MISSION DRIVEN

Providers Test Medicaid Waters

KATHLEEN LOURDE

The popularity of assisted living as an alternative to nursing facility care is undiminished, but for many elderly Americans with low incomes, assisted living isn't an option they can afford. Demand is large: The Centers for Excellence in Assisted Living (CEAL), a broad-based coalition of assisted living stakeholders, estimates that 63,000 affordable assisted living units will be needed within the next decade.

Unfortunately, Medicaid, which pays for the health care of many low-income elderly people, in most cases isn't helping. Across the country, Medicaid reimbursement doesn't cover the full cost of providing services, say providers and other experts. Some assisted living providers don't take Medicaid residents at all for that reason, and many of those that do can only afford to take a few, mostly those who moved in as a private-pay residents and spent down their assets.

While Medicaid covers room and board for nursing facility patients, it doesn't do the same for assisted living residents. These residents typically try to pay for room and board out of their Supplemental Security Income (SSI) check, which is only $637 a month in 2008—far less than the cost of room and board in the vast majority of assisted living facilities (ALFs).

A few dedicated professionals are finding ways to develop ALFs that low-income elderly can afford. But it's a complicated and risky undertaking, requiring creative financing arrangements involving numerous sources and negotiating conflicting requirements from public funding agencies.

Affordable assisted living can be a tricky and risky endeavor.

Medicaid AL Usage Declining

Assisted living is still growing. In fact, the number of state-licensed assisted

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living facilities grew 6 percent between 2004 and 2007, according to the "Residential Care and Assisted Living Compendium: 2007," by Robert Mollica and Kristin Sims-Kastelein, National Academy for State Health Policy; and Janet O'Keeffe, RTI International, and published by the U.S. Department of Health and Human Services (HHS).

And it has become an established residential care option across the country: Forty-three states and the District of Columbia now have a licensing category or statute that uses the term "assisted living," according to the compendium. At the same time, the number of nursing facilities is declining, according to a paper by the National Association of State Units on Aging.

The number of home- and community-based waivers is growing, says Suzy Bosstick, assisted living expert for the Centers for Medicare & Medicaid Services' (CMS') Disabled & Elderly Health Programs Group. In fact, more than 40 states currently provide funding for assisted living settings through their Medicaid or other public programs, although these programs are generally limited in size and often have substantial waiting lists, wrote Robert Jenkens, director of The Coming Home Program of NCB Capital Impact and a board member of CEAL.

But despite these trends and the fact that about 1 million Americans now make their homes in ALFs, according to the HHS compendium, low-income elderly individuals' access to the popular care setting is becoming more limited: The number of Medicaid residents in ALFs is actually shrinking—down from 121,000 in 2004 to 115,000 in 2007, according to the HHS compendium.

"That decline shows us that something's going wrong with our public policies," says David Kyllo, executive director of the National Center for Assisted Living (NCAL). Although most of that decline was in two states, "the fact that [the number of Medicaid residents in assisted living] didn't grow at a time when assisted living facilities were growing by 6 percent is troubling," Kyllo says. "That growth, coupled with the movement to deinstitutionalize people, everyone would have expected that the number of Medicaid residents in assisted living would have increased, not decreased overall."

"The reported drop in Medicaid coverage is cause for concern, as there already was a large unmet demand for affordable assisted living options for low-income frail elderly Americans," wrote Karl Polzer, senior policy director for NCAL, in a paper for CEAL, which has established a task force focusing on affordable assisted living.

"While no one can be sure why this decrease occurred, several systemic issues concerning Medicaid policy and reimbursement may be contributing factors. Medicaid home- and community-based funding does not cover the cost of housing, utilities, and food in assisted living settings, and Medicaid reimbursement rates set by many states are not adequate to cover the cost of care," he said.

