OHIO ASSISTED LIVING ASSOCIATION

Comments on Am Sub HB 64 by the Ohio Assisted Living Association

Chairman Oelslager, Ranking Member Skindell and Members of the Senate Finance Committee, thank you for this opportunity to respond to Am Sub HB 64 as it impacts assisted living. My name is Jean Thompson and I am the Executive Director of the Ohio Assisted Living Association representing over 415 licensed Assisted Living communities in Ohio.

Assisted Living Waiver (ALW) Reimbursement

Absent in the budget bill is any increase for the Assisted Living Medicaid Waiver. The Waiver program provides services to Ohioans (over 4,500) who qualify for nursing home placement, and, but for the ALW established in 2006, would be cared for there. The ALW is unique in the waiver system in that it provides 24 hour oversight; offering supervision, Activities of Daily Living and nursing services. This 24 hour custodial type care is often required due to cognitive and physical disability.

Unfortunately, this valuable program that is **saving approximately $217,759,500 per year** (a mix of federal and state dollars and based on the number of individuals enrolled as of October 2014) ***is still being reimbursed at its initial rate set in 2006.*** This program can not continue or grow to meet Ohio's need for home-like, cost-effective options, serving individuals who require a 24 hour supervised environment, without an increase. The ALW is not *sustaining* Assisted Living providers, evidenced by the rapid growth of Assisted Living in recent years, primarily fueled by the private pay market.

During the last biennial budget (HB 59), while other Home and Community Based Waiver programs (i.e. Adult Day Services, PASSPORT) received increases, ***Assisted Living did not.*** At that time, we were told that a study needed to be done first to look at the payment structure for the program. The Ohio Department of Aging did have Scripps Gerontology Center at Miami University, complete a study and although the report was finalized in 2014, the information has not been made publicly available. It is our understanding, from the information we have seen, that the study concluded that the program reimbursement needed to be increased in some way. We have included in our supporting documents two quotes from the study alluding to a need to increase room and board rates which are currently based on the federal SSI amount, which is well below market rate, especially in urban areas. ***We are asking for a 3% increase in each of the budget years, (an increase in GRF line item 651525 of $631,740 state share in FY 2016 and $652,178 state share in FY 2017).***

Additionally, in the mid-biennium review (HB 483) of the previous General Assembly, there was bipartisan support for an increase in reimbursement for the ALW on both sides of the aisle and an amendment was included during House deliberations on the bill to provide an increase for the ALW program. However, we were informed very late in the HB 483 budget process by the

Office of Health Transformation (OHT) that making a rate adjustment to any waiver program operating in our state would trigger a large "rule compliance mandate" from the federal government. OHT indicated that many of the state's waiver programs were not ready to comply with this mandate and as a result, the Senate removed the increase. **When the increase was removed, we were told that an increase in reimbursement would be likely in the next biennial budget; but this has not happened, although in recent discussions with the administration, we have been told they would not oppose an increase if the legislature should determine to include one.**

In order to see the need for the increase, we have attached with our materials a chart of what other programs providing similar services, but less than 24 hours a day, like the Assisted Living Waiver, are receiving in reimbursement. Additionally, it shows the average nursing home cost. ***These programs are not overpaid – we are underpaid. We are asking for an amendment to increase the Assisted Living Waiver reimbursement by 3% in each budget year.***

Also in our supporting documents is a slide taken from Governor Kasich's budget highlight presentation, showing the average annual costs of all waiver programs. While we are fully supportive of services at home, whenever they can meet an individual's needs, it's worth noting that the average annual cost of Assisted Living providing a 24 hour supportive environment is currently only $1,600 more per year than the average annual part-time PASSPORT care cost. Generally PASSPORT services depend on needs that can be scheduled and some level of family or friend support available, which is not always the case and which is less likely given our demographics in the future.

Permitting Double Occupancy The language in HB64, added during the House deliberations (Sec. 173.548), that permits rules to be written that expand **the option of double occupancy in the Assisted Living waiver, even if there is no pre-existing relationship, as is currently required, is a very positive step.** It corresponds with the findings of the Scripps Study on Assisted Living which indicated that the room and board reimbursement needed to be increased. It is important that this language remain in the budget and that rules written correspond to its intent.

