBS wavier quality monitoring requirements, state licensure and certification agency efforts and some efforts through State Long-Term Care Ombudsman programs.

***Julie Strauss, Office of Licensing and Quality of Care, Seniors and People with Disabilities Division, Oregon Department of Human Services*:**

Deficiencies are a result of failing to maintain minimum standards of care and safety as outlined in OAR.

***Patricia Will, CEO, Belmont Village Senior Living*:**

States are responsible for regulating assisted living. While regulatory models differ from state to state, many states share common requirements in physical plant requirements and areas related to life safety, resident rights, consumer disclosure, security features, etc.

In many states, assisted living is a specific model with a consumer-oriented service philosophy, private apartment-style units, and a broad array of services that support aging-in-place. In other states, residential care licensing categories have been consolidated under a set of "assisted living" rules that reflect the new model of assisted living as well as board and care. And while there is variability in how states define assisted living, states have not shirked from their responsibility to periodically revise their regulations concerning consumer disclosure, resident assessments, staffing, training, resident rights, and a host of other provisions related to preserving resident dignity and choice, quality of life, and quality of care.

States are also responsible for establishing requirements for providers to participate in the state's Medicaid waiver program. The state's Medicaid program is subject to federal approval. Importantly, as part of the approval and renewal process, CMS is required to ensure that states have systems in place to adequately protect the health and safety of waiver beneficiaries.

24. Recognizing that states differ across the board in their regulations, are there any particular practices that most states consider to be a deficiency as it relates to their surveys of facilities?

***Christy Allen, Assistant Commissioner, Bureau of Health Licensure and Regulation, Tennessee Department of Health*:**

The most common ACLF violation in Tennessee is an inappropriately placed resident, which is defined, generally, as one for whom the ACLF can no longer safely and effectively meet his/her medical needs or a resident whose verbal or physical aggressive behavior poses an imminent threat to him/herself or others. The ACLF is required to regularly assess each resident to ensure the resident's needs for services are consistent with the Board's rules and those residents who should be transferred to a higher level of care.

***Brenda Bacon, President and CEO, Brandywine Senior Living*:**

Every state agency is committed to protecting the health, safety and welfare of assisted living residents. All states have considerable overlap in what might constitute deficiencies. For

example, in any state, if the state regulatory agency comes to believe that a resident's safety and welfare is in jeopardy, it will most likely lead to the identification of deficiencies that need to be corrected.

Every state regulatory framework also enforces resident rights. Any violation of a resident's rights would constitute a deficiency. And, of course, no state will tolerate elder abuse, neglect or exploitation.

***Eric Carlson, Directing Attorney, National Senior Citizen's Law Center*:**

Recent deficiencies cited by state agencies often reflect insufficient numbers of staff and poorly trained staff. Sometimes the deficiencies discuss quality of care problems, but the root cause is likely staffing inadequacies.

For example, North Carolina officials recently cited poorly trained staff and unsafe diabetes care as leading to six fatal cases of hepatitis B in a North Carolina assisted living facility. Over several years the state fined 42 facilities for deficiencies involving the insulin administration, often by unlicensed "med techs." Thomas Goldsmith, *Diabetes Care Raises Alarm*, News & Observer (Dec. 26, 2010), www.newsobserver.com/2010/12/26/881880/diabetes-care-raises-alarm.html#.

***Irene Collins, Commissioner, Alabama Department of Senior Services*:**

The length of time between inspections appears to be a problem for many states.

***Kevin Coughlin, Director, Wisconsin Bureau of Assisted Living*:**

Most states identify the same issues with respect to requirements for resident rights, provision of services, care planning, life safety, and a home-like physical environment. If a state were to give an example of harm that occurred to a resident because of something the community or staff did or did not do, it is likely that almost all states would similarly identify it as a deficient practice. The wording of regulations may differ from state to state, but most would aim at achieving similar outcomes.

***Howard Groff, President, Tealwood Care Centers*:**

A 2010 report, published by the Long Term Care Community Coalition (LTCCC) and titled "Overview of State Survey and Enforcement Laws, Regulations and Policies for Assisted Living," found that state departments of health or departments of social services conduct oversight of assisted living facilities. In some states, multiple state agencies are involved. The report found that most states inspect assisted living facilities annually, biannually, biennially or over a specified time spanning one to two years. While a building's initial survey may be announced, most subsequent surveys are unannounced. According to the LTCCC report, surveyors typically examine if residents are informed of their rights, resident assessments, care plans, resident satisfaction surveys, staff criminal background checks, and availability of past inspection reports. Almost every state requires that copies of inspections either be posted or made available upon request. At least two states now post deficiencies on their web sites.

***Krista Hughes, Director, Division of Aging and Adult Services, Arkansas Department of Health and Human Services*:**

A response would require a survey of all states' regulations. It is assumed, however, that failure to provide mandates or agreed-upon care and services would constitute a deficiency.

***Charley Reed, Member, Board of Directors, AARP*:**

In 2002, The National Academy for State Health Policy (NASHP) conducted a survey of licensing officials in all the states and asked them to rank ten areas by the frequency of deficiencies and complaints on assisted living surveys.[20] Thirty-four states ranked the areas in the following order:

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

***Martha Roherty, Executive Director, National Association of States United for Aging and Disabilities (NASUAD)*:**

As noted above, variation in oversight is tremendous. The most common deficiencies would relate to the health, safety and welfare of the residents.

***Julie Strauss, Office of Licensing and Quality of Care, Seniors and People with Disabilities Division, Oregon Department of Human Services*:**

Oregon uses the same format for surveying ALF as for nursing facilities (Federal 2567 form). For all deficiencies cited, a plan of correction must be submitted and a revisit or other documentation must demonstrate the facility is in compliance or further agency action occurs.

***Patricia Will, CEO, Belmont Village Senior Living*:**

As states have increasingly allowed communities to serve residents with higher acuity needs and with more residents taking increasing number of medications, regulators consider practices

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[20] *State Residential Care and Assisted Living Policy: 2004, Section 1. Overview of Residential Care and Assisted Living Policy.* Robert Mollica and Heather Johnson-Lamarche, National Academy of State Health Policy and Janet O'Keefe, RTI International. March 31, 2005. U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. http://aspe.hhs.gov/daltcp/reports/04alcom1.htm#quality

related to medication administration and assistance with self-medication of utmost importance in the survey process. Other practices related to life safety, resident rights, resident assessment standards, development of service plans, negotiated risk agreements, and disclosure requirements, are all areas of focus among surveyors across all states.

25. What constitutes a successful survey process? Please feel free to allude to examples from any State.

***Christy Allen, Assistant Commissioner, Bureau of Health Licensure and Regulation, Tennessee Department of Health*:**

Pursuant to Tennessee law, a successful survey process is one in which a facility is inspected without prior notice and with regular frequency (no less frequently than once every fifteen (15) months for licensure) and one in which, if a violation is found, affords the facility a reasonable opportunity under the circumstances to correct the deficiency. If the ACLF timely (within ten days) provides a plan of corrective action that explains how the deficiency will be corrected, the date upon which each deficiency will be corrected, the measures or systemic changes that will be put in place to ensure the deficient practice does not recur, and how the corrective action will be monitored to ensure the deficient practice does not recur, staff will re-visit the facility as necessary to ensure the plan has been followed. If the deficiencies are not corrected at this stage, the ACLF may be subject to a penalty by the Board (either against the license, or a civil penalty, or both). Additionally, if any licensed professionals are found to have engaged in deficient practices, those professionals are referred to their respective licensing boards for appropriate action.

Staff conducts additional surveys to investigate complaints that are filed (complaints may be in writing, or a complainant may contact the Department through a toll-free number and speak with a registered nurse on staff about his/her concerns). The same process as above is utilized to address complaints.

***Josh Allen, President, American Assisted Living Nurses Association*:**

We believe a successful survey process should be focused primarily on ensuring the provision of quality housing, care, and services that meet the needs and preferences of the individual residents, and takes into consideration the balance of safety, autonomy, privacy, and choice. We also believe an effective survey process is based on a partnership between the state regulatory agency and the assisted living provider, rather than an adversarial relationship. Ultimately both the state regulators and assisted living providers should be working together to ensure the best possible care, services, and outcomes for assisted living residents.

***Brenda Bacon, President and CEO, Brandywine Senior Living*:**

The most successful survey processes are those where there is close collaboration between the provider and the state regulator; and all are focused on the best interests of the individual resident. This process often breaks down when the regulator generalizes about the needs of all seniors in a community, county, or state and applies one-size-fits all solutions.

***Kevin Coughlin, Director, Wisconsin Bureau of Assisted Living*:**

Wisconsin has a very successful survey process. The survey process includes all of the following:

a. Abbreviated surveys for communities with good compliance
b. Providing technical assistance as part of the survey process
c. Utilizing "notice of findings" for violations that are isolated and have low potential for harm
d. Creative enforcement strategy utilizing "directed plans of correction" to help a community fix systems to correct and sustain compliance. Utilization of a progressive enforcement strategy that results in getting a community into compliance or out of the business of harming our most vulnerable citizens.
e. Collaboration with all key stakeholders to help improve assisted living communities.
f. Helping assisted living communities with resources that can help them provide good quality of care.
g. Arming consumers with good information about assisted living communities so they are well informed to make these critical decisions and can influence quality through the market place.

While not receiving new resources to keep up with the growth of the industry, the regulatory agency has limited survey backlogs to the communities that qualify for an abbreviated survey (open for 3 years, no substantiated complaints for 3 years and no enforcement action in 3 years). A remarkable outcome has been despite not surveying the best communities as frequently, they have stayed in compliance. As a regulatory agency Wisconsin is making a difference by focusing on the "left side of the bell curve".

Many states have adapted components of the Wisconsin assisted living regulatory model to the special situations in their own states. These include Michigan, Florida, California, Colorado, Arkansas, Idaho, Rhode Island, Washington D.C. New York, Oregon and North Carolina.

***Eric Carlson, Directing Attorney, National Senior Citizen's Law Center*:**

A successful survey process requires a comprehensive, validated survey protocol; well-trained surveyors working in a multi-disciplinary team; unannounced annual surveys; and timely complaint investigations. To our knowledge, no state system includes all of these features. States generally do not have a formal survey protocol and do not require special training for their surveyors. We are unaware of any validation of survey protocols in the states that use specific protocols. *See* Long-Term Care Community Coalition, *Oversight of Assisted Living in the United States: Summaries of State Requirements and Practices* (2010).

Moreover, due to budgetary restrictions, state surveys are becoming less frequent and less comprehensive. States are increasingly relying on models of surveying that call for surveying of only certain facilities or certain aspects of a facility, depending on certain "key indicators." Relying on such indicators has not been tested in the assisted living context, and states use these systems not because states think that these systems are the most effective, but because such systems are less expensive. We recommend against such trade-offs, and contend that a more

comprehensive oversight approach is needed to protect the increasingly vulnerable population of assisted living residents. *See* Webinar of Assisted Living Consumer Alliance, Aug. 10, 2010, www.assistedlivingconsumers.org/digest.2010-07-27.6518695705 .

***Irene Collins, Commissioner, Alabama Department of Senior Services*:**

Checking compliance, quality and consumer confidence are critical as a part of the process.

***Kevin Coughlin, Director, Wisconsin Bureau of Assisted Living*:**

In Wisconsin, a successful survey is where the regulatory agency is able to identify if the assisted living community is in substantial compliance with the regulations. If it is not in substantial compliance, the community is put on notice through the issuance of a Statement of Deficiency (SOD) in a clear and concise manner, so that it knows how to correct the deficiency. If harm has occurred to a resident due to non-compliance, the community is issued a sanction that will help them fix the systems that are causing the negative outcome. If harm continues, then progressively more punitive enforcement is utilized to help the community come into compliance and sustain compliance, or help them leave this important industry, which cares for some of Wisconsin's most vulnerable citizens. Technical assistance may be provided to help the community achieve better outcomes for their residents. If a community has achieved good compliance over time, they are rewarded with a less intensive, abbreviated survey.

***Howard Groff, President, Tealwood Care Centers*:**

Surveys should be completed at the state level every two to three years. The survey process should have clear expectations for providers. The process could include a satisfaction survey of residents and families, clinical outcomes, disclosure of services and costs, and recognition of individual resident choice. The process should not be "cookie cutter" in nature and made to fit all types of assisted living. The process should support residents' individuality and choice. Minnesota has vulnerable adult laws that include mandatory abuse and neglect reporting requirements for all providers. This is another way for states to monitor/survey assisted living facilities.

***Krista Hughes, Director, Division of Aging and Adult Services, Arkansas Department of Health and Human Services*:**

When there is minimum disruption to services, and in the least amount of time possible, to determine facility compliance with regulatory or other applicable requirements.

***Larry Polivka, Executive Director, Claude Pepper Center*:**

When the ALF administrator and the state regulatory agency work together in a collaborative process.

***Charley Reed, Member, Board of Directors, AARP*:**

Most importantly, a successful survey process is one with adequate numbers of well-trained staff available for survey and monitoring activities. In the 2002 NASHP survey of state licensing officials mentioned above, over half the states reported that the number of staff available for

survey and monitoring was not keeping pace with the growth in the supply of facilities. We would surmise that this situation has worsened over time, given state budget situations.

In April 2004, the Government Accountability Office (GAO) issued a report on quality assurance initiatives in four states. One particular effort from Washington State involved the creation of a group of quality consultants who provided training and advice to assisted living providers on a voluntary basis. This assistance was separate from the survey and enforcement activities. Evaluations at six months and two years after implementation documented improvements in provider compliance as well as resident health and safety. However, a statewide budget crisis required the state to end funding for the program in order to maintain traditional licensing enforcement functions. A good explanation of Washington State's system for regulating assisted living facilities is available at http://www.assistedlivingconsumers.org/legal-library/government-oversight/digest.2007-02-08.6076817936.

The survey of state licensing officials cited above highlighted some effective survey process components. These included using follow-up visits when surveys indicate problems, having and making use when appropriate of a full range of remedies, and making unannounced visits. Also successful is progressive enforcement where the state imposes more serious sanctions and/or penalties against facilities that fail to meet requirements. In addition, using state nurse consultants and specialty staff, such as pharmacists and dieticians, to monitor facilities with serious or numerous problems has been shown to be successful.

***Julie Strauss, Office of Licensing and Quality of Care, Seniors and People with Disabilities Division, Oregon Department of Human Services*:**

Oregon's regulatory agency partners with provider associations, the LTCO, the Quality Review Organization and others in quality initiatives. Recent initiatives have included pressure ulcer prevention, fall prevention and root cause analysis training. Two years ago the Oregon Legislature established the Quality Care Fund to maintain these initiatives to ensure quality throughout our long-term care system.

***Patricia Will, CEO, Belmont Village Senior Living*:**

A successful survey process is one that incorporates a collaborative approach in which staff accompanies the surveyor during the review; observations are discussed during the process; identified problem areas are reviewed in the context of the regulatory requirements; and deficiency citations focus on outcomes. Kansas is an excellent example of a state which has adopted a collaborative oversight approach and conducts periodic training for nursing staff in areas of resident assessment, medications, etc.

Wisconsin is another example of a state that provides technical assistance to staff in interpreting regulatory requirements and provides guidance on quality of life and quality of care and new and innovative programs. Wisconsin also conducts different types of surveys based on a range of factors, including a community's citation history. For example, abbreviated surveys are performed for communities without any enforcement actions over the past three years or any substantial complaints or deficiency citations.

In sum, state quality assurance strategies that combine consultation, technical assistance, and training and maintain a consumer perspective that focuses on improving care constitute a successful survey process.

26. What sort of policies and resources do assisted living communities have in place to ensure quality? Are there any quality assurance policies of note that have been planned for the future?

***Josh Allen, President, American Assisted Living Nurses Association*:**

Assisted living communities implement a number of practices to ensure quality, and we believe licensed nurses play a critical role in the ongoing quality improvement process. Quality measures frequently implemented include the retention of licensed nurses on staff; policies and procedures to address resident care, coordination of health services, and overall operations; staff training programs; resident and employee satisfaction surveys; and incident monitoring and reporting programs.

***Brenda Bacon, President and CEO, Brandywine Senior Living*:**

Assisted living communities are in competition with other assisted living communities to attract consumers and retain their residents. To this end, they are continuously improving quality and quality services to ensure satisfied residents and families. One outcome is that most professionally managed assisted living communities far exceed the minimum requirements of state regulations.

One critical way to measure quality is through customer satisfaction surveys. Providers conduct these surveys to identify strengths and weakness and make changes as appropriate. In addition, professionally managed assisted living communities conduct internal quality assurance surveys. Further, since quality care is often dependent on the staff providing the care, there are high expectations of team members who are qualified and committed to seniors. They are well-trained and, in the professionally managed assisted living communities, sought out for feedback through meetings and surveys on how to improve quality.

***Eric Carlson, Directing Attorney, National Senior Citizen's Law Center*:**

Ideally, an assisted living facility will provide a comprehensive training program for all of its direct-care workers. State requirements in this area can be weak—California, for example, sets a minimum of only ten hours of initial training for direct-care employees—so in most states it is critical that facilities exceed the state-set minimum. *See* Section 87441(c) of Title 22 of the California Code of Regulations.

It is similarly critical that facilities set staffing levels at an adequately high level. Most states do not set firm numerical staffing minimums, leaving to individual facilities the responsibility to determine adequate staffing levels.

Care should be coordinated through a written plan of care, and that plan should fully incorporate health care, personal care services, activities, and other aspects of the resident's life in the facility.

***Kevin Coughlin, Director, Wisconsin Bureau of Assisted Living*:**

In Wisconsin, the state regulatory agency has helped initiate the Wisconsin Coalition for Collaborative Excellence in Assisted Living (WCCEAL). This collaborative involves the Wisconsin regulatory agency, Wisconsin trade associations, Wisconsin advocacy groups, national trade associations and the University of Wisconsin/Madison Center for Health Systems Research and Analysis. The goal is to create a program to help communities adopt and implement successful comprehensive internal quality assurance and quality improvement standards.

***Howard Groff, President, Tealwood Care Centers*:**

At Tealwood, we use a web-based program called MyInnerview, not only for our resident, family, and employee satisfaction surveys, but also for our quality profile. This enables us to benchmark our quality measures against other users of MyInnerview, by state and also nationally. This helps to drive and improve our quality outcomes. Staff in our assisted living facilities are being trained in quality assurance, quality improvement, and root cause analysis, thereby involving them in overall continuous improvement in quality areas. In addition, we are in the process of developing a business relationship with a physician group to provide services to our residents if they choose. These services are intended to help residents to stay in their homes longer, monitor and adjust medications when needed, and hopefully decrease hospitalizations related to chronic illnesses, because physician services can be brought into their home rather than having to travel to a clinic setting. Our goal also is to provide medical director services, where physicians are available to oversee care policies and be an advisor to the assisted living facility on new services available, infection control, medication services, and other areas as they are identified. We would ask the medical director to be involved in our quality assurance and improvement programs, as well.

***Krista Hughes, Director, Division of Aging and Adult Services, Arkansas Department of Health and Human Services*:**

Under Arkansas regulations, facilities must develop and maintain a quality assessment unit. The unit must meet at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary, and to develop and implement appropriate plans of action to correctly identify quality deficiencies. The quality assessment unit must consist of the individual or individuals identified by the facility as having the ability to recognize and identify issues of quality deficiencies and to implement changes to facility and employee practices designed to eliminate identified issues of quality deficiencies.

To promote quality assurance efforts, good faith attempts by the quality assurance unit to identify and correct quality deficiencies are not used as a basis for sanctions.

***Larry Polivka, Executive Director, Claude Pepper Center*:**

In Florida this occurs with the survey process, monitoring complaint investigations, partnerships with Fire Marshall, depart of health, ombudsman, and professional organizations.

***Charley Reed, Member, Board of Directors, AARP*:**

Provider organizations are in a better place than we are to describe the quality assurance and improvement programs they have in place. AARP would add that the best policies are oriented toward measuring and responding to the experiences of residents and their families. Many providers have detailed measures that give useful feedback about both quality of care and quality of life issues. Many providers also have active resident and family councils where emerging problems can be discussed and resolved. Effective quality assurance also requires ongoing staff training and willingness to involve direct care staff members, who are most likely to observe quality problems, in decision-making.

***Julie Strauss, Office of Licensing and Quality of Care, Seniors and People with Disabilities Division, Oregon Department of Human Services*:**

In Oregon, ALFs have provided a cost effective alternative to nursing facilities. However, Oregon serves as many Medicaid clients in their homes as in community based care. In- home services remain the most cost-effective alternative. Additionally, other models such as RCF and Adult Foster Homes can be lower cost alternatives to ALF.

***Patricia Will, CEO, Belmont Village Senior Living*:**

Assisted living communities have been, and continue to be, an attractive choice for frail seniors and their families. The significant and growing consumer demand for assisted living has evolved in large part because of its emphasis on creating a residential living environment where quality of care and quality of life define the resident's living experience.

Respecting resident privacy, independence and choice are hallmarks of assisted living and integral to ensuring quality in all its dimensions. Providers take very seriously their responsibility to ensure that these fundamental assisted living principles are fully integrated into their quality assurance standards and protocols. In fact, many assisted living companies structure their compensation packages to promote additional incentive for members of the community management team to meet certain performance objectives on their state survey as well as employee and resident satisfaction surveys.

Assisted living companies routinely monitor individual community compliance in various ways, including on-site quality assurance consultations and formal surveys conducted by a team of QA professionals. Should it be determined by the QA team that more intensive intervention is needed to bring a community into full compliance with corporate standards, their job is to provide the necessary technical and consultative support to ensure compliance in areas identified as requiring immediate attention.

