The University of Kansas
School of Social Welfare
Office of Aging and Long Term Care

Assisted Living/Residential Health Care Facility Participation in the Medicaid HCBS-FE Waiver: A Five Year Follow-Up

Final Report

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Executive Summary

Study Purpose

The primary focus of this study is to identify changes in the availability of, and access to, Assisted Living/Residential (AL/RHC) health care facilities for Medicaid-enrolled older adults in the state of Kansas from 1999 to 2004. The objective of the study is to provide policymakers, providers and consumers of AL/RHCs services with information on Medicaid-Waiver participation in AL/RHCs over a five year period. This study serves as a follow-up to one we conducted in 1999 in collaboration with the Kansas Department on Aging (KDOA), and Social and Rehabilitation Services (SRS), entitled, “A Study of Assisted Living and Residential Health Care Facilities” (Chapin, Dobbs, Moore, & Waltner, 1999). This research report presents new findings from the 2004 study as well as comparisons to baseline findings from the 1999 study. (As appropriate, comparisons are also made to a follow-up study we conducted in 2000 which provided a profile of key characteristics of Kansas AL/RHCs.)

The 1999 study examined facility and resident characteristics including facility type, location, capacity size, ownership and profit status, length of stay, average cost, type of financial arrangements accepted by facilities, factors related to aging in place, and common reasons for discharge and discharge destinations. This research report provides a comparison of the 1999 and 2004 studies on many of these characteristics. In addition, this 2004 study explores reasons for acceptance or non-acceptance of the Medicaid Home and Community-based Services (HCBS) Waiver, barriers to utilization of the Waiver and strategies to address them, as well as examination of the roles and functions of social workers within AL/RHCs. We mailed a survey questionnaire to administrators of all licensed AL/RHC facilities in the state of Kansas (N = 237). We received a 71% response rate (n = 168). Our survey respondents closely mirror Kansas AL/RHC facilities on key characteristics such as facility type, location, size and profit status.

Key Findings: Facility Descriptives

- 65.5 percent (n = 110) of AL/RHC facilities in Kansas who responded to the survey were freestanding facilities; 27.3% were non-profit (n = 46), and 72.6% (n = 122) were for-profit facilities. In terms of location, 12.5% of respondents were from rural areas (n = 21), 51.1% (n = 86) from mid-size communities, and 36.3% (n = 61) were from metropolitan areas.
The average length of time in operation for AL/RHC facilities who responded to our survey was 7.42 years. Thirty-three percent of AL/RHC facilities who responded to our survey indicated their facility was individually owned (n = 55) and 36% (n = 60) indicated they were part of a chain; the remaining facilities (31.6%) described their ownership status as ‘other’ (n = 53).

The mean length of stay for residents in AL/RHCs from 1999 to 2004 nearly doubled from 1.5 years average length of stay in 1999 to 2.8 years in 2004.

The mean occupancy rate for all Kansas AL/RHC facilities in 2004 was 67.3%, similar to 1999 which showed 70%. Kansas occupancy rates are lower than national rates, which suggest estimates of 81% (NIC, 2004), pointing towards potential market saturation and unused capacity.

Key Findings: Availability/Accessibility of AL/RHCs in Kansas

- There has been continued growth of AL/RHCs in Kansas statewide from 169 licensed facilities in 1999 to 237 in 2004. Most of the growth has been in metropolitan areas which witnessed a 60% increase in the number of AL/RHCs. Facilities in rural areas increased by 27% over the same time period, and those in mid-sized communities increased by 21%. The percentage of AL/RHC facilities in rural, mid-size and metropolitan communities remained relatively constant from 1999 to 2004, with 12% of all Kansas facilities located in rural areas in 2004 as compared to 13% in 1999.
- Since 1999, there has been an overall increase of 51% in available AL/RHC beds throughout the state. The greatest growth is reflected in metropolitan areas which saw a 71% increase in available beds from 1999 to 2004. Despite the notable increase in available beds, many parts of the state remain below the state average of 25 beds per 1,000 people age 65 and older.
- In 1999 there were 56 counties without AL/RHCs, 39 counties did not have AL/RHC facilities in 2004.

Key Findings: AL/RHC Cost

- Based on survey responses, the minimum costs of AL/RHCs for private pay residents for a one bedroom unit increased by 33% from 2000 to 2004. The average minimum monthly fee in 2004 for a one bedroom private pay unit in AL/RHCs in Kansas was $2,224, increasing from $1,671 in 2000.
Based on survey responses, for residents who utilized the HCBS-FE Waiver, \textit{average monthly room and board fees} increased from $514 in 2000 to $1,156 in 2004, an increase of 125%. When the cost of services are added to the average monthly room and board fees, the total costs for HCBS-FE Waiver residents shows an increase of 70%, from $1,246 in 2000 to $2,128 in 2004.

\textbf{Key Findings: Presence of a Social Worker}

- 60% of survey respondents indicated that they have a social worker on their staff (n = 44), or have access to a social worker who is not on their staff (n = 56). Access to social workers appears considerably greater than in study year 2000, where approximately 35% of AL/RHC facilities reported having full or part-time social work or social services staff either as a consultant or on their payroll.

- The most commonly reported role and function of AL/RHC social workers in 2004 as reported by facilities which had or had access to a social worker (n =100) was that of resident advocate (64%). Survey respondents also reported that social workers served as a liaison between the resident/family and facility (60%), and performed the function of crisis intervention (52%).

\textbf{Key Findings: Medicaid HCBS-FE Waiver Utilization}

- 2004 study findings indicate that 70% (n =118) of the 168 facilities who responded to our survey accepted both private pay and Medicaid HCBS-FE Waiver residents. This is an increase from to 62% in survey year 1999. Notably, 56 more AL/RHC facilities accepted Medicaid HCBS-FE Waiver residents in 2004 than in 1999.

- While the number and percentage of facilities that accept the Medicaid HCBS-FE Waiver has increased over the five year study period, the overall proportion of Waiver residents in AL/RHCs has remained relatively similar. In 1999, of those who responded to our survey, 15% of AL/RHC residents were Waiver participants. In 2004, this increased to 16.2%.

- Despite the small increase from 1999 to 2004 in the proportion of residents in AL/RHCs who utilize the HCBS-FE Waiver, the number of residents who utilize the Medicaid HCBS-FE Waiver increased by 49%, from 536 individuals in 1999 to 796 in 2004 (based on survey respondents).
In 2004, 38% (n = 45) of the respondents who accepted the Medicaid HCBS-FE Waiver (n =118) reported there was a limit to the number of HCBS-FE Waiver residents they could accept with over half of those who imposed limits also indicating they had a waiting list (n = 25).

70% of facilities who did not participate in the HCBC-FE Waiver program indicated that the most common reason for non-participation was due to ‘low reimbursement rates’ (n = 35).

Focus group participants indicated appreciation for prompt problem-solving by KDOA staff related to HCBS-FE Waiver participation and strong support by AAA case managers. They also supported continuing communication between KDOA and AL/RHC providers as essential to good service provision for HCBS-FE Waiver residents.