Allowing two individuals to share a larger Assisted Living waiver apartment is just common sense, what private pay Assisted Living residents do to conserve funds, and essential for continued provider participation in the program. With the room and board rate in the waiver program being held artificially below market value ($683), based on the federal SSI amount, permitting double occupancy is a way the state can allow the provider reimbursement to increase without costing Ohio funds. We are very supportive of any effort to permit double occupancy for ALW clients, as it would expand provider participation, in essence creating a more equitable room and board reimbursement for providers; and, we request that this choice be made available to Assisted Living providers who wish to serve these residents.

Unlicensed Assistive Personnel (UAP). We were also supportive of the proposed Unlicensed Assistive Personnel (UAP) training and certification program that was introduced, but then

removed from the house bill. ***We ask that this important program be reintroduced.*** UAPs have been used very effectively in Assisted Living in other states, at least 23, and we would welcome this initiative, **if** they were **permitted to work with ALL residents within an assisted living – not just those residents that are being served on the waiver.** It would then have the effect, in addition to promoting Assisted Living Waiver services, of potentially reducing costs for all Assisted Living residents, which ultimately serves the state as these individuals are then able to privately pay for their own care longer. Extending the reach of licensed healthcare professionals through the training and education of others is critical as healthcare needs and costs increase.

*We have also attached with our comments a research brief from the Center for Excellence in Assisted Living that finds that unlicensed trained staff do not have a higher rate of medication errors than licensed staff.

Assisted Living Family Satisfaction Survey

We are not sure why such a survey is necessary. Assisted Living, as a primarily private pay setting, already has a state commissioned Resident Satisfaction Survey. Results of the every 2 year survey have been very positive. The last overall satisfaction rate was 92.3 %. The addition of another survey would increase costs to providers each year and ***not*** be reimbursed as it is to nursing home providers.

State Funded ALW program

We endorse this proposal to permit presumptive eligibility and enrollment in the State Funded ALW program beyond 90 days, if an individual has not received their final financial Medicaid eligibility determination from their County Department of Jobs and Family Services. Any individual on this program has already "passed" the financial review of the Area Agency on Aging and is very likely to be determined financially eligible. In fact, the Area Agencies on Aging have been over 97% correct in their financial reviews. This simply makes sense as any gap can lead to a premature, unnecessary – and expensive - move to a nursing home.

Thank you for your time and consideration. I would be glad to answer any questions I can.

Jean B. Thompson

Jean B. Thompson
Executive Director
The Ohio Assisted Living Association
614.481.1950
jthompson@ohioassistedliving.org

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Below are quotes from a **July 2014** report by Robert Applebaum and John Bowblis from Scripps Gerontology Center at Miami University (Oxford, OH). The report is titled ***"A Review of the Reimbursement Approach for Ohio's Assisted Living Medicaid Waiver Program"***.

> *"A third question was how to set the room and board component of the assisted living rate. To ensure that Medicaid recipients who relied on the Supplemental Security Income Program (SSI) could use the assisted living waiver option, state officials set the room and board rate at the federal SSI amount, minus a $50 personal allowance. The advantage of this approach is that very low income individuals with qualifying levels of disability can participate in the program. A major disadvantage is that the room and board rate is set below the prevailing private pay charges creating a disincentive for providers to participate in the waiver program. States have dealt with this issue through a range of approaches. The majority of states (40) and all states with 1915C waivers do not include room and board as part of the waiver rates. Twenty three states cap the room and board rate in the program. Twenty four states subsidize the federal SSI payment for waiver participants. Twenty five states allow families or third parties to supplement room and board charges (Mollica, 2009). Currently, Ohio does not allow families or third parties to supplement the room and board charges." (p. 3)*

In the recommendations section of this report:

> *"3b. Explore a payment system that allows facilities to receive a room and board rate that is closer to actual cost, rather than one set by the SSI amount. We estimate that more than 80% of waiver participants could afford to pay a higher monthly room and board rate out of personal income. When combined with the opportunity for family supplementation described above, we believe this could serve as a vehicle to more accurately reimburse assisted living facilities under the waiver and help to ensure additional access for low income individuals. Under such an approach a portion of this increase should be used to enhance the personal needs allowance. This would also be consistent with the new CMS-HCBS setting regulations which emphasize the community nature of the assisted living option. The development of such an option would have to consider how to mitigate the impact on low income residents." (p. 16)*

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A cost comparison of Medicaid programs providing similar services to the Assisted Living Waiver program.