Medicaid Rate-Setting Methods

States use five primary approaches to set rates for Medicaid services provided in residential care settings:

- Flat rates;
- Flat rates that vary by type of setting;
- Tiered rates;
- Case-mix rates; and
- Cost-based reimbursement and fee-for-service

Medicaid Long Term Care Spending

(in billions)

	1996		2006	
Service	**Spending**	**Percent**	**Spending**	**Percent**
Home health	$2.1	1.4%	$3.6	1.2%
Personal care state plan	$2.9	1.9%	$9.3	3.1%
HCBS waiver	$6.2	4.0%	$25.6	8.6%
ICF-MR	$9.7	6.3%	$12.5	4.2%
Nursing facility	$31.8	20.6%	$47.7	16%
Total long term care	**$51.8**	**33.6%**	**$99.3**	**33.2%**
Total Medicaid	**$154.2**		**$298.7**	

Source: "Residential Care and Assisted Living Compendium: 2007," by Robert Mollica and Kristin Sims-Kastelein, National Academy for State Health Policy, and Janet O'Keeffe, RTI International, published by the U.S. Department of Health and Human Services

Trend Toward HCBS Continues

Despite the shrinking number of Medicaid residents in assisted living, there's a clearly defined trend among states to provide care in home- and community-based settings rather than in nursing facilities. The less-restrictive settings tend to also be less expensive, lawmakers contend. Still, is the trend bypassing assisted living?

"CMS has been quite active in encouraging states to provide non-institutional care," says Bosstick. "We've been issuing waivers and the authority to add home-based services to state plans. We've certainly seen an increase in the number of waivers that are interested in providing services to people in assisted living, and I think that parallels the growth of the assisted

living industry." Still, the recent Money Follows the Person and Cash and Counseling programs do seem to bypass assisted living by making it difficult for beneficiaries in the programs to use their funds for assisted living.

"There are some who believe that assisted living is institutional and not a home- and community-based alternative," says Kyllo. "We couldn't disagree more. Assisted living is a community-based alternative. It is people's homes, and it's important for policy makers to understand that."

Don Redfoot, strategic policy advisor in AARP's Public Policy Institute, an internal think-tank, agrees that assisted living should be covered under home- and community-based services (HCBS) Medicaid waivers.

"Part of [AARP's] focus is trying to give consumers genuine choices and options for services in the settings they choose. In general, people want to stay put in their own homes if at all possible, but if not possible, they generally prefer assisted living to skilled nursing facilities." AARP wants to move in the direction of HCBS, he says. "In that mix would be assisted living."

AARP isn't alone in its desire to see more care provided in homes and communities, says Redfoot. "One of the promising things emerging over the past several years is a remarkable degree of political consensus about what direction we should go in with emphasizing more consumer control" and HCBS, he says. This "resonates across the political spectrum from very conservative Republicans to liberal Democrats, [although the] rhetoric is different on each side and there are a lot of differences over the specifics."

The trend is causing problems in some states. For example, Vermont delicensed about 400 nursing facility beds in the past few years, "and the goal is to de-license another 400 beds and not to spend Medicaid dollars in an institutional setting," says Nancy Eldridge, administrator of Cathedral Square Assisted Living, Burlington, Vt.

"But what's happening is that when we do have a person in our assisted living facility who really shouldn't be there," it's hard to find a nursing facility bed for them, she says. "We have someone with a score of 22 activities of daily living [ADLs] who needs a Hoyer lift to get into bed and to go to the bathroom, and the concrete construction doesn't allow us to put a lift in close enough to the bathroom," says Eldridge.

LENDERS DON'T LIKE *to invest money in a project whose revenue stream is poor and subject to cuts.*

Vermont's policy is that if a Medicaid recipient approaches a nursing facility they are to receive options counseling and be redirected back into the community.

"That's a great goal, but they need to then make the reimbursement suitable so that we can take really good care of these people, which we can't under current rates," says Eldridge. "I think this is going to be a huge issue for the country as [states] face deficits and are forced to seek out the lower-cost settings." But simply transferring Medicaid nursing facility residents to assisted living facilities isn't always an option, because since Medicaid doesn't cover room and board, many low-income seniors can't afford to live there.

Affordable Assisted Living

Affordable assisted living is in scarce supply for numerous reasons, predominantly inadequate Medicaid reimbursement, high acuity levels of Medicaid residents, and numerous barriers to financing and developing an affordable assisted living project.

