



**EVALUATION OF OHIO'S ASSISTED
LIVING MEDICAID WAIVER PROGRAM:
FINAL SUMMARY REPORT**

**Robert Applebaum
Valerie Wellin
Cary Kart
J. Scott Brown
Heather Menne
Farida Ejaz
Keren Brown Wilson**



**Miami University
Oxford, Ohio 45056**

June 2007

TABLE OF CONTENTS

TABLE OF CONTENTS **i**
ACKNOWLEDGMENTS **ii**
EXECUTIVE SUMMARY **iii**
 Key Evaluation Findings..... iii
BACKGROUND **1**
STUDY QUESTIONS AND METHODOLOGY **3**
PROFILE OF ASSISTED LIVING RESIDENTS **5**
 Characteristics of Enrollees 5
 Comparison of Assisted Living, Nursing Home, and PASSPORT Consumers 7
ASSESSMENT OF PROGRAM QUALITY **9**
 Participants Leaving the Program..... 14
 Non-Enrollees 15
PROGRAM COSTS **18**
 Service Tiers 18
 Service Tier Change of Residents 22
 Comparison of Assisted Living Waiver and Nursing Home Medicaid Costs 23
PROGRAM IMPLEMENTATION LESSONS **26**
 Program Design 27
 Implementation Experience 28
 Financial Matters 29
CONCLUSION **30**
 Eligibility Criteria..... 30
 Number of Assisted Living Residences 30
 Approach to Ongoing Implementation Issues..... 31
 Evaluation Limitations..... 31
REFERENCES..... **32**

ACKNOWLEDGMENTS

Many individuals provided support for evaluation activities. Hope Hagans and Jeremy Newman at the Ohio Department of Aging provided us with access to program information and ongoing technical support. Members of the Assisted Living Advisory Committee provided valuable feedback on the design and comments on the study reports. Staff from the PASSPORT Administrative Agencies and from assisted living residences freely shared their knowledge about the program and assisted living with us. Justin Johnson and Brenda Peters from Benjamin Rose assisted with site visit data collection and coding. From Scripps, Kirsten Song and Ellie Stone completed interviews and coded survey data, Karl Chow was responsible for data processing and analysis and Lisa Grant ably produced the report. Finally, we wish to thank the consumers and their families who helped us get a better understanding of how this program is working.

EXECUTIVE SUMMARY

In the 2006/2007 biennium budget, the Ohio Legislature authorized the Ohio Department of Aging to develop and evaluate an Assisted Living Medicaid Waiver Program. The waiver program received approval from the Federal Centers for Medicare and Medicaid Services (CMS) to begin program operations in July 2006. The waiver is administered by the Ohio Department of Aging and operated through the regional network of PASSPORT Administrative Agencies. This study evaluates program performance for the initial implementation period, July 2006 through March 2007. During that period the program enrolled 134 participants. As of June 1, 2007, 193 individuals had entered the program and 190 were on a waiting list to enroll, but had been unable to find an assisted living facility. As of June 1, 2007, 54 assisted living residences were certified for participation in the program.

Key Evaluation Findings

- Enrollment in the program was slower than originally anticipated. Although Ohio's implementation experience is similar to other states, several issues were raised in the evaluation on this topic. First, there was universal agreement that the program eligibility criteria should be expanded to include current assisted living residents. Second, there was wide-scale agreement that the personal allowance (\$50 per month) was not adequate for many residents, particularly in light of the new Medicare Part D co-pay requirements, which do not apply to nursing home residents. Third, as of June 1, 2007, the number of participating facilities statewide was 54, and of the 190 consumers on the program waiting list, 95% reported that there was no facility available. There are approximately 279 facilities in the state that meet the assisted living waiver requirements, indicating that in order to meet program goals either new facilities will need to be developed or a much higher proportion of current facilities will need to participate in the program.
- Participants in the Assisted Living Waiver Program report high levels of disability. Half have four or more impairments in their ability to perform activities of daily living such as bathing and dressing; three quarters have three or more activity limitations. Assisted living waiver residents on average report higher levels of disability when compared to PASSPORT participants, but are not as impaired as nursing home residents.

- Assisted living waiver participants report high levels of satisfaction with the enrollment process, with 85 to 90% rating the help from assisted living facilities and case managers as good or excellent. Residents reported high levels of satisfaction with the facilities, although in select areas suggestions for improvements were identified. Our case study interviews with residents, on-site coordinators, and case managers indicate that the program is doing a good job in helping residents achieve privacy, autonomy, and choice in the services they receive.
- The waiver program classifies residents into three tiers for the purposes of establishing reimbursement rates for services. Tier 1 service rates are \$50 per day, Tier 2 \$60, and Tier 3 \$70. The 2007 room and board rate is \$573 per month, which is added to each service rate. None of the residents were placed in Tier 1 and only 10% of residents were classified as Tier 2. The average rate across all regions of the state, combining room and board and service was \$2,711. The statewide average rate by region for Medicaid nursing home care was \$5,059. That the vast majority of assisted living residents are placed in Tier 3 (90%) suggests that the classification strategy needs to be carefully reviewed as the program moves forward.
- Overall, the program appears to be receptive to input from stakeholders; however, respondents identified a series of program implementation issues that require examination. Such comments are typical for a program of this nature and suggest that it will be important for the Assisted Living Waiver Program to set up a mechanism for ongoing program modifications and improvements.
- This study provides an important first look at the program. However, because of the slower than expected build-up and the short time frame of the evaluation, results should be viewed as preliminary in nature. As the program expands both the number of consumers and the type and number of facilities that participate in the waiver, ongoing monitoring of data on the profile of residents, quality, and costs will be essential.

In addition to this summary report, the evaluation includes three topical reports:

Consumer Access and Satisfaction, Assessment and Service Plan Development Process, and Program Costs. All reports are available on the Scripps and Ohio Department of Aging web sites.

(scrippsaging.org – Goldenbuckeye.com)

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). In Ohio, from 2000 to 2005 total Medicaid long-term care costs increased from \$3.2 billion to \$4.8 billion (50% increase) (Burwell et al., 2006). Since the number of older people with disability in Ohio is estimated to more than double by 2035, the state faces a serious challenge in developing a system of long-term care that will meet the needs of Ohioans in an efficient and effective manner (Mehdizadeh et al., 2007).