Assisted living providers also have ongoing access to a host of quality assurance resources, including in-house corporate staff with clinical expertise in assisted living; trade association industry websites which routinely post recognized best practices; and in-service training provided by a range of quality experts (i.e. corporate-based staff, local area consultants, state regulators, etc).

27. Would you describe assisted living as a cost effective model for long-term care? Please explain why or why not.

***Josh Allen, President, American Assisted Living Nurses Association*:**

Yes, assisted living is absolutely an affordable long-term care option. In the 2010 edition of their annual cost of care survey, Genworth financial reported the national median annual rate for a private assisted living unit was $38,200. By comparison, the median annual rate for a private room in a skilled nursing facility was over $75,190; nearly double the cost of assisted living.

The autonomy provided through the state regulatory environment allows the maintenance of cost effective assisted living services by eliminating additional regulatory layers unnecessary to provide a consumer driven product.

***Brenda Bacon, President and CEO, Brandywine Senior Living*:**

Yes. Assisted living is a cost effective resident-centered alternative to institutional care such as that offered by skilled nursing facilities and hospitals. Sadly, many seniors who do not need the more intensive forms of care provided in skilled nursing environments end up living there and at a substantial premium. Assisted living is one-third to one-half the cost of skilled nursing care.

In comparison to home care, the fact is our country is facing a shortage in healthcare workers. Deploying the limited number of workers today to an individual's home is time consuming and inefficient. Assisted living communities are a much more efficient use of resources and offer a safe, social and service-rich environment for seniors to live together "under one roof," but still enjoy privacy. Many custom-built assisted living communities were designed to most efficiently serve each individual resident and deploy staff resources effectively in their daily roles.

***Eric Carlson, Directing Attorney, National Senior Citizen's Law Center*:**

Assisted living is potentially a cost effective model for long-term care. It is difficult to generalize in this area, as assisted living facilities can differ greatly from one another, both from state to state and within the same state. Assisted living care is cost effective to the extent that it allows persons to move out of nursing facilities, or delays the need for nursing facility care. On the other hand, assisted living care is not cost effective to the extent that residents could otherwise be living at home with the necessary services, and if poor quality assisted living care leads to adverse outcomes and unnecessary hospitalizations.

***Irene Collins, Commissioner, Alabama Department of Senior Services*:**

It can definitely be a good model, especially when the facility is part of a livable community designed for long term care.

***Kevin Coughlin, Director, Wisconsin Bureau of Assisted Living*:**

In Wisconsin, Family Care "cost effective" is defined as effective in meeting the needs of the enrollee and ensuring that costs are aligned with another alternative that would also meet an individual's needs. To the extent that assisted living is usually less costly than nursing homes, we would define it as cost effective. In instances where the level of care and specific services would

result in a cost of care that is higher than the cost of a nursing home, the service could still be described as cost effective if it meets the needs of the enrollee in a manner that is less restrictive. When the risk of negative health outcomes is greater in an assisted living facility, a nursing home may be defined as more cost effective.

***Howard Groff, President, Tealwood Care Centers*:**

There is no one best level of long term care. Individuals choose different levels of long term care based on factors including their needs, preferences, and the availability to them of an informal care network. With that in mind, assisted living is a very cost-effective model for long-term care for a large number of people. A recent U.S. Department of Health and Human Services study tracking how people used long term care (LTC) insurance benefits can serve as a "natural experiment" exploring where people choose to receive care when they have financing, and how much it costs. The study found that a major impact of having LTC insurance is enabling claimants to exercise preferences for alternatives to nursing home care. Titled "Private Long-term Care Insurance: Value to Claimants and Implications for Long-term Care Financing," the study was recently published online by the Gerontological Society of America. (See: http://gerontologist.oxfordjournals.org/content/early/2010/03/18/geront.gnq021.)

Researchers took a random sample from 10 LTC insurance companies of 1,474 individuals receiving benefits who were interviewed in-person by a trained nurse and then by telephone every four months for a 28-month period. About 96 % of those filing claims were approved for payment. At baseline, 37 % received home care, 23 % assisted living, 14 % were in a nursing home, and 26 % had not yet begun receiving care.

Researchers found that only 20 % of those studied ever received nursing home care over the 28-month period. Also, "despite the oft-cited preferences of the elderly individuals to remain at home with paid services if required, LTCI claimants frequently chose assisted living rather than paid home care or nursing home care." The study found that the most disabled claimants resided in nursing homes and the least disabled in assisted living settings. However, nursing home and assisted living residents studied had comparable levels of cognitive impairment (64 % and 63 %, respectively), significantly greater than paid home care users (28 %). Based on 3,604 person-waves of data, nursing home residents had the highest average monthly cost ($5,561) and assisted living residents had the lowest average monthly cost ($2,653) while those who received care at home spent $3,601 on average. The overwhelming majority were satisfied with their service providers, including nursing home providers, although nursing home residents were less highly satisfied than assisted living residents or paid home care users.

Assisted living is cost effective when compared with nursing homes. In Minnesota, construction costs for assisted living range from $80 per square foot in rural areas to $150 per square foot in metropolitan areas. That equates to about $80,000 to $165,000 per unit (including common space of 25% to 30%). This compares to construction costs for nursing facilities at around $250,000 per (private) room. Assisted living also requires less staffing than do nursing homes as it does not require nursing on site 24 hours per day; MDS coordinators; and other nursing home staff.

***Krista Hughes, Director, Division of Aging and Adult Services, Arkansas Department of Health and Human Services*:**

Yes - in Arkansas, the tiered per diem rate for ALF ranges from $61.15 to $73.62; the SFY '09 weighted average per diem for nursing homes was $143.59.

***Robert Jenkens, Director – The Green House Project, NCB Capital Impact*:**

Assisted living is a cost-effective model of Medicaid-funded long-term care. It serves nursing home eligible residents at roughly ½ the Medicaid cost of traditional nursing home care (NGA, 2000). It does this through a focus on nursing home eligible individuals with high needs but relatively stable conditions that do not require 24-hour unscheduled clinical interventions. Assisted living's cost effectiveness is facilitated by, on average, more flexible and outcome-oriented regulatory standards.

***Larry Polivka, Executive Director, Claude Pepper Center*:**

Yes because the range of payment can vary based on the type and size of facility which does not affect the quality of care. Third party services can be added to keep the cost of AL living more affordable to a wide range of residents.

***Charley Reed, Member, Board of Directors, AARP*:**

An assisted living residence can be a cost effective model for long-term care. Though costs can vary with services provided, it costs less for people to be served in assisted living than in a nursing home. The 2010 Genworth Cost of Care Survey found that the national median monthly rate for an assisted living facility (one bedroom/single occupancy) is $3,185 or $38,220 annually. The same survey found that the national median daily rate for a private room in a nursing home is roughly twice as high – $206 daily, $6,180 monthly or $75,190 annually. In addition, on average, the Medicaid program can provide home and community-based services to three people for the cost of serving one person in a nursing home.

***Martha Roherty, Executive Director, National Association of States United for Aging and Disabilities (NASUAD)*:**

In general, assisted living is a cost effective model for long-term care. Service needs generally may be met without the administrative overhead expenses associated with nursing homes.

***Julie Strauss, Office of Licensing and Quality of Care, Seniors and People with Disabilities Division, Oregon Department of Human Services*:**

If clients cannot be served in their home, ALF is generally the most preferred option since it enables the resident to have an independent apartment while still receiving minimum services.

***Patricia Will, CEO, Belmont Village Senior Living*:**

Assisted living historically has been a very cost effective long term care alternative when compared to the cost of nursing home care. In 2009, the national average median monthly rate

for a private one-bedroom assisted living unit was $2,825.25, or approximately $93 per day. [21] This compares to a national average median daily rate of $203.31 for a private nursing home room. [22] Admittedly, the health care needs of nursing home residents are typically more extensive and thus more costly to deliver than the supportive needs of assisted living residents. Nevertheless, for the millions of frail seniors who do not require 24-hour nursing care, but rather require assistance with activities of daily living and specialized dementia care services, they can realize significant cost savings in assisted living.

28. How does customer satisfaction in assisted living communities compare with other long term care options?

***Josh Allen, President, American Assisted Living Nurses Association*:**

We believe assisted living consumers report a higher level of satisfaction with the housing, care, and services received in assisted living communities when compared to traditional long term care options, such as a nursing home. Consumers report to our members that assisted living "feels more like home."

***Brenda Bacon, President and CEO, Brandywine Senior Living*:**

A national research survey conducted in 2007 by Public Opinion Strategies showed that 90 percent of assisted living residents expressed satisfaction with their community, 97 percent of residents were satisfied with the level of safety they feel in the community, 96 percent were satisfied with their own personal living space and 95 percent were satisfied with the level of personal independence they have in their community.

***Eric Carlson, Directing Attorney, National Senior Citizen's Law Center*:**

We do not know of any data that definitively answer this question. Consumer satisfaction measures for long-term care facilities can be of questionable validity, depending on the methodology. Residents often suffer from cognitive deficits and, given that residents are living under the supervision of facility staff, both residents and family members can feel pressure to answer questions in a way that would satisfy facility staff.

***Irene Collins, Commissioner, Alabama Department of Senior Services*:**

As an example, we are a private pay state yet we have 90% of our beds filled in regular Assisted Living and 95% of our Specialty Care Assisted Living Facilities (SCALF) filled.

***Kevin Coughlin, Director, Wisconsin Bureau of Assisted Living*:**

In Wisconsin there is currently no data showing such comparisons. In a couple of years, with the WCCEAL project as described above in #26, there will be data available to compare. Nationally, satisfaction in assisted living usually scores higher than nursing homes.

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[21] Genworth 2009 Cost of Care Survey
[22] Ibid.

***Howard Groff, President, Tealwood Care Centers*:**

Measurement of satisfaction in assisted living communities is very common although the methods vary. While many providers use third-party organizations to measure satisfaction, many measure satisfaction using internal tools and resources. This variability makes it challenging to determine satisfaction rates amongst residents and families in assisted living.

Two sources of data can provide insights in answering this question. The first source is My InnerView. In early 2008, NCAL announced a strategic partnership with My InnerView to provide consumers, policymakers, and the profession with evidence-based satisfaction data from residents, family members, and employees. My InnerView is a recognized leader in measuring long term care resident, family, and staff satisfaction. This initiative will eventually enable assisted living providers to measure their performance based against their customers' expectations, and also benchmark it against other communities in their local area, statewide, and nationally.

Based on the most recent data available from My InnerView, assisted living providers experience an overall satisfaction rate of 90%. This compares to an 89% overall satisfaction rating for skilled nursing residents and a 93% overall satisfaction rating for residents residing in independent living.

Assisted living residents have a 91% rating when asked if they would recommend their assisted living community to others for care. This compares to an 89% rating from skilled nursing residents for recommendation to others for care and a 93% rating for recommendation to others from residents residing in independent living communities. *(Note: no risk or severity of illness adjustments have been made in the data available from My InnerView, so this is not necessarily an apples-to-apples comparison.)*

The second source of data is from a recent consumer poll completed by The Mellman Group for the American Health Care Association and NCAL. In 2010, 1,000 likely general election voters across the nation were surveyed on their overall impression of different health care settings and services. The results showed an 82% favorability rating for assisted living, with only doctors and hospitals having comparable or higher ratings, 88% and 84% respectively.

***Krista Hughes, Director, Division of Aging and Adult Services, Arkansas Department of Health and Human Services*:**

The Office of Long Term Care does not generally attempt to determine customer satisfaction. However, customers can file complaints with the Office of Long Term Care when the customer believes that the assisted living facility is not adhering to agreed-upon levels of care or services.

***Robert Jenkens, Director – The Green House Project, NCB Capital Impact*:**

The long-term care market place has provided strong signals of consumer satisfaction with assisted living, or, perhaps also, its dissatisfaction with the prevalent institutional model of nursing home care. The last 20 years have shown that when someone cannot stay at home, the individual and their family prefer assisted living settings if the individual is eligible and can afford it. While nursing home "beds" grew by just over 300,000 (or 19%) from 1991 to 1999, assisted living added over 400,000 units, a growth rate of 119% (AARP, 2003).

***Larry Polivka, Executive Director, Claude Pepper Center*:**

While we do not have data, we believe that customer satisfaction in assisted living is high. That is evident by the continuing growth in the industry.

***Charley Reed, Member, Board of Directors, AARP*:**

One way of answering this question is to look at the choices that people make when they have insurance to pay for their services and money is less of an issue. According to recent research sponsored by the Office of the Assistant Secretary for Planning and Evaluation at the Department of Health and Human Services (HHS), among those filing claims for private long-term care insurance (LTCi) 37 percent were receiving home care, 23 percent assisted living, 14 percent were in nursing homes and 26 percent had not yet begun receiving services. In terms of satisfaction, home care and assisted living ranked higher during the first wave of the survey and remained high, while satisfaction with nursing home services was somewhat lower to start with and declined over time. Among those receiving home care, 74 percent of home care recipients, 74 percent of assisted living residents, and 60 percent of nursing home residents reported that they were very satisfied in wave 1 of the study. By wave 7, 79 percent of home care recipients, 72 percent of assisted living residents, and 49 percent of nursing home residents reported being very satisfied. It should, however, be noted that disability levels (measured by activities of daily living limitations) were lowest among assisted living residents, though levels of cognitive impairment were comparable to nursing home residents – with both much higher than home care recipients.[23] It is also important for consumers to stay in the same facility and get all the care they need instead of moving to a nursing home.

***Julie Strauss, Office of Licensing and Quality of Care, Seniors and People with Disabilities Division, Oregon Department of Human Services*:**

Oregon has a strong regulatory presence in ALFs. There are no additional regulations that can be identified as necessary from the federal government.

***Patricia Will, CEO, Belmont Village Senior Living*:**

Historically, assisted living has enjoyed very high customer satisfaction compared with nursing homes. Occupancy levels nationally continue to remain high averaging 90 percent, and in many markets of the country, exceed 90 percent. As a further testament to high customer satisfaction in the assisted living sector, is the fact that assisted living has experienced enormous growth in the last 15 years. More than 50 percent of the current supply of assisted living units in the top 100 metropolitan markets has been developed since 1995.[24] This compares to the nursing home market where the overall supply of beds in the largest 100 metro markets actually declined by 1.7% since the fourth quarter of 2005.[25]

Strong private pay demand for assisted living has been largely driven by the quality of life experienced in assisted living and the emphasis placed on service innovation and customer

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[23] "Private Long-term Care Insurance: Value to Claimants and Implications for Long-term Care Financing," Pamela Doty, Marc Cohen, Jessica Miller, and Xiaomei Shi, *The Gerontologist,* Vol. 50, No. 5, pages 613-622, 2010.
[24] NIC Investment Guide 2010
[25] Ibid.

satisfaction. In contrast to nursing homes which are generally oriented toward a "one-size-fits-all" approach, assisted living offers a highly customized approach, from innovative building designs to a service delivery model that is resident-directed and a philosophy of care that empowers staff decision-making based on respecting residents' dignity, choice, independence and privacy—core values of assisted living. Most assisted living communities offer a wide range of features not typically available in nursing homes, such as private, lockable apartment-style units in a wide range of unit sizes, highly residentially-appointed common areas, and flexible pricing models based on resident acuity levels.

29. In light of the evolution of effective and rigorous state oversight of assisted living, what would necessitate a greater federal role apart from Medicaid?

***Josh Allen, President, American Assisted Living Nurses Association*:**

We believe the needs of consumers are best served when assisted living is regulated at the state level. State oversight has shown that it can lead to the development of housing and care models that respond to a wide range of consumers with varying needs and preferences for services. The state governed option permits immediate responses to and remedies for state identified issues and consumer requests.

***Brenda Bacon, President and CEO, Brandywine Senior Living*:**

We do not see the need for the federal government to play an additional role in the oversight of assisted living. However at times there are federal legislative proposals that could improve the lives of seniors in general that ALFA supports. Two bills that come to mind are the Silver Alert legislation which, like the Amber Alert, would help find seniors who may have become confused and wandered from their home or another setting.

Efforts to prevent elder abuse, neglect and exploitation for all seniors such as Senator Kohl's Elder Abuse Victims Act is also a good legislative proposal.

***Eric Carlson, Directing Attorney, National Senior Citizen's Law Center*:**

We do not agree with this question's premise. State oversight of assisted living is not necessarily effective or rigorous. As discussed in our answer to Question #25, surveys in many states are conducted infrequently. For example, California law generally requires a state survey of an assisted living facility (called a "Residential Care Facility for the Elderly" under California law) only once every five years. *See* Section 1569.33(d) of the California Health and Safety Code.

Even when deficiencies are cited, enforcement consequences may be grossly inadequate as compared to the magnitude of the violation. For example, Florida imposed only a $10,000 fine (reduced to $7,500) when a 93-year old assisted living resident with advanced Alzheimer's disease died, with severe burns to his esophagus, 18 hours after he drank a sodium hydroxide solution used as dishwasher detergent. Earlier, the facility had been fined $3,000 "related to a February 2009 incident in which at least 10 residents became sick with norovirus. An April 2009 inspection led to a $1,500 fine after questions arose about the treatment of a resident's bed sores." Jon Burstein, *Suburban Delray Beach Assisted Living Facility Fined in Resident's Poisoning Death; Homewood Residence at Delay Beach Did Not Admit Responsibility*, The Palm

Beach Post (Nov. 15, 2010), www.palmbeachpost.com/news/crime/suburban-delray-beach-assisted-living-facility-fined-in-1048659.html.

Also, assisted living standards are often inadequate, particularly given residents' increasingly significant care needs. In too many states, standards are based on disclosure or on the terms of a facility's admission agreement with the resident.

As the question implies, a greater federal role is justified by the significant Medicaid payment for assisted living services. Also, a greater federal role can be supported by the inadequate standards and enforcement seen in many states. Finally, the increased involvement of the Federal Trade Commission is supported by the problems seen in assisted living contracts, and in the not infrequent discrepancy in assisted living between what is promised and what is delivered.

***Kevin Coughlin, Director, Wisconsin Bureau of Assisted Living*:**

In Wisconsin, there is a very efficient and effective assisted living regulatory model. This fact, combined with the collaboration with the Medicaid agency and their oversight of Medicaid recipients in assisted living has led to significant improvement in the assisted living industry. In the last eight years, assisted living beds in Wisconsin have increased by 50%, while the incidence of complaints (ratio of # complaints to # facilities) has decreased by 40%. This is in direct contrast to what is occurring in Wisconsin nursing homes. Where a federal role can have the greatest impact on the assisted living industry is with more creative ways to create "affordable assisted living," with tax credits or subsidies that decrease the housing cost component so that Medicaid can adequately cover the provision of services.

***Howard Groff, President, Tealwood Care Centers*:**

At this point, as discussed above, states have been steadily developing assisted living regulations and responding to consumer concerns as they arise. Any federal intervention should be carefully considered in terms of additional costs and unintended consequences.

CMS' ongoing attempt to define Medicaid home and community-based settings for the first time has the potential to exclude many assisted living providers from the Medicaid program, thereby dramatically reducing access to needed housing and services to low-income individuals. For example, CMS recently published a proposed rule implementing the Community First Choice Option under the Affordable Care Act in which the agency seeks to define for the first time what a home- and community-based (HCB) setting can be under the Medicaid program. The proposed rule states "that certain settings are clearly outside of what would be considered home and community-based because they are not integrated into the community . . . home and community settings would not include a building that is also a publicly or privately operated facility which provide inpatient institutional treatment or custodial care; or in a building on the grounds of, or immediately adjacent to, a public institution or disability-specific housing complex, designed expressly around an individual's diagnosis that is geographically segregated from the larger community, as determined by the Secretary." . (See "E. Setting" section on page 10740 of the Feb. 25, 2011 *Federal Register*.) Depending on how such language might be interpreted, it could exclude assisted living communities currently operating in proximity to institutional facilities, on a campus or otherwise, as well as assisted living units in Continuing Care Retirement Communities. If such a definition were to be adopted in all Medicaid wavier

programs, this means that many of my assisted living residents served by Medicaid who live on campus settings would be forced to move to away from their chosen homes or to a nursing home. Such a definition is discriminatory and would harm America's seniors with limited resources.

NCAL believes that any definition of HCB settings should include all assisted living communities participating in Medicaid. Indeed, under the logic of the landmark Olmstead decision, depriving Medicaid beneficiaries of a major type of housing with services – assisted living – would be the opposite of a reasonable accommodation, especially for those seniors who prefer to live in assisted living and those for whom assisted living is the least institutional option available based on their clinical needs.

AHCA/NCAL also continues to have concerns regarding CMS' 2009 advanced notice of proposed rulemaking (ANPR) announcing the agency's intent to publish proposed amendments to the regulations implementing Medicaid HCB services waivers under Sec. 1915(c) of the Social Security Act and soliciting advance public comments 1) on the merits of providing states with the option to combine or eliminate the existing three permitted waiver targeting groups and 2) on the most effective means to define home and community settings. (Federal Register, Medicaid Program: Home and Community-Based (HCBS) Services Waivers, June 22, 2008.) As we have noted our comments on the ANPR, defining HCB settings is a complex undertaking and should be done in a way that does not inadvertently reduce viable housing and services options for these vulnerable low-income populations. We are pleased that CMS understands the complexity of the undertaking as evidenced by the issuance of an ANPR that provides notice of a deliberative stakeholder process.

In response to the ANPR, AHCA/NCAL's main concerns are as follows:

- Attempts to define what qualifies as a community-based setting may limit beneficiary choice by excluding some types of assisted living providers or homes for people with developmental disabilities (DD) from the Medicaid HCB program;
- Combining target populations may lead to a loss of access to Medicaid services for beneficiary groups that are less politically powerful than others; and

Combining target populations such as persons with mental illness with persons with DD or frail seniors in waivers may increase the risk of inappropriate placement of vulnerable populations, as well as create safety issues.

