An Evaluation of the Assisted Living Medicaid Waiver Program

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EXECUTIVE SUMMARY

In the past decade the number of older people across the United States with disability has increased by about 20%, and the national Medicaid long-term care costs have nearly doubled. In response to these challenges, states are in the process of changing their long-term care delivery systems to include a wider range of service options. The development of the Assisted Living Waiver Program in 2006 represented an additional attempt by Ohio to expand the range of long-term care options for individuals with disability. This study reports findings from the second phase of Ohio's Assisted Living Waiver Program evaluation.

This report focuses on five areas of study. We begin by presenting a profile of Ohio's assisted living industry overall and of those providers participating in the Assisted Living Waiver Program. Second, we present a profile of assisted living waiver participants and a comparison to other long-term care programs operated in the state. This component will also include a review of individuals who are waiting to enroll in the program and interviews with Area Agencies on Aging across the state about the enrollment tracking process. Third, data are presented on the satisfaction of waiver participants, including a comparison to the overall satisfaction of assisted living residents. Fourth, we include an analysis of assisted living waiver participant program and Medicaid costs, including a comparison of Medicaid costs for nursing home residents. Finally, we examine the overall program design issues faced in the implementation of the program based on a qualitative assessment with potential residents and family members and an update on assisted living research and operational experiences across the U.S.

SUMMARY OF FINDINGS

This report evaluates the state's experiences in the implementation of the Ohio Assisted Living Medicaid Waiver Program. The program, which enrolled fewer people than expected during the first year of implementation has increased enrollment considerably and trends suggest that the state will be close to meeting its maximum number of CMS allocated slots in the program by the end of this biennium. Major findings from the evaluation are documented below.

1. After the initial year of operation, there were 54 certified providers and 193 participants. As of February 1, 2009, there were 169 certified providers and over 1000 active participants.

2. Based on our statewide survey of residential care facilities in Ohio, 367 residences appear to meet the criteria required to be a waiver provider. The 169 providers represent a 46% participation rate. Despite this increase nearly 40% of Ohio's counties do not have a facility participating in the waiver program.

3. There is considerable regional variation in both the total number of residences that meet the waiver criteria and in the rate of participating facilities. Although more heavily populated regions such as Cleveland, Columbus, and Cincinnati have the largest number of providers, Rio Grande (100%), Cambridge (78%), and Youngstown (63%) are the three regions with the highest facility participation rates.

4. Despite the increase in program enrollment and in participating residences, there are more than 500 individuals waiting to enroll in the program. The lack of an available facility was the primary barrier to enrollment. Although 167 days was the average wait time for all reasons, those waiting for enrollment because no provider is available waited an average 239 days.

5. Assisted Living Waiver Program participants meet level of care and experience high levels of impairment. Waiver participants have lower ADL impairment scores than were reported in the initial evaluation (2.6 vs. 3.3) and appear to be less functionally impaired than nursing home residents (4.4 ADL impairments) or PASSPORT (3.0 impairments) consumers. Assisted living waiver residents report higher levels of cognitive impairment compared to PASSPORT.

6. Over the course of the program about 20% of participants have left the program (284 individuals as of October 31, 2008), a rate lower than the discharge rate for nursing homes or PASSPORT. The two most common reasons for leaving the program are nursing home placement (49%) and death (22%).

7. Assisted living residents report high levels of satisfaction with both the program and the assisted living residence. In the majority of satisfaction areas waiver participants reported satisfaction scores comparable to non-waiver assisted living residents.

8. The overwhelming majority (90%) of waiver participants have been placed in Tier 3 (the highest category) for reimbursement purposes. Only one person out of almost 1000 participants was placed in the lowest reimbursement category, Tier 1.

9. Data do not identify any systematic differences between participants placed in Tier 2 and those placed in Tier 3.

10. Medicaid expenditures for assisted living waiver participants averaged $30,600 per year, with the assisted living expenditure portion at $24,200 or 80% of the total. Medicaid expenditures for long-stay nursing home residents totaled $67,500, with $44,200 being the actual nursing home portion. Nursing home residents are more disabled than assisted living residents, so cost differences are expected.

11. Both assisted living and nursing home residents under age 65, and therefore not eligible for Medicare, are considerably more costly than residents age 65 and older. Assisted living residents under age 65 had Medicaid expenditures of $40,500 compared to $28,700 for the over age 65 group, and nursing home residents under age 65 had expenditures of $116,900 compared to $57,900 for their over age 65 counterparts.

12. Focus groups with consumers and caregivers identify three important factors affecting use of assisted living: consumer and family awareness of the option, readiness to make the transition decision, and access to an assisted living facility of choice.

13. Focus groups with case managers identified concerns about the large number of individuals waiting to find a facility, but they voiced widespread support for the Assisted Living Waiver Program.

14. A review of other state programs identified several common issues, such as the importance of adequate reimbursement and consistent financing and regulation, but most important, respondents discussed the need to have a good mechanism to ensure sound communication between funders, regulators, and providers.

PROGRAM RECOMMENDATIONS

- The waiver program has been able to substantially increase the number of participating residences, but a persistent lack of available providers remains a major challenge. The top barrier for the more than 500 individuals who are waiting to enroll is that no acceptable facility is in their area. Currently 46% of eligible facilities are participating. This is a reasonably high rate at this stage of the waiver program, but even if this continues to grow additional residential options will be necessary. Because some PAAs have been very successful at attracting facilities, it would be advantageous for ODA and the AAAs to share successful approaches across regions.

ODA, ODJFS, and the Unified Budget Committee are pursuing strategies to expand residential assisted living and other supportive housing options. These data suggest that housing remains a critical challenge in long-term care.

- The assisted living waiver appears to be meeting a need in the market that is different from PASSPORT. For example, assisted living residents are older than PASSPORT consumers (43% vs. 18% over age 85) and much less likely to be married (7% vs. 21%). Assisted living waiver residents report fewer ADL limitations than in the earlier evaluation and in comparison to PASSPORT consumers and nursing home residents (2.6 vs. 2.9 vs. 4.5, respectively). Assisted living waiver residents have much higher rates of cognitive impairment with 38% requiring supervision compared to 20% for PASSPORT. Although the higher proportion of assisted living residents requiring supervision provides an explanation for the somewhat lower ADL scores, this trend should be monitored carefully by ODA and the AAAs. The assisted living waiver is clearly designed as a nursing home alternative program and efforts to ensure that the most disabled use this program will be critical to Ohio's overall long-term care system design efforts.

- As is the case for PASSPORT, the major reason that individuals leave the Assisted Living Waiver Program is to be placed in a nursing home. Although the disenrollment rate for the assisted living waiver is lower than PASSPORT, one important question raised is whether the program is doing everything that it can to keep participants in their assisted living residence. Case manager respondents and residents participating in the satisfaction interviews have discussed the limitations of the $50 personal allowance, particularly for individuals that have high cost sharing requirements for Medicare Part D. Respondents to our survey of residential care facilities discussed reimbursement limitations, which also could lead to high needs residents leaving the facility. We recommend that ODA and the AAAs look carefully at individuals who disenroll to nursing homes to better understand if some of these nursing home placements can be avoided.

- The current tier reimbursement system does not work. Nine of ten waiver residents are placed in Tier 3, the highest reimbursement category, and one person out of almost 1000 has been placed in Tier 1, the lowest reimbursement group. Although Tier 3 residents were supposed to be more disabled, we find no discernable difference between residents placed in Tier 2 and Tier 3. Because assisted living waiver residents experience high rates of cognitive impairment, there may be reason for reimbursement rates to reflect some of these challenges and we recommend that ODA and ODJFS work on revisions to the reimbursement system during the next phase of the waiver.

- Medicaid expenditures for both assisted living and nursing home residents who are under age 65 represent a considerable expense for the state. Because these individuals are not eligible for Medicare and have high care needs, the state should carefully examine approaches to integrating the acute and long-term care needs of the population under age 65. The population age 65 and over is much less expensive to

serve, since their acute care needs are covered by Medicare. In fact, these data suggest that efforts to move Medicare recipients into managed care programs would provide very little costs savings to the state.

- Focus groups with consumers and their families again underscore the importance in getting good and timely information to long-term care consumers. Although the consumer guide represents a significant effort by Ohio to provide information to individuals about facilities, assistance with the decision making process is the missing piece of the equation. It is clear that the majority of families are committed to providing care to their loved ones, but assistance with making decisions about how to help is often the challenge faced by consumers and their families.

- Our review of other state programs identified some lessons that are important for Ohio to examine as it continues to develop its assisted living and residential care options. There are many challenges in the financing and regulatory worlds that states face as they expand this area of service delivery, particularly in a tight economy. State respondents told us that solid communication between state officials, Area Agencies on Aging, and industry providers are critical to the health of the assisted living option. To this end, we recommend that the state continue to use its assisted living advisory group, and in fact, expand it to include additional types of housing providers.

OVERVIEW OF THE EVALUATION

BACKGROUND

The increase in the number of older people in the United States who experience a long-term disability has been dramatic, as have the costs of caring for this population. In the past decade the number of older people across the United States with disability has increased by about 20%, and the national Medicaid long-term care costs have nearly doubled from $49 to $95 billion (Georgetown University, 2007)[1]. In Ohio, from 2000 to 2008 total Medicaid long-term care costs increased from $3.2 billion to $4.8 billion (50% increase) (Burwell, 2008).[2] With estimates that the number of older people in Ohio with a disability will more than double by 2035, the state faces a serious challenge in developing a system of long-term services and supports that will meet the needs of Ohioans in an efficient and effective manner (Mehdizadeh, 2008)[3].

In response to these challenges, states are in the process of changing their long-term care delivery systems to include a wider range of service options. Because the original Medicaid legislation, the primary funding source of public long-term care emphasized care in the institutional setting, most states developed systems in which the vast majority of Medicaid services and expenditures were in nursing homes. In the past two decades states have made a serious effort to reform long-term care. In Ohio this includes an expansion of in-home services through the PASSPORT program, which has an active caseload of 28,000 home care recipients. Accompanying this expansion has been a number of other efforts including a nursing home pre-admission assessment process, the development of two Program of All-Inclusive Care to the

[1] Georgetown University. (2007). *National spending for long-term care*. Washington, DC: Health Policy Institute.
[2] Burwell, B., K. Sredl, & S. Eiken. (2008). *Medicaid Long-Term Care Expenditures in FY 2007.* Cambridge, MA: Thomson Reuters.
[3] Mehdizadeh, S. (2008). *Disability in Ohio: Current and future demand for services*. Oxford, OH: Scripps Gerontology Center, Miami University.

Elderly (PACE) sites, nursing home reimbursement reform, and a recent Money Follows the Person initiative to ensure that individuals who are older and/ or disabled can reside in the setting of their choice. The development of the Assisted Living Waiver Program in 2006 represented an additional attempt by Ohio to expand the range of long-term care options for people with disability. Ohio became the 42nd state to implement a Medicaid Assisted Living Waiver Program.

To implement the Assisted Living Waiver Program, the Ohio Department of Aging (ODA) partners with the Ohio Department of Job and Family Services (ODJFS), the single state Medicaid agency. ODA is responsible for day-to-day management of the program, while ODJFS has administrative and fiduciary responsibility. The program uses case managers, located in the 13 regional agencies referred to as PASSPORT Administrative Agencies (PAA) that administer the Assisted Living Waiver Program, to assess applicant need and eligibility and to assist consumers in accessing and transitioning into assisted living facilities as part of the waiver program. After a consumer is enrolled, PAA case managers are responsible for monitoring the resident's condition and the services provided in the assisted living facility.

To be eligible for the assisted living waiver at the outset, participants had to be at risk of nursing home placement and be either nursing home residents or currently enrolled in the PASSPORT, Choices, Ohio Home Care, or Transitions Waiver programs. As of March 2008, individuals who had been residents of an assisted living facility for at least six months and had spent down their resources to qualify for Medicaid were also deemed eligible. Additionally, participants must be 21 years of age, meet the nursing home level of care criteria, and be Medicaid eligible. To enroll, eligible consumers must find a facility that has been approved by the Area Agency on Aging and is able to accommodate the resident. As of February 1, 2009, 169

facilities had received program approval to enroll Medicaid waiver participants. Program build-up, which had been slower than originally anticipated in year 1 of the waiver, has now increased and as of February 2009, more than 1000 Ohioans were enrolled in the program. The current waiver allows for 1800 unduplicated participants (slots) in any given year, which means that residents who leave the program cannot be replaced during that year. Ohio has used about 1200 *slots* this year and given current enrollment patterns will be close to reaching capacity by the end of the biennium.

EVALUATION QUESTIONS

This evaluation report focuses on five areas of study. We begin by presenting a profile of Ohio's assisted living industry overall and of those providers participating in the Assisted Living Waiver Program. Second, we present a profile of assisted living waiver participants and a comparison to other long-term care programs operated in the state. This component will also include a review of individuals who are waiting to enroll in the program and interviews with Area Agencies on Aging across the state about the enrollment tracking process. Third, data are presented on the satisfaction of waiver participants, including a comparison to the overall satisfaction of assisted living residents. Fourth, we include an analysis of assisted living waiver participant program and Medicaid costs, including a comparison of Medicaid costs for nursing home residents. Finally, we examine the overall program design issues faced in the implementation of the program based on a qualitative assessment with potential residents and family members and an update on assisted living research and operational experiences across the U.S.

