

## Number Of Medicaid Waiver Participants Remains Low

Between 1995 and 2002, participation in state Medicaid waiver-funded residential care programs increased almost threefold, to 120,000 individuals, and expenditures more than quadrupled, to \$2.3 billion. Yet researchers say low-income beneficiaries remain under-represented in residential care because state programs vary considerably by target population and by level of care.

Residential care services analyzed for this research included the broadest range of options, including adult foster homes, board and care, and assisted living. Generally, researchers considered residential care to be any non-nursing facility that provides room, board, assistance with activities of daily living, and 24-hour oversight.

"Although many states are increasingly using Medicaid waiver dollars to pay for residential care services, the total number of participants remains relatively small—about 12 percent of the licensed beds that were available in 2002," says lead researcher Martin Kitchener of the University of California, San Francisco. Among the possible explanations for the relatively low percentage of Medicaid residential care services participation, Kitchener says, are lack of funding, low reimbursement levels, and lack of Medicaid coverage for residential care.

In addition, researchers' interviews and policy discussions suggest that providers and developers may not be attracted to Medicaid reimbursement due to the possibility of insufficient payment, frozen payment levels over time, reduced profit margins, concerns about increased regulatory oversight, and higher client-service costs.

In a recent issue of *The Gerontologist*, researchers published their findings in an article titled, "Residential Care Provision in Medicaid Home- and Community-Based Waivers: A National

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## NCAL Adopts Open System For Electing Board Members

Recently adopted changes to NCAL's bylaws opened the field to qualified NCAL members interested in becoming candidates for "at-large" seats on the board of directors and set an organization precedent by holding its first annual election of the board seats at the association's annual convention.

"Changing the board of directors from a regional appointment process to an 'at-large' system is one of the most significant changes to NCAL's governance structure since the inception of NCAL," says NCAL Executive Director Dave Kylo.

The changes occurred in April, when NCAL's board of directors and state leaders unanimously approved a series of bylaw changes. Among those changes was a provision that replaced the regional appointment system with an "at-large" system that would allow any NCAL member in "good standing" to become a candidate for the board. Interested members must apply to become a candidate and undergo a certification process conducted by the American Health Care Association (AHCA)/NCAL Ethics Committee.

Previously, the 14 directors were appointed by AHCA's regional vice chairs. In October 2005, however, AHCA adopted a new governance structure that eliminated the regional vice chairs, thereby nullifying NCAL's board nomination system.

Directors will be elected to two-year terms, except for the 2006/2007 term, when seven of the directors will be elected to a one-year term in order to begin a staggered voting schedule. NCAL had determined that some leadership continuity could be preserved if only seven director

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## CMS Extends Part D Enrollment For Low-Income Beneficiaries

The Centers for Medicare & Medicaid Services has announced that Medicare beneficiaries who qualify after May 15, 2006, for the limited-income subsidy (LIS) available through the Medicare prescription drug program will have a one-time opportunity, using a special enrollment period, to enroll in the Medicare prescription drug benefit if they have not done so already.

Medicare will continue to facilitate enrollment in a drug plan for people who qualify for the LIS if they do not choose a plan on their own. After the May 15 deadline, most Medicare beneficiaries who wish to enroll in a Part D drug plan will have to wait until Nov. 15, which is the beginning of the first annual enrollment period.

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seats became open each year, with seven directors elected during odd years and seven directors elected during even years.

Beginning this year with the 2006/2007 term, NCAL elections for the 14 at-large board positions and the four officer positions—chair, vice chair, treasurer, and secretary—will be held at the 57th AHCA/NCAL/THCA (Texas Health Care Association) Annual Convention & Exposition in San Antonio, Texas, Oct. 8-10, 2006.

A copy of NCAL's revised bylaws is available under the "Governance" section of the NCAL "Members Only" Web site at [www.ncal.org](http://www.ncal.org). NCAL will make applications for the board seats available in July.

## NCAL Builds Coalition: Senators Join Forces To Support Part D Co-Pay Bill

NCAL is building a coalition to support a Senate bill that seeks to eliminate the Medicare prescription drug co-payments for dual-eligible individuals—those eligible for both the Medicare and Medicaid programs—and living in assisted living and residential care (AL/RC) facilities.

