

# Access to Residential Care Settings for Medicaid Beneficiaries

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**National HCBS Conference**  
**August 30, 2016**  
**Washington, DC**

# Primary Resources

- Compendium of Residential Care and Assisted Living Regulations and Policy (O’Keeffe et al., 2015)
- State Medicaid Reimbursement Policies and Practices in Assisted Living (Mollica, 2009)
- Data from the National Study of Long-Term Care Providers (Harris-Kojetin et al., 2016) and National Survey of Residential Care Facilities (Greene et al., 2013)
- Understanding Medicaid Home and Community Services: A Primer, 2010 Edition (O’Keeffe et al., 2010)

- Residential care settings (RCSs) are a key provider of home and community-based services (HCBS)
- Medicaid and RCSs
  - Medicaid cannot cover room and board costs, only services provided in RCSs
  - As of 2015, 45 states and DC cover services in RCSs through their Medicaid programs
  - 15% of residents in RCSs used Medicaid as a payer source in 2014
- Several factors may affect Medicaid beneficiaries' access to services in RCSs

- **Advantages for access:**

- Special income rule (300% of SSI) to determine financial eligibility
- Provides comprehensive range of HCBS

- **Disadvantages for access:**

- Only individuals who meet the state's nursing home level-of-care criteria are eligible
- States can limit enrollment in their waiver programs

- **Advantages for access:**

- States not permitted to limit enrollment
- Individuals not need to meet the nursing home level-of-care requirement

- **Disadvantages for access:**

- Authority is broad in terms of eligibility, but service coverage is narrow
- States cannot use 300% of SSI to determine financial eligibility

## **§1115 Research and Demonstration Waivers**

- Effect on access depends on the specific design and implementation of a state's demonstration
- Most recent demonstration waivers have focused on delivering health care or LTSS through managed care organizations

## **§1915(k) and §1915(i) State Plan options**

- Advantages and disadvantages to access depend on financial and program eligibility criteria

# Medicaid Rates and Rate-Setting Methodologies

- Medicaid rates for RC services differ from private-pay charges, which commonly include room and board.
- States use a variety of rate-setting methodologies to pay for residential care services
  - Rate methodologies are not mutually exclusive, and many states use multiple methods
  - If a state uses more than one Medicaid authority to cover RC services, the rate methodology may differ by Medicaid authority

# Medicaid Rate-Setting Methodologies

Type of Rate	Definition
Flat Rate	Same payment regardless of RCS costs or the type of services provided or needed by the Medicaid beneficiary.
Tiered Rate	Based on residents' level of functioning and subsequent service needs, typically 3–5 payment levels based on the type, number, and severity of ADL limitations and other impairments
Case-mix Rate	Applies when rate is determined along a continuum based on the resident's assessment. No pre-defined tiers used to cluster individuals within a reimbursement rate group.
Cost-based Rate	Determined by using RCS cost reports that summarize expenses associated with provision of services and corresponding revenue
Fee-for-service Rate	Payment amounts are determined by the number of units of specific types of service(s) used by a Medicaid beneficiary, which are identified from the resident's service plan
Negotiated Rate	Reimbursement rates are not determined by any particular methodology, but are the result of deliberations between stakeholders (e.g., individual residents, providers, the state, or a managed care organization)



# State Policies to Help Beneficiaries Afford Room and Board

- Medicaid beneficiaries with limited income may not be able to manage room and board expenses unless states take specific steps to make them affordable.
- States use several strategies to make room and board more affordable, including:
  - Limiting room and board charges
  - Providing monthly state supplemental payment
  - Using 300% of SSI income standard and setting adequate personal maintenance allowances
  - Allowing family supplementation

# Home and Community-Based Setting Regulations

CMS issued final regulations that define the required characteristics of community-based settings including RCSs. Rules do not apply to Medicaid State Plan personal care services.\*

- Anticipated challenges RCSs may face in meeting the requirements
  - Ensuring full community access for all of their residents
  - Adhering to certain homelike standards
  - Required heightened scrutiny review process to determine whether the setting has the effect of isolating individuals from the broader community
  - RCSs with high Medicaid populations may have hardest time meeting regulations

\* CMS. 2014. Medicaid program; State Plan home and community-based services, 5-year period for waivers, provider payment reassignment, and home and community-based setting requirements for community first choice and home and community-based services (HCBS) waivers. Final rule. *Federal Register*, 79(11), 2947–3039. Available at <http://www.gpo.gov/fdsys/pkg/FR-2014-01-16/pdf/2014-00487.pdf>

# Managed Long-Term Services and Supports

- Number of states using managed long-term services and supports (MLTSS) is increasing.
- Uncertainty about how MLTSS may affect Medicaid beneficiaries' access to RCSs
  - Limited information about rates and rate-setting methodologies used by managed care organizations

## Other Factors that May Affect Access to RC Services

- Adequacy and delay of payment rates
- Lack of retroactive payments
- Market trends that affect supply of available RC beds for Medicaid beneficiaries

# Conclusions

- Provision of RC services is a key component of federal and state policies to better balance spending on LTSS by shifting expenditures from institutional care to HCBS.
- Most states cover services in RCSs through their Medicaid programs, but several factors may influence Medicaid beneficiaries' access to RCSs
  - Medicaid authorities used for coverage
  - Rate-setting methodologies
  - Policies for affordability of room and board costs
  - HCBS regulations and MLTSS
- Barriers to access may lead to increase usage of unlicensed RCSs

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# Understanding Unlicensed Care Homes

2016 HCBS Conference, Washington, DC

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# Disclaimer

- This research was supported by the Office of the Assistant Secretary for Planning and Evaluation/U.S. Department of Health and Human Services under Contract HHSP23320100021WI.
- We gratefully acknowledge the contributions of Emily Rosenoff and Gavin Kennedy for their thoughtful review and comments on the interview guides and the final report.
- The views expressed in this presentation are those of the authors and do not necessarily represent the views of the U.S. DHHS or RTI International.



