District of Columbia
Assisted Living Services Study

A review of DHCF's approach to the coverage and reimbursement of services delivered in Assisted Living Residences to Medicaid beneficiaries

September 2023

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Introduction

The Department of Health Care Finance (DHCF) in the District of Columbia (DC) has engaged an independent consulting firm, Advantageous Strategies, to undertake a comprehensive study of DC's approach to providing assisted living services to Medicaid beneficiaries in Assisted-Living Residences (ALRs).

The purpose of the analysis is to provide DHCF with:

1. An objective evaluation of the strengths, weaknesses, and opportunities presented by DC's current assisted living services program.
2. A detailed assessment of other states' approaches to providing coverage and reimbursement for ALR services to Medicaid beneficiaries.

Specifically, the research is intended to address the following questions:

- How does DC's current policy authority and reimbursement model for Medicaid-financed assisted living fare in terms of ensuring access to high-quality assisted living services?
- What challenges or barriers exist in DC's current approach to expanding or maintaining access to assisted living services under the Medicaid program?
- What Medicaid policy authorities (e.g., 1915(c), 1915(i), State Plan, etc.) are used by Medicaid programs across the country to cover and offer Medicaid-financed ALR services?
- What other funding streams are used in Medicaid-funded ALR programs in other states to ensure ALR services are accessible to low-income Medicaid beneficiaries, since Medicaid reimbursement may be limited due to the exclusion of room and board costs?
- What barriers to expansion or implementation of Medicaid coverage for ALRs are cited by other Medicaid programs? What circumstances facilitate expansion?
- Are there ALR-specific considerations for DC's implementation of Managed Long-Term Services and Support (MLTSS) programs or programs integrating Medicare and Medicaid services for dual eligibles?
- What factors typically influence state Medicaid agencies' ALR reimbursement methods?
- How does DC's ALR reimbursement compare to other jurisdictions' Medicaid reimbursement, adjusted for geographic variation in costs?
- Are there policy authorities that would allow DC to reimburse for ALR services delivered to Medicaid beneficiaries who do not meet the nursing facility level of care criteria, but instead meet a lower-acuity level of care standard?

The overall goal is to produce an improvement in DC's health outcomes by uncovering more effective approaches to person-centered service delivery, and more efficient and fairer methods for providing reimbursement to beneficiaries and service providers.

Approach

Between April 17 and June 30, 2023, the Advantageous Strategies research team conducted a total of 22 interviews and focus groups with DHCF stakeholders and beneficiaries who were willing and able to share their experiences of working with the Medicaid program in assisted living facilities. Appendix A1 Interview guide provides copies of the interview guides for each of the three interview groups:

1. Representatives from DC's primary agencies.
2. Staff and administrators from a cross-section of ALRs throughout DC.
3. ALR residents and beneficiaries.

The research team also gathered and analyzed secondary data from grey literature—reports and analyses from the websites of relevant state and federal agencies as well as research organizations such as the National Center for Assisted Living—to perform a comparative analysis between DC's model for assisted living service delivery and the programs in use in other states.

Current-state assessment

This section analyzes DC's approach to administering the delivery of assisted living services to Medicaid beneficiaries. It begins with a high-level summary of how the program currently works and is followed by a breakdown of the key findings emanating from the interviews with stakeholders and beneficiaries.

Overview of DC's policy authority and reimbursement model

There are three primary agencies involved in providing oversight and support to ALR providers and beneficiaries in DC:

- Department of Health (DOH)
- Department of Health Care Finance (DHCF)
- Department of Aging and Community Living (DACL)

Additional agencies that lend auxiliary support to providers and/or beneficiaries include:

- Office of the DC Long-Term Care Ombudsman (DCLTCOP)
- Office of Inspector General (OIG)
- Trade associations such as the National Center for Assisted Living (NCAL)

Licensing, certification, and oversight of ALR providers

The DOH is responsible for licensing all ALR providers in DC. Through its Intermediate Care Facilities Division, the department also performs inspections to ensure providers are complying with regulatory requirements.

Applicants wishing to provide ALR services in DC must fulfill the following requirements prior to admitting any residents into their facility:

1. Obtain a Certificate of Occupancy.
2. Show proof of insurance.
3. Pass a series of DOH inspections.

Once the provider has received their ALR license, they may apply for certification to accept Medicaid-funded residents. The overall process is shown in Figure 1.

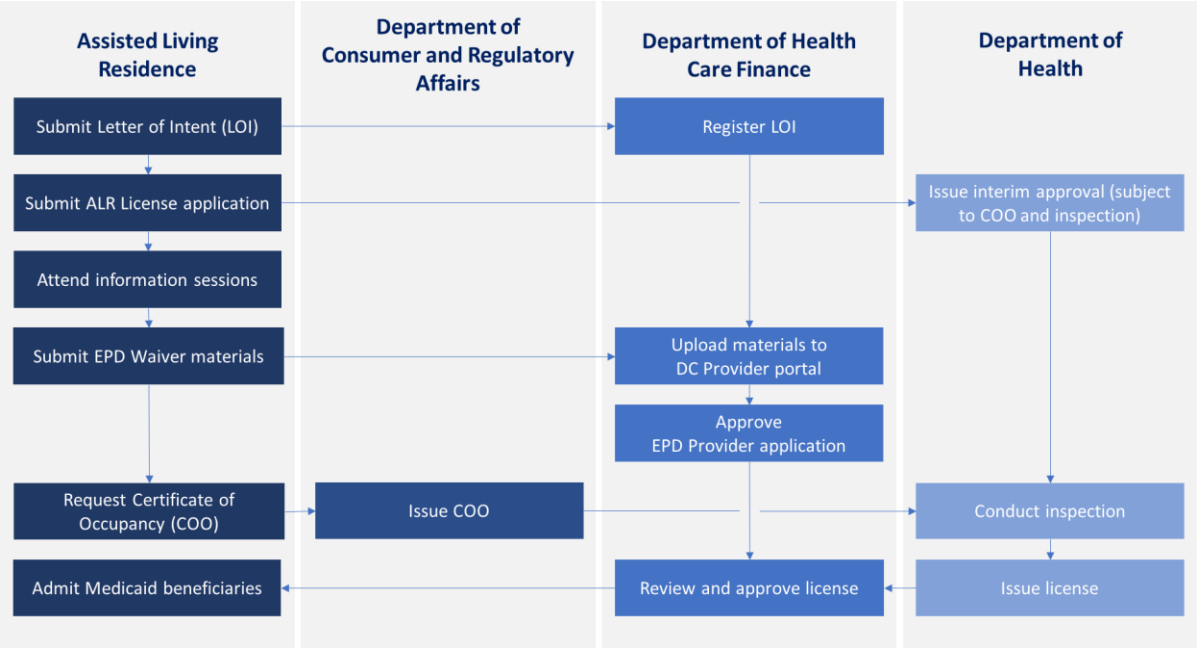

Figure 1: Process to obtain an ALR license and Medicaid certification

Medicaid delivery and administration

DHCF is DC's Medicaid agency. Its Long-Term Care Administration (LTCA) department provides oversight and monitoring of all of DC's Medicaid-financed Long-Term Care (LTC) services. This includes the Elderly and Persons with Physical Disabilities (EPD) Waiver Program—a special program that allows Medicaid-eligible DC residents, who might otherwise require nursing home care, to receive LTC services and support while living in their home or an assisted living community.

To qualify for the EPD Waiver program, beneficiaries must meet a set of financial as well as non-financial requirements. The application process begins with a face-to-face assessment to assign the beneficiary a Level of Care (LOC) designation. The assessment, which is conducted by a Registered Nurse or a Clinical Social Worker employed by Liberty Health (the third-party vendor employed by DHCF), evaluates functional limitations, cognitive and behavioral issues, and the level of support needed for daily living activities. If the beneficiary meets minimum clinical eligibility requirements, they must complete two further application forms to determine their eligibility for the EPD Waiver program. The applicant may obtain assistance from DACL's team of Medicaid Eligibility Specialists as part of this process. DACL then sends the completed forms to DHCF for the purpose of validating the beneficiary's financial eligibility.

If the applicant is eligible for the EPD Waiver, DACL assigns the individual to a Case Management Agency of their choosing. The Case Manager then gains access to the applicant's profile inside DC's clinical case management system, DC Care Connect. The Case Manager will meet with the beneficiary to develop a Person-Centered Service Plan (PCSP), which specifies the beneficiary's choice of ALR and other services. The Case Manager must then request Prior Authorization (PA) from the District's Quality Improvement Organization (QIO). Until the PA is issued, the ALR cannot bill for services. Likewise, approval of the completed PCSP allows the ALR provider to access the beneficiary's profile in DC Care Connect.

The District reassesses every beneficiary's eligibility for EPD Waiver services on an annual basis. The Case Manager must initiate the recertification process at least 90 days before the current LTC recertification due date. The Case Manager is also responsible for updating the beneficiary's PCSP.

DHCF is responsible for paying ALR providers for delivering services under the EPD Waiver. As of July 2023, the daily rate for an EPD Waiver beneficiary was $218.56.

The maximum room and board allowance that an ALR provider may charge a beneficiary depends on the ALR's bed capacity and ranges from $1,554 to $1,664 per month. Beneficiaries may either use private funds or their Supplemental Security Income (SSI) benefits (if they receive them) to cover the room and board cost. Beneficiaries may be eligible to receive additional funding through the Optional State Supplementation Payment (OSSP) if their SSI benefits come to less than the total cost of room and board. The amount of OSSP is the difference between the individual's SSI and their room and board costs but cannot exceed $750 per month.

DHCF makes a lump-sum payment to the Social Security Administration (SSA) each month, and the SSA calculates the OSSP amount to be included in the beneficiary's monthly Social Security check. The resident pays the room and board allowance directly to the ALR, less a $100 Personal Needs Allowance (PNA) to be kept for personal expenses.

Strengths, weaknesses, and opportunities with DC's current model

The following subsections summarize the findings from the interviews conducted with representatives of the primary government agencies, ALR service providers, and beneficiaries involved in the Medicaid ALR program in DC. They highlight the strengths, weaknesses, and opportunities for improvement in the current model, as illustrated in Figure 2.

Figure 2: Current model strengths, weaknesses, and opportunities for improvement

For the purposes of this assessment, Advantageous Strategies applied an analytic framework developed by the National Academy of Medicine (formerly known as the Institute of Medicine) to determine the extent to which high-quality assisted living services are being delivered in DC's ALR setting.[1] This framework examines the question from the perspective of six different domains, as shown in Figure 3.

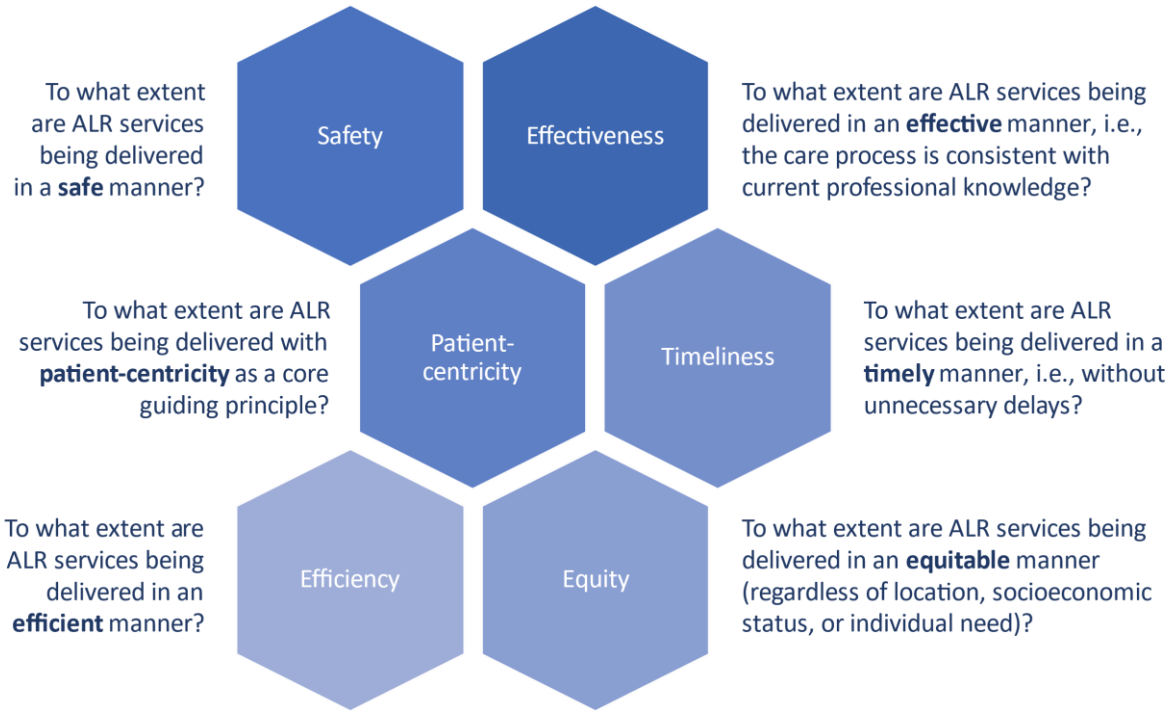

Figure 3: Framework for assessing the quality of assisted living services

Safety: To what extent are ALR services being delivered in a **safe** manner?

