



THE BASICS

Assisted Living: Facilities, Financing, and Oversight

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Assisted living facilities provide long-term services and supports (LTSS) to people with functional or cognitive impairments who do not need the level of skilled nursing care provided in nursing homes but cannot live independently. These facilities generally offer more independence, choice, privacy, and home-like environments than nursing homes.

There is no singular definition of assisted living facilities. The generic term “assisted living facility” has been given in recent years to certain types of residences that provide room and board; supportive services, such as personal care, supervision, and medication assistance; and other health-related services to adults with impairments. Depending on state policy and practice, these settings may be referred to as personal care homes, board and care homes, adult foster care, group homes, supportive living arrangements, and community residential settings, among many others. There is wide variation among states, and sometimes within states, in the types and levels of care provided and in the populations served in assisted living residences.

FACILITIES, SERVICES, AND RESIDENTS

The National Survey of Residential Care Facilities, a 2010 survey by the National Center for Health Statistics (NCHS) and the Office of the Assistant Secretary for Planning and Evaluation (ASPE) within the U.S. Department of Health and Human Services (HHS), found 31,100 residential care facilities with almost 972,000 beds.¹ (The survey used the term “residential care” facilities² to describe assisted living and similar facilities; this document uses the term “assisted living” facilities.) In comparison, in 2009 the number of Medicare- and Medicaid-certified nursing

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facilities was 15,658 and the number of beds was 1.7 million.³ It is difficult to estimate the actual rate of growth in assisted living facilities because previous studies used different definitions to describe this type of residential care. However, many experts have noted that a significant increase has occurred over the past several decades in response to the aging of the population and older consumers' demand for housing plus services, as well as state restrictions on nursing home construction. In some states assisted living facility beds now outnumber nursing home beds.⁴

According to the HHS survey, about half of assisted living facilities were small facilities with between 4 and 10 beds; the rest were facilities with 11 to 25 beds (16 percent), or with 26 to 100 beds or more (35 percent). While half of facilities were small, a majority of residents lived in larger facilities with 26 to 100 beds. About 82 percent of facilities were private, for-profit facilities; the remainder were private non-profit or were owned by state, city, or local government. About 38 percent were chain-affiliated, and larger facilities were more likely to be part of chains.⁵

Assisted living facilities generally provide 24-hour staff to respond to scheduled and unscheduled needs of residents.⁶ According to the HHS survey, in addition to room and board, nearly all facilities provided basic health monitoring, incontinence care, social and recreational activities, special diets, and laundry services. Other services, such as occupational and physical therapy, social services counseling, and case management varied by size of facility. About 38 to 40 percent of all assisted living facilities provided some skilled nursing services.⁷ Only 11 percent of facilities had policies that would admit a person who needed regular nursing services, and the vast majority (83 percent) would discharge a person who needed such care.⁸ In general, state policies define the level of care that that assisted living facilities may provide, and many states specify that facilities cannot serve residents when they incur certain types or levels of disability.⁹

Residents' need for LTSS assistance varies widely and differs by type of facility. People who reside in assisted living facilities tend to be less impaired than most people residing in nursing homes. However, some residents may have the same level of need exhibited by nursing home residents. According to the HHS survey, almost 40 percent of residents received assistance with three or more activities of daily living (ADLs).¹⁰ In comparison, of all

nursing home residents in 2004, 85 percent received assistance with three or more ADLs.¹¹ People who receive assistance with toileting, transferring from a bed or a chair, or eating are considered to be more impaired than those who receive help with just bathing or dressing. Of all residents in the HHS survey, just over one-third received help with toileting, one-quarter received help with transferring, and just over one-fifth received help with eating.¹² The presence of cognitive disabilities is often one of the key factors leading to admission to an assisted living facility. The HHS survey found that about 42 percent of assisted living facility residents had Alzheimer's disease and other dementias.¹³

COSTS AND FINANCING

The fees charged for assisted living facilities vary by size, type, and location of the facility; needs and characteristics of residents; and type of services provided, among other factors. The 2012 MetLife Market Survey of assisted living facilities found that the national average assisted living base rate was \$42,600 annually. Costs vary considerably depending on the services a resident needs. In many facilities residents have contracts that spell out the types and range of services they will receive and the associated costs. According to the survey, residents may have the following services offered (depending on their chosen level of service): care management and monitoring, assistance with ADLs, housekeeping and laundry, medication management, recreational activities, and transportation, among others. The add-on costs for services above a basic level of care can be substantial. For example, the MetLife survey found that the average base rate for a resident with Alzheimer's disease or other dementias was \$57,684 annually in 2012.¹⁴ People may incur additional costs as their care needs increase over time.