I. PROFILE OF ASSISTED LIVING RESIDENCES AND PARTICIPATING PROVIDERS

The state of Ohio does not have a licensure category specifically for assisted living. Instead residences operate under the residential care facility licensure category. For purposes of the assisted living waiver, as required by the Centers for Medicare and Medicaid Services (CMS), it was necessary for ODA and ODJFS to develop specific criteria that facilities were required to meet in order to participate in the program. Requirements include a single occupancy room, private bathroom, locking door, identifiable area for socialization, availability of a registered nurse, and 24-hour staffing. To get an idea about the potential number of providers in Ohio we present a profile of assisted living residences in the state that reported, through our biannual survey of residential care facilities, that they meet the waiver program criteria. We also present the characteristics of participating providers. Finally, we examine how the assisted living providers, both participating and non-participating, are distributed across the state.

Based on our survey of residential care facilities across the state we found 367 residences that appear to meet the Assisted Living Waiver Program criteria (see Table 1). At the time of the survey 153 (42%) of these facilities reported participating in the waiver program (as of February 1, 2009, there were 169 participating providers). In comparing participating and non-participating providers we observe some similarities and some differences between the groups. The participating and non-participating residences are similar in size (average 77 beds) and report serving a similar proportion of residents needing assistance with bathing (64%). The participating facilities report lower monthly charges for the standard one bedroom unit ($2,574 vs. $2,896). The participating residences are more likely to be part of a continuing care

Table 1
Residential Care Facilities in Ohio Meeting Assisted Living Waiver Requirements and Participating Assisted Living Waiver Residences

	Residences Participating in the Assisted Living Waiver	Residences Not Participating in the Assisted Living Waiver	Residences That Meet Waiver Criteria
Number of facilities	153	214	367
Mean number of licensed beds	76	77	77
Mean monthly cost for 1 bedroom unit/private bath	$2,574	$2,896	$2,750
Residents needing bathing assistance (percent – yes)	64	64	64
Part of CRCC (percent – yes)	42	30	34
Not-for-profit (percent – yes)	40	25	34
Part of a chain (percent – yes)	52	64	61

retirement community (CCRC) (42% vs. 30%), more likely to be not-for-profit (40% vs. 25%), and less likely to be part of a chain (52% vs. 64%).

We also examine the distribution of assisted living facilities across the state. Table 2 presents the participating and total number of assisted living residences broken down by the 12 Area Agency on Aging regions of Ohio. By and large the urban areas have higher numbers of facilities. For example, the Cleveland area has 20 facilities, Dayton 18, Youngstown 17, and Cincinnati, Columbus, and Toledo have 16 facilities each. We also present data on the ratio of participating facilities out of the total number of facilities in each region. Under this analysis Cleveland has the largest number of participating facilities, this number represents 29% of the

Table 2
Distribution of Residences Participating in the Assisted Living Waiver and Meeting Waiver Criteria by Area Agency Region

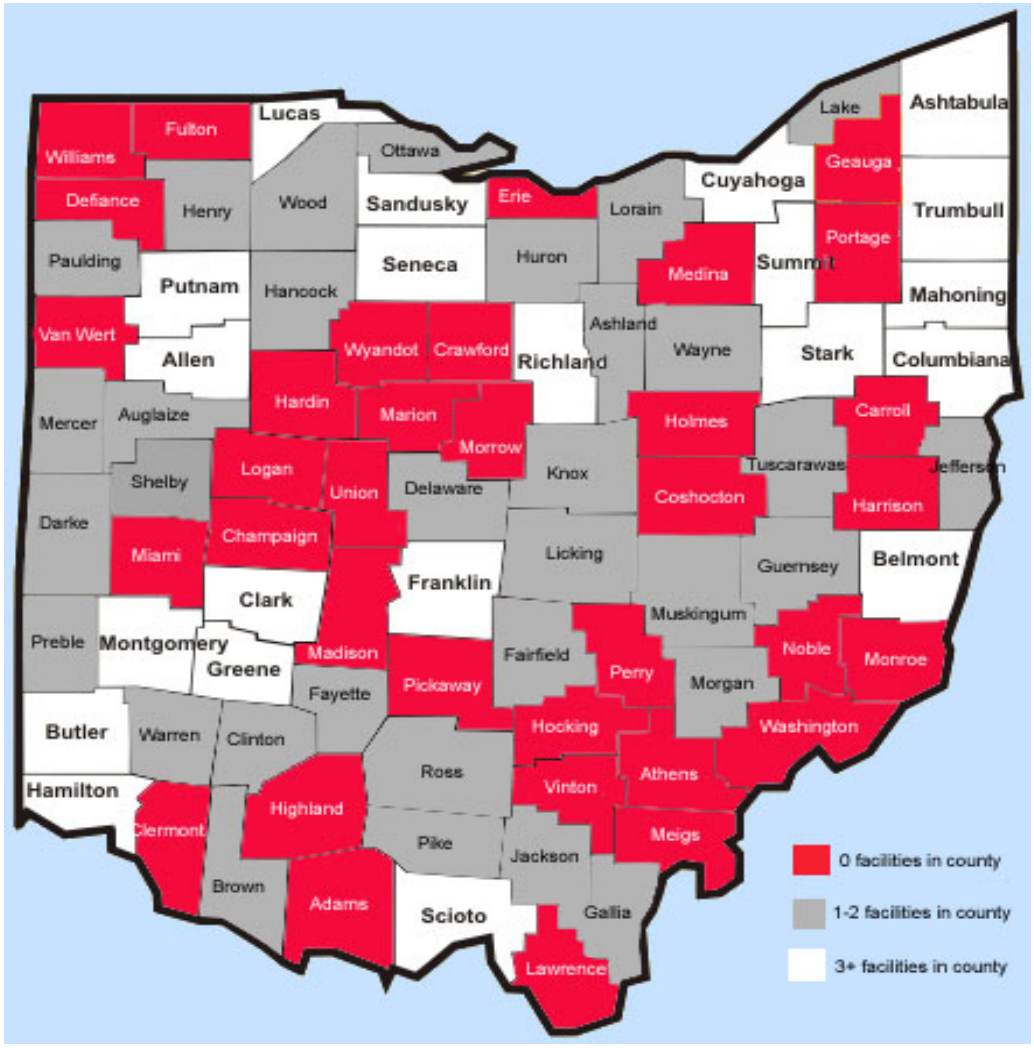
Area Agency on Aging		Participating Residences		Total Number of Residences Meeting Criteria		Ratio of Participating to Total Number of Residences	Count of Active Residents	
		Number	Percent of state	Number	Percent of state	Percent for region	Number	Percent of state
PAA 1	Cincinnati	16	10.5	49	13.4	33	142	14.5
PAA 2	Dayton	18	11.8	37	7.4	47	106	10.8
PAA 3	Lima	12	7.8	24	6.5	50	53	5.4
PAA 4	Toledo	16	10.5	31	8.4	52	29	3.0
PAA 5	Mansfield	10	6.5	19	5.2	53	51	5.2
PAA 6	Columbus	16	10.5	49	13.1	33	122	12.5
PAA 7	Rio Grande	8	5.2	8	2.2	100	111	11.3
PAA 8	Marietta	1	.7	4	1.1	25	5	.5
PAA 9	Cambridge	7	4.6	9	2.5	78	45	4.6
PAA 10[a]	Cleveland	20	13.1	71	19.1	29	128	13.1
PAA 10[b]	Akron	10	6.5	39	10.6	26	55	5.6
PAA 11	Youngstown	17	11.1	27	7.4	63	131	13.4
Total		**153**	**100**	**367**	**100**	**100**	**978**	**100**

total available residences (20 of 71) in the state. Looking at participation ratios across the state, we identify Rio Grande (100%), Cambridge (78%), and Youngstown (63%) as the three regions with the highest rates of facility participation. With a range of 25% to 100% in participation rates, efforts to better understand regional differences will help Ohio in ensuring comparable accessibility to the assisted living waiver across the state.

Facility participation varies by county and by geographical region (See Figure 1). The southeastern and central areas of Ohio are especially underrepresented. Thirty-five counties (39.7%) have no participating facilities and 32 counties (36.4%) have one or two participating facilities. In looking at the overall assisted living supply we find that five Ohio counties do not have any facilities meeting the waiver criteria and 20 counties have only one such facility.

In the last two columns of Table 2, we provide a count of the number and the percent of active assisted living participants as of October 31, 2008. Cincinnati was serving 142 individuals (14.5%), the largest number of waiver participants in the state, followed by Youngstown (131, 13.4%), Cleveland (128, 13.1%), Columbus (122, 12.5%), Rio Grande (111, 11.3%), and Dayton (106, 10.8%). These findings reinforce our assumptions that the urban centers would account for the largest proportion of assisted living participants. The exception to this is Rio Grande; although it is one of the more rural regions of the state, it continues to have a larger than expected consumer participation rate.

Figure 1
Assisted Living Waiver Facility Supply by County



Source: The Ohio Department of Aging.

II. RESIDENT PROFILE

RESIDENT CHARACTERISTICS

The examination of the characteristics of assisted living waiver residents uses the demographic and functioning data available in ODA's PASSPORT Information Management System (PIMS). The analysis includes an overall profile of residents enrolled in the assisted living waiver. For comparison purposes we will use data on PASSPORT enrollees, also available from PIMS, and data on Medicaid nursing home residents, available from the nursing home Minimum Data Set (MDS).

Table 3 shows the demographic and functional profile of all assisted living waiver participants as of October 31, 2008. Assisted Living Waiver Program residents are on average about 80 years old, with about one in four age 91 or older. Four in five residents are female and residents are typically white (89%). Nine out of ten participants are not married and may have more limited access to social supports. With rare exception, almost all residents are experiencing difficulty with all five instrumental activities of daily living (IADLs) (between 94% and 99.5% for each IADL), as well as difficulty with the bathing activity of daily living task (ADL) (91.8%). A majority of participants also report difficulty with mobility (72.7%). About one-half of the residents report difficulty in dressing, and more than one in five report having difficulty getting to the toilet and grooming. Difficulty with eating is the least common ADL impairment among waiver participants (4.2%).

Although Assisted Living Waiver Program participants meet the nursing home level of care, the level of ADL impairment found in this phase of the evaluation is lower than impairment levels noted in the initial evaluation (June 2007). For example, our initial evaluation showed assisted living waiver participants as having on average 3.3 ADL limitations and the current

Table 3
Demographic and Functional Characteristics of Enrollees in the Assisted Living Waiver Program
October 2008

Characteristics	Percent
Age	
≤45	1.1
46-59	6.4
60-64	5.7
65-69	6.0
70-74	8.3
75-79	12.0
80-84	17.6
85-90	25.3
91+	17.6
Average Age	79.8
Gender	
Female	79.2
Male	20.8
Race	
White	88.9
Black	9.2
Other	1.9
Marital Status	
Non-Married	92.7
Married	7.3
ADL Impairment	
Eating	4.2
Toileting	23.3
Grooming	22.8
Dressing	47.0
Mobility	72.7
Bathing	91.8
IADL Impairment	
Shopping	97.6
Laundry	94.0
Meal Preparation	97.8
Community Access	96.9
Environmental Management	99.5
Sample Size	978

Source: PASSPORT Information Management System (PIMS)

participant averages 2.6. A comparison of the current assisted living participants with a sample of PASSPORT consumers and Medicaid nursing home residents who enrolled during the same time period helps to clarify the full disability profile of Assisted Living Waiver Program participants.

Table 4 provides a demographic and functional comparison of assisted living waiver participants with PASSPORT consumers and Medicaid nursing home residents. This review shows that assisted living waiver participants are somewhat different demographically than both PASSPORT consumers and Medicaid nursing home residents. A higher proportion of assisted living waiver residents are age 85 and older (43%) compared to 18% of PASSPORT consumers and 27% of nursing home residents. Assisted Living participants also tend to consist of proportionally more females than either PASSPORT or nursing home consumers. PASSPORT serves a higher proportion of minorities (29%) than nursing homes (20%) and assisted living facilities (11%). The marital status variable shows that while about 20% of Medicaid nursing home residents and PASSPORT consumers are married, assisted living waiver residents are less likely to be married (7.3%).

Regarding ADL impairment, group differences are noteworthy. Although the vast majority in each of the three groups has difficulty bathing, nursing home residents show consistently higher rates of overall ADL impairment than found in either PASSPORT or Assisted Living. For example, nursing home residents average 4.5 ADL limitations compared to 2.9 for PASSPORT and 2.6 for the assisted living waiver participants. About three in four PASSPORT consumers, assisted living waiver participants, and nursing home residents experience difficulty with mobility. Similarly, about one in five individuals in assisted living and PASSPORT have difficulty toileting. On the other hand, PASSPORT consumers are more likely

to have problems dressing (58% vs. 47%) and grooming (27.0% vs. 22.8%) than assisted living residents.

These comparative findings are somewhat difficult to interpret because the measurement of disability is related to the individual's environment and circumstances. For example, despite recording the highest number of ADL limitations, nursing home residents have the lowest levels of disability on the bathing item, in part because of the availability of bathing equipment. On the other hand, nursing home residents report considerably higher rates of impairment in getting to the toilet, which in nursing homes could be more difficult to do because of the environment. This overall pattern of results is inconsistent with the findings from the initial evaluation report where assisted living waiver participants had greater levels of ADL impairment than PASSPORT consumers, typically falling between the latter group and nursing home residents on ADL limitations. An explanation for this pattern lies in the need for supervision, the final comparison, which is displayed in Table 4. While one in five PASSPORT consumers need either partial or ongoing supervision (20%), almost two in five assisted living waiver residents require some form of supervision (38%). The need for supervision can originate from many sources, but one of the primary causal factors behind such need frequently is some level of cognitive and/or mental health impairment, either alone or in combination with physical impairment. Further examination of diagnosis data for assisted living waiver participants (not shown) is consistent with this explanation. Specifically, an examination of diagnosis data revealed that more than one in five (20.3%) assisted living waiver participants have a diagnosis that includes depression (0.8%), Alzheimer's disease (5.1%), or other dementia (14.3%). PASSPORT reports 9.2% of its participants with a comparable diagnosis.