Strengths	Weaknesses
• Current regulations help promote a safe facility environment. • ALRs demonstrate a strong commitment toward maintaining a safe environment for their residents and complying with the regulations to provide quality care. • ALR staff members undergo extensive, mandated safety training. • Training procedures are of a high standard, demonstrating service providers' commitment to resident wellbeing.	• ALR service providers perceive they are doing a much better job of meeting safety requirements than do residents and the Ombudsman. • Factors/issues external to the ALRs make residents feel less safe in the ALRs. • There is a lack of robust safety plans for residents with special needs such as dementia. • A growing shortage of qualified ALR staff.

Opportunities for improvement

- Strengthen communications channels relating to safety issues between relevant agencies, ALRs, residents, and/or the Ombudsman to ensure any safety concerns the residents and/or Ombudsman have addressed.
- Foster initiatives that will increase recruitment and retention rates for skilled ALR staff.
- Offer non-financial incentives, such as recognition and rewards, to commend exceptional ALRs that receive favorable safety performance feedback from relevant agencies and residents.

Figure 4: Strengths, weaknesses, and opportunities in the Safety domain

Compliance with Medicaid ALR Program safety regulations

Assisted living communities need to be well aware of and equipped with strategies to avert risks and ensure the safety of their residents, particularly since those living in such communities are especially vulnerable.[2] With respect to this research, several ALR providers mentioned the current regulatory framework as helping to foster a safer overall experience in their facilities. As an example, most ALRs have safety process maps in place as a direct result of DC's Medicaid ALR Program safety requirements being adhered to. At others, safety committees hold regular meetings to review regulatory requirements such as fire drills and address any emerging safety issues.

> "Regarding safety, there are always nurses present who perform regular checks and provide emergency pendants to residents. There is also 24-hour security in the building. Additionally, there are call lights in bathrooms and laundry rooms, which notify the nurses when activated."
>
> ALR Administrator

ALR staff, too, were in broad agreement that their facilities showed a strong commitment toward maintaining a safe environment for their residents and complying with DC's regulations to provide quality care. But the system is certainly not foolproof. One service provider divulged how a series of safety breaches had driven them to change their check-in policies and processes: "We had to revise the logbook and ensure all relevant information, including unit numbers and duration of visits, were accurately documented."

From the beneficiaries' perspective, safety concerns were most often attributed to external factors outside of the facility. One resident interviewee noted a lack of visitation policy compliance and lax security in the surrounding area. "The residents frequently encountered gunshots and unauthorized individuals entering the building through the back doors. Visitors sometimes stayed longer than permitted, and the lack of proper security measures allowed them to roam the halls freely." Other concerns were raised regarding the management of residents with special needs: "There is uncertainty around safety plans for individuals with conditions such as dementia, particularly if they wander off the facility's premises."

Such issues suggest that stakeholders and service providers may be at odds with each other in terms of how they appraise the level of safety being delivered in ALRs. When asked to rate the safety of ALRs in DC on a scale of one to ten (with ten being the safest), the Ombudsman suggested a rating of only five or six. While the ALRs possess the responsibility for upgrading their protective measures if a safety-related issue arises, this can be safeguarded by ensuring strict timeframes for follow-up to ensure the required safety standards have been met—especially when it comes to older buildings and infrastructure that may be more subject to wear and tear, e.g., loose guardrails. The Ombudsman was at pains to emphasize this point, stressing "the importance of 24-hour supervision and safety in assisted living facilities, and [the availability of] surveyors to verify staffing coverage and adherence to safety protocols."

To encourage and promote consistently high standards of safety, DHCF may wish to consider implementing some form of non-monetary incentive program to reward high performance by ALRs. For example, Idaho has a gold/silver star recognition system for ALRs that achieve back-to-back, error-free annual surveys, giving those providers the opportunity to promote the strength of their facility in advertising materials.

Staffing coverage and training

The Medicaid ALR program requires ALR staff members to undergo extensive safety training on a wide range of topics including:

- mental health—signs and symptoms to watch for
- when to notify healthcare professionals
- patient confidentiality
- resident rights
- fire drills
- emergency preparedness

In addition, some ALRs have made use of the Relias Healthcare Workforce Enablement system to provide elective as well as mandatory safety training to employees. The Relias training program covers extra topics such as cognitive behavioral training, fall prevention, and Alzheimer's care.

Given these measures, ALR staff were in general agreement that the current training procedures were of a high standard, and clearly demonstrated service providers' commitment to resident wellbeing. But along with commitment, staff must be available to provide coverage and backfill. Agency personnel and residents outlined several situations where promised services, such as transportation to doctors, medication management, and special diets, were not provided by ALRs due to staffing shortages.

With respect to staffing numbers, interview participants acknowledged the efforts the DC government had made to address the shortage of Certified Nursing Assistant (CNA) and Personal Care Assistant (PCA) staff—such as offering free training programs and providing a more favorable daily rate to help ALRs with recruitment and retention. However, there is still a recognized shortage of qualified personnel due to increased competition from elsewhere in the sector, along with experienced individuals opting to take a different career path. The Medicaid and CHIP Payment and Access Commission (MACPAC), for instance, previously highlighted how the COVID-19 pandemic exacerbated pre-existing workforce shortages. It also brought to light several critical issues affecting HCBS workers nationwide:

- **Low or minimum wages:** Many HCBS workers, including home health aides, personal care aides, and direct support professionals, were being paid low or minimum wages for their demanding work. While the pandemic emphasized the essential nature of their roles, their compensation did not match the level of responsibility and risk that they faced.
- **High turnover:** The HCBS industry faced significant turnover rates even before the pandemic due to the above-mentioned challenges. The pandemic added physical and mental demands that have further contributed to burnout and attrition, worsening the shortage of qualified workers.
- **Increased mental and physical demands:** The COVID-19 pandemic placed HCBS workers on the frontlines, where they needed to provide care and support to vulnerable individuals at higher risk of severe illness. This increased the physical and mental demands of the job, and exposed workers to greater risk of infection, longer working hours, and emotional stress.

DHCF should continue its efforts to address the current shortfall, as well as to halt and reverse the emerging trend (to the extent possible within its scope and authority).

Effectiveness: To what extent are ALR services being delivered in an **effective** manner?

Strengths	Weaknesses
• Increases in the availability of beds. • A lot of evidence there is often consistent and effective Inter-agency collaboration and communication.	• Although collaboration and communication amongst District agencies as well as between caregivers, nurses, and ALR providers is often consistent and effective, there is still room for improvement.
Opportunities for improvement	
• Strengthen the communication, collaboration, and outreach efforts around pre- and post-Provider Enrollment processes as well as ALR Operations support to increase the level of clarity and understanding about roles and responsibilities across the ALR program.	

Figure 5: Strengths, weaknesses, and opportunities in the Effectiveness domain

Effectiveness is a measure of how well a system achieves its outcomes. Those outcomes are framed around DHCF's Mission and Strategic Objectives, as shown in Table 1.

Table 1: DHCF Mission and Strategic Objectives

Mission	To improve health outcomes by providing access to comprehensive, cost-effective, and quality health care services for residents of the District of Columbia.
Strategic Objectives	1. Provide access to comprehensive healthcare services for District residents.
	2. Ensure the delivery of high-quality healthcare services to District residents.
	3. Deter fraud, waste, and abuse by promoting integrity throughout the Medicaid program.
	4. Create and maintain a highly efficient, transparent, and responsive District government.

Inter-agency coordination is a crucial aspect of operating a Medicaid ALR program. In DC's case, there was general recognition that DHCF, DACL, DOH, and the case management agencies collaborate well together and have a shared vision for ensuring a smooth transition process for beneficiaries. Yet each agency comes with its own set of rules and regulations to guide its operations. When different entities have divergent goals or nonaligned mandates, stakeholders can sometimes find themselves caught in the middle trying to navigate competing demands and objectives. Some of the ALR providers interviewed, for example, felt that there was a degree of overlap in the responsibilities and work being performed by DHCF and DC Health, in particular. Another concern raised by an ALR provider pertains to the conflicting timeframes between obtaining a license for an ALR facility in the District and those applicable to the Low-Income Housing Tax Credit (LIHTC) Program. The LIHTC Program falls under the purview of the DC Department of Housing and Community Development (DHCD) and mandates that developers fully lease up an ALR within a specified time to maximize the tax credit benefits. Based on the conducted interviews, DHCF lacks awareness regarding the specific deadlines developers must adhere to in order to receive the full tax credit benefits. This awareness is vital for DHCF to effectively collaborate with stakeholders such as ALR developers who utilize tax credits.

The ALR developer/provider who raised this issue does not seem to believe it is necessary for DHCF to employ a subject matter expert in LIHTC but rather individuals who are knowledgeable about how the LIHTC program's timelines intersect with the licensing timelines of an ALR. DHCF could establish communication with designated personnel at DHCD to remain informed about the deadlines faced by ALR developers and collaborate to help ALR developers find a harmonious way to comply with all regulatory requirements.

Providing greater clarity around the roles and responsibilities across all the tasks and processes that need to be conducted to fulfill the program's mission may be all that is necessary to tidy up the areas of concern. For example, have the end-to-end processes been mapped out to identify gaps or overlaps? Is there a need to have a RACI (Responsible, Accountable, Consulted, Informed) conversation? Having a visible (and accessible) representation of how the system is supposed to work will help to reduce confusion and misunderstanding over what needs to be done as well as by whom. It should also provide a broader perspective on the 'big picture' items that need to be overhauled rather than focusing on fixing individual components through point solutions.

Patient-centricity: To what extent are ALR services being delivered with **patient-centricity** as a guiding principle?

Strengths	Weaknesses
• DC receives top marks from residents for the standard of health care they are being delivered in ALRs. • DHCF places a strong emphasis on person-centered care, backed up by regular care training for providers. • Resident Councils and the Ombudsman provide channels for raising concerns and complaints.	• Lack of clear protocols and procedures related to establishment and implementation of the person-centered service plan. • Residents' fear of retribution from ALR staff after raising grievances.

Opportunities for improvement

- Make ALRs aware that some ALR residents do not think they can file grievances without fear of retribution.
- Strengthen the ALR reporting requirements surrounding resident admittance and person-centered service plan implementation.

Figure 6: Strengths, weaknesses, and opportunities in the Patient-centricity domain

Patient-centered care relates to the provision of patients' wants and preferences, with a strong focus on their choices, values, and requirements[3]. It is a crucial element in delivering quality care to ALR residents. To DHCF's credit, the ALR residents interviewed for this research expressed a high level of contentment with the health care being provided to them. Staff members were widely recognized for providing care in a dignified manner and treating residents with kindness and respect, especially in areas that require individual attention such as during medical check-ups. This result may, in part, be attributed to DHCF emphasizing the importance of person-centered care, and regularly conducting care training for providers.