It's a two-part problem—housing and services—and each side carries its own difficulties and barriers.

On the services side the biggest problem is inadequate Medicaid reimbursement. On the housing side the biggest problem is finding financing for a development that's going to be dependent on inadequate reimbursement. Lenders don't like to invest money in a project whose revenue stream is poor and subject to state budget cuts.

"Making assisted living affordable to low-income persons requires reducing the monthly expenses, including the costs of the housing (in the form of rent) and the cost of the services (in the form of personnel)," according to a white paper on the topic published by CEAL.

CEAL's board has identified affordable assisted living as a key area and has established a committee on affordability. "We're looking at the whole range of things and saying, 'How can you make this both high quality—we do not want to defeat the assisted living philosophy of more residential settings and having the kind of amenities that make it a good place to live in"—and affordable, says Redfoot, who is chair of the task force and a former chair of CEAL.

"The question is how do we provide a dependable stream of finance that provides an array of choices for every-

one from some kind of mix of public, private, and individual [resources]," he says. "How do we [put] a delivery system out there that provides [individuals] a much broader array of choices and gives people more control over those choices?"

Nationally, the average annual cost of assisted living is $36,090, according to a new study by Genworth Financial, Richmond, Va. Yet 65 percent of Americans aged 75 years and older have incomes under $25,000. Over half of all households headed by a person aged 85 or older reported annual income of less than $10,000.

Many private-pay assisted living residents must spend down their assets in order to live in assisted living. According to the "2006 Overview of Assisted Living," published by five industry groups, the median income of assisted living residents was $15,686, while median assets, including home, was about $250,000.

So how can these individuals afford assisted living?

CEAL, according to its white paper, "Making Quality Assisted Living an Affordable Community-Based Care Option: Identifying Roles, Risks, and Recommendations for Medicaid and Other Public Subsidies," defines an affordable assisted living project as one in which 25 percent or more of the residents are receiving Medicaid.

Most providers have to subsidize the Medicaid residents through having a majority of market-rate apartments.

Making assisted living affordable to low-income residents may require putting together a package of subsidies—such as Section 8 housing assistance to cover rent and becoming a food stamp vendor to cover food, if the facility is eligible—along with finding creditors willing to invest in a potentially risky project.

Barriers To Affordable Properties

Along with all the usual difficulties in developing and operating a long term care facility, such as the nurse and personal care attendant shortage, affordable assisted living faces some unique challenges. These include a heavy reliance on inadequate Medicaid reimbursement, scarcity of funders willing to extend low-cost capital for the housing component, and lack of experience putting together a complicated package of subsidies and debt that makes affordable assisted living possible.

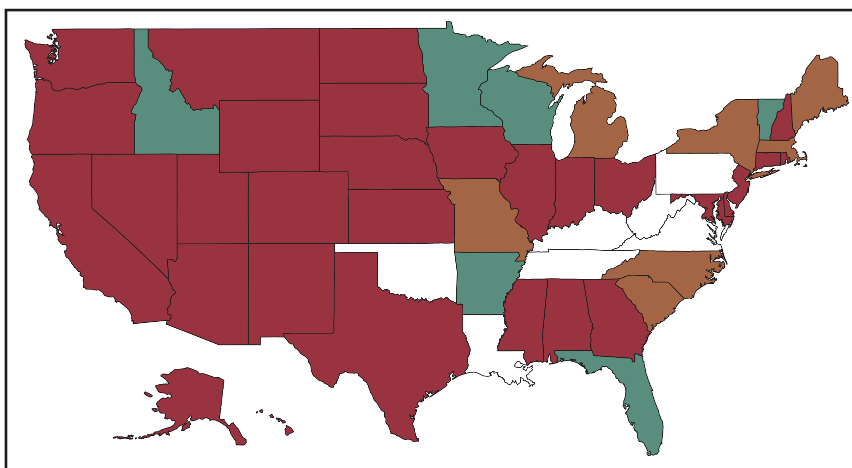
Further, developers must negotiate conflicts between housing subsidies and licensing requirements, such as the low-income housing tax credit program's prohibitions against frequent or continual nursing services.

