

## ***ASSISTED LIVING IN OHIO***

### **Facts and figures you should know.....**

- **552 licensed residential care facilities** in the state of Ohio, commonly called Assisted Living
- **33,000 Ohio citizens** live in assisted living communities
- Average age: **83** ● Average community size is **58.4 apartments**
- Average cost per day **\$108** (2005)

Assisted living communities stand alone, are part of continuing care retirement communities, or are combined with nursing homes or independent living. Residential care facilities are licensed and regularly surveyed by The Ohio Department of Health, Division of Quality Assurance, Bureau of Long-Term Care. Per license, they serve 16 or more individuals, *or less*, if they provide skilled services to residents. Assisted living communities must provide 24 hour supervision and assistance with activities of daily living. They can provide skilled care, such as medication administration, special diets and dressing changes up to 365 days per year and other part-time intermittent skilled cares up to 120 days per year.

Communities determine the level of services they will provide within these parameters and are required to disclose these services and limits to all prospective residents. **This service package, the staffing it requires, the size of apartment and amenities, and their location in the state determine their fees.**

Essentially, there are two models of assisted living across the state, a social model which provides less nursing service and serves lower acuity residents and a higher acuity model meeting more nursing needs. For example, the lower acuity model might only “remind” residents about medications, whereas the higher acuity model provides medication administration.

Currently the majority of assisted living (licensed RCFs) in the state serve a frail, elderly population who benefit not only from the services provided, but the socialization and security afforded in a communal setting. In this area, there may be significant differences between the needs and desires of younger disabled individuals and the elderly. Many elderly individuals suffer from loneliness and isolation, depending on their available support network.

### **Assisted Living Medicaid Waiver**

The Assisted Living Medicaid Waiver is a Home and Community based waiver program (HCBS), serving up to 1800 individuals, from designated settings, in certified and licensed residential care facilities, who require an Intermediate Level of Care (ILOC/nursing home) and are Medicaid eligible. **Service costs are shared by the state and the federal government (CMS) and room and board is paid by participating individuals. Service reimbursement is based on care plan and either \$50, \$60 or \$70 day. Room and board payment is set by the state (but paid by individuals) at the SSI level less \$50 personal allowance for the client, or \$573 per month.**

Services that must be provided or be able to be provided under the waiver are: 1) personal care services (bathing, dressing, continence, mobility, etc.); 2) supportive services, such as housekeeping, laundry and maintenance; 3) 24 hour supervision and response to needs; 4) 3 meals and snacks; 5) social and recreational programming; 6) scheduled transportation; and, 7) nursing services, ( health assessments, monitoring, medication administration, supervision of special diets, dressing changes and incidental skilled nursing).

Additionally, there is a one-time “community transition” service offered easing the move to the community, for example, by assisting with the purchase of necessary furniture.

Providers must employ or contract with a licensed nurse to provide the services outlined in addition to personal care staff. Also, they may be required to employ or contract with a dietitian and physician or psychologist dependent on the diagnoses of the individuals served.

The Area Agencies on Aging are the “gatekeepers” and client care managers for individuals on this program. They set the care level of participants, monitor and meet with the communities they reside in and assist in certifying communities for participation, making sure they have complied with and continue to comply with all waiver rules and all conditions of participation as a waiver provider, required by The Ohio Department of Aging. They also ensure that all applicant communities have met residential care facility licensure.

Consumer eligibility was expanded in the last budget bill, allowing residents of licensed RCFs who run out of funds to apply for waiver slots. This was a very positive step. Other eligible populations are: Medicaid nursing facility residents, and PASSPORT, Choices, or Home Care waiver clients. **A unified budget would have to remove “slots” (numbers), designated pre-enrollment placements and base participation on choice, and appropriate placement.**

Currently, participation by providers in the program is low. While there may be many reasons for this, including the newness of the program, the primary reason is the rate of reimbursement.

- ***Recommendation: Increase Reimbursement***
  - **Per 30 day month the maximum reimbursement to the provider from the state and client is \$2673. \$2100 in services and \$573 in room and board. This falls below the “average” rate per month in licensed RCFs as reported by Scripps in 2005 (\$3240.). The rate reported by Scripps assumes an “average” service package, while the service package required by the program is large.**

- While the required service package is large, it is, in part, addressed by the tier structure for services employed by the state (\$50, \$60 or \$70 per day based on service plan), although on the higher end, given the costs of nursing services and the supervision required for significantly cognitive impaired individuals, it could be increased. **The real problem is the room and board payment which is not sufficient in many areas of the state to cover costs.**
- States with AL waivers primarily use the SSI payment as the room and board fee, however, some states have encouraged participation and increased provider reimbursement in this area by allowing providers to certify and offer shared apartments. Some states that permit this are: New Jersey, Delaware, Kansas, Idaho and Minnesota. This has the effect of opening up assisted living communities in more expensive areas of the state to clients. Clients always have the right to choose whether to accept the shared arrangement or not. Some do, however, in order to be in the area (close to children, etc.) they want to be in. It's what happens if an individual is not on Medicaid and wishes to live in a particular community but can only afford a shared living arrangement there.

