Assisted Living Program Revised Payment Model Study

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Study of Assisted Living Program Rate Methodology

Abstract

In consultation with Medicaid provider associations and stakeholders, the Department of Health and Human Services (HHS) explored options for a revised payment model for reimbursement of assisted living programs that provide services to Medicaid recipients. The study considered all funding sources utilized by residents of assisted living programs. This report outlines the findings of that study.

HHS convened workgroups from September 2024 through October 2024. The workgroup participants included individuals from provider agencies and provider associations. To supplement the workgroup, HHS surveyed assisted living program rate methodologies utilized by other states.

This report outlines the options collected from the workgroup and supplemental research. Before implementing any of the options from this study, additional research is required to fully understand the overall system and financial impact that could result from implementing any of the options.

Introduction

The 2024 Iowa Legislature required exploring a revised payment model for assisted living programs that provide services to Medicaid recipients. The following language from House File 2698 outlines the requirement.

> "The department of health and human services, in consultation with Medicaid provider associations and stakeholders, shall explore options for a revised payment model for reimbursement of assisted living programs that provide services to Medicaid recipients. The study shall include consideration of all sources of funding utilized by residents of assisted living programs. The department of health and human services shall report all options identified to the general assembly by December 1, 2024."

Assisted living programs play a vital role in the long-term care continuum. This option allows individuals to live in a safe and supportive environment while maintaining their maximum level of independence. Iowa defines assisted living programs in Iowa Code §231C.2 in the following way.

> ""Assisted living" provision of housing with services which may include but are not limited to health-related care, personal care, and assistance with instrumental activities of daily living to three or more tenants in a physical structure which provides a homelike environment. "Assisted living" also includes encouragement of family involvement, tenant self-direction, and tenant participation in decisions

> that emphasize choice, dignity, privacy, individuality, shared risk, and independence. “Assisted living” includes the provision of housing and assistance with instrumental activities of daily living only if personal care or health-related care is also included. “Assisted living” includes twenty-four hours per day response staff to meet scheduled and unscheduled or unpredictable needs in a manner that promotes maximum dignity and independence and provides supervision, safety, and security.”

In addition to the traditional Medicaid state plan benefits, the Iowa Department of Health and Human Services currently operates home and community-based service (HCBS) Medicaid waivers and the Program of All-inclusive Care for the Elderly (PACE), which offer services to support Iowans residing in community-based settings including Assisted Living Facilities (ALFs). Both HCBS Medicaid waivers and PACE have specific enrollment and eligibility criteria.

HCBS Medicaid Waivers

HCBS Medicaid waivers offer long-term services and supports to qualified individuals so they can remain in their preferred community-based setting instead of an institution. Access to services depends on the type of Medicaid waiver the individual is approved for. Traditionally, individuals living in an assisted living setting access the Medicaid Elderly Waiver and typically have a menu of services that includes but is not limited to assisted living service, home-delivered meals, consumer-directed attendant care, and personal emergency response services.

PACE

PACE organizations receive a capitation required to provide all Medicare and Medicaid coverage. If there is a medical necessity for a PACE participant to access an assisted living setting and the participant is approved, they have the option to move to an assisted living setting. The PACE organization is responsible for contracting with and paying the assisted living provider.

Methodology

As directed by House File 2698, HHS consulted with Medicaid provider associations and stakeholders to explore options for a revised payment model for reimbursement of assisted living programs that provide services to Medicaid recipients. From September 19, 2024, to October 31, 2024, HHS met with representatives of Medicaid providers and provider associations. In addition to these meetings, HHS conducted independent research of methodologies used in other states.

The workgroup conversations included an open forum to discuss options providers and associations had for consideration. While the group brought forward some options for changing the rate methodology, a significant number of the recommendations were related to the administrative operations of the assisted living program.

Summary of Findings

The workgroup and independent research yielded several possible funding sources utilized by residents of assisted living programs and potential options for procedural changes that assisted living providers and associations believe could impact the financial stability of assisted living programs. The table provides a list of the options that resulted from the meeting and a description.

