The Medicaid Program and Assisted Living Properties: How the Rules Stymie Government and Industry Needs

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Abstract

Medicaid is now paying for assisted living services in most states, either through state plans or Medicaid waivers. The rules, scope, and effectiveness of these programs vary, state by state. States vary in their administration of assisted living Medicaid programs in the following ways: how they set rates and structure the reimbursement process; financial eligibility, including spend-down rules, the role of SSI, family supplements, and other payments; and the relationship of Medicaid paperwork to assisted living best practice. The purpose of this article is to describe the range of such programs and to delineate the factors that make such programs more or less effective for assisted living providers and useful for low-income elders who wish to move to assisted living settings.

Background

State programs to serve low-income older people at risk of entering a nursing home began in the mid-1970s. Home care programs expanded further when, in 1981, Congress passed section 1915(c), which permits waivers to allow states to pay for services that were not traditionally covered under Medicaid, including "Home and Community Based Services" (HCBS). This program recognizes that many individuals at risk of institutionalization can be cared for in their homes and communities, preserving their independence and ties to family and friends. Waivers are initially granted for three years and may be renewed for five years.

Home and Community Based Services for older beneficiaries typically include personal care, homemaker and chore services, respite care, adult day care, home-delivered meals, adult foster care, and others. In the early 1990s, states became interested in covering services in assisted living and other residential settings. These residential HCBS programs were especially targeted to those who needed more than intermittent services, or whose informal supports were not available during nights and weekends. In addition to the HCBS waiver program, similar services may also be covered by Medicaid under a second program, known as a "state plan." By 2001, forty states had received approval to cover services in assisted living. Twenty-eight states cover services under an HCBS waiver, six states use the state plan, three states cover services using both the waiver and state plan, and two states cover services under other managed care authority. Six states also use state general revenues to pay for services. Through these mechanisms, Medicaid has become a significant source of funding for services in assisted living.

In July 1999, the Supreme Court issued the Olmstead v. L.C. decision, which interpreted the Americans with Disabilities Act to require states to administer their services, programs, and activities (including their Medicaid reimbursement policies) "in the most integrated setting appropriate to the needs of qualified individuals with disabilities." As assisted living can be an important resource in meeting these goals, compliance with the Olmstead ruling is likely to increase the use of Medicaid funding for assisted living. In view of this, it is particularly important that we take stock of the diverse state Medicaid programs and identify factors that have been particularly effective in allowing assisted living providers to serve low-income elders.

Differences Between Waiver and State Plan Services

HCBS waivers and state plan services differ in several important ways. First, waiver services are available only to beneficiaries who meet the state's nursing home level of care criteria; that is, they would be eligible to enter a nursing home if they applied. Nursing home eligibility is not required for beneficiaries using state plan services.

Second, states set limits on the number of beneficiaries that can be served through waiver programs. The limits are defined as expenditure caps that are part of the cost neutrality formula required for approval. Waivers are only approved if the state demonstrates that Medicaid long term care expenditures under the waiver will not exceed expenditures that would have been made in the absence of the waiver. States do not receive federal reimbursements for any waiver expenditures that exceed the amount stated in the cost neutrality calculation. In contrast, state plan services are an entitlement, meaning that all beneficiaries who meet the eligibility criteria must be served. Federal funding continues to match state expenditures without any cap.

Perhaps the most significant difference is the ability to use a more generous eligibility standard for noninstitutional residents. HCBS programs allow states to use the optional eligibility category that allows beneficiaries with incomes less than 300 percent of the federal Supplemental Security Income (SSI) benefit ($545 a month in 2002) to be eligible and receive all Medicaid services. In the absence of

this provision, people who live at home and have too much income to quality for Medicaid would be forced to spend down their income and assets to qualify, often by needlessly entering an expensive nursing home. Using the optional eligibility approach, states can pay for assisted living and other services to give people options to nursing home admission. Tenants who meet the nursing home criteria can become eligible for Medicaid without spending their excess income *before* they are eligible. They may retain the income to pay the room-and-board costs while Medicaid covers the services. In contrast to the more generous eligibility option available under §1915(c) Home and Community Based Services waivers, the regular Medicaid state plan covers only those individuals who receive SSI or meet the state's medically needy standards. Of the thirty states with §1915(c) waivers, twenty-two use the 300 percent option; seven states do not use it; and one state reported that is has not determined if it will be used.

