



Expanding Publicly Financed Assisted Living and Other Residential Alternatives for Disabled Older Persons: Issues and Options

Public financing of long-term care services for older persons living in residential alternatives to nursing homes has grown substantially in recent years. By the end of 1999, 35 states funded at least some long-term care services in assisted living facilities (ALFs) or other supportive housing settings, primarily through the Medicaid program.¹ As states shift more resources to residential alternatives to nursing homes, they face a number of difficult issues related to service delivery, financing, and regulation. This policy brief draws on current research and expert opinion to highlight key issues and identify strategies that state policymakers can pursue to expand assisted living and other types of supportive housing for older persons in need of publicly financed services.

Key Issues for Policymakers

Public financing of long-term care services in assisted living and other residential settings is still relatively modest. As policymakers decide whether and how to expand this financing, several key questions emerge:

- What policy goals can be achieved by expanding public financing of ALFs and other supportive housing settings?

- What types of settings should be eligible for public financing? Will payment be directed to settings meeting relatively stringent privacy and service standards?
- Who should be eligible for publicly funded services in ALFs and other supportive housing settings? To what extent will these individuals differ from nursing home residents?
- What is the source of public dollars that will finance services in ALFs? How will residents pay for room and board? How will spending on services be controlled?
- What policies will promote good outcomes at reasonable costs? How can ALFs be regulated in ways that ensure quality of care while allowing flexibility in how they provide services?

Determine Goals

Two broad goals are leading policymakers to expand public financing of long-term care services in assisted living and other residential settings.

- 1 They seek to:
 - Increase access to settings that provide a better quality of life compared to nursing homes. Proponents believe that ALFs can offer home-like settings that allow disabled individuals to age in place and to live more normal lifestyles in the areas of privacy, choice, and independence.

2 Provide care that is less costly than care in nursing homes. Many state policy-makers are hopeful that shifting long-term care spending from nursing homes to residential alternatives will result in a more affordable system. Others, however, question whether savings can reasonably be expected from these settings if the case-mix is the same as in nursing homes and, indeed, whether savings should be an impetus behind expanding assisted living.

Conclusive data are not available on the extent of any savings to be gained from public funding of services in ALFs and other residential alternatives to nursing homes.

Policymakers should realize that while the state’s per person costs typically are lower for residents of ALFs compared to nursing homes,² overall cost savings will be difficult to achieve in the short run unless the state shifts bed capacity from nursing homes to ALFs. Although bed conversion grants and payment systems that penalize nursing homes for low occupancy rates are two possible strategies, shifting bed capacity is difficult because of political and other barriers.

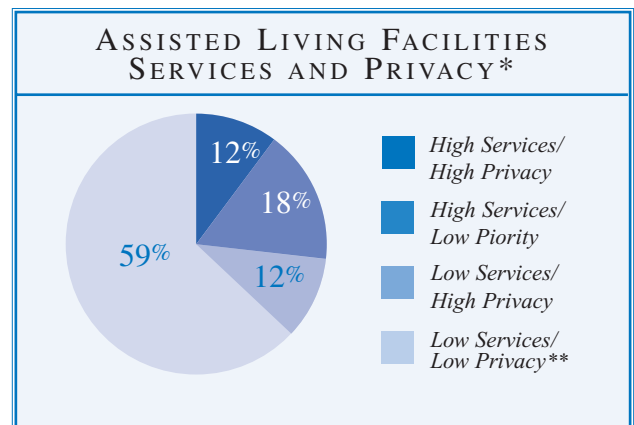
Identify Settings to be Targeted

Residential nursing home alternatives are marketed, reimbursed, and regulated under various categories across and within different states. These categories include assisted living, community-based residential care, adult family homes, and personal care homes. Even within the single category “assisted living,” states face a considerable challenge defining what the setting should be and differentiating it from traditional board and care.

Ardent proponents of home-like settings argue that the defining features of ALFs should be private rooms and bathrooms, lockable doors, and individual cooking facilities or appliances. In addition,

these proponents argue that ALFs should have available a range of services including assessment and care planning, personal care, medication assistance, the option of three meals per day, and 24-hour staffing and access to nursing services. However, a recent survey of facilities that self-identified as ALFs suggests that the great majority of these residential settings for older persons do not fit the assisted living model put forward by proponents.

When ALFs are classified along two dimensions – privacy and services – only a small percentage of ALFs offer high services and high privacy (figure below). In other words, only a small portion of the over 11,000 facilities nationwide meet the definition of what many consider to be “assisted living.”³



*From Hawes C, M Rose, and CD Phillips. 1999. A National Study of Assisted Living for the Frail Elderly (Beachwood, OH: The Myers Research Institute, Menorah Park Center for Senior Living).

**The “low services/low privacy” category includes facilities with low services and low privacy and facilities with either minimal services or minimal privacy.

Policymakers must decide whether they want to designate new public funding only for settings that meet stringent privacy and service criteria or whether they want to fund services in a broader

range of settings. From the perspective of some assisted living proponents, public financing should be targeted to settings that incorporate most features of the high privacy/high services ALF model. However, in states with a large supply of older residential facilities that fail to meet strict ALF criteria, providers can be expected to resist a regulatory category that would exclude their facilities.

