



Two steps forward, one (or more?) steps back

*Expanding access to assisted living*

Mauro Hernandez, PhD, CEO  
Concepts in Community Living, Inc.  
Clackamas, Oregon

[mhernandez@ccliving.com](mailto:mhernandez@ccliving.com)  
[www.ccliving.com](http://www.ccliving.com)

National Health Policy Forum, Washington, DC, November 30, 2012

# About CCL

- Small, private management and development consulting firm
  - Own and/or operate 16 supportive housing settings in 4 states
  - Various market research and development consulting projects
- Origins (est. 1988)
  - Early policy and practice innovations informed by research, theory and experience
  - Collaborated with Oregon to pilot Medicaid demonstration in apartment-style, high service capacity AL
  - Research and policy collaborations with state agencies, AARP, trade associations, etc.
- Core Activities
  - Start-up, turnaround and ongoing operations for AL/RCs
  - Market research and development consulting for 200+ projects
  - Start-up management for 30+ projects
  - Specialize in smaller-sized buildings; niche and underserved markets; Medicaid access

## **Our Mission**

We create housing and service solutions that offer fulfillment and provide value.



## **Our Vision**

Concepts in Community Living exists to enrich the lives of elders.

We envision supportive communities that elevate the meaning of life, fulfill human needs, and reflect the uniqueness of those served.

We demonstrate sincerity and integrity in all our actions and are dedicated to supporting a mutually respectful, open, and gratifying culture.



## **Our Values**

Service Excellence  
Community Engagement  
Life Enrichment  
Mutual Respect  
Self Direction  
Accountability  
Diversity  
Innovation

## Mix of nonprofit and investor-owned AL/RCs, mostly affordable and on West Coast

- 14 licensed AL/RCs + 2 rent-subsidized senior apartments
- Operating in Oregon, Washington, Arkansas, California
- Varied ownership & management structures
  - 7 managed for community-based non-profits
  - 4 co-owned & managed with individual investors
  - 3 managed for individual investors
  - 2 long-term leases (NP & Investor owned)

Compared to national supply, our AL/RCs are more likely to serve residents with lower income and rural location

- Medicaid contracted: 93%
- Medicaid residents: 44%
- Local community population: 15,600 (med); 58,621 (avg)
- Avg. Building Size: 41.5 apartments
- Avg. Building Age: 14.2 years
- Memory care: 79% have secured egress; 1 separate memory care wing

# *A few insights from Oregon*

# Licensed Long-Term Care Settings in Oregon

- Adult Foster Homes (AFH)
- Residential Care Facilities (RC)
- Assisted Living Facilities (AL)
- Nursing Facilities (NF)

# What's so special about in Oregon?

- Early policy and programmatic changes 'rebalanced' the state's LTC system
- Reduced nursing facility use by increasing home and community based service (HCBS) use, such as AL, resulting in considerable estimated savings
- Oregon ranks highest among states in:
  - supply of AL/RC beds per older population
  - use of AL/RC by Medicaid waiver participants