Establishing Rates

Setting rates based on the needs of residents can be complicated and time-consuming. States using Medicaid are only permitted to reimburse facilities for the cost of services covered under the Medicaid program. Room and board cannot be included; however, using §1915(c), the cost of preparing, serving, and cleaning up after meals can be considered as part of the service component. States may, but are not required to, limit the amount a facility may charge for room and board to a resident who is receiving public support. States that choose to limit room-and-board charges usually set the amount in relation to the SSI benefit or state supplement payment, where applicable. States determine how much must be retained by the resident as a personal needs allowance and how much may be charged for room and board.

There are three basic approaches to establishment of the rates with respect to room-and-board costs: limit charges to the state's SSI payment standard for all Medicaid beneficiaries; set rates for services and allow the "rent" to be determined between the resident and facility; and limit the room-and-board charge for SSI beneficiaries and allow higher amounts to be charged to Medicaid beneficiaries who do not receive SSI.

State Approaches to Reimbursement

As in any reimbursement system, the amount of the payment and the approach to reimbursement serve as incentives or disincentives for providers and play a major role in provider behavior. Five primary approaches are used by states in setting rates for assisted living and/or board-and-care services:

Table 1 summarizes the rate-setting approaches used by states.

Table 2 categorizes the rate-setting approaches used by states that reimburse assisted living services.

Room and Board

One of the critical issues facing expansion of assisted living for Medicaid beneficiaries is room and board. Under §1915(c), Medicaid cannot pay for room and board outside an institution except in limited circumstances such as respite care and meals that are served as part of a day care program (§441.360[b]). The part of the monthly fee in assisted living that is attributable to room-and-board costs must be paid by the beneficiary. While the beneficiary is responsible for room and board, Medicaid policy has a critical impact on access to assisted living through its payment decisions. Medicaid's historical approach to setting rates for nursing homes has carried over to assisted living. Nursing home rates include the costs of services, meals, and housing. Nine states set rates that include services, meals, and housing costs, even though Medicaid pays only for the services. Medicaid programs typically limit how much facilities may charge

Table 1. Rate-Setting Methods

Options	Description
Flat rates	Each facility is paid the same amount regardless of the needs of the resident
Vary by accommodation	The flat payment varies by single-occupancy apartment, double-occupancy apartment, and room
Tiered rates	Usually 3-5 different payments based on the frailty or functional capacity of the resident
Case-mix systems	Mirror acuity-based payment systems for nursing homes, usually more than 5 payment levels
Care plan or fee-for-service	Payments are determined by the tasks performed, units of service, and the price per unit

Table 2. State Rate-Setting Approaches

Flat Rates	Vary by Accommodation	Tiered Rates	Case Mix	Care Plan
Colorado	New Jersey[6]	Alaska	Minnesota (caps)[2]	Arkansas
Florida	Texas	Arizona	New York	Idaho
Georgia		Arkansas[5]		Iowa
Illinois[3]		Delaware		Kansas
Massachusetts		Maryland		Maine[1]
Mississippi		Oregon	**Modified Case Mix**	Michigan
Nebraska		Utah[4]		Minnesota[2]
Nevada		Vermont[7]		Missouri
New Hampshire		Washington[3]	Maine[1]	Montana
New Mexico			North Carolina[1]	North Dakota
Rhode Island				Wisconsin
South Dakota				
Vermont[7]				