AHCA/NCAL recommends that CMS should:

- Continue gathering stakeholder input, including by holding several stakeholder meetings, before defining what qualifies as a community-based setting so as to ensure that there are no negative, inadvertent consequences for Medicaid beneficiaries;
- Ensure that beneficiaries have choice of the entire spectrum of long term care settings and ensure that attempts to define community-based settings do not limit that choice;
- Acknowledge that assisted living communities must meet care and regulatory standards under state law that help ensure resident safety and that these standards typically do not apply to beneficiaries receiving services in their own homes;

- Not use the number of residents in a setting as a factor in determining whether a setting is considered institutional or community-like;
- Acknowledge that assisted living communities offer residents a wide variety of opportunities for community integration while maximizing independence, privacy, choice, and freedom of action, and respecting the rights and needs of other residents;
- Continue working with the Center for Excellence in Assisted Living (CEAL) and take into consideration a CEAL white paper on what person-centered care means in the assisted living context;
- Acknowledge that Medicaid's failure to pay for room and board in assisted living settings creates a payment gap that makes it difficult to provide private apartments in many states;
- Not attempt to mandate exact congruency between standards applying to 1915(i) and 1915(c) programs since the levels of care under the two programs are set at different points; and
- Develop safeguards ensuring that politically weaker target groups do not lose access to services and that target groups are not inappropriately mixed in residential settings and thereby exposed to harm, if states are allowed to mix target populations under Medicaid waivers.

AHCA/NCAL's full comments to CMS on the NPMR can be found at: http://www.ahcancal.org/advocacy/Letters/LtrCMS_ANPRMresponse.pdf.

***Krista Hughes, Director, Division of Aging and Adult Services, Arkansas Department of Health and Human Services*:**

Consistency of services and physical plant. Since each state is free to define what constitutes assisted living, it is possible that the actual level of services or of the physical plant can vary widely from state to state. Uniform national regulations would ensure that someone seeking assisted living services would be assured, no matter the state, of receiving at least a minimum level of services.

***Larry Polivka, Executive Director, Claude Pepper Center*:**

None. No Federal oversight is necessary.

***Charley Reed, Member, Board of Directors, AARP*:**

State oversight of assisted living is of uneven quality and intensity across states. Some states may have effective and rigorous oversight of assisted living, while other states clearly do not. Levels of oversight for assisted living can vary even within a state. In this time of state budget crises, some states may be cutting back on effective and rigorous oversight or reducing already inadequate levels of oversight due to state budget cuts.

***Martha Roherty, Executive Director, National Association of States United for Aging and Disabilities (NASUAD)*:**

NASUAD suggests development of a template federal framework for:

a. Assisted Living Bill of Rights; and

b. Assisted Living Disclosure Statement.

Additionally, potential residents, particularly individuals and families of low to middle income who could quickly exhaust their resources and turn to Medicaid, need objective, third party assistance with understanding their assisted living options and what they can afford and for how long. Options counseling could be extremely helpful to this population. States currently do not have the funding to meet such demand.

***Julie Strauss, Office of Licensing and Quality of Care, Seniors and People with Disabilities Division, Oregon Department of Human Services*:**

OAR 411-054-0080 outlines the process for notification of involuntary move-out and the due process afforded residents who receive such notice. There are no rights to "age in place" if a resident's condition changes and the facility can no longer support their service needs.

***Patricia Will, CEO, Belmont Village Senior Living*:**

State regulators historically have worked collaboratively with key assisted living stakeholders (i.e. consumer groups, policymakers, providers) to build a strong foundation for responsible regulations that promote quality care and support the core values of assisted living. Consumer demand for assisted living has remained strong over the years and continues to grow in popularity across all parts of this country which suggests that state regulators have been very effective in striking the right balance in their oversight role. The need for a greater federal oversight role is simply not indicated. To the contrary, an enhanced federal role in assisted living has the potential to undo much of the progress and collaborative efforts that have made assisted living the preferred long term care choice among seniors across this country.

30. Where there is a resident who wishes to age in place and the acuity of services have increased such that the facility does not offer the services needed, is there a protocol, either by law or best practices, in place for assisted living communities to follow? Does your state grant residents any particular rights to "age in place?" What, if any, federal laws address this issue?

***Christy Allen, Assistant Commissioner, Bureau of Health Licensure and Regulation, Tennessee Department of Health*:**

An ACLF may admit and permit the continued stay of a person who meets medical eligibility (i.e., level of care requirements for nursing facility services) so long as the person's treating physician certifies that the person's needs, including medical services, can be safely and effectively met and the facility can provide assurances of timely evacuation in case of fire or emergency.

In addition, while an ACLF may not admit residents who require nasopharyngeal or tracheotomy aspiration, nasogastric feedings, gastrostomy feedings, or intravenous therapy or intravenous feedings, it may allow the continued stay of existing residents who require these treatments only on an intermittent basis. If the resident requires these treatments on an ongoing, rather than an intermittent, basis, and the resident does not qualify for nursing facility level of care, the ACLF may seek a waiver from the Board allowing the resident to remain in the ACLF. If a person

needs these treatments and can self-care for the condition without the assistance of facility personnel or other appropriately licensed entity may be admitted or permitted to continue as a resident of an ACLF.

Notwithstanding all of the above, any ACLF resident, including residents and new admissions who have qualified for hospice care prior to admission to the ACLF, may receive hospice care services and continue as a resident of the ACLF as long as the resident's treating physician certifies that hospice care can be appropriately provided at the facility. The hospice provider and the ACLF are jointly responsible for the development of a plan of care that ensures the safety and well-being of the resident's living environment and for the provision of the resident's health care needs. The hospice provider is required to be available to assess, plan, monitor, direct and evaluate the resident's palliative care in conjunction with the resident's physician and in cooperation with the ACLF.

***Josh Allen, President, American Assisted Living Nurses Association*:**

Assisted living nurses, the professionals who frequently hold the responsibility of overseeing the care of assisted living residents, overwhelmingly support the concept of "aging in place." This is rooted in the fundamental concept that an assisted living community is the resident's home; it is not a "facility." Assisted living nurses believe in working with their residents, the residents' families, providers, medical professionals, and state regulators, to find a way to allow a resident to remain in the assisted living community throughout their lifespan, or as long as the resident so desires. By developing resident-centered service plans that tailor care and services to the unique needs of the individual, this goal is often achievable. Federal laws are not in place at this time to direct these processes, state regulations and consumer needs and choices effectively drive the current processes.

***Brenda Bacon, President and CEO, Brandywine Senior Living*:**

Many states do a great job addressing the issue of aging in place. In New Jersey, for example, the state regulations define aging in place as "a process whereby individuals remain in their living environment despite the physical and/or mental decline and growing needs for supportive services that may occur in the course of aging. For aging in place to occur, services are added, increased or adjusted to compensate for the person's physical and or mental decline. "

Americans are protected by the Olmstead Act (allowing them to live in the least restrictive setting), the Fair Housing Act (protecting home buyers from discrimination), and the Americans with Disabilities Act (protecting the disabled—such as frail elderly seniors--from discrimination).

***Eric Carlson, Directing Attorney, National Senior Citizen's Law Center*:**

Ideally, state law will specify what services must be offered by an assisted living facility. A state might have one package of required services for all assisted living facilities or, alternatively, might have a different package of required services for different assisted living licensure classifications (e.g., Assisted Living I, II, or III).

In a less desirable state licensing system, a facility is not required to provide a particular package of services, but is instead required to disclose which services will or will not be provided. As

discussed in our answer to Question #1, comprehensive disclosure can be helpful to consumers, but disclosure is not a panacea or a substitute for regulatory standards. Disclosure is inadequate because consumers searching for a facility generally are not prepared to distinguish between different facilities in this way, due to consumers' unfamiliarity with the relevant issues, and to the stress and time pressure that often accompany a search for a long-term care facility.

I am based in California, which operates under regulations that only loosely describe the minimum "basic services" offered by Residential Care Facilities for the Elderly (RCFEs, California's term for assisted living facilities). *See* Section 87464(f) of Title 22 of the California Code of Regulations. In addition to the basic services, certain health conditions—such as diabetes and incontinence—are "restricted" and in general can be accommodated under licensure rules only if the necessary care can be provided by the resident or by an appropriately skilled professional. The regulations speak generally of what the facility "may" do, as opposed to what it "must" do, suggesting that a facility would have the option of whether or not to arrange for the necessary care for any restricted condition. *See* Sections 87609- 87631 of Title 22 of the California Code of Regulations.

Thus, California RCFE law does not give a resident a right to age in place in an RCFE: a facility is not required to provide the necessary care for a restricted health condition. Additionally, a facility but not a resident has the authority to seek waiver of a "prohibited" health condition such as a Stage III or IV pressure sore. *See* Section 87616 of Title 22 of the California Code of Regulations.

In federal law, these situations are addressed by the Americans with Disabilities Act (ADA) and the Fair Housing Amendments Act (FHAA), each of which requires facilities to offer reasonable accommodations for persons with disabilities, as long as the reasonable accommodation does not constitute a fundamental alternation to the facility's operation, or cause an undue administrative or financial burden. As long as a state's licensing law allows a facility to provide care for a certain condition, the facility under the ADA is required to provide the necessary care as a reasonable accommodation that would not be a fundamental alteration, and likely would not cause an undue burden. The assisted living law in the State of Washington explicitly incorporates the ADA's reasonable accommodation requirements, but the ADA and the FHAA apply with equal force in any state, whether or not the state's assisted living law mentions them. *See* Wash. Rev. Code Ann. §§ 18.20.310(2), 18.20.320(1), 18.20.330(1).

***Kevin Coughlin, Director, Wisconsin Bureau of Assisted Living*:**

In Wisconsin the regulations do allow for "aging in place." Some assisted living communities that allow their residents to "age in place" will disclose that information in the admission agreement and will ramp up services to meet the needs of the resident as they occur. If the services exceed some regulatory requirement, the assisted living community can request a waiver or variance. The Department will almost always grant a waiver if the community has a good compliance history, has the capacity to provide the additional services, and it is the resident's wish to remain at the community. Usually there will be additional conditions added to the waiver approval to ensure safety. Heavy consideration is given to the fact that this is the resident's home and to try to avoid "transfer trauma" when possible.

If on the other hand an assisted living community does not allow for "aging in place," they will disclose that information in the admission agreement and will itemize the conditions that could trigger a discharge (as long as the conditions are not contrary to regulations). If there is an involuntary discharge, there are appeal rights that apply to one of our three assisted living models. In all cases, the assisted living community needs to assist the resident in locating an appropriate living arrangement prior to discharge.

***Howard Groff, President, Tealwood Care Centers*:**

At Tealwood, we do not segregate service levels in different buildings. Our model allows for incoming residents to select a unit they are comfortable with and we then bring services to their unit/home as their needs dictate through assessments performed by licensed nursing staff. We are currently piloting a "Continuity of Care" program whereby we coordinate with a certified (Medicare) Home Health Agency to provide higher level nursing services to home-bound residents under the Medicare Part A and B programs.

We also are currently working with a physician group to have them do clinical visits in our assisted living buildings. Through this program, they can become the primary physicians for our clients and provide the appropriate care without residents having to leave their homes.

***Krista Hughes, Director, Division of Aging and Adult Services, Arkansas Department of Health and Human Services*:**

Arkansas does not grant a right to age in place. The level of care a facility may provide is dependent on the type of facility. When a resident's level of care exceeds the level of care that a particular facility type may provide, the resident must move to a facility type that can provide the higher level of care. In Arkansas, by example, assisted living facilities may not provide twenty-four (24) hour nursing services. If a resident requires that level of care, the resident must move to a nursing facility. There are regulations for assisted living facilities in Arkansas that recognizes that a resident's level of care may temporarily increase, and the regulations provide a limited time period (up to 90 days) in which the resident may receive the higher level of care in an assisted living facility so long as it is medically determined that the increase in need is temporary. Additionally, that period can be extended by another 90 days for a total of 180 days.

***Larry Polivka, Executive Director, Claude Pepper Center*:**

There are many options available to residents that allow them to age in place such as hospice. However, if the resident becomes inappropriate for the ALF they should be moved to a more appropriate setting for their well-being. There is no need for federal laws to address this.

***Charley Reed, Member, Board of Directors, AARP*:**

An excellent report entitled "Aging in Place in Assisted Living: State Regulations and Practice" prepared by Robert Mollica in 2005 may be instructive. The paper profiles regulations in five states with assisted living regulations that support and encourage aging in place.

According to that report, states typically use one or more of five factors to establish admission/retention policies in assisted living residences:

- General condition;
- Health related conditions;
- Functional capacity;
- Alzheimer's disease and dementia; and
- Behaviors.

State rules usually set the parameters for admission and retention but allow individual residences to determine whom they will serve and what services will be provided within the parameters set by regulation. Assisted living residences vary, both within and across states, in terms of the residents they will serve on admission and the criteria for retaining residents after admission.

While there are variations among the states, all have established policies that allow assisted living providers to respond to the preferences of consumers and family members to receive additional services as conditions change. According to Mollica, "the importance of the regulations in these states is not how many residents require very high levels of service but that the flexibility to do so has been established. It may take several more years to implement the full extent of the regulations but the direction in recent years is heading in the intended direction."

Also, see response to Question 21.

Martha Roherty, Executive Director, National Association of States United for Aging and Disabilities (NASUAD):

Such requirements would be laid out in licensure rule or in Medicaid service definitions.

Patricia Will, CEO, Belmont Village Senior Living:

In cases where a resident wishes to age in place and state regulations do not permit the provision of higher acuity services required by the resident or the community is not equipped or staffed to provide such services, arrangements with a licensed home health agency to provide health care related services may be possible provided that the arrangements for higher level services comply with state regulations and community policy.

31. As many know, there are ways to creatively qualify for Medicaid where one ordinarily would not (i.e. estate planning to hide income and assets.) With that in mind, are there any State laws and/or best practices in the assisted living industry to protect against any instances of such fraud?

Brenda Bacon, President and CEO, Brandywine Senior Living:

We find that people are much more willing to pay for a product or service that they want. Likewise people don't want to pay for services or products they don't want. The point is people today save their money and then someone tells them they have to spend that hard earned money to go into a nursing home and they say no. I did not save my money to pay for this.

However, with customer satisfaction in assisted living at 90 percent, people are much more likely to spend their savings to live in assisted living. In fact families are also willing to spend their

money and will help out so that mom and dad can stay in assisted living and don't have to go to a nursing home.

Medicaid fraud is against the law and those who violate the law should be sanctioned. It is not the business of the assisted living provider to critically assess an individual's private financial affairs.

Eric Carlson, Directing Attorney, National Senior Citizen's Law Center:

Particularly after changes made by the 2005 Deficit Reduction Act, federal Medicaid law has strong provisions that do not allow persons to hide income or assets. A Medicaid applicant for nursing facility care or HCBS waiver services is penalized for any give-away made within five years prior to the date of application. The penalty is a period of ineligibility for the number of months for which the transferred-away money could have paid for the relevant services.

As a result, there is no incentive to give away money. If (for example) a person were to give $20,000 away, he or she would incur $20,000 of private-pay charges in the facility during ineligibility.

Furthermore, Medicaid programs in some states are following procedures that make a person ineligible forever for HCBS waiver services after transfer of even a small amount of money. In these states, the period of ineligibility is deemed to run only after the person is admitted to a nursing facility. So for an assisted living resident, the penalty period will never begin running, and will last forever.

Recently, a federal district court in New Jersey ruled that the New Jersey Medicaid program violated federal law in imposing the never-ending penalty. *See Frugard v. Velez*, 2010 WL 1462944, 2010 U.S. Dist. LEXIS 34996 (D. N.J. Apr. 8, 2010). This court ruling, however, explicitly addressed only the individual plaintiffs, and state Medicaid programs are still imposing never-ending penalties on person seeking waiver coverage. *See, e.g.*, Arkansas Dep't of Health & Human Servs., Division of County Operations, Policy Directive, Medical Services Policy Manual, MS 06-09.

The National Senior Citizens Law Center recently published a policy issue brief on this issue, entitled *Transfer of Assets: Making Assisted Living Residents Ineligible Forever.* A copy of this white paper is submitted with these answers.

Kevin Coughlin, Director, Wisconsin Bureau of Assisted Living:

In Wisconsin there are various state laws to protect against Medicaid fraud, including divestiture rules.

Howard Groff, President, Tealwood Care Centers:

Detecting fraud and improper transfer of assets is the responsibility of state Medicaid fraud units and many other government agencies.

At Tealwood, we currently utilize a Pre-Admission Financial Profile (see attached form). We discuss and project residents' financial needs for the coming months. The primary source of funding for private paying residents is a combination of their Social Security and savings.

Frequently, there is a home involved that is eventually sold. Where we encounter a great deal of difficulty is with regard to property ownership in rural areas. Often there are challenges with family farms and identifying who is the actual owner. At this time, we do not routinely perform property ownership searches prior to admission.

Where the resident is coming in qualified for Medicaid coverage under the Elderly Waiver and/or Group Residential Housing (GRH), we are dependent on the county social worker having done their due diligence.

Krista Hughes, Director, Division of Aging and Adult Services, Arkansas Department of Health and Human Services:

No. Care providers have no responsibility for determining an individual's eligibility for Medicaid coverage. However, if the provider conspired with the applicant to hide assets, the provider would be guilty of criminal fraud and would be excluded as a Medicaid provider.

Larry Polivka, Executive Director, Claude Pepper Center:

Medicaid law prevails here. Assisted living law doesn't address that issue in Florida.

Charley Reed, Member, Board of Directors, AARP:

While assisted living is preferred by many seniors as an alternative to a nursing home, it is not financially feasible for many older people with low or moderate incomes. Many older adults lack the financial capacity to pay for care in an assisted living facility, often relying upon family or public programs when available to fund such services. Many are unaware that Medicare will not cover nursing home or assisted living care.

For those older adults who rely upon Medicaid to help pay for long-term care services, historically their choices were limited to nursing home care, which is a Medicaid mandatory service. However, to reduce Medicaid expenditures on more costly institutional settings, states have increasingly developed and implemented less expensive alternatives to nursing home care, including Medicaid waiver programs for home and community-based services (HCBS) including assisted living.

Medicaid has always denied long-term care coverage to those who intentionally made themselves poor in order to qualify for Medicaid. However, the Deficit Reduction Act of 2005 made significant changes in Medicaid law by extending the look back and penalty periods on transfers of assets, which affect when an individual is eligible to receive long-term services. The look-back period was lengthened from three to five years. And, the start date for the penalty period was changed from the date of transfer to the later of the first day of month of transfer or date of eligibility for Medicaid long-term care.

While there is consensus that individuals should not gain Medicaid eligibility by inappropriately shielding substantial wealth, the research clearly demonstrates that most elderly attempting to qualify for Medicaid nursing home care (there is no research we can find on assisted living) have few assets and the incidence of asset transfer is quite small. According to a GAO study,[26] in

[26] *Medicaid: Transfers of Assets by Elderly Individuals to Obtain Long-Term Care Coverage.* Government Accountability Office. September 2005. http://www.gao.gov/new.items/d05968.pdf

2002, over 80 percent of the approximately 28 million elderly households (those where at least one person was aged 65 or over) had annual incomes of $50,000 or less, and about one-half had non-housing resources, which excluded the primary residence, of $50,000 or less. About 6 million elderly households (22 percent) reported transferring cash, with amounts that varied depending on the households' income and resource levels. In general, the higher the household's asset level, the more likely it was to have transferred cash during the two years prior to the 2002 Health and Retirement Survey (HRS) study. Overall, disabled elderly households—who are at higher risk of needing long-term care—were less likely to transfer cash than nondisabled elderly households. For those with incomes greater than $24,200 and non housing resources over $51,500, approximately 31.7% transferred cash in the previous two years and the medium dollar amount transferred was $4,000.

Martha Roherty, Executive Director, National Association of States United for Aging and Disabilities (NASUAD):

NASUAD is not aware of industry practices. The states' Deficit Reduction Act look back process would impact this.

Julie Strauss, Office of Licensing and Quality of Care, Seniors and People with Disabilities Division, Oregon Department of Human Services:

Fraudulent activities to qualify for Medicaid rarely occur. Private pay rates are higher than Medicaid, so facilities are motivated to report any suspected fraud to become Medicaid eligible to the Agency.

Patricia Will, CEO, Belmont Village Senior Living:

Federal and state government enforcement agencies are responsible and the best equipped to detect and protect against instances of Medicaid fraud. We are not aware of any best practices in the assisted living industry to fight against such fraud.

32. Presuming that they would be in a position to do so, should assisted living providers have a duty to help the State identify instances of Medicaid eligibility fraud? If so, please explain.

Josh Allen, President, American Assisted Living Nurses Association:

As healthcare professionals, assisted living nurses believe any provider who chooses to participate in the Medicaid system should bear some responsibility for reporting cases of egregious fraud. With that said, it is beyond the capabilities of assisted living providers to expect them to actively identify, monitor for, or investigate suspected fraud.

Brenda Bacon, President and CEO, Brandywine Senior Living:

It is the ethical duty of individual citizens to report Medicaid eligibility fraud or the violation of any law. However, assisted living provider companies are in the business of providing services to seniors; they are not in the business to investigate suspicious behavior or to be an agent of law enforcement.