On occasion, of course, things do not always go to plan. Some interviewees noted the presence of Resident Councils along with the ability to file grievances through the Ombudsman—two effective channels for residents to voice their concerns while protecting their identities. But at the same time, others suggested occasionally being hesitant to file complaints due to worrying that this may lead to some form of retaliation from the staff they interact with every day. Residents were unable to cite any *specific* instances of this happening; nevertheless, the fear exists.

Front-line agency staff have reported a significant lack of communication and collaboration among caregivers, nurses, and ALR providers in managing individual medical records and person-centered service plans, as well as in monitoring the adherence to these plans. Currently, there is no requirement for ALRs to provide feedback on the execution of their risk assessment plans for new residents, or to address any identified issues within a 90-day timeframe after the plans have been put into action. Without such oversight mechanisms in place, there is no assurance that residents are receiving the essential services outlined in their plans, such as transportation to medical appointments, medication management, and special dietary needs.

Furthermore, ensuring that ALRs foster a sense of community living rather than isolating residents in their rooms with limited interaction proves to be a challenge. Agency staff recommended conducting post-admission assessments to gauge how well individuals are adapting to the assisted living environment.

Timeliness: To what extent are ALR services being delivered in a **timely** manner?

Strengths	Weaknesses
• DACL provides valuable assistance with the EPD Waiver application process, as well as support for transitioning individuals from nursing homes or rehabilitation facilities into ALRs.	• A lack of information and guidelines on the process of registering a new ALR facility. • A complicated and lengthy EPD Waiver application and assessment process that may become more streamlined with the new DC Access System. • Delays with the annual EPD Waiver recertification process leading to an expired LOC status. • Slowness with the procedure for updating codes for transitional residents.

Opportunities for improvement

- Ensure clarity surrounding the process for applying to register a new ALR facility such that the process is made as time-efficient as possible.
- Enable the creation of more accurate, tailored care assessments through the integration of clinical data.

Figure 7: Strengths, weaknesses, and opportunities in the Timeliness domain

The fourth domain relates to the timeliness of completing processes for opening a new ALR, applying for and renewing EPD Waiver eligibility for residents, and transitioning residents from a nursing facility to an ALR.

Service providers reported challenges with licensing and enrolling a new facility due to a lack of informational materials and guidelines, leading to process delays as well as difficulties understanding the regulations. Equally, several DHCF staff members expressed a desire for ALR providers to become more involved in the planning process, to help everyone gain a better understanding of the front-end work and coordination required to make the program work smoothly.

The current paper-based EPD Waiver application process was repeatedly labelled as “complicated,” requiring an extensive amount of information to fulfil federal requirements. Applicants must complete multiple forms, provide original documentation, and undergo an assessment by Liberty Health to determine their eligibility. Some DHCF staff expressed reservations about the lack of readily available information to help individuals get through the process. Struggles were also cited for cases involving residents with cognitive impairments, due to the potentially inaccurate self-reporting captured on assessments along with occasional stakeholder confusion regarding the scoring of the District’s Nursing Facility Level of Care (NFLOC) criteria.

There was general agreement among the ALR service providers interviewed that they experience delays or issues in the annual EPD Waiver renewal process about 30-40% of the time. These delays can result in an expired Level of Care status, creating more delays.

Fortunately, DACL provides much-needed support in these areas, as well as help to transition individuals from nursing homes or rehabilitation facilities to ALRs. The ongoing updates to the DC Access System (DCAS) should also help to streamline the application process, eliminate some (if not all) of the paper documentation, and create a unified portal for all clients, providers, and government agencies.

Unfortunately, the process challenges do not always end with a successful registration and transition: several ALR staff and managers complained about the slowness of updating codes for transitional residents, resulting in delayed payments. Repeated calls to DHCF were often necessary to resolve holdups with a code update. Integrating the 1346 form into the application system should help to improve the efficiency and timeliness of the transition process.

Efficiency: To what extent are ALR services being delivered in an **efficient** manner?

Strengths	Weaknesses
• The DC Care Connect integrated network and billing systems, offering ease-of-use and fast responsiveness. • Funding assistance for service providers to transition from paper to electronic health records. • Dual Choice program for dually eligible beneficiaries. • DC's current, daily reimbursement rate of $218.56 was approved by over a majority of ALR providers, especially those operating in other states.	• Limited access to DC Care Connect for all ALR service providers. • Slow, manual processes with UHC's billing system. • Steep learning curve for new providers regarding their roles and responsibilities within the ALR program.

Opportunities for improvement

- Increase the utility of DC Care Connect by providing ALRs more access within the system.
- Automate billing through UHC.
- Increase learning and retention with a training program for new ALR providers.

Figure 8: Strengths, weaknesses, and opportunities in the Efficiency domain

Efficiency is defined as "the achievement of a higher level of performance in relation to the inputs used, such as time, money, and other resources."[4] Within the context of this study, efficiency was explored in terms of the performance of the agencies and ALRs involved in providing care to beneficiaries and patients. Their focus was primarily on the value of having an integrated system for filing for admissions, transitions, and other regulatory requirements.

One of the cornerstones of DC's Medicaid ALR program is DC Care Connect, which several interview participants noted provided a more integrated and streamlined user experience than the previous care coordination system. Some perceived downsides, though, are that the system uses role-based access to information and functionality, and visibility to a record can be lost due to the lack of an active or approved PCSP. Providers are encouraged to collaborate with the assigned Case Management Agency and their DHCF liaison to address any issues relating to the PCSP approval. Provider permissions are also being considered for part of the system's next upgrade.

Users also reported occasional problems getting access to all the required information in the system such as the status of potential residents, and inconsistencies with automated notifications (meaning they must constantly check the system for updates). Expanding access to and synchronization with DC Care Connect will ensure that providers can obtain a better understanding of the needs of their potential residents prior to them moving into the ALR.

Despite the apparent success of DC Care Connect as an integrated coordination platform, some providers still fail to use this channel or the Electronic Provider Programmatic Report (ePPR) system to communicate beneficiary-related issues and administrative concerns. This prevents LTCA from tracking and resolving issues quickly and efficiently. However, the reluctance of providers to use DC Care Connect may not be because of any outright resistance; it could simply come down to a lack of understanding of all the complex processes involved in the ALR program—a particularly steep challenge for new providers. While providers do attend in-person training, a large gap remains in terms of their ability to effectively implement the principles learned in the training. An onboarding checklist may help to reduce confusion and misunderstanding about the roles and responsibilities of each of the parties involved in delivering assisted living services.

ALR providers reported that billing for services through DHCF was easy and timely, with few denials. As with DC Care Connect, they found the billing software application to be very user-friendly, especially since it allowed for the creation of templates to streamline the submission process. The funding assistance offered by DHCF to help providers transition from paper documentation to electronic health records was also widely appreciated.

Another improvement that DHCF has made regarding increasing accessibility is the recent introduction of the District Dual Choice program for dually eligible beneficiaries. Dual Choice enrollment is done through the private health plan offered by UnitedHealthcare (UHC). In contrast to DHCF's billing system however, billing through UHC is manual and slow, requiring inputting data into many tabs and each claim taking several minutes to complete.

Although the current daily reimbursement rate of $218.56 in the District was approved by a majority of ALR providers, agency personnel and some ALR providers have expressed a keen interest in investigating the feasibility of adopting an acuity-based reimbursement rate system. These ALR providers emphasized their preference for a more streamlined and uniform rate structure that considers acuity levels, promotes the shift from institutional to residential care, and guarantees the financial sustainability of providers.

Equity: To what extent are ALR services being delivered in an **equitable** manner?

Strengths	Weaknesses
• DHCF is actively involved in minimizing discrepancies between the service available to Medicaid versus private-pay beneficiaries.	• Perceived inequity between the quality and level of services provided to EPD Waiver beneficiaries and private-pay beneficiaries. • The PNA is not seen to be sufficient to cover beneficiaries' actual daily costs. • DC does not have a bed-hold payment policy.
Opportunities for improvement	
• Increase visibility and awareness of the steps being taken to reduce inequities in the quality of care – perceived or otherwise. • Establish a bed-hold payment policy.	

Figure 9: Strengths, weaknesses, and opportunities in the Equity domain

The provision of equitable services relates to having access to care based on one's actual needs and without discrimination.[5] It involves recognizing that everyone has different circumstances, then allocating the exact resources and opportunities necessary to produce a fair and equal outcome across the entirety of the population being served.

One popular topic of discussion that emerged during the group interviews with the beneficiaries centered on the perception of a high degree of *inequity* between the services provided to EPD Waiver beneficiaries as compared to private-pay beneficiaries. It was felt that EPD Waiver beneficiaries were not receiving the same level of quality care, cleanliness, access to activities, or even shuttle services as private-pay residents. The participants attributed this apparent disparity to rate-related issues with the overall funding process, which in turn affected the operating budgets at the facilities. The Ombudsman stated that beneficiaries' concerns were not without merit based on his observations of operations at non-Medicaid-financed facilities.

Certainly, an underlying aim of DC's Medicaid ALR program is to prevent such disparities from occurring. Keeping a watchful eye on any actual variations in the quality of care being delivered to private-pay residents as opposed to EPD Waiver beneficiaries—and promptly addressing any major differences—may be all that is necessary to maintain an even balance. Having accurate data to back up this argument should also help to allay beneficiaries' concerns about any apparent discrepancies.

The PNA (which allows beneficiaries to keep a portion of their income to help pay for items that the ALR is not required to provide) was another problem area—specifically in terms of providing an insufficient amount to cover the actual daily costs faced by residents in DC. This concern was voiced by both beneficiaries and ALR representatives alike, with providers particularly worried about the downstream impact on the wellbeing and quality of life for their residents. While the interview participants recognized that budget constraints will always limit the amount that can be allocated toward the PNA, they proposed that tying the PNA to annual cost of living increases was seen as one way to provide more financial security to beneficiaries. Commencing in 2024, the District will undergo an annual update of its PNA, aligning it with the federal Cost-of-Living Adjustment (COLA) set by the Social Security Administration. It will be intriguing to observe whether this policy shift effectively addresses the concerns voiced by both residents and ALR providers.

Finally, DC has not instituted a bed-hold payment policy, which would allow ALRs to reserve the bed of hospitalized Medicaid residents and be compensated by some amount for the resident's absence. This way, the ALR resident can be assured of having a continuous place of residence and the provider can minimize their loss of income during the period.[6] But in the absence of a bed-hold policy, some residents may instead refuse hospitalization altogether to avoid the risk of losing their beds.[7]

Comparative multi-state analysis

This section examines how selected states in the U.S. approach the coverage and reimbursement of ALR services delivered to Medicaid beneficiaries. It compares those experiences to the program in DC for the purpose of identifying potentially better options for providing access to high-quality assisted living services.

Advantageous Strategies examined all Section 1915(c) Waivers that are active within the U.S. covering the provision of services within assisted living facilities. The purpose was to identify those waivers that cover Nursing Facility diversion, and that provide for assisted living services within an ALR. Medicaid State Plans, Section 1115 Demonstration Waivers, and Waivers with operational authority under Sections 1915(b) and 1915(i) were also examined.

In total, 76 state Medicaid Waivers and State Plans were identified as offering services within assisted living facilities. However, 51 of these Waivers do not cover the full extent of assisted living services as defined by the Centers for Medicare and Medicaid Services (CMS); rather, they offer individual components of CMS-defined assisted living as separate services. Twenty-five states including DC provide full coverage — 20 being under Section 1915(c) authority, and five operating a Section 1115 Demonstration Waiver.

Table 2 shows, by state, the waivers that cover nursing facility diversion and services in an assisted living facility.