[1] *Maine reimburses two forms of assisted living: congregate housing which is paid according to a care plan and residential care facilities which are paid on a blended cost-based and case-mix system.*
North Carolina has a modified case-mix payment system.
[2] *Minnesota established statewide caps by case-mix category on reimbursement that vary by groupings of counties. Counties negotiate rates with assisted living providers that have a basic payment and variable payments based on client care needs.*
[3] *Rates include regional variations.*
[4] *Utah is planning to develop a tiered rate for its pilot program that covers assisted living through an HMO.*
[5] *Planned for payment of waiver services.*
[6] *Developing a tiered rate.*
[7] *Vermont has a tiered rate for waivered services and a flat rate for state plan services.*

Table 3. State HCBS Waiver Payment Rates and Room and Board

Rate Includes Room and Board		Service-Only Rates		
Arizona	New Jersey	Alaska	Iowa	New Mexico
Georgia	Oregon	Colorado	Illinois	New York
Maine	South Dakota	Connecticut	Kansas	Rhode Island
Maryland	Washington	Delaware	Michigan	Texas
Nebraska		Florida	Minnesota	Wisconsin
		Georgia	Montana	
		Idaho	Nevada	

for room and board, and the amount is usually tied to the state's SSI payment for a single elderly beneficiary living in the community. However, this policy may create disincentives for facilities to serve Medicaid beneficiaries since the SSI payment, and therefore the maximum amount beneficiaries may be charged for housing costs, may be well below the facility's actual housing and meal costs.

As states set rates for assisted living, they must answer two separate questions. The first is should the Medicaid rate address the housing costs? There is historical precedent for states to address housing costs; however, there are significant differences between nursing homes and assisted living. Medicaid pays the costs of housing in nursing homes. Medicaid sets the payment rate, residents apply their income to the rate, and Medicaid pays any remaining balance. Since Medicaid cannot cover housing costs in assisted living, there is no need for Medicaid to address this area, particularly if it does so in a way that limits access to care. The amount paid for the housing costs could be left to the resident and the facility to determine.

The second question deals with the needs of two different groups: SSI beneficiaries and non-cash beneficiaries. States that do set a rate that includes housing costs paid by the resident usually limit the housing component to the state's SSI payment (federal SSI payment plus the state supplement, if any). This payment may be below the actual cost of housing. Massachusetts and other states have recognized the difference between the community benefit standard and the cost of housing in assisted living. Massachusetts created a separate living arrangement for assisted living with a higher payment standard of $966.

Most Medicaid nursing home residents are not SSI recipients. They have too much income to qualify for SSI and are eligible under medically needy spend-down rules or meet the state's optional eligibility category based on a percentage of the federal SSI payment. These beneficiaries have too much income to qualify under categorical standards but would meet them upon entering a nursing home and using their income and assets to pay for care including the housing component. Normally medically needy beneficiaries would not meet the financial qualifications for §1915(c) waiver eligibility because they are not likely to incur sufficient expenses to meet the spend-down requirements while living in the community. Expenses equal to the amount of excess income are easily incurred in a nursing home.

Many of these beneficiaries have sufficient income from Social Security and/or pensions to pay the "rent" and meal costs. How much of the income is actually available depends upon the state's policy. States that limit the housing costs to the SSI community living arrangement apply any excess income to reduce the Medicaid service payment. If the spend-down standard is below the SSI state supplement, it may create barriers to facilities to participate in the program.

Section 1915(c) waivers allow states to serve nursing home certified beneficiaries whose income is below 300 percent of the federal SSI benefit, or $1635 a month in 2002. This option must be applied in both institutional and community settings; however, states with a medically needy program may include both standards in their state plan. This option does not expand eligibility for institutional care in a state with a medically needy program. However, it does expand eligibility for §1915(c) services to a group of beneficiaries whose spend-down amount to reach Medicaid eligibility levels could only be met in a nursing home.

Once eligible, this special income option triggers very different procedures for treating income for people living in the community. The post-eligibility treatment of income rules (42 CFR Chapter IV §435.726 and §434.735) require that states set a maintenance allowance, that is, the amount of income that the beneficiary may retain to pay for maintenance needs. The maintenance allowance permits beneficiaries living in the community to keep enough money to pay their rent, utilities, food, clothing, and other costs. Beneficiaries have a similar need if they enter an assisted living facility. In order to enable beneficiaries to pay the assisted living facility's room-and-board fee,

states need to set the maintenance allowance high enough to allow them to do so. If states set the maintenance allowance above the SSI level, facilities whose housing costs are greater than $545 a month, or the amount of the state SSI supplement, would be able to serve low-income beneficiaries. If the maintenance allowance is too low, or lower than the facility's room-and-board charge, the resident may be forced to move to a nursing home.