Decisions about the types of facilities to be targeted involve important tradeoffs. Directing payment to the relatively small portion of facilities that embody the features of model ALFs (described above) may be the preferred strategy if improving quality of life is the major priority. Targeting public payments only to these facilities, however, is incompatible with rapid expansion of access to residential alternatives to nursing home care.

Identify the Population to be Targeted

The range of services that ALFs and other supportive housing settings should provide is directly related to the care needs of individuals who live in these settings. Although current residents of alternative settings are less disabled on average than nursing home residents, they often have significant disabilities.

Data from a recent national survey of ALFs indicate that almost one fourth of ALF residents receive help with three or more ADLs, and approximately one third have moderate to severe cognitive impairments.⁴ A study of ALFs in Oregon found that more than half of ALF residents use a wheelchair or some other mobility aid.⁵

Most states that currently finance services in ALFs and other residential settings through the Medicaid program use a nursing home disability level as the eligibility standard. However, the level of care that ALFs and other residential alternatives are able to provide varies greatly.⁶

In order for ALFs and other residential settings to be true alternatives to nursing homes, the level of care criteria for publicly financed services in residential settings should be the same as for nursing home care. Otherwise, these settings will simply create another long-term care service category and ultimately lead to a more expensive long-term care system overall.

Some states, such as Oregon, rely on coordinated case management systems to direct individuals with long-term care needs to the appropriate care setting.⁷ Ideally, these systems target publicly financed long-term care services as efficiently as possible by matching individuals with needed services.

States with a single screening and eligibility process for nursing home care and home and community-based services are in the best position to effectively implement targeting decisions.

Determine How Services Will be Financed

Medicaid is the primary source of public financing being used to expand access to ALFs and other residential facilities. Although some states pay for services in ALFs and other supportive settings as state-plan benefits (typically personal care), Medicaid waiver programs are the main vehicle that policymakers use. Medicaid HCBS waivers allow states to constrain spending by limiting the number of waiver program “slots.” However, by allowing states to limit access, HCBS waivers do not guarantee that all eligible beneficiaries in a state receive services.

In ALFs and other residential settings Medicaid can only pay for services that are delivered. Room and board expenses – which Medicaid reimburses in hospitals and nursing homes – typically are financed from a resident’s income, including supplemental security income (SSI) and state supple-

ments to SSI, Social Security, private pensions, and – in some states – family supplementation.

*Although 35 states funded at least some services in ALFs and other supportive housing settings in 1999, the level of Medicaid funding for assisted living is still small in most states (table below). To date, most new ALFs serve privately paying individuals rather than individuals relying on public assistance.*⁸

SELECTED MEDICAID PARTICIPATION RATES
IN ASSISTED LIVING, 1998*

State	SUPPLY**		MEDICAID**	
	Facilities	Units	Facilities	Units
NJ	33	2,772	21 (64%)	120 (4%)
OR	95	4,583	35 (37%)	1,500 (33%)
TX	900	25,203	179 (20%)	565 (2%)
VA	589	28,416	165 (28%)	1,400 (5%)
WA	439	18,515	104 (24%)	1,500 (8%)

*From Mollica RL. 2000. State Trends in Assisted Living. Presentation for the Home Care Research Initiative, March 2000.

** Although “supply” refers to assisted living facilities, these data may represent different regulatory categories in different states. Unfortunately, it is difficult to determine if these data refer to uniform facility categories.

“Medicaid” refers to HCBS waiver coverage of residential alternatives to nursing home care.

State financing policies largely determine the extent to which individuals with low incomes have access to care in ALFs and other residential settings. Payment rates – including service payments through Medicaid and room and board payments through SSI, state supplements to SSI, and other sources of residents’ income – must be high enough to encourage facilities to contract with Medicaid but low enough to satisfy the goal of cost containment (i.e., cost less than nursing homes).

Oregon is one of the few states where Medicaid is a major player in assisted living (table opposite). Proponents of assisted living often point to Oregon as a model for other states, not only for the high penetration of Medicaid in the state’s assisted living industry but also for the high level of services and privacy that ALFs in the state must offer. Importantly, Medicaid rates for ALFs in Oregon have (until recently) been comparable to private rates, helping to ensure access for Medicaid beneficiaries.⁹

To promote access to high service/high privacy facilities for Medicaid beneficiaries, the combined sources of payment, including Medicaid payments and resident income sources, must at least cover marginal costs. In a market with a tight ALF bed supply, even covering marginal costs may not ensure access for Medicaid enrollees.

To promote access to ALFs and other residential settings for individuals with relatively high-level needs, policymakers should consider case-mix adjusted payment methodologies.

Develop Strategy for Ensuring Good Quality of Care

Efforts to expand residential long-term care options are tempered by concerns about care coordination and quality. The primary concerns of state policymakers and advocates for the elderly fall into three areas:

- Availability of physicians and other acute care services
- Medication management
- Adequacy of staffing

While not necessarily discounting these concerns, advocates of assisted living consider quality of life (especially autonomy and privacy) and consumer satisfaction of equal importance when evaluating quality of care.