Table 4
Comparison of Assisted Living Waiver, Nursing Home, and PASSPORT Consumers
July 2006 to October 2008

	Assisted Living Waiver Consumers (Percentages)	PASSPORT Consumers (Percentages)	Medicaid Nursing Home Residents (Percentages)
Age			
≤45	1.1	N/A	5.8
46-59	6.4	N/A	15.2
60-64	5.7	17.5	6.7
65-69	6.0	16.6	7.5
70-74	8.3	16.6	8.9
75-79	12.0	16.3	12.3
80-84	17.6	15.5	16.7
85-90	25.3	12.5	17.3
91+	17.6	5.0	9.6
Gender			
Female	79.2	75.1	64.0
Race			
White	88.9	71.3	79.7
Black	9.2	25.1	18.9
Other	1.9	3.6	1.4
Marital Status			
Married	7.3	21.2	18.2
Divorced/Widowed/Separated	80.2	70.0	62.1
Never Married	12.5	8.8	19.7
ADL			
Bathing	91.8	94.1	83.7
Dressing	47.0	57.2	81.5
Eating	4.2	5.2	28.8
Toileting	23.3	22.1	76.8
Mobility	72.7	74.2	75.1
Grooming	22.8	27.0	81.0
Number of ADL Impairments			
0	1.0	1.4	10.0
1	13.9	5.1	5.5
2	37.1	36.8	4.1
3	26.8	31.5	4.9
4+	21.3	25.2	75.5
Average Number of ADL Impairments	2.6	2.9	4.5
Medication Administration	82.6	38.6	--
Needed Supervision			
Ongoing	10.8	8.4	--
Partial	27.0	11.3	--
Number of Consumers or Residents	978	14,513	26,435

Source: MDS 2.0 July 2006 to September 2008
PASSPORT Information Management System (PIMS)

When combined with key demographic and physical impairment characteristics, cognitive impairment problems help to clarify the comparison of assisted living waiver participants to PASSPORT consumers and Medicaid nursing home residents. Nursing home residents are consistently the most disabled of the three groups. Physical impairments are slightly more common among PASSPORT consumers than assisted living waiver participants. However, assisted living residents require more supervision than PASSPORT consumers, a service requirement that likely stems from a combination of their higher rates of cognitive impairment coupled with their considerably lower likelihood of having spousal support available. Thus it appears that as the Assisted Living Waiver Program has evolved it has attracted a higher proportion of individuals who are unmarried and who experience higher levels of cognitive impairment.

RESIDENT ENROLLMENT AND WAITING LIST

Despite the increase in participants during the past year, not everyone who is interested in and who is deemed eligible for the Assisted Living Waiver Program is immediately enrolled. Reasons for not enrolling include such factors as: there is no provider available in the applicant's geographic area; there is no provider willing to accept the individual's care needs; and the person is not ready to be discharged from a nursing home. The people who are waiting to be enrolled are on what is known as the *enrollment tracking list,* which is recorded in the PASSPORT Management Information System (PIMS). Although these individual are waiting to enroll in the program, they are thought of differently than individuals who are placed on a waiting list because there are no more available *slots* for the current enrollment period. At the end of January 2009, no one was waiting to enroll in the waiver program because of a lack of slots.

The program experienced a slow initial implementation. After the first year there were 54 certified providers and nearly the same number of people enrolled as waiting for enrollment (193 vs. 190). During the second phase of the program's evaluation (the period of this study) both residences and enrollees increased substantially; as noted earlier, by February 2009 enrollment had increased to over 1000, and tracking showed 545 people were waiting to enroll.

With such a large list of applicants waiting for enrollment it is important to understand the circumstances surrounding the individual's situation and the processes used by the PAAs to monitor and counsel those applicants. To examine this area we reviewed data from PIMS, where reasons and length of time that passed prior to enrollment were recorded for each individual by region. We also completed telephone interviews to better understand the enrollment process with each of the 13 PAAs. The respondents had a variety of titles; most were managers/supervisors, while some were case managers. The telephone interviews ranged in duration from 45 minutes to 1 hour and 45 minutes and the instrument consisted of a combination of open- and closed-ended questions.

Enrollment Tracking

Each PAA manages enrollment for their region. PAAs place an individual on the tracking list after the applicant has had an in-person assessment, meets all the non-financial eligibility requirements including level of care (LOC), and if the PAA cannot offer enrollment. Case managers are not assigned to a particular individual until the point when the client moves to an assisted living residence. Respondents stated that the reason the individual is waiting for enrollment is updated if the person's circumstances change. Typically this occurs once financial eligibility is established.

As of February 2009, 545 applicants were waiting to enroll into the Assisted Living Waiver Program (see Table 5). These data represent a snapshot of those waiting at the start of the month and does not include those who have enrolled or decided against enrollment. More than half of the applicants did not have an available provider and an additional 18% were still trying to decide on a facility. That provider issues were the driving factor for 70% of those waiting to enroll was consistent with the data reported by case managers. Almost one in five applicants was waiting to receive their Medicaid eligibility determination, an issue also discussed by case managers.

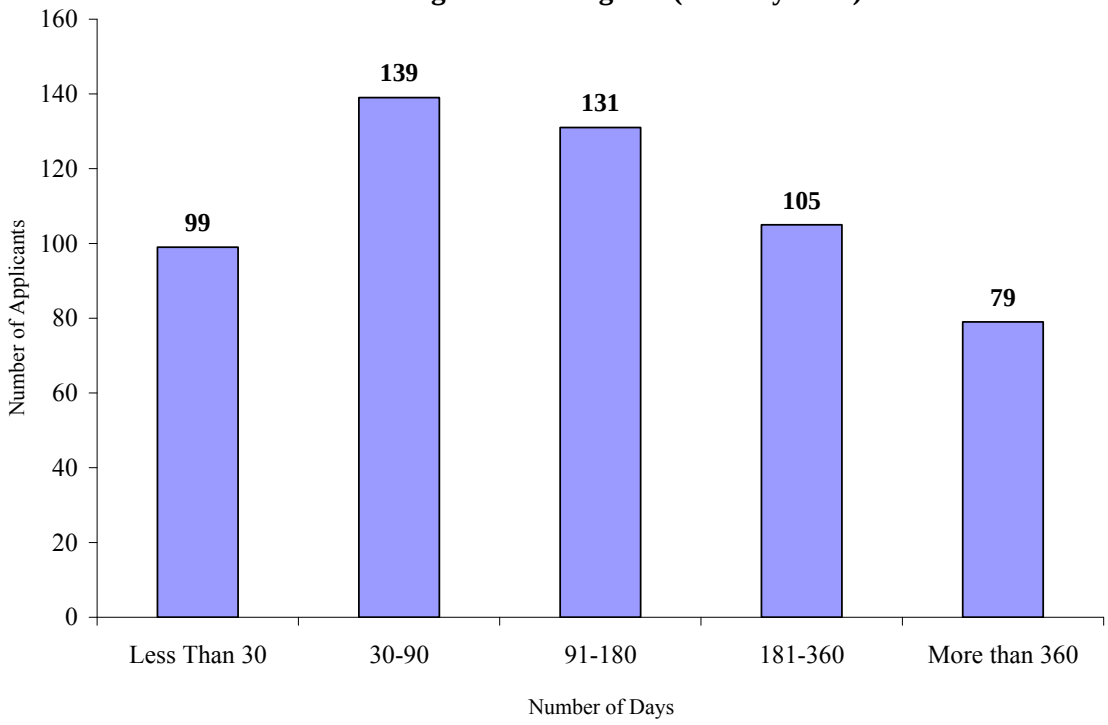
On average, those waiting to enroll did so for between five and six months (avg. 167 days) (See Table 5). The length of time waiting to enroll did vary by reason. Those waiting to enroll because there was no provider available had the longest waiting time (avg. 239 days), while individuals waiting for a doctor's approval (56 days) and those waiting for Medicaid determination (73 days) were typically on for two to three months. A further breakdown of wait times is presented in Figure 2. About one fifth of those waiting to enroll had been waiting less than one month, while 15% were on for one year or longer and another 20% were waiting between six months and one year. Efforts to better understand the circumstances of those waiting and developing an intervention to shorten this time will be important to ongoing program success.

In our interviews with sites about the enrollment tracking process, most respondents had a common understanding of the definitions for reasons for the waiting, but there was some surprising variation from the standard interpretation. For example, the most commonly used reason among all sites, *No provider available,* was not used at all at one PAA. Another site did

Table 5
Assisted Living Waiver Applicants Waiting to Enroll

Reason for Waiting	Number	Percent	Average Number of Days Waiting
No Medicaid determination	93	17.0	73
Not ready to leave nursing home	41	7.5	111
Consumer is deciding on specific provider	96	17.6	108
No AL provider available	282	51.7	239
Need doctor's verbal approval	9	1.7	56
Other	24	4.4	98
Total	545	100	167
Waiting to Enroll by PAA			
PAA 1	72	13.2	
PAA 2	23	4.2	
PAA 3	17	3.1	
PAA 4	16	2.9	
PAA 5	20	3.7	
PAA 6	84	15.4	
PAA 7	12	2.2	
PAA 8	3	0.5	
PAA 9	15	2.8	
PAA 10a	98	18.0	
PAA 10b	161	29.5	
PAA 11	24	4.4	
Total	545	100	

Figure 2
Number of Days Applicants are Waiting to Enroll in the Assisted Living Waiver Program (January 2009)



not use the *No Medicaid determination* category, although all other sites use it when an applicant's financial eligibility is not yet determined. Some respondents claim not to use other reasons for waiting at all even though the use of these reasons is standard at other sites. Several sites said they do not use *Consumer is deciding on estate recovery*, while others do. Although efforts have been made to standardize information system definitions, these data suggest that further refinements are needed.

The proportion of applicants waiting to enroll did vary by PAA from just a few to 161. The urban regions, such as Akron (30%), Cleveland (18%), Columbus (15%), and Dayton (13%) account for more than three quarters of all those waiting to enroll.

Frequency of Contact – There is no externally mandated frequency of contact for PAAs although the recommendation is for this to occur at least quarterly. All sites reported meeting the recommendation and often viewed monthly contact as a goal, which was realized at a few sites. Activities involved in contacting the applicants include asking the individual or family member whether there is still interest in the program, whether they would be willing to be enrolled in a different facility than their initial choice, and to provide an honest appraisal of the length of time they might remain on the list. Many respondents said that as soon as a new facility came online, that appropriate applicants were contacted about a possible match with that new facility.

Most sites do not have a formal process to help applicants make a decision about how long to remain on the list. Besides contacting individuals regularly, they often suggested other options such as accepting placement in another facility. Several respondents said that they do not suggest that their longer waiting applicants drop out because they are eminently placeable – there just aren't enough providers.

The reasons that individuals are removed from enrollment tracking include: enrollment in the program; an alternate option is chosen, such as permanent move to a nursing home; denial of Medicaid eligibility; care needs become excessive; an individual decides they cannot live on the $50 monthly allowance; and death.

Establishing Financial Eligibility

Although financial eligibility is established through each County Department of Job and Family Services (CDJFS), the determination process involves follow up and tracking by the PAAs. The respondents identified obstacles/ delays to establishing Medicaid financial eligibility as originating from the CDJFS as well as through the applicants and their families. Perhaps one of the inherent problems with county-level administration is a lack of consistency in the way

each county determines eligibility and this was found to be true regarding who does the determination, how long it takes, and even in the criteria for establishing eligibility (such as the length of look-back periods). This lack of consistency between counties makes for a more complicated process of oversight for the PAAs and for an inconsistent application of eligibility for consumers.

The amount of time that the eligibility process takes varies by county (this ranged from 2 weeks to 3 months). Several respondents said that some counties have specialists while other counties have generalists- the specialists get the determination done more quickly compared to the generalists. Regarding CDJFS staff, respondents gave mixed opinions, one said that it was a lack of expertise at the county level, not a lack of staff that caused delays; other said that the counties were understaffed and overworked.

Provider Affect on Enrollment

Two main issues were addressed regarding providers and their acceptance of Assisted Living Medicaid Waiver Program resident referrals: What types of providers are willing to take applicants with higher care needs? And are some providers only accepting their own residents (who have spent down as private pay residents and are now Medicaid eligible)? Several respondents said that many of their providers will take residents with higher care needs, but often, (but not always) these facilities are ones that already have had a prior affiliation with the resident – they have had the individual as a private pay resident or know them through some other way. Other respondents said that CCRCs, facilities with a nursing facility component, or those with 24-hour a day staffing are more likely to take residents with higher care needs.

Most sites reported that there are facilities in their region that only take 'their own residents.' Some even said that only taking their own residents was the reason that the facilities

applied for certification in the program. More common though was the opinion that many facilities give priority enrollment to their own residents, but will take other applicants as well.