MEDICAID Reimbursement		
Assisted Living Waiver	**24 hours per day** service package	**Tier 1 $49.98*** **Tier 2 $60.00** **Tier 3 $69.98**
Certified Adult Day Services	**4-8 hours** (Transportation & additional services billed separately)	**Enhanced $49.39**** **Intensive $64.84**
PASSPORT Personal Care Service	**4 hours**	**$69.44** ($17.36/hr)**
Nursing Home	**24 hours per day**	**$ 167.00 per day*****

Source: *OAC 5101:3-1-06.5 Appendix A
**OAC 5160-1-06.1 Appendix A
***Scripps Gerontology Center 2011 Biennial Survey (average, double occupancy)

The Association has prepared this comparison to highlight the Medicaid reimbursement rates for similar services being provided to older adults in Ohio.

Based on this comparison, the Assisted Living Medicaid waiver service reimbursement ***needs to be increased***.

- It is especially important for the state to offer a significantly ***increased rate for memory care***. Residents with cognitive impairment require much more supervision and staff time, even though their needs are not necessarily medical in nature. This makes Assisted Living the appropriate cost-effective setting for memory care, versus the much more expensive nursing home alternative. However, with the current Assisted Living waiver reimbursement rate, providers cannot make this staff intensive care available; especially placements in secure units.
- Additionally the **room and board payment**, which at $683 per month is well below market value, ***needs to be increased***; or other cost-savings options, such as sharing an apartment with another resident considered.

Below is what is included in the Assisted Living waiver service, compared with the other Medicaid programs offering long-term services and supports.

I. Assisted Living Medicaid Waiver Reimbursement Rates: 60% Federal, 40% State Funded
Service Package

- **Tier 1-** $49.98/day- includes occasional cognitive prompts, or up to 2.75 hrs of personal care/day
- **Tier 2**-$60.00/day- includes daily cuing and prompts, supervision with medications (staff involved in procurement, storage and reminders), weekly or monthly hands on care by LPN or RN, or more than 2.75, but not more than 3.35 hours per day of personal care.
- **Tier 3**-$69.98/day- includes ongoing cuing prompts, and redirection, medication administration by licensed nurse, daily nursing care, or more than 3.35 hours of personal care per day.

All Service Tiers include: ADL assistance, laundry and housekeeping services, 24 hour staff to respond to needs, social programming, non-medical transportation, and licensed nurse.

Room and Board: $683/monthly (rate set by SSI) - **Paid by the resident**

- Private apartment/bath (includes shower or tub)

AL Waiver Providers are also subject to additional compliance reviews by the Dept. of Aging, in addition to the annual RCF licensure inspection conducted by the Dept. of Health.

II. Certified Adult Day Services (4-8 hours) **Enhanced**: $49.39 **Intensive** : $64.84

- **Enhanced** - Structured activities, health assessments, supervision of ADLs and medication, assistance with 1 ADL (except bathing), assistance with medication administration, therapeutic activities, intermittent health status, assistance with personal hygiene (except bathing).
- **Intensive** - Services in the Enhanced level plus, assistance with 2 or more ADLs and bathing, regular health status monitoring and intervention, skilled nursing services, rehabilitative/restorative services (physical, speech, occupational therapy & social work).

(Source: www.aspe.hhs.gov ; Ohio reports & the National Adult Day Services Association.)

III. PASSPORT Personal Care Service $69.44 (4 hours); $17.36/hr) can include…

- Assisting the consumer with ADLs and IADLs
- Assistance with self-administration of medications
- Meal preparation and household chores; can include assisting consumer with managing household or handling personal affairs.

Source: OAC 173-39-02.11

IV. Average Nursing Home Medicaid reimbursement : $167.00/day

- Assistance with ADLs
- All nursing services
- Double occupancy permitted
- No requirement for space in room "separate from the sleeping area"

Ohio Medicaid Home and Community Based Services (HCBS) Waiver Programs

Waiver	Enrollment	Average Cost	Lead Agency
MyCare Ohio	24,105	Within MCO cap	Medicaid
Ohio Home Care	5,705	$23,360	Medicaid
Transitions II	1,374	$24,106	Medicaid
PASSPORT	18,069	$10,936	Medicaid/Aging
Assisted Living	2,598	$12,564	Medicaid/Aging
Transitions DD	2,903	$23,944	Medicaid/DODD
Individual Options	17,803	$58,181	Medicaid/DODD
Level One	13,765	$11,124	Medicaid/DODD
S.E.L.F.	332	--	Medicaid/DODD

Ohio | Governor's Office of Health Transformation

Source: Office of Health Transformation, *Prioritize Home and Community Based Services* (February 2015).