Financing for assisted living facilities comes from multiple sources. Most people pay out-of-pocket for room and board and the services they receive. In some cases, private long-term care insurance policies can support assisted living residence. For those with limited income and assets, at the option of each state, Medicaid can finance the cost of the services provided to eligible individuals, excluding room and board. The HHS survey found that 43 percent of residential care facilities had at least one resident

whose services were paid by Medicaid. However, of all facility residents, only 19 percent had their care financed by Medicaid.¹⁵

State Medicaid agencies can provide services under a number of options, including the section 1915(c) home- and community-based services (HCBS) waiver program and other Medicaid state plan options.¹⁶ The most frequently used Medicaid option for financing services, such as home health aide, personal care, and homemaker services, for Medicaid-eligible residents is the section 1915(c) HCBS waiver program. A recent report by the HHS Office of the Inspector General (OIG) found that, in 2009, 35 state Medicaid programs covered services for more than 54,000 Medicaid beneficiaries in 12,000 facilities under 40 section 1915(c) waiver programs. The total annual cost to the Medicaid program was estimated at \$1.7 billion with an average annual cost of \$31,000 per resident.¹⁷

REGULATION AND OVERSIGHT

The federal role in ensuring quality in assisted living facilities is minimal. Unlike nursing homes, for which federal law establishes a national minimum set of requirements that Medicare- and Medicaid-funded facilities must meet to ensure quality care of residents, licensing and quality of care oversight in assisted living facilities and other residential care arrangements are the province of state and local governments.¹⁸ State requirements for ensuring quality vary widely; oversight responsibilities are often shared among multiple state and local agencies.

If a state covers HCBS services to Medicaid beneficiaries in assisted living facilities under a section 1915(c) waiver program, federal law and regulations require states to ensure that necessary safeguards are in place to protect residents' health and welfare. Safeguards include requirements that states have adequate provider standards as part of state licensing or certification rules and that facilities have written plans of care for each resident based on an individual assessment. The Centers for Medicare & Medicaid Services (CMS) is responsible for determining whether states comply with these requirements. The recent OIG review found that, based on a sample of 7 of 35 states with the highest number of Medicaid assisted living beneficiaries, over three-quarters of beneficiaries were in facilities that had been cited by the state

for one or more deficiencies regarding state licensure or certification requirements. Deficiencies included failure to furnish services according to a resident's plan of care, failure to dispense or administer medication as prescribed by a physician, or failure to complete initial resident assessments. The report recommended that CMS issue guidance to state Medicaid programs emphasizing the need to comply with federal requirements for covering HCBS under section 1915(c) waiver programs.¹⁹

The Long-Term Care Ombudsman Program, funded by the federal government in the Older Americans Act and by states, is mandated to directly assist residents by investigating and resolving resident complaints. Its program resources have been quite limited since inception and have been further stressed by recent federal and state fiscal pressures. In many states the program does not meet recommended staffing goals; in most states, ombudsmen do not conduct regular quarterly visits to assisted living facilities, leaving many consumers without access to ombudsman services. (For more information on the Older Americans Act program, see "The Role of Ombudsmen in Assuring Quality for Residents of Long-Term Care Facilities: Straining to Make Ends Meet," National Health Policy Forum, Background Paper No. 71, December 2, 2009, available at www.nhpf.org/library/details.cfm/2767.)

Some advocates have been concerned about the quality of care provided by some assisted living facilities. Issues that have arisen over the years include involuntary discharge of residents when their care needs change, discrimination against Medicaid-eligible residents, and adequacy of staff training.²⁰ During the past decade, various national provider organizations have promoted adoption of improved quality of care standards by states and assisted living providers, as well as greater protections for consumers.²¹ Although states have adopted regulatory standards, the ability of states to enforce these standards has been of concern. The issues of quality of care and abuse of residents sometimes receive press attention.²² In some cases, press reports have led to improvements in state regulatory and oversight policies.²³

ENDNOTES

1. Eunice Park-Lee *et al.*, “Residential Care Facilities: A Key Sector in the Spectrum of Long-Term Care Providers in the United States,” NCHS Data Brief, No. 78, December 2011, available at www.cdc.gov/nchs/data/databriefs/db78.pdf. For more on the survey, see also www.cdc.gov/nchs/nsrcf.htm.
2. The National Survey of Residential Care Facilities defined a “residential care facility” as one that had four or more beds; served primarily an adult population; had at least one resident at the time of the interview; was licensed, registered, listed, certified, or otherwise regulated by the state to provide room and board with at least two meals a day; provided around-the-clock on-site supervision; and offered help with personal care or health-related services. Excluded were nursing homes and facilities exclusively serving adults with severe mental illness or developmental disabilities. Lauren Harris-Kojetin, Manisha Sengupta, and Emily Rosenoff, slides from a presentation at the National Conference on Health Statistics, August 7, 2012, available at www.cdc.gov/nchs/ppt/nchs2012/SS-06_HARRIS.pdf.
3. Charlene Harrington *et al.*, *Nursing Facilities, Staffing, Residents and Facility Deficiencies, 2004 Through 2009*, University of California at San Francisco, September 2010, available at www.pascenter.org/documents/OSCAR_complete_2010.pdf.
4. Administration on Aging, “2010 National Ombudsman Reporting System Data Tables,” table A-6, available at www.aoa.gov/AoARoot/AoA_Programs/Elder_Rights/Ombudsman/National_State_Data/2010/Index.aspx.
5. Park-Lee *et al.*, “Residential Care Facilities.”
6. Having 24-hour staff was a requirement for inclusion in the HHS survey of residential care facilities and is often a state requirement.
7. Park-Lee *et al.*, “Residential Care Facilities.” Skilled nursing services are defined in the survey as “services essential to the maintenance or restoration of health that are provided to sick or disabled persons by a registered nurse or licensed practical nurse.”
8. The Scan Foundation, “Trends in the Residential Care Industry,” Data Brief, No. 32, October 2012, available at www.thescanfoundation.org/sites/thescanfoundation.org/files/1pgdatabrief_no32_trends_in_the_residential_care_industry.pdf.
9. Mauro Hernandez, “Disparities in Assisted Living: Does It Meet the HCBS Test?” *Generations*, Spring 2012, available at www.asaging.org/blog/disparities-assisted-living-does-it-meet-hcbs-test.
10. ADLs refer to the following activities: eating, bathing and showering; using the toilet; dressing; walking across a small room; and transferring (getting in or out of a bed or chair).
11. A. L. Jones *et al.*, “The National Nursing Home Survey: 2004 Overview,” National Center for Health Statistics, Vital and Health Statics, 13, No. 167, June 2009, available at www.cdc.gov/nchs/data/series/sr_13/sr13_167.pdf.