Table 2: State assisted living waiver programs

State	Name of Waiver	Policy Authority	Concurrent Authority
Connecticut	Home and Community Based Services Waiver for Elders	1915(c)	1915(b)(4)
Connecticut	Mental Health Waiver	1915(c)	
Delaware	Delaware Diamond State Health Plan (Diamond State Health Plan Plus)	1115	
District of Columbia	Elderly & Persons With Physical Disabilities	1915(c)	1915(a) 1915(i)
Florida	Florida Long-Term Care	1915(c)	1915(b)(1) 1915(b)(4)
Hawaii	Hawaii QUEST Integration	1115	
Illinois	Illinois Supportive Living Program	1915(c)	1915(a) 1915(b)(1) 1115
Indiana	Aged and Disabled Waiver	1915(c)	
Indiana	Traumatic Brain Injury Waiver	1915(c)	
Iowa	Home and Community Based Services – Elderly Waiver	1915(c)	1915(b)(1) 1915(b)(3) 1915(b)(4)
Massachusetts	Acquired Brain Injury with Residential Habilitation Waiver	1915(c)	
Massachusetts	MFP Residential Supports	1915(c)	
Mississippi	Assisted Living Waiver	1915(c)	
Montana	Montana Big Sky	1915(c)	1915(b)(4)
Nebraska	Aged and Disabled Waiver	1915(c)	

State	Name of Waiver	Policy Authority	Concurrent Authority
Nevada	HCBS Waiver for Persons with Physical Disabilities	1915(c)	
New Jersey	New Jersey FamilyCare Comprehensive Demonstration	1115	
New Mexico	Centennial Care 2.0	1115	
Ohio	Integrated Care Delivery System (ICDS) Waiver (MyCare Ohio)	1915(c)	
Ohio	Assisted Living	1915(c)	
Oklahoma	ADvantage	1915(c)	
Rhode Island	Rhode Island Comprehensive Demonstration	1115	
South Dakota	Home and Community-Based Options and Person-Centered Excellence (HOPE) Waiver	1915(c)	
Texas	Texas Healthcare Transformation and Quality Improvement Program (Texas STAR+PLUS HCBS Program)	1115	
Wyoming	Community Choices Waiver (CCW)	1915(c)	

Review of policy authorities

The 25 identified waivers operate under a diverse suite of policy authorities. Of these:

- 13 use only Section 1915(c) waiver authority, with no concurrent authorities.
- Six use Section 1915(c) authority concurrently with other waiver authorities.
- Six use Section 1115 Demonstration Waivers.

Seven of the thirteen states that use only Section 1915(c) Waivers without any concurrent authorities (Indiana, Mississippi, Nebraska, Nevada, Ohio, Oklahoma, South Dakota, and Wyoming, with Massachusetts as the outlier) are tightly clustered around their average Medicaid expenditure per enrollee and population range. All seven have an annual Medicaid expenditure per full-year equivalent enrollee of between $6,000 and $7,500 (the 51-state range is between $4,125 and $10,166). Although these seven states have an average 65-and-older population size (16.4%) that is almost identical to the national average (16.7%), their 65-and-older percentage range is much tighter than the national average. For these seven states that only use 1915(c) authority, their 65-and-older population percentage range is between 15.3% and 17.4%, compared to the national range of 11.7% to 21.7%.

Six states use Section 1915(c) Waivers concurrent with Section 1915(b) Waiver authorities. 1915(b)(1) allows states to create managed care plans as well as to place limits on participant freedom of choice. Likewise, these six states using the Section 1915(b) authority have a wide range of Medicaid expenditures per enrollee, which is reflective of each state's highly individualized care plans. Connecticut, Florida, Illinois, Iowa, Montana, and Ohio all use Section 1915(b)(4) authority for selective contracting, allowing them to restrict the number of Medicaid providers. Iowa is the only state using a Section 1915(c) Waiver concurrent with a Section 1915(b)(3) authority, allowing the state to offer non-medical services within its waiver program.[8]

All 19 of the Section 1915(c) Waivers examined in this report are open to participation by dual-eligibles. Dual-eligibles have the advantage of receiving more health coverage for lower out-of-pocket costs.[9] Medicare is the primary payer for dual-eligibles, providing state Medicaid programs with some respite in terms of their financial obligations. Forty-five states are now using Dual-Eligible Special Needs Plans (D-SNPs), which are designed to reduce nursing facility utilization. D-SNPs provide an effective model for those short-stay residents transitioning from a hospital or institutional care and into community-based care.[10] DC is the only state operating under Section 1915(c) Waiver Authority currently using D-SNPs for dual-eligibles. Rhode Island's Section 1115 Demonstration Waiver provides options for PACE and Medicare-Medicaid (MMP) dual-eligible participation. Hawaii's Section 1115 Demonstration Waiver is exploring the use of a D-SNP. Although Illinois is not pursuing D-SNP specifically, the state enhances its 1915(c) care to dual eligibles through its 1115 Waiver participation in CMS' Medicare-Medicaid Alignment Initiative (MMAI) Demonstration.

For those waivers that are concurrent with Section 1915(b) authorities, the average Medicaid expenditure per enrollee runs from $4,700 in Florida up to $8,600 in Connecticut. Otherwise, there are no discernible demographic similarities between the states that shed any light on how concurrent Section 1915(b) Waivers may be affected by a state's rural/urban mix or age.

There is also no distinction in the number of care services offered by a Section 1915(c) Waiver, which is true whether or not the Section 1915(c) Waiver is concurrent with a Section 1915(b) authority. The average number of care services offered per Section 1915(c) Waiver is 10.5, with a range of 7 to 14 (this excludes the Waivers in Illinois and Mississippi, as well as Ohio's Assisted Living Waiver Program, all being dedicated assisted living-only waivers). As such, there is no tendency for Section 1915(b) Waivers to offer more or less care services than standalone Section 1915(c) Waivers.

The states that use Section 1115 Demonstration Waivers to provide their assisted living services are Hawaii, Delaware, New Jersey, New Mexico, Rhode Island, and Texas. These states use the Section 1115 authority to fund large, all-encompassing Medicaid health plans that contain both HCBS and non-HCBS services, and are typically operated by Managed Care Organizations. Demographically, these states have a comparatively high percentage of their population residing in urban areas, ranging from 75% to 84% of the total population.

DC is the only jurisdiction to operate the Section 1915(c) Waiver concurrently with Section 1915(a) and 1915(i) authorities, although Illinois also uses 1915(a). Section 1915(a) allows states to create a voluntary managed-care program through providers using a competitive procurement process,[11] while Section 1915(i) allows state Medicaid programs to cover HCBS through the Medicaid State Plan.[12] Section 1915(i) does not require states to show that HCBS reduces Medicaid's institutional care costs, thus DC uses Section 1915(i) solely for its Adult Day Health program.[13] Connecticut, by contrast, has three HCBS programs; two offered through Section 1915(c) for institutional diversion, one of which serves the elderly and the other focusing on mental health; and its third HCBS program is offered under Section 1915(i) within its State Plan for individuals not meeting institutional levels of care. This third policy authority used by Connecticut is an example of a policy authority that would allow DC to reimburse for ALR services delivered to Medicaid beneficiaries who do not meet the NFLOC criteria but instead meet a lower-acuity standard. Indiana and Massachusetts also have two HCBS programs for nursing facility diversion, with both states opting to carve out their beneficiaries with brain injuries into separate waivers dedicated to that condition.

Target groups and providers

Table 3 provides a sample of the number of ALR providers and beds in representative states.[14]

Table 3: ALR statistics by state

State	Number of assisted living providers	Number of beds/units	% of ALR resident relying on Medicaid
Connecticut	139	Not available	66%
Delaware	35	2,542	8%
District of Columbia	14	1,001	9%
Florida	2,997	114,610	24%
Hawaii	17	Not available	7%
Illinois	495	Not available	34%
Indiana	226	22,246	27%
Iowa	484	27,348	11%
Massachusetts	267	18,593	12%
Mississippi	204	8,242	7%
Montana	206	Not available	22%
Nebraska	284	13,918	24%
New Jersey	297	24,438	25%
New Mexico	73	Not available	14%
Nevada	399	9,261	8%
Ohio	106	Not available	12%
Oklahoma	15	Not available	5%
Rhode Island	63	Not available	23%
South Dakota	182	5,633	23%
Texas	2,005	81,534	8%
Wyoming	34	248	20%

As might be expected, all Section 1915(c) Assisted Living Waivers have diverse target groups of participants. Of the waivers examined, they all serve both Medicare-Medicaid dual-eligibles and beneficiaries aged 65 and over, but there is also a wide range of individuals with disabilities being served by these waivers. That is whether or not the Section 1915(c) Waiver is concurrent with Sections 1915(a), 1915(b), or 1915(i) Waiver Authorities.

Examples of the range in disabilities covered by different Section 1915(c) Assisted Living Waivers are as follows:

- Physical disabilities, 0 to 64
- Physical disabilities, 18 and over
- Physical disabilities, 18 to 64
- Physical disabilities, 18 to 64, including individuals who are medically fragile, suffer from HIV/AIDS, or have brain injuries
- Physical disabilities, 21 to 64
- Physical disabilities, 22 to 64
- Intellectual disabilities, 0 to 64

- Intellectual disabilities, 18 and over
- Intellectual disabilities, 19 to 64
- Intellectual disabilities, 21 to 64
- Mental Illness, 22 and older
- Brain injury, no age limits
- Brain injury, 22 and older

Only Connecticut and Iowa have Section 1915(c) Waivers for HCBS assisted living services that serve only individuals aged 65 and over (excluding younger persons with disabilities). Only a few pairs of states share common target groups in their 1915(c) Waivers, with Mississippi and Oklahoma serving individuals with physical and intellectual disabilities ages 21 to 64. Montana, Nevada, and Nebraska also share a common target group, with three states serving individuals with physical and intellectual disabilities ages 0 to 64.

By comparison, the six states using Section 1115 Demonstration Waivers for their HCBS assisted living services use some variation of the HCBS eligibility standard set by 42 C.F.R. Section 435.217 for individuals receiving home and community-based services:

- Texas specifies that its Section 1115 Demonstration Waiver serves individuals aged 65 and older, or those aged 21 and older with disabilities.
- Delaware uses its Section 1115 Demonstration Waiver to serve the 217-like Elderly and Disabled HCBS Group and the 217-like HIV/AIDS HCBS Group.
- New Mexico, Rhode Island, and Hawaii serve the 217-like Group with their Section 1115 Demonstration Waivers.
- New Jersey uses its Section 115 waiver to serve all individuals 65 and over, individuals 21 and older with a nursing facility level of care, and individuals ages 0 to 20 with functional disabilities.

CMS gives wide latitude to the types of care facilities that may provide assisted living services. However, for the purposes of this analysis, providers must be assisted living facilities that are licensed by their state licensing authorities. These waivers also require that only assisted living facility staff, or other individuals who are coordinated by the ALR, may provide assisted living services under the waivers. DC is the only jurisdiction requiring assisted living staff to undergo additional training in subjects such as Supported Decision-Making and Supported Community Integration.

Changes to populations and services

The review of state waivers showed that states rarely make significant changes to their program or policy over the years. Nebraska stands alone in terms of removing a service (Chore Historical) to bring the state into line with updated federal requirements. Conversely, Oklahoma is the only state to have added services to its Section 1915(c) Waiver, by including Assistive Technology and Remote Supports to address the state's particularly large and geographically dispersed rural population. While there is consistent application of the Section 1915(c) Waiver for providing HCBS to individuals aged 65 and older, considerable variation exists across the states in terms of how they address the assisted living needs of their disabled populations. Among the 21 states examined in this analysis, 18 include individuals with physical disabilities in their HCBS assisted living populations. Individuals with physical disabilities under the age of 21 are most often covered by separate, distinct HCBS 1915(c) Waivers that are more closely tailored to their needs. Ten of the 21 states incorporate some form of intellectual disability into their Section 1915(c) assisted living Nursing Facility diversion programs.

The remaining 11 states have established their own Section 1915(c) HCBS *non*-Assisted Living Waivers to cater for their populations with intellectual disabilities.

In general, states tend to compartmentalize their Section 1915(c) Nursing Facility diversion programs separately from their other Section 1915(c) Waivers. This strategy is likely to be motivated by the considerable costs associated with providing MLTSS in assisted living facilities, aiming to manage and control these expenses more effectively.