Characteristics of Difficult Placements

Although all assisted living waiver applicants meet level of care requirements, some have characteristics which cause them to be more difficult to place than others. Respondents viewed difficult placements as falling into two categories: care needs and non-care related issues. There was a considerable amount of variation among respondents regarding what types of care needs make an applicant harder to place in an assisted living facility. Most agreed that the need for more than a one-person assist/ transfer was a deal breaker with facilities. Elopement risk, swallowing problems (liability), falls risk, 24-hour supervision, mental health and behavior issues, unplanned needs, bowel incontinence (frequently bladder incontinence is okay, however) all were mentioned as circumstances that would make a person harder to place.

Non care-related circumstances that are perceived as barriers to placement are younger applicants, smokers, and pet owners. Apart from the observation that younger people in assisted living sometimes have behavior/ mental health problems, the respondents said that facility administration may view younger people as not 'fitting in' with the other residents, they are less likely to be happy in a placement, and therefore are often not accepted as a referral. Residents who smoke are more difficult to place as many of Ohio's assisted living facilities are on smoke-free campuses. Although some residences accept residents who own cats, few agree to take dogs (frequently, if allowed at all, there is a size restriction) and often pet ownership is a barrier to assisted living placement.

Reflection of Need

More than half of the respondents viewed the number of individuals waiting to enroll as an accurate reflection of the need for waiver services in their region. Others indicated it was not an accurate reflection because many people who qualify for the services do not apply. Some find out about the $50 a month allowance and decide that they cannot live on that; others discover that there is no facility anywhere near their home and decide not to pursue admission to the program.

Respondent Suggestions

Although many respondents stated that the enrollment tracking process works well, they still had suggestions for improving the system. Most said that their region needs more certified residences, better geographic dispersion of facilities – as there are whole areas of Ohio (including several contiguous counties, especially in rural areas) that have no certified facilities – and more facilities that accept referrals outside of their own residents. They view lack of facility availability as the main barrier to shortening waiting time and increasing enrollment. Most respondents agreed that there are a small group of people waiting who will never be or are not likely to be enrolled because of high or complex care needs or because of circumstances that make them difficult placements, but most thought that under better market circumstances most individuals would be able to find a residence.

Suggestions for improving the provider base included improving provider procurement/ recruitment activities, making certification a less cumbersome process, building in incentives for participation, and revisiting the reimbursement methodology, including the tier system. Regarding shortening the time to enrollment some respondents suggested creating another

reimbursement tier for residents with mental health issues or other special needs. Another general suggestion included increasing the resident's monthly allowance.

There was a short period of about 40 days in the late fall of 2008 when, because of budgetary constraints, monthly enrollment in each PAA was restricted by the state. During that time, which was known as *managed enrollment*, some sites were restricted to as few as one new enrollee per month. Although the respondents were relieved that *managed enrollment* was short-lived, some sites were still feeling its impact. Several thought that the waiver program lost some credibility among providers (especially among new providers and those in the process of being certified).

DISENROLLMENT FROM THE ASSISTED LIVING WAIVER PROGRAM

From the inception of the program in June 2006 through October 2008, 1300 individuals have enrolled in the Assisted Living Waiver Program. During this time period 264 participants have left the program. Table 6 presents data on the primary reasons for leaving the program. Two categories, nursing home placement (48%) and death (25%), account for more than 70% of all those leaving the program. About 10% of those who left did so because the assisted living service package did not meet their needs. Another 10% left the program because their needs could be met by family or community resources. Finally, about 6% no longer met the financial or functional eligibility criteria for the program.

Table 6
Reasons for Disenrollment
Through October 2008

Disenrollment Reason	Number of Disenrollees	Percent
Consumer died	70	24.7
Consumer needs met by community resources	28	9.9
Consumer is admitted to NF (30+ days)	136	47.9
CDHS denial/termination	16	5.6
Needs no longer met by the assisted living service package	28	9.9
Other	6	2.0
Total	**284**	

III. RESIDENT SATISFACTION

ASSISTED LIVING RESIDENT SURVEY

An important area to examine regarding the Assisted Living Waiver Program involves resident satisfaction with the facility and the waiver program. Our review of resident outcomes is focused on two questions: (1) How does the resident rate the quality of the waiver program? And (2) How does the resident rate the quality of the assisted living residence? To understand Ohio's Assisted Living Waiver Program from the resident perspective, interviews were conducted with a random sample of waiver residents from across the state. Interviews were completed between June and October of 2008. At the time of the interviews, 145 assisted living facilities in Ohio accepted waiver residents; 34 different facilities are represented through the residents interviewed in this study. In order to make sure residents had enough time to form an opinion we restricted our sample to individuals who had been enrolled for three months or longer. In this sample the residents had enrolled in the waiver program between January 2007 and May 2008. Eighty-three waiver residents agreed to participate in the in-person interviews (out of 113 sampled), for an interview response rate of 73%. The interviews lasted an average of 38 minutes (ranging from 12 – 77 minutes).

The waiver residents who were interviewed are similar to the overall assisted living enrollees on the gender and marital status variables (see Table 7). Almost four in five were women (77%) and residents were most often not married (89%). Functional ability did show some differences between the groups with the interview sample appearing to be more disabled. For example, the interview sample averaged 3.3 ADL limitations compared to 2.6 for the overall enrollee group. Finally, with an average age of 76, those interviewed were slightly younger than the overall group of enrollees (avg. = 80). Residents who participated in the evaluation interview

were evenly distributed across urban (30.1%), suburban (38.6%), and rural (32.3%) regions of the state.

Non-participation analysis (i.e., independent samples t-test and logistic regression) showed that the 83 residents completing the interview did not significantly differ from the 30 individuals who did not complete the interview in such areas as age, gender, race, marital status, and activities of daily living dependencies.

Measures

The State of Ohio collects satisfaction information for all residential care facilities as a critical component of its web-based long-term care consumer guide (See www.LTCOHIO.org). The satisfaction survey was completed by residents in 529 out of 544 residential care facilities in Ohio, which include assisted living facilities (Vital Research, 2008). To assess satisfaction for waiver participants we used the same residential satisfaction questions as used in the statewide survey. The residential satisfaction survey includes items that make up 11 different domains of satisfaction (e.g., activities, employee relations, general satisfaction). We also added questions about the assisted living waiver enrollment process and a review of the case management element of the program.

Resident satisfaction data collected from the Medicaid assisted living waiver participants were compared to resident satisfaction data collected from non-Medicaid assisted living waiver residents residing in the same 34 assisted living facilities. Independent samples t-tests were used to determine whether there were differences between the two samples on the individual satisfaction items and on the satisfaction domains.

Table 7
Assisted Living Waiver Residents' Satisfaction Interview
Sample Description (n = 83)

	Percent
Mean age	75.91
Gender	
Female	77.1
Male	22.9
Race	
White	78.3
Non-White	21.7
Marital status	
Married	10.8
Widowed	54.2
Divorced/Separated	24.1
Single	10.8
Assistance with activities of daily living	
Bathing	95.2
Dressing	75.9
Eating	12.0
Grooming	28.9
Mobility	80.7
Toileting	38.6
Mean ADL score	3.3
Location	
Urban	30.1
Suburban	38.6
Rural	32.3

Results

Questions about the waiver program from the perspective of the residents are presented in Table 8. Sixty percent of the interviewed residents were aware of the waiver program. Of those who were aware of the waiver program, the vast majority (89%) knew how to reach their case manager and most (83%) reported having regular contact with their case manager. Overall, residents generally rated the information they received about the waiver program and the helpfulness of the case manager, facility staff, and their own family as good/excellent. However, almost one quarter did express concerns about the quality of the financial information provided about the waiver program. Around 15% of respondents reported negative responses concerning the information received and the helpfulness of staff and case managers.

Table 8
Assisted Living Waiver Residents' Ratings of the Program and Enrollment Process

	Percentage Response	
How would you rate . . . ?	Poor/Fair	Good/Excellent
The information received about the services here.	12.7	87.2
The financial information regarding the ALF waiver program.	23.3	76.7
The helpfulness of the case manager during your move to the facility.	13.7	86.3
The information you received from staff concerning services here.	15.9	84.2
The helpfulness of the staff during your move to the facility.	14.8	85.3
The helpfulness of your family during your move to the facility.	9.1	90.9

Overall, facility satisfaction ratings for waiver residents were relatively high (see Table 9). More than nine of ten gave high ratings in the areas of employee relations (courteous, respectful, friendly), facility environment (attractive, clean) resident environment (privacy, safety) and choice (choose bed time, rules reasonable). The lowest rating was for meals and

dining (food tasty, food you like – 81% favorable) and care and services (snacks available, medications timely – 84%). Twenty-eight percent of waiver residents did not think the food was tasty and 22% did not think employees explained the care and services very well.

In comparing the sample of waiver residents to a sample of non-waiver residents from the same 34 facilities there was little difference in regard to overall satisfaction. In 9 of the 11 domains there were no differences between the two groups. However, in two areas, communications and meals and dining, there were significant differences between the two

Table 9
Comparison of Resident Satisfaction for Waiver and Non-Waiver Residents

Quality Domain	Assisted Living Facility Waiver Residents	Assisted Living Facility non-Waiver Residents
Employee Relations	**93.24 (10.0)**	**94.69 (10.9)**
Are the employees courteous to you?	94.04 (12.8)	95.52 (12.5)
Can you count on the employees?	90.34 (15.1)	91.50 (17.1)
Are the employees here friendly to you?*	92.45 (13.9)	95.93 (12.0)
Do employees treat you with respect?	96.01 (12.0)	95.85 (13.5)
Employee Responsiveness		
Confident employees know how to do their job?	87.36 (17.0)	89.95 (18.5)
Communications**	**85.92 (15.7)**	**90.46 (14.7)**
Are people in charge available to talk to?*	84.52 (19.9)	90.07 (21.0)
Do people in charge treat you with respect?	95.39 (12.7)	96.28 (13.9)
Are you comfortable making a complaint?*	81.47 (29.1)	89.00 (25.1)
Know who to go to when you have a problem?	83.35 (29.8)	88.44 (26.3)
Do your problems get taken care of?	84.97 (24.3)	87.36 (23.2)
Care and Services	**83.50 (17.8)**	**84.64 (17.8)**
Can you get snacks when you want?	81.62 (30.0)	80.82 (31.5)
Do employees explain care and services to you?	78.00 (27.8)	80.05 (32.3)
Do you get your medication on time?	93.55 (15.3)	93.59 (15.4)
Do the employees who take care of you know what you like and don't like?	81.89 (23.4)	85.26 (21.4)
Activities	**85.78 (19.3)**	**84.39 (20.3)**
Do you have enough to do here?	83.59 (24.4)	83.24 (26.1)
Do you get enough information about activities?	91.07 (21.0)	88.25 (23.6)
Are you satisfied with activities here?	82.96 (25.2)	83.03 (25.4)
Laundry	**91.73 (13.2)**	**93.91 (13.2)**
Do you get your clothing back from laundry?	91.72 (18.7)	93.04 (15.8)
Do your clothes come back in good condition?	91.75 (14.4)	94.97 (14.5)

Table 9 (continued)
Comparison of Resident Satisfaction for Waiver and Non-Waiver Residents

Quality Domain	Assisted Living Facility Waiver Residents	Assisted Living Facility non-Waiver Residents
Meals and Dining**	**80.75 (18.6)**	**86.61 (15.2)**
Do you get enough to eat?	93.95 (13.9)	96.19 (13.2)
Is the food tasty?**	71.75 (29.6)	80.20 (24.2)
Can you get the foods you like?**	69.24 (30.9)	78.36 (26.1)
Is food served at right temperature?**	79.19 (25.9)	86.53 (20.8)
Do you like the way meals are served?	89.46 (21.5)	91.44 (19.4)
Facility Environment	**94.04 (9.3)**	**94.79 (9.5)**
Do you like the location of this place?	90.90 (23.0)	92.29 (20.7)
Are outside walkways taken care of?	96.13 (12.0)	96.29 (12.1)
Does this place look attractive?	94.35 (15.5)	94.53 (15.8)
Is this place kept clean?	94.83 (12.1)	96.29 (12.6)
Is this place quiet?	94.42 (13.5)	95.09 (14.0)
Resident Environment	**92.79 (12.0)**	**95.30 (10.6)**
Do you have enough privacy?	95.61 (12.4)	96.71 (12.6)
Are you satisfied with your room?	92.42 (18.9)	94.98 (14.5)
Do you feel safe here?	94.82 (13.2)	97.08 (12.9)
Are your belongings safe?	87.41 (26.0)	92.55 (19.9)
Is this an appealing place to visit?	94.63 (15.3)	95.42 (14.0)
Choice	**94.58 (9.0)**	**94.19 (11.3)**
Can you go to bed when you like?	97.20 (10.6)	97.06 (12.2)
Do employees leave you alone?	95.52 (11.4)	95.10 (15.4)
Do employees let you do things for yourself?	95.55 (13.6)	94.81 (16.3)

*Statistically significant at the .05 level
** Statistically significant at the .01 level

samples, and in each case the non-waiver residents reported higher satisfaction ratings.

Communications. The overall domain score for communications was significantly different as were two individual items (all at $p < .05$). For the items "Are people in charge available to talk to?" and "Are you comfortable making a complaint?" Residents who were not in the waiver program were more satisfied with these communication areas than waiver residents. Correlation and regression analyses revealed that regardless of resident type, older residents recorded higher satisfaction scores in this domain.

Meals and Dining. The meals and dining domain was significantly different as well with non-waiver residents being more satisfied compared to waiver residents ($p < .01$). Also, three of the five items that compose this domain were significantly different, "Is the food tasty?" ($p < .01$), "Can you get the foods you like?" ($p < .01$), and "Is food served at the right temperature?" ($p < .01$). Further correlation analysis indicated that older waiver residents and female non-waiver residents rated the domain higher than their counterparts. An additional regression analysis, controlling for the other characteristics, indicated that individuals who were non-waiver residents and female tended to report higher satisfaction scores for the meals and dining domain.