***Eric Carlson, Directing Attorney, National Senior Citizen's Law Center*:**

It would not be appropriate to impose on assisted living providers a duty to help the State identify instances of Medicaid eligibility fraud. Determination of Medicaid eligibility can be a complex process. Detailed rules govern when particular income or resources are counted or excluded, and determine whether and to what degree an at-home spouse will be entitled to an allocation of income or resources from the spouse in the assisted living facility. Providers are not in a position to judge these rules' applicability to residents, and should not be expected to do so.

Privacy and personal autonomy should be a hallmark of assisted living care. Placing "identification" duties on facilities would run contrary to those principles, and could be interpreted by facilities as an invitation or requirement to scrutinize residents' personal affairs. Also, such duties would constitute discrimination against Medicaid-eligible residents. As discussed in question and answer #17, Medicaid-eligible residents already face discrimination from providers. A provider could use an "identification" duty as a lever against less desirable residents. Residents and their families are vulnerable to unjustified claims that they have run afoul of Medicaid's program complexities and could easily be frightened into accepting an unjustified discharge rather than risking loss of Medicaid eligibility.

***Kevin Coughlin, Director, Wisconsin Bureau of Assisted Living*:**

Everyone has a duty to report Medicaid fraud. More money available to qualified recipients will only improve the overall system. Wisconsin has a Medicaid Fraud Task force whose mission it is to identify Medicaid fraud in Wisconsin nursing homes and assisted living. The committee is made up of U.S Dept. of Justice (DOJ), the WI DOJ, the WI Division of Quality Assurance, the WI Office of Legal Counsel, U.S. Office of Inspector General, the Federal Bureau of Investigation, U. S. Attorney's Office, the WI Medicaid agency, the WI Ombudsman, and the Coalition of Wisconsin Aging Groups. This group has successfully identified and stopped Medicaid fraud in both nursing homes and assisted living.

***Howard Groff, President, Tealwood Care Centers*:**

State Medicaid programs should do due diligence in determining whether an individual has been truthful in completing his or her Medicaid application form. Anecdotally, I don't think there are many who work in long term care who have not seen wealthy individuals who legally are eligible for Medicaid on paper. This will continue until laws are changed that allow people to legally shelter and transfer assets to others in order to qualify for Medicaid and avoid using their assets to pay for their care.

***Krista Hughes, Director, Division of Aging and Adult Services, Arkansas Department of Health and Human Services*:**

It would seem, as a matter of public policy, that any entity that learns of or has reasonable grounds to suspect Medicaid fraud should have to report it. Medicaid provider agreements regulate provider conduct, not recipient conduct. For example, providers may not bill for services that are not medically necessary or submit false claims. Providers have no legal duty to monitor recipient conduct (as contrast to medical need) that impacts eligibility. Of course,

providers may not solicit a patient to commit fraud, may not conspire with or assist a patient in committing fraud, and must cooperate in any fraud investigation.

***Larry Polivka, Executive Director, Claude Pepper Center*:**

This is beyond the scope of their responsibility.

***Charley Reed, Member, Board of Directors, AARP*:**

Generally speaking, the Medicaid certified home and community-based provider (including one delivering services in an assisted living facility), is not responsible for determining eligibility for a service unless the state Medicaid agency has specifically delegated that responsibility to the provider. It should go without saying, however, that Medicaid certified or participating providers should report known instances of eligibility fraud in their own program if they want to avoid a complicated and embarrassing audit.

***Martha Roherty, Executive Director, National Association of States United for Aging and Disabilities (NASUAD)*:**

States' Medicaid provider agreements include stipulations on provider responsibilities to be responsible, ethical businesses. Additionally, if a provider has revenues of five million or more per year, the Deficit Reduction Act Whistleblower provisions apply.

***Patricia Will, CEO, Belmont Village Senior Living*:**

Assisted living providers are not in a position to be in the Medicaid policing business. They do not possess the requisite expertise or resources to identify instances of Medicaid eligibility fraud and therefore, it would be highly ill-advised to expect providers to perform this function.

Access

33. Are there ways to streamline federal programs to reduce barriers to public assistance for low-income senior housing projects? How are any of the relevant federal agencies working to achieve this? If none are, please describe some ways in which they could.

***Brenda Bacon, President and CEO, Brandywine Senior Living*:**

We are unaware of any federal agencies purposefully attempting to reduce barriers to public assistance. However, HUD has promised to open up a special queue for tax credit projects but has not done so yet. Fannie Mae will not accept communities with more than 20% Medicaid.

***Eric Carlson, Directing Attorney, National Senior Citizen's Law Center*:**

Application cycles for the various programs should be coordinated so that the various types of funding (federal, state, local) can be lined up at the same time. Similarly, funding for housing and services also should run on the same or similar cycles.

HUD has proposed legislative reforms to the Section 202 and Section 811 programs to provide supportive housing for the elderly and to people with disabilities. Information regarding those proposals is available at www.hud.gov/offices/hsg/mfh/202811/sec202reform.cfm (Section 202) and www.hud.gov/offices/hsg/mfh/202811/sec811reform.cfm (Section 811).

***Krista Hughes, Director, Division of Aging and Adult Services, Arkansas Department of Health and Human Services*:**

One example is HUD and IRS working together on the LIHTC program, though success is questionable. LIHTC program is dependent upon investors and their interests. HOME is a cash program, which in Arkansas, is structured as a low interest loan in order for the funds to revolve and produce program income for future use. LIHTC and HOME are administered at the local or state level and are subject to local restrictions in addition to the federal requirements, regardless of streamlined efforts. Also, USDA Rural Development Multi-Family funding is not included in any "streamlining" efforts (to the knowledge of Arkansas Development Finance Authority), thereby leaving another important financing source (particularly in rural areas) operating under its own set of rules, regulations, requirements with no local input.

***Robert Jenkens, Director – The Green House Project, NCB Capital Impact*:**

Please see my responses to Questions 10, 11, 12, 14, & 15

***Charley Reed, Member, Board of Directors, AARP*:**

Generally, AARP believes that Congress should modify the Low-Income Housing Tax Credit (LIHTC) to provide greater flexibility in the development of housing projects for older people. Specifically, AARP's policy recommends that Congress change the definition of the income rent cap under the LIHTC program for service-enhanced housing, such as assisted living, by either raising the 30-percent-of-income rent cap, which is inappropriate for housing models that include basic services in the monthly rent, or modifying the definition of "rent" so that it does not include the cost of basic services.

***Martha Roherty, Executive Director, National Association of States United for Aging and Disabilities (NASUAD)*:**

Affordable AL is developed using a combination of housing financing and Medicaid as well as public housing programs. Any steps that that HUD and HHS could take to streamline requirements and reporting for states would be extremely helpful. While many states have developed working groups to address the "layer cake" effect (e.g., licensure, Medicaid waiver requirements, life safety, and housing requirements), coordinating all of these sometimes competing requirements is a challenge particularly in tight budget times. Competing interests are particularly of concern – e.g., a licensure "medical" model versus a waiver program's home/person centered expectations.

***Michael Vaughn, Acting Director, Asset Management and Lender Relations, Office of Residential Care Facilities, Office of Healthcare Programs, HUD*:**

Since February 23, 2011, HUD's Office of Healthcare Programs, which administers the Section 232 program, has established a policy of moving LIHTC deals up in the queue to ensure that in-service deadlines are met.

In the President's 2012 Budget Request, it was specifically noted that the Section 202 program is undergoing significant administrative and legislative reforms, in large part to facilitate the kinds of mixed-finance transactions that are critical for leveraging a variety of funding sources. HUD has recently issued a proposed notice and will be doing a rulemaking process in 2011 looking to remove excess regulatory burden and oversight, particularly in the context of projects that have other significant public investments (e.g. tax credits overseen by state housing finance agencies).

Further, on March 2nd, 2011 HUD published in the federal register a notice of proposed rulemaking titled "Reducing Regulatory Burden". In this notice, HUD is soliciting input from stakeholders on regulations that are unnecessary or unduly burdensome.

***Patricia Will, CEO, Belmont Village Senior Living*:**

What is needed is a clear IRS ruling that tax credits can be used for developing affordable assisted living provided certain requirements are met.

34. Please describe the process for a developer to obtain financing for a multi-unit assisted living community. Does it differ for smaller projects (for example, less than 20 units) and if so, how?

***Brenda Bacon, President and CEO, Brandywine Senior Living*:**

Today, there are only three ways to finance multi unit assisted living affordable communities; HUD 232, tax credits where available, and USDA guaranteed loans. Very few banks will finance assisted living communities, and those are mostly small banks but not large ones. Market rate projects can use Real Estate Investment Trusts (REITS) of course but we haven't found any that do affordable projects yet.

***Howard Groff, President, Tealwood Care Centers*:**

See also question #6. In addition to the government-related lending, there is bank financing. The two challenges here are the equity requirements along with personal guarantees. Traditionally, the required equity was 20% of the project costs. Today, banks are increasing that requirement in the upwards of 30% – 35%. Thus, the cash needed to get a project off the ground has increased substantially, thereby leading to decreased financial returns.

Personal guarantee requirements have become far more stringent. For instance, all investments must be proven out by the holding institution. In addition, they are requiring that a greater percentage of the guarantor's assets be liquid.

***Krista Hughes, Director, Division of Aging and Adult Services, Arkansas Department of Health and Human Services*:**

Affordable assisted living developments in Arkansas primarily utilize the LIHTC program, which is not feasible for use in smaller developments due to the investor resistance. Smaller developments are more difficult to "cash flow" and for which to obtain resources. In Arkansas, Rural Development funds would be necessary for (1) rural areas and (2) rental assistance. Currently, Rural Development does not have Section 515 funds.

***Robert Jenkens, Director – The Green House Project, NCB Capital Impact*:**

Please see my responses to Questions 11 & 12 for a general discussion of this issue. In regard to smaller projects, they are typically harder to finance than medium or large developments due to their typically tight margins caused by the inability to spread out fixed overhead and financing costs. In addition, smaller projects generally occur in rural areas with limited markets. These markets generally have lower average incomes and a higher demand for Medicaid-eligible services. Combining somewhat higher costs with a lower private pay census is a difficult combination to overcome without significant federal and state subsidies.

***Charley Reed, Member, Board of Directors, AARP*:**

Other participants can better address this question.

***Martha Roherty, Executive Director, National Association of States United for Aging and Disabilities (NASUAD)*:**

NASUAD defers to the industry.

***Michael Vaughn, Acting Director, Asset Management and Lender Relations, Office of Residential Care Facilities, Office of Healthcare Programs, HUD*:**

Assisted living facilities under section 232 must be 5 or more units. Otherwise program requirements are the same.

***Patricia Will, CEO, Belmont Village Senior Living*:**

The process regarding financing is addressed in question 36.

35. What lessons learned in the elderly-only public housing sector could be applied to private sector assisted living?

***Brenda Bacon, President and CEO, Brandywine Senior Living*:**

The most important lesson learned is that each individual has his or her own unique needs, hopes and aspirations. The initial government effort lumped disabled young, disabled elderly, and frail elderly together as if they were all the same. This proved to be a disaster. The needs of a 25-year old in a wheelchair are markedly different than the needs of a healthy, vibrant 90 year old, or a frail, elderly 75 year old.

***Howard Groff, President, Tealwood Care Centers*:**

If we look at HUD Section 8 or 202 buildings, they were built to house people in an affordable environment and must be owned by a non-profit entity. There was little, if any, thought given to the use of these buildings in the future. What reality has taught us is that the people residing in these buildings have now aged in place. Frequently the aged populations in these buildings are in need of services. These services can range from housekeeping to nutrition to medication management. None of these buildings were built with sufficient common space to accommodate the provision of these services.

Here is a great example of a failed attempt to revamp a low-income housing setting. In Minnesota, the state provides grants to convert existing buildings to accommodate the provision of services to the tenants in an attempt to delay their needing to go to a nursing home for services. This is done through the Community Service/Service Development Grants program. The board of directors of a Section 8 affordable housing setting had identified that many of the tenants residing in the building were in need of services. They applied for grant money to construct a commercial kitchen and provide additional office space for caregivers. The grant required a 50-50 match. The not-for-profit owner had no mechanism to go back to HUD to obtain the matching funds (in this case, $250,000), so the project went by the wayside and many tenants with care needs were left to go to other settings for their service needs.

***Krista Hughes, Director, Division of Aging and Adult Services, Arkansas Department of Health and Human Services*:**

(1) Unit configuration conducive to needs of Assisted Living tenants; (2) tenant preferences on services provided; (3) need for specially trained caregivers/service providers; and (4) need for specialized funding sources.

***Charley Reed, Member, Board of Directors, AARP*:**

Publicly subsidized housing is developed from the perspective of meeting the housing needs of older adults with low incomes - it generally offers protections against rent increases and unfair evictions for residents, a process to submit complaints, and follows a housing philosophy that excludes some practices common in medical facilities, such as "forced" roommates.

A "housing needs" perspective ensures that a wide range of rights and protections are considered, and these housing considerations must be included along with service needs in assisted living – this form of housing is a hybrid, and as such, should meet needs and include protections in both areas.

***Martha Roherty, Executive Director, National Association of States United for Aging and Disabilities (NASUAD)*:**

As noted above, private sector assisted living likely serves as a pathway to Medicaid. In the absence of objective information and counseling, many low to middle income individuals and families purchase assisted living services without a clear understanding of the costs. Objective third party options counseling would be very helpful. Additionally, more resources for Adult Protective Services and State Long-Term Care Ombudsman services would be helpful since private sector assisted living is not subject to Medicaid-financed assisted living oversight, only

state licensure. Typically, state licensure agencies survey only once per year unless a complaint is submitted. State Long-Term Care Ombudsman could work closely with state licensure agencies.

***Michael Vaughn, Acting Director, Asset Management and Lender Relations, Office of Residential Care Facilities, Office of Healthcare Programs, HUD*:**

HUD facilitates PHA efforts to serve an increasing elderly population through the designated housing process. Through this process, 203 PHAs have been approved to designate 72,109 units of public housing for elderly families, and 2,539 units for a mix of elderly and non-elderly disabled families. These PHAs are responding to a demand by elderly families for elderly-only developments that include accessibility features in a service-rich environment.

In the past, the nature of public housing stock in some communities had prevented PHAs from providing developments with the features sought by elderly families. An increasing percentage of the request for designated housing for elderly families has been a result of new construction opportunities realized by PHAs through ARRA and mixed-finance development opportunities.

New construction and renovation gives PHAs the flexibility to ensure developments are constructed with extensive and expandable accessibility features, and ample community space allowing for a flexible program environment. Many of these developments are built to Uniform Federal Accessibility Standards, or can be easily converted to meet these standards, in recognition that elderly families may require a variety of accessibility features not found in standard public housing stock. Additionally, these developments feature extensive partnerships with local service providers.

Private sector assisted living development programs have the opportunity to meet the demand for elderly-only developments by introducing accessible, service-rich living environments in partnership with PHAs.

***Patricia Will, CEO, Belmont Village Senior Living*:**

One of the biggest mistakes made in U.S. housing policy was allowing non-elderly disabled persons including those with mental disabilities to reside jointly with seniors in HUD and public housing. This practice of mixing elderly and non-elderly disabled occurred during the early 1990's led to a number of tragic outcomes for frail seniors. After much public outcry, HUD wisely abandoned this practice.

36. Please describe the underwriting and credit guidelines applied to assisted living providers by lenders. What are the requirements for borrower eligibility, credit, income, cash reserves, clinical reviews for quality issues, legal filings, and survey deficiencies?

***Brenda Bacon, President and CEO, Brandywine Senior Living*:**

Most are 80/20 equity with a minimum debt service ratio of 1.2 or higher. All require cash reserves equal to at least 6 months Estimated Medicaid charges and many require a line of credit

(LOC) to cover 1 year debt service. Financing doesn't require clinical reviews but the licensing agency does.

***Howard Groff, President, Tealwood Care Centers*:**

Requirements include:

- Equity of 30% – 35% of the project costs;
- Reserves, usually equal to 18 months of revenue;
- Operating deficit reserves or working capital (Lenders are expecting properties to have 45 to 90 days of cash on hand.);
- Rent up reserves – sufficient cash reserves to fund operating expenses and debt service costs until a stabilized or positive cash flow is achieved, which can take 12 to 24 months;
- Debt service reserves – usually 12 to 24 months of debt service (principal and interest);
- Documented information on ownership of 10% or more;
- Lending institution charges of 2% – 3% of the amount of the debt;
- Underwriting fee, usually .5%;
- Legal fees to document the loan – 1% of the loan;
- Appraisals costing $8,000 to $15,000;
- Architectural reviews, usually 12 at $2,000 per review during construction;
- Environment studies ($5,000);
- Mortgage registration at .2% of construction costs;
- Park dedication fees of $5,000 per unit; and
- Title insurance – .015 of construction costs.

***Krista Hughes, Director, Division of Aging and Adult Services, Arkansas Department of Health and Human Services*:**

In Arkansas for LIHTC access, a minimum of one (1) development team member must have successfully completed a previous LIHTC development. Loans are underwritten to a 1.15 or 1.20 debt coverage ratio dependent on participating lender requirement. The developer must demonstrate sustainable "cash flow" for the full affordability period (30 years). Reserves for operating and replacement are the standard amounts required in other LIHTC – funded developments. In Arkansas, investors in the LIHTC program have required very large reserves to be set aside and funded for possible conversion of the assisted living facility to standard "elderly" affordable housing. This requirement is to ensure continued operation of LIHTC – eligible units in the event the assisted living development fails (purportedly due to discontinuance of Medicaid assistance). Increased reserve requirements increase the development budget and make obtaining sufficient financing even more difficult.

***Robert Jenkens, Director – The Green House Project, NCB Capital Impact*:**

These guidelines vary considerably between lenders depending on their goals and sources of capital. Generally, lenders are very cautious about projects that combine two businesses (e.g., housing and licensed long-term care services) due to the added financial complexity and market risks involved. This initial complexity is exacerbated when projects rely on multiple public programs together with some private payments. Lenders equate complexity with risk and will almost always choose a less risky deal for the same return. This risk perception leaves many good affordable assisted living projects unfunded or struggling under premium (risk adjusted) debt pricing. Creating a dedicated funding source, designed to address system and individual business risks, would facilitate the expansion of affordable assisted living very well.

***Charley Reed, Member, Board of Directors, AARP*:**

Other participants can better address this question.

***Martha Roherty, Executive Director, National Association of States United for Aging and Disabilities (NASUAD)*:**

NASUAD defers to the industry.

***Michael Vaughn, Acting Director, Asset Management and Lender Relations, Office of Residential Care Facilities, Office of Healthcare Programs, HUD*:**

The market has been very limited for affordable assisted living mortgage funding since the crisis in the capital markets in 2008. Neither large banks nor the GSE's have been particularly active in this sector over the past year. Fortunately HUD is still providing long-term fixed rate funding for these projects, if properly underwritten. We should note however, that HUD stresses several key attributes of a successful project.

a. Experienced Sponsorship – Owners and Operators with a broad track record of developing, leasing up, managing and successfully providing care in this type of facility.
b. Financial strength – Our underwriting requirements call for substantial cash equity investment. While the requirements are less stringent for non-profit entities, they still require real equity investment, and we are looking for sponsors with the overall financial strength to weather market uncertainties.
c. Conservative underwriting – while vacancy risk is lower with below-market units, it is still necessary to correctly gauge the strength and level of the market, and provide income for necessary operations, maintenance and provision of care at the appropriate level. On the tax credit side, unless assisted living units constitute a small portion of total units, lenders will want to underwrite a robust and long-term service delivery package and if the services fall away, they will want the ability to remove regulatory requirements for deep services and replace frail elderly with less service dependent elderly households.

***Patricia Will, CEO, Belmont Village Senior Living*:**

Underwriting criteria for lending to assisted living providers through Fannie Mae and Freddie Mac is a maximum 75% loan-to-value and a 1.45X debt cover on stabilized properties that have at least a 90% occupancy rate. Loans are non-recourse; therefore the credit-worthiness of the borrower is underwritten but not with a view of specified financial covenants but rather their experience in the industry (i.e. a minimum 225 units or 3 properties) as well as in the region in which the community being underwritten is located. The historical performance of the borrower's other communities, particularly if the operator is a related entity, is the most critical, as well as their licensing track record.

Today, permanent financing is only available through Fannie Mae and Freddie Mac whereas construction and bridge financing is provided primarily by commercial banks. The banks, however, will underwrite their loans to the standards that Fannie and Freddie have established, as these have been accepted and proven in the marketplace and the borrower's ability to access a permanent loan from Fannie and Freddie will affect their ability to eventually repay their loan with the bank.

37. In what ways do lenders give any consideration to Medicaid participation by a provider as part of the underwriting process?

***Brenda Bacon, President and CEO, Brandywine Senior Living*:**

Serving Medicaid populations are always seen as negative by lenders at first. A provider's reputation will generally overcome those doubts but it is becoming very difficult for new projects to become financed. Illinois tries to give licenses to new companies but most if not all have to come to established companies in order to get financing.

***Howard Groff, President, Tealwood Care Centers*:**

During underwriting, all sources of revenue are scrutinized by the lending institutions. Because Minnesota's Elderly Waiver only pays for services and not room and board, it creates difficulty for the bankers and underwriters to fully understand the sources of revenue. They also will have the developer prove its experience with the Elderly Waiver and frequently require the county's commitment to contract with the developer, prior to loan approval.

***Krista Hughes, Director, Division of Aging and Adult Services, Arkansas Department of Health and Human Services*:**

None, or very little, due to lack of assurances of program continuity.