Expansion of Medicaid coverage

The Affordable Care Act (ACA) expanded Medicaid by providing additional federal funding to incentivize states to extend coverage to a broader population.[15] The expansion primarily targeted adults aged between 19 and 64 with incomes up to 138 percent of the Federal Poverty Level (FPL). As of July 2023, 41 states (including DC) have adopted the Medicaid expansion.[16]

While Medicaid's expansion has resulted in positive changes, there are still issues surrounding its funding and stability, which include:

- **Funding uncertainties.** As the economy changes, so does the government's financial focus. This has led to budget cuts in Medicaid and reduced funding for Medicaid-approved ALRs.
- **Impacts on State budgets.** Medicaid opponents argue that its financial cost is already too high for the country. States had to start covering parts of the expansion cost in 2017, and from 2020 they cover 10 percent of its total price.

Other issues relate to enrollment; provider capacity; the inadequacy of the current workforce and infrastructure; and complexities associated with the implementation of the policy:[17]

- **Enrollment Challenges:** Following the expansion of Medicaid eligibility, states experienced a surge in new enrollments, leading to increased administrative workloads for Medicaid agencies. This effect negatively impacted the efficiency and timeliness of processing and managing large pools of beneficiaries.
- **Provider Capacity and Access to Services:** The higher demand for healthcare services may exceed the capacity of healthcare providers in some states or specialties.
- **Workforce and Infrastructure Challenges:** Increased enrollments in Medicaid places additional stress and pressure on the healthcare workforce and the underlying infrastructure.
- **Policy and Implementation Complexity:** Each state has applied a variety of different eligibility thresholds, coverage options, and program frameworks, making it challenging to understand and adhere to the processes. What is more, the labyrinthian variety in how programs are structured and delivered in each jurisdiction makes it impractical to obtain an apples-for-apples comparison between one state and the next.

Managed Long-Term Services and Supports (MLTSS)

States have the flexibility to use Section 1115 Demonstration Waivers and 1915 Waivers for MLTSS delivery systems, which cover the delivery of long-term services and supports through capitated Medicaid managed care programs. As of 2020, MLTSS programs were operational in 11 of the states examined in this study: Delaware, Florida, Hawaii, Illinois, Iowa, Massachusetts, New Jersey, New Mexico, Nevada, Ohio, Rhode Island, and Texas.[18]

Managed care models that implement MLTSS present a range of opportunities for enhancing care coordination and expanding access to HCBS. When contemplating the implementation of MLTSS for ALRs, the Kaiser Commission on Medicaid and the Uninsured makes the following suggestions:[19]

- Ensure that ALRs adhere to all necessary regulatory standards for safety, care quality, and staffing, as they are subject to state-specific regulations and licensing requirements.
- Develop effective communication channels and care plans that involve both medical and non-medical personnel, including ALR staff, to foster seamless coordination of care.
- Establish assessments that consider both the healthcare needs of residents and their ability to safely reside within the ALR setting.
- Define which services are covered for ALR residents within the MLTSS program. These services may encompass personal care, medication management, transportation to medical appointments, and specific healthcare services. It is crucial to establish clear guidelines to ensure that ALR residents receive the necessary services.
- Determine the payment model for ALR services within the MLTSS program. This may involve capitated payments to ALRs, where the facility receives a set monthly payment per resident, or it employs alternative reimbursement mechanisms.
- Implement quality assurance measures tailored to ALRs, which may include routine inspections, performance metrics, and surveys to gauge resident satisfaction, ensuring that care quality within ALRs meets the required standards.
- Ensure that ALR staff are adequately trained to operate effectively within the MLTSS framework. This may entail familiarization with care plans, understanding documentation requirements, and adhering to communication protocols with other healthcare providers.
- Plan for effective transitions when residents move into or out of ALRs, emphasizing the importance of continuity of care. MLTSS programs should establish protocols for seamless transitions and coordination of services during these periods.
- Clearly specify the responsibilities of ALR staff in administering and monitoring medications, recognizing that ALR residents often require assistance with medication management.
- Foster effective communication and collaboration among ALRs, healthcare providers, care managers, and other stakeholders. Regular meetings and information sharing can help ensure that the needs of ALR residents are met.
- Develop emergency response plans specific to ALRs, accounting for the unique needs of residents and the available resources and capabilities of the facility.
- Respect and support the choices of ALR residents regarding their care and living arrangements, ensuring that the MLTSS program aligns with the resident's preferences to the greatest extent possible.

Transition plans

All Section 1915(c) Waivers are required to have a transition plan for participants included in the waiver application. These transitions plans must describe how the state will ensure continuity of care for participants as they are moved from a nursing facility into HCBS services.

Transitioning between facilities can be complicated. Improving transitions into community-based settings has been studied at length by health researchers since the Supreme Court’s 1999 Olmstead decision ruled that keeping individuals in institutions when appropriate community supports were available constituted discrimination.[20]

The Money Follows the Person (MFP) grant, a federal Medicaid program, is widely used by state Medicaid programs (including DC), with the primary aim being to improve HCBS accessibility or seniors and individuals with disabilities during their transition from institutional care.[21] Within the framework of the MFP grant, transitional support includes locating affordable housing, covering security and utility deposits, and procuring essential household items. With regard to the states examined as part of this study that did *not* have an MFP Program (Delaware, Florida, Mississippi, New England, and Wyoming), none of them offered alternative programs that demonstrated a higher level of innovation or comprehensiveness when compared to MFP.[22]

Spending down assets to meet financial eligibility has always been an issue across the Medicaid population. For the Section 1915(c) Waivers examined in this analysis, the income limits ranged from 100% of the Federal Poverty Level (FPL) to 300% of the Social Security Income benefit rate. The definition of assets can also differ between states, with most including cash, stocks, bonds, investments, bank accounts, and real estate in which one does not reside.[23] States generally exempt personal belongings, household furnishings, automobiles, irrevocable burial trusts, IRAs in payout status, and a primary residence. But states do have different asset requirements for married versus single applicants.

To help meet the issue of income eligibility, some states have begun offering the option for beneficiaries to enter a Miller Trust. These trusts name the state as beneficiary of the participant's funds in these accounts, and upon the participant's death the state receives these funds as reimbursement for the care provided to the individual.[24] Currently, half of states offer Miller Trusts to Medicaid beneficiaries. Other states are 'Spend Down' States. In Spend Down States, Medicaid applicants who are over the income limit can spend 'excess' income on medical and care expenses.[25] Once their income is 'spent down' to the Medically Needy Income Limit, they are income-eligible for Medicaid for the rest of the spend down period. DC is a 'Spend Down State.'

Health and Welfare metrics

Health and Welfare metrics used by Section 1915(c) Waiver states are fairly consistent.[26] This may be due to the CMS Section 1915(c) Waiver application, which requires states to create performance measures addressing specific occurrences. Thus, all Section 1915(c) states have developed performance measures covering:

- instances of abuse, neglect, and exploitation
- occurrences of unexplained deaths
- the use of unapproved restrictive interventions, such as restraints and seclusion
- incidences of critical incidents
- unexplained deaths
- dissemination of educational materials to participants and their families
- case management

Less common performance measures among states include:

- medication errors
- preventive health visits

Although states may have common performance measures driven by the standard CMS Section 1915(c) Waiver application, states at this time are given wide latitude as to how they shape their performance measures. For example, several states combine all unapproved seclusion and restraints into a single performance measure, while other states separate seclusion from restraints. Some also include instances of unexplained deaths in the same performance measure as instances of abuse, neglect, and exploitation. Additionally, the use of a Quality-of-Life survey for states is optional. Only two-thirds of waiver states employ these surveys.

DC differs from other states in that it sets specific time periods (e.g., 24 hours, 48 hours, or one week) in which incidents and investigations are to be completed. Other states simply reference reports and investigations to be completed "within a specified time." DC is also one of a few Section 1915(c) states that includes a performance measure for preventive health visits. Even so, DC can benefit from expanding the range of performance measures that it uses. Whereas most states have between seven and 14 Health and Welfare performance measures, DC currently uses six. This is mainly because DC has combined multiple factors into a single measure. For example, most states have a measure for unexplained deaths and a second measure for abuse, neglect, and exploitation; however, DC combines these into one. By separating out its combined performance measures, DC can increase the granularity of its data collection efforts and potentially drive further improvements in the waiver.

Section 1115 Demonstration Waivers do not require a specific application and must only follow general CMS guidelines. As such, these waivers do not involve the same level of granularity as Section 1915(c) Waivers in terms of defining participant Health and Welfare performance measures.[27] As a result, Section 1115 states only have a general acknowledgement that the MCOs they monitor are reducing threats to participant health and safety.

Payment methodologies

Non-tiered payment methodologies

State reimbursement methodologies are difficult to standardize in a way that allows for straightforward comparisons. Although states are required to detail their reimbursement methodologies in their waiver applications, they will often simply state that "a study was done" or "historic data was used" to set their reimbursement baselines, but they will not cite the underlying data. State payment methodologies will also often use a variety of different data sources and different variables to set their baseline rates. For example, states have used previous years' CMS 372 reports, historic claims data, and even data from previous state waivers to build their case. The following lengthy explanation of Florida's methodology (as submitted to CMS) serves to illustrate the size of the challenge:

LTC capitation rate range development

The State of Florida's Agency for Health Care Administration (AHCA) contracted with Mercer Government Human Services Consulting (Mercer) to develop actuarially sound capitation rate ranges for the Statewide Medicaid Managed Care (SMMC) Long-term Care (LTC) program for the implementation year (August 1, 2013 – August 31, 2014), and for the second year (September 1, 2014 – August 31, 2015). For the third year, AHCA retained Milliman to develop LTC capitation rates (September 1, 2015 – August 31, 2016).

During the rate setting process, AHCA provides several opportunities for public comment. First, we have regular meetings with actuaries and the plans (individually and as a group) to discuss any issues that need to be accounted for in the base data used to develop rates. Second, we share draft rates with the plans, meet with them to discuss case mix of HCBS and non-HCBS enrollees. Case mix is determined by staff in the Medicaid Bureau of Data Analytics using encounter data and assistance category assignments from the Florida Medicaid Management Information System (FMMIS).

Once the case mix is established, AHCA makes an adjustment for the statutorily required HCBS transition percentage. The transition percentage is applied until no more than 35% of MCO's enrollees are placed in institutional settings (non-HCBS). For the third year of the LTC contract, the transition requirement is 3%. In addition, the HCBS certified rate is reduced by a small withholding amount to reimburse plans with a large number of very costly enrollees who receive HCBS. The withholding constitutes a Community High Risk Pool (CHRP), implemented in July 2014, risk mitigation mechanism for the HCBS rate cell. A percentage of HCBS rates is withheld to fund CHRP and varies by region. Seventy-five percent of member expenditures greater than $7,500 per month ("pooled claims") are eligible to be reimbursed by the CHRP. At the end of the contract period, if CHRP funds are inadequate to reimburse all pooled claims, the pooled claims will be funded on a proportional basis for each MCO. If CHRP funds exceed the level of pooled claims, excess CHRP funds will be returned to MCOs on a PMPM basis.

AHCA then calculates a final blended rate for each plan using the process above.

LTC plan capitation rates are available on the Agency's Web site at the following link: http://ahca.myflorida.com/medicaid/Finance/data_analytics/actuarial/index.shtml.

The Florida Medicaid Management Information System (FMMIS) has recipient eligibility and provider information. The recipient information is updated as part of the eligibility redetermination process. When a recipient is enrolled in the Long-Term Care Managed Care Program/a LTC plan, this will be reflected on his/her eligibility file. Provider information is established upon enrollment of each LTC plan. Capitated payments flow directly to capitated LTC plans from FMMIS. For each recipient enrolled with an LTC plan, a monthly payment is generated. Capitated LTC plans are responsible for paying provider claims and submitting encounters to the State. Edits in FMMIS are designed to ensure that claims for enrollees for services covered by a capitated LTC plan will be denied.

The only uniform element of state reimbursement methodologies relates to how they trend their data for future waiver years—usually from past claims data. Most methodologies are fee-for-service. However, Florida, New Mexico, and one of Ohio's two Assisted Living Waivers use capitation for payment purposes.