**Conclusion**

Findings from this study shed important light on access to AL/RHCs for low-income older adults in the state of Kansas. Comparisons of key findings from 1999 to 2004 provide critical information for state policymakers, advocates and consumers of AL/RHCs in Kansas to consider when making decisions about long-term care. Since 1999, there has been considerable growth in the number of facilities that accept Medicaid Waiver residents. The overall proportion of individuals served by the HCBS-FE Medicaid Waiver in Kansas AL/RHCs has increased slightly percentage-wise. However, the number of residents who utilize the Medicaid HCBS-FE Waiver increased by 49%. Opportunities for older adults to ‘age in place’ in Kansas AL/RHCs are evident by a nearly double average length of stay from 1999 to 2004. The services of a social worker are now available in the majority of AL/RHC facilities across Kansas, up considerably from 1999.

While the number of AL/RHC facilities in Kansas has increased since 1999 and the number of available beds has shown dramatic growth, occupancy rates are slightly lower than in 1999, and still remain below the national average. This may point to excess capacity. However, room and board costs for Medicaid HCBS-FE Waiver residents have increased considerably since 1999, presenting a significant challenge to Medicaid residents. By continuing its efforts to enhance AL/RHC participation in the Waiver program, the state of Kansas may realize cost savings and potential delays in nursing facility placement for low-income older adults.
Assisted Living/Residential Health Care Facility
Participation in the Medicaid HCBS-FE Waiver: A Five Year Follow-Up

Introduction

Assisted living is an increasingly important component of the long-term care system that has the potential to help states reduce their reliance on more expensive institutional care for Medicaid long-term care recipients, and to create a more home-like environment for an aging population in need of minimal to moderate care. In 1999, Chapin et al. at the University of Kansas, Office of Aging and Long-Term Care, School of Social Welfare, in collaboration with the Kansas Department on Aging (KDOA) and Social and Rehabilitation Services (SRS), conducted the first study of its kind in Kansas to examine facility and resident characteristics in assisted living and residential health care facilities within the state. Some of the characteristics examined were average cost, profit status, admission and retention policies, professional staffing, resident physical and cognitive functioning, and levels of resident income. The availability of, and access to, the Medicaid Home and Community-Based Services for Frail Elderly (HCBS-FE) Waiver for low-income older adults residing in Kansas assisted living and residential health care facilities (AL/RHCs) was of particular focus in this study. An additional study was completed in 2000 to provide a more detailed description of key characteristics of AL/RHCs in Kansas. Some of the areas examined in the 2000 study included facility features, services and service use, fees, ownership status, Medicaid and Medicare participation, and admission and retention policies (Dobbs-Kepper, Chapin, Rachlin, & Waltner, 2000).

The follow-up study detailed here was conducted in 2004-2005. Administrators of all AL/RHCs were surveyed in order to:

- Identify changes in the availability of, and access to, AL/RHCs for Medicaid-enrolled older adults.
- Describe demographic factors such as urban/rural location, ownership status of facilities, profit status, and types of financial arrangements accepted by facilities.
- Explore the roles and function of social workers within facilities.
- Explore facility reasons for accepting or not accepting the Medicaid HCBS-FE Waiver.
- Explore common reasons for discharge and the discharge destinations of private pay and Medicaid-funded residents.
Several research questions were identified to guide our study. They were designed to allow us to compare findings from this study to earlier studies as well as to gather additional information. Key questions driving the study included:

1. Are there barriers to low-income older adults’ utilization of the Medicaid HCBS-FE Waiver in AL/RHCs in Kansas, and, if so, what are they?

2. Are there regional differences and patterns in the utilization of the Medicaid HCBS-FE Waiver by AL/RHC residents?

3. How do social workers in AL/RHCs impact low-income older adults’ utilization of the Medicaid HCBS-FE Waiver?

4. Are there specific factors that impede facilities’ ability to accept residents who utilize the Medicaid HCBS-FE Waiver, and if so, what are they?

Additional specific questions were incorporated into the 2004 survey that were not asked in 1999 or 2000 in order to gather more specific information about key aspects of HCBS-FE Waiver utilization in AL/RHCs. We asked whether or not administrators were aware of the existence of the Medicaid HCBS-FE Waiver, reasons they might not participate in the program, and, if they did participate, was there a limit to the number of Medicaid HCBS-FE Waiver residents they could accept. We also inquired as to how long facilities had accepted residents who were recipients of the Medicaid HCBS-FE Waiver, and whether or not they had waiting lists for private pay and/or Medicaid HCBS-FE Waiver residents. In addition, we examined the most common reasons for discharge and discharge destinations related to individual resident payor status (i.e., Medicaid vs. private pay) in order to ascertain whether or not significant differences existed. We also examined the role social workers play in helping clients access Medicaid HCBS-FE Waiver services in Kansas AL/RHCs. The information gathered from this study will enhance state policy makers, AL/RHC providers, advocates and consumers’ understanding of the role of the Medicaid HCBS-FE Waiver in AL/RHCs in Kansas and the effects that the Medicaid HCBS-FE Waiver has on low-income older adults’ access to ALs and RHCs.
This report includes background information on assisted living and residential health care facilities and discusses utilization of the Medicaid HCBS-FE Waiver in AL/RHCs both nationwide and in the state of Kansas. Findings from the 2004 study are presented and comparisons are made to the 1999 study and to the 2000 study, as appropriate. These include: facility location, length of time in operation, capacity and occupancy, facility type, profit versus non-profit status, length of stay, cost, entrance fees, presence and utilization of social workers in AL/RHCs, and reasons for resident discharge and discharge destinations. A detailed analysis of utilization and barriers to utilization of the Medicaid HCBS-FE Waiver is also included. In addition, focus group findings which provide detailed information from AL/RHC administrators on Medicaid HCBS-FE Waiver utilization in Kansas are discussed. Lastly, implications of the study findings for the state of Kansas are presented.

Background Literature on Assisted Living and the Medicaid HCBS-FE Waiver

The Assisted Living Quality Coalition, a national organization comprised of leading service and advocacy groups, indicates the purpose of assisted living is to accommodate residents’ needs, encourage community and family involvement, and maximize the autonomy, dignity, independence, privacy and safety of its residents (Hawes, 2001). While definitions of “assisted living” vary widely from state to state, assisted living is most often referred to as a residential setting that provides personal care and other supportive services for older adults (Robert Wood Johnson Foundation, 2005). In essence, assisted living blurs the distinction between receiving care in a home setting and an “institution.” Nationally, assisted living was the most rapidly growing sector of housing for older adults during the 1990s (Hawes, Phillips, Holan, Sherman, & Hutchinson, 2005). Recent reports indicate the numbers of licensed facilities grew from 32,826 to 36,299 between 2000 and 2002 (Mollica, 2003). In the same time period, the number of new licensed units grew from 795,400 to 910,486 (Mollica, 2003). The growth of AL/RHCs in Kansas parallels these national trends, as the number of AL/RHC facilities in the state increased from 169 to 237 between the years of 1999 to 2004 (Chapin, Dobbs, Moore & Waltner, 1999; State of Kansas, 2005). Specific trends have emerged with the increase in assisted living and residential health care facilities. For example, some facilities have adopted a community-like atmosphere in which residents have the option to take classes, participate in
physical activities, and even receive special care if they are suffering from dementia (Scott, 1999). However, the increasing popularity of assisted living has also created additional challenges:

- Market saturation in metropolitan areas as a result of the rapid growth of the industry during the late 1990s.
- Rising levels of illness and disability among residents raises the question of how much medical assistance should be provided in an assisted living facility.
- Some states have laws that prohibit or limit the care of residents with Alzheimer’s or dementia within an assisted living facility (Kleyman, 1998).