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. An expansion of in-home services through the PASSPORT program was Ohio's initial major response to this challenge. Accompanying this expansion have been a number of efforts including a nursing home pre-admission assessment process, development of two Program of All-Inclusive Care to the Elderly (PACE) sites, nursing home reimbursement reform, and a recent Money Follows the Person initiative to ensure that individuals with disability can reside in the setting of their choice. The development of the Assisted Living Waiver Program represents an additional attempt by Ohio to expand the range of

long-term care options for people with disability. Ohio is the 42nd state to implement a Medicaid Assisted Living Waiver Program.

To implement the Assisted Living Waiver Program, the Ohio Department of Aging (ODA), which is responsible for its day-to-day management, partners with two other state agencies, the Ohio Department of Job and Family Services (ODJFS) and the Ohio Department of Health (ODH). ODJFS, as the single state Medicaid agency, has fiduciary responsibility for the program, and ODH is responsible for licensing residential care facilities and for collecting data used by ODA for the certification of assisted living providers that participate in the program. The program uses case managers located in the 13 regional agencies that administer the PASSPORT 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, PASSPORT Administrative Agency (PAA) case managers are responsible for monitoring the consumer's condition and the services provided in the assisted living facility.

The concept of assisted living is based on the philosophy that the traditional institutional setting did not maximize choice and autonomy for residents. The assisted living model, with a single occupancy room, private bathroom, locking door, and socialization space is designed to support residents in their efforts to lead their lives with as much privacy, independence, and choice as is possible. A negotiated service plan is the mechanism used in the assisted living program to help residents and facilities to achieve these important goals.

To be eligible for the assisted living waiver, participants must 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. Additionally, participants must be 21 years of age, meet the nursing home level of care criteria, have a need for assistance with activities of

daily living that cannot be scheduled, and be Medicaid eligible. To enroll, eligible consumers must find a facility that has been certified by ODA and is able to accommodate the resident. As of June 1, 2007, 54 facilities had received program approval to enroll Medicaid waiver participants. Program build-up has been considerably slower than originally anticipated and although this experience is typical for assisted living waiver programs nationally, it will be important to better understand the reasons for these enrollment patterns.

STUDY QUESTIONS AND METHODOLOGY

This evaluation examines three major dimensions of Ohio's Assisted Living Waiver Program: (1) a profile of participants, (2) an assessment of program quality, and (3) a review of program costs. The study examines the experience of those consumers who applied and/or enrolled in the waiver program between July 2006 and March 2007. Data on the demographic and functional health profile of residents come from the PASSPORT Management Information System (PIMS). These data are recorded by case managers employed by the PASSPORT Administrative Agencies as part of the program's assessment, eligibility, and care planning process. Information on those who were found to be eligible but chose not to enroll and those who left the program after moving into a participating facility are also included in the PIMS.

Data on program quality come from several sources. First, we conducted a telephone survey with program participants who had been residents for two months or longer to assess their satisfaction with the waiver program and the assisted living facility. Telephone interviews were also completed with individuals (or their proxies) who did not enroll or who left the program.

Second, to gain a more in-depth perspective on program and facility quality and satisfaction we completed in-person interviews with a sample of waiver participants. While visiting the assisted living facility, interviews were also completed with the assisted living on-

site coordinator (the person at the facility who was most involved in the program) and the administrator. The site visits included interviews with 20 assisted living residents housed in ten facilities that were located in five regions of the state. These regions included urban, rural, and suburban areas. On-site coordinators were interviewed in-person regarding 17 of the 20 residents (some were not completed because the on-site coordinator was not available). PASSPORT Administrative Agency case managers were asked to complete a mailed survey regarding the 20 residents and 14 of these surveys were returned.

Residents participating in the in-person interviews were asked about their satisfaction with the move-in process, satisfaction with the assisted living facility and the program, and their involvement in decision making about joining the program and in selecting the assisted living facility. Respondents also answered open-ended questions about: a) what they liked the most about the assisted living residence, b) what they liked the least about the assisted living residence, and c) how their life had changed since moving to the residence. The length of the in-person interviews ranged from 23 minutes to 80 minutes, with an average of 44 minutes.

The assisted living on-site coordinators answered open-ended questions about the service plans of those residents who were interviewed and how the plans maintained the residents' privacy, choice, and independence. When on-site coordinators were unavailable for an in-person interview a survey was mailed to them.

PAA case managers were asked to complete a mailed survey for those program participants who had been interviewed during the site visit. Questions focused on the resident's initial assessment and service plan, including how case managers developed the initial plan to promote the privacy, choice, and independence of the consumer.

Upon visiting a site to conduct the resident and on-site coordinator interviews, researchers also met with the facility's administrator about the program. Along with the rest of the information that was gathered on site, notes from interviews with the administrators were reviewed to provide an additional perspective about the waiver program.

The costs of the assisted living residents were compared to nursing home residents in the same region of the state. The data sources for this component of the analysis include the PASSPORT Information Management System (PIMS), the Nursing Facility Minimum Data Set (MDS) and the 2005 Survey of Long-Term Care Facilities in Ohio. Because the analysis sample for the study included only 134 assisted living residents, results represent preliminary findings.

PROFILE OF ASSISTED LIVING RESIDENTS

Characteristics of Enrollees

The basic demographic characteristics of those who enrolled between July 2006 and March 2007 are presented in Table 1. Ages ranged from 48-99 years, with an average age of 78 and a median age of 79.5 years. Most enrollees were female (78%), White (87%), and widowed (55%); approximately 10% were currently married. Data on the extent to which residents required assistance with activities and instrumental activities of daily living are important indicators of the need for long-term care. Activities of daily living (ADL) include such items as bathing, dressing, and grooming. Instrumental activities of daily living (IADL) include such tasks as shopping, meal preparation, and laundry. Two additional behavioral indicators were available from assessment data: whether the applicant was incontinent and whether the applicant required no, partial, or ongoing supervision.