# Background

- Our nation, states and communities face the challenge of providing housing and supportive services to vulnerable groups.
- Unlicensed care homes fill some of the gaps in providing services to these vulnerable populations.
- Some states permit unlicensed care homes to operate legally under the guidance of state regulation, others do not.

# Background (cont)

- Unlicensed care homes receive minimal or no oversight by state and local entities.
- Media and other reports highlight potential concerns about these places.
- Most information focuses on unlicensed care homes operating illegally.

# Project Purpose

- Exploratory study to understand
  - How unlicensed care homes function as a residential care option
  - The types of individuals who reside in unlicensed care homes
  - Characteristics of these places
  - Policies that influence the supply of and demand for these homes

- **Environmental Scan**

- Covered 5-year period from 2009 to 2014
- Targeted peer-reviewed literature, grey literature, abuse blogs, and media reports

- **Subject Matter Expert (SME) Interviews**

- 17 total SME Interviews

- **Site Visits**

- Three communities were selected based on SME interviews and the environmental scan: Raleigh/Durham, NC; Allegheny County, PA; and Atlanta, GA

# Findings: Populations Served

- **Mostly vulnerable adults**
  - Individuals with severe mental illness, physical disabilities, and persons with substance use disorders as well as the elderly
  - Individuals who were formerly homeless, formerly incarcerated
- **Mixed populations served within the same home**
  - Elderly residents and individuals with severe and persistent mental illness
- **Residents often poor**
  - Low income
  - SSI recipients

# Finding: Conditions and Service Provision

- **Poor and unsafe conditions**

- Living environments are often unsanitary and uncomfortable.
- Housing conditions are often improper and unsafe.
- Licensure and building codes often go unmet.
- Fire safety codes may not be followed, which creates a potentially dangerous environment for residents.

- *“[Unlicensed care home residents] basic needs are not being met, [their] hygiene is bad, mattresses on the floor; then you might have six people in a room that is not [up to state] standards.”*

# Finding: Conditions and Service Provision (cont)

- **Inadequate provision of services**

- Meals and nutrition are often inadequate.
- Level of care provided is often inappropriate.
- Management of residents' medications is often improper.

*“The majority offer no significant services... just food and shelter. No staff present, etc. Some will do a minimum of med administration in the AM, but do nothing to accommodate health care.”*

# Findings: Abuse, Neglect and Financial Exploitation

- Emotional and physical abuse including threats and intimidation
- Neglect, including lack of access to food and water and restriction of access to basic needs for residents
- Non-treatment of residents' healthcare needs (reportedly to avoid detection by authorities)
- Collecting residents food stamps and selling on the black market
- Representative payee keeping all of an individual's SSI payments
- Restricting freedom of movement and access to basic necessities

*“The vulnerable population is going to be easier to exploit. Someone who can think for themselves is not going to be easily taken advantage of, and they [unlicensed care homes operators] want that element of disability that they can exploit.”*



# Strategies for Identifying, Monitoring, or Closing Unlicensed Care Homes

- Proactive strategies to identify unlicensed care homes include:
  - Tracking individuals' public benefits;
  - Obtaining list of unlicensed places from health care and advocacy organizations;
  - Speaking with licensed care home operators for help identifying unlicensed places.
- Take action when unlicensed care homes are identified.
  - Fine the operators or if possible, begin the process to shut them down.
  - Educate discharge planners against placing individuals in them.
- Enact state laws or penalties related to the operation of illegally unlicensed care homes.
- Establish interagency and multidisciplinary teams to track and monitor until the home is closed.

# Strategies for Identifying, Monitoring or Closing Unlicensed Care Homes (cont)

- *“I get hundreds of calls. I have 76 employees, I talk to probably a thousand people a year. We don’t keep track of phone calls.”*
- *“There’s no requirement for us to dig and determine how many are out there; we find out anecdotally, then we go in and try and do a site visit. Because they are unlicensed, they can slam the door in our face. More often, they let us in and we find a variety of things. Some are happy to apply [for licensure]; we [also] find those who knew they should be licensed and are trying to fly under the radar and are doing a poor job caring [for residents].”*

# Factors Affecting Demand for Unlicensed Care Homes

- Licensed care home admission and discharge policies
- Modest payments made by SSI or State Supplemental Payments to licensed residential care homes
- Closure of mental health institutions and transition of previously-institutionalized individuals to community-based care settings
- Financial pressure on hospitals to free up hospital beds

# Study Limitations

- The study is limited to the perspectives of several SMEs and informants in three communities in three states.
- Complaints are the foremost source for identifying unlicensed care homes.
- Media highlights and reports on unlicensed care homes are primarily negative.
- The voice of the operators is not represented in our findings.

# Conclusions

- Strategies to identify and address the problem of unlicensed places appear to be reactive.
- Conditions in some unlicensed care homes are unsafe, abusive, financially exploitative, and neglectful of residents' basic needs.
- Financial abuse may represent considerable financial fraud of federal programs including SSI, food stamps, and the programs paying for residents' medications.
- Efforts are needed to understand how illegally unlicensed care homes successfully evade licensure.

# More Information

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