NCAL has begun asking more than 40 consumer groups, professional organizations, and related stakeholders to join in supporting passage of the bill, the Home and Community Services Co-payment Equity Act of 2006 (S. 2409).

Support also appears to be building in the U.S. Senate. Four senators have signed on to the bill, which is sponsored by Sen. Gordon Smith (D-Ore.). Smith refiled his bill on March 14 to include two colleagues—Sens. Bill Nelson (D-Fla.) and Hillary Clinton (D-N.Y.)—who previously had co-sponsored similar legislation. Other co-sponsors of S. 2409 are Sens. Jeff Bingaman (D-N.M.) and Blanche Lincoln (D-Ark.). NCAL applauds Sen. Smith and his

colleagues for uniting behind one bill.

The legislation would eliminate Part D co-payments for dual-eligible residents of assisted living and residential care facilities as well as other licensed facilities such as group homes for people with mental retardation and developmental disabilities, psychiatric health facilities, and mental health rehabilitation centers. Dual eligibles receiving services under home- and community-based waivers in a home setting would also be relieved of Part D co-payments under the bill.

"Unfortunately, the original Part D legislation did not eliminate co-payments for dual-eligible residents of AL/RC and other facilities serving nursing facility-eligible people under Medicaid and Medicare," says Dave Kylo, executive director of NCAL. "We will continue to push for support of this important legislation that is so critical to ensuring that low-income residents receive their required medications and maintain their quality of life."

## Trustees Say Medicare, Social Security Insolvency To Arrive Sooner

The Centers for Medicare & Medicaid Services has released its "2006 Medicare Trustees Report."

That report says Medicare expenditures will exceed the program's assets in 2006. With costs expected to rise along with the onslaught of retiring baby boomers after 2010, Medicare will be exhausted by 2018—two years ahead of last year's projection, the report says. Social Security's reserves will begin falling short of its outlays by 2017, and its resources will be exhaust-

ed by 2040—a year earlier than last year's projections. The report calls on officials to consider "taking measured and reasonable action now to reduce Medicare spending growth."

Insurance premiums for Medicare Part B in 2007 are expected to rise to \$98.20 per month, an increase of 11 percent from the 2006 premium rate of \$88.50 per month, the report says. The Medicare Part B premiums are automatically deducted from Social Security checks.



## State Legislatures Address Medicaid In Assisted Living

In order to address the needs of America's growing senior population, assisted living facilities offer a variety of services to satisfy their varied clientele. These range from individual apartments with private kitchens to small studio-style dwellings with common rooms for eating and activities. The shared element is that each is arranged in a community setting that can provide personal services, 24-hour supervision, and assistance with activities of daily living. Yet, no matter the specific arrangement of the facility, assisted living care can be an expensive proposition, particularly for seniors with small or fixed incomes.

For those seniors who cannot afford to pay out-of-pocket, there are state

Medicaid programs. When Medicaid was created in 1965 as a joint federal-state medical assistance program, states were required to comply with strict requirements to receive funds from the federal government. However, as the needs and demographics of various states differ, federal officials developed waiver programs that permit individual states to meet the needs of their Medicaid recipients while containing costs within their Medicaid programs. In short, the term "waiver" is used to describe the statutory authority under which the federal government, through the Centers for Medicare & Medicaid Services, allows states to receive federally matched funds for assistance programs that do not comply with the

original 1965 requirements of the Social Security Act.

Accordingly, not all types of long term care are covered by all state Medicaid programs. Each state is free to determine the level of care provided through public assistance. Over the past decade, the number of states that offer Medicaid coverage for assisted living has more than doubled. In 1996, only 21 states granted public aid for assisted living; currently, 43 states (*see map on page 5*) provide some degree of Medicaid funding for residential care, assisted living, or licensed board-and-care facilities.

Although the number of states offering assisted living coverage

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through Medicaid has more than doubled in the past decade, the 2006 state legislative sessions have not produced a sizeable number of new initiatives. This year, the focus has been on home- and community-based services. However, Maryland, New York, Ohio, and Washington are among the states that have proposed or enacted changes to their existing Medicaid waiver programs since January 2006.

## Maryland

Maryland lawmakers have introduced House Bill 1633, requiring the state secretary of aging to regulate the amount of subsidies necessary to provide adequate financial aid for low-income elderly individuals who seek residence in state assisted living facilities.