A continuing challenge remains to provide assisted living as a viable and affordable option for low-income older adults while controlling Medicaid spending. One option for states is the use of Home and Community-Based Services waivers. The Home and Community-Based Services (HCBS) Waiver Program was enacted by Congress in 1981 as part of the 1915(c) provision of the Social Security Act. The purpose of the program is to provide alternatives to institutionalization. Kansas applied for and was granted a Home and Community-based Services Waiver which began operation in 1982, though the ability for residents to utilize the waiver within AL/RHCs began in 1997. The state of Kansas developed a broad based program that served the physically disabled, mentally retarded and older adults. The frail elderly population became a targeted group for service under the Medicaid HCBS-FE Waiver Program. The main goal of the program is to help Medicaid-eligible older adults receive services in their homes or in assisted living settings rather than in an institutional setting such as a nursing home or hospital (Coalition for Independence, 2004). Individuals who apply for the 1915(c) waiver must meet the same eligibility criteria (in other words, require the same level of care and meet financial eligibility requirements) as those who enter nursing facilities (U.S. Department of Health and Human Services, 2004). The program (which exists in 49 states, with Arizona offering a different form of the waiver) currently assists more than 700,000 older adults and persons with disabilities to remain in community settings and avoid institutionalization (U.S. Department of Health and Human Services, 2004). The rise in the number of older adults needing assistance on a national level resulted in an increase in state and federal spending on the HCBS waiver program from $8.2 billion in 1997 to $16.3 billion in 2002 (Eiken & Burwell, 2003). In fact,
older adults and persons with disabilities accounted for 70% of Medicaid expenditures and 25% of enrollment in Medicaid programs nationwide in 2002 (Milne, Chang, & Mollica, 2004).

The Kansas HCBS-FE Waiver Program serves to provide home and community-based services as an alternative to nursing home placement for Kansas’ older adult population. Furthermore, estimates suggest that the program saves the state a considerable amount of taxpayer dollars, with some estimates of 60% cost savings over the cost of institutional care (Central Plains Area Agency on Aging, 2004). This is consistent with national figures which suggest that Medicaid HCBS expenditures are less costly than institutional care (Burwell, 1999, in Harrington & LeBlanc, 2001). While states have options under the Medicaid HCBS-FE Waiver program in terms of the scope of services they provide, some commonly utilized Waiver services include: the provision of medical, social, rehabilitative and supportive services, as well as personal care services to eligible older adults in assisted living and residential health care facilities (Coleman, 1998).

**Barriers to Low-Income Adults’ Utilization of the Waiver in AL/RHCs**

Despite the benefits of the Waiver of cost-savings and individual choice for aging in place, the ability of individuals to pay for long-term care remains a serious concern. The trend of growing income inequality in the United States raises concern that the gap in older adults’ ability to pay for long-term care will expand (Muramatsu & Campbell, 2002). This is especially evident in relation to access to AL/RHC living for low-income older adults. Mollica (2001) reports that as private pay residents have increasingly entered assisted living from nursing homes, “subsidies for low-income beneficiaries have lagged behind” (p. 32). Furthermore, participation in Medicaid programs that cover services in assisted living is low, leaving many low-income residents with few options other than entering a nursing home (Mollica, 2001).

Another barrier to low-income older adults’ utilization of the Medicaid HCBS-FE Waiver in AL/RHCs is the fact that Medicaid allows payment for room and board in nursing facilities, but not in assisted living or residential health care facilities (Milne, Chang & Mollica, 2004). Because most public and private health insurance does not pay for assisted living, most assisted-living residents must cover the costs of room and board themselves (Robert Wood Johnson, 2005). In addition, because assisted living is largely a private-pay market, low-income older adults are less likely to utilize it as an option (Hawes, Phillips, Holan & Sherman, 2003).
An additional barrier to low-income older adults’ utilization of the Medicaid HCBS-FE Waiver relates to the geographic location of assisted living facilities. Older adults living in rural areas tend to be poorer than those living in urban areas (Hawes, Phillips, Holan & Sherman, 2003). Because assisted living facilities also largely tend to be located in urban areas where larger numbers of potential residents live, there remains an under-supply of assisted living beds in rural areas (Hawes, Phillips, Holan, Sherman, & Hutchinson, 2003). Hawes, et al. further noted that facilities in rural areas are generally smaller than those located in urban areas (2005). Therefore, low-income older adults who live in rural areas may face an additional barrier of poor or limited access to assisted living due to the concentration of facilities in urban areas, making them potentially more reliant on nursing homes for long-term care. It is also noted that even if low-income older adults in rural areas are able to access assisted living services, the average price remains unaffordable (Hawes, Phillips, Holan & Sherman, 2005). The resultant ‘bottom line’ appears to be that rural older adults have fewer financial resources to spend on assisted living and fewer assisted living options in their communities (Robert Wood Johnson, 2005). Furthermore, when cut backs in the Medicaid program occur, older adults and facilities in rural areas are disproportionately affected as compared to those in urban areas (Silberman, Rudolf, D’Alpe, Randolph, & Slifkin, 2003).

In order for assisted living and residential health care facilities to combat issues of affordability and services for older adults in rural or under-funded areas, some states are exploring the idea of expanded federal and/or state funding for room and board in assisted living facilities. Some states have expanded coverage for assisted living by using Supplemental Security Income (SSI) and a state supplement to SSI to pay for room and board costs (Hawes et al., 2005). Essentially, this means that a higher than standard SSI benefit is set using supplemental state dollars in order to help offset the higher housing costs associated with assisted living. Other states have adopted a framework in which the room cost of a low-income assisted living facility is reduced, and personal care services are funded through Medicaid (Robert Wood Johnson, 2005). In addition to increased affordability, some researchers also recommend increased recruiting and retaining of social workers who are knowledgeable in the area of lower-income older adults and long-term care, because a lack of trained social workers in long-term care facilities impacts the type of social support services—including the Medicaid waiver—that are made available to lower-income older adults (Malench, 2004).
Methodology

Sample and Procedures

This study sampled all assisted living facilities and residential care facilities in the state of Kansas. The Directory of Kansas Assisted Living Facilities was used to identify all ALs and RHCs in Kansas (State of Kansas, 2004). This directory included free-standing ALs and RHCs, facilities with both AL and RHC beds, and facilities with an attached nursing facility (NF). A twenty-four item survey questionnaire was mailed to AL/RHC (N = 237) administrators in November of 2004 (see Appendix B). A 70% overall response rate was achieved with a total of 168 responses. Of these, 109 respondents indicated they had AL beds, 54 had RHC beds, and 5 had both AL and RHC beds. Additionally, many of these facilities had more than one type of bed. These included: twenty-nine combination AL and NF; twenty-six combination NF and RHC; 2 combination NF, AL, and RHC and 3 combination AL and RHC. The remaining 108 facilities were not part of any combination, i.e., they were considered stand alone facilities. This information is presented in Table 1 on page 13 where comparisons are made to Kansas as a whole. The survey questionnaire addressed the following areas:

- Facility descriptives such as location, facility type, size, ownership status, number of units, and cost.
- Acceptance or non-acceptance of Medicaid HCBS-FE Waiver residents.
- Barriers to acceptance of HCBS-FE Waiver residents.
- Common reasons for discharge and discharge destinations.
- Presence of a social worker.
- The role and function of the social worker.