Option	Description
Rate Determinations	Development of either a fully or partially blended rate methodology. Several other states report utilizing a blended rate structure to fund assisted living programs. This would result in all or some of the HCBS services delivered in ALFs today being combined into one bundled service. This will require an in-depth review of Centers for Medicare and Medicaid (CMS) regulations and policies regarding the permissibility of bundled payments and an intensive financial impact analysis to understand the impact of this type of change fully. Determination of individual rates based on acuity. This method would result in members with higher needs for services being reimbursed at a higher level. The group discussed utilizing a level of care assessment, which could result in a tier that would translate to a specific rate for services provided under an individual's Medicaid waiver. This will require an in-depth review of CMS regulations and intensive financial impact analysis to understand this change's impact fully. Determination of provider HCBS Medicaid waiver rates based on geographical locations. Providers would be reimbursed based on whether they were in rural or urban areas. More analysis would need to be done to understand the positive and negative impacts this could have on providers.
Clarification of Service Scope Definition	Iowa Administrative Code chapter 78 outlines assisted living services available under the HCBS Medicaid Elderly waiver. Chapter 78 defines the service as "unanticipated and unscheduled personal care and supportive services that are furnished to waiver participants who reside in a homelike, noninstitutional setting," which differs from Iowa Code §231C.2. This will require additional analysis of the 1915(c) federal authority and additional CMS federal

	guidance to understand the reason for the difference. Additional fiscal analysis will also be required to understand the budgetary impact of this change.
Decrease Time to Service	Assisted living program providers and associations report a delay in service initiation following enrollment in the HCBS waiver. The time to service varies for waiver participants; the aggregated average is forty-five days. This is due to the processes to identify, request, and authorize services. HCBS requires a person-centered service plan to be completed before services are authorized. Providers indicate that waiting for a case manager to come to the assisted living facility to complete the plan can result in an individual having to pay privately for services that they should be able to receive through the HCBS waiver. This will require better coordination with case managers to ensure service plans are developed in a timelier manner. Recent changes to the requirements for case managers, including the HCBS participant-to-case manager ratios and case manager certification, are expected to improve the time to service across the HCBS waivers. Assisted living providers and associations voiced a desire to explore utilization of in-lieu of services (ILOS) available through Managed Care Organizations. Currently, ILOS is available to individuals enrolled with an MCO and on one of the HCBS Medicaid waiver waiting lists. However, the Elderly waiver does not currently have a waiting list; therefore, these services are unavailable to these individuals. ILOSs can be used, at the option of the managed care plan and the enrollee, as immediate or longer-term substitutes for state plan-covered services or settings or when the ILOSs can be expected to reduce or avoid the future need to utilize state plan-covered services or setting. An approved ILOS must be authorized and identified in the managed care plan contract. States must obtain CMS approval of states' managed care plan contracts that include ILOS(s) in accordance with 42 CFR § 438.3(a). This option would require additional research, fiscal analysis, and agreement from the MCOs.
Accessing Other Existing Resources	Assisted living providers report requesting Veteran's Affairs benefits as part of their admissions criteria. The VA benefits may unlock other options for funding assisted

	living programs. There may be an opportunity to build connections and share resources available through the VA. Rental assistance can help individuals afford the rental expenses at the assisted living program. There may be opportunities to build connections and share resources available through different rental assistance resources, including Housing and Urban Development, Section 8, and the HCBS Rent Subsidy through the Iowa Finance Authority. Iowa also has funding available through the Older Americans Act to support aging Iowans. There may be an opportunity to build connections and share resources available to Iowans who are not eligible for Iowa Medicaid waiver services.
Eligibility Considerations	Presumptive eligibility for HCBS Medicaid waiver level of care was suggested as an option. There has been little information uncovered on this topic; however, the little information available indicates that there may be an opportunity to explore how to determine whether an individual is presumed to be eligible based on their Medicare status. This option will require an in-depth review of CMS regulations and intensive financial impact analysis to understand this change's impact fully. Assisted living providers and associations reported that they would like to explore the option of allowing individuals who are in the process of spending down to be eligible for an HCBS Medicaid waiver to utilize the money they're spending down to pre-pay for services at the assisted living. This option will require an in-depth review of CMS regulations and intensive financial impact analysis to fully understand the impact of this type of change.

Conclusion

In consultation with Medicaid providers, associations, and stakeholders, HHS explored options for a revised payment model for reimbursement of assisted living programs that provide services to Medicaid recipients. As required, HHS has compiled the findings of this study into this report to deliver to the general assembly. The workgroup was able to consider the multitude of funding utilized by residents of assisted living programs. Any

options discussed in this study will require extensive research to fully understand the impact of any recommended change and additional time to execute any prospective change fully.