State payment methodologies also rely on different data sources and different variables to set their baseline rates. For some states, an inflation rate is built into each year of its waiver, although most states shift a cost burden onto providers by not taking inflation into account. The basis of inflation rates between states can also vary, with states using medical inflation indexes, cost of living indexes, trended historical data, or a flat rate approved by their legislatures.

To gain their estimates for a waiver's expected number of users, states largely depend on historic claims data to set their baseline number of users for the first waiver year and trend the number of users upwards for each successive waiver year. Although most states perform these estimates in-house, Mississippi and Nebraska rely on market analyses prepared by third-party contractors to set their baseline rates and user estimates.

Tiered payment methodologies

To save money, some states have begun introducing tiered payment methodologies into their Section 1915(c) Assisted Living Waiver programs. Tiered rates save money when most participants are distributed at the lower rate of tiers. However, a disadvantage of tiered structures is that it can be difficult for providers to understand exactly how much they are likely to earn for their services.[28]

Six states are now using a tiered rate methodology for their assisted living services: Indiana, South Dakota, Connecticut, Ohio, Montana, and Nebraska. As with many other aspects of states' Medicaid Waivers, these tiered methodologies are highly diverse. The five states have managed to develop four different methodologies for determining their assisted living payment rates. For example, Connecticut, Montana, and South Dakota have developed tiered methodologies based on service intensity. Connecticut's methodology is:

- Tier 1: Occasional Personal Service – 1 hour per week, up to 3.75 hours per week of personal services plus nursing visits as needed.
- Tier 2: Limited Personal Service – 4 hours per week, up to 8.75 hours per week of personal services plus nursing visits as needed.
- Tier 3 - Moderate Personal Service – 9 hours per week, up to 14.75 hours per week of personal services plus nursing visits as needed.
- Tier 4: Extensive Personal Services – 15 hours per week, up to 25 hours per week of personal services plus nursing visits as needed.
- Montana's tiers also include a separate tier for individuals exhibiting at-risk behaviors.

Indiana's tiered methodology is focused on adjusting the rates for the assisted living service's individual component services:

- Level 1 – Attendant Care, Home Maker and Skilled Nursing rate components of the assisted living service are adjusted downward by 10%.
- Level 2 – Baseline assisted living service, with unadjusted components.
- Level 3 – Attendant Care, Home Maker and Skilled Nursing rate components of the assisted living service are adjusted upwards by 17%.

Nebraska has developed a tiered methodology that is monthly and based on the occupancy of the assisted living arrangement, and whether the assisted living arrangement is in an urban or rural area:

- Level 40 – Rural single occupancy ($2,501)
- Level 41 – Rural multiple occupancy ($2,018)
- Level 42 – Urban single occupancy ($2,817)
- Level 43 – Urban multiple occupancy ($2,273)

Ohio has developed a multi-tiered payment methodology that is based on patient acuity:

- Acuity Level 1: The need for medication assistance/administration
    - Tier 1: Independent with medications
    - Tier 2: Supervision with medications
    - Tier 3: Medication administration
- Acuity Level 2: The presence of the need for nursing services
    - Tier 1: No nursing needs

  - Tier 2: Weekly and/or monthly nursing needs
  - Tier 3: Daily nursing needs
- Acuity Level 3: The degree of need for supervision to prevent harm
  - Tier 1: Occasional prompts
  - Tier 2: Daily cuing and prompts
  - Tier 3: Ongoing cuing, prompts, and re-direction

Room and board costs

Since Medicaid does not pay for the cost of room and board at assisted living facilities, some low-income beneficiaries may still not have enough money to cover their full room and board cost. States have used a variety of different methods to tackle this problem, such as a combination of state and federal funds, aid from non-profit organizations, or contributions from private companies.

Forty-six states plus DC offer the Optional State Supplementation (OSS) option. Eligibility is typically based on the candidate's income level, although each state has the authority to set their own eligibility requirements and guidelines.[29] Some states set a cutoff point at a higher or lower level than the Federal SSI benefit rate, while others use an entirely different scale and methodology. One common approach involves setting income eligibility based on a percentage of the state's own median income. Such flexibility allows states to tailor their programs to the specific needs and demographics of their aging populations.

The benefit is usually provisioned as a cash payment on top of the amount the resident receives from their SSI.[30] Some states administer the supplement such that individuals receive a separate payment. These states include Connecticut, Delaware, the District, Florida, Indiana, Iowa, Nebraska, New Mexico, Ohio, Oklahoma, Rhode Island, South Dakota, Texas, and Wyoming. OSS benefits may also be administered through the Social Security Administration. States that have chosen this option include Delaware, DC, Hawaii, Iowa, and New Jersey.[31]

Assistance ranges from insignificant amounts (just a few dollars per month) to more than $1,000. The dramatic variation in how, and by what amount, states deliver their OSS payments is illustrated through the examples in Table 4.

Table 4: Examples of state OSS benefits

State	Implementation of OSS benefits
Connecticut	Connecticut has an OSS for room and board. However, the state uses a narrower definition for "assisted living." "Managed residential community" residents are not qualified, but those in "residential care homes" are.[32] Residential care homes include adult foster care and memory care homes for individuals with Alzheimer's and dementia.
Delaware	Delaware provides financial aid in addition to SSI for residents in certain adult care and assisted living facilities. The specific amount, which can be up to $140, is determined by the level of care required by the individual. Eligibility criteria are set by the state's Department of Health and Social Services. This state-level aid exists alongside federally matched Medicaid programs, which have expanded over time to cover various healthcare needs.[33]
District of Columbia	DC provides a Social Security supplement to assist eligible individuals with room and board costs in ALRs. The amount of the supplement varies and is based on room and board for the facility. Supplements range from $640 to $750 per month. While this is higher than most states, it must be noted that DC also has some of the highest ALR costs in the country.[34]

State	Implementation of OSS benefits
Florida	Florida provides a monthly income supplement for room and board fees of around $79 to their eligible citizens.[35]
Hawaii	Eligible residents of specific adult care facilities in Hawaii, such as Community Care Foster Family Homes and Adult Residential Care Homes, can receive a state-provided OSS payment. The combined monthly SSI and OSS payment ranges from $1,445 to $1,553; the state's share is between $650 and $760. Eligibility hinges on income and resource limitations, including asset caps of $2,000 for individuals.[36]
Indiana	Indiana provides a Social Security supplement for eligible Medicaid and SSI recipients who cannot reside independently. The state also offers the Residential Care Assistance Program (RCAP), which supports qualified individuals in state-approved facilities by covering costs such as housing and food.[37]
Iowa	Iowa's State Supplementary Assistance provides financial aid for various populations, including individuals residing in Residential Care Facilities (RCFs). These RCFs often provide a level of care that is more intensive than assisted living, but less so than nursing homes. The program's financial thresholds may exceed traditional SSI guidelines. Therefore, before admission, it is crucial to verify whether the specific RCF accepts this additional funding, which is also subject to regular Medicaid provisions.[38]
Nebraska	A monthly Social Security supplement is available for seniors and disabled individuals under 65 residing in certain assisted living facilities. Eligibility criteria include receiving federal Supplemental Security Income and not being Medicaid-funded for facility care.[39]
Ohio	The Residential State Supplement (RSS) is available for Ohio residents living in adult foster care or group homes, ranging from $506 to $606 per month. The state caps its monthly room and board fees to the Federal SSI benefit for Medicaid recipients in ALRs.[40]
Rhode Island	Rhode Island's OSS offers a $332 monthly aid for those in assisted living, with a higher amount of up to $797 for residents in specialized care settings. These payments are added to the federal SSI rate of $794. Despite these supplements, the cost of assisted living in the state remains elevated.[41]
South Dakota	South Dakota provides additional financial assistance to those who qualify for federal SSI and are residents of assisted living communities or adult foster care homes. The state supplement serves to enhance the federal SSI benefits, offering additional economic relief specifically for individuals residing in these types of care facilities.[42]
Texas	Supplementary financial aid is extended to low-income residents in long-term care facilities that are sanctioned by Medicaid. This is provided over and above federal SSI benefits, and aims to ease the financial constraints associated with long-term care. The aid is notably limited to individuals in Medicaid-certified long-term care settings, thus narrowing its scope compared to OSS in other states.[43]

Some states (usually those with lower ALR costs) do not offer an OSS benefit but provide other options. For example:

- In Mississippi, resources are also available to aid families in identifying appropriate residential placements for their loved ones.[44]
- Oklahoma and Wyoming provide access to free resources such as assistance with searching for lower-cost ALRs or finding other types of funding.[45]

Veterans Affairs has a range of benefits specifically for veterans. Although Veterans Affairs is a federal agency, benefits and cash assistance programs can still differ by state.[46]

The American Council on Aging offers benefits to residents of selected states. To apply, one must be considered low-income, and be a citizen of the US or a lawful permanent resident.[47]

Other programs of note include Project RELIEF; the Alzheimer's Disease Initiative; Community Care for the Elderly; Home Care for the Elderly; and Supportive Housing for the Elderly Program (funded by the Department of Housing and Urban Development).

Comparing DC's reimbursement rate and methodology with other jurisdictions

Medicaid reimbursement rates specify the amount that Medicaid pays to health providers for covered services. In the case of assisted living facilities, Medicaid covers the ALR for all necessary resident care. Each state sets their own rate according to the cost and demand for providing care in their region. Surprisingly though, there is as much as a *fivefold difference* in Medicaid rates between the highest- and lowest-paying states, with DC holding the top spot.

A useful gauge for assessing how much DC spends in real dollars compared to other jurisdictions comes from examining the Medicaid Long-Term Services and Supports Annual Expenditures Report for Federal Fiscal Year 2019, published in December 2021.[48] As shown in Figure 10, DC was estimated to have had the highest Medicaid LTSS expenditures per capita in the country (at $1,391.06 per resident). The U.S. average was less than half that amount, at $608.25.

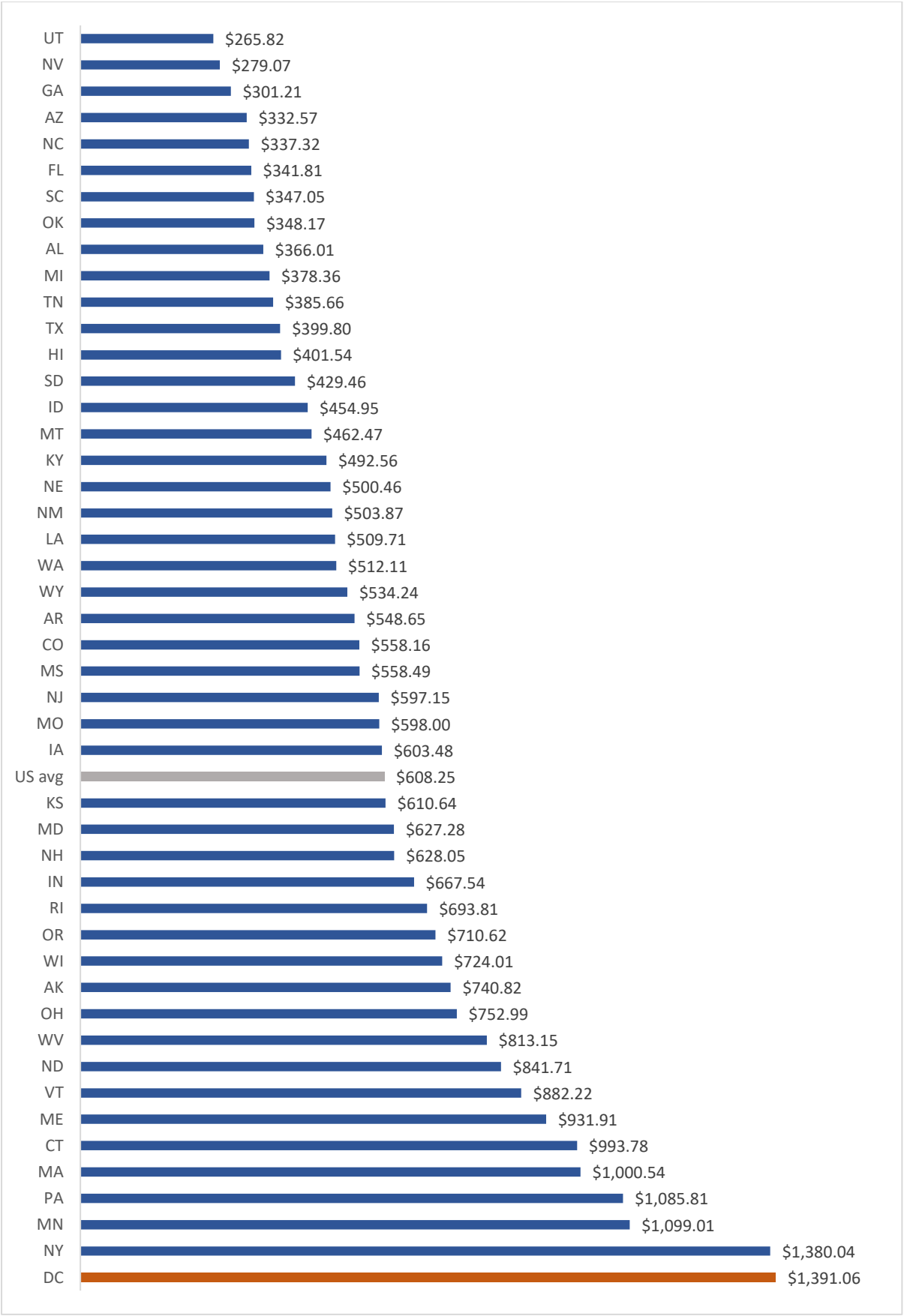

Figure 10: Medicaid MLTSS expenditures per resident by state (2019)