12. Christine Caffrey *et al.*, “Residents Living in Residential Care Facilities: United States, 2010.” NCHS Data Brief, No. 91, April 2012, available at www.cdc.gov/nchs/data/databriefs/db91.pdf.
13. Caffrey *et al.*, “Residents Living in Residential Care Facilities.”
14. MetLife Mature Market Institute and LifePlans, Inc., “Market Survey of Long-Term Care Costs,” November 2012, available at <https://www.metlife.com/assets/cao/mmi/publications/studies/2012/studies/mmi-2012-market-survey-long-term-care-costs.pdf>.
15. Park-Lee *et al.*, “Residential Care Facilities”; and Caffrey *et al.*, “Residents Living in Residential Care Facilities.”
16. Barbara Edwards, testimony before the Senate Committee on Aging, November 2, 2011, available at <http://aging.senate.gov/publications/1122011.pdf>.
17. U.S. Department of Health and Human Services, Office of the Inspector General (OIG), “Home and Community-Based Services in Assisted Living Facilities,” OEI-09-08-00360, December 10, 2012, available at <https://oig.hhs.gov/oei/reports/oei-09-08-00360.asp>.
18. See Karl Polzer, “Assisted Living State Regulatory Review,” National Center for Assisted Living, March 2012, available at www.ahcancal.org/ncal/resources/Documents/Final%2012%20Reg%20Review.pdf.
19. OIG, “Home and Community-Based Services in Assisted Living Facilities.”
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21. Assisted Living Consumer Alliance, www.assistedlivingconsumers.org; National Senior Citizens Law Center, www.nsclc.org; The National Consumer Voice for Quality Long-Term Care, www.theconsumervoice.org; Center for Excellence in Assisted Living, www.theceal.org; LeadingAge, www.leadingage.org/quality_first.aspx; National Center for Assisted Living, www.ahcancal.org/ncal/operations/Pages/ClinicalPracticeGuidelines.aspx; and Assisted Living Federation of America, www.alfa.org/alfa/CorePrinciples.asp.
22. For example, see *Miami Herald* series on assisted living, “Neglected to Death,” available at www.miamiherald.com/1688. Also see Julie Appleby, “Sexual Assaults Haunt Families of Elderly Victims,” USA Today, May 26, 2004, available at http://usatoday30.usatoday.com/money/industries/health/2004-05-26-assist-3-day_x.htm?csp=34; “Assisted Living Facilities,” transcript with Maurice Jones,

Washington Post, May 24, 2004, available at www.washingtonpost.com/wp-dyn/articles/A46113-2004May21.html; and David S. Fallis, "As Care Declines, Cost Can Be Injury, Death," *Washington Post*, May 23, 2004, available at www.washingtonpost.com/wp-dyn/articles/A47732-2004May22.html; "The Dangers of Va. Assisted Living: A Washington Post Investigation," available at www.washingtonpost.com/wp-srv/content/nation/investigative/assistedliving.html.

23. For example, see Carol Marbin Miller, Michael Sallah, and Rob Barry, "Florida task force to help boost troubled assisted living facilities," *Miami Herald*, June 21, 2011, available at www.miamiherald.com/2011/06/27/2288340/florida-task-force-to-help-boost.html; Michael Sallah and Carol Marbin Miller, "Lawmakers: Regulators need to crack down on ALFs," *Miami Herald*, September 19, 2011, available at www.miamiherald.com/2011/09/19/2415429/lawmakers-regulators-need-to-crack.html; Florida Agency for Health Care Administration, Assisted Living Workgroup, "Final Report and Recommendations," available at <http://ahca.myflorida.com/SCHS/CommitteesCouncils/ALWG/archived/docs/2011/ALWorkgroupFinalReport.pdf>.