Setting a higher maintenance allowance may allow more beneficiaries to be served in assisted living settings; however, it will increase Medicaid's service payment since it reduces the "excess income" that is applied to the cost of services. Despite the higher service payment, Medicaid will still pay less for services in assisted living than it would for nursing home care.

Although most nursing home residents meet non-cash eligibility requirements, those who are SSI beneficiaries may have insufficient income to meet the room-and-board charge in assisted living. States might consider establishing a state supplement to the federal SSI payment for assisted living residents. States are able to create multiple living arrangements under their state supplement, and creating a separate payment level would enable this group of consumers to gain access to assisted living. States may also address this dilemma by allowing third parties (family members and others) to supplement the resident's income.

Separate Maintenance Allowances

Post-eligibility treatment of income rules for §1915(c) waivers allow states to use reasonable standards to establish the maintenance allowance. The allowance could vary based on the beneficiary's circumstances. For example, a beneficiary living alone may need to retain more income than a beneficiary living with a spouse or other family member. A person living in an assisted living facility may have a higher or lower need than a person living alone in a single-family home. Colorado allows people living in their home or apartment to retain nearly all their income while those living in personal care homes retain an amount equal to the SSI benefit standard, which is used for personal needs and room and board.

Beneficiaries living in assisted living facilities may have different income needs depending on the type of facility: private market-rate facilities or subsidized facilities. The "rent" component of the monthly fee charged by facilities built with low-income housing tax credits will be lower than the rent charged by privately financed facilities. Through tax credits, rents in assisted living can be reduced to around $400 a month, which is paid by the resident, while Medicaid pays the service costs. Setting the allowance based on the area's average monthly charge for room and board may be overly generous when applied to residents in subsidized units. On the other hand, setting the maintenance allowance based on the amount paid by residents in subsidized units may be too low for private market facilities and create access barriers. If a state wants to improve access to both private and subsidized assisted living facilities, it could consider setting a separate maintenance allowance for each setting.

Family Supplementation

Family members may be willing to help with room-and-board costs when the beneficiary is unable to pay them. Nineteen states reported that they allow supplementation and four states have not set a policy on this issue. Seven states do not allow supplementation. Several states indicated that supplementation allows beneficiaries to upgrade to a private unit. States set their own rules governing its payment. Since Medicaid does not pay for room and board, normal rules regarding supplementation in nursing facilities (e.g., families may not supplement payment for any service that is covered in the Medicaid rate which shall be considered payment in full) do not apply. While supplementation is not prohibited, it is considered in determining eligibility for Medicaid and SSI.

Several examples help illustrate the point. The first applies to states using the 300 percent option and

assumes that the maintenance allowance is set at $1,300 a month. The facility's room-and-board charge is $1,200, but the resident has Social Security and pension income of only $1,000. The family offers to supplement the resident's income by $300, allowing the resident to pay the room and board and retain $100 a month for other expenses. Since the beneficiary's total income (Social Security, pension, and family supplementation) is below 300 percent, the resident is eligible for Medicaid and post-eligibility treatment of income rules apply. Since the combined income is less than the maintenance allowance, the third party contribution allows the resident to remain in the facility.

Medically needy beneficiaries present different circumstances. The beneficiary's excess income would include the amount contributed by family members. Incurred expenses for regular health services covered under the Medicaid state plan and HCBS waiver would be counted. Since room and board is not a covered expense, these costs could not be used to offset income.