Survey questions were developed building on the 1999 and 2000 studies. However, additional questions were added related to the presence, role and function of a social worker and about specific HCBS-FE Waiver access issues, as previously noted. Surveys were piloted with two AL/RHC administrators, an AL/RHC industry consultant, and key staff members from KDOA. Feedback from these key individuals, including the OALTC research staff, was received and incorporated into the survey. To optimize the response rate, we collaborated with local AL/RHC organizations and associations including KAHSA, KHCA and ALFA-KAN. The survey/project was also mentioned in Kansas AL/RHC trade association newsletters. A notice to AL/RHC administrators about the upcoming survey was also posted on the ALFA-KAN website.
Surveys were mailed in three waves, with the first wave producing 90 responses. The second wave, mailed one month later, resulted in 45 responses. An additional 33 responses were received in the third and final wave in February of 2005, resulting in an overall response rate of 70% (see Appendix A for a facility data log and map of survey response status). As surveys were received by the OALTC, responses were entered into specially designed survey software and analyzed using the Statistical Program for the Social Sciences (SPSS), Version 12.0.

Focus Group

One focus group was conducted with five administrators of Kansas AL/RHCs representing rural and urban areas, private pay and HCBS-FE Waiver utilization, and various combinations of facility types. The purpose of the focus group was to expand on the existing survey findings and gain in-depth information from administrators regarding barriers to utilization of the Medicaid Waiver by AL/RHCs and barriers to access for low-income older adults. The focus group was facilitated by OALTC research staff on April 22, 2005, and a ten-item questionnaire was utilized to guide the discussion (see Appendix C). Administrators were asked to discuss what they saw as positive aspects of the Medicaid HCBS-FE Waiver Program, how the state of Kansas has facilitated efforts to utilize the Medicaid Waiver Program, and what they could do to further enhance utilization. They were also asked to name some of the reasons why facilities might not utilize the Medicaid HCBS-FE Waiver Program, how facilities could accommodate increased numbers of Medicaid Waiver participants, who assisted their residents with the referral and application process for the program, and other ways, beside the Waiver, that facilities might financially assist residents. Focus group participants suggested strategies to address barriers to utilization of the Medicaid HCBS-FE Waiver that they identified.

Comparison of AL/RHC Survey Respondents to all AL/RHCs in Kansas

In order to demonstrate how our study findings represent the state of Kansas as a whole, we compared survey respondents to all AL/RHCs in Kansas on the following characteristics: facility type, size, location and profit status. The following table shows the percentage of facilities who responded to our survey by facility type, comparing them to all Kansas AL/RHC facilities. It is noteworthy that on the variable of facility type our survey respondents represented at least 60% percent of total Kansas facilities.
Table 1. Respondents by Facility Type Compared to All Kansas AL/RHC Facilities

<table>
<thead>
<tr>
<th>Facility Type</th>
<th>Survey Respondents</th>
<th>Kansas Facilities</th>
<th>Percent Who Responded</th>
</tr>
</thead>
<tbody>
<tr>
<td>AL free standing</td>
<td>80</td>
<td>104</td>
<td>77%</td>
</tr>
<tr>
<td>RHC free standing</td>
<td>28</td>
<td>47</td>
<td>60%</td>
</tr>
<tr>
<td>AL/NF</td>
<td>29</td>
<td>41</td>
<td>71%</td>
</tr>
<tr>
<td>AL/NF/RHC</td>
<td>3</td>
<td>5</td>
<td>60%</td>
</tr>
<tr>
<td>AL/RHC</td>
<td>2</td>
<td>2</td>
<td>100%</td>
</tr>
<tr>
<td>RHC/NF</td>
<td>26</td>
<td>38</td>
<td>68%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>168</td>
<td>237</td>
<td></td>
</tr>
</tbody>
</table>

The percent who responded in each type of facility represented above ranged from 60-100% indicating that our data approximates Kansas facilities overall.

Facility location was another characteristic on which we compared our respondents to Kansas overall. The geographic locations used for this study consist of three categories: rural, mid-sized areas, and metropolitan statistical areas (MSAs). These categories were adopted by the University of Kansas Health Wave Study and were based on the number of persons per square mile, calculated using U.S. Census Bureau Estimates (University of Kansas Health Services Research Group, 1999). Within these categories, rural areas are defined as those with populations of less than 10,000, and mid-sized towns are those defined as having populations of 10,000 or greater, but are not designated as metropolitan. Metropolitan cities are those listed as a metropolitan statistical area (MSA) by the U.S. Census Bureau and have a city with a population of at least 50,000 or more persons, and a total metropolitan population of at least 100,000. For comparability purposes, the same population classifications were utilized in the 1999 and 2004 studies.

The following table shows how rural, mid-size, and metropolitan locations of our respondents approximate Kansas numbers. Within those who responded on the location characteristic, we had at least two-thirds of each type of characteristic represented.
Table 2. Respondents by Location Compared to All Kansas AL/RHC Facilities

<table>
<thead>
<tr>
<th>Location of Facility</th>
<th>Survey Respondents (N = 168)</th>
<th>Kansas Facilities (N = 237)</th>
<th>Percent Who Responded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural</td>
<td>21</td>
<td>28</td>
<td>75%</td>
</tr>
<tr>
<td>Mid-size</td>
<td>86</td>
<td>118</td>
<td>73%</td>
</tr>
<tr>
<td>Metropolitan</td>
<td>61</td>
<td>91</td>
<td>67%</td>
</tr>
</tbody>
</table>

An additional category included analysis of facility size. Table 3 below shows how survey respondents compare to Kansas as a whole. Categories of facilities include: small (less than 25 units), small to medium (26-40 units), medium to large (41-60 units), and large (61 or more units). Again, two-thirds of each type of facility by size is represented from our survey respondents.