***Robert Jenkens, Director – The Green House Project, NCB Capital Impact*:**

See answer to #36

***Charley Reed, Member, Board of Directors, AARP*:**

A white paper by the Center for Excellence in Assisted Living noted that underwriters typically discount Medicaid participation in assisted living because, unlike nursing homes, assisted living

providers have no assurance that Medicaid funding will last beyond a short-term commitment. In today's budget climate, the discretionary nature of Medicaid assisted living funding makes it a relatively easy target. Few financial underwriters would be willing to give financing for 10 to 20 years based on the politically risky commitment of a year's worth of Medicaid funding.[27]

Martha Roherty, Executive Director, National Association of States United for Aging and Disabilities (NASUAD):

NASUAD defers to the industry.

Julie Strauss, Office of Licensing and Quality of Care, Seniors and People with Disabilities Division, Oregon Department of Human Services:

For licensing, Oregon asks all initial applicants whether they would be willing to serve Medicaid clients.

Patricia Will, CEO, Belmont Village Senior Living:

Fannie and Freddie lending limits Medicaid participation to a maximum of 25% and will apply more conservative underwriting standards to the loan generally requiring a 1.50-1.55 debt cover and no more than a 70% loan-to-value. In addition to the previously mentioned due diligence, the lender will also underwrite the state's Medicaid waiver program in terms of how long it has been in existence; the state's reimbursements practices; the consistency of reimbursement rates; and the overall financial strength of the state's economy. The reason for the more conservative underwriting is the uncertainty associated with having a public (i.e. government) source of payment as well as the long term bureaucracy inherent in the system. Many have experienced the booms and busts of the nursing home industry and lenders want to protect against the fluctuations in income and operating capacity.

If Medicaid waiver slots are not available, the assisted living community will have to look elsewhere for new residents. Accordingly, lenders may require that communities establish a reserve to cover low occupancy in the event that Medicaid funds are not as available as forecast.

38. How is the current or expected inclusion of assisted living in a state's Medicaid program for home and community-based services considered during the development, credit, underwriting, or licensing process? Please answer as applicable to your expertise.

Brenda Bacon, President and CEO, Brandywine Senior Living:

Without licensing being in effect, financing of communities over 25 units would be almost impossible.

[27] *Making Quality Assisted Living an Affordable Community-Based Option,* op cit.

Howard Groff, President, Tealwood Care Centers:

We have contracts to provide Elderly Waiver services in all of our assisted living communities. The primary reason is that if existing residents spends down their assets, they can continue to live in their home.

In the last year, the state of Minnesota implemented its 24-hour Customized Living criteria. The basis of the payment is an assessment done by an employee of the county (essentially a check-the-box a la carte form). Experience has proven that these are not usually accurate, thereby leading to underpayment.

Medicaid programs in South Dakota, Iowa, and Nebraska pay a flat rate; therefore, the provider must be careful in assessing the overall care needs of the individual so that all the needed services can be provided within the financial payment.

Most underwriters are confused between the eligibility requirements of the Elderly Waiver program and those for affordable units.

***Krista Hughes, Director, Division of Aging and Adult Services, Arkansas Department of Health and Human Services*:**

Little consideration from a credit or underwriting perspective. It would be more relevant in support of services to be provided.

***Robert Jenkens, Director – The Green House Project, NCB Capital Impact*:**

Lenders and underwriters are very cautious and will likely not include a planned assisted living Medicaid program in their underwriting until it is approved, funded, and implemented. Project relying on a Medicaid benefit for assisted living will need to wait to apply for financing until the program is being rolled out. The only impact a planned Medicaid program might have on underwriting is if that planned program was not related to assisted living but might negatively impact reimbursement rates, benefit availability, and occupancy due to increased competition and pressure on scare state resources. If this were the case, underwriters would likely reduce income and occupancy assumptions to account for the potential new program's impact.

***Charley Reed, Member, Board of Directors, AARP*:**

Early in the developmental years of assisted living, an investment banker noted that underwriting nursing homes was easy – "just show me your CON (certificate of need) and your Medicaid reimbursement rate." What this comment reflects is how little consumer demand of choices drove the development of nursing homes. In contrast, assisted living has been a largely private pay option that has had to appeal to consumers – largely without the market distorting effects of supply constraints and a reimbursement monopoly. But as a result, developing affordable assisted living has been a great deal more challenging, given less predictable market conditions and public commitments to reimbursements. Giving sponsors more predictability, while still retaining the more competitive consumer responsiveness, is the challenge of promoting innovative care facilities for the future.

Martha Roherty, Executive Director, National Association of States United for Aging and Disabilities (NASUAD):

NASUAD defers to the industry.

Patricia Will, CEO, Belmont Village Senior Living:

Credit policies preclude a borrower's ability to begin participating in the Medicaid program without the lender's approval. The reason for this is that the underwriting criteria for loans with Medicaid are more conservative for the reasons stated above. The lender would not want to lend based on one set of assumptions, in effect, giving the borrower more lenient lending parameters when the operations merited a more conservative set of parameters.

39. Because of the recent economic downturn, has anything changed in underwriting and credit guidelines for assisted living communities looking for financing?

Brenda Bacon, President and CEO, Brandywine Senior Living:

The main change is that financing commercially through a bank like the industry used to do on a regular basis is almost impossible. Because FDIC has pressured banks on commercial loans, bank financing has dried up. Second is that banks who used to invest money into funds to buy tax credits can't afford to invest, hence much less dollars are available through tax credits

Howard Groff, President, Tealwood Care Centers:

Yes. The following changes have occurred:

- Debt service coverage ratios have increased;
- Equity requirements have increased;
- Personal guarantee requirements have expanded; and
- The underwritten time to stabilization has increased, and therefore the reserve requirements have gone up commensurately.

Krista Hughes, Director, Division of Aging and Adult Services, Arkansas Department of Health and Human Services:

(1) Underwriting and credit requirements have been tightened and (2) available resources for financing expected to be reduced.

Robert Jenkens, Director – The Green House Project, NCB Capital Impact:

The recent economic downturn and its impact on state Medicaid programs and rates severely impacted underwriting guidelines and credit decisions. Until the downturn, lenders and underwriters generally assumed a flat Medicaid revenue stream for several years at a time, and then a periodic increase. Today, with several states cutting their Medicaid payments and eliminating optional programs, underwriters have responded with more conservative assumptions that make formerly viable projects infeasible. The economic downturn has also temporarily disabled one of the best sources of subsidy for affordable assisted living – the LIHTC program.

With few investors seeking tax benefits, LIHTC markets have suffered and made LIHTCs less valuable than before the economic downturn.

***Charley Reed, Member, Board of Directors, AARP*:**

Other participants can better address this question.

***Martha Roherty, Executive Director, National Association of States United for Aging and Disabilities (NASUAD)*:**

This is not yet clear.

***Julie Strauss, Office of Licensing and Quality of Care, Seniors and People with Disabilities Division, Oregon Department of Human Services*:**

Anecdotally, providers have suggested the economic downturn has affected the ability to attract private pay residents to ALFs, as well as other facilities. With the economy showing signs of improvement and the demographic aging, the anticipation is demand will begin to increase. This may have an impact on Medicaid access.

***Michael Vaughn, Acting Director, Asset Management and Lender Relations, Office of Residential Care Facilities, Office of Healthcare Programs, HUD*:**

Private and GSE sources have become far more conservative and reluctant to enter this market. HUD has increased its cash equity requirements and is emphasizing the sponsorship and market strength requirements outlined above. The specific underwriting guidelines have changed from a required 1.2 Debt Service Coverage to a required 1.45 DSC, and to an 80% loan to value for non-profit sponsors and 75% for for-profit sponsors.

***Patricia Will, CEO, Belmont Village Senior Living*:**

All lenders have tightened their lending standards over the past five years. Written policies have not changed, but loans being quoted and closed are more conservative and more expensive. Given the relative strong performance of the assisted living industry relative to other types of real estate, including the more independent segments of seniors housing, lenders have begun to view assisted living as less risky in a relative sense. On the construction front, there has been virtually no financing available for construction of new assisted living until very recently for highly qualified borrowers and for projects in prime market locations.

An important public policy goal must be to continue to provide liquidity to the multifamily housing market, and in particular the seniors housing sector. For decades, Fannie Mae and Freddie Mac have served as the primary source of reliable and reasonably priced capital to the seniors housing industry. Beyond Fannie and Freddie, no other capital sources have come close to approaching the level of liquidity necessary to sustain the seniors housing sector. Assisted living is a critical component of the nation's seniors housing market, and the private market simply cannot meet a majority of the industry's capital needs. A federally backed secondary market is absolutely critical to the sector's health and our ability to continue to meet the nation's growing demand for assisted living.

40. How has the financial downturn affected the industry as a whole? How are loans to assisted living communities performing?

***Josh Allen, President, American Assisted Living Nurses Association*:**

Some AALNA members have reported an increase in healthcare needs and overall "acuity" of assisted living residents related to the economic downturn of the past several years. This has been demonstrated, in some instances, in the healthcare needs of individuals at the time he/she first moves into an assisted living community. As individuals and families have struggled with how to manage limited financial options, they may have elected to stay in their home longer, or to move into the home of a family member. It is not until their health or cognitive status declines further that they elect to seek residence in an assisted living community. Residents are staying home longer and presenting upon move in, according to recent surveys, with the need for assistance with 3 to 5 activities of daily living, as opposed to the 2-3 ADL needs of five years ago.

***Brenda Bacon, President and CEO, Brandywine Senior Living*:**

While not speaking for the entire industry, an ALFA member provider has stated that all of their loans are performing well and occupancies have stayed above 98%. In general senior living companies that operate licensed assisted living were less affected by the downturn than those who provide independent living services. The decision to move into assisted living is usually based on the need for services.

***Irene Collins, Commissioner, Alabama Department of Senior Services*:**

Many of our smaller family owned facilities are being consolidated by larger operators which help with financial viability.

***Howard Groff, President, Tealwood Care Centers*:**

The assisted living industry so far has weathered the economic downturn fairly well and better than many other industries and sectors of the housing market. Demand for assisted living is largely needs-driven and the industry generally is not over-built. However, the industry has experienced some negative impacts from the recession, varying by region and individual markets.

Nationally, assisted living occupancy rates declined from 90.2% in the 3rd quarter of 2007 to 88.5% in the 3rd quarter of 2010, according to the National Investment Center for the Seniors Housing & Care Industry (NIC). Over the same three-year period, the percent of non-performing seniors housing loans increased from 0.3% to 2.5% (non-performing refers to loans with at least two payments past due, or foreclosed loans), according to NIC data.

***Krista Hughes, Director, Division of Aging and Adult Services, Arkansas Department of Health and Human Services*:**

In Arkansas, assisted living loans are performing successfully, albeit with very small profit margins. Assisted living development and operating costs are difficult to obtain financing for,

particularly for long periods of time with loan terms (or grants) lenient enough to offset costs. The economic downturn has exacerbated an already difficult financing process.

***Robert Jenkens, Director – The Green House Project, NCB Capital Impact*:**

The economic downturn has hurt private pay assisted living occupancy and, consequently, providers' ability to maintain debt covenants and payments. On average, consumers appear to be putting off new expenditures to conserve resources. Affordable assisted living, however, so far has been spared significant Medicaid or housing program cuts. This has left the affordable assisted live providers I know at or near full occupancy and in relatively good financial shape.

***Charley Reed, Member, Board of Directors, AARP*:**

Other participants can better address this question.

***Martha Roherty, Executive Director, National Association of States United for Aging and Disabilities (NASUAD)*:**

NASUAD defers to the industry.

***Patricia Will, CEO, Belmont Village Senior Living*:**

The industry has proven itself to be "recession-resistant" but not necessarily recession-proof. Operations have remained relatively strong for assisted living as compared to other sectors of the seniors housing industry with occupancies averaging 90% occupancy nationwide. Nevertheless, the downturn in the economy has forced some residents to look for ways to economize, such as downsizing to smaller units or sharing a unit with another resident.

Loan performance has been excellent. Freddie Mac has no defaults or losses on their portfolio of seniors housing which totals over five billion dollars. Fannie Mae's default rate in seniors housing has also been negligible, averaging less than one percent. Indeed, loan performance has been exceptionally good, largely because community operational performance has held up so well. Moreover, the loan underwriting criteria of 75% loan-to-value and 1.45 debt cover is relatively conservative, thus providing margin for the borrower should cash flow decline as many have experienced during the recession.

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STATEMENT
Of
HOWIE GROFF

President & CEO of Tealwood Care Centers

&
Immediate Past Chair,

National Center for Assisted Living

For the

U.S. Senate Special Committee on Aging
"Assisted Living Roundtable"

March 15, 2011

Thank you Chairman Kohl, Ranking Member Corker, and the entire Committee. My name is Howie Groff and I am the President of Tealwood Care Centers and Immediate Past Chair of the National Center for Assisted Living (NCAL). NCAL represents more than 2,800 assisted living providers nationwide, and is the assisted living voice of the American Health Care Association (AHCA). I have more than 30 years of experience in the long term care field. In 1989, I formed Tealwood Care Centers with business partners, Steve Harl, a licensed nursing home administrator, and Gail Sheridan, a registered nurse. As President of Tealwood Care Centers, I am responsible for financial and operational issues related to the company's independent, assisted living, residential care, and skilled nursing facilities, as well as policy and business development.

With headquarters in Bloomington, Minnesota, Tealwood operates more than 40 assisted living and nursing facilities in Iowa, Minnesota, Nebraska, and South Dakota. Each Tealwood Care Center takes a holistic approach to meeting each individual's unique physical, psychological, sociological, and spiritual needs. The Tealwood philosophy—offering up-to-date, well-maintained care environments that are safe, comfortable, and designed with the special needs of the elderly in mind—is embraced by the leadership team and by Tealwood's skilled caregiving

staff, who seek ongoing training to continually improve the quality of care for each resident. In 1999, I co-founded The Waters Senior Living along with the owners of Shelter Corporation. The Waters has management responsibilities for post-acute care facilities owned by Senior Care Communities, a not-for-profit corporation. The Waters also develops housing with services facilities. I also serve on the executive committee of Care Providers of Minnesota and play an ongoing leadership role with AHCA/NCAL.

I am grateful for the opportunity to be with you today and to submit this statement for the record on behalf of NCAL. I commend the Senate Special Committee on Aging for holding this roundtable and inviting me to offer our profession's perspective on the wide variety of issues that affect assisted living, including the quality and financing of care, availability of affordable assisted living, Medicaid coverage, and industry regulation.

About one million Americans make their home in assisted living/residential care communities, including about 131,000 receiving assistance under the Medicaid program. A long term care option preferred by many individuals and their families for its emphasis on resident choice, dignity, and privacy, assisted living continues to grow and focus on consumers' wants, needs, and preferences.

Eight years have passed since the Assisted Living Workgroup submitted a report to this committee entitled, *Assuring Quality in Assisted Living: Guidelines for Federal and State Policy, State Regulation, and Operations.* A landmark in the development of assisted living policy, the report offered guidance to policymakers and states about regulating the profession at a key juncture, and this is an appropriate time to take stock of where we are now.

Overview

I would like to thank the Committee once again for convening this discussion and inviting me to participate. Among the main points that I raise are the following:

- Assisted living is a dynamic, resident-centered and cost-effective long term care model that is a vital option for seniors and people with disabilities.
- Regulation of assisted living should remain at the state level. The body of state laws and regulations relating to assisted living has evolved steadily since the Assisted Living Workgroup issued its report in 2003. States have responded as assisted living has expanded and accommodated residents with higher levels of needs.
- The issues facing Medicaid coverage in assisted living are fundamentally economic, not regulatory. Sub-market Medicaid payment rates, lack of payment for room and board, and restrictive state policies are the root causes of limited options for low-income seniors in many states.

- Even though public funds remain limited, it is imperative for policymakers to consider ways to expand the availability of affordable assisted living and to help states cover the gaps in Medicaid funding for assisted living. Broadly speaking from a national perspective, policies that could be considered include: making housing vouchers available to low-income assisted living residents including Medicaid beneficiaries; providing increased public financing or loan supports for construction of affordable assisted living; building a housing financing component into or alongside Medicaid services payments for beneficiaries living in community-based settings, including assisted living; and expanding incentives and financial vehicles for individuals and families to save for future long term care costs.
- The Centers for Medicare & Medicaid Services' (CMS') efforts to define Medicaid community-based settings should include all assisted living communities participating in Medicaid. Indeed, under the logic of the landmark Olmstead Supreme Court decision, depriving Medicaid beneficiaries of a major type of housing with services—assisted living—would be the opposite of a reasonable accommodation, especially for those seniors who prefer to live in assisted living and those for whom assisted living is the least institutional option available based on their clinical needs. Any attempt to mandate that home and community-based services only be provided in small, board-and-care type settings with traditional lease agreements, lockable doors, and cooking stoves, as is being considered by CMS, is wrong, denies choice, and discriminates against people with Alzheimer's disease and related dementias.
- The assisted living profession has taken many steps toward innovative quality improvements and developing measurements of quality. These efforts need to be nurtured by public policymakers.

Assisted Living Residents and Philosophy of Care

Assisted living is a growing and dynamic form of residential care, serving primarily elderly people and individuals with disabilities. Assisted living is more than a physical setting—it embraces a philosophy of care. Created in response to customer preferences and demand for individual-centered care, assisted living residences provide assistance with physical activities and health-related needs. They also strive to meet the social, emotional, cultural, intellectual, and spiritual well-being of residents.

Assisted living has evolved in a variety of models based on consumer preferences and regional differences. As a result, states take a variety of approaches in overseeing the industry and establishing standards. While assisted living is the most common term used in the nation both by the industry and state regulatory agencies, assisted living settings may be known by different names, including, but not limited to, residential care, personal care, adult congregate care, boarding homes, and domiciliary care. Regardless of what they are called, assisted living communities typically are:

- Congregate residential settings that provide or coordinate personal services, 24-hour supervision and assistance (scheduled and unscheduled), activities and health-related services, and that include at least one awake staff member at all times;
- Designed to minimize the need to move;
- Designed to accommodate individual residents' changing needs and preferences;
- Designed to maximize residents' dignity, autonomy, privacy, socialization, independence, choice, and safety;
- Designed to encourage family and community involvement; and
- Settings that provide assistance in maintaining and enhancing the physical, emotional, intellectual, social, and spiritual well-being of residents based on their preferences.

Assisted living also encourages:

- The personal development of residents, on an individual basis;
- Physical activity that maintains and enhances fitness;
- Family and community involvement; and
- Development of positive relationships among residents, staff, families, and the community.

(See "NCAL's Guiding Principles for Assisted Living," available at http://www.ahcancal.org/ncal/about/Documents/GPAssistedLiving.pdf.)

The typical assisted living resident is a middle-class, widowed 87-year-old woman on a fixed income. Residents' median income is less than $19,000 a year, according to the "2009 Overview of Assisted Living," a national study sponsored by five industry groups. About 66% of assisted living residents have hypertension; 42% have arthritis; 38% have Alzheimer's disease or other dementias; 33% have coronary heart disease, and 30% suffer from depression, according to the study. Residents on average take about 10 medications and more than 80% needs help managing their medications. On average, 64% of residents need help with bathing, 39% with dressing, and 26% with toileting.

Regulation of Assisted Living/Residential Care

Although many federal laws impact assisted living, regulation of assisted living occurs primarily at the state level. Though state licensure terms vary[i], there is much commonality in the range of services that assisted living communities provide across the country. Assisted living communities provide housing with services, including assistance with activities of daily living, such as dressing and bathing, and help with medication administration. Many assisted living communities provide specialized services for people with Alzheimer's disease or other dementias.

Since the work group issued its report, the body of state laws and regulations has grown steadily.[ii] All 50 states and the District of Columbia regulate assisted living/residential care facilities. The continuing development of the body of state law and regulations governing assisted living is described in several reports including the Department of Health and Human Services' (HHS') "Assisted Living and Residential Care Policy Compendium, 2007 Update," (which is updated every few years) and NCAL's annual "Assisted Living State Regulatory Review." Research conducted for the just-released 2011 edition of NCAL's "Regulatory Review" shows that more than a third of states changed their assisted living/residential care laws or regulations over the past year, a rate of change similar to what has been happening since 2003. States have responded as assisted living has grown and as some communities serve residents with more complex health and chronic care needs. While state assisted living regulation remains a work in progress and is not perfect, states generally have responded to issues that have arisen and adjusted their regulatory systems appropriately.

In 2010 and January 2011, even though the pace of regulatory change slowed somewhat as states faced enormous fiscal pressures, at least 18 states reported making statutory, regulatory, or policy changes impacting assisted living/residential care communities, according to data collected for the 2011 edition of NCAL's "Assisted Living State Regulatory Review." At least six states made major changes including Idaho, Kentucky, Oregon, Pennsylvania, South Carolina, and Texas. Focal points of state assisted living policy development in 2010 include life safety, disclosure of information, Alzheimer's/dementia standards, medication management, background checks, and regulatory enforcement. Other areas of change include move-in/move-out requirements, resident assessment, protection from exploitation, staff training, and TB testing standards.[iii]

Pennsylvania is the last of many states that have implemented multi-tiered regulatory systems, in part to accommodate the expanded role that assisted living is playing within the spectrum of long term care housing and services. Pursuant to legislation enacted in 2007, Pennsylvania implemented new assisted living regulations on January 18, 2011, thereby creating a second level of licensure alongside personal care homes. Oregon developed new rules for the endorsement of Memory Care Communities, enhancing its regulations for Alzheimer's care. Oregon's endorsement rules focus on person-centered care, consumer protection, staff training specific to caring for people with dementia, and enhanced physical plant and environmental requirements. Rhode Island passed legislation that, once implemented, will expand the types of assisted living residents that may receive skilled nursing care or therapy and the length of time they may receive such services.

Washington state clarified that boarding homes (the state's licensure term for assisted living) must fully disclose to residents a facility's policy on accepting Medicaid as a payment source. New Jersey passed legislation requiring an assisted living residence or comprehensive personal

care home that surrenders its license and promised not to discharge Medicaid residents to escrow funds to pay for care in an alternate facility.