Unfortunately, our analysis is constrained by two important factors. First, the sample size is limited for the waiver interviews. Second, the fact that the interview sample appears to be younger and more disabled than even the overall waiver group, could also suggest that there are even bigger differences between the waiver and non-waiver samples. Because the non-waiver results come from the consumer guide data collection, demographic and functional data for comparison purposes do not exist. Thus differences in satisfaction rates could be driven by non-program factors, such as having a higher proportion of individuals with higher levels of impairment. Despite these important methodological limitations, these findings indicate that further study of this issue is warranted. For example, could communication patterns be different with non-waiver residents, resulting in perceived quality differences for waiver participants?

IV. PROGRAM AND MEDICAID COSTS

PROGRAM COSTS

Residents in the Assisted Living Waiver Program are assigned to one of three service tiers based on level of need, with a corresponding increase in daily service payments. Tier 1 residents require no more than 2.75 hours of services per day. Tier 2 residents require between 2.75 and 3.35 hours with a need for daily hands on assistance and weekly nursing assistance. The most severely impaired assisted living residents are placed in Tier 3, which is characterized by ongoing assistance with daily needs from both general and nursing staff and requiring more than 3.35 hours of help per day. The need for assistance with medication administration automatically results in a Tier 3 assignment. Daily service payments by tier are $50 for Tier 1, $60 for Tier 2, and $70 for Tier 3. A flat rate reimbursement for room and board, set at $573 per month and paid for by the resident, is applied across all tiers. The respective monthly reimbursement rates are $2,123, $2,433, and $2,743.

One of the findings from the initial evaluation of the Assisted Living Waiver Program was the complete absence of any Tier 1 clients. The small number of participants in that report limited the conclusions that could be made about this particular tier issue. However, in the phase II evaluation the number of participants is almost 1000, and thus, more definitive conclusions can be drawn. Specifically, of the 978 assisted living waiver participants, only four experienced any Tier 1 costs. Of these, only a single individual was exclusively in Tier 1, with the remaining three individuals transitioning across tiers. With such sparse use of this level of care, Tier 1 appears to serve no real function within the Assisted Living Waiver Program.

Table 10 and 11 provide detailed demographic and functional comparisons for Tier 2 and Tier 3 residents, as well as for a small group of individuals who transition between Tier 2 and

Tier 3. Only about 5% of assisted living waiver residents are found exclusively within Tier 2, and an additional 2.7% of individuals transition between Tier 2 and Tier 3 (in virtually all instances the transition is from Tier 2 to Tier 3). The overwhelming majority of participants (about nine out of ten) are exclusively at the Tier 3 service level.

A breakdown of tier assignments by PAA (not shown) generally revealed that most sites assigned more than 90% of participants to Tier 3; a rate that was similar to the one found in the full data analysis. However, one PAA substantially deviated from this pattern. In PAA 9 (Cambridge), just under one-half of assisted living waiver participants were assigned to Tier 3. Nearly 30% of individuals in this region were assigned to Tier 2 with an additional 16% transitioning between Tier 2 and Tier 3.

Although some variation exists on the demographic and functional characteristics of residents, there do not appear to be systematic differences across tiers. At the outset of the program there was an expectation that residents placed in Tier 3 would experience higher levels of disability. A review of ADL and IADL items across Tier 2 and 3 residents indicates that the functional impairment levels are quite comparable. Data on supervision needs also do not indicate differences that would explain group assignment. Almost one-third of the Tier 2 group requires partial supervision, but only about 6% require ongoing supervision. The Tier 3 group shows no one requiring only partial supervision, but more than one in ten requires ongoing supervision. In sum these data suggest few functional differences between Tier 2 and Tier 3 residents.

There are modest demographic differences between tiers; however, the small sample sizes of Tier 2 and the transition tier limit our conclusions. The fact that a good portion of the Tier 2 residents are from one PAA, drives some of the differences noted.

Table 10
Demographic Characteristics of Assisted Living Waiver Participants by Service Tier[a]

	Tier 2 (%)	Tier 3 (%)	Tier 2 & 3 (%)
Gender			
Male	10.4	20.8	23.1
Female	89.6	79.2	76.9
Race[b]			
White	93.8	82.3	76.9
Black	4.2	9.2	0.0
Other	0.0	1.1	3.9
Ethnicity			
Hispanic	0.0	1.0	0.0
Non-Hispanic	100.0	95.0	100.0
Age			
46-59	10.4	6.5	7.7
60-64	8.3	5.4	3.9
65-69	2.1	5.5	11.5
70-74	8.3	8.3	7.7
75-79	12.5	11.9	7.7
80-84	10.4	18.0	3.9
85-90	22.9	20.1	42.3
91+	20.8	23.6	11.5
Marital Status			
Married	8.3	6.7	7.7
Divorced	20.8	20.0	15.4
Widowed	47.9	59.0	61.5
Single	20.8	11.3	15.4
Unknown	2.1	2.0	0.0
N	48	851	26

[a]Only 4 clients placed in Tier 1; Only 1 client solely in Tier 1 – Data not shown.
[b]Due to significant missing data for race of individuals under Tier 3 (7.4%) and individuals under both Tier 2 and Tier 3 (19.2%), the results should be interpreted with caution. Similarly, more than 4% of Tier 3 clients do not indicate their Hispanic ethnicity.

Source: PASSPORT Information Management System (PIMS)

Table 11
Disability Characteristics of Assisted Living
Waiver Participants by Service Tier [a]

	Tier 2 (%)	Tier 3 (%)	Tier 2 & 3 (%)
ADL			
Bathing	97.9	91.3	94.2
Dressing	47.9	47.2	65.8
Eating	2.1	4.4	10.0
Toileting	20.8	23.4	35.8
Mobility	72.9	72.4	88.3
Incontinence	6.3	2.8	7.7
Grooming	29.2	21.4	36.7
IADL			
Community access	97.9	96.8	99.2
Environmental management	100.0	99.4	100.0
Shopping	95.8	97.7	97.5
Meal preparation	93.8	97.8	99.2
Laundry	91.7	94.0	97.5
Needed Supervision			
Ongoing	6.3	11.5	13.3
Partial	29.2	0.0	7.5
None	64.6	88.5	79.2
N	48	851	26

[a]Only 4 participants placed in Tier 1; Only 1 person solely in Tier 1 – Data not shown.

Source: PASSPORT Information Management System (PIMS)

MEDICAID COSTS AND COMPARISON TO NURSING HOME RESIDENTS

In this section, we examine the total Medicaid costs for assisted living waiver participants and compare these costs to a sample of nursing home residents. We chose nursing home residents who were admitted between July 1, 2006 and September 30, 2008. For comparability purposes the samples were age stratified. Because of the facility-based case mix reimbursement system in Ohio we are unable to get costs for a comparable sample of nursing home residents. However, because the first month of nursing home care is often the most expensive following a hospitalization or a major health change we excluded the expenditures for the first 30 days of nursing home and assisted living in our calculations. Therefore the annual expenditures are based on expenditures from day 31 to the persons last day of stay or October 31st whichever was appropriate.

Previous results indicated that nursing home residents are more functionally impaired overall than assisted living participants, so some cost differential would be expected. Thus, while cost comparisons are important information to examine, these differences need to be interpreted carefully. Additionally, because Medicaid costs are considerably higher for individuals under age 65 who are not eligible for Medicare, in addition to overall costs we present separate cost comparisons for individuals who are over and under age 65.

Medicaid expenditure data are presented for assisted living waiver participants and nursing home residents covering a nearly two-year period from July 2006 to March 2008. Although the expenditures for some individuals cover more than 12 months, and in some instances less than 12 months, all costs are standardized for a one year time period. So for an individual for whom we had 18 months worth of data we calculated an average daily cost for the full time period and then multiplied by 365 to get an annual expenditure rate.

Table 12 includes Medicaid expenditure data for all assisted living waiver participants who had enrolled prior to April 2008, and a comparison sample of nursing home residents. In looking at the assisted living waiver participants we see total annual expenditures at just over $30,600. As expected, the cost of assisted living is the largest single Medicaid expenditure, averaging more than $24,000 annually. This one expenditure category accounts for almost 80% of total Medicaid expenditures for these individuals. Case management expenditures, at about $1,200 per year, was the next highest expenditure category, followed closely by inpatient and outpatient hospital services ($847, $818). Prescription drugs ($794), nursing home care ($765), and physician services ($583) round out the top expenditure categories.

Total annual expenditures for nursing home residents were more than $67,500, with nursing home care at $44,200, accounting for about two-thirds of the total. Perhaps reflecting the higher frailty and acuity levels, hospice ($8,779) and inpatient hospital care ($4,859) are the second and third most costly services for this group. With the exceptions of assisted living and care management expenditures, services not utilized by nursing home residents, all other Medicaid expenditures are higher for nursing home residents than for assisted living waiver participants.

To get a better understanding of the Medicaid expenditure patterns we divide the assisted living and nursing home samples into two groups with age 65 as the cut off. This division is important because the lack of availability of Medicare for individuals under 65 has a significant impact on Medicaid. For example, as shown in Table 13, assisted living residents under age 65 have average annual expenditures of $40,500, compared to $28,700 for assisted living residents 65 and older. The comparisons are even more dramatic for nursing home

Table 12
Medicaid Expenditures for Assisted Living Waiver and Nursing Home Consumers
Per Person, Per Year (All Ages)
July 1, 2006 – March 31, 2008

Type of Expenditures (in Dollars)	Assisted Living (All Ages)	Nursing Home (All Ages)
Assisted living	24,213	0
Case management expenditures	1,194	0
Inpatient hospital	847	4,859
Outpatient hospital	818	1,394
Prescription medication	794	2,023
Nursing home care	765	44,200
Durable medical equipment	481	872
Physician services	583	1,723
Ambulance services	487	1,271
Mental health services	147	752
Home health	59	635
Hospice	48	8,779
Therapies	35	424
Other	160	612
Total	30,631	67,544
Number of Residents	467	13,010

residents, with the 65 and over group averaging $57,900 annually, compared to $117,000 for the under 65 nursing home resident group. Not unexpectedly, items covered by Medicare including hospital and hospice use, prescription drugs, physician, and ambulance services, show the biggest differences between age groups. For example, assisted living participants over age 65 recorded $415 in yearly inpatient hospital use compared to $3,200 for under 65 assisted living residents. Again the nursing home comparison is even more pronounced with residents 65 and

Table 13
Medicaid Expenditures for Assisted Living Waiver and Nursing Home Consumers
Per Person, Per Year
July 1, 2006 – March 31, 2008

Type of Expenditures (in dollars)	Assisted Living 65 plus	Nursing Home 65 plus	Assisted Living Under 65	Nursing Home Under 65
Assisted living	24,241	0	20,075	0
Case management expenditures	1,194	0	1,194	0
Inpatient hospital	415	1,485	3,176	22,508
Outpatient hospital	248	593	3,843	5,584
Prescription medication	305	680	3,044	8,615
Nursing home care	783	43,299	733	48,916
Durable medical equipment	420	680	780	1762
Physician services	497	1,078	1,061	5,096
Ambulance services	311	802	1,364	3,276
Mental health services	52	121	530	4,047
Home health	10	300	320	2,390
Hospice	52	8,535	30	10,055
Therapies	24	96	93	2,142
Other	126	251	304	2,497
Total	28,678	57,920	40,547	116,888
Number of Residents	387	10,922	74	2,088

over averaging just under $1,500 in annual inpatient expenditures compared to $22,500 for the under 65 group.

Although comparisons of Medicaid expenditures across settings are instructive, we must use caution in interpreting the meaning of these patterns. Given the higher acuity and frailty scores of nursing home residents some cost differences across settings are expected. However, because these Medicaid expenditures are significant it will be important for the state to make

sure both assisted living and nursing home residents are using Medicaid services in the most efficient and effective manner possible.

V. PROGRAM DESIGN AND IMPLEMENTATION ISSUES

QUALITATIVE ASSESSMENT OF POTENTIAL RESIDENTS AND FAMILY MEMBERS

As discussed earlier, initially enrollment into the waiver was lower than had been projected by program planners. Although enrollment has increased substantially in the second year, program administrators wanted to get a better idea of the impediments to assisted living experienced by community-based residents. How is enrollment in the Assisted Living Waiver Program influenced by perceptions and attitudes of potential assisted living consumers and their caregivers? What factors and system dynamics contribute to consumers' transitions from home care to assisted living? In this evaluation, we explore perceptions, attitudes, decision making, actions, and experiences related to assisted living, its function in the long-term care continuum, and enrollment into the waiver program. We focused on consumers currently receiving care and services at home.

Methodology

For this component of the study we conducted four focus groups to explore attitudes and perceptions about assisted living. The sample size and data gathering method are not intended to yield findings generalizable to the entire population of consumers. Instead, the method is used to identify both shared and variable patterns of perspectives and experiences and to capture the complexity of the long-term care experience, especially as related to assisted living.

The focus groups were comprised as follows.

Group 1. Levy program and Title III (Older Americans Act services) home- and community-based care consumers. (These individuals are not currently eligible for the waiver program, that is, they do not receive services through Medicaid programs). Seven females, one male, ages 67 to 77.

Group 2. PASSPORT consumers (assisted living waiver eligible). Six females, one male, ages 70s and 80s.