SSI beneficiaries are also affected by supplementation. Federal SSI regulations contain provisions for treating unearned income, and these provisions are applied during the eligibility and benefit determination process. The rules include a definition of an institution that covers assisted living: "an establishment that makes available some treatment or services in addition to food and shelter to four or more persons who are not related to the proprietor." (Title 20 CFR, Chapter III, §416.201.)

The regulations provide for a one-third reduction in the federal SSI benefit amount for beneficiaries living in another person's household. While assisted living is not considered another person's household, the regulations do address the treatment of unearned income. Income received directly by the beneficiary is treated differently than contributions made to the facility on behalf of the beneficiary. While the rules are subject to some interpretation, the "presumed value" rule applies to persons living in a non-profit retirement home (§416.1144) or a non-medical, for-profit institution (§416.1145). These sections treat income provided to the facility on behalf of the resident as unearned income under the "presumed value" rule. The federal SSI benefit is reduced by one-third or, if documented, the actual amount of support provided if it is lower than one-third of the federal benefit.

If the facility has a room-and-board rate of $800, and the SSI payment is not high enough to cover the charge, family members may agree to help pay the cost. If the payment is made directly to the facility, the amount of the payment is considered "in-kind," and the one-third reduction rule applies, that is the federal benefit, $545 in 2002, is reduced by $181. If the payment is made to the resident, it is considered unearned income and the federal SSI payment is reduced $1 for $1 in unearned income, after a $20 per month exclusion.

Assuming the payment is made directly to the facility and the resident receives $545 a month from SSI with no state supplementation, then he or she retains a $30 a month personal needs allowance. The room-and-board charge is $800 a month. If the family provides additional support, the federal payment is reduced to $344, the resident retains $30, and pays the facility $314. The family must then contribute $466 a month. Medicaid eligibility is not affected since the resident continues to receive a reduced SSI payment.

State rules in Florida, for example, set a "cost of care" standard of $665 a month which can be paid to residents in special living arrangements such as adult congregate living arrangements (an older term used to describe assisted living). The rules specifically allow third parties to supplement the state payment. Florida Administrative Code §65A-2.035(1)(b) provides:

> A person may receive additional supplementation from third parties to contribute to his cost of care. The payment shall be made to the adult congregate care facility ... or other special living arrangement, on behalf of the person and not directly to the Optional State Supplementation recipient.

Using 1999 figures, a person receiving a federal SSI payment of $500 would exclude $43 for personal needs, and an OSS payment of $208 would be made. If the person also received third-party supplementa-

Table 4. Family Supplementation

Allow Supplementation			Prohibit Supplementation		No Policy
Alaska	Kansas	North Carolina	Colorado	Maine	Missouri
Arizona	Michigan	Rhode Island	Delaware	Maryland	Nebraska
Connecticut	Montana	South Dakota	Hawaii	Oregon	New Hampshire
Florida	Nevada	Texas	Illinois		Washington
Georgia	New Jersey	Wisconsin			
Idaho	New Mexico				
Iowa	New York				

tion, the federal SSI payment would be reduced to $343 and the OSS payment would remain at $208. OSS payments are not increased to make up for reductions in the federal payment.

The regulation limits the amount of supplementation to twice the state's payment standard. That is, third parties could provide up to $1,330 and the beneficiary would also receive a federal payment of $333. Any third party contribution above $1,330 would be counted as income and used to reduce the state supplement.

Effect of Medicaid and State Plan Rules on Provider Participation

Based on interviews with assisted living providers who use Medicaid-funded programs in approximately a dozen states, as well as with providers who do not use the available programs, there appear to be a number of issues that make these programs less useable and effective than they might be. These issues include:

Payment Levels in some states are not adequate when compared to the level of services the program requires. This may be especially true at the higher levels of acuity, as many states offer a flat rate that does not take resident needs into account. Many providers subsidize this underpayment through higher rates for non-Medicaid residents.

Pre-Approval Process. Some states have a pre-approval process that is lengthy, complex, or unpredictable. Some state agencies or their designees are backlogged. This problem is compounded in states that require the resident to be living in the building before the application will be considered. Providers are faced with accepting residents who may later be denied. This puts providers at risk and can be disruptive to new residents who move in, only to find out that they are not eligible.