In 2009, 22 states reported making statutory, regulatory, or policy changes impacting assisted living/residential care communities or assisted living Medicaid coverage, and at least eight of these states made major statutory or regulatory changes or overhauled sections of their rules.[iv] In 2008, at least 18 states made regulatory changes impacting assisted living/residential care communities with at least six of these states making major modifications to their regulations.[v]

As assisted living has evolved, states have acted to protect vulnerable populations. According to HHS' "Assisted Living and Residential Care Policy Compendium," in 2007, 45 states had requirements for residential care facilities serving residents with Alzheimer's disease and other dementias (up from 44 states in 2004, 36 in 2002, and 28 in 2000),"[vi] And the number of states with rules specifically geared for the care of Alzheimer's patients in assisted living has grown since then. In 2009, for example, Georgia, New Mexico, and Iowa created or added to protections for residents with Alzheimer's disease or other dementias.[vii]

Almost all states require specified information in residency agreements. The HHS report noted the following state disclosure requirements within residency agreements:

- Services included in basic rates – required by 49 states.
- Cost of service package – 44 states.
- Rate changes – 30 states.
- Refund policy – 30 states.
- Cost of additional services – 28 states.
- Admission/discharge information – 28 states.

States continue adding to disclosure requirements and are placing more information on their web sites concerning assisted living facilities.

According to the HHS report, while only a few states do not allow individuals who meet the state's minimum nursing level of care criteria to receive care in assisted living settings, no states allow persons needing a skilled level of care to be served in an assisted living setting for an extended period of time (needing 24-hour-a-day skilled nursing oversight or daily skilled nursing services).[viii] States take different approaches for setting admission/retention policies and can be group into three categories (or combinations thereof):

- Full continuum (e.g., OR, HI, WA, ME). These states allow AL facilities to serve a wide range of needs.
- Discharge triggers. These states specify a list of medical needs or treatments that cannot be provided in AL and that will result in discharge (e.g., TN, VA).

- Levels of licensure (e.g., AZ, AR, FL, UT). AL facilities are licensed based on needs of residents. In recent years, more states have moved to different levels of licensure.

NCAL's "Assisted Living State Regulatory Review" tracks and summarizes state regulations in several categories including the licensure term, definition, disclosure rules, facility scope of care, third party scope of care, move-in/move-out requirements, resident assessment, medication management, physical plant requirements, residents allows per room, bathroom requirements, life safety, Alzheimer's unit requirements, staff training for Alzheimer's care, staffing requirements, administrator education/training requirements, staff education/training requirements, continuing education requirements, and Medicaid coverage. These rules have evolved steadily as have the many other aspects of assisted living that states regulate that are not included within the scope of the report.

NCAL's Perspective

NCAL strongly supports regulation of assisted living at the state level. NCAL believes that all assisted living/residential care communities should be licensed or certified by the states and surveyed by the states at reasonable regular intervals. States should provide adequate funding to perform periodic surveys at least every two years and conduct timely surveys in response to complaints or issues of a serious nature as they arise. NCAL also believes that providers that have historically demonstrated a high level of customer satisfaction and excellence should be rewarded. For example, providers demonstrating excellence could be recognized for excellent performance on a public web site or surveyed less frequently.

While some argue that the federal government should extend its system of regulation for nursing facilities to encompass assisted living/residential care communities, NCAL opposes this for many reasons. For one thing, federal government regulation of nursing homes has not been an unblemished success story. It is punitive in nature and gives providers little, if any, incentive for quality improvement. Federal regulation of nursing homes, along with sub-market Medicaid reimbursement levels, has played a key role in creating and rigidifying a medical model of housing with services and making it difficult for the nursing home industry to update physical plant and improve quality. (Despite these challenges, the nursing home industry has documented quality improvements in recent years.) In addition, Federal regulation has been slow to keep pace with the evolution of nursing homes. Just last year, CMS put into place new rules recognizing the culture change movement – years after the movement began transforming nursing home settings and creating more home-like environments. On the other hand, state governments have a long history of responding quickly on the regulatory front to changes occurring in assisted living.

In order to meet the needs of different types of consumers, assisted living communities come in many models and designs. Assisted living can be provided in a high-rise building housing

several hundred individuals, in a small home with just a few, or within a campus offering many levels of care. The key to assisted living is providing resident-centered care in a secure setting that respects individual lifestyle choices, dignity, and privacy. Living accommodations can include a full size apartment, a single room, or living with another person. In some facilities, services are limited to meal preparation, housekeeping, medication reminders, and minimal assistance. In others, more intensive services, including help with administering medications, on-site nurses, and regular assistance with daily activities such as bathing and dressing are available. Assisted living also can be a very good place for many people with Alzheimer's to live. There is no need to impose uniformity in senior housing, including assisted living. People seeking assisted living services should have a wide array of choices, unlike the current situation with highly regulated nursing homes. States are best positioned to regulate assisted living, especially since there is wide variation among states on the types of housing available, availability and support for community-based settings, and definitions of what is considered an institutional level of care under the Medicaid program.

An important difference between assisted living and nursing homes is the primary source of financing. Federal regulation of nursing homes arose in part because the federal government paid for much of the physical plant (through the Hill-Burton Act) and continues to pay for most nursing home care through the Medicare and Medicaid programs. While federal/state Medicaid programs finance care for more than 60% of nursing home residents, Medicaid finances care (services only – not board and care costs) of only about 13% of assisted living residents. Assisted living is primarily financed with private-sector dollars. Because of this, market forces can exert more influence on the level of quality in assisted living facilities than nursing homes: private-pay residents unhappy with the care they receive are more likely to be able to move to another facility than those relying on government programs with limited choices.

States continue developing oversight of assisted living/residential care, even though some are now facing major budget constraints. According to a 2006 report by the U.S. Agency for Healthcare Research and Quality (AHRQ), all states reported that they receive and investigate complaints in assisted living settings.[ix] Oversight and monitoring of assisted living facilities vary by state; much like nursing home inspections, assisted living surveyors follows protocols to enforce licensing requirements and standards. According to the report, the typical survey process includes an annual unannounced inspection of the facility. While a few states do not provide enough funding to perform surveys required under their statutes, most are doing at least an adequate job of inspecting assisted living facilities.

The AHRQ report also mentions a few states that have begun using collaborative approaches toward assisted living oversight.[x] Rather than moving assisted living to the federal regulatory approach that has been taken for nursing homes, policymakers should follow the lead of states such as Wisconsin that have taken a more collaborative approach with assisted living regulation and oversight.[xi]

A 2010 report, published by the Long Term Care Community Coalition (LTCCC) and titled "Overview of State Survey and Enforcement Laws, Regulations and Policies for Assisted Living," found that state departments of health or departments of social services conduct oversight of assisted living facilities. In some states, multiple state agencies are involved. The report found that most states inspect assisted living facilities annually, biannually, biennially or over a specified time spanning one to two years. While a building's initial survey may be announced, most subsequent surveys are unannounced. According to the LTCCC report, surveyors typically examine if residents are informed of their rights, resident assessments, care plans, resident satisfaction surveys, staff criminal background checks, and availability of past inspection reports. Almost every state requires that copies of inspections either be posted or made available upon request. At least two states now post deficiencies on their web sites.

Survey teams should interview residents, family members, and caregivers, and observe staff, and not simply do paper reviews of records. NCAL believes that successful survey protocols should examine resident and family satisfaction findings and examine staff satisfaction due to its correlation with quality care. NCAL also believes that it makes sense to allow abbreviated surveys for communities with a consistent track record of good surveys. This would allow states to focus their limited resources on communities lacking consistent good performance. We believe the separate complaint survey systems that states have in place would identify issues that might arise between abbreviated surveys.

Medicaid Coverage and Assisted Living

Over the years, the primary issues facing Medicaid coverage for assisted living have been economic, not regulatory. And this is even more the case today as many states facing huge budget shortfalls now contemplate deep and painful cuts in programs serving low-income Americans.

Medicaid coverage in assisted living is much more limited than Medicaid coverage for nursing homes. While nursing home coverage is a mandated benefit under Medicaid, states have the option to cover assisted living services under the program. Furthermore, under Medicaid waivers, states can limit assisted living Medicaid coverage to a geographic area or to a certain number of slots. This is not the case for nursing homes. Under the Medicaid program, assisted living is considered a home and community-based (HBC) setting and consequently Medicaid does not pay the cost of room and board, utilities, and food. These gaps in Medicaid financing mean that states must consider a number of design decisions to finance costs that Medicaid does not cover. As a result, financing streams for assisted living receiving Medicaid tend to be very complex and funding for residents receiving Medicaid tends to be vastly lower than private-pay funding.

The latest study detailing national and state-by-state Medicaid payment and policy for assisted living was prepared by independent researcher Robert Mollica in 2009.[xii] Entitled "State

Medicaid Reimbursement Policies and Practices in Assisted Living," the report updated previous research done by HHS and detailed the wide variation in how states determine Medicaid payment levels for assisted living communities and other related policy issues. Among the findings is that the number of people receiving Medicaid coverage in assisted living communities grew significantly from 2007 to 2009 after virtually no growth over the previous three years. The report describes how states respond to the lack of Medicaid funding for room and board costs in determining a variety of policies, including whether or how much states supplement payments for room and board; whether states allow families and individuals to supplement room and board payments for Medicaid beneficiaries; and whether states allow beneficiaries to share apartments, and under what conditions.

Among the major findings were the following:

- The number of people receiving Medicaid coverage for services in licensed assisted living settings increased 9.2% between 2007 and 2009, and 43.7% between 2002 and 2009.

- Nationwide, about 131,000 low-income frail elderly Americans received services in assisted living communities under the Medicaid program (about 134,500 if programs with state-only funding are included).

- Thirty-seven states provided coverage under §1915 (c) home and community based services waivers to cover services in residential settings; thirteen states provided coverage directly under their state Medicaid state plan; four included services in residential settings under §1115 demonstration program authority; and six used state general revenues. States may use more than one funding source.

- Tiered rates were the most common methodology for reimbursing assisted living providers (19 states) and flat rates were used in 17 states.

- Twenty-three states capped the amount that may be charged for room and board.

- Twenty-four states supplemented the beneficiary's federal Supplemental Security Income (SSI) payment, which states typically use as the basis for room and board payment. SSI payments combined with state supplements ranged from $722 to $1,350 a month depending on the state. Some states provide no supplement.

- Twenty-five states permitted family members or third parties to supplement room and board charges.

- Twenty-three states required apartment style units; 40 states allowed units to be shared; and 24 states allowed sharing by choice of the residents.

- Screening for mental health needs was performed by case managers and assisted living community staff in nine states; by case managers only in 10 states; and by assisted living staff only in nine states.

- Mental health services were arranged by assisted living communities in 16 states; case managers in 20 states; and may be provided directly by assisted living communities in three states.

While Medicaid does not pay for room and board in assisted living settings, payment rates for Medicaid services are typically lower than private market rates. Gaps in the funding system drive many of the other problems facing Medicaid coverage in assisted living. Room and board typically comprises about 40-50% of the cost of assisted living and the SSI payment of $674 a month is often inadequate, even in instances where states supplement SSI to match or come close to private-pay costs of a private room, food, and utilities.

Given the core economic issues described above, NCAL strongly opposes proposals to force providers to accept Medicaid coverage or to accept Medicaid-specified amounts as the entire payment. NCAL believes that families should be able to supplement room and board payments for residents receiving Medicaid coverage so that they can afford single-occupancy units.

Mandating that providers accept Medicaid coverage in a system where Medicaid typically pays far less than the cost of providing housing and services will end shrinking the supply of assisted living available to low-income seniors and may compromise the quality of care. Forbidding providers from controlling how many units are available for Medicaid coverage will expose them to great financial risk. Mandating providers to provide Medicaid coverage in a system that often severely underpays for Medicaid also places a hidden tax on private-pay residents in the facility that will face higher payments as a result of the Medicaid underpayment. For many residents, ironically, this cost shifting will mean spending down their private assets faster and facing the prospect of going on Medicaid sooner than they otherwise would have done. NCAL believes that the impact of any new Medicaid mandate needs to be carefully analyzed in terms of cost shifting onto privately-paying assisted living residents, many of whom have limited assets and income.[xiii] Adding more mandates or an additional overlay of federal regulation would be especially detrimental in the current economic environment in which many states already are cutting Medicaid rates and coverage.

Providing quality Medicaid coverage will become even more difficult in 2014 when assisted living providers, like other employers, will have to comply with the new coverage expansion mandates in the Affordable Care Act. Because industries with high percentages of low-wage workers, including long term care, tend to have relatively high percentages of uninsured and

underinsured workers, complying with the law's health insurance coverage expansion requirements will cause their labor costs to increase significantly. While AHCA/NCAL supports efforts to expand health coverage, Medicaid rates will need to be adjusted to account for these added costs.

Despite these concerns, and even though public money is currently scarce, it is imperative for policymakers to consider ways to help states cover the gaps in Medicaid funding. Policies that could be considered include making housing vouchers available to low-income assisted living residents including Medicaid beneficiaries, providing increased public financing for construction of affordable assisted living, and expanding incentives and mechanisms for families to save for future long term care costs.

While Medicaid coverage for assisted living faces harsh economic constraints, NCAL recognizes the need for protecting beneficiaries from unfair market practices. NCAL believes that assisted living providers that promised private-pay residents they would provide Medicaid coverage should the residents exhaust their ability to pay, should honor those promises. After the abrupt withdrawal of one assisted living provider from the Medicaid market, several states have responded to consumer concerns. Two years ago, for example, the state of Washington enacted a law requiring boarding homes withdrawing from the Medicaid program to continue to provide Medicaid services to existing Medicaid residents and to residents who have been paying privately for at least two years and who become eligible for Medicaid within 180 days of the withdrawal. As noted above, Washington also requires that boarding homes fully disclose to residents a facility's policy on accepting Medicaid as a payment source. Last year, New Jersey passed legislation requiring an assisted living residence or comprehensive personal care home that surrenders its license and promised not to discharge Medicaid residents to escrow funds to pay for care in an alternate facility.

Some Good News: CMS Proposes Timely Implementation of Medicare Part D Co-Pay Legislation

NCAL, AHCA, and other national organizations recently commended CMS for proposing to implement Sec. 3309 of the Affordable Care Act on Jan. 1, 2012.[xiv] The result of five years of advocacy by a coalition of national organizations, this legislation will eliminate cost sharing under the Medicare Part D prescription drug program for an estimated 600,000 dual eligible beneficiaries receiving HCB services, including those living in assisted living communities. Sec. 3309 will bring needed financial relief to this vulnerable group of very low-income seniors and people with disabilities and improve their medical care. It also will create parity in Part D cost sharing requirements between dual eligible beneficiaries in institutional and HCB settings. As noted in AHCA/NCAL's letter to CMS Administrator Donald Berwick, M.D., CMS is proposing the earliest possible implementation date allowable for this provision under wording in the health reform statute. In a modest way, Sec. 3309 also may serve to ease financial pressure in some

states, many of which have had to increase Medicaid beneficiaries' personal needs allowances so they can afford Part D medication co-payments.

Passage and implementation of Sec. 3309 provides a good example of how the larger assisted living community – including consumer advocates, providers, health professionals, state and federal agencies, and many other constituencies – can work together to gain the resources needed to improve the lives of the frail, elderly people that they all serve.

Improvements Needed To Expand Affordable Assisted Living

The recent dialogue and increased coordination between HHS and the U.S. Department of Housing and Urban Development (HUD) is a welcome development and holds great promise for expanding housing-with-services options available to low-income seniors and people with disabilities. However, while HUD recently made a number of housing vouchers available for non-elderly, low-income people to help them transition from institutional settings or remain in community settings, so far such vouchers have not been made available to elderly individuals. Lack of funding for housing also continues to be a major barrier to the transitioning individuals to community-based settings under the Money Follows the Person grant program.

Even though public money is currently scarce, it is imperative for policymakers to consider ways to help states cover the gaps in Medicaid funding. Policies that could be considered include making housing vouchers available to low-income assisted living residents including Medicaid beneficiaries, providing increased public financing for construction of affordable assisted living, and expanding incentives and mechanisms for families to save for future long term care costs.

CMS Attempt To Define HCB Settings, Combine Waivers Raises Concerns

CMS' ongoing attempt to define Medicaid home and community-based settings for the first time has the potential to exclude many assisted living providers from the Medicaid program, thereby dramatically reducing access to needed housing and services to low-income individuals. For example, CMS' recently published proposed rule implementing the Community First Choice Option under the Affordable Care Act seeks to define for the first time what a home and community-based (HCB) setting can be under the Medicaid program. The proposed rule states "that certain settings are clearly outside of what would be considered home and community-based because they are not integrated into the community . . . home and community settings would not include a building that is also a publicly or privately operated facility which provide inpatient institutional treatment or custodial care; or in a building on the grounds of, or immediately adjacent to, a public institution or disability-specific housing complex, designed expressly around an individual's diagnosis that is geographically segregated from the larger community, as determined by the Secretary." (See "E. Setting" section on page 10740 of the Feb. 25, 2011 *Federal Register*.) Depending on how such language might be interpreted, it could exclude assisted living communities currently operating in proximity to institutional facilities, on

a campus or otherwise, as well as assisted living units in Continuing Care Retirement Communities. Many seniors choose this campus model over freestanding models. The CMS proposed rule would deny this choice to low income seniors who rely on Medicaid. That's wrong.

NCAL believes that any definition of HCB settings should include all assisted living communities participating in Medicaid. Indeed, under the logic of the landmark Olmstead decision, depriving Medicaid beneficiaries of a major type of housing with services—assisted living—would be the opposite of a reasonable accommodation, especially for those seniors who prefer to live in assisted living and those for whom assisted living is the least institutional option available based on their clinical needs.

AHCA/NCAL also continues to have concerns regarding CMS' 2009 advanced notice of proposed rulemaking (ANPR) announcing the agency's intent to publish proposed amendments to the regulations implementing Medicaid HCB services waivers under Sec. 1915(c) of the Social Security Act and soliciting advance public comments: 1) on the merits of providing states with the option to combine or eliminate the existing three permitted waiver targeting groups and 2) on the most effective means to define home and community-based settings. (Federal Register, Medicaid Program: Home and Community-Based (HCBS) Services Waivers, June 22, 2008.) As we have noted in our comments on the ANPR, defining HCB settings is a complex undertaking and should be done in a way that does not inadvertently reduce viable housing and services options for these vulnerable low-income populations. We are pleased that CMS understands the complexity of the undertaking as evidenced by the issuance of an ANPR that provides notice of a deliberative stakeholder process.

In response to the ANPR, AHCA/NCAL's main concerns are as follows:

- Attempts to define what qualifies as a community-based setting may limit beneficiary choice by excluding some types of assisted living providers or homes for people with developmental disabilities (DD) from the Medicaid HCB program;
- Combining target populations may lead to a loss of access to Medicaid services for beneficiary groups that are less politically powerful than others; and
- Combining target populations such as persons with mental illness with persons with DD or frail seniors in waivers may increase the risk of inappropriate placement of vulnerable populations, as well as create safety issues.

AHCA/NCAL recommends that CMS should:

- Continue gathering stakeholder input, including holding several stakeholder meetings, before defining what qualifies as a community-based setting so as to ensure that there are no negative or inadvertent consequences for Medicaid beneficiaries;

- Ensure that beneficiaries have choice of the entire spectrum of long term care settings and ensure that attempts to define community-based settings do not limit that choice;
- Acknowledge that assisted living communities must meet care and regulatory standards under state law that help ensure resident safety and that these standards typically do not apply to beneficiaries receiving services in their own homes;
- Not use the number of residents in a setting as a factor in determining whether a setting is considered institutional or community-like;
- Acknowledge that assisted living communities offer residents a wide variety of opportunities for community integration while maximizing independence, privacy, choice, and freedom of action, and respecting the rights and needs of other residents;
- Continue working with the Center for Excellence in Assisted Living (CEAL) and take into consideration a CEAL white paper on what person-centered care means in the assisted living context;
- Acknowledge that Medicaid's failure to pay for room and board in assisted living settings creates a payment gap that may make it difficult to provide private apartments in many states;
- Not attempt to mandate exact congruency between standards applying to 1915(i) and 1915(c) programs since the levels of care under the two programs are set at different points; and
- Develop safeguards ensuring that politically weaker target groups do not lose access to services and that target groups are not inappropriately mixed in residential settings and thereby exposed to harm, if states are allowed to mix target populations under Medicaid waivers.

AHCA/NCAL's full comments to CMS on the NPRM can be found at: http://www.ahcancal.org/advocacy/Letters/LtrCMS_ANPRMresponse.pdf.

NCAL Quality Initiatives & the Importance of Person-Centered Care

NCAL is pleased to report that our industry has been indentifying best practices and key resources for assisted living providers nationwide since this Committee last focused on assisted living. At its last meeting, in April of 2003, the Assisted Living Workgroup provided the Senate Special Committee on Aging a comprehensive compendium of more than 100 recommendations designed for consistent quality in assisted living communities. These recommendations spanned seven different areas and were agreed upon through a consensus process.

Since 2003, the assisted living profession has continued collaborative efforts of identifying and developing best practices through a variety of organizations. NCAL have been part of many of those efforts. NCAL participated on a national task force organized by the National Multiple Sclerosis Society (NMSS) in 2004. From this effort, the NMSS published a 46-page document for assisted living providers to better serve those residents with Multiple Sclerosis (MS) residing

in assisted living. The guidelines outline what MS is, its set of clinical conditions, and how to maximize the quality of life for those living with MS. These guidelines may be found on the NMSS Web site at http://www.nationalmssociety.org/search-results/index.aspx?q=assisted+living&start=0&num=20.