# What's so special about AL in Oregon?

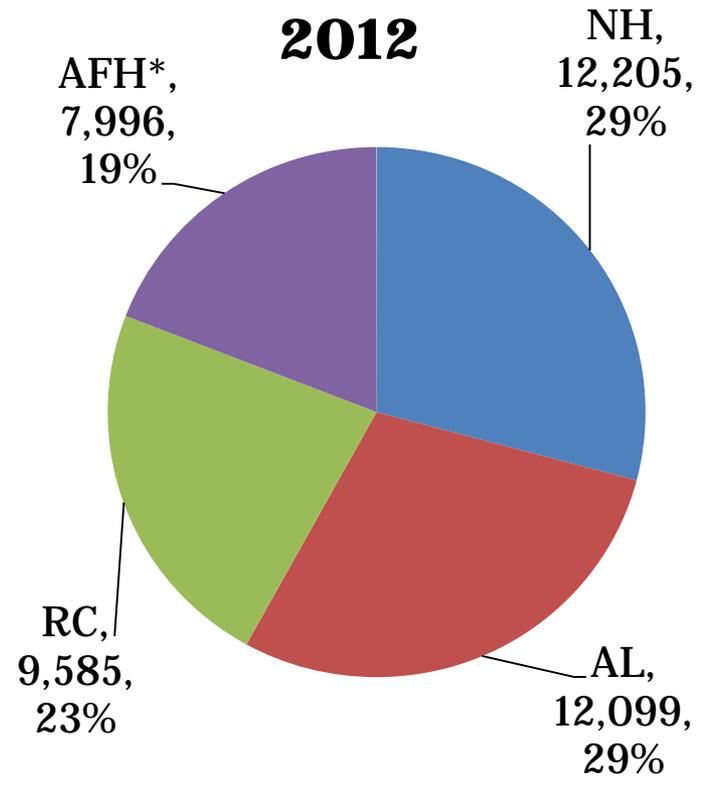
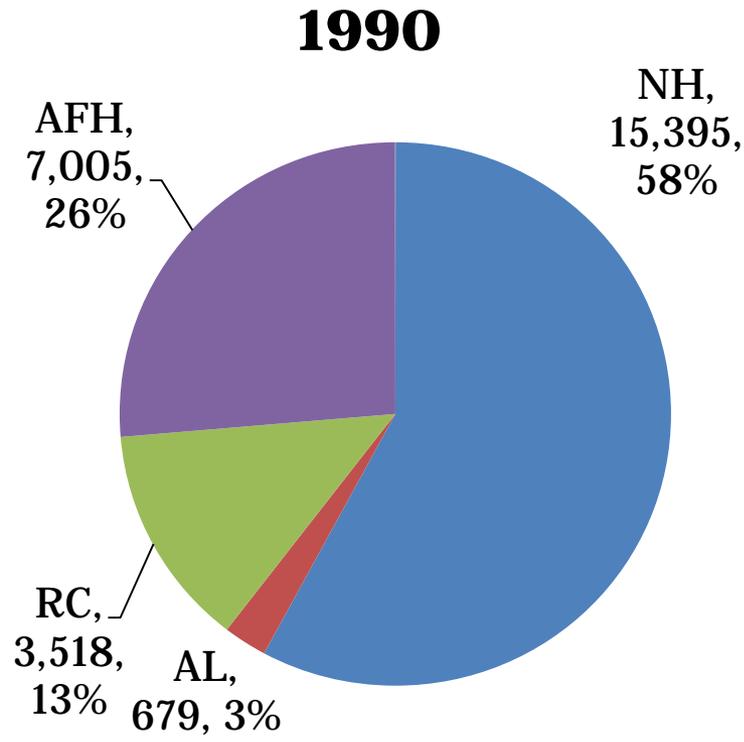
- Oregon has long been recognized for innovations in Assisted Living (AL) financing, regulation, design and practice
  - Positive outcomes and reported cost savings from a pilot project evaluation led to new AL regulations and Medicaid financing statewide
  - Distinguishing features of Oregon's AL model originally included the physical environment, high service capacity, and consumer-oriented values
  - Oregon AL studies have compared outcome trajectories and placement preferences for AL and NF residents; operationalization of AL values in marketing materials and daily practice; as well as policy, supply and Medicaid utilization trends.
  - Apartment-style AL have been more accessible in rural markets and to Medicaid nursing-home eligible residents than traditional RC

# Oregon State Policy Considerations

- Financing: OHCS' Elderly & Disabled Loan Program
- Medicaid: First state to obtain Medicaid HCBS waiver in 1981; reimbursement policies vary by provider
- Licensing:
  - ALF and RCF rules historically separate but converging with increased service capacity
  - AFH licensed separately, also have high service capacity
- Nurse Delegation: Permits provision of selected nursing tasks by trained caregivers

# Realigning Oregon's LTC Supply

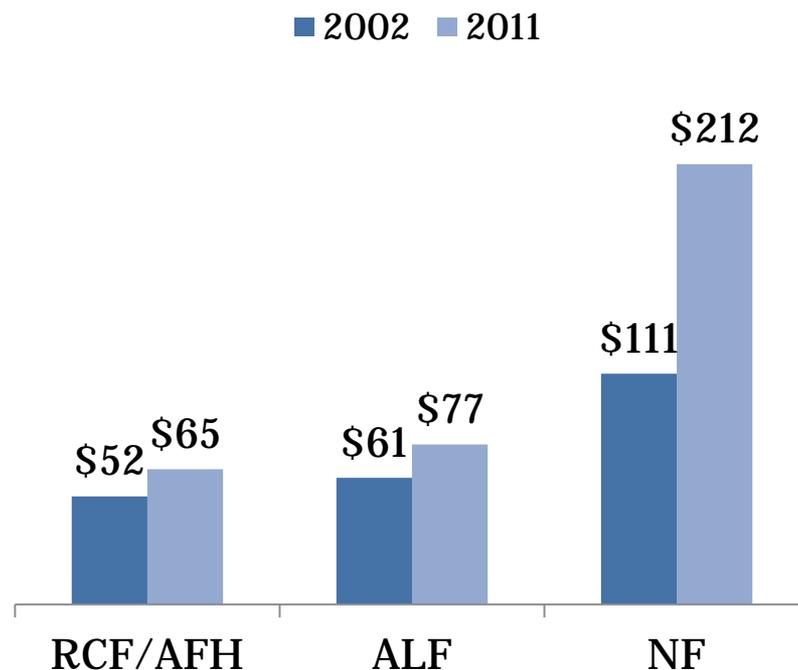
Proportion of Oregon LTC Beds by Setting, 1990 & 2008



# Oregon LTC Medicaid Provider Rate Trends

- Between 2002 and 2011, Medicaid reimbursement rates increased by:
  - 24% (3% per year) for RCFs and AFHs
  - 28% (3% per year) for ALFs
  - 90% (10% per year) for NFs
- Assuming operating costs have increased by 4 - 6% per year during this period, Medicaid reimbursement rates have effectively declined by 9 - 18% since 2002 for HCB settings