The majority of residents required assistance with bathing (94%), mobility (89%), and dressing (64%). Almost four in ten participants required assistance with grooming (40%) and

Table 1
Demographic and Functional Characteristics of Enrollees
in the Assisted Living Waiver Program,
April, 2007

Characteristics	
Age	
46-59	9.0%
60-64	8.2%
65-69	7.5%
70-74	11.2%
75-79	14.2%
80-84	9.7%
85-90	23.1%
91+	17.2%
Average Age	78.0
Gender	
Female	77.6%
Males	22.4%
Race^a	
Non-Whites	12.9%
Whites	87.1%
Marital Status	
Non-Married	90.1%
Married	9.9%
ADLs	
Eating	9.7%
Toileting	35.1%
Grooming	39.6%
Dressing	64.2%
Mobility	88.8%
Bathing	94.0%
IADLs	
Shopping	97.8%
Laundry	97.8%
Meal Preparation	98.5%
Community Access	98.5%
Environmental Management	100.0%
Sample Size	134

^aRace data should be viewed with caution because of a high rate of missing data.

Source: PASSPORT Information Management System (PIMS)

toileting (35%); one in ten required assistance with eating. For the IADLs, almost all of the residents (98%) required assistance. In addition, almost one fourth of participants were identified as incontinent and one in five required some level of supervision, with 12% classified as needing ongoing supervision.

Comparison of Assisted Living, Nursing Home, and PASSPORT Consumers

Table 2 provides a comparison of assisted living waiver participants, nursing home residents supported by Medicaid, and PASSPORT consumers. Assisted living participants, as are nursing home residents and PASSPORT consumers, are typically female and widowed or divorced. Assisted living residents are less likely to be married than their counterparts — less than 10% compared to 15% of nursing home residents and 20% of PASSPORT participants. Four in ten assisted living residents are age 85 and older. This proportion is comparable to nursing home residents and more than twice the PASSPORT figure.

Impairment levels across the three groups vary. Almost all assisted living participants, nursing home residents, and PASSPORT consumers report having difficulty with bathing, indicating that persons in all three settings have significant physical impairment. For all other ADL items, assisted living residents are between the nursing home and PASSPORT consumer profiles. For example, the measure of difficulty in dressing shows 64% of assisted living residents with impairment, compared to 82% of nursing home residents and 60% of PASSPORT participants. Ability to get to and use the toilet shows more than one in three assisted living residents to be impaired, compared to three quarters of nursing home residents and one in five PASSPORT consumers. Regarding incontinence, assisted living residents (23%) are less impaired than nursing home residents (62%), but are more impaired than PASSPORT consumers (14%). It should be noted that environmental and regulatory constraints in nursing homes limit

Table 2
Comparison of Assisted Living, Nursing Home, and PASSPORT Consumers

	Assisted Living Consumers (%)	PASSPORT Consumers (%)	Medicaid Nursing Home Residents (2006) (%)
Age			
46-59	9.0	N/A	11.2
60-64	8.2	10.7	5.5
65-69	7.5	16.0	6.2
70-74	11.2	17.4	7.7
75-79	14.2	18.5	12.1
80-84	9.7	18.2	17.3
85-90	23.1	11.5	20.4
91+	17.2	7.5	15.5
Gender			
Female	77.6	76.7	71.1
Race^a			
White	87.1	78.7	83.0
Non-White	12.9	21.3	17.0
Marital Status			
Married	9.7	19.8	14.3
Divorced/Widowed	77.6	73.6	65.3
Never Married	10.4	6.6	20.3
ADL			
Bathing	94.0	96.0	91.6
Dressing	64.2	60.1	81.8
Transferring	--	--	70.1
Eating	9.7	10.9	33.3
Toileting	35.1	21.1	76.3
Mobility	88.8	75.6	--
Grooming	39.6	32.9	81.9
Number of ADL Impairments			
0	0.0	0.8	7.2
1	6.0	3.5	7.2
2	20.1	34.6	4.7
3	25.4	33.6	5.7
4+	48.5	27.5	75.3
Average Number of ADL Impairments			
	3.3	3.0	4.4
Incontinence			
	23.1	14.1	62.3
Needed Supervision			
Ongoing	11.9	9.5	--
Partial	6.7	9.1	--
N	134	28,565	36,678

^aRace data should be viewed with caution because of a high rate of missing data.

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

resident mobility making disability comparisons across settings somewhat more difficult to interpret. For example, a nursing home resident who is slow in getting to the bathroom may be classified as impaired in that setting, while an assisted living or PASSPORT participant may be classified as independent.

In examining the summary measure of total ADL deficits, again the assisted living waiver participants are in between the other two groups. Almost half of assisted living residents have at least four ADL deficits, compared to about three in ten PASSPORT consumers and four of five nursing home residents. The average number of ADL impairments also follows this pattern with assisted living residents (3.3) between nursing home residents (4.4) and PASSPORT consumers (3.0). Because of the measurement challenges associated with some of the mobility items, we also compared those with three or more ADL impairments by setting. Almost three quarters of the assisted living residents have three or more ADL limitations, compared to six in ten for PASSPORT and 81% of nursing home residents. This grouping shows fewer differences across settings and suggests that further study of ADL measurement by location would be important to better understand program comparisons.

ASSESSMENT OF PROGRAM QUALITY

Our efforts to assess program quality involved interviews with residents (or their proxies), assisted living staff, and case managers. Consumer interviews included current and former residents and those who were determined eligible for the program but who chose not to enroll. The relatively small number of respondents in the sample limits our ability to conduct a detailed analysis in this area.

To assess the effectiveness of the program, consumers were asked questions such as their reasons for moving to the assisted living residence, the help they received in selecting the residence, their satisfaction with the services, and how their independence, privacy, and choice

were maintained. To examine resident satisfaction, we identified 97 individuals who had lived in assisted living for two months or longer and asked them to participate in a survey about their experience enrolling in the program and residing in the facility. In February and March 2007, 41 telephone or in-person interviews were completed with enrollees or their proxies. Many residents did not have a phone in their room; repeated attempts to contact these individuals yielded a response rate of 42%. Residents (or their proxies) were asked a series of questions to assess their perceptions of the quality of care and their satisfaction with the services that they were receiving at the assisted living residence. Twenty of these surveys were conducted in person and those interviews provided more in-depth information about the resident's experience. The in-person interviews also recorded much higher response rates.