A National Community-Based Participatory Research Partnership

The Center for Excellence in Assisted Living (CEAL) and the University of North Carolina at Chapel Hill Collaborative Studies of Long-Term Care (UNC)

Collaborative Studies of Long-Term Care

Research Brief: Medication Administration in Assisted Living
~ Medication Administration Errors ~
~ The Importance of Training in Medication Administration ~
~ The Usefulness of Competency Assessment ~

Introduction and Purpose

Assisted living communities provide care for approximately one million older persons, the majority of whom have chronic illnesses and require multiple medications.[1] This Research Brief summarizes key findings from a study of medication administration in eleven assisted living communities in two states. The goals were to determine the frequency and type of medication administration errors, which medications are associated with potentially significant administration errors, and whether administration error rates differ between trained medication technicians and licensed nurses.

The project was conducted by the Center for Excellence in Assisted Living (CEAL) and the University of North Carolina-based Collaborative Studies of Long-Term Care (UNC).[2] It was conducted using a method known as *community based participatory research* in which community members work as full partners with researchers to identify an issue needing study, obtain information about that issue, and interpret what they have found and the implications for practice and policy.

Because the need for assistance in taking medications is one of the reasons that many older adults move to assisted living, this topic is relevant to all assisted living providers, consumers, policy makers, advocates, practitioners, and educators. Assisted living residents take an average of almost nine different medications daily, and as many as 80% of residents require assistance with medication administration.[3,4] In the simplest terms, medication administration involves ensuring that the correct medication is administered to the right resident at the right time in the right dosage.

Concern has been raised that assisted living staff do not always administer the correct medications and that insufficiently trained staff may at times dispense medications.[5] In reference to the latter point, there is ongoing debate as to whether nurses should be required to administer medications in assisted living. On one side are those who believe that the clinical expertise of a nurse is necessary to avoid medication errors; on the other side are those who contend that unlicensed medication aides can safely administer medications with appropriate training and supervision, and that allowing them to do so will reduce assisted living cost and improve access to care.

This project examined medication administration in South Carolina, which allows unlicensed but trained medication technicians ("aides") to administer medications, and Tennessee, which requires licensed nurses to administer medications. Medication preparation and administration were observed for three consecutive days, resulting in 4403 medications observed being given during 83 passes for 320 residents. Observations were compared to the orders written on the medication administration record. Errors were determined based on the discrepancy between medication orders and observations; an expert team including pharmacists, nurses, and a geriatrician determined the clinical severity of the errors. Also, the assisted living staff who administered the medications completed a paper-and-pencil medication administration knowledge and practices questionnaire.

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[1] Zimmerman, S., Sloane, P.D., Eckert, J.K., Gruber-Baldini, A. L., Morgan, L.A., Hebel, J.R., Magaziner, J., Stearns, S.C., & Chen, C.K. (2005). How good is assisted living? Findings and implications from an outcomes study. *Journal of Gerontology: Social Sciences, 60B*, 195-204.

[2] The project was funded by the Agency for Healthcare Research and Quality (R21HS016171). The CEAL leads were Karen Love and Jane Tilly and the UNC leads were Sheryl Zimmerman, Lauren Cohen, and Philip Sloane.

[3] National Center for Assisted Living. (2006). *2006 Overview of assisted living (facts & trends)*. Washington, D.C.

[4] Hawes, C., Phillips, C., & Rose, M. *High service or high privacy assisted living facilities, their residents and staff: results from a national survey*. Available at: http://aspe.hhs.gov/daltcp/reports/hshp.htm

[5] General Accounting Office, United States Congress. (1999). *Assisted living: quality of care and consumer protection issues in four states*. Report to Congressional Requesters. Washington, D.C.: U.S. Government Printing Office.

Key Findings

- While 35% of all medication administrations involved an error, 71% of these errors involved the drug being administered more than two hours outside the requested administration time. This type of error rarely has the potential to cause clinical harm.

- Fewer than 3% of all medications passed involved errors with moderate to significant potential to cause harm, meaning the potential to cause discomfort or annoyance (moderate harm) or lead to physician intervention, hospitalization, or disability (significant harm).

- Only 14 of the 4403 medication administrations involved an error with significant potential for harm. These medications included:

  - Warfarin (blood thinner; wrong dose): 5 of all potentially significant errors
  - Insulin (injectable diabetes drug; wrong dose or wrong time): 4 of all potentially significant errors
  - Risperidone (antipsychotic; wrong dose): 3 of all potentially significant errors
  - Glyburide/metformin (oral diabetes drug; wrong dose): 1 of all potentially significant errors
  - Oxybutynin (bladder medicine; wrong dose): 1 of all potentially significant errors

- Medication technicians did not have a higher rate of medication errors with a moderate to significant potential to cause harm than did nurses.