Table 3. Respondents by Facility Size Compared to All Kansas AL/RHC Facilities

<table>
<thead>
<tr>
<th>Facility Size</th>
<th>Survey Respondents (N = 168)</th>
<th>Kansas Facilities (N = 237)</th>
<th>Percent Who Responded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small</td>
<td>54</td>
<td>75</td>
<td>72%</td>
</tr>
<tr>
<td>Small to Medium</td>
<td>52</td>
<td>73</td>
<td>71%</td>
</tr>
<tr>
<td>Medium to Large</td>
<td>45</td>
<td>67</td>
<td>67%</td>
</tr>
<tr>
<td>Large</td>
<td>17</td>
<td>22</td>
<td>77%</td>
</tr>
</tbody>
</table>

The following table presents a comparison of profit versus non-profit status for survey respondents and facilities in Kansas as a whole. Sixty-eight percent of the for-profit AL/RHC facilities in Kansas responded to our survey and 79% of the non-profit facilities responded.
Table 4. Respondents by Profit Status Compared to All Kansas AL/RHC Facilities

<table>
<thead>
<tr>
<th>Profit Status</th>
<th>Survey Respondents (N = 168)</th>
<th>Kansas Facilities (N = 237)</th>
<th>Percent Who Responded</th>
</tr>
</thead>
<tbody>
<tr>
<td>For Profit</td>
<td>122</td>
<td>179</td>
<td>68%</td>
</tr>
<tr>
<td>Non Profit</td>
<td>46</td>
<td>58</td>
<td>79%</td>
</tr>
</tbody>
</table>

2004 Survey Findings

The following findings are based on results from the 168 respondents of our 2004 survey of all AL/RHC facilities (N=237).

Location

In 1999, of those who responded to the survey, 9% of ALs were located in rural areas, and 22% of RHC facilities were located in rural areas. This compares to 2004 survey results in which 12.3% of ALs were located in rural areas, and 13% of RHCs were located in rural areas. In 1999, of those who responded to the survey, 53% of ALs were located in mid-sized areas, and 58% of RHCs were located in mid-sized areas. This compares to 2004 survey findings in which 47.4% of AL facilities were located in mid-sized areas, and 59.3% of RHC facilities were located in mid-sized areas. Finally, in 1999, of those who responded to the survey, 38% of ALs were
located in metropolitan areas, while 20% of RHC facilities were located in metropolitan areas. This compares to 2004 survey results, in which 40.4% of AL facilities were located in metropolitan areas, and 27.8% of RHCs were located in metropolitan areas. Map 1 on the previous page illustrates the distribution of AL/RHC facilities in Kansas by location.

We compared the location of facilities in 1999 to the location of facilities in 2004 for all Kansas AL/RHC facilities. We found that the proportion of AL/RHC facilities located in rural areas has stayed relatively constant from 1999 (13%) to 2004 (12%). However, the percent growth from 1999 to 2004 in the number of facilities in rural areas was much lower than the percent growth in the number of facilities in metropolitan areas. There was a 60% increase in the number of AL/RHC facilities in metropolitan areas (from 57 to 91), a 21% increase in the number of AL/RHC facilities in midsize areas (from 90 to 118), and only a 27% increase in the number of AL/RHC facilities in rural areas (from 22 to 28). Table 5 below illustrates the growth of AL/RHC facilities in the state of Kansas between the years of 1999 to 2004.

**Table 5. Comparison of Facility Location in Study Years 1999 and 2004 Based on All Kansas Facilities**

<table>
<thead>
<tr>
<th>Facility Location</th>
<th>1999 AL (N=10)</th>
<th>1999 RHC (N=12)</th>
<th>1999 AL/RHC Total (N=22)</th>
<th>2004 AL (N=18)</th>
<th>2004 RHC (N=10)</th>
<th>2004 AL/RHC Total (N=28)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural</td>
<td>10% (N=10)</td>
<td>17% (N=12)</td>
<td>13% (N=22)</td>
<td>12% (N=18)</td>
<td>12% (N=10)</td>
<td>12% (N=28)</td>
</tr>
<tr>
<td>Midsize</td>
<td>50% (N=49)</td>
<td>58% (N=41)</td>
<td>53% (N=90)</td>
<td>46% (N=70)</td>
<td>56% (N=48)</td>
<td>50% (N=118)</td>
</tr>
<tr>
<td>Metropolitan</td>
<td>40% (N=39)</td>
<td>25% (N=18)</td>
<td>34% (N=57)</td>
<td>42% (N=64)</td>
<td>32% (N=27)</td>
<td>38% (N=91)</td>
</tr>
</tbody>
</table>
Length of Time in Operation

The average facility length of time in operation of those AL/RHCs combined who responded to our survey in 2004 was 7.42 years, with a range of 1 to 20. This compares to a 1999 finding of average length of time AL/RHC facilities had been in operation of 4.4 years, with a range of 8 months to 15 years. It is noteworthy that prior to 1995, facilities were not licensed as AL or RHCs in the state of Kansas. Prior to 1995, these facilities may have been considered a ‘personal care’ facility, a title category that was changed in 1995 to AL or RHC via Kansas legislative action.

Capacity Size

The total number of units, or assisted living beds, in AL/RHC facilities who responded to our survey ranged from 5-124 units with a mean of 38. The current study findings are comparable to those from 1999 and 2000. The following tables show the range and mean number of units by facility type for each of the years: 1999, 2000, and 2004.

Table 6. Comparison of Range and Mean Number of AL Units in Study Years 1999, 2000 and 2004 Based on Survey Responses

<table>
<thead>
<tr>
<th></th>
<th>Range</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>AL 1999</td>
<td>7-227</td>
<td>43</td>
</tr>
<tr>
<td>AL 2000</td>
<td>8-131</td>
<td>39</td>
</tr>
<tr>
<td>AL 2004</td>
<td>7-124</td>
<td>42</td>
</tr>
</tbody>
</table>

1 Facilities that began operation prior to 1984 were excluded from analysis as the year 1984 provided a natural cut-off point in the data.
According to the Adult Care Home Semi-Annual Report (2004), the total number of AL/RHC beds in 2004 in the state of Kansas was 9,180 with a mean occupancy rate of 67.3%, and a range of 5-226 AL/RHC beds (University of Kansas, 2005). In 1999, there were 6,076 available beds and a 70% occupancy rate. Median occupancy rates in ALs were 72% and 77% for RHCs in 1999 (Chapin, Dobbs, Moore & Waltner, 1999). National figures estimate mean national occupancy rates in 2003 at 88 percent (NIC, 2004). The increase in Kansas in the number of available AL/RHC beds from 1999 to 2004 constitutes a 51% increase, while occupancy rates in both years remain similar. Occupancy rates in Kansas AL/RHCs are lower than national rates, pointing towards potential market saturation and unused capacity.

In addition, the number of AL/RHC beds in rural areas has increased by 42% (from 477 beds to 676 beds) between 1999 and 2004, while the number of AL/RHC beds in metropolitan areas has increased by 71% (from 2,723 beds to 4,655 beds) during the same time period. Table 8 on the following page illustrates the increase in beds by location of all facilities in the state of Kansas.