Putting together an affordable assisted living project requires a lot of moving parts to make it happen, says Mauro Hernandez, chief executive officer of Concepts in Community Living (CCL), Clackamas, Ore. "The two major ones are dealing with the shelter portion, keeping that price down through such means as donated properties, and the service side in terms of keeping operating costs low."

Despite all the challenges, providers are out there with a mission to provide assisted living care for low-income residents.

"On the services side, the obvious challenge is how to provide services without compromising quality," says Hernandez. "You can only lower costs so much." It's important to look beyond Medicaid to find subsidies for services among private sources, "collaborating with a nonprofit to subsidize the shortfall between what the

STATES USING MEDICAID TO COVER SERVICES IN RESIDENTIAL CARE FACILITIES



Waiver only (29): Alaska Arizona California Colorado Connecticut Delaware Georgia Hawaii Illinois Indiana Iowa Kansas Maryland Mississippi Montana Nebraska Nevada New Hampshire New Jersey New Mexico North Dakota Ohio Oregon Rhode Island South Dakota Texas Utah Washington Wyoming

State plan only (7): Maine Massachusetts Michigan Missouri New York North Carolina South Carolina

Waiver and state plan (6): Arkansas Florida Idaho Minnesota Vermont Wisconsin

Source: "Residential Care and Assisted Living Compendium: 2007," by Robert Mollica and Kristin Sims-Kastelein, National Academy for State Health Policy, and Janet O'Keeffe, RTI International, published by the U.S. Department of Health and Human Services

resident can afford and what it actually costs to live there," he says.

"Having services provided by a home care agency reduced personnel costs to American House, which has 29 affordable independent living facilities in southeastern Michigan.

"But because Medicaid is the payer for assisted living services for low-income seniors, it's impossible to get around the fact of inadequate reimbursement rates."

Understanding affordable assisted living requires understanding certain things about Medicaid.

SOME STATES ARE VERY *experienced in using Medicaid funding for assisted living, while others have only just begun the process.*

Medicaid 101

Some states, such as Colorado, Oregon, and Washington, are very experienced in using Medicaid funding for assisted living, while others have only begun to figure out how to provide Medicaid reimbursement for assisted living, according to "Coming Home: Affordable Assisted Living," published by the Robert Woods Johnson Foundation (RWJF).

States can use Medicaid to fund assisted living care in several ways: through the Medicaid state plan, HCBS waivers (also called 1915[c] waivers), and Section 1115 demonstration programs, according to the HHS compendium. States usually use the HCBS waiver.

Most waiver programs operate on a specific appropriation based on a limited number of "slots." So even if a state has an HCBS waiver that covers assisted living care, the number of individuals able to take advantage of it may be small compared to the demand—hence the long waiting lists in so many states. Some states, however, have found ways to appropriate funds to provide more of their citizens with HBCS, including in assisted living facilities.

Because waiver services are not an entitlement, they are often on the chopping block when a state is facing a deficit. "In the event of a budget deficit, non-entitlement services are the most vulnerable to budget cuts," according to the compendium. And 23 states, along with Puerto Rico, are expected to run a collective $26 billion in deficits in fiscal year 2009, according to a new report.

Referring to the HHS study, Kyllo notes that while the number of people in assisted living covered by Medicaid has declined, "during the same period the amount of money the government is spending on HCBS has increased every year, so it's not being spent on assisted living." Reasons why fewer Medicaid beneficiaries are being served in assisted living include that reimbursement rates in many states have remained constant for years, so few providers can afford to care for them.

"What's happening is because the rates have not increased for services over the years, [providers] are saying 'we cannot do this,'" says Kyllo. "Assisted living providers as a whole may not want to be large in the Medicaid arena, but many do want to be able to help those residents that have spent down to remain in the community, so they would like to be able to participate from that perspective.

"When you see the dollar amount some of these states are paying, it's laughable what they're paying to deliver services to a human being," he says.

"When states don't pay adequate Medicaid rates, it is in effect putting a hidden tax on the private-pay residents, whose rates will inevitably have to be raised to help subsidize Medicaid residents," says Polzer. "In fact, the higher private-pay rates may squeeze out middle-income potential clients with modest incomes and may cause residents to spend down their assests to Medicaid sooner."