In general, participants in the assisted living waiver program reported positive ratings about the help they received in moving to the residence. The vast majority of residents (about 90%) responded with an "excellent" or "good" for items in this category (see Table 3). A handful of consumers did express concerns about the information received describing the program. Three quarters of the residents indicated that they were not alone in making the decision to be part of the waiver program. They had assistance selecting the assisted living residence primarily from family members. About half of the respondents reported moving from a nursing home to the assisted living residence.

A series of questions were also asked about participant satisfaction with the assisted living residence (see Table 4). On questions about employee behaviors, residents appeared relatively satisfied; 86% reported that employees always let residents do what they want for themselves, three of four residents found employees to be always courteous, and seven in ten described employees as always available to help. Questions were asked about food and in each

Table 3
Ratings of the Quality of Help in Moving Into the Assisted Living Residence

How would you rate the ...	Excellent	Good	Fair	Poor
Information you received concerning the services here? (N = 30)	43.3%	43.3%	10.0%	3.3%
Financial information regarding the AL waiver program? (N = 26)	61.5%	34.6%	3.8%	--
Helpfulness of the staff during your move to the facility? (N = 34)	55.9%	35.3%	2.9%	5.9%
Helpfulness of the AAA case manager during your move to the facility? (N = 27)	55.6%	33.3%	7.4%	3.7%
Helpfulness of your family during your move to the facility? (N = 29)	62.1%	27.6%	3.4%	6.9%

Table 4
Resident Satisfaction with Care and Services in the Assisted Living Residence

	Yes, always	Yes, sometimes	No, hardly ever	No, never
Are the employees courteous to you? (N = 40)	75.0%	25.0%	--	--
Are employees available to help you if you need it? (N = 37)	70.3%	27.0%	2.7%	--
Do the employees let you do things you want to for yourself? (N = 36)	86.1%	13.9%	--	--
Do you have a choice of what to eat and drink? (N = 39)	69.2%	12.8%	17.9%	
Is your food served at the right temperature? (N = 36)	69.4%	25.0%	5.6%	
Are your belongings safe here? (N = 36)	75.0%	19.4%	2.8%	2.8%
Are the rules here reasonable? (N = 33)	75.8%	24.2%	--	--
Can you go to bed when you like? (N = 37)	94.6%	5.4%	--	--
Is it acceptable to make a complaint here? (N = 34)	64.7%	23.5%	5.9%	5.9%

case more than two of three participants were satisfied that there was always choice in the selection of food and drink and that food was always served at the right temperature. It is worth noting that almost one in five respondents (18%) did complain that at their place of residence they hardly ever had choice in what to eat or drink.

Three of four residents responded that their belongings were always safe. Questions were asked about the rules at the residential facility: almost all agreed that they could always go to bed when they liked, three quarters asserted that the rules were always reasonable, and two thirds responded that it was always acceptable to make a complaint at their residence.

Overall satisfaction with the assisted living residence was also examined (see Table 5). In general, it appears that the residents (or their proxies) interviewed were satisfied with their assisted living arrangements. Almost four of five indicated that they always get the care and services they need, and three of four revealed that they always feel comfortable in their residence. More than nine in ten participants always find their residence to be an appealing place for others to visit and 72% are always satisfied with the activities offered. Three in four would always recommend the residence to a family member or friend, but 10% would “never... recommend this place to a family member or friend.” Finally, when asked in the in-person interviews “if you had a choice would you move to another facility?” 17 of 20 respondents indicated “no, definitely not.”

Respondents were also asked what they liked most/least about living at the residence. Several of the residents commented on the good staff and the opportunity to socialize. A few residents mentioned they felt that they experienced personal growth and improved health since moving into assisted living. Residents also commented that they felt more independent because they did not have to deal with daily burdens such as shopping or cooking. However, a few

Table 5
Enrollee Global Satisfaction with Their Residential Setting
in the Assisted Living Waiver Program,
April 2007

	Yes, always	Yes, sometimes	No, hardly ever	No, never
Do you get the care and services that you need? (N = 39)	79.5%	20.5%	--	--
Do you feel comfortable here? (N = 33)	75.8%	24.2%	--	--
Do you think this is an appealing place for people to visit? (N = 34)	91.2%	8.8%	--	--
Are you satisfied with the activities they offer here? (N = 32)	71.9%	21.9%	6.3%	
Overall, do you like living here? (N = 38)	65.8%	23.7%	2.6%	7.9%
Would you recommend this place to a family member or friend? (N = 40)	72.5%	17.5%	--	10.0%

respondents commented that the facility was isolated and/or there was a lack of available transportation. A few residents also mentioned that they did not have enough spending money, thereby implying that this limited their independence to a certain degree. A majority of residents said that they could never prepare food in their room.

In addition to residents' comments, on-site coordinators and PAA case managers also provided various examples of how residents' choices were taken into consideration. For example, on-site coordinators mentioned that residents had the opportunity to participate in various activities and could choose what they did/did not want to do. They also commented that residents

had a choice in selecting foods to eat. At least one on-site coordinator noted that residents could choose what time they ate meals at the facility or whether they went out to a restaurant.

PAA case managers noted that the independence of the residents was maintained because of policies at the assisted living facilities. For example, they mentioned that residents could provide input on developing/changing their care plans. From on-site coordinators, the most common example was that residents receive periodic assessments to evaluate their level of independence in activities of daily living. Such assessments are documented in the service plan and help maintain resident independence. One other response focused on how residents' independence was maintained by the activities that they chose to engage in: being active in the community, and going out shopping whenever they wanted.

Resident respondents also commented positively on increased privacy and feeling safe and secure in the residence. On-site coordinators and PAA case managers echoed the comments of residents by noting the importance of the private room with a bathroom. Another example of privacy, mentioned by on-site coordinators, included maintaining the confidentiality of the service records (e.g., not discussing issues such as diagnoses or payer information in front of or with other residents). A few residents offered negative comments and noted limited privacy and felt that, in a few instances, the staff members emphasized rules over consumer needs.