In 2006, NCAL was part of a collaborative effort sponsored by the Alzheimer's Association that developed Dementia Care Practice Recommendations for Assisted Living Residences and Nursing Homes. These guidelines provide providers of long term care strategies for improving the quality of care provided to and quality of life experienced by the residents of assisted living. The guidelines cover six areas of care including food and fluid consumption, pain management, social engagement, wandering, falls, and physical restraints. NCAL provided copies of these guidelines to its entire membership for review and adoption. The guidelines may be found at http://www.alz.org/national/documents/brochure_DCPRphases1n2.pdf.

In 2009, NCAL was invited to review the work of the American Medical Directors Association on Caregiver Communication, Medication Management, and Diabetes Management. All three tools were developed for assisted living providers as resources to provide quality care for their residents. These resources may be accessed at http://www.amda.com/resources/alproducts.cfm#ALDIAB.

As a result of the Assisted Living Workgroup, CEAL was formed in 2004 and is a national non-profit collaborative organization of 11 organizations. One of CEAL's major objectives is to foster high quality care through creating resources and acting as an objective source of information to facilitate quality improvement in assisted living; increasing the availability of research on quality practices in assisted living; establishing and maintaining a national clearinghouse of information on assisted living; and providing resources and technical expertise to facilitate the development and operations of high-quality, affordable assisted living programs to serve low- and moderate-income individuals.

Additionally, CEAL has published two white papers on topics including person-centered caring and medication management. In 2010, CEAL partnered with Med-Pass to create a Medication Administration Pocket Guide for Medication Technicians. More information may be found at www.theceal.org. In 2009, CEAL became a collaborative partner with the Agency for Healthcare Research and Quality to assist in the development of a consumer disclosure tool to assist consumers in their search for the best community for their loved ones.

NCAL's state affiliate in New Jersey, the Health Care Association of New Jersey, has a best-practices site which lists best practices for Medication Management, Fall Management, Pain Management and Performance Improvement. These resources may be found at http://www.hcanj.org/bestpractices.htm.

NCAL developed its Advocating Care Excellence (ACE) in 2009 to demonstrate its commitment to quality and performance excellence in assisted living. NCAL believes that successful quality

initiatives raise the bar for resident satisfaction, quality of life, and improved operational performance. NCAL's ACE houses all of NCAL's current quality resources and tools. All of NCAL's work towards quality care is based on NCAL's series of Guiding Principles:

- Guiding Principles for Assisted Living
- Guiding Principles for Consumer Information
- Guiding Principles for Dementia Care in Assisted Living
- Guiding Principles for Leadership in Assisted Living
- Guiding Principles for Quality in Assisted Living

These five documents serve as the foundation for all of NCAL's Inservice Training Tools and Quality Resources that it develops for its membership.

In 2010, NCAL launched its Performance Measures Initiative aimed at identifying and collecting data on areas that lend themselves to high quality care and quality of life for the residents and staff living and working in assisted living communities. NCAL collected data on its Tier I Performance Measures, those elements that contribute to increased quality of life for residents residing in assisted living. Copies of the 2010 NCAL Performance Measure Report can be obtained by contacting NCAL's director of workforce and quality improvement. This survey report was based on a 16 percent response rate of the NCAL membership. Of those responding, some of the key findings include:

- 91 percent of the communities measured resident and family satisfaction;
- 94 percent of the communities reviewed incident reports for residents;
- 95 percent of the communities reviewed incident reports for staff;
- 94 percent of the communicates had a licensed nurse available to the staff and residents 24 hours a day (through various means); and
- 98 percent of the communities conducted criminal background checks on all new employees.

NCAL is currently in the development phase of its Tier II Performance Measures, or those elements that contribute to an increased level of quality care. These initial measures include collecting data on falls, pain management, weight change, pressure ulcers, infection control, medication management, hospitalizations, elopements, depression, and advanced care planning. These areas will be incorporated into future surveys of the NCAL membership beginning in 2012.

Conclusion

I would like to thank the Committee once again for convening this discussion and inviting me to participate. As the Committee considers all the information that was shared today at the Roundtable, I hope you will remember that it has been seniors in the private sector marketplace

that have shaped assisted living and created one of the most popular settings in which Americans freely choose to receive care. If we lose sight of this basic foundation upon which assisted living has been built, then seniors, and especially Baby Boomers, will circumvent providers and government to build another model of care that meets their needs and preferences. Seniors today reject inflexible, highly regulated cookie-cutter care and care settings. I believe that if government and the provider community are to deliver on the promise of helping our seniors age successfully, then we must always let consumers be our guide and work together to develop programs that will allow those without adequate resources to have access to assisted living settings across the country.

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[i] More than two-thirds of the states use the licensure term "assisted living" and some states use a similar term (e.g., Tennessee uses "Assisted Care Living Facilities"). While the second most used term is "residential care," other state licensure terms include "boarding home, basic care facility, community residence, enriched housing program, home for the aged, personal care home, and shared housing establishment." Source: NCAL Assisted Living State Regulatory Review, 2011, National Center for Assisted Living, Washington, D.C., 2011.

[ii] This growth has been documented by both research done by the U.S. Department of Health and Human Services, which has published major reports on assisted living/residential care regulation and Medicaid policy in 2004 and 2007, and through NCAL's annual Assisted Living State Regulatory Review, which summarizes state regulations and analyzes regulatory changes and trends.

[iii] Analysis based on information collected for the National Center for Assisted Living (NCAL) *Assisted Living State Regulatory Review 2011*, NCAL, Washington, D.C. For additional information, please contact Karl Polzer, NCAL Senior Policy Director, at 202-898-6320 or kpolzer@ncal.org.

[iv] NCAL Assisted Living State Regulatory Review, 2010 edition.

[v] NCAL Assisted Living State Regulatory Review, 2009 edition.

[vi] U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation, "Assisted Living and Residential Care Policy Compendium, 2007 Update," by Robert Mollica and Kristin Sims-Kastelein of the National Academy for State Health Policy.

[vii] NCAL Regulatory Review, 2010 edition.

[viii] "Assisted Living and Residential Care Policy Compendium..."

[ix] U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, "Residential Care and Assisted Living: State Oversight Practices and State Information Available to Consumers," Robert Mollica, September 2006.

[x] "Residential Care and Assisted Living: State Oversight Practices..."

[xi] *Governing* magazine, "Public Officials of the Year: 2007 Winner: Kevin Coughlin: Common-Sense Compliance," by Penelope Lemov, http://www.governing.com/poy/2007/coughlin.htm.

[xii] "State Medicaid Reimbursement Policies and Practices in Assisted Living," Robert Mollica, National Center for Assisted Living, Washington, D.C., October 2009. Information for the report was obtained from two primary sources. Baseline information on state assisted living reimbursement policies and practices was obtained from previous studies sponsored by the U.S. Department of Health and Human Services, Office of the Assistant

Secretary for Policy and Evaluation, and RTI International in 2002, 2004, and 2007. The information was updated through an electronic survey and telephone calls with state officials responsible for managing Medicaid services in licensed assisted living/residential care settings. Information was also obtained from state websites when available. Responses were received from 45 states and the District of Columbia. Information for states that did not respond to the survey was obtained from previous reports and material found on state web sites. Data were collected between March and June 2009. To obtain a copy of the report, visit *www.NCAL.org*.

[xiii] According the latest national survey of assisted living residents and facilities, median assisted living resident income was $18,972 in 2009, about half the average cost of assisted living. This implies that most private-pay residents are spending down assets. See "2009 Overview of Assisted Living," AAHSA, ASHA, ALFA, NCAL & NIC, Washington, D.C., 2009.

[xiv] Federal Register, Medicare Program; Proposed Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs for Contract Year 2012 and Other Proposed Changes, Nov. 22, 2010, p. 71190.

Written Statement of Michael Vaughn,

Acting Director Asset Management and Lender Relations

Office of Residential Healthcare Facilities

Senate Special Committee on Aging, Assisted Living Facilities Roundtable

March 15, 2011

Thank you Chairman Kohl, Ranking Member Corker and members of the Committee for hosting this roundtable to discuss the care and quality of life for individuals in assisted living facilities. The Department of Housing and Urban Development plays a critical role in the creation and management of housing for low-income seniors.

HUD's efforts to assist seniors fall into two broad categories: (1) capital and rental subsidies, and (2) mortgage insurance. Today, over 1.4 million households, with at least one member who is over 62 years of age, live in HUD subsidized housing. This represents over 30% of all HUD assisted households. In addition, over 1 million persons with disabilities are residents of HUD assisted housing. An additional 300,000 seniors and persons with disabilities reside in facilities with mortgages insured under HUD's Section 232 program. Through mortgages insured under this program, and under the Section 542 Risk-Sharing program for state Housing Finance Agencies, HUD supports both conventional and affordable Assisted Living Projects. Both the Section 232 and Section 542 mortgage insurance programs are often used in conjunction with other federal and state financing for the creation of affordable Assisted Living facilities.

The Section 232 program has seen a dramatic increase in activity over the last 3 years, as commercial bank and other funding sources have reduced their exposure to the Skilled Nursing Facility and Assisted Living market. Implementation of "Lean" process improvements has enabled FHA to provide more reliable, expeditious delivery of mortgage insurance commitments and at the same time improving underwriting risk assessment. Volume of applications has tripled, and although HUD staff is unable to keep up with demand, over $1.7 billion in mortgage insurance commitments have been issued so far in fiscal 2001.

A good example of the way the Section 232 program has been used to provide funding for affordable Assisted Living projects is Victory Center of Vernon Hills Supportive Living Facility in Lake County, Illinois. The 120 unit facility provides studio apartments with Assisted Living Services. Under the Supportive Living Facility program, a portion of the project's units must be set aside for occupancy by Medicaid –eligible residents. Although the minimum under the

program is 25%, in Victory Center 60% of the units will be leased to Medicaid-eligible residents at Medicaid reimbursement rates with the remaining 40% of the project leased to private pay residents. As the project utilizes Low Income Housing Tax Credits, a portion of the project units must be set aside for tenants earning 30%, 50% and 60% of Area Median Income (AMI). 60% of the units will meet this requirement. The developer, Pathway Development, and its non-profit partner, Lake County Residential Development Corp. are experienced in both the development and management of affordable Assisted Living Communities. Funding for the project is provided by the $12.5 Million Section 232 Mortgage, $11.2 billion in Low Income Housing Tax Credit Proceeds, $1.24 Million in Tax Credit Assistance Program funds provided by HUD under the American Recovery and Reinvestment Act, and $195,000 in Illinois tax credit funds.

The vast majority of HUD-assisted housing that receives capital or rent subsidies is focused on independent living and would not be considered traditional single site, congregate assisted-living housing. These programs include:

- The **Section 202** program which provides approximately $350 million a year through competitive grants to nonprofits to develop new affordable housing communities for low-income elderly, including frail elderly, and provides ongoing rental assistance to support approximately 300,000 elderly households currently living in Section 202 properties. While an estimated 38% of all current residents could be considered "frail" or "near-frail", most of these access community based services. Only a small portion of these resources are use for traditional assisted living programs For example, HUD's Section 202 Assisted Living Conversion program has historically provided small capital grants to 5 or 6 projects a year to support them in converting their buildings to licensed assisted living facilities. In the most recent award year, 5 projects totaling $18 million were recipients of these grants. HUD also administers the **811** program, which is similar to the 202 program but targets persons with disabilities.
- The **HOME** program with allocates approximately $1.5 to 2 billion annually in grants/soft loans to local/state governments for their use in acquiring, constructing, and rehabilitating affordable housing. However, the overwhelming bulk of these funds support affordable family or elderly housing other than assisted living facilities
- HUD's largest programs, the **Public Housing** programs, the **Section 8 Rental Assistance Programs**, and the **Housing Choice Voucher** programs serve the vast majority of seniors and persons with disabilities in both scattered site (individual units in the community) and congregate settings, some of which are senior only communities.

It should be noted that many of HUD's capital and subsidy programs work in conjunction with **Low Income Housing Tax Credits** administered by the Department of the Treasury as well as other federal and state programs. The Tax Credit program facilitates approximately $8 billion per year in affordable housing investments. However, like HUD's capital and rental subsidy programs, only a small portion ultimately goes to assisted living projects.

Most recently, the passage of S. 118, the Section 202 Supportive Housing for the Elderly Act, signed into law on January 4, 2011, made it easier for HUD to improve the program in several ways. The bill makes it easier to refinance older Section 202 projects in need of rehabilitation; provides flexibility in transforming less marketable studio apartments into one bedrooms; it established new rental assistance contracts for seniors at risk of being unable to afford rent increases due to refinances; and it made it easier for owners to make health and supportive services available to residents through service-enriched housing.

A good example of how HUD can play a critical role in supporting elderly with a range of health needs can be found in Columbus, Ohio. In Columbus, a nonprofit organization National Church Residences (NCR) received a Section 202 award of $3.5 million, plus a commitment from HUD of ongoing rental assistance (which included the costs of a property manager and service coordinator but not direct services), to develop a 39 unit independent living community for low-income elderly households. Shortly after the property opened in early 2010, NCR surveyed its residents and found that its residents had an average annual income of approximately $11,000 and average savings of approximately $5,000. 69% of residents were Medicaid eligible and 10% had actually left a nursing home setting to live at this Section 202-funded property. Of the 39 households, some were active and independent, not requiring any services or support at all. Others were benefiting from linkages to community-based services provided by an on-site service coordinator. And quite a few were receiving intensive Medicaid home and community based care services. In particular, 12 were receiving personal care services; 14 were receiving homemaking services; 9 were receiving physical/occupational therapy services; and 10 were receiving nursing services.

In recent years, the aging of HUD tenants has paralleled the changing demographics in the nation, and HUD has considered its role in ensuring that HUD tenants, who choose to, can age in place. At the same time the Department has focused on ways to address the growing number of seniors who will need affordable housing in the coming years.

HUD is working administratively to prioritize new Section 202 and new Section 811 programs that make more explicit connections to services to ensure that residents (whether elderly or non-elderly disabled) have the resources they need to live independently in the community for as long as possible. In addition, the president's budget request for FY 2012 includes $40 million for HUD's Assisted Living Conversion Program, mentioned above, that helps existing owners of

Section 202s retrofit their properties to better accommodate the delivery of licensed services to frail elderly and/or conversion of independent living facilities to licensed affordable assisted living properties.

HUD has also supported public housing authorities' (PHAs) efforts to serve an increasing elderly population through the designated housing process. Through this process, 203 PHAs have been approved to designate 72,109 units of public housing for elderly families, and 2,539 units for a mix of elderly and non-elderly disabled families. These PHAs are responding to a demand by elderly families for elderly-only developments that include accessibility features in a service-rich environment.

HUD has developed a close partnership with the Department of Health and Human Services (DHHS) to better align housing programs with health and social service programs for seniors and persons with disabilities. For example, over the past year, HUD has released 5,300 Housing Choice Vouchers for Non-Elderly Disabled persons (NED vouchers), 1,000 of which were in conjunction with the HHS Money Follows the Person (MFP) program. The two departments are implementing a joint capacity building effort to promote collaboration between health, human service, and housing agencies at the federal, state and local levels to improve the support of persons with disabilities.

PHA's have also used HUD funding in combination with other sources to provide affordable Assisted Living facilities. One example is Lapham Park, a 200 unit Assisted Living Facility in Milwaukee, Wisconsin. An existing Public Housing Seniors facility was facing low occupancy because of lack of services for an aging population. With a combination of HUD capital funding and other private and PHA funds, the facility was renovated, and a contract was signed with a non-profit management company to provide the necessary services. The operating costs are paid for by a combination of state Medicaid Waiver funding, Optional State Supplement to SSI, HUD Operating and Utility Funding, and private payments from residents. The savings to the State of Wisconsin over Nursing Home resident fees are over $1 million annually . 100% of the units are affordable to 50% of the Area Median Income (AMI) or below

HUD's primary focus in these efforts is to allow seniors in HUD housing and in the broader community to age in place by providing affordable housing in conjunction with a rich array of Home and Community Based Services provided by federal, state and local partners. However HUD funding and mortgage insurance, in connection with other state, federal and private sources can be used to create communities that follow the affordable assisted living model.

Statement of Freddie Mac
To the United States Senate
Special Committee on Aging Roundtable
March 15, 2011

Freddie Mac appreciates the opportunity to provide a statement to the United States Senate Special Committee on an important policy matter: the care and quality of life for individuals in assisted living communities.

Freddie Mac supports housing for both homeowners and renters. Freddie Mac does not originate loans, rather we purchase mortgage loans from lenders in the U.S. secondary mortgage market. Through our Multifamily Division, we work with lenders to finance apartment developments throughout the United States. We do this by purchasing multifamily loans, typically to property developers or managers, from approved lenders

Freddie Mac has purchased multifamily loans secured by senior housing facilities for almost 15 years. Due to a variety of demographic trends, such as longer life expectancy and dual wage earning status of adult children, there is increasing need for seniors housing options. In response, Freddie Mac's Multifamily Division has made seniors housing an increasingly important part of our multifamily business. Freddie Mac has developed mortgage products designed for the purchase or refinance of seniors housing that offers multiple financing options with flexible loan terms. These mortgage products are specifically designed for senior apartments, independent living properties, assisted living properties, dementia care properties and seniors housing properties with limited skilled nursing.

During the recent economic crisis, the multifamily loan market experienced an exodus of private capital that also affected the single-family mortgage market. We responded to this withdrawal of private capital by expanding our business capacity to fund a greater share of multifamily loans than in years past. Indeed, since 2008, Freddie Mac has funded between 30 and 40 percent of all new multifamily loans.

Roughly seven percent of our investments in multifamily mortgage loans consist of various types of senior housing loans. As of December 31, 2010, of the $6.2 billion in unpaid principal balance invested in senior housing loans, more than half - $3.3 billion - supports assisted living facilities (generally defined as those facilities where at least half of the residents receive round-the-clock assistance for functional limitations, are offered active daily living programs, and are provided with regular meals and limited nursing evaluation).

Freddie Mac primarily purchases multifamily mortgage loans secured by senior housing facilities that are private pay; however we also purchase multifamily mortgages that finance facilities that have a Medicare, Medicaid or similar governmental program for residents of the facility. We review the percentage of subsidy income in relation to the

total income and, in some cases, have required additional credit support when the levels are high enough to potentially impact payment of mortgage debt service payments if the subsidy were ever to be reduced.

Freddie Mac's senior housing portfolio has consistently performed well. There has never been a foreclosure on any of the senior housing loans we have purchased and none of these senior housing loans currently have payment delinquencies. We attribute the success of this portfolio to our strong multifamily and seniors housing loan underwriting standards, including our assessment of the property owner's financial capacity and creditworthiness. We have strict underwriting guidelines regarding the property owners/borrowers and property managers that may vary based on certain conditions related to the senior housing facility itself, including whether the facility is primarily independent living or assisted living and loan-to-value limits.

In addition, prior to purchasing a senior housing loan, borrowers are subject to a rigorous examination to determine that the senior housing facility will be well managed. For example, all borrowers/property managers must meet specific standards that demonstrate a proven track record of effectively owning and/or managing senior housing facilities. These borrowers/property managers must also work through our approved network of Freddie Mac lenders, who also must meet a different set of equally rigorous standards to be eligible to sell senior housing loans to Freddie Mac. While we do not manage the individual senior housing facilities, we take seriously the provision of services that are provided to the residents of those facilities.

Freddie Mac remains committed to bringing liquidity to the mortgage markets, and will continue its efforts to focus on the increasing needs for seniors housing.

Thank you for the opportunity to comment on this important matter.

Testimony of Charla S. Long, Esq.
Creator and Director, TransformAging Program
Lipscomb University
Nashville, Tennessee

Roundtable: Assisted Living at the Dawn of America's "Age Wave": What Have States Achieved and How is the Federal Role Evolving?
U.S. Senate Special Committee on Aging
March 15, 2011

Workforce Challenges for Our Aging Society

Thank you for the opportunity to submit this written testimony as a supplement to your recent hearing on the government's role in assisted living held March 15, 2011. The testimony given provided an informative assessment of the industry's current standing and an optimistic outlook on the future of aging services.

I would like to share my response to the Committee's question, shedding light on the workforce challenges that currently exist and will continue to exist without intervening action.

During the past two years, I have created a program called **TransformAging** at Lipscomb University. This program is the result of an institutional commitment to help find lasting and meaningful solutions to the problems faced by our aging society. Our research has identified five vital areas that must be addressed in order to improve the aging services industry. Development in these areas will be aggrandizing for both the industry and the aging consumer.

1. Refine curricular offerings at universities and community colleges to address the competencies needed for aging services employees at all levels of learning;
2. Create collaborative partnerships between institutions of higher learning and the aging services industry so as to design revolutionary, interdisciplinary programs that will prepare the workforce of tomorrow;
3. Increase the pipeline of passionate young people interested in pursuing careers with the aging through intergenerational instructional opportunities and enhanced guidance counselor training in our K-12 educational system;
4. Launch perception leadership campaigns on multiple levels to raise the value placed on these essential and meaningful careers; and
5. Address compensation disparities and remove barriers to entry in this field of employment.

We are facing significant workforce challenges in the field of aging services. If not addressed, these challenges will cause serious harm to aging and aged Americans. We have heard all of the statistics:

- In the next twenty years, twenty percent of all Americans will be over age 65.
- The population of those 85 and over will increase five-fold
- Three million new healthcare jobs will be needed by 2018, and 3.5 million will be needed by 2030 to maintain today's status quo.
- By 2018, our Nation will need 4.3 million direct care workers – more than the law enforcement & public safety personnel, K-12 teachers, and registered nurses.
- Today's direct care worker is, on average, 55 years old.