Inadequate Medicaid reimbursement rates compound the problem of rising costs of providing assisted living services. "The cost of energy has driven up utility costs," notes Redfoot. "High food costs are driving up operating costs. Worker shortages are driving up wages." Liability insurance rates are also on the increase.

"With rising costs, providers have to constantly determine if they can keep [Medicaid] residents," says Kathy Fiery, director, Division of Assisted Living/Alternative Care for the Health Care Association of New Jersey. "We're hopeful that Medicaid is getting more realistic. None of us can survive on a rate freeze."

Waiver Residents' Higher Acuity

Another thing facilities have to consider when determining whether to accept Medicaid is that Medicaid residents tend to have higher acuity and are more challenging and costly to care for than the average resident.

"When somebody goes on the Medicaid waiver, they are nursing home-eligible; they have a number of ADLs. These are not light-care patients. These are costlier residents," says Eldridge. "There are only seven assisted living residences in all of the state of Vermont, and the reason for that is Vermont's regulations for assisted living set the bar very high in terms

of the discharge requirements. Vermont's goal was to create an alternative to the full-blown nursing home. So they said to assisted living residences, 'You can't discharge a resident until they reach a score of 10 ADLs.' That's a very high acuity level."

That's a great comfort to residents looking to age in place, "but it's risky, particularly if you're offering Medicaid assisted living, because the reimbursement rates don't cover costs," says Eldridge. "So you have to be willing to [raise funds] and do anything to make the numbers work."

Hernandez has some advice for providers considering taking on Medicaid residents.

"If you haven't worked with Medicaid residents before, [there are] some things to keep in mind," says Hernandez. "Be prepared for serving people with higher service needs, if you're in a state that has a Medicaid waiver." To qualify the resident has to qualify for the state's nursing facility level of care, "so if you're doing assisted living lite, and you're wanting to do assisted living for people with Medicaid, you're going to have to relook at service capacity."

Another thing Hernandez recommends is being prepared to look at how to manage case mix and spend down. In most states a provider can control how many Medicaid clients the facility can financially maintain, "keeping in mind that some private-pay clients will run out of money and spend down to Medicaid," he notes. "You have to ask questions in terms of people's assets and be a little more proactive in talking and thinking about whether this person will spend down in the next six months."

Third, Medicaid residents come with case managers who are gatekeepers to providing services like transportation or supplies that the facility isn't able to provide. This person must be notified of changes in condition and is ultimately another client who must be pleased.

But managing issues surrounding services is only half of the equation. Possibly the more complicated portion is the housing side.

The Housing Issue

"The big expense is obviously the building, and that is getting more and more expensive," says Michael DeShane, president of Concepts in Community Living. And the costs are going up. When CCL was building its first affordable assisted living facilities a decade or so ago, construction costs "were $55 and $60 per square foot," says DeShane. "We're working in Louisiana now and paying $160 per square foot."

"It's hard to find financial support

for the real estate portion of affordable assisted living projects," according to CEAL's white paper. The reason is the uncertainty surrounding Medicaid rates.

Construction financing is generally for 10 to 15 years—and longer, if one can get it—"but on the Medicaid financing side you can only get at most a one-year commitment," says Redfoot, because states generally make their funding decisions about Medicaid for only one year.

"It's hard to go to your lender and say give me a 15-year commitment but I only have a one-year commitment on [Medicaid] financing," he says. "Medicaid isn't a guaranteed funding stream as it is with skilled nursing facilities."

Affordable assisted living developments often require three to five equity sources, "and this complexity, combined with the limited number of sources that provide such equity, increases the difficulty," writes CEAL.

Most Common Funding Sources

Although developers have used a wide array of financing vehicles, the most common, according to RWJF and other sources, are some combination of the following:

■ *Sponsor equity.* Any ability to lower the amount of debt financing through the developer putting in money of its own will lower the cost of operating the facility and make the units more affordable for low-income seniors.