Participants Leaving the Program

Over the first nine months of the waiver program, eight of the 134 participants left the program; three of these individuals died. We completed interviews with three of the five participants who chose to leave the program and/or their proxies. Individuals (or proxies) were asked, "What were your reasons for deciding to leave the assisted living facility?" The very small number in this category limits any analysis, but we present these data as a sample of future

data collection efforts in this area. Two individuals responded that the facility did not provide the services/activities that they required, whereas another indicated the specific need for a nursing home. One married respondent wanted to be reunited with the spouse, who had been placed in a nursing home. One individual stated that the decision to leave was made entirely on his/her own; the two others indicated receiving help from family members, primarily a spouse and adult children, and from a case manager. One individual went to live with a family member and two others went to a nursing home.

Although the small number of participants leaving the program limits our ability to analyze data on the experiences of these individuals, it is the small number itself that may be the most important finding in this area. That only five of the 134 participants chose to leave during the time period of the evaluation could be an important indicator. Given the high rates of disability of assisted living waiver participants, the relatively stable nature of this population may suggest that the referral and placement system is working well. An ongoing monitoring of this rate will be an important program outcome for future evaluation efforts.

Non-Enrollees

As of April 2007, 44 applicants were assessed, deemed eligible for participation, but did not enroll in the Assisted Living Waiver Program. The characteristics of these individuals were similar to those who did enroll: mostly female, non-Hispanic White, not married (widowed, divorced, or single). The age range was 48-87 years with an average age of 71. Those who did not enroll had similar levels of disability compared to assisted living program participants. The limited sample size make any findings preliminary, at best.

Telephone interviews were completed with 13 of the 44 non-enrolled applicants or their proxies between November 2006 and March 30, 2007. Many applicants had moved from the

location in which they lived at the time of their assessment and could not be reached. Applicants reported getting information about the Assisted Living Waiver Program in diverse ways including from a case manager, another long-term care professional, a family member or friend, through the PASSPORT program, from someone at the nursing home, an AARP flyer, and the newspaper.

Four of these non-enrollees or their proxies were able to visit an assisted living facility participating in the waiver program. Reasons why others were not able to visit a facility included the absence of a participating facility in their community (8), no transportation (2), or because they were too impaired or too ill to visit a facility (3); one of the non-enrollees did report that a family member or friend/neighbor was able to visit a participating facility in his/her stead.

A number of non-enrollees (7) reported that they were able to get all the information they wanted before making a decision; others did not get that far as they assumed transportation would not be available to physician appointments and the like or that more care would be required than an assisted living facility could provide. When asked how satisfied they were with the information they did receive about the waiver program, five non-enrollees responded that they were “satisfied” (one even responded “very satisfied”) and three were dissatisfied; others did not know or refused to answer.

Non-enrollees (or their proxies) were asked to identify their reasons for not entering assisted living and these reasons are listed in Table 6. All responses were recorded, as a number of the non-enrollees had multiple reasons for not entering a facility in the waiver program.

Costs were among the most frequently cited reasons for not entering an assisted living facility in the waiver program, receiving a total of seven mentions from non-enrollees, and this pattern was confirmed when respondents were asked to identify the most important reason for

Table 6
Reasons Non-Enrollees did not Enter an Assisted Living Facility

Reasons for not entering an assisted living facility

Had to pay own costs (e.g., co-pays, Rx).
The rent was too high.
Did not like the accommodations.
The facility did not have the services/activities needed.
The facility was too far from family.
The facility was too far from friends/neighbors.
Other
 The facility was confining, too much like a nursing home.
 Cable TV was not included in the package.
 Unable to host family or have family sleep over.
 Current place of residence is just fine.
 Had used up all money in assisted living and could not move directly into the waiver program.
 Would have taken all money and applicant didn't agree with that.
 Loss of independence and unable to smoke.
 Preferred to stay in community.

not entering an assisted living facility. Three respondents specifically identified having to pay their own costs, including co-pays and prescriptions; three identified the rent as being too high; and another was concerned that assisted living would use up all her money.

Two respondents did not like the accommodations (with direct and specific mentions given to the absence of a kitchen and the small size of the rooms) and two asserted that the assisted living facility available to them did not have the services/activities that were needed. (A proxy for one non-enrollee was particularly adamant that with her mother's Alzheimer's disease and insulin-dependent diabetes, more one-to-one care was required than could be provided in the assisted living facility.)

Several respondents (3) also spoke to concerns about staying in the community; two expressed these concerns indirectly in remarking that the facility available to them was too far from family (1) or friends/neighbors (1), whereas a third spoke directly to the preference to stay

in her home community. Nine of the respondents indicated that the decision not to enroll was solely their own, with two others identifying family members (i.e., a daughter and extended family members) who helped make the decision.

Finally, we asked non-enrollees (or their proxies) to think back over the entire experience of applying, gathering information, and trying to decide whether to enter the waiver program and rate the overall experience as excellent, very good, good, fair, or poor. Only eight responded, with four indicating “very good/good” and four indicating “fair/poor.” We followed up by asking this group of non-enrollees what they would recommend to make the program better, and Table 7 lists their recommendations. Again, several respondents were at a loss to make recommendations, whereas others had a bounty of ideas. Cost issues appear to dominate – at least two non-enrollees offered that information about out-of-pocket costs associated with the waiver program should be provided earlier so that it could be factored into the decision-making process. Five respondents suggested that enrollees be allowed to retain sufficient money to purchase discretionary items and other necessities. Other recommendations included making sure that assisted living facilities participating in the program had available transportation for physician visits and other medical needs, allowing for larger rooms, and speeding up the application/eligibility assessment.