There are few quantitative studies of outcomes in supportive housing settings. These studies are difficult to conduct for a variety of reasons including a rapidly changing case mix, difficulty separating the impact of treatment from the normal trajectory of illness, and different opinions about how much weight to give quality of life and consumer satisfaction when evaluating outcomes.

*One study comparing new admissions to adult foster care homes with new admissions to nursing homes in Oregon found that persons who were admitted to adult foster care were less likely to improve and more likely to decline in physical functioning over a one-year period than persons admitted to nursing homes. No information was available on other outcomes.*¹⁰

*A more recent study comparing residents of ALFs with residents of nursing homes in Oregon found, after adjusting for case mix, no difference in terms of functional outcomes, mental health outcomes, pain and discomfort, or mortality.*¹¹

Given the very limited number of quantitative studies and the huge variation in physical environment and services available in ALFs and other residential settings, policymakers should be cautious in drawing general conclusions about the quality of care provided in these settings from specific findings.

One particular area of concern regarding ALF policies is the retention of individuals as they grow more frail and disabled. Two somewhat contradictory fears about retention policies lead to quality concerns:

- Some fear that residents will be discharged as soon as their care needs increase, breaking the promise that individuals will be allowed to age in place. For example, only one-quarter of ALFs will retain residents who have behavioral problems

(e.g., wandering or mild dementia) according to one survey.¹²

- Others fear that residents will not be discharged to a more intensive setting if their needs outstrip what ALFs can provide. This may be especially true if the market for residential alternatives to nursing homes is relatively saturated in a particular area, making high occupancy (and profitability) more difficult to maintain.

Currently, consumers and their families are very reliant on providers for information on admission and discharge policies, services included in the basic rate, and the pricing structure for other services.

*One recent study of ALFs in four states concluded that facilities do not provide enough information to prospective residents to make informed choices with respect to services, costs, and policies (e.g., retention policies). The report found that promotional materials often were vague and misleading. The report also identified limited access to physicians, staffing problems, and medication-related complaints as quality of care issues.*¹³

States need to take a more active role in ensuring the adequacy and accuracy of information that ALFs and other residential facilities provide to consumers.

Whether to license or how best to regulate ALFs and other residential care settings is being debated in many states. On one side are providers and some ALF advocates who are concerned about excessive regulation and fear that many of the strengths of new residential models of care will be diminished if nursing home-like regulations are implemented. On the other side of the debate are some consumer advocates and policymakers who are more concerned about safety and quality of care than innovation. Currently, states vary considerably in

how they regulate residential alternatives to nursing homes.

Some states currently license and regulate ALFs and other supportive housing settings similarly to nursing homes. Others have taken a different approach. One approach that states have used is to establish housing and service requirements and to emphasize resident autonomy and choice, but not necessarily to establish specific staffing requirements. Another approach is to focus only on the services delivered and not the facility structure, relying instead on existing building codes and requirements to address the housing structure.

State policymakers developing strategies to regulate ALFs and other residential settings should consider new approaches that encourage flexibility and innovation in service delivery.

Endnotes

¹ Four additional states have approved – but not yet operationalized – financing of care in these residential settings. Mollica RL. 2000. State Trends in Assisted Living. Presentation for the Home Care Research Initiative, March 2000 Conference.

² Murtaugh CM, MS Sparer, PH Feldman, JS Lee, A Basch, A Sherlock, and AL Clark. 1999. State Strategies for Allocating Resources to Home and Community-Based Care. New York, NY: Center for Home Care Policy and Research, Visiting Nurse Service of New York.

³ Hawes C, M Rose, and CD Phillips. 1999. A National Study of Assisted Living for the Frail Elderly: Results of a National Survey of Facilities. (Prepared for the Office of Disability, Aging and Long-Term Care Policy, Assistant Secretary for Planning and Evaluation, and the Public Policy Institute, AARP). Beachwood, OH: The Myers Research Institute, Menorah Park Center for Senior Living.

⁴ Ibid.

⁵ Frytak J, RA Kane, MD Finch, RL Kane, and R Maude-Griffin. In Press. Outcome Trajectories for Assisted Living and Nursing Facility Residents in Oregon. Health Services Research.

⁶ Mollica RL. 1998. State Assisted Living Policy: 1998. Portland, ME: National Academy for State Health Policy.

⁷ Sparer M. 1999. Health Care for Low-Income People in Oregon. Washington, D.C.: The Urban Institute.

⁸ Mollica 2000, op cit.

⁹ Sparer, op cit.

¹⁰ Stark AJ, RL Kane, RA Kane and M Finch. 1995. Effect on Physical Functioning of Care in Adult Foster Homes and Nursing Homes. The Gerontologist 35(5):648-655.

¹¹ Frytak et al., op cit.

¹² Hawes et al.,op cit.

¹³ United States General Accounting Office. 1999. Assisted Living: Quality of Care and Consumer Protection Issues in Four States. Washington, D.C.: U.S. General Accounting Office.

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