Non-Entitlement Programs. In some cases either the state has a limited number of slots or has approved a limited number of slots at a given assisted living residence. This limitation on slots may be advantageous for the assisted living provider, because it limits the number of underpaying residents, and thus the financial risk. However, it can be difficult for existing residents who have spent down to the eligibility limits. Such residents may not be able to access a slot. Depending on state rules, priority may go to people being discharged from nursing homes or just simply not be available.

Paperwork and Other Regulatory Requirements for those residents receiving Medicaid payments may be entirely different than for the rest of the people living in a particular assisted living residence. For those assisted living providers who wish to have a small number of such slots (particularly where the reimbursement is so low that they require an internal subsidy), this means setting up a parallel operational system and second set of records, or operating the entire building in a way that is not consistent with their philosophy and primary regulatory mandate.

Bed Hold. Most states do not include payments while a resident is in a hospital or rehabilitation facility. As one informant describe the situation, "It's not like a nursing home where you can strip the bed and someone else can go in the bed. It's an apartment with their furniture and personal possessions, phone, and cable."

Limits on Multiple Contractors. In community-based care, providers often use multiple contractors, meals programs, community transportation, adult day programs, and home health, to create a system of supports a particular elder requires. In some states, the assisted living Medicaid program is not set up to accommodate such multiple program systems. As one informant stated, "The payment agencies are not understanding that the administrative rate needs to be spread across several items."

Coverage for Skilled Nursing Services. With the reduction of Medicare payments for skilled nursing, the assisted living providers in some states are faced with providing limited skilled nursing through their own staff. While reimbursement for home care allows agencies to bill both for skilled nursing visits and for nursing supervision included in the homemaker rate, in most Medicaid waiver and state programs, any skilled nursing needs must be billed separately to another agency, which may not, under its rules, be able to cover such services.

ADL Requirements. While Medicaid waiver programs require that the clinical eligibility level, usually measured in number of Activities of Daily Living (ADL) for which assistance is needed, be the same as for nursing home Medicaid eligibility, in other states there exists a slightly lower standard. In either case, there is variability from state to state in whether medication assistance is counted in the ADL list. This makes it more difficult for multi-state providers to determine whom they will be serving. However, uniform eligibility requirements would require national standards that might limit flexibility and introduce federal regulations over assisted living.

Variations in Financial Eligibility. Some states require individuals to meet the poverty standard; others will qualify people as high as 300 percent of the poverty level. Given the real costs of room and board, the higher level is more realistic. Also, in many states the SSI supplement rules are different from, and may conflict with, the Medicaid waiver rules, adding to the uncertainty of whom providers can serve under these programs.

Summary and Recommendations

In the coming years, particularly in response to the Olmstead decision, Medicaid rules are likely to change to allow for increasing amounts of non-nursing home long term care services, including assisted living. The diverse "experiments" in the use of Medicaid to pay for assisted living during the past decade, through state and waiver plans, provide a body of information about which mechanisms are most effective in meeting the needs of residents, providers, regulators, and the tax-paying public with respect to assisted living services.

It will be important to create systems, at both the state and federal level, that maintain the uniquely flexible and diverse character of assisted living and do not replicate the problems created in the nursing home industry. As one informant pointed out, "Contract agencies are still thinking 'reimbursement for services' not 'contract,' and are often using nursing home type rules." These rules make it difficult to maintain the flexibility and diversity of approaches for which consumers value assisted living. One informant suggested that a portable voucher system would give consumers a choice of living situations and services without obliging assisted living providers to conform with systems that may not meet the needs of either the providers or their residents. Those advocating vouchers need to be aware that, under current Medicaid rules, any facility

accepting a voucher becomes a Medicaid provider and would have to meet Medicaid provider requirements.

Consumers should have choice. At the same time, it is unlikely that Medicaid will approve a system in which the payer has no oversight of the facilities/providers chosen. Balancing the unique values of consumer choice and provider diversity with such oversight will remain a challenge for the foreseeable future.

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