PROGRAM COSTS

Service Tiers

Consumers in the Assisted Living Waiver Program are assigned to one of three service tiers based on levels of needed care, with corresponding increases in daily service payments. Although all enrollees in the Assisted Living Waiver Program must meet the nursing home level of care criteria, there are expected differences in disability and care needs between tier groupings. Tier 1 clients require no more than 2.75 hours of service per day. Tier 2 clients require more

Table 7
Non-Enrollee Recommendations to Improve the Assisted Living Waiver Program,
April 2007

Recommendations
Provide transportation (e.g., physician appointments or dialysis). People should be allowed to keep enough of their money/resources to purchase cable TV or other needed items (e.g., eliminate co-pays). Provide larger rooms (e.g., respondent dislikes twin beds). If information about costs were provided first, the decision would have been made more quickly. “It took too long to tell if I was eligible.” People should be able to move from assisted living right into the waiver program. Assisted living waiver was “not the right solution.” Some services should be made available (e.g., hairdressing).

daily hands-on assistance from staff and up to weekly nursing assistance. These consumers use between 2.75 and 3.35 hours of service per day. The most severely impaired assisted living clients are placed in Tier 3, which is characterized by ongoing daily needs from both general staff and nursing assistance that requires more than 3.35 hours of service per day. The need for assistance with medication administration automatically results in a Tier 3 assignment.

The increasing care needs across the three tiers correspond to increases in daily service payments. 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 & board of \$573 per month in 2007 is applied across all tiers. Thus, the respective monthly reimbursement rates across the three tiers are \$2,123, \$2,433, and \$2,743 (assumes a 31 day month).

Table 8 shows the characteristics of Assisted Living Waiver Program enrollees across the three service tiers. Perhaps the most striking result in the table is the absence of any Tier 1 residents from the 134 persons enrolled through March 2007. Fourteen residents (10%) were

Table 8
Demographic Characteristics of Assisted Living
Waiver Participants by Service Tier

	Tier 1 ^a	Tier 2 (%)	Tier 3 (%)
Gender			
Male	--	7.1	24.2
Female	--	92.9	75.8
Race^b			
White	--	88.9	86.9
Black	--	0.0	4.9
Other	--	11.1	8.2
Ethnicity			
Hispanic	--	0.0	0.8
Non-Hispanic	--	78.6	97.5
Age			
46-59	--	14.3	8.3
60-64	--	7.1	8.3
65-69	--	14.3	6.7
70-74	--	0.0	12.5
75-79	--	0.0	15.8
80-84	--	0.0	10.8
85-90	--	42.9	20.8
91+	--	21.4	16.7
Marital Status			
Married	--	7.1	10.0
Divorced	--	14.3	25.0
Widowed	--	57.1	53.3
Single	--	14.3	10.0
Unknown	--	0.0	1.7
N	0	14	120

^aNo clients placed in Tier 1.

^bPercentages for race based only on completed responses. Due to excessive missing data for race, the results should be interpreted with caution.

Source: PASSPORT Information Management System (PIMS)

placed in Tier 2, with the remaining 90% of participants being placed in Tier 3. Residents in both Tier 2 and Tier 3 are quite similar, mostly female and largely non-Hispanic White. The majority of individuals in both tiers are widowed with less than 10% having a living spouse. About half of all residents are age 80 or older.

Residents in both service tiers have similar levels of disability (See Table 9). For the activities (ADL) and instrumental activities of daily living (IADL) there is little difference between the two tiers. Residents in both tiers, with only a handful of exceptions, are disabled on all IADL items. This is also the case for both the bathing and mobility ADL items, with approximately 90% of individuals in the two tiers reporting difficulty in these domains. About one third of residents in both tiers report difficulty toileting, and 7-10% of participants across both tiers report difficulty with eating. The only item that does not appear to fit the expected pattern is grooming, which shows more impairment for the Tier 2 grouping. Interpretation of this finding is limited by the small sample size of Tier 2 and will require additional analysis as the program increases in size.

The assessment of need for either partial or ongoing supervision appears to be an area of potential importance in making comparisons between the two tiers. None of the Tier 2 clients had a need for either partial or ongoing supervision, whereas one in five Tier 3 residents did require some supervision. Given the similarity in ADL and IADL characteristics, this item may turn out to be an important factor in tier assignment and will need further assessment as the program expands.

Table 9
Disability Characteristics of Assisted Living
Waiver Participants by Service Tier

	Tier 1 ^a	Tier 2 (%)	Tier 3 (%)
ADL			
Bathing	--	92.9	94.2
Dressing	--	50.0	65.8
Eating	--	7.1	10.0
Toileting	--	28.6	35.8
Mobility	--	92.9	88.3
Incontinence	--	14.3	24.2
Grooming	--	64.3	36.7
IADL			
Community Access	--	92.9	99.2
Environmental	--	100.0	100.0
Shopping	--	100.0	97.5
Meal Preparation	--	92.9	99.2
Laundry	--	100.0	97.5
Needed Supervision			
Ongoing	--	0.0	13.3
Partial	--	0.0	7.5
None	--	100.0	79.2
N	0	14	120

^aNo clients placed in Tier 1.

Source: PASSPORT Information Management System (PIMS)

Service Tier Change of Residents

To learn more about tier assignment and change we collected data on this topic as part of our site visits. A tier change was reported for two of the twenty residents who were interviewed on site. One resident had a tier change within the first month after enrollment, and the second person had a tier change after he/ she had been in the assisted living for a few months. For both

of the residents the tier assignment changed from Tier 2 to Tier 3. In one case it became clear that the resident needed assistance with administration of medications. This change was made in consultation with the resident, the PAA case manager, and the on-site coordinator. For the second resident, there is less information available about the tier change as neither the on-site coordinator survey nor PAA case manager survey was returned. Based on information from the resident, more services are being received now than prior to the tier change. The resident indicated that the tier change occurred because of a need for more help with mobility and the need for more assistance with activities of daily living. The resident commented that she/he was part of the decision and is now “very satisfied” with the current services and care. It is not surprising that only two residents had a tier change in our sample because 15 of the 20 residents that participated in the case study were originally assigned to Tier 3, which provides the highest level of care to the resident and also provides the facility with the highest level of reimbursement.