**Oregon Daily Medicaid Rates by LTC Setting**



Source: SPD Rate Schedules, 2002 & 2011

Notes: Used highest monthly Medicaid rates for Adult Foster Homes (AFH), Assisted Living Facilities (ALF) and Residential Care Facilities (RCF) divided by 30.4; used Basic daily rate for Nursing Facilities (NF)

# *Future Challenges*

Affordable supply growth

Policy options for addressing access disparities

Managing transitions

## Barriers to expanding affordable AL/RC supply

- Medicaid inadequacy and instability unappealing to loan underwriters and private investors
- Reliance on multiple funding sources adds complexities, development costs and lengthy delays
- More conservative lending environment makes financing startup projects difficult for new providers
- Other barriers include:
  - Larger sponsor capital requirements
  - High land and construction costs

## Typical provider concerns with Medicaid participation

- Medicaid payment inadequacy
  - Wide pricing gap for private-pay and cross-subsidizing
  - Payment erosion over time
  - Rates unresponsive to changing resident needs
- Higher resident service needs
- Program instability
- Case mix management
- Inadequate room & board
- Uneven case management support
- Higher revenue loss for extended absences

# State Policy Toolkit for “Affordable” AL

- Public development & construction financing
- Permissive & cost effective regulatory structures
  - Flexible residency (aka “admission/discharge”) restrictions that reduce avoidable moves
  - Medication and treatment provision by unlicensed, qualified caregivers (e.g. nurse delegation)
  - Expansive scope of services
  - Less institutional fire & life safety design features
- Competitive Medicaid payment rates that:
  - Narrow private – public payment gap
  - Incentivize “aging in place”
  - Include erosion protections

# Other Policy Focus Areas for Addressing Persistent Access Disparities

## State:

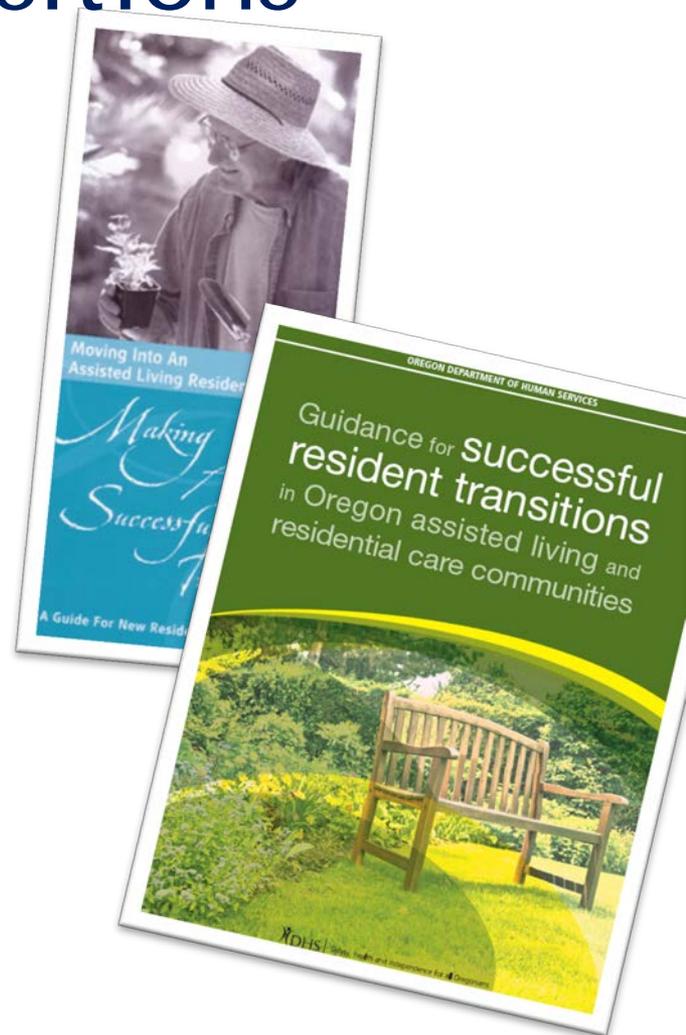
- Medicaid program size and reimbursement rates
- Medicaid eligibility criteria
- Optional state supplement programs
- Low-interest, state loan programs

## Federal:

- LTC finance reform
- Need for AL supply and use data
- Research that examines state policies and effects

# Managing Resident Transitions

- Most new residents move from own or relative's home, often following a hospital or temporary nursing home stay. Moves from other AL/RCs are also common
- The most common reasons for moving are death or nursing home relocation. Less common moves include another AL, back home or closer to family.
- States and providers can adopt a range of tools and practices to: (a) reduce avoidable moves and (b) manage expectations and communicate more effectively
- Health care reform poses a new set of challenges and opportunities for AL/RCs



# Concluding thoughts

- AL studies show considerable supply growth, diversity of organizational forms and variable access
- Aggregated findings mask more promising policy and organizational innovations for sustainable LTSS reform
- What policy and market incentives and pressures will help diffuse these innovations?
- How will various organizational forms adapt, remain unchanged or fade away?