Furthermore, when examining the per-participant Year 5 expenditures for assisted living services, the District dwarfs other states in terms of the amount of money it is spending. DC spends $56,500 on average for each of its 404 participants in Year 5. By comparison, the next most expensive jurisdiction – Indiana – is spending $24,297 for each one of 8,609 participants, and Wyoming is spending $22,068 for each one of 463 participants.

As shown in Table 5, DC's high assisted living cost per participant is driven by three main factors:

- Length of Stay: DC has the highest length of stay at 338 days; South Dakota has the second-highest length of stay with 308 days.
- Cost per Unit: DC's cost per unit for 1 day is the second highest at $192.70 and ranks only after Indiana's $197.86. Nebraska's monthly unit of $4,400 equates to $146.67 per day.
- Low Number of Participants: DC has the lowest number of WY5 expected users at 404.

Table 5 Section 1915(c) HCBS Assisted Living Waiver: Year-5 costs for assisted living services

State	Yr 5 avg ALR cost per user	Length of stay	Yr 5 # of users	Yr 5 units per user	Yr 5 avg cost per unit	Yr 5 total assisted living-only cost
District of Columbia	$56,499.64	338	404	293.20	$192.70	$22,825,854.56
Illinois	$32,961.06	246	17158	246	$133.91	$565.545.852.48
Massachusetts	$29,626.40	305	15	239	$123.91	$444,396
Nevada	$29,085.00	322	22	277	$105.00	$639,870
Indiana	$24,297.21	285	8619	122.8	$197.86	$209,417,635.75
Wyoming	$22,068.15	306	463	313.29	$70.44	$10,217,552.34
Ohio	$18,844.86	292	3716	178	$105.87	$70,027,499.76
South Dakota	$16,797.24	308	974	272.02	$61.75	$16,360,506.89
Florida	$14,825.56	272	28760	34.45	$430.55	$426,383,033.70
Nebraska	$14,575.19	287	3300	6.5	$4,400.00	$48,098,139.93
Mississippi	$13,288.11	240	1191	201	$66.11	$15,826,139.01
Connecticut	$8,058.63	307	838	129	$62.47	$6,753,131.94
Iowa	$5,484.70	300	1227	217.13	$25.26	$6,729,731.56
Montana	$1,657.46	305	905	250	$92.00	$1,500,000
Oklahoma	$831.11	299	1181	166.69	$93.62	$981,540.00

DC's relatively high costs have, at least, generated significant indirect value. During the interviews with ALR providers, Advantageous Strategies found that recent rate increases for ALR services in the District have served to attract more private developers and private equity into the sector, resulting in a substantial increase in the number of available beds. Even so, interview participants highlighted a lack of transparency around how the reimbursement rate in DC is calculated, making it more challenging and riskier to build a business case around future developments.

To improve the return on investment in assisted living services, DC should consider adopting a payment methodology that follows a tiered rate structure. The District is currently paying the same rate for all participants, regardless of their acuity and service needs. The geographic and demographic diversity among the five states that use tiered payment methodologies suggests significant potential to "trim the fat" off states' Medicaid budgets. Any combination of service intensity, patient acuity, service component use, occupancy, and geographic area could be applied within DC to construct a more effective and equitable tiered payment system.

At over $56,000 projected to be spent per user during its final year of operation, the District of Columbia's Elderly & Persons with Physical Disabilities waiver has the highest cost of care per user of any state in the nation, 57% more than that of the second-highest state, Illinois. But what has been received for its expenditure is a deep interest from long-term care providers who are attracted to the District's high length of stay and high reimbursement for its direct care workers. By heavily investing into both its quality of care and its workforce, the Elderly & Persons with Physical Disabilities waiver may find itself being the nation's flagship waiver for assisted living, becoming the example of how heavy investment in care on the front end can actually save money by reducing long-term expenditures.

Recommendations

Advantageous Strategies has developed the following set of recommendations based on an analysis of the needs and expectations of stakeholders, providers, and residents/beneficiaries in DC's Medicaid ALR program. Many of these recommendations originated directly from study participants' perspectives on the best ways to tackle the challenges, optimize the use of existing resources, and improve the design and delivery of the program.

The recommendations are organized around the six domains defined by the framework for assessing the quality of assisted living services: Safety, Effectiveness, Patient-centricity, Timeliness, Efficiency, and Equity.

Recommendations for improving safety

1. **Identify and foster initiatives to strengthen communications regarding safety issues between relevant agencies, ALRs and residents and the Ombudsman** to ensure that ALRs are aware of any safety concerns that these stakeholders have.
2. **Continue the current dialogue with ALR providers** to jointly find ways to address ongoing staffing concerns.
3. **Expand recruitment and retention initiatives** to attract and maintain qualified CNA and PCA staff in the District.
4. **Establish a non-monetary recognition and reward program** for top performing ALRs to encourage and promote consistently high standards of safety performance.
5. **Expand the range of Health and Welfare performance measures** to increase the granularity of data collection efforts, potentially driving future improvements in the Waiver.

Recommendations for improving effectiveness

6. **Map out the end-to-end provider enrollment process** for the entire Medicaid ALR program in DC to provide greater clarity around the roles and responsibilities within and across agencies, providers, and third-party suppliers.

Recommendations for improving patient-centricity

7. **Increase awareness and promote the use of Resident's Councils and the Ombudsman** as safe and effective channels for ALR residents to share ideas, propose solutions, and file grievances without risk of retribution.
8. **Strengthen the ALR reporting requirements surrounding resident admittance and person-centered service plan implementation** to ensure compliance with those plans and that any identified issues are resolved.

Recommendations for improving timeliness

9. **Update guidelines and informational materials** for registering a new facility to ensure clarity about the process and reduce or eliminate current processing delays.
10. **Continue actively identifying opportunities for improvement in the assessment process** while ensuring that any changes or improvements in the assessment process align with the specific needs and conditions of the District, taking into account the urban setting and proximity of facilities.

11. **Explore the use of parallel workflows** to speed up the process of admitting residents into ALRs. Specifically, consider modifying the current process to what is shown in Figure 11.

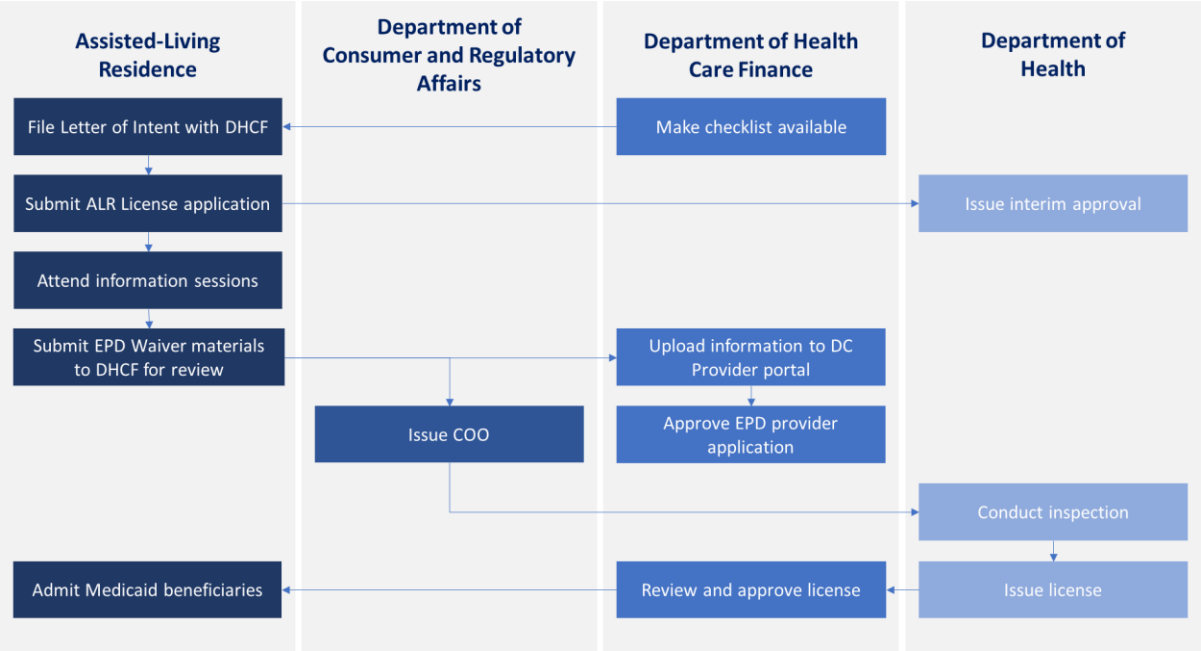

Figure 11: Revised process to obtain an ALR license and Medicaid certification

Recommendations for improving efficiency

12. **Expand access of ALR providers to DC Care Connect** to maximize the utility and coverage of that core system.
13. **Automate the billing and payment processing service** through UHC to reduce manual data entry and errors.
14. **Encourage providers to leverage in-person training** gained as part of Pre/Post Provider Enrollment processes to enhance their readiness for implementing systems and procedures effectively in their facilities.
15. **Adopt a payment methodology that follows a tiered rate structure** because such an approach will more closely align DC's Medicaid coverage with actual costs.
16. **Increase the level of transparency for how the reimbursement rate is calculated** so that ALR providers can create more accurate forecasts and plans around future developments.

Recommendations for improving equity

17. **Continually monitor variations in the quality of care** being delivered in private-pay versus Medicaid-financed ALRs—and promptly address any differences if they arise.
18. **Explore the cost versus benefit** of introducing a bed-hold payment policy in DC, to compensate ALR providers during extended periods of hospitalization while reducing or eliminating the risk of patients losing their beds. For example, consider adopting a similar bed-hold policy to the one currently used by the District regarding nursing facilities: If a recipient is hospitalized for an extended period or takes a therapeutic leave, Medicaid reimbursement is available for 18 bed-hold days per fiscal year.

Appendices

A1 Interview guide

Introduction

Advantageous Strategies' Interview Guide is designed to assist in the collection of data which can aid in answering the following questions:

- How does DC's current policy authority and reimbursement model for Medicaid-financed assisted living fare in terms of ensuring access to high-quality assisted living services?
- What challenges or barriers exist in DC's current approach to expanding or maintaining access to assisted living services under the Medicaid program?