<table>
<thead>
<tr>
<th></th>
<th>Range</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>RHC 1999</td>
<td>5-77</td>
<td>25</td>
</tr>
<tr>
<td>RHC 2000</td>
<td>5-97</td>
<td>24</td>
</tr>
<tr>
<td>RHC 2004</td>
<td>5-119</td>
<td>27</td>
</tr>
</tbody>
</table>
Table 8. Comparison of Number of Beds by Location in All Kansas AL/RHCs for Study Years 1999 and 2004

<table>
<thead>
<tr>
<th>Facility Location</th>
<th>1999 AL Beds</th>
<th>1999 RHC Beds</th>
<th>1999 AL/RHC Total Beds</th>
<th>2004 AL Beds</th>
<th>2004 RHC Beds</th>
<th>2004 AL/RHC Total Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural</td>
<td>249</td>
<td>228</td>
<td>477</td>
<td>460</td>
<td>216</td>
<td>676</td>
</tr>
<tr>
<td>Midsize</td>
<td>1819</td>
<td>1057</td>
<td>2876</td>
<td>2588</td>
<td>1261</td>
<td>3849</td>
</tr>
<tr>
<td>Metropolitan</td>
<td>2067</td>
<td>656</td>
<td>2723</td>
<td>3321</td>
<td>1334</td>
<td>4655</td>
</tr>
<tr>
<td>Total</td>
<td>4135</td>
<td>1941</td>
<td>6076</td>
<td>6369</td>
<td>2811</td>
<td>9180</td>
</tr>
</tbody>
</table>

Facility Type: Freestanding versus Nursing Facility

In 2004, there were 237 licensed AL and RHC facilities in the state of Kansas, of whom 168 responded to our survey. Sixty-eight percent of these were AL (n = 114) and 32% were RHCs (n = 54). When these are examined by freestanding versus those attached to a nursing facility, we found in our 2004 study that 65.5% of AL/RHC facilities who responded to the survey were freestanding facilities (n = 110). Study findings from 2000 indicated that 59.4% of facilities who responded to the survey were freestanding. This represents an increase of approximately 6% from 2000 to 2004 of facilities responding to our survey that defined themselves as freestanding facilities.

For Profit vs. Non-profit

Table 9 shows a comparison of non-profit versus for-profit status for Kansas AL/RHC facilities who responded to our surveys in years 1999, 2000 and 2004. Since these figures represent only those who responded to the survey, 30% of AL/RHC facilities who did not respond are excluded. The most dramatic change noted is in RHC facilities as shown in the table below. From 1999 to 2004, the percentage of non-profit RHCs decreased from 45% to 22%, and the percent of for-profit RHCs increased from 55% to 78%.
Table 9. Comparison of Profit Versus Non-Profit Status of AL/RHCs in Study Years 1999, 2000 and 2004 Based on Survey Responses

<table>
<thead>
<tr>
<th>Profit Status AL</th>
<th>1999</th>
<th>2000</th>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-profit AL</td>
<td>27%</td>
<td>24%</td>
<td>30%</td>
</tr>
<tr>
<td>For profit AL</td>
<td>73%</td>
<td>76%</td>
<td>70%</td>
</tr>
<tr>
<td>Profit Status RHC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-profit RHC</td>
<td>45%</td>
<td>28%</td>
<td>22%</td>
</tr>
<tr>
<td>For-profit RHC</td>
<td>55%</td>
<td>72%</td>
<td>78%</td>
</tr>
</tbody>
</table>

National figures show that 82.5% of assisted living facilities are for-profit status, and 17.5% are not-for profit (American Seniors Housing, 2005). Our survey results were comparable but slightly lower than national results, with 72.6% representing for-profit facilities, and 27.4% representing non-profit facilities.

Of those who responded to the 2004 survey, 32.7% of AL/RHC facilities indicated their facility was individually owned, 35.7% reported being part of a chain, and the remaining 31.6% of facilities were categorized as ‘other’.

Length of Stay

In 2004, we asked facilities to report their recorded length of stay for residents or their best estimate of the length of stay of their residents. Of those who recorded their resident length of stay (n = 29, 19%) a range of 1-8 years was found, with a mean of 2.8 years. Those who provided a best estimate of resident length of stay (n = 120) showed a range of 6 months to 6.5 years, with a mean of 2.8 years length of stay. Regardless of whether or not this was exactly recorded or provided as a best estimate, the mean length of stay for AL/RHC residents was the same at 2.8 years. This compares with a 1999 figure of 1.5 years average length of stay, with a range of ¾ year to 5.5 years. Importantly, the mean length of stay in years from 1999 to 2004 has nearly doubled from 1.5 years to 2.8 years. This increase may be due to the relatively minimal length of time facilities in 1999 had been in operation because AL/RHCs were essentially a new entity in the state, coming into existence largely in 1995. The national average in length of stay for AL/RHC residents is 2.5-3 years, yet additional estimates indicate that this
may actually be lower at 22.9 months, which is a little less than two years (AARP, 2005; NIC, 2004). Thus, the Kansas average closely resembles the national average.

Cost

We asked administrators to provide the minimum monthly fee for a one-bedroom unit for a private pay resident. In 2004, the *average minimum monthly fee for a one-bedroom private pay unit* in Kansas AL/RHCs who responded to our survey was $2,224. This compares with the year 2000 average minimum monthly fee of $1,671 for AL/RHCs who responded to the 2000 survey. This is an increase of $553 (33%) over the four year period.

We also asked administrators for the *range of fees for room and board only for Medicaid HCBS-FE* residents. The range was from $0 to $4500 with an average room and board fee for a Medicaid HCBS-FE Waiver resident, based on survey respondents, of $1,156 in 2004. In 2000, the average of the range of fees for room and board only, based on those who responded to the 2000 survey, was $514. This shows an increase of $642 (125%) for room and board for a Medicaid HCBS-FE resident, more than double the cost in 2000. This average monthly fee for Waiver residents, combined with the average cost of HCBS-FE services ($972)² brings the average monthly cost for Medicaid HCBS-FE residents to $2,128. Based on survey respondents in 2000, the average monthly cost of room and board and services for a Medicaid HCBS-FE resident in 2000 was $1246. This is an increase of $882, or 70%, from 2000 to 2004. Potential reasons for increases may include facility costs of labor, and liability insurance costs, all of which were substantiated in discussions with administrators in survey focus groups.

Given that the average minimum monthly fee for private pay residents was $2224 as noted above, there remains only a $96 average per month difference between the minimum monthly fee for private pay residents and the average monthly cost of Medicaid HCBS-FE Waiver residents in AL/RHCs ($2128). Considering that Medicaid HCBS-FE residents likely

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² This was obtained by averaging the 2004 monthly cost of service for RHCs ($1123.17), and ALS ($821.62) for Medicaid HCBS-FE residents with cost of service information provided by KDOA, July 2005.
have higher acuity levels than the private pay residents the finding that the average cost for the Medicaid-FE residents was less than the minimum private pay costs is notable.

**Entrance Fees**

In 2004, we asked whether or not there was an entrance fee for residents, and if there were different fees for Medicaid HCBS-FE Waiver residents than private pay residents. 37.5% of those who answered this question indicated they had an entrance fee, regardless of whether they were a private pay or a Medicaid HCBS-FE Waiver provider. Of those facilities who accepted Medicaid HCBS-FE Waiver residents and answered this question, 16.7% (n = 28) had different entrance fees for Medicaid Waiver residents than private pay residents. Over half of the respondents reporting having an entrance fee of $500 (n = 15) for Medicaid Waiver residents. This may present a financial burden for low-income older adults who need assisted living/residential health care, or deter their utilization of AL/RHC living.