Group 3. Family members/caregivers of eligible and non-eligible consumers. Caregivers included one wife, one son, five daughters, and one son-in-law (married to one of the daughters in the group), ages mid-forties to mid-seventies.

Group 4. PASSPORT and Assisted Living case managers were recruited through direct request to the 13 PAAs. One case manager or case management supervisor from each of eleven PAAs participated. All were responsible for participants on the assisted living waiver; some were overseeing the utilization of both PASSPORT and the Assisted Living Waiver Program.

Each of the consumer focus groups was conducted at one of three Area Agencies on Aging in three corners of the state. Participants were contacted and recruited through a liaison at the AAA who provided a list of 10 to 12 potential participants. Potential participants were then invited from that list to participate in the focus groups.

We used an interview guide in all four groups. In the consumer groups, we explored attitudes toward home- and community-based care and support, nursing home care, and assisted living; awareness of and knowledge about assisted living; and the circumstances under which consumers could foresee a transition to assisted living. The case manager group explored thoughts and ideas about residential alternatives for consumers' care; experiences case managers have had in discussing options with consumers and their families; and perspectives about how the assisted living waiver is working, to include challenges and successes. Each focus group lasted two hours and was audio-recorded and transcribed verbatim. The text of the interviews was the data for analysis. We used an open coding and constant comparative data analysis technique.

FOCUS GROUP FINDINGS

We learned through these focus groups that the transition from home-based care to assisted living requires the simultaneous opening of two doors: the door at home, from which the consumer exits; and the door of the assisted living setting, through which the consumer enters. We have identified several challenges to achieving this outcome. Our analysis suggests that successful and appropriate utilization of the assisted living waiver requires a strategic alignment of 1) **awareness**, 2) **readiness**, and 3) **access**. Consumers and their caregivers must be aware of, and accurately informed about, the assisted living option; they must be ready on many levels to make the transition; and an appropriate setting must be available for them. In the following discussion, we outline the challenges present in each of these areas.

Awareness

Many consumers are confused about assisted living; this is especially true in the group of waiver-eligible consumers. They appear confused by the wide range of levels of care and services from facility to facility, as well as the range of physical sites and settings, from former nursing homes, to units of nursing homes, to components of CCRCs, to free-standing facilities. Assisted living was often confused with nursing homes. In addition, significantly, several of the focus group participants who are currently enrolled in PASSPORT live in congregate housing, yet claim to live in assisted living. Among all the consumer groups, sources of assisted living awareness and knowledge include: personal experience (for example, a friend or relative is a resident); advertising; in one case, the internet; and in very few cases, the case manager. Only two or three of the waiver-eligible consumers and caregivers claimed to be aware of the actual waiver program. It appears that the variability of the assisted living product has produced a

branding problem; many consumers are unable to identify assisted living as a care/housing option because they aren't exactly certain what it is and where it fits in the long-term care continuum. Why knock on the assisted living door if one doesn't know, or fully understand, where it is and what's behind it?

Readiness

What does it take to be ready – and willing – to transition from home-based care to assisted living, that is, to "walk" out the door of care at home into the relative unknown behind the assisted living door? As one caregiver asked, "Where's the line?" In fact, most of the consumers in our focus groups were still at home because they had not yet come to that line of readiness, and of course, most hoped not ever to. This was frequently expressed when participants were asked to imagine the circumstances under which they would move to assisted living: "I don't think I'm quite ready for…the next step yet." "I take it one day at a time." "Not at this point." "[Care at home] works for her." "[A]t the moment, I'm still in my 'I can manage' mode." For the most part, these are not people looking to leave home and their current care arrangements. From a policy and program perspective, as well as an individual and family perspective, this works as long as care at home is healthy and appropriate. Ideally, the Assisted Living Waiver Program functions to respond to that point of transition readiness, no sooner and no later.

Importantly, readiness is a family affair, that is, all or most family members, including care receivers *and* caregivers, must arrive at the ready together, with shared or at least compatible attitudes and perspectives. Readiness appears determined by several factors, described below.

Preference for home. The preference for home is a well-known value in the field of aging and it was prominent in our group interviews as a source of resistance to any kind of institutional care. One case manager summed it up: "People…don't want to move. They want to stay where they live…" The preference for home at nearly all costs appears to run deep and, as such, can be a daunting challenge to readiness.

Preference for family or other informal care. Participants in our groups, both caregivers and care receivers, expressed a preference for family or other informal care; yet, unlike the preference for home, this preference was more complicated and often conditional. Caregivers described preferences to keep care at home based on ideas of respect for, obligation to, and debt to their care receivers. Many expressed convictions that they were the "only ones" capable of providing the necessary care and support, especially when the care receiver posed care demands that "only" family could handle or tolerate. Many caregivers expressed an absolute determination to keep care at home, some even having made a promise to do so.

Preference for formal services at home, with or without family care. Many of the participants described what they perceived to be a very satisfactory arrangement of care at home, through the use of formal services (PASSPORT, levy, or Title III), often in partnership with family members. In fact, consumers embraced care at home with services as the ideal care arrangement. Many expressed extreme satisfaction with the support they were receiving through their Area Agencies on Aging. In this sense, the very success of formal home- and community-based services appears to produce a reluctance to imagine an alternative. As one participant said, "PASSPORT plus adult day services is better than assisted living."

Negative attitudes about nursing home care: the spillover effect. To the extent that assisted living is unfamiliar to our participants, perceptions risk being tied to the overall negative attitudes

expressed by consumers toward nursing home care. With these participants anyway, perceptions about assisted living are in some cases contaminated by a blurring with nursing home care and in other cases helped by an awareness of the differences between them. Where the confusion and negative attitudes are present and tangled, readiness is challenged. Where there is more perceived distinction between assisted living and nursing home care, there is more openness to assisted living as a care option.

Mixed attitudes toward assisted living. A striking positive about assisted living had less to do with amenities and care and more with the profile of the clientele. According to some, because assisted living residents are higher functioning than nursing home residents, they can better attend to their own needs (therefore assisted living "doesn't smell") and they are better able to have a voice in the quality of the facility's care and services. Assisted living was also described as a social and active place.

Other perceptions were less positive, though again, we can't be sure how the nursing home spillover effect is operating here. Assisted living was described as "isolating" and age segregated, and a place of "helplessness." One participant complained about "deceitful advertising," suggesting that all assisted living facilities claim to be "the best."

Toward the end of each group, we asked participants if assisted living was more like home or more like a nursing home. Significantly, the unanimous response was that assisted living is more like home. As one caregiver participant said, "Assisted living is a little touch of home without the constant relative." These findings suggest that assisted living, once understood, can be an appealing, or at least acceptable, care option to prospective residents and their families, much preferred to nursing homes. But our findings strongly suggest that until a clear distinction is perceived between nursing homes and assisted living, the readiness of families may be

compromised. In addition, the considerable loss of personal financial control and actual resources represented by enrollment appears a "deal-breaker" for some.

Access

We have established that, for consumers to leave their homes and their home care arrangements for an assisted living alternative, they must be aware of assisted living and ready for it. The third requirement for successful assisted living transition is access. The assisted living door must be open when the consumer is ready to enter. One case manager expressed the consensus in her group: "Once we get them into the facility [the program] does really well." Yet the time lag between readiness and access is a significant problem in the waiver program.

Provider Availability – Provider availability and "bed" availability are critical to timely consumer transition into the program. Some Area Agencies on Aging are actively working to bring more providers into the program. This has met with mixed success. Case managers cited regulations as "barriers" and expressed some sympathy for providers, especially those converting beds, units, or whole facilities from nursing home to assisted living.

Readiness assessment – Initial and ongoing consumer assessments appear important to case managers' ability to negotiate and implement a timely and appropriate transition to assisted living. Several challenges to readiness were identified. First, there is no clearly defined marker for readiness for transition; as we have discussed earlier, many variables are associated with readiness and identifying the readiness "moment" is a complex task. Furthermore the readiness "moment" may come and go for a variety of reasons, not the least of which is the waiting list (enrollment tracking) issue. This requires ongoing readiness assessment, monitoring, and negotiation. Finally, as one case manager pointed out, initial assessments are taking longer these

days (some "over three hours"), especially with Medicare Part D issues. This places an unusual demand on an already stressed system.

Consumer-facility "match" – The appropriate and timely match between consumers and facilities is impeded by two contrasting provider issues: lenient intake/admissions and "cherry-picking" intake/admissions. Two issues are operating here: the willingness of providers to accept consumers and their capacity to accommodate their needs.

Regarding the lenient intake and admissions practices of some providers, case managers reported that the capacity of the facility to match the acuity level of the consumers is a problem and tied to assessment issues on the providers' side. One case manager said that, in new providers' eagerness to "get going" in the program, "they are taking anyone and everyone even though we're saying they need to look very closely, and then two or three months down the line, here we are with thirty-day notices [or] hospitalizations where they don't want to take [the consumer] back. They just haven't really assessed carefully."

Even more problematic across the state is the "cherry-picking" of consumers by providers. Case managers identified the problem of providers picking their own residents off the waiting list; providers are not required to go down the list systematically. Providers "are picking and choosing the lightest care." "These new providers…are gung-ho and they see cute little ladies wheeling in and they're saying, well, you're first on our list, but they might be thirty-first on ours. [Though we've tried to work this out with them], if they've got their heart set on Mrs. Smith, that's who's more than likely going to get in." Most crucially, one case manager reported that "we've found time and time again that consumers are able to stay in their homes with a lot more needs than the assisted living is willing to accept." Case managers in the group report facility waiting time as long as two years and more, in their most extreme cases.

Another interesting match issue is the prospect of some consumers improving in the assisted living setting to the extent that home care is again possible. "[We've] had some people who were really compromised that went into assisted living and then because of med compliance, good nutrition, they suddenly do well and…want to go home."

Consumers themselves can be "picky" about the transition and this contributes to the lag between readiness and placement. As one case manager said, "They'll wait 'til kingdom come" for "a specific facility…..They have their mind made up. They're only going to such-and-such facility." The consumer may reject a placement offer for a variety of reasons, reported by case managers: the facility is "not on a bus line….the only way [my family] can get to me is by bus"; "a certain location" including those consumers who do not want to go far from home and their families, particularly to another county; the consumer wants "Spanish speaking nurses and aides."

From slippers to shoes – Whether moving from home or from a nursing facility, the transition to assisted living is a lifestyle transition. The transition from a nursing facility to assisted living may be characterized as a move "from slippers to shoes." A case manager shares, "When [consumers] come out of the nursing home and if they don't have family, they usually don't have coats and shoes. They may have slippers." Successful transition, then, calls for assistance with this lifestyle adjustment. The need for shoes and coats reflects a change in the nature of activities and of the day-to-day routine of a less medical and more social setting. According to the case managers, new freedoms in assisted living, while a highly valued benefit of the transition, raise issues of income disparity between waiver program and private paying residents. "You're putting them in the population of the people that are privately paying. I mean that has a lot to do with their self esteem." Waiver program residents, with their limited allowances, "can't get their hair

done"… "can't afford to go on outings…[and] can't afford lunch when they go out. That is kind of a struggle." A successful lifestyle transition requires the "props" (the shoes and coats, even furniture) and sufficient cash resources to fully and comfortably participate in assisted living life.

CONCLUSION

Overall, case managers are extremely enthusiastic about the success of the assisted living waiver when access is achieved at the right time for consumers and their families. According to case managers, it's a "great," "wonderful," "fabulous" program that "really saves so many people in the community." "We've had great success." "It's another option that [consumers] have never had before." Consumers are "thrilled." Case managers' expressed commitment to resolving program challenges seems to reflect their belief in the importance of the program.

UPDATE ON ASSISTED LIVING RESEARCH AND OPERATIONAL EXPERIENCES

With more than 40 states now implementing assisted living waiver programs, an array of experiences have now been recorded. Several states have faced many of the same challenges identified in Ohio, such as recognizing a need to expand the supply of assisted living facilities, developing the most efficient and effective reimbursement strategies, and exploring how assisted living facilities can best serve individuals with dementia. In this section of the report we present the most up-to-date research literature and information based on key informant interviews with program officials from select states across the nation to better understand the Ohio experience.

For the past 25 years states have been using federal waivers to fund residential long-term care services in settings other than licensed nursing homes. The approaches taken, although similar in many respects, remain distinct enough that categorizing them can be problematic. This is certainly the case in describing how states have implemented assisted living programs. Each of

the states examined for this study has a specific federal waiver to provide personal care and limited nursing services to adults who experience a disability. Some, like Florida, have more than one waiver; others, like Washington have more integrated budgets and services. Every state uses some form of assessment and case management process to determine eligibility based on financial and functional criteria, which is tied, theoretically, to eligibility for nursing home placement. How each state licenses providers, pays for, and monitors service provision also varies significantly. For this work our focus is on the current supply of Medicaid providers for assisted living services and factors that affect that supply.

METHODOLOGY

The experience of six states with Medicaid assisted living programs was examined: Washington, New Jersey, Wisconsin, Minnesota, Florida, and California. We chose states that had been identified as having a good supply of assisted living residences or states that had been actively involved in efforts to enhance their supply. Washington and New Jersey were selected as examples of states using a well-established housing with services model, in which program criteria define both housing and services, which are provided in-house and included in the set rates. Wisconsin and Minnesota were selected as examples of programs using a housing and services model, which rely on a range of settings, with variability in what types and how services are provided. Florida and California were selected as examples of a mixed model, in which the programs are neither as strictly prescribed as in housing with service models, nor as variable as the housing and services models. Some states like New Jersey and Washington were early implementers of assisted living waivers; other states, like California, are still in the developmental stage without a fully implemented Medicaid assisted living program. (Table 14 provides an overview of the states that are using Medicaid to fund assisted living.)