Higher Learning Needs to Refine and Broaden Its Offerings

Institutions of Higher Learning have traditionally offered programs for doctors, nurses, pharmacists, physical therapists, and advanced degree social workers. Yet, the needs for an educated workforce are much broader than those areas of education. The aging services industry also needs direct care workers, nursing home administrators, physician assistants, elder mediators, financial planners, aging services leaders and executives, clergy, rehabilitation specialists, nurse practitioners, parish nursing, construction managers, certified age-in-place retrofitters, and the like. An examination of academic programs reveals a void or minimal educational offerings for these professions.

In 2008, the Partnership for Health in Aging (PHA) developed a set of core competencies in the care of older adults. Ten healthcare disciplines have endorsed these competencies as relevant to all entry-level healthcare professionals. And yet, these competencies have yet to be fully implemented in academic institutions. We have industry wide consensus as to what principles need to be taught in our schools. Now, we simply must act on the information that has been set before us. We must produce the aging services professional as requested by the industry.

For example, since fifty-five percent of direct care workers have a high school degree or less, institutions and colleges need to work with the industry on GED completion programs. These programs can then serve as feeder initiatives for formalized college education and initial training in the field of aging services.

Additionally, federal law requires only seventy-five hours of training for certified nurse assistants and home health aides. These hours of training could be offered by academic institutions and serve to incentivize front-line care providers to higher levels of formalized learning.

The Department of Health and Human Services and The Department of Education could play an important role by funding current efforts to increase formalized geriatric training.

Collaboration Between Aging Industry and the Academy

A recent report by the American Society on Aging reveals that every medical school requires students to complete a clinical rotation in pediatric settings; however, almost no medical schools require a geriatric rotation. Less than 10 percent even require students to take a geriatrics course. Baccalaureate-level nursing programs rarely expose students to the geriatric care needed by long-term care clients. About 80 percent of students graduating with a Bachelor's degree in social work have never had a course in aging, and master's degree students specializing in gerontological social work are rare. Collaborations between the aging industry and the academy could rectify these issues.

Academicians should work alongside industry counterparts to gain a greater understanding of and appreciation for those engaged in aging services. Faculty development programs should be created to increase knowledge of geriatrics and today's aging services industry. These efforts would not only increase the academy's ability to teach from a gerontological perspective, but it would also increase learning for aging services personnel.

Colleges and universities should eliminate academic discipline silos and create interdisciplinary teams for teaching and research purposes. Students in training to be nurses, doctors, and social workers should work alongside aspiring business leaders, lawyers, engineers, theologians, and computer scientists. Learning in a truly interdisciplinary manner would greatly augment the academic preparedness of future industry leaders.

Increase the Workforce Pipeline

We must increase the number of young people who want to passionately pursue careers in aging services. This can be achieved through intergenerational curricular programming and enhanced K-12 guidance counselor training. We would recommend that all public schools be required to add an intergenerational component to their curriculum, such as a writing a biography about a senior, creating a community garden at a local assisted living community, or participating in an arts and craft fair with nursing home residents. This intergenerational requirement would allow students to experience careers in aging services.

High school guidance counselors are highly influential in the career choice of many young people. The aging services industry, perhaps through the Administration on Aging, should launch an initiative targeting these shepherds of our future work force. This campaign should educate counselors about the wide range of careers in aging services. Counselors need to understand the variety of skills and competencies needed, as well as the demand for these types of workers. Counselors could be given the opportunity to complete a summer externship with a local aging services leader so the counselor is better able to describe the field's opportunities.

Launch Perception Leadership Campaigns

College students do not aspire to work in the field of aging services. The national sentiment disregards the values of this noble industry. This must change. The care and protection of our aging citizens is a career that should be universally esteemed and respected. A recent survey showed that nurses in the field of aging services reported a lack of respect and a lack of acknowledgement about the important roles they play. This should never be the case. We must work to develop a more flattering and positive representation of the field of geriatrics to display the true value and necessity of these individuals who work valiantly as bastions of protection and angels of support for our seniors.

We would recommend industry associations, in cooperation with local, state and federal government, create perception leadership campaigns designed to change public sentiment. In particular, campaigns should target:

- Unemployed individuals who could be retooled for a career in aging services – a field more resilient to economic downturns;
- Healthcare professionals who may believe careers in aging services are less prestigious than careers in acute care areas;
- Aging services leaders who need to address compensation disparities between aging services and acute care professionals; and
- Young people who are still deciding their career fields.

Plug Holes in Pipeline By Addressing Compensation Disparities

The recent passage of PPACA will flood the healthcare industry with newly insured Americans. This increase will proportionately catalyze the demand for healthcare professionals. Acute and primary care will garner the majority of this incoming workforce – the aging services industry will not.

This should not be surprising when long-term-care RNs make about $10,000 less per year than acute-care nurses, according to a recent study. Doctors who do choose geriatrics have the lowest median salary among medical specialties in the United States. This expectedly has caused a decrease in geriatric doctors across the board since the additional time spent and tuition paid for the specialty is simply not being financially rewarded.

For the field of geriatrics to grow and develop in a positive way, there must be adequate compensation for the doctors, nurses, and other professionals that serve in this industry. They are providing a necessary service that our nation greatly needs. In addition, this need will increase exponentially over the next decade.

As for direct care workers, the median annual earnings in 2009 for direct-care workers averaged just $16,800. Due to their low earnings, nearly half of direct-care

workers lived in households that received one or more public benefits, such as food stamps, Medicaid, housing, childcare, or energy assistance. It is difficult to entice someone to pursue a career, which does not even allow that individual to live above the poverty line.

The federal government is incentivizing states to expand home and community based services through the Patient Protection and Affordable Care Act. However, until the industry pays wages comparable to other healthcare settings, the U.S. will not have the workforce it needs to accomplish such a goal.

Conclusion

In conclusion, I would urge Congress to partner with state and local governments, non-profit organizations, for-profit aging services companies, and institutions of higher learning to find meaningful solutions to the workforce development challenges this industry faces. Working in cooperation with one another, we can meet the needs of the aging population of our great Nation.

Thank you for your consideration.

LTCCC LONG TERM CARE COMMUNITY COALITION
Working to improve long term care through research, education & advocacy

STATEMENT OF THE LONG TERM CARE COMMUNITY COALITION on

ASSISTED LIVING: TOWARD GOVERNMENT POLICIES THAT PROTECT ELDERLY & DISABLED AMERICANS AND ENSURE ACCESS TO DECENT CARE AND THE "PROMISE" OF ASSISTED LIVING

To the

UNITED STATES SENATE, SPECIAL COMMITTEE ON AGING,

ROUNDTABLE: ASSISTED LIVING AT THE DAWN OF AMERICA'S "AGE WAVE"

MARCH 15, 2011

Introduction

Assisted living is often described as the fastest growing form of senior housing, offering the option of residential care, personal services and safety without the institutional setting of the traditional nursing home. The promise of assisted living – to furnish care in a home-like setting, fostering resident choice and autonomy – dovetails perfectly with both the desires of our aging "baby boomers" to maintain an active and engaged lifestyle and with the growing recognition in the law that every individual has the right to receive care in the least restrictive setting possible for them as individuals. Unfortunately, the law and public policy have not kept pace with these developments: assisted living has received minimal attention at the federal level and state standards and oversight, to the extent they exist, are highly inconsistent, confused and, for the most part, inadequate to effectively protect residents.

Thus, we are glad to see the Special Committee on Aging take up this burgeoning issue at this time and hope that this roundtable will be the beginning of a meaningful national discussion on establishing policies that both protect vulnerable consumers and sets the stage for a high-performing and robust industry that truly fulfills the promise of assisted living. To that end, following are some of the issue areas that we think are crucial to the development of sound public policy in this area.

Consumer Disclosures

Though not a substitute for meaningful standards and enforcement, comprehensive consumer disclosures are key. By their very nature, assisted living facilities come in different forms, catering to different communities, needs and desires. At the same time, prospective assisted living consumers are generally faced with a highly difficult, pressured and stressful decision-making process, which itself often comes on the heals of illness, hospitalization or loss. These circumstances are ripe for abuse and, even under the best circumstances, misunderstanding.

Following are some of the issues which we believe are essential components of minimum requirements for disclosure:

1. Costs and other financial issues, including:

Statement of the Long Term Care Community Coalition to U.S. Senate Special Committee on Aging Regarding Assisted Living

- rates, charges, deposits, and services included and not included in the base rate;
- payment schemes for any charges beyond base rate;
- facility's policies on personal funds, refunds, any other fees;
- facility's policies on payment sources (e.g., if it accepts public funding (and if so under what circumstance), LTC insurance, requires a guarantor, etc...).

2. Care provided, including:
   - assessment and care planning policies;
   - whether or not the facility is licensed and, if so, the scope of the license held;
   - the extent to which the facility provides care for dementia;
   - the extent to which the facility allows for "aging in place" as residents become more frail and the specific limitations, if any, for aging in place (e.g., not for wheel chair bound or limited to 6 "slots," etc...);
   - how is medication handled and by whom (when not the resident).
3. Quality of life provided, including:
   - Characteristics of residents' rooms, including availability of single room, policy regarding single rooms, privacy policies, availability of private vs. shared bathroom, availability of private kitchen and/or access to communal kitchen or pantry; ability of residents to decorate and/or furnish;
   - Availability and provision of social & recreational services, including: activities taking place in the residence, access to activities in the outside community;
   - The facility's policy re. access to and scheduling of services (such as bathing assistance or availability of meals).
4. Nature of care staff, including:
   - staffing levels, including day/evening/weekend staffing patterns;
   - training, credentials and qualifications of staff;
   - whether or not there is resident choice in providers of care.
5. Residents' rights, including:
   - admission, retention, and transfer standards, including involuntary transfer rights;
   - room hold policies during hospitalization;
   - contact information for the state Long Term Care Ombudsman and other oversight agencies.

Federal Regulatory Structure and Oversight

The fact that assisted living facilities have positioned themselves as a residential care setting distinct from nursing homes has resulted in the industry largely avoiding meaningful quality assurance and oversight. Industry representatives frequently cite the need for "flexibility" and

"choice" and point to the industry being based on a "social model" rather than the "medical model" typified by the traditional, institutional nursing home. Nevertheless, the growing popularity of assisted living and the growing population of elderly and older elderly (over 85) Americans has resulted in assisted living providing care to resident populations that are increasingly similar to those who traditionally have been relegated to nursing homes. This is true in terms of both the level of need of residents and their vulnerability. Yet, despite their increasing functional similarities, (as noted above) assisted living has largely escaped accountability for quality of care and services, or even for meeting the "social" aspects of the promise of assisted living.

The result is a system in which assisted living facilities are entrusted with the care of frail Americans who have – or are approaching – a nursing home level of needs without the minimum standards and oversight that nursing homes have. While this system of standards and oversight is considered onerous by many in the provider industry, the fact is that it is, every day, proven woefully insufficient to protect our nursing home residents. Every day, across the nation, frail elderly and disabled nursing home residents face abuse and neglect. Every state has nursing homes that regularly fail to meet minimum standards of care.

We should not repeat this scenario in assisted living. While a national regulatory framework for assisted living can – and should – be different from that for nursing home care, it must clearly articulate standards that are appropriate for the needs of assisted living residents and the level(s) of care promised by facilities and, minimally, include enforcement criteria and mechanisms that vigorously and effectively ensure resident safety, fulfillment of assisted living's "promise" of resident choice and autonomy in a home-like setting, and fairness in contract.

Development Of An Affordable Assisted Living Model That Promotes Dignity, Autonomy and Independence

The absence of national standards and oversight, and the patchwork of state standards, has resulted in a wide diversity in quality of care and quality of life provided by assisted living facilities. Many assisted living provide a high quality of care, including professional care staff. Many assisted living provide the quality of life that assisted living promises, with private rooms (for those who prefer them) and a lifestyle that fosters resident dignity, autonomy and engagement.

Unfortunately, there are also many assisted living providers that do not follow these practices and principles. Many assisted living across the country are staffed with individuals who lack the training and expertise to provide the care that their residents need. We would not permit this in other situations in which vulnerable individuals receive care, yet, all too often, the "promise" of assisted living functions as a cover for the industry to escape crucial standards. Similarly, many providers function under the premise that assisted living's promise of "choice" and "flexibility" are meant to apply more to them than to consumers. As a result, many assisted living facilities provide an environment and lifestyle that is centered on the facility's needs and convenience, furnishing a lifestyle for the residents that, in its institutional, facility-oriented nature, would not even pass muster under our national Nursing Home Reform Law's requirements for resident dignity and quality of life.

Government policies and funding that move us away from traditional nursing home care, and towards more consumer-oriented, less restrict settings, must be predicated on supporting settings that provide at least the same level of safety and care as required in traditional settings

while offering substantive differences in quality of life, choice and dignity for the consumer. Anything less, from our viewpoint, is patently inconsistent with the Supreme Court's ruling in *Olmstead* and decades of changes in our society's conception of the needs and rights of elderly and disabled healthcare consumers (of which the *Olmstead* ruling is, of course, an important part).

In light of these concerns, following are three fundamental recommendations for moving forward on the development of affordable assisted living:

1. Before allocating additional resources to assisted living the federal government should first identify a model of assisted living that meets the standards that it wants to perpetuate in terms of both quality of care and quality of life. This model must provide for resident quality of life – including dignity, autonomy and privacy – beyond the minimum standards required for nursing homes. In addition, this model must ensure the provision of appropriate care and safety though meaningful standards and enforcement.
2. The federal government should establish a stream-lined and rational funding process that fosters a viable assisted living industry. As noted above, there are many assisted living providers across the country that are not staffed to provide promised care services to their residents and/or do not provide assisted living's promised quality of life, dignity and autonomy. At the same time, many assisted living facilities do provide a residence and community that meets the care and quality of life needs of its residents. As the industry expands, our population ages and we endeavor to move to supporting non-institutional long term care services, it is crucial that we encourage and foster a provider industry that is competent and capable.
3. Agencies responsible for oversight and quality assurance of long term care, including CMS, the state oversight agencies and the Long Term Care Ombudsman Program(s) must be adequately funded, independent, and empowered to assure quality of care in any – and every – setting. As with the need to maintain standards in care practices, it is essential that quality assurance and accountability are sufficient to ensure that individuals are safe, minimum standards are enforced, and public monies are used appropriately. While this may not, ultimately, require an exact duplication of the system in place for nursing homes (just as nursing home oversight differs from that for acute care facilities), it must be sufficient and effective to meet the needs of assisted living consumers.

National Association of States
United for Aging and Disabilities

Senator Herb Kohl (WI)
Chairman
Senate Special Committee on Aging

Senator Bob Corker
Ranking Member
Senate Special Committee on Aging

March 29, 2011

Dear Sirs,

Thank you for you for the inviting the National Association of States United for Aging and Disabilities (NASUAD) to participate in the United States Senate Special Committee on Aging Assisted Living Round Table. The Association also greatly appreciated the opportunity to serve as a resource to Senate Special Committee on Aging staff as they selected Round Table participants from states.

Below, the Association provides background on the Association as well as an overview of its responses to the Assisted Living Round Table discussion questions. ***Attachment A*** contains Association responses question by question for questions appropriate for state comment.

Background

NASUAD was founded in 1964 under the name National Association of State Units on Aging (NASUA). In 2010, the organization changed its name to NASUAD in an effort to formally recognize the work that the state agencies were undertaking in the field of disability policy and advocacy. Today, NASUAD represents the nation's 56 state and territorial agencies on aging and disabilities and supports visionary state leadership, the advancement of state systems innovation and the articulation of national policies that support home and community based services for older adults and individuals with disabilities.

The Association's mission is to *design, improve, and sustain state systems delivering home and community-based services and supports for people who are older or have a disability and their caregivers.* Our responses are based on the Association's mission to foster the development of state long-term services and supports systems (LTSS) that support individuals of all abilities and ages as well as their families.

While NASUAD member state agencies' roles vary from state to state, Association members develop and operate Medicaid-financed assisted living services in collaboration with their partners in the Single State Medicaid Agency (SSMA), oversee assisted living operations in the context of Medicaid quality monitoring strategies, lead or participate in affordable assisted living program development, provide resident advocacy services through Adult Protective Services (APS) and State Long-Term Care Ombudsman (SLTCO) programs, deliver information about assisted living as an LTSS option via

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information and referral (I&R) programs and Aging and Disability Resource Centers. With the exception of Medicaid –financed assisted living services program functions (i.e., Medicaid Section 1915(c) waiver quality monitoring requirements, Medicaid waiver eligibility), most of these assisted living-related functions are performed for both private and publicly financed assisted living. NASUAD also participated in the Senate Special Committee on Aging 2003 assisted living effort.

NASUAD Response Overview

Discussions with member state agencies, resulted in several key themes including: a) agreement that some federal guidance on what makes assisted living distinct from nursing home services but with flexibility in any federal framework -- particular any definition; b) the need for tools to better inform potential assisted living residents about their rights and assisted living costs; and c) tools and mechanisms to oversee assisted living and advocate for residents – particularly private pay residents.

- Related to the themes above both state directors as well as staff with assisted living-specific roles, produced the following concepts: ***Broad Federal Definition*** -- a federal definition based on the 2003 core principles of assisted living (i.e. efforts to support the autonomy, choice, privacy and dignity of residents) rather than a definition that includes specific housing elements (i.e. private bathroom, kitchen and lockable door to single-occupancy room);

- ***Federal Survey Agency Guidance and Training Framework*** – based on the core principles above, federal guidance on the key differences between nursing facilities and assisted living, and a framework for assisted living licensure including surveyor training tools on assisted living-specific licensure requirements ;

- ***Assisted Living Resident Bill of Rights*** – building on the 2003 Senate Special Committee on Aging Assisted Living Work Group, federal guidance on a framework for a resident bill of rights and disclosure statement;

- ***Building State Capacity to Support Informed Potential Resident Decision-Making*** -- increased federal funding and guidance for options counseling including such counseling services delivered by I&R staff and ADRCs in order to educate potential residents about the marketplace for both public and private assisted living settings;

- ***Projecting LTSS Demand*** -- Develop federal technical assistance and a tool for states to estimate demand for LTSS including assisted living services and incorporate such information into their State LTSS Plan;

- ***Federal Funding for the Elder Justice Act and Increased Federal SLTCO***-- Increased federal funding for state programs that provide resident advocacy services (e.g., Adult Protective Services and SLTCO) regardless of payment source and federal tools for data collection on abuse and neglect in the assisted living setting

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Definition (Philosophy: #2, 3, 4, 29; Licensure: #5, 23)
There is tremendous variation among state assisted living definitions, therefore any federal definition must be broad enough to address the array of state models including housing with services, small assisted living facilities structured similarly to Adult Foster care, as well as larger settings. Components of the definition should address: autonomy, choice, privacy and dignity of residents. States have also indicated that a federal framework for assisted living licensure that distinguishes it from nursing facilities would be helpful as well as tools for training surveyors on assisted living licensure requirements.

Resident Bill of Rights, Disclosure Statement, Options Counseling (#5, 17, 18, 19)
The only minimum federal expectations or requirements for state oversight and monitoring of assisted living are in the context of Section 1915(c) waivers and under the new Section 1915(i) and related quality assurance requirements. A federal framework for a resident bill of rights and disclosure statement along with a suggested tool for states to ensure compliance, would help to standardize this need among assisted living residences nationwide.

Options counseling by a third party such as ADRCs, could help educate prospective residents (both older adults and younger adults with special needs) on their rights, options and long term affordability of both public and private assisted living residences, as well as their options if spend down to Medicaid occurs. This could help support

Estimating demand for Assisted Living Services (#7, 13)
Development of a standardized federal tool to estimate demand for assisted living services would be helpful to states. NASUAD is not aware of any public or private sector projections for how many affordable assisted living units are needed in the future, however waiver waiting lists could be used as benchmarks for data collection. Estimating demand for assisted living also varies significantly from state to state based on the widely differing admission and discharge requirements. NASUAD members report concern with rates not keeping pace with increases in acuity as people age in place and more out of residence days due to hospitalizations or post-acute care placement.

Increased Federal Funding: Affordable Assisted Living/Medicaid, Ombudsman, and Elder Justice

Medicaid (#6, 8, 10, 15)
As states report a higher demand for assisted living, with fewer dollars to fund the increased demand, more federal dollars are needed. Affordable AL is a developed using a combination of housing financing and Medicaid as well as public housing funds. Efforts by HUD and HHS to streamline requirements and reporting for states through dually eligible beneficiaries and administrative simplification would be helpful to states.

Ombudsman (#17, 23, 26)
One of the only commonalities throughout the states with respect to oversight and quality insurance measures is maintenance of ombudsman programs. However, these programs rarely have the funding they need to complete the tasks to which they are assigned.

Elder Justice (#17, 18, 19)

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As more consumers age and require a wide array of services including AL, there will also be a need for further protection and advocacy for those who are most vulnerable. In addition to the state and local ombudsman, adequate funding needs to be provided to improve the quality, quantity and accessibility of information and resources regarding long-term care including AL. The Elder Justice Act included in the Affordable Care Act provides for various safeguards and protections but does not provide a funding stream to carry out the duties assigned in the act. Without federal funding and guidance for these important provisions, many of the enhancements outlined in the Elder Justice Act will not be implemented.

NASUAD was very pleased to participate in the Assisted Living Roundtable and welcomes the opportunity for further discussion. Please feel free to contact either myself or Mike Cheek at mcheck@nasuad.org if you have any questions.

Very truly yours,

Martha A. Roherty

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Executive Director

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