**Medicaid HCBS-FE Waiver**

Services for low-income older adults in Kansas AL/RHCs may be covered using the 1915(c) Home and Community-Based Waiver Program. Our study findings indicate that 70% (n = 118) of the 168 facilities who responded to our survey accepted both private pay and

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* AL/RHC Facilities by Type of Payment(s) Accepted Based on Survey Respondents* (N=168)

* Survey respondents are those facilities that responded by March 21, 2005 to the Assisted Living/Residential Health Care Facility Administrator Survey conducted by the Office of Aging and Long Term Care, School of Social Welfare, The University of Kansas.
Medicaid HCBS-FE residents. This compares to 70% in the year 2000 study who responded to the survey, and 62% in 1999. Map 2 on the previous page illustrates the location of the facilities who responded to the 2004 survey, and the type of payment they accept.

While the overall percentage of facilities who accept the Medicaid HCBS-FE Waiver is similar in years 2000 and 2004, the growth of the number of AL/RHC facilities in the state of Kansas reveals that more facilities have begun to accept the Waiver as a form of payment. Since 1999, based on 2004 survey results, 56 additional facilities have accepted Medicaid HCBS-FE Waiver residents. Of those, 32 have accepted HCBS-FE Waiver residents for three years or less. Map 3 below illustrates the number of facilities, based on 2004 survey results, within each PSA that accept the Medicaid HCBS-FE Waiver.

**Number of Facilities that Accept Medicaid HCBS-FE Waiver by PSA**

Based on Survey Responses (N=168)

![Map of Number of Facilities](image)

Legend:
- 1 - 4
- 5 - 11
- 12 - 20
Of the 94 facilities who answered this question, the number of years that AL/RHC facilities have accepted the Medicaid HCBS-FE Waiver ranges from 1-9 years, with an average of 4.7 years.\(^3\)

Our 2004 survey findings indicate that of those who responded to our survey, 796 HCBS-FE Waiver recipients reside in 111 AL/RHCs.\(^4\) This is an increase from survey respondents in both 1999 (536) and 2000 (457). In 2004, of those who responded to our survey, 16.2% of the AL/RHCs residents were Medicaid HCBS-FE Waiver recipients. In 1999, this figure was 15%, and in 2000, it was 14.3%. While the actual number of recipients has increased, the overall percentage of recipients has remained similar due to the overall increase in the AL/RHC resident population in the state of Kansas. In 2004, again, based on those who responded to the survey, the range of Medicaid HCBS-FE residents in ALs/RHCs that accept the Waiver was 0-40 residents, with an average of six. This is a slight increase from 2000, where the range was 1-20, with an average of 5 residents. (In 1999, AL/RHC facilities maintained an average of 4 Medicaid HCBS-FE Waiver residents.)

The following table represents the number of AL/RHC facilities by PSA who accept the HCBS-FE Waiver and who responded to our survey. It also shows the proportion of AL/RHC residents who utilize the Medicaid HCBS-FE Waiver by PSA. For the state as a whole, the percent of AL/RHC residents who were Medicaid HCBS-FE Waiver recipients in each assisted living facility ranged from 0-82.6%, with a mean of 26.3%. PSA 5 and 11 represent the highest percentages of Medicaid recipients in AL/RHCs with 33.5% Medicaid residents and 42% respectively.

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\(^3\) The HCBS-FE Waiver was implemented in Kansas in 1997. Facilities who reported accepting the Waiver prior to its formal inception in the state were excluded from this analysis (N = 10).

\(^4\) For the state as a whole, the number of Medicaid HCBS-FE Waiver beneficiaries in Kansas who resided in AL/RHCs in 2004 was: 847 in ALs, and 125 in RHCs, with the total number of HCBS beneficiaries in the state at 6,858 (KDOA, 2004).
<table>
<thead>
<tr>
<th>PSA</th>
<th>Number of AL/RHC Facilities Who Responded to the Survey</th>
<th>Number of Facilities That Accept Medicaid HCBS-FE Waiver</th>
<th>Number of Facilities That Have Medicaid HCBS-FE Waiver Residents</th>
<th>Percent of AL/RHC Residents Receiving the HCBS-FE Waiver</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2*</td>
<td>16.8%</td>
</tr>
<tr>
<td>2</td>
<td>22</td>
<td>14</td>
<td>14</td>
<td>22.4%</td>
</tr>
<tr>
<td>3</td>
<td>8</td>
<td>7</td>
<td>7</td>
<td>18.6%</td>
</tr>
<tr>
<td>4</td>
<td>16</td>
<td>9</td>
<td>9</td>
<td>27.6%</td>
</tr>
<tr>
<td>5</td>
<td>21</td>
<td>18</td>
<td>18</td>
<td>33.5%</td>
</tr>
<tr>
<td>6</td>
<td>15</td>
<td>11</td>
<td>11</td>
<td>29.0%</td>
</tr>
<tr>
<td>7</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>29.7%</td>
</tr>
<tr>
<td>8</td>
<td>27</td>
<td>23</td>
<td>23</td>
<td>20.9%</td>
</tr>
<tr>
<td>9</td>
<td>9</td>
<td>7</td>
<td>7</td>
<td>27.3%</td>
</tr>
<tr>
<td>10</td>
<td>21</td>
<td>16</td>
<td>16</td>
<td>26.9%</td>
</tr>
<tr>
<td>11</td>
<td>18</td>
<td>4</td>
<td>5*</td>
<td>42.0%</td>
</tr>
</tbody>
</table>

* In PSAs 1 and 11, the number of facilities who accept Medicaid HCBS-FE Waiver residents is less than those who have Medicaid HCBS-FE Waiver residents. This may be due to the fact that those facilities may no longer accept Waiver residents, but they may have maintained those residents who were on the Waiver prior to them not accepting Waiver residents.
Map 4 below represents the percentage of AL/RHC facilities who participate in the HCBS-FE Waiver program based on our survey respondents.

SSI

Respondents were asked how many of their Medicaid HCBS-FE customers received Supplemental Security Income (SSI). Of those who responded to this question (n = 118), more than 41.5% (N = 49) had no Waiver residents receiving SSI. 58.5% (n = 69) had at least one SSI resident, with a range of 0-15, and a mean of 4 residents. Overall, of the 796 residents utilizing the Medicaid HCBS-FE Waiver in AL/RHCs in 2004, 150 or 18.8% were receiving SSI. In 2000, 27.6% of Medicaid HCBS-FE Waiver residents in AL/RHCs were receiving SSI. In 2004, there were 339 more Medicaid HCBS-FE Waiver residents than in 2000, but the percentage of those residents who receive SSI has decreased. Reasons for low utilization of SSI may be related to: first, individuals with higher income who therefore are eligible for Waiver via spend down, and secondly, potential bureaucratic reasons such as paperwork, application, etc. for SSI. It is
noteworthy that survey respondents were not asked to complete a chart review in order to answer this question, so results should be considered estimates only.

**HCBS Customers Admitted as Private Pay**

In 2004, 225 of the 796 AL/RHC residents (28.2%) who currently utilized the Medicaid HCBS-FE Waiver in the facilities who responded to our survey were admitted as private pay. This is slightly lower than with 2000 survey respondents, of which 36.5% were admitted as private pay. This may suggest that more residents are admitted to AL/RHCs already Medicaid HCBS-FE Waiver eligible than in 2000, which accounts for this difference.