Our approach involved in-depth telephone interviews with state officials, consultants, agency directors, program analysts, and other high-ranking agency officials in the study states. In-depth structured telephone interviews were conducted with a total of 30 respondents. Key informants were interviewed over the phone and asked a mixture of closed- and open-ended questions regarding the nature of assisted living programs in their states. In regard to closed-ended questions, each respondent was asked: 1) whether or not their state had assisted living waiver programs and how they were funded; 2) the nature of the services provided by these programs and how reimbursement rates were calculated; and 3) to evaluate the overall quality of provider supply. Respondents were also asked to describe their overall perception of the quality and efficiency of assisted living waiver programs in their states. Finally, respondents were asked specific questions about providing services to residents with dementia.

Regardless of length of experience, size of the program, number of waivers, or the structure used, several cross-cutting themes related to supply were present in all states: 1) adequacy of funding; 2) state-provider relationships; 3) determination of payment; and 4) client/program characteristics. All of these elements influenced the availability of Medicaid funded assisted living.

RESULTS

Adequacy of Funding

Medicaid assisted living program funding problems are two-fold: state budget difficulties in general and the rate of payment for assisted living. In some states the lack of matching funds needed to expand the Medicaid program severely limited the number of funded assisted living slots, essentially capping program participation and creating long waiting lists. In such cases the programs remain relatively small, or in demonstration mode unable to expand. As

respondents, including representatives from state government, stated, this is exacerbated by provider payment rates that need to be increased. Respondents reported that low payment rates in these states have had several effects:

- low provider interest and participation rates;
- low acuity thresholds/ less aging-in-place; and
- lower service and/or service requirements for licensure.

Table 14
Review of State Medicaid Assisted Living Programs

State	Waiver? Y/N	Name of Waiver	Type of Waiver (Mollica 2004)	# Facilities (Mollica 2004)	# Residents (Mollica 2004)
Alabama	Y Approved by CMS in 2003. Not implemented; budget limitations.	SCALF (Specialty Care Assisted Living Facility)	1915 (c)	NA	NA
Alaska	Y (a broad waiver covers AL services)		1915 (c)	174	632
Arizona	Y (1115 waiver)		1115	NA	3,076
Arkansas	Y	Living Choices Assisted Living	1915 (c)	5	50
California	Y (Pilot project only)	ALWPP	Pilot		
Colorado	Y	Elderly, Blind and Disabled	1915 (c)	273	3,804
Connecticut	Y (don't see on CT website)		1915 (c)	34	65
DC	Y Approved by CMS in 2003. Regulations have not been passed.		1915 (c)		
Delaware	Y	Assisted Living	1915 (c)	29	14
Florida	Y	Assisted Living for the Elderly (ALE); Nursing Home Diversion (must be dual elig. and a resident of certain counties)	1915 (c)	581	4,167
Georgia	Y	Community Care Services Program (CCSP)	1915 (c)	465	2,851
Hawaii	Y (began in 2000- no AL providers have applied)	Residential Alternative Community Care Program	1915 (c)	0	0
Idaho	Y	Aged & Disabled	1915 (c)	265	1,870
Illinois	Y	Supportive Living Facilities	1915 (c)	81 (http://www.hfs.illinois.gov/hcbswaivers/slf.html) (09/07 numbers)	3139 (09/07 numbers) (http://www.hfs.illinois.gov/hcbswaivers/slf.html)
Indiana	Y	Assisted Living	1915 (c)	14	71
Iowa	Y	Elderly Waiver	1915 (c)	73	126
Kansas	Y		1915 (c)	155	769
Kentucky	N			0	0

Table 14 (continued)
Review of State Medicaid Assisted Living Programs

State	Waiver? Y/N	Name of Waiver	Type of Waiver (Mollica 2004)	# Facilities (Mollica 2004)	# Residents (Mollica 2004)
Maine	Y (AL is not listed as a covered waiver service, but residents can receive some HCBS waiver services [pss, homemaker, chore, pers, etc} as long as there is no duplication of services.		1915 (c)	150	3,762
Maryland	Y	Older Adults	1915 (c)	763	1,473
Massachusetts	N (uses Medicaid state plan)			101	1,120
Michigan	Y		1915 (c)		
Minnesota	Y (2 waivers)	Elderly Waiver; Community Alternatives for Disabled Individuals (CADI)	1915 (c)	396	4,114
Mississippi	Y	Assisted Living	1915 (c)	6	68
Missouri	N (uses Medicaid state plan)			494	8125 (2003 count)
Montana	Y		1915 (c)	165	475
Nebraska	Y (2 waivers)	Aged/Disabled & TBI	1915 (c)	187	1,500
Nevada	Y	Waiver for the Elderly in Adult Residential Care (WEARC)	1915 (c)	52	222
New Hampshire	Y	Elderly & Chronic Illness (HCBC-ECI)	1915 (c)	42	176
New Jersey	Y	Enhanced Community Options (a.k.a. Assisted Living waiver)	1915 (c)	159	2,195
New Mexico	Y	Disability and Elderly Waiver (D&E)	1915 (c)	NR	189
New York	Y	Assisted Living Program (ALP)		57	3,315
North Carolina	N (uses Medicaid state plan)			2,200	24,000
North Dakota	Y (two waivers)	Aged & Disabled TBI	1915 (c)	42	31
Ohio	Y	Assisted living			
Oklahoma	N				
Oregon	Y		1915 (c)	ALF- 170; RCF - 165	ALF - 3,731; RCF - 1,127
Pennsylvania	Y		1915 (c)		

Table 14 (continued)
Review of State Medicaid Assisted Living Programs

State	Waiver? Y/N	Name of Waiver	Type of Waiver (Mollica 2004)	# Facilities (Mollica 2004)	# Residents (Mollica 2004)
Rhode Island	Y (2 waivers)	Assisted Living & Dept. of Elderly Affairs' Medicaid Waiver	1915 (c)	35	230
South Carolina	N (uses Medicaid state plan)				
South Dakota	Y (very limited- med admin only)	Elderly	1915 (c)	140	500
Tennessee	N (for respite only)	Elderly/ Disabled (aka Statewide)			
Texas	Y	Community Based Alternatives	1915 (c)	300	2,851
Utah	N (uses Medicaid state plan)				
Vermont	Y	Enhanced Residential Care (ERC) (1115 program)	1915 (c)	43	157
Virginia	N				
Washington	Y	Community Options Program Entry System (COPES) & Medically Needy Residential (MNRW)	1915 (c)	368	5,292
West Virginia	Y		1915 (c)		
Wisconsin	Y	COP- W (waiver)	1915 (c)	RCAC- NA; CBRF - NA	RCAC- 144; CBRF- 3,812
Wyoming	Y	Elderly & Physically Disabled (Assisted Living)	1915 (c)	10	100

Other states in which assisted living is fully established have a different funding problem, more related to states' economic health and their budget priorities. Although funding is secure for assisted living, the money may be inadequate to fund every individual who meets the defined criteria or to adjust rates for contracted providers serving Medicaid participants. This, in turn, had the following impact:

- "unofficial" tightening of functional eligibility criteria;
- "official" revisions of assessment processes to tighten eligibility criteria;
- suppressed rates and a widening gap between private and Medicaid rates;
- withdrawal of providers from program;
- limitation on number of Medicaid clients accepted by providers; and
- decreased willingness to accept and retain difficult-to-serve Medicaid clients.

To those interviewed the greatest threat to the viability of the Medicaid assisted living program was the availability and adequacy of funding. While public awareness and demand for assisted living has grown significantly over the past two decades, the ability of individuals to pay privately has declined as acuity has increased, stays have lengthened, and rates have increased. Medicaid rates generally have not increased proportionately to those of private rates, leading some to argue that subsidization levels have risen significantly. Nor have Medicaid rate adjustments kept pace proportionately with rate adjustments for nursing homes, although requirements (rules and regulations) associated with participation in the Medicaid assisted living programs have continued to increase.

State-Provider Relationships

Respondents reported tension between the state and the assisted living provider community. In some states there has been an attempt to limit the provider's ability to set parameters of their participation in the Medicaid program (e.g., being required to retain consumers if roll-over to Medicaid occurs, requiring pre-approval for discharge to a nursing home, and establishing required Medicaid set asides). These might be called back-end attempts to maintain supply. For their part providers are relying more upon front-end control: who gets admitted. One result is growing strain between providers and the state and regional entities that oversee state Medicaid assisted living programs.

Generally the open collaboration between states and providers in the implementation of assisted living programs has been reduced by growing concern on each side about the *behavior* of the other side. There is increasing use of *data* to generate evidence to support a position. For example, states are using impairment data provided by their case managers to illustrate levels of acuity to justify rate positions; providers are using cost data to illustrate the impact of state imposed mandates of various types.

States increasingly describe a desire for *transparency* from providers. This transparency seems most related to charges for private pay residents, concerns over spend-down, and the processes related to roll-over or transfer to locations that accept Medicaid. For their part, providers perceive states as trying to place the more difficult-to-serve residents in lower cost settings without adequate reimbursement. Programs that have been in operation comparatively longer and that have established criteria, such as New Jersey and Washington, report high levels of concern about this issue. This strain has led some providers to opt out and others to curtail

participation in the programs. One significant consequence appears to be a scarcity of providers for difficult-to-serve clients, based on type of impairment and/ or geographical location.

Determination of Payment

A tiered or case mix reimbursement, based upon level of need, was the most common approach used in the states we examined. In this approach payment is based upon the projected cost of contracted services, which are determined as needed through an assessment. States that use this approach reason that having the ability to adjust rates permits more latitude in dealing with changing conditions, in particular as clients age-in-place and as their service needs increase. Providers in states with high setting and service requirements, such as Washington, feel that a tiered system allows them to effectively utilize universal workers in acuity derived models. Wisconsin and Florida have flat or cost-based reimbursement schemes. In Florida, the monthly rate is dependent upon the type of waiver used. Wisconsin has a monthly rate for registered homes and cost-based rates for other community options. Opinion was mixed among the respondents about which payment method works best and why. There is some movement toward flat rates by providers and the states since such an approach offers both groups some predictability. On the one hand, with a flat rate states could more readily predict and budget slots. In uncertain budget times or when it seems unlikely that enough money can be allocated to meet demand, this approach has appeal as a way to ration resources. Providers, on the other hand, feel they would be less likely to fall prey to reduction in payments when states redefine criteria for each level of payment. In some cases budgetary constraints have resulted in some consumers being deemed ineligible for services or payment rates reduced even when needs have not changed. Many providers feel that if staffing ratios are mandated, cost-based flat rates

provide the same kind of predictability states are seeking: resources are easier to budget and easier to manage.

All of the study states had an assessment process designed to determine level of need. They typically use case managers or eligibility workers to determine whether an individual meets the functional and financial criteria for waiver services. What the process is and how it is used depends somewhat upon the policy focus of the state. For some states the priority of placement is delay of long-term nursing home admission; in other states it is the relocation of clients from nursing homes. Florida, for example, has three waivers, each with a different stated purpose. The Nursing Home Diversion waiver is targeted toward individuals who are not in nursing homes and who have significant impairment levels but can be safely served in a community setting. The Assisted Living for the Elderly waiver is directed at those who are awaiting discharge from nursing homes and are unable to return to their prior living arrangement. Finally, the Aged and Disabled Adults waiver is targeted toward those who would require nursing home placement if not provided with home- and community-based care.

Payment rates are different for each of Florida's waivers and the type of license or setting in which services can be provided are also different. Interestingly, the levels of functional impairment do not appear very different on paper; the major difference appears to be how or if nursing services are required or provided. In many locations differential rates and licensing requirements make it more difficult to place some clients than others. The waiting list in Florida is significant and the prospects for reducing the list currently are slim because of ongoing budgetary issues.

Wisconsin also has significant waiting lists. Unlike Florida, the issue appears less related to budgetary constraints than to the fluidity of policy. Over the past 25 years Wisconsin has

relied heavily upon community efforts to create provider capacity. The result of these efforts has been mixed with experienced providers hesitant to invest resources to create capacity and higher costs associated with the highly individualized approaches.

Interestingly, like Florida, Wisconsin has decided to use a managed care approach instead of case management to operate its waiver programs. Three advantages in using a managed care approach were identified by respondents. First, the state is able to maintain a smaller permanent work force. Second, it is able to distance itself from direct constituent pressure at a local level. Third, and perhaps most important, it allows the flexibility to change course rapidly in an uncertain political landscape by simply changing contract conditions or contractors. Some policy analysts and researchers who have examined the managed care approach in Florida have expressed concern that the portion of the dollars used to manage the care leaves relatively less to provide the care. Also there are concerns that the managed care entities are not well versed in the long-term care delivery system.

Wisconsin, unlike Florida, proposes a state-wide managed care organization responsible for securing providers for the benefit of long-term care. This characterization implies that community-based long-term care services such as assisted living would not be limited to waiver dollars. The increased financial risk to a state associated with such a broadened definition implies the need for a more centralized approach to establishing service and payment criteria than has existed previously at the county level.

Client/Program Characteristics

Over the past decade, providers and advocacy groups have increasingly shied away from using the term aging-in-place. This hesitancy is the result of mismatched expectations between consumers and providers about the capacity of assisted living to adequately serve certain

populations. Many consumers believed that to age-in-place meant never having to leave an assisted living residence. Providers identified certain circumstances such as unstable medical conditions, continuous and unscheduled skilled nursing needs, or cognitive decline or mental illness accompanied by behaviors such as wandering or physical aggression, which under certain situations, could require the resident to live in a different setting, such as a nursing home.