■ *Low-income housing tax credits.* These federal credits are allocated by the state to housing projects. They are the most common source of equity for affordable assisted living projects and tend to account for half or more of development costs. They're packaged by the housing project's developer or sponsor and sold. The purchasers, usually corporations or financial intermediaries, receive tax benefits. "There is no other form of financing, save an outright grant, that can have as significant an effect on decreasing the ongoing operating costs of a facility as the raising of equity funds through the sale of tax credits," writes RWJF.

Unfortunately, developers can't sell tax credits for the same prices as before the housing bust. Investors "were paying people 115 percent, but with the [housing crisis] they're paying less: as low as 80 percent," says DeShane. "So they'll get a $100 tax credit and only pay $80. I hope this is a temporary condition."

■ *HOME Investment Partnership Program.* The HOME program provides funding for affordable housing, often in the form of grants, forgivable loans, or low-interest loans.

■ *Community development block grants.* Every year, the U.S. Department of

Housing and Urban Development (HUD) allocates money to municipalities. Getting access to this money is very competitive, according to RWJF.

■ *Foundation grants.* Some regional and local foundations may make a capital grant for local projects.

■ *Tax-exempt bonds.* Nonprofits may issue bonds to raise money for development or renovations. The interest rate and amortization are better than taxable alternatives, according to RWJF.

■ *U.S. Department of Agriculture (USDA)-Rural Housing Community Facilities Loan Program.* This program provides direct loans at 4.5 percent (maximum 40 years amortization), is available to communities with populations of less than 20,000, and can be used to construct or improve facilities for health care and public services.

■ *Affordable Housing Program.* This is a private banking effort to assist in the creation of affordable housing that is run by the Federal Home Loan Bank through member banks in regions around the country.

Experience Makes It Easier

Although most sources report that putting together a financing package to fund an affordable assisted living development is complicated and difficult, Eldridge says Cathedral Square didn't have trouble getting financing. The nonprofit is well-versed in finding needed money. "We have a whole bunch of funding sources we used," she says. In addition to a HUD Assisted Living Conversion Program grant, Cathedral Square obtained about $700,000 from Vermont's trust fund for housing. "We also went to the City of Burlington and received some community development funds and city trust funds," she says. "We had nine funding sources, and then we had to put some of our own savings into it to fill the gap."

Other funding sources included a Community Development Block Grant, HOME funds, and the Vermont Housing Conservation Board. All sources together raised $3.9 million. Total capital costs for the project were $3.1 million, with the balance in soft costs and relocation of existing residents.

Cathedral Square developed the first assisted living facility in Vermont "so there was a really good strong spirit of trying to make it work from the state [which had yet to develop regulations] and from the funders," she says.

THE COST OF MEALS AND *other services such as transportation is slightly over $600 a month.*

"I do think that lenders are going to be a little more cautious now that they've seen how tricky it can be—not from a quality perspective, because it's far surpassed our goals in terms of the high acuity levels we were able to take care of—but I do think lenders are thinking, 'How do we underwrite this thing where we can see the gaps between service cost and [reimbursement]?'" she says.

An underwriter on CEAL's panel of affordable assisted living experts said that lenders have to try to calculate the certainty of repayment of a loan, "and lenders have not been able to assess the capacity of affordable assisted living operators to run a financially secure facility over time."

Keep Affordable Unit Levels Modest

Along with arranging financing, providers interested in providing affordable assisted living need to think about how many affordable units they can afford to provide.

About 40 percent of CCL's units, on average, are for low-income residents, but that percentage is skewed a little due to CCL's single 100 percent affordable assisted living development. "Most others we try to keep at under 30 percent," says DeShane.

"I think people trying to do affordable are trying to keep it around 25 to 30 percent," says Hernandez. "When you get up higher than that it just gets a little risky in terms of if Medicaid reimbursement rates don't increase with the operating costs."

The Coming Home program found that it wasn't feasible to shoot for 100 percent affordable assisted living developments, although that had been its initial goal. The program revised its definition of affordable assisted living to be a facility that has at least 25 percent of its units set aside for low-income seniors.

"In the Medicaid home- and community-based waiver we have an explicit statutory exclusion that doesn't allow us to pay for room and board," says Bosstick.