- Staff members who were less trained than medication technicians to administer medications and were "assisting" residents to administer their own medications caused the most medication errors with moderate or significant potential for harm; their error rate was higher than nurses. These individuals included certified nursing assistants, non-certified caregivers, and others. In South Carolina (the state that allowed medication technicians to administer medications) these individuals represented 42% of those who handled medications, and in Tennessee (the state that required nurses to administer medications) they represented 65% of those who handled medications.

- Those who made medication errors were more likely to score lower on the paper-and-pencil medication administration knowledge and practices questionnaire.

Heather Young and colleagues[6] conducted a cross-sectional observational medication administration study of medication aides in 12 assisted living communities in three states (Oregon, Washington and New Jersey) which permit unlicensed staff to administer medications. This study also found that wrong time accounted for the majority of medication administration errors (71%), in this case none of which were considered to be clinically significant. Similar to the CEAL-UNC Collaborative project, there were few errors with significant potential for clinical harm, which occurred more commonly with higher risk medications (e.g., insulin and warfarin). This finding is especially important because in general, residents taking higher risk medications are in less stable health.

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[6] Young, H.M., Gray, S.L., McCormick, W.C., Sikma, S.K., Reinhard, S., Johnson Trippett, L., Christlieb, C., & Allen, T. (2008). Types, prevalence, and potential clinical significance of medication administration errors in assisted living. *Journal of the American Geriatrics Society, 56*, 1199-1205

Conclusions and Recommendations

- Regarding timing of medication administration:
  - Assisted living administrators and health care supervisors are advised to work with physicians and pharmacies to allow more flexibility in medication orders. Doing so will avoid considering timing an error in instances when it is not truly an error.
  - State surveyors could be flexible in determining the acceptable window of timing for medication administration. Doing so will allow them to devote attention to medication errors with a moderate to significant potential to cause harm.
- Regarding medication errors with a moderate to significant potential to cause harm:
  - Pharmacists could flag the medications that are most likely to result in errors with a significant potential to cause harm if administered incorrectly. Doing so may help assisted living staff be more vigilant to proper administration and monitoring of these important medications.
  - Additional training in the proper administration and monitoring of high-risk drugs is indicated for nurses, medication technicians, and others who supervise, administer, and assist with the medications. Doing so may increase their safe use. High-risk drugs include:
    - drugs with low therapeutic ratios (i.e., drugs where the difference between a therapeutic dose and a toxic dose is small, such as insulin, warfarin, narcotics and many tranquilizers)
    - drugs where timing is especially important, such as insulin and levadopa/carbidopa (Sinemet)
    - medications such as eye drops or breathing treatments, because their administration requires special skill, training, and care
- Regarding staff training:
  - Staff members who are less trained than medication technicians are handling resident medications in the process of assisting residents with self-administration. Given the sometimes subtle differences between the administration of medications and assistance with self-administration of medications, all staff who handle resident medications should be trained to the level of a medication technician. Doing so will decrease medication errors.
    - The need for such training seems especially important in states that do not allow medication technicians to administer medications, in that less trained staff may more often be involved assisting residents in those states.
  - Training programs that focus on specific medication-related competencies and that assess mastery of that competency should be developed and evaluated. Using such programs to train all non-licensed staff who handle medications may decrease medication errors.

Recommended citation: Zimmerman, S., Love, K., Cohen, L.W., Sloane, P.D., and the CEAL-UNC Partnership. (2009). Research Brief: Medication Administration in Assisted Living. University of North Carolina at Chapel Hill.

Members of the CEAL-UNC Partnership who participated in this project include Janice Brickley, Kathy Cameron, Paula Carder, Thomas Clark, Lauren Cohen, Geni Eng, Sandi Flores, Patricia Giorgio, Daniel Haimowitz, Jena Ivey, Karen Love, Ethel Mitty, Jackie Pinkowitz, David Reed, Philip Sloane, Lynn Spragens, Jane Tilly, Paul Williams, Rebecca Youngblut, and Sheryl Zimmerman. For information about this project, contact Karen Love (karenlove4@verizon.net) or Sheryl Zimmerman (Sheryl_Zimmerman@unc.edu).