

**STATEMENT
Of
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&

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For the

**U.S. Senate Special Committee on Aging
“Assisted Living Roundtable”**

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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

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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 vary¹, 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 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'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/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.

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.