Advantageous Strategies will use the analytic framework put forth by the National Academy of Medicine (AOM) to determine whether 'high-quality assisted living services' are being provided. This framework requires consideration of whether the assisted living services meet the following six aims:

1. Safe—does the ALR provide adequate care and supervision to meet the safety needs of beneficiaries? If not, what barriers exist to prevent the delivery of adequate services?
2. Effective—are the care needs of beneficiaries being effectively met by the ALR services provided in DC?
3. Patient-centered—is the care provided to beneficiaries respectful of and responsive to individual patient preferences, needs, and values? Do beneficiary values guide the services being received?
4. Timely—are ALR services being provided in a timely manner?
5. Efficient—are the ALR services provided in DC cost effective?
6. Equitable—does beneficiary care vary in quality or services being delivered because of socioeconomic status or any other personal characteristic? Is provider reimbursement equitable and sufficient to allow effective care to be delivered to beneficiaries?

Interview questions have been designed and organized to assess if the six aims are being met. Individual questions for each stakeholder group—Beneficiaries, Providers, and DHCF staff members—will hang on this framework, with the end goal of determining whether DC's current policy authority and reimbursement model for assisted living services either creates or inhibits an environment where the six domains of quality can be met. The questions for each stakeholder group are organized into the six aims as topical clusters, with ordered general-to-specific prompts that will allow, to the extent time permits, the interviewer to probe further based on interviewee responses.

Questions for beneficiaries

Question Identification Key: Questions in **bold** font are primary questions. *Italicized* questions are secondary prompts.

Safe

1. **Do you feel safe living at your current setting?**
2. *Have you ever met the administrator/executive director of your current assisted living facility? If yes, did you meet him/her prior to moving in?*
3. *Have you been given a list of the facility's policies and procedures?*
4. *Have you ever turned in a complaint to your current provider? If so, was the situation resolved to your satisfaction?*
5. *Have you ever turned in a complaint to your District regulator? If so, was the situation resolved to your satisfaction?*

Effective

1. **Do you feel that your care needs are being met?**
2. *Is there a resident or family council provided by your current assisted living setting? If so, do you participate? Why or why not?*
3. *Describe your experience with moving into your current assisted living setting.*
4. *Did your current provider assist with your move-in experience to your satisfaction? If no, what could they have done better?*
5. *Describe your experience with moving out of your last setting.*
6. *Was it your decision to move out of your last setting or did you move for other reasons?*

Patient-centered

1. **What do you enjoy about living at your current setting?**
2. **Do you feel like you are being treated and cared for in a dignified manner?**
3. **Do you feel all residents are treated the same, regardless of who pays for their care?**
4. *Do you know the names of the caregivers who provide services to you?*
5. *Do they treat you with kindness and dignity?*
6. *What would you change about the care you are currently receiving?*
7. *Do you like the food at your current setting?*

Timely

1. **Are there any services you wish you were receiving, but currently are not?**
2. *Does your current provider have a robust activity schedule?*
    a. *What are activities you wish were available to you that currently are not?*

Efficient

1. **What is your overall impression of the assisted living services you are receiving?**

Equitable

1. **Do you know how your housing and care are paid for? If so, please describe.**

2. **What do you know about your personal needs allowance (PNA)?**
    a. **Do you feel it adequately meets your personal monthly spending needs?**
    b. **If no, what amount would meet your personal monthly spending needs?**
3. *Are you an EPD waiver beneficiary or private pay?*

Questions for DHCF stakeholders

Safe

1. **Describe the licensure and certifications required for ALR staff that are currently in place to ensure the health and safety of all residents.**
    a. **Are any of these being reviewed or new requirements being considered?**
2. **Describe how DHCF addresses abuse and neglect allegations and cases.**
3. *What type of experience and training is required of providers to (1) become licensed, and (2) continue providing services?*

Effective

1. **What regulations are currently in place to ensure proficiency and competency of ALR staff?**
2. **Describe the ALR survey process.**
    a. **How well do you believe DHCF is implementing its surveys?**
    b. **Do you track provider feedback of surveys?**
3. *What are the most pressing challenges to providers of ALR services in the DC area?*
4. *What are your challenges or frustrations when working with ALR providers?*

Patient-Centered

1. **Describe the quality of care being rendered by assisted living providers.**
2. **Describe the specific quality initiatives or standards required of providers.**
3. *Are there any incentives DC implements besides the general licensing requirements to encourage quality within ALRs?*
    a. *How are these communicated and assessed?*
    b. *Does DC track quality of care metrics? If so, how?*
4. *How do admission criteria for ALRs provide residents care that respects their preferences, needs, and values?*

Timely

1. **How many ALRs have opened in the past 5 years?**
    a. **How many have closed?**
    b. **What are the categorized reasons for these closures?**

Efficient

1. **What are providers currently doing well?**
2. **What can providers do better?**
    a. **What DHCF programs or initiatives could be made available to help providers get better?**
3. *What measures are currently being implemented to reduce the number of Emergency Room visits and/or hospital readmissions?*

Equitable

1. **Is there currently sufficient ALR bed availability for Medicaid beneficiaries?**

2. *Is increasing bed availability being considered by DHCF?*
   a. *How will the needs for potential increased availability be assessed?*

Questions for providers

Safe

1. **Describe how your facility manages the safety of your residents.**
2. *Does the facility have policies and procedures for the following:*
   a. *admitting dangerous beneficiaries?*
   b. *beneficiaries requiring treatment for active, infectious, and reportable diseases?*
   c. *determining the resident's ability to self-medicate?*
   d. *managing resident falls?*
   e. *Do you have a fall-prevention program? Please describe.*
3. *Describe your staff training program, for both new hires and for meeting the needs of continuing education for all employees.*
   a. *Do you train employees on how to provide population-specific ADL's, such as Alzheimer's-specific training?*
   b. *Do you run background checks on all employees?*

Effective

1. **Please describe DHCF rules and regulations.**
2. **Describe the beneficiary admission process.**

Describe the case management services provided to your EPD waiver patients.

Patient-Centered

1. **Describe how your facility provides patient-centered care.**
2. **Do you serve both private pay and EPD waiver patients in your ALR?**
   a. **If so, is there a difference in the services that the two payer types may access?**
3. *How does the facility facilitate access for a resident to appropriate health and social services, including social work, home health agencies, nursing, rehabilitative, hospice, medical, dental, dietary, counseling, and psychiatric services?*
4. *Do you have an internal quality program and/or do you participate in any third-party quality award programs such as AHCA/NCAL's?*
   a. *Do you have a designated staff member responsible for your quality program?*
5. *Describe how your organization manages resident concerns and complaints.*
   a. *Do you have a clearly defined process for documenting resident and family concerns?*
   b. *How are those concerns communicated to and supported by all staff?*
   c. *Do you have a detailed description of the process that tells all residents and family members how to pursue resolution of a concern and a timeframe as to when they can expect a response?*
   d. *Do you have a follow up process that verifies that a concern has been resolved to the resident's and family's satisfaction?*

Timely

1. **Describe the process for filing claims for reimbursement of the Medicaid services you provide.**
    a. **Is reimbursement timely?**
    b. **Is the billing protocol easy or difficult to navigate and understand?**
    c. **How often are claims rejected and what is the process to re-file claims?**

Efficient

1. **Describe the process for how beneficiaries apply for ALR services.**
2. **Describe the face-to-face assessment process performed by the DHCF vendor RN and how it bears on the authorization and delivery of your services.**
    a. **How would you improve or what would you change about the assessment process?**
3. **Describe the Individualized Service Plan process.**
4. **Describe your organization's participation in and/or contributions to waiver PCSPs.**
5. *Does your facility have dedicated personnel responsible for assisted living billing?*
    a. *If not, who does the billing?*
6. *Does the facility have difficulties obtaining the resident's medical, rehabilitation, and psychosocial assessment within 30 days prior to admission?*

Equitable

1. **Describe how the Medicaid authorization and reimbursement processes work for EPD waiver beneficiaries.**
2. **Do you feel that the reimbursement adequately covers the services being rendered to the resident?**
    a. **If reimbursement is not adequate, what would provide adequate coverage?**
3. *Is the facility familiar with DC's Medicaid income-eligibility rules and cost-sharing requirements to determine whether Medicaid beneficiaries can afford assisted living?*
    a. *If so, please describe.*

Provider demographic questionnaire

What is the demographic of the current residents your facility serves?

- Age:
- Race:
- Ethnicity:
- Gender:
- Current/Former Marital Status:
- Income:
- Education:
- Current/Former Employment:
- Payment Method:

How many total beds is the facility licensed for?

- How many Medicaid beds is the facility licensed for?
- Please describe the types of units in your facility (e.g., studios, single bedrooms, etc.).

What is your facility's staff ratio for the following staff types?

- Direct care providers:
- RN's:
- LPN's:
- CNA's:
- PT/OT:
- Executive management:
- Other:

What services do you provide?

☐ Private Rooms
☐ Semi-Private Rooms
☐ Activities of Daily Living (ADLs)
☐ 24 Hour Staff
☐ Meals (Breakfast, Lunch, Dinner, and Snacks)
☐ Special or Therapeutic Diets
☐ Indoor Recreational and Social Activities
☐ Outdoor Recreational and Social Activities
☐ Medication Management
☐ Transportation
☐ Medical care
☐ Wound Care
☐ Respite Care
☐ Hospice Care
☐ Memory Care/Alzheimer's Care

☐ Diabetes and Insulin Care

What does the facility charge for private pay residents at the facility?

- Private room?
- Shared room?

Does the facility accept Elderly and Persons with Disabilities (EPD) Waiver Program residents?

If yes, how many EPD Waiver Program residents does the facility accept?

Do you find the EPD Waiver Program monthly rate adequate for the resident's monthly needs?

Is the EPD Waiver Program monthly rate above or below the facility cost of care?

How does the facility cover costs outside of what is reimbursed by Medicaid?

Does the facility receive payment from the resident's family/family representative or outside resources?

Does the facility utilize the Optional State Supplement Payment Program (OSSP)? The OSSP provides an income supplement to increase access to residential care settings in areas with high housing costs (like DC).

Who, if anyone, assists the resident and their family in completing the EPD Wavier Program application?

If the facility is not currently enrolled to provide Medicaid ALF services:

- What are the reasons?
- What would motivate the facility to accept EPD Waiver Program residents?

How many of each of the following does the facility staff?

☐ Licensed Nurse _____
☐ PCA _____
☐ CNA _____
☐ Physician _____
☐ Physician Asst _____
☐ Certified Med Tech _____

Additional questions for providers participating by questionnaire only

Safe

1. **Describe how your facility manages the safety of your residents.**
2. *Does the facility have policies and procedures for the following:*
    - **a.** *admitting dangerous beneficiaries?*
    - **b.** *beneficiaries requiring treatment for active, infectious, and reportable diseases?*
    - **c.** *determining the resident's ability to self-medicate?*
    - **d.** *managing resident falls?*
3. *Do you have a fall-prevention program? Please describe.*

Effective

1. **Please describe DHCF rules and regulations.**
2. **Describe the beneficiary admission process.**

Patient-Centered

1. **Describe how your facility provides patient-centered care.**
2. **Do you serve both private pay and EPD waiver patients in your ALR?**
    - **a. If so, is there a difference in the services that the two payer types may access?**

Timely

1. **If applicable, describe the process for filing claims for reimbursement of the Medicaid services you provide.**
    - **a. Is reimbursement timely?**
    - **b. Is the billing protocol easy or difficult to navigate and understand?**
    - **c. How often are claims rejected and what is the process to re-file claims?**

Efficient

1. **If applicable, describe the process for how beneficiaries apply for ALR services.**
2. **Describe the face-to-face assessment process performed by the DHCF vendor RN and how it bears on the authorization and delivery of your services.**
    - **a. How would you improve or what would you change about the assessment process?**
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Equitable

1. **Describe how the Medicaid authorization and reimbursement processes work for EPD waiver beneficiaries.**
2. **Do you feel that the reimbursement adequately covers the services being rendered to the resident?**
    - **a. If reimbursement is not adequate, what would provide adequate coverage?**

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