Under the current statute, subsidies for assisted living care are required to meet the gap between income and cost of care to a maximum of \$650 per month.

The measure is currently awaiting the governor's signature, and if it is passed, the new law will take effect Oct. 1, 2006. According to Sheila Mackertich of the Health Facilities Association of Maryland (HFAM), this bill was not a primary focus for HFAM this year because it only increased the flexibility of the subsidy amounts.

Several measures relating to other pivotal assisted living issues, particularly the licensure process, uniform disclosure, and emergency preparedness and disaster planning, gleaned more HFAM interest during the 2006 legislative

session.

## New York

The New York Department of Health has requested a CMS waiver to establish a pilot program under which Medicaid-eligible nursing facility residents may apply to receive care at home, in adult day programs, or in assisted living facilities.

The pilot is an effort to curb soaring Medicaid expenditures on long term care, and, if approved, up to 5,000 seniors would be shifted out of nursing

According to Lauri St. Ours of the Washington Health Care Association /Washington Center for Assisted Living (WHCA/WCAL), this legislation was drafted by WHCA/WCAL as a means of restoring payments for facilities with a high number of Medicaid residents. She explained that the original capital add-on rate was implemented in 1999 to encourage assisted living providers to construct facilities in accordance with the state Department of Social and Health Services' stringent building standards. However, this \$4.87 per-day add-

on to cover building expenses was eliminated for most facilities in 2002, after a state budget deficit necessitated funding cuts to certain programs.

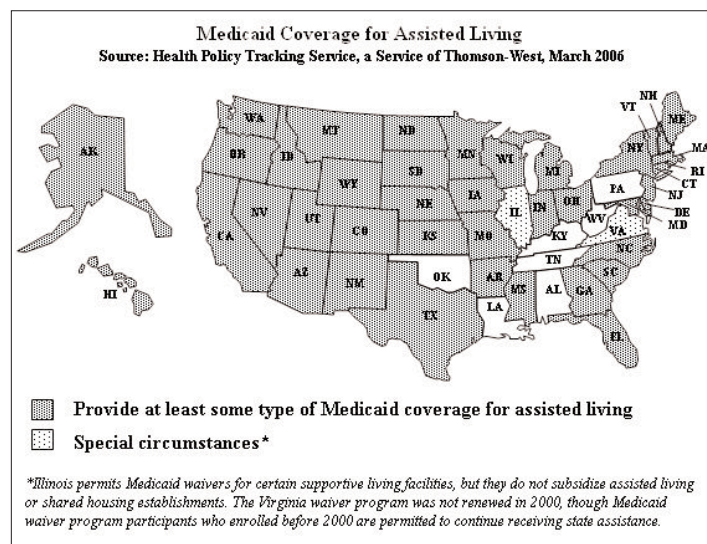
The new law, adopted March 27, restores the add-on rate for facilities with sizeable Medicaid populations. It also adds another \$1.6 million in assisted living Medicaid reimbursement for 2006.

"The expenses related to

building to the higher standards don't go away just because the state doesn't pay the capital add-on rate," says Jonathan Eames, WHCA/WCAL executive director. "WHCA/WCAL will fight to continue to increase the number of facilities receiving the capital add-on rate in the 2007 legislative session."

The Washington state legislature also adopted a second bill (S.B. 6373) that requires adult residential care services, enhanced adult residential care services, or assisted living facilities to continue the current policy of holding the beds

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facilities over a three-year period. The program is likely to commence summer 2006, contingent upon CMS approval.

## Washington

Legislators in Washington adopted two measures affecting assisted living facilities during the 2006 Legislative Session. The first, House Bill 2925, establishes a "capital add-on" rate for those assisted living facilities contracting with the Department of Social and Health Services that have a Medicaid occupancy rate of 60 percent or greater.



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of Medicaid residents in the event that eligible residents require short-term care in a nursing facility or hospital. In essence, the initiative removes the July 2006 date of expiration for the current policy of Medicaid bed-holds in assisted living or other residential care facilities.

“WHCA/WCAL’s priority for the [Medicaid bed hold] policy has been to ensure that resources are directed to actual need and are based on actual use. Passage of this legislation maintains the current policy to pay for holding a bed based on actual use,” says St. Ours.