**Regardless of what approach is taken, whether the service fee is increased or a means of increasing the room and board is achieved, increased total (service, plus room and board) reimbursement to providers is critical to achieving greater participation. While increasing reimbursement would in the short term potentially decrease the number of individuals who could be served, in planning for a unified long-term care budget, it should not matter as “caps” or “silos” would be eliminated.**

- ***Recommendation: Remove Rule Impediments***

- **Only 279 of the 552 licensed RCF's meet the physical requirements of the waiver.** Of that, not all meet the service package requirements, creating a limited pool of potential waiver providers.

The waiver requires private apartments for residents with areas for socialization (living, dining), complete bathrooms (toilet, commode, shower/tub) and areas in the general community for dining and socialization.

Major obstacles in these requirements are the complete bath and required private apartments. Many older facilities in the state, do not have complete baths in each unit, they are missing the tub or shower. Currently private pay assisted living residents have selected these apartments, and have even “testified” to have them included in the program. In the future, this will not be an issue as recently revised RCF rules mandate a private bath for each apartment with a shower or tub for all new builds and conversions.

While currently this appears to be an issue with CMS, even though in the past they have permitted it, the issue has been creatively resolved in some states by creating separate assisted living waiver programs called something other than the Assisted Living Waiver, like the “Residential Care Waiver” or “Enhanced Community Options Waiver”, or having the pre-existing facilities grandfathered (Kansas). Numbers of states offer several types of “Assisted Living Waivers” that vary depending on circumstances. Some examples are New Jersey and Washington where there are multiple types of assisted living contracts.

Private apartments are the other issue, and while they are the most desirable, they may not always be possible, unless reimbursement is increased. As long as selection and option is left to the client, it should not be a barrier.

Also, some of the rule requirements surrounding the service package should be reviewed. For example, many communities do not “supervise special diets” in the list of services they offer, although they prepare and offer them as ordered. As they are not currently offering that service to their private pay clients, they are unlikely to add the service just to participate in the program. In this particular area, our waiver package seems to exceed that of other states.

Additionally, some other rule impediments, are the lack of “presumed eligibility”, and issues related to the cost of “bed holds”. The lack of presumed eligibility for residents of residential care facilities who run out of funds is a real issue given the “lag” time on Medicaid eligibility determinations in areas of the state. An individual can not be enrolled in the program until they have received their eligibility which does not happen until they spend down to \$1500 which would not be enough to pay their next month’s bill. Bed holds can also be very costly for providers, particularly given the low room and board rate and some states have supplemented this using state funds (Illinois).

- **Consumer Issues with the AL Waiver**

In addition to issues facing providers, the current waiver structure also creates some issues for consumers. Assisted living clients, unlike their nursing home counterparts, have to pay their prescription drug co-payments. This can be a significant issue, given the number of medications many elderly people take and the small personal allowance of \$50 they are permitted to keep.

The prescription co-payment issue is a federal issue and there have been attempts to address it. Unfortunately, a partial fix in the (SCHIP) State Children’s Health Insurance Program was vetoed. Even without the prescription issue, however, the \$50 personal allowance may not be adequate given the more active nature of assisted living residents.

- **Current Waiver Status as of Oct. 31, 2007**

- 70 providers participating
- 300 clients enrolled
- 403 clients on waiting list primarily for certified providers in their geographic area

It appears a number of states have employed several types of waivers in varying assisted living settings in an effort to address a number of issues mentioned. Such formatting may provide solutions to some of the issues raised. When the Assisted Living Waiver was initially discussed, we assumed it would operate in a consumer directed or “money follows the person” manner. In other words, clients entitled to public long-term care services could elect to use their money, in other settings, provided those settings were less costly, yet met their needs, with quality controlled through licensure standards. While that is very simplistic, it encompasses the ultimate goal of this group: a seamless, cost-effective, consumer driven long term care continuum.

**If reimbursement were raised to generate approximately \$3,000 to \$3200 total compensation to providers, participation would definitely increase. Even if reimbursement were increased, there would still be significant savings, in a setting desired by many consumers.**

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