Comparison of Assisted Living Waiver and Nursing Home Medicaid Costs

Comparison of costs between the Assisted Living Waiver Program and nursing homes is a particularly difficult task for two reasons. First, the basis of reimbursement rates is fundamentally different in these two contexts. As noted, for the assisted living waiver, reimbursement rates are determined by an individual’s placement into one of three tiers based on disability and service need. Reimbursement in the nursing home context, however, is not based on individual factors, but rather on the average health and disability conditions of all residents in the facility — the case mix. Thus, for example, a review of Medicaid nursing home costs for an individual with severe physical impairments who resides in a facility of predominantly moderately disabled persons may show lower Medicaid costs than a less disabled individual in a facility with more severely impaired residents. Second, reimbursement rates for the assisted

living waiver are applied on a statewide basis, whereas Medicaid nursing home reimbursement rates vary by region and by facility.

Table 10 shows the average Medicaid reimbursement rate for nursing homes and the average costs of assisted living waiver residents by region in Ohio. Nursing home Medicaid costs averaged by region are about \$5,100 compared to an average of about \$2,700 for the Assisted Living Waiver Program across all regions of Ohio. Since most assisted living residents are placed in Tier 3, and there are no regional differences in reimbursement rates, the level of regional variability in monthly public costs is considerably greater for nursing homes. The result of this regional variability in costs is a corresponding regional variability in the cost difference between nursing homes and assisted living.

Monthly average individual costs are least different in Rio Grande (PAA 7) where nursing home reimbursement is \$1,738 higher than assisted living waiver costs. At the other end of the spectrum, nursing home reimbursements are most different from assisted living waiver costs in Cleveland (PAA 10a) where average monthly Medicaid nursing home costs are \$3,207 more than the average costs in the waiver program. Given that nursing home reimbursements vary due to cost-of-living reimbursement adjustments for more expensive urban areas of Ohio, these comparisons suggest the current assisted living rate may be more attractive in lower cost areas of the state. This may be one of the factors explaining why Rio Grande is the region with the second highest number of assisted living waiver participants (26% of all enrollees), despite being a less populated area of the state.

An important policy question asks whether assisted living waiver participants would be likely served in nursing homes. Because nursing home placement depends on a variety of

Table 10
Average Monthly Reimbursement Rates by Region*:
Nursing Home Residents vs. Assisted Living Waiver Participants

PAA	Region Name	Assisted Living Waiver Costs** (2007)	Nursing Home Medicaid Costs** (2005)
PAA 1	Cincinnati	\$2,742.38	\$5,680.75
PAA 2	Dayton	\$2,618.63	\$5,236.21
PAA 3	Lima	\$2,742.38	\$4,602.26
PAA 4	Toledo	\$2,742.38	\$4,910.09
PAA 5	Mansfield	\$2,742.38	\$4,761.91
PAA 6	Columbus	\$2,742.38	\$5,141.04
PAA 7	Rio Grande	\$2,671.66	\$4,410.37
PAA 9	Cambridge	\$2,639.25	\$4,393.94
PAA 10 ^a	Cleveland	\$2,716.60	\$5,923.79
PAA 11	Youngstown	\$2,718.58	\$4,785.47
CSS	Sidney	\$2,742.38	\$5,802.76
Statewide Average Costs		\$2,710.82	\$5,058.96

*PAA 8 and PAA 10B are excluded since data show no Assisted Living Waiver participants in these regions.

**Assisted living costs are for 2007, nursing home costs are based on the 2005 survey of long-term care facilities. Assisted living reimbursement rates do not vary by region.

Source: PASSPORT Information Management System (PIMS)
2006 Annual Survey of Long-Term Care Facilities

functional, behavioral, social, and environmental factors, such comparisons are difficult to make. However, a comparison of functional rates of disability can provide estimate ranges.

As shown earlier, (see Table 2) Medicaid nursing home residents on average are generally more disabled than assisted living waiver participants. With the exception of bathing, which does not differ for any group, Medicaid nursing home residents have a higher prevalence of ADL deficits. Medicaid nursing home residents average about one additional ADL item compared to assisted living waiver participants. Three quarters of Medicaid nursing home residents have four or more ADL impairments compared to half of the assisted living residents. On the other hand, the proportion of individuals with three or more ADL deficits is similar. Additionally, about one in five Medicaid nursing home residents have two or fewer ADL impairments, with almost 15% having zero or one impairment.

Applying these disability rates to assess what proportion of assisted living waiver participants would use nursing homes in the absence of the program is not methodologically possible. However, given that almost half of the assisted living residents have four or more ADL deficits, and that almost three quarters have three or more ADL impairments, it appears that there is considerable overlap between programs. As the program expands, a more in-depth comparison of assisted living participants to nursing home residents and an analysis of Medicaid costs for a longer period of time will be necessary to better understand issues of cost-effectiveness.

PROGRAM IMPLEMENTATION LESSONS

In addition to information on program operations and quality, respondents also provided feedback about the waiver program. Although this study did not include a formal implementation evaluation, this information does provide some added insights into the design and implementation issues faced during the initial nine months of the waiver program. The comments

are organized around three basic issues: (1) program design, (2) implementation experience, (3) and financial issues.

Program Design

The most frequent comment about the program was about the requirement that assisted living residents who have “spent down” their private funds must move temporarily to a nursing facility before they become eligible for the waiver program. Having current assisted living residents move to a nursing home in order to be eligible for the waiver was seen as an unnecessary barrier for both the resident and facility.

It was suggested by PAA case managers, and to a lesser extent by facility staff, that eligibility criteria for the various Medicaid-based programs needed to be streamlined in order to promote a seamless system of care. Waiting for Medicaid approval for these programs resulted in time delays causing frustration for residents, families, and staff.

There were many positive comments regarding the design of the Assisted Living Waiver Program. Many responses indicated that the program helps facilities fill empty rooms and increases their census in a competitive environment. They also had altruistic comments about the program and believed that it provides a worthwhile service to low-income people. One administrator commented that he participated in the program because it was “the right thing to do.” Others pointed to how the program was beneficial because it helped to transition people who do not really need the care provided by a skilled nursing facility. It was also suggested that the program was very good for residents because they have a private room, a “homey” setting, more independence, and they “see more hope” than being in a nursing home setting. A smaller number voiced the opinion that the program was somehow unfair to private pay residents since the waiver resident often got similar services for a lower cost.