Conversely, providers typically perceived aging-in-place to mean services they could provide under their license or through a third party so long as continued residency did not pose an undue financial, legal, or operational burden upon them. Failure to reach mutual agreement on when another care option was desirable caused many consumers and providers to want more clarity about admission and retention criteria, as well as service capacity. Defining and establishing expectations for assisted living continues to be a critical issue.

There were several program components identified by states as problem areas. State respondents were concerned that private pay clients be able to rollover to Medicaid when their funds were exhausted. They felt that this was an important consideration in setting priorities for waiver funding. State respondents described the desire to have assisted living providers have the right vis-à-vis regulatory restrictions as well as the willingness vis-à-vis internal capacity to provide more intensive personal care and nursing services. Their motive was not couched in terms of consumer choice; rather it was deemed as necessary capacity to take regular nursing home beds off line. This view is more prevalent in states with no waiting list, strong state-wide capacity, and a well established supply of providers such as in Washington and New Jersey.

Without exception states and providers saw assisted living as increasing the standards for the physical environment. Privacy was mentioned by all states and providers as expected, although paying for this element is a point of contention. Room and board rates were recognized

as increasingly inadequate to meet this standard by both the states and providers. Furthermore, in states with high financial eligibility thresholds (set at 100% of poverty level) or without the ability to use voluntary contributions to subsidize the rate, this shortfall must be covered with higher rates for private pay clients. Few suggestions as how to remedy this problem were offered by respondents.

Ultimately, it would appear there is growing divergence between providers and states about the role of assisted living in long-term care. Providers increasingly see assisted living as a stop along the continuum of care for larger numbers of frail individuals who can't live independently for a variety of reasons, but who do not have highly specialized ongoing care needs. States, under the fiscal burden of meeting ever increasing demands for long-term care want assisted living to provide a lower cost alternative for persons with high levels of need for personal and routine nursing care.

Serving Residents with Dementia

Dementia care is available in assisted living for all of the states included in the study. California and Washington have a special designation or licensure category with specific requirements for those who provide dementia care. New Jersey, Minnesota, and Florida have additional requirements in statute or administrative rules for residences that advertise that they provide dementia care. The additional requirements address how security is to be provided for egress and access to the outdoors, as well as supplemental training for staff. With the exception of Washington these rules or requirements are not addressed separately as Medicaid assisted living issues. In Washington, a boarding home, the license under which assisted living operates with a special Medicaid contract, may apply for an enhanced license for dementia care. It is possible for such boarding homes, in limited circumstances, to receive an enhanced rate.

A few states have developed more expanded special programs for dementia or Alzheimer related care. For example, Oregon has a special license designation for Alzheimer care. While any assisted living residences can provide Alzheimer care under their license, some seek designation as an Alzheimer Care Unit. Under this designation the provider typically receives a special negotiated Medicaid rate equivalent to, or higher than, the highest rate paid to other assisted living providers. There are building and service specifications and design requirements in addition to the general criteria for assisted living. These include separate common space for dining and activities (if the unit is part of a larger residence), access to a secure outdoor space, and design elements to address common issues for those with dementia such as secured egress and capacity to monitor residents. Programmatically, the special unit has additional requirements for training and therapeutic activities.

Implications of Other State Experiences

Several themes emerge as potentially important issues to address, both in the short term and over the long term, if assisted living is to thrive as an option to Medicaid eligible clients. First, is the need to recognize the impact of unstable or inadequate funding on the industry. Both act to limit provider interest and/or commitment to the program. As states experience longer histories with assisted living waiver programs, the inability to establish acceptable rates or fund sufficient slots could impact nursing home use patterns over time. Providers increasingly appear to express muted enthusiasm in participating in or rolling over residents to Medicaid. Clearly, a further examination of the methods used for rate setting would be valuable. In particular, the bed and board portion of rates increasingly is a problem that needs discussion.

A second issue is the continuing inability to establish a clear and mutually acceptable understanding of assisted living among states and providers. One phrase used to describe the on-

going confusion and conflict is the "desire for greater transparency." This lack of agreement is most evident in growing levels of mistrust between states and providers. Various tactics such as uniform disclosure statements, individual contractual agreements with residents, and involuntary move-out notifications are some strategies states have used to address their concerns regarding aging-in-place. They express concern that consumers are spending down in assisted living at a faster rate than in the past. For their part, providers are responding by more narrowly defining scope of services or terminating their participation in Medicaid. Their suspicion is that as a way to cope with budget problems states want providers to broadly define service capacity, then force them to accept or retain high acuity Medicaid clients at a reimbursement rate significantly lower than what is paid to nursing homes for similar clients. States openly talk of assisted living in terms of cost savings or as a way to take nursing home beds off line. There is a growing perception that each side is trying to trick the other and is unwilling to participate in open discussion. A mechanism to foster such discussions among interest groups, including consumers, would be one way to bring such issues out in a more constructive way.

Finally, it seems clear that increasingly assisted living is expected to provide an alternative to individuals with significant IADL needs who need more than bed and board. Clearly the longer a state has used assisted living, the higher the expectation that it serve those individuals with on-going, intermittent nursing needs, including those services performed by a registered nurse. This move toward a more medically fragile population has created heightened tension between a tradition of more aggressive medical intervention in nursing homes and a more palliative approach available to frail older adults in non-skilled care settings. As licensed settings striving to be more like home, this is creating increased challenges for assisted living providers and states alike. But dialogue again is needed to bring this issue into the open.

In short, the experiences of other states suggest that an established mechanism to bring issues to the table for discussion and resolution would well serve both providers and the states. Clearly, the early cooperation between states and providers is less in evidence now and one result is decreased trust, coupled with less willingness to find joint solutions to concerns expressed by both. Mechanisms designed to facilitate open discussion and joint problem solving would likely help address the concerns identified in the review of states' experience with Medicaid assisted living programs.

SUMMARY OF FINDINGS AND IMPLICATIONS

SUMMARY OF FINDINGS

This report evaluates the state's experiences in the implementation of the Ohio Assisted Living Medicaid Waiver Program. The program, which enrolled fewer people than expected during the first year of implementation has increased enrollment considerably and trends suggest that the state will be close to meeting its maximum number of CMS allocated slots in the program by the end of this biennium. Major evaluation findings are documented below.

1. After the initial year of operation, there were 54 certified providers and 193 participants. As of February 1, 2009, there were 169 certified providers and over 1000 active participants.

2. Based on our statewide survey of residential care facilities in Ohio, 367 residences appear to meet the criteria required to be a waiver provider. The 169 providers represent a 46% participation rate. Despite an increase nearly 40% of Ohio's counties do not have a facility participating in the waiver program.

3. There is considerable regional variation in both the total number of residences that meet the waiver criteria and in the rate of participating facilities. Although more heavily populated regions such as Cleveland, Columbus, and Cincinnati have the largest number of providers, Rio Grande (100%), Cambridge (78%), and Youngstown (63%) are the three regions with the highest facility participation rates.

4. Despite the increase in program enrollment and in participating residences, there are more than 500 individuals waiting to enroll in the program. The lack of an available facility was the primary barrier to enrollment. Although 167 days was the average wait time for all reasons, those waiting for enrollment because no provider is available waited an average 239 days.

5. Assisted Living Waiver Program participants meet level of care and experience high levels of impairment. Waiver participants have lower ADL impairment scores than were reported in the initial evaluation (2.6 vs. 3.3) and appear to be less functionally impaired than nursing home residents (4.4 ADL impairments) or PASSPORT (3.0 impairments) consumers. Assisted living waiver residents report higher levels of cognitive impairment compared to PASSPORT.

6. Over the course of the program about 20% of participants have left the program (284 individuals as of October 31, 2008), a rate lower than the discharge rate for nursing homes or PASSPORT. The two most common reasons for leaving the program are nursing home placement (49%) and death (22%).

7. Assisted living residents report high levels of satisfaction with both the program and the assisted living residence. In the majority of satisfaction areas waiver participants reported satisfaction scores comparable to non-waiver assisted living residents.

8. The overwhelming majority (90%) of waiver participants have been placed in Tier 3 (the highest category) for reimbursement purposes. Only one person out of almost 1000 participants was placed in the lowest reimbursement category, Tier 1.

9. Data do not identify any systematic differences between participants placed in Tier 2 and those placed in Tier 3.

10. Medicaid expenditures for assisted living waiver participants averaged $30,600 per year, with the assisted living expenditure portion at $24,200 or 80% of the total. Medicaid expenditures for long-stay nursing home residents totaled $67,500, with $44,200 being the actual nursing home portion. Nursing home residents are more disabled than assisted living residents, so cost differences are expected.

11. Both assisted living and nursing home residents under age 65, and therefore not eligible for Medicare, are considerably more costly than residents age 65 and older. Assisted living residents under age 65 had Medicaid expenditures of $40,500 compared to $28,700 for the over age 65 group, and nursing home residents under age 65 had expenditures of $116,900 compared to $57,900 for their over age 65 counterparts.

12. Focus groups with consumers and caregivers identify three important factors affecting use of assisted living: consumer and family awareness of the option, readiness to make the transition decision, and access to an assisted living facility of choice.

13. Focus groups with case managers identified concerns about the large number of individuals waiting to find a facility, but they voiced widespread support for the Assisted Living Waiver Program.

14. A review of other state programs identified several common issues, such as the importance of adequate reimbursement and consistent financing and regulation, but most important, respondents discussed the need to have a good mechanism to ensure sound communication between funders, regulators, and providers.

PROGRAM RECOMMENDATIONS

- The waiver program has been able to substantially increase the number of participating residences, but a persistent lack of available providers remains a major challenge. The top barrier for the more than 500 individuals who are waiting to enroll is that no acceptable facility is in their area and 40% of counties do not have a participating facility. Currently 46% of eligible facilities are participating. This is a reasonably high rate at this stage of the waiver program, but even if this continues to grow additional residential options will be necessary. Because some PAAs have been very successful at attracting facilities, it would be advantageous for ODA and the AAAs to share successful approaches across regions. ODA, ODJFS, and the Unified Budget Committee are pursuing strategies to expand residential assisted living and other supportive housing options. These data suggest that housing remains a critical challenge in long-term care.

- The assisted living waiver appears to be meeting a need in the market that is different from PASSPORT. For example, assisted living residents are older than PASSPORT consumers (43% vs. 18% over age 85) and much less likely to be married (7% vs. 21%). Assisted living waiver residents report fewer ADL limitations than in the earlier evaluation and in comparison to PASSPORT consumers and nursing home residents (2.6 vs. 2.9 vs. 4.5, respectively). Assisted living waiver residents have much higher rates of cognitive impairment with 38% requiring supervision compared to less than 20% for PASSPORT. Although the higher proportion of assisted living residents requiring supervision provides an explanation for the somewhat lower ADL scores, this trend should be monitored carefully by ODA and the AAAs. The assisted living waiver is clearly designed as a nursing home alternative program and efforts to ensure that the most disabled use this program will be critical to Ohio's overall long-term care system design efforts.

- As is the case for PASSPORT, the major reason that individuals leave the Assisted Living Waiver Program is to be placed in a nursing home. Although the disenrollment rate for the assisted living waiver is lower than PASSPORT, one important question raised is whether the program is doing everything that it can to keep participants in their assisted living residence. Case manager respondents and residents participating in the satisfaction interviews have discussed the limitations of the $50 personal allowance, particularly for individuals that have high cost sharing requirements for Medicare Part D. Respondents to our survey of residential care facilities discussed reimbursement limitations, which also could lead to high needs residents leaving the facility. We recommend that ODA and the AAAs look carefully at individuals who disenroll to nursing homes to better understand if some of these nursing home placements can be avoided.

- The current tier reimbursement system does not work. Nine of ten waiver residents are placed in Tier 3, the highest reimbursement category, and one person out of almost 1000 has been placed in Tier 1, the lowest reimbursement group. Although Tier 3 residents were supposed to be more disabled, we find no discernable difference

between residents placed in Tier 2 and Tier 3. Because assisted living waiver residents experience high rates of cognitive impairment, there may be reason for reimbursement rates to reflect some of these challenges and we recommend that ODA and ODJFS work on revisions to the reimbursement system during the next phase of the waiver.

- Medicaid expenditures for both assisted living and nursing home residents who are under age 65 represent a considerable expense for the state. Because these individuals are not eligible for Medicare and have high care needs, the state should carefully examine approaches to integrating the acute and long-term care needs of the population under age 65. The population age 65 and over is much less expensive to serve, since their acute care needs are covered by Medicare. In fact, these data suggest that efforts to move Medicare recipients into managed care programs would provide very little costs savings to the state.

- Focus groups with consumers and their families again underscore the importance in getting good and timely information to long-term care consumers. Although the consumer guide represents a significant effort by Ohio to provide information to individuals about facilities, assistance with the decision making process is the missing piece of the equation. It is clear that the majority of families are committed to providing care to their loved ones, but assistance with making decisions about how to help is often the challenge faced by consumers and their families.

- Our review of other state programs identified some lessons that are important for Ohio to examine as it continues to develop its assisted living and residential care options. There are many challenges in the financing and regulatory worlds that states face as they expand this area of service delivery, particularly in a tight economy. State respondents told us that solid communication between state officials, Area Agencies on Aging, and industry providers are critical to the health of the assisted living option. To this end, we recommend that the state continue to use its assisted living advisory group, and in fact, expand it to include additional types of housing providers.