### Ohio

With the passage of Ohio’s 2005-2006 biennial state budget, the Ohio General Assembly adopted Gov. Bob Taft’s (R) proposal for the creation of a Medicaid-funded assisted living waiver to

serve 1,800 low-income seniors. The waiver application was submitted to CMS on Jan. 6, 2006, and gained approval on March 31, 2006, with implementation slated to begin July 1. Enrollment is limited to two Medicaid-eligible groups: nursing facility residents wishing to relocate to assisted living and existing Medicaid waiver consumers (who include PASSPORT, Ohio Homes Care, or Choices participants) who are discontinuing enrollment from their current waiver program and would otherwise permanently enter a nursing facility. Assisted living providers must first be licensed as residential care facilities and then agree to the certification requirements set forth by the Ohio Department of Aging (ODA) to participate. In addition, providers must agree to accept a maximum room-and-board rate, paid by the consumer, of \$553 a

month, with no family supplementation permitted, and a service payment of either \$49.98 a day (Tier 1), \$60.00 a day (Tier 2), or \$69.98 a day (Tier 3). Movement between the service tiers is predominately triggered by nursing services and medication administration. Since December 2005, ODA has been meeting with key stakeholders, including representatives from the Ohio Centers for Assisted

Living (OCAL), to develop criteria for the new assisted living waiver. Providers remain concerned that some of the criteria, such as the need for private bathrooms as set forth by CMS, may significantly limit provider participation throughout Ohio, says Diane Dietz, Ohio Health Care Association (OHCA)/OCAL vice president, member services. She said the issues yet to be determined center around security deposits, hold days, level-of-care and discharge triggers, which collectively keep the assisted living provider community in Ohio cautiously optimistic about the success of this new program.

“OCAL remains committed to working with the Ohio Department of Aging to resolve any and all implementation issues that would hinder provider acceptance of this program,” she said.

### Conclusion

Since roughly half of all states have completed their 2006 general sessions or are out of session this year, it is unlikely that lawmakers will adopt many more initiatives pertaining to Medicaid coverage for assisted living in 2006. However, as officials consider their budgetary needs for the coming fiscal year, the assisted living industry may see a resurgence of waiver legislation. There is also a strong likelihood that states will turn to modified Medicaid waiver programs in an effort to reduce the expense of providing care to seniors, while encouraging more affordable assisted living and community care environments.

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### 2006 Congressional Briefing

NCAL encourages members to register for the 2006 Congressional Briefing June 27-28, at the Marriott Crystal Gateway in Arlington, Va. While online registration closed on May 6, registration will occur onsite.

At this year’s conference, NCAL members will lobby their representatives about Medicare Part D issues.

AHCA/NCAL has established a method of identifying legislators and setting up appointments. Go to the Families 4 Care Web site at <http://longtermcareliving.com/act/> and type in your home ZIP code. After you have sent an e-mail or called your representatives office requesting a meeting, AHCA/NCAL asks that you send an e-mail to [congressionalbriefing@ahca.org](mailto:congressionalbriefing@ahca.org).

NCAL will prepare materials, including talking points, for your visit and arrange for an AHCA/NCAL lobbyist to accompany you if you like. For those registering onsite, print out a copy of the registration form and bring it with you when you register on June 24. Hotel reservations received after June 6 will be subject to availability.



## Proof Of Identity, Citizenship Required Under DRA

**M**edicaid recipients will be asked to produce documented proof of both citizenship and identity under a provision of last year's Deficit Reduction Act (DRA), which makes such documentation a requirement for states to receive federal matching funds.

Guidance from the Centers for Medicare & Medicaid Services (CMS) to state Medicaid directors describes the form that documentation must take to comply with the new requirement, which takes effect July 1.

The following are acceptable proof of both citizenship and identity: a U.S. passport, certificate of Naturalization, certificate of U.S. citizenship, or driver's license in states that require proof of citizenship before issuing. Various types of birth records are acceptable forms of citizenship verification, but not of identity. State-issued identity cards and other documents deemed acceptable by the state might be used to verify identity.

According to survey results from the Center on Budget and Policy Priorities (CBPP), the measure jeopardizes benefits for 3.2 million to 4.6 million U.S. citizens "because they do not have a passport or birth certificate readily available." The DRA requirements apply to both current Medicaid recipients, who will have to produce documentation to maintain eligibility, and new applicants seeking benefits for the first time, CBPP says.