Implementation Experience

Respondents identified a series of implementation issues faced by the program. Some of these comments related to delays in enrolling residents, payment delays as well as inconsistent rules and determinations, and concerns about reimbursement rates. Some staff reported they had to make multiple calls to the state and the PAA to find out how to handle certain administrative tasks. Several facilities mentioned having to take a risk on purchasing needed items for residents and only finding out later if the item was eligible for reimbursement. They noted having to be careful or else they would be “stuck” with the cost of ineligible items, or experiencing uncertainty because various program decision makers had different interpretations of the guidelines. They felt that because the program was new, not everyone they talked to was clear about the rules and regulations of the program.

Some facilities noted that the assisted living waiver was not a high priority for the PAAs or the Department of Health. In particular, the process of certifying facilities for participation was reported to be slow from the perspective of the provider. The providers also wished for better communication, better training, and better procedures to handle less routine tasks, and better publicity about the program. On-site coordinators commented on the burden of completing and maintaining service/care plans since they were unaccustomed to doing so much documentation. Case managers also expressed some frustration when the program requirements were not made clear, suggesting that they would welcome better guidelines.

On a positive note, most administrators and on-site coordinators felt that the service plans were fairly accurate in meeting residents’ needs. They also praised their experiences with the PAA case managers and their ease of working with these individuals. On a few occasions, however, it was noted that some residents were not appropriate for assisted living because they

needed too much care or had psychiatric issues. It was suggested that a more thorough assessment might have prevented an inappropriate placement.

Financial Matters

There were several financial-related comments made by assisted living facility staff. Residence staff and PAA case managers expressed concerns that the program does not provide adequate funding on various levels. For example, the personal allowance of \$50 for residents' spending money was considered inadequate, especially in light of Medicare Part D prescription co-pays and costs for other needed supplies such as adult diapers. A number of residents reported that financial concerns were the biggest barrier faced in considering the program.

Another concern was that the \$1,500 transition allowance for residents to move into the assisted living facilities was not adequate, especially when furniture has to be purchased. Another issue regarding the spending of this money was that it is too time-limited (money must be spent within 60 days of the move in).

Assisted living staff also thought that reimbursement rates were not adequate. Reasons for this insufficient reimbursement include the private room requirement, the increase in the minimum wage for all workers in the state (e.g., resident assistants and other direct care workers), and the cost of administrative requirements such as the bed hold policy. The bed hold policy allows facilities to be reimbursed for room and board but not for services when the resident is not at the facility, such as if they are admitted to a hospital. A few staff members suggested improvements to the reimbursement system in order to expedite payments, which were often delayed. Some administrative staff, on the other hand, had positive views about reimbursement, indicating that the tier reimbursement rates were fair or adequate.

CONCLUSION

This report provides a first look at Ohio's Assisted Living Waiver Program. As expected, most participants are severely disabled. Half of assisted living waiver participants have four or more ADL deficits and three quarters have three or more impairments. On average, residents reported high levels of satisfaction with the transition process into the assisted living residence and with the quality of services provided. A very small proportion of those entering the program left during the evaluation time period. The slower than expected build-up, although typical in waiver programs of this nature, does raise some important challenges for program design. The evaluation identified four issues of potential significance in examining the overall program experience during the first nine months of operations.

Eligibility Criteria — There seems to be almost universal agreement that the requirement that applicants must come from a nursing home or one of the existing waiver programs has contributed to slower enrollment into the program. Although we recognize the need for Ohio to place limits on Medicaid growth, our review of waiver programs across the United States did not identify any other state in which enrollments were restricted in this manner (Mollica & Johnson-Lamarche, 2005). Given that the state controls program growth by being able to specify in the waiver the number of individuals to be served, the strict eligibility criteria do not seem necessary.

Number of Assisted Living Residences — Ohio's waiver is designed to serve 1800 consumers. Based on our recent survey of residential care facilities we identified 279 residences in the state that meet the assisted living definitions as outlined in the waiver program (Mehdizadeh, et al., 2007). With the typical facility serving around 45 residents, every eligible facility in the state would need to enroll about 15% of their resident population in order for the state to reach the target of 1800 participants. As of June 1, 54 providers had been certified for participation.

Almost all of the 190 consumers currently on the program waiting list are there because there is no available facility in their geographic area. In order for the state to develop a viable assisted living program, a plan to increase provider participation is critical.

Approach to Ongoing Implementation Issues — Any new program faces an array of implementation challenges during its initial phase of operations. Although Ohio's challenges are similar to those faced in other states, the complexity of the assisted living waiver does suggest that an ongoing structure to gain input from the range of stakeholders will be essential as the program strives to reach its target enrollment goals. The perspectives of residents and their families, providers, case managers, and representatives of the Departments of Aging and Health will be needed to refine the program as it develops. Issues of consumer eligibility criteria and enrollment procedures, reimbursement rates, provider certification, and program communication will require input from the range of stakeholders involved in the program. Every new program needs to evolve and therefore a solid structure to identify and implement necessary changes will be crucial for long-term program success.

Evaluation Limitations — Although this study represents an important first step in assessing program performance, the slower than expected build-up and the short time frame for the study limits the findings available from the evaluation. In a number of areas, preliminary findings are suggestive of program performance. It will be important for the program to incorporate ongoing data collection activities into operations in order to monitor outcomes as the numbers of enrolled facilities and residents increase.

REFERENCES

- Burwell, B., Sredl, K., & Eiken, S. (2006). *Medicaid long-term care expenditures in FY 2005*. Cambridge, MA: The Medstat Group.
- Georgetown University. (2007). *National spending for long-term care*. Washington, DC: Health Policy Institute.
- Mehdizadeh, S., Applebaum, R., Nelson, I. M., Straker, J., & Baker, H. (2007). *The changing face of long-term care: Ohio's experience 1993-2005*. Oxford, OH: Scripps Gerontology Center, Miami University.
- Mollica, R. and Johnson-Lamarche, H. (2005). *State residential care and assisted living policy: 2004*. National Academy of State Health Policy.