To make assisted living affordable for low-income seniors, providers have to get creative in finding subsidies for rent and food.

Room and board comprise real estate costs (debt service, maintenance, utilities, and taxes) and food, according to the HHS compendium. The cost of preparing, serving, and cleaning up after meals can be covered as a waiver service.

To help Medicaid residents with

room and board in affordable assisted living, states can do a number of things. They can limit the facility's room-and-board charge to the federal SSI benefit, minus a small personal needs allowance. Some states supplement the SSI payment and limit the amount that can be charged to the combined amount. States can provide housing subsidies, allow family supplementation, and use the federal Food Stamp Program. States can also examine facilities' monthly room-and-board charges to identify any services, such as laundry assistance, light housekeeping, or food preparation, that Medicaid can reimburse.

USDA regulations allow meals provided in group living arrangements—defined as residential care settings that serve no more than 16 residents—to be supported by food stamps. Facilities that qualify can receive food stamps from beneficiaries and use them as payment toward meal costs.

For larger facilities, trying to find a subsidy for food costs can be frustrating. The cost of meals and other services like transportation is slightly over $600 a month per resident for Cathedral Square, "but residents on SSI don't have that much left in their wallets, so we just take what they can afford to pay us," says Eldridge. "It makes affordable assisted living difficult. We thought maybe we could get food stamps and that didn't work; tried for a community meal subsidy and that didn't work. But now we're talking about trying to fix this for any affordable assisted living residence in the country."

RESIDENTS ON SSI DON'T HAVE *much left in their wallets, so we just take what they can afford to pay us. It makes affordable assisted living difficult.*

Regulatory Environment

Some assisted living providers are concerned that accepting Medicaid payments will result in additional regulatory requirements that will have the effect of turning assisted living facilities into something more closely resembling a nursing facility.

"The HHS Office of Inspector General 2008 Work Plan is looking at HHS oversight for the Medicaid program for assisted living, so the feds are paying attention to the whole issue," says NCAL's Kyllo. The work plan includes reviews of payment for and oversight of Medicaid services in ALFs, according to NCAL. The work plan notes that states are required to provide safeguards to protect Medicaid recipients' health and welfare.

In 2007, the pace of regulatory change quickened across the country, according to NCAL's "Assisted Living State Regulatory Review 2008." More than 20 states made statutory or regulatory changes affecting assisted living. Several states plan to make major regulatory changes in 2008.

The trend toward directing people to ALFs rather than skilled nursing facilities "leads many to speculate that the federal government will become increasingly involved in setting minimum standards of care in residences electing to participate in the federal-state Medicaid program," according to the Administration on Aging.

A first step toward standardized quality assessment in Medicaid HCBS settings, the Deficit Reduction Act directed the Agency for Health Care Research and Quality "to develop quality-of-care measures that can be used to assess Medicaid HCBS programs with regard to program performance, client functioning, and client satisfaction," according to The Kaiser Commission on Medicaid and the Uninsured.

For these reasons and to try to get Medicaid rates brought up to a more reasonable level, it's important that providers make their voices heard in the statehouse.

"One of our priorities is to try to move the legislature and the governor to a reasonable Medicaid rate for assisted living homes," says Gary Weeks, executive director of the Washington Health Care Association. "It's one of the main goals of our association with this next session to work on a fair rate."

Because of the rising and lowering tide of the state budget, and the effect that has on Medicaid reimbursement rates, says Hernandez, "you have to be active and vocal within the state association and with legislators. Where we can have a lot more influence [on] state policy is becoming active in the state association. I've definitely seen that work well in Oregon when a lot of people decided [Medicaid] wasn't paying enough and left the program."

"I'm in the statehouse every year trying to increase the rates," says Eldridge. When Cathedral Square first converted its building to assisted living, the daily reimbursement rate was $14.56 for 24 hours of care. "So it was crazy because you can't even hire a good [direct caregiver] for an hour for that. So every year we go to the statehouse and ask for an increase. That basic rate as of last week is now up to $36.25, so it's much more than doubled in the nine or so years we've been trying to fix the problem. We think we're getting there." ■