Based on a telephone survey of 2,026 adults, conducted by Opinion Research Corp. in January, CBPP found that senior citizens, African American adults, adults in rural areas, and adults without a high school diploma were at

greater risk of losing benefits than other populations because they were less likely to have required documentation.

CBPP warned, however, that the results were conservative. Populations at an even higher risk, including nursing facility patients, Katrina survivors in temporary housing, and homeless people, were not represented in the survey. Had they been included, the percentage of individuals who may lose benefits would be even higher, the organization said in its report on survey findings.

The American Health Care Association (AHCA) and NCAL have

contacted CMS about the difficulties that long term care beneficiaries will experience in trying to obtain documentation, and the agency is working on the problem.

"We have made clear that documentation simply is not available in many cases," said an April 27 AHCA/NCAL summary and analysis of the issue from Janice Zalen, senior director of special programs. CMS is "working with the Office of General Counsel to develop policy guidance" to states, the memo said. The agency "has the authority to add alternative documentation," AHCA/NCAL said.

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Study of Program Trends." They performed the first-ever analysis of the Centers for Medicare & Medicaid Services' (CMS') data for each state waiver program from 1995 to 2002—the latest data available. According to their findings, three policy concerns were raised:

- 1.) Medicaid-supported residents remain underrepresented in residential care compared to the supply of licensed residential care.
- 2.) Large interstate variation persists in Medicaid residential care service provision.
- 3.) State policy choices favor Medicaid spending on residential care for persons with mental retardation or developmental disabilities.

In 2002, 60,174 people were covered under aged or disabled waiver programs. Medicaid paid \$8,925 per recipient for a total of \$537 million, or 23 percent, of all waiver expenditures for residential care services.

In 2002, there were 58,099 people participating under mental retardation and developmental disability (MR/DD) waiver programs, at an average cost of \$30,136 per participant. Seventy-six percent, or \$1.75 billion of \$2.3 billion in waiver expenditures was spent on MR/DD program participants. The higher costs could be attributed to higher levels of care requiring more staff, according to the study.

Thirty-eight states offered 65 different waiver programs, with 30 states providing Medicaid reimbursement for residential care programs for seniors or people with disabilities, while only 15 states targeted waiver programs for MR/DD participants.

"We have been examining Medicaid waiver trends across states for more than a decade, partly to provide policy makers and advocates with the information they might need to see how their programs stack up with other states," said Kitchener. "Looking at participation and expenditure trends can help identify opportunities for improving [state] policies and programs, while also identifying other states that may have valuable lessons to teach."



**Tom Kelly** has been named president of Florida Center for Assisted Living. He will be responsible for relaunching the organization that represents Florida's assisted living providers and is associated with the Florida Health Care Association. Kelly was president of the Florida Health Care Association from 1994 to 1996.

Lloyd Ganton Retirement Centers, a Spring Arbor, Mich. based company, has appointed **Paul Buchholz** as the company's chief financial officer. Buchholz has been an employee of the company for the past 11 years. He is the administrator of Summit Park Assisted Living in Jackson, Mich. and Spring Arbor Assisted Living and Alzheimer's Center in Spring Arbor.

Los Angeles-based LifeHouse Retirement Properties (LHRP) board of directors named **Lou Andriotti** the company's chief operating officer

(COO). Andriotti has been with LifeHouse since Sept. 2004 managing the company's facilities. Prior to being named COO, Andriotti was president of LifeHouse Management Services, a wholly owned subsidiary of LifeHouse Retirement Properties. The LHRP board also appointed **Tracy Clark** to become chief financial officer (CFO). **David Todd**, one of LHRP's founders and the company's former CFO, will continue as a director and secretary/treasurer, focusing on new business development.

Ventas, Louisville, Ken., has promoted CFO **Richard Schwinhart** and Chief Investment Officer **Raymond Lewis** to executive vice presidents, elevating them both from their senior vice president titles. Schwinhart joined the company in May 2002 and became the CFO in December 2002. Lewis joined Ventas in October 2002.

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**Editor:** Lisa Gelhaus

**Advertising Sales/ Production**

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Your suggestions and feedback about NCAL FOCUS are welcome. Contact Lisa Gelhaus by e-mail (lgelhaus@ncal.org), by phone (202-898-2825), or by writing to the address above.

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NCAL Focus  
1201 L Street, NW  
Washington, DC 20005