Findings from 2004 also indicate that 28% of the 118 facilities (n = 33) in our survey that accept the Medicaid HCBS-FE Waiver report that none of their current Medicaid HCBS-FE Waiver residents were admitted as private pay. Twenty-three percent report only one person was admitted as private pay before becoming Waiver eligible. 20.8% had two or more individuals who entered as private pay before becoming Medicaid eligible. The overall range of residents who entered these facilities as private pay was 0-21, with a mean of 2 residents.

**Limit to Number of Waiver Residents AL/RHCs Can Accept**

In 2004, we asked whether or not AL/RHC facilities limited the number of HCBS-FE Waiver residents they could or would accept. Of those who accepted the Medicaid HCBS-FE Waiver (N = 118), 45 facilities, or 38%, reported there was a limit to the number of Waiver residents they could or would accept. Of these 45 facilities, twenty-five had a waiting list, indicating that over half of those who had a limit to the number of Waiver residents they could accept also had a waiting list. Of the 25 facilities who had a waiting list, the number of Waiver residents on the waiting list ranged from 1-11, with a mean of 3.68 residents. If the average length of stay is 2.8 years and the mean number of Medicaid residents on waiting lists is 3.68, then the waiting list for a Medicaid resident could be several years. This also raises a question about the status of Medicaid eligible residents who are on AL/RHC waiting lists, and whether or not they are unnecessarily admitted to NFs due to the long waiting lists at some AL/RHCs who accept Medicaid HCBS-FE Waiver residents.

**Reasons for Not Participating in the Waiver**

In 2004, we asked whether or not facilities participated in the HCBS-FE Waiver Program, and if not, what were possible reasons for not participating. Fifty facilities (30% of facilities who responded to this survey) did not participate in the HCBS-FE Waiver Program.
The reasons they provided for not accepting Medicaid HCBS-FE Waiver residents are not mutually exclusive, with administrators free to choose more than one answer. The most common reason reported for not participating in the Waiver program was “low reimbursement rates.” Seventy percent of facilities who did not participate in the Waiver program reported that this was the most common reason (n = 35). The second most common reason for which 40% of facilities chose not to participate (n = 20) was “too much paperwork and red tape”. The third most common reason for which 8% (n = 4) of facilities did not participate was “I didn’t know about the program”. The fourth most common reason reported by 8% (n = 4) was “lack of adequate staffing to support the program”.

A new finding from the 2004 survey shows that 8% of those who chose not to participate in the Waiver program did not know about the program. This raises potential opportunities for continuing education and outreach to ensure adequate information is available to AL/RHC providers. For those administrators who did know about the program and chose not to participate, their decision not to participate appeared to be heavily influenced by financial and bureaucratic concerns. Some of these concerns related to what they saw as excessive paperwork and documentation, both of which affected them financially in a negative way.

Other Waiver Findings

In 2004, we examined relationships between several aspects of the Medicaid HCBS-FE Waiver Program in AL/RHCs which affect low-income older adults’ ability to age in place. One of these areas included the relationship between how long a facility had been in operation and acceptance of Waiver residents. Findings show a small positive correlation between the length of time a facility had been in operation and the likelihood of accepting Medicaid HCBS-FE Waiver residents (r = .18, p < .05). This may mean that facilities that had been in operation longer may have less overhead costs associated with their property, and therefore, were somewhat more likely to accept Medicaid HCBS-FE recipients despite lower reimbursement rates.

Another relationship we examined was between the number of beds for which a facility was licensed and acceptance of the Waiver. We found that the fewer the number of beds a facility had, the more likely they were to accept the Waiver (r = -.19, p < .05 ). This may be related to the possibility that smaller facilities are older and/or in rural areas and thus may find it harder to fill beds, or that they are attached to a nursing facility that has a social worker.
We also examined the influence of facility location on Waiver acceptance. Analysis revealed that facilities in rural areas were more likely than those in mid-sized or metropolitan areas to accept the Medicaid HCBS-FE Waiver ($r = .28$, $p < .01$). We also explored whether or not there was a relationship between having a social worker, the number of Waiver residents, and utilization of the Medicaid HCBS-FE Waiver Program. We found a positive relationship between a facility having a social worker and having Waiver residents in the facility ($r = .20$, $p < .01$) suggesting that facilities that had a social worker either on staff or available to them, were somewhat more likely to have Waiver residents. However, we found no significant relationship between an AL/RHC facility having a social worker and the overall likelihood that they would accept Medicaid HCBS-FE Waiver residents. In other words, while having a social worker present may coincide with more Waiver residents, it does not mean that the AL/RHC overall is more likely to initially accept Waiver residents. Greater numbers of Waiver residents in a facility with social workers could be related to facility type, (i.e., a combination facility which is connected to a nursing home) which is required by some federal funding regulations to have a social worker or social work designee available to residents.

We also examined the roles and functions of social workers in AL/RHCs. Our findings indicate that all social work functions (mental health counseling, resident advocate, marketing functions, admissions, discharge planning, liaison, and crisis intervention), with the exception of assisting with Medicaid applications, were positively correlated with freestanding AL/RHCs. In other words, a social worker was more likely to perform these key social work roles and functions in a freestanding facility as opposed to a combination AL/RHC/NF facility, except for assisting with Medicaid applications. This is consistent with the previous discussion of social workers assisting with Medicaid applications in facilities that have an attached nursing facility.

Reasons for Discharge and Discharge Destinations

In 2004, we asked administrators to rank order the three most common reasons for discharge based on resident payor status (private pay or Medicaid), other than death, from their AL/RHC in the previous calendar year. Administrators were given a list of five common reasons for discharge and an ‘other’ category. Scores were assigned to the three most common reasons (ranging from zero to three) with the first most common reason assigned a score of 3, the second most common reason assigned a score of 2, and the third most common reason assigned a score of 1. Reasons not ranked were assigned a score of zero. An average score was computed for
each reason. The three highest reasons for discharge in 2004, based on mean scores, are represented below.

Table 11. Three Most Common Reasons for Discharge for AL/RHC Residents by Payor Status (by 1\textsuperscript{st}, 2\textsuperscript{nd} and 3\textsuperscript{rd} ranking)

<table>
<thead>
<tr>
<th>Most Common Reasons for Discharge</th>
<th>Private pay (mean score)</th>
<th>Medicaid HCBS-FE Waiver (mean score)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care needs too great</td>
<td>1 (2.58)</td>
<td>1 (2.64)</td>
</tr>
<tr>
<td>Resident died</td>
<td>2 (2.02)</td>
<td>2 (1.97)</td>
</tr>
<tr>
<td>Behavior problems</td>
<td>3 (1.62)</td>
<td>*</td>
</tr>
<tr>
<td>Functioning improved</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Not enough funds</td>
<td>*</td>
<td>3 (1.66)</td>
</tr>
<tr>
<td>Spouse died/moved</td>
<td>*</td>
<td>*</td>
</tr>
</tbody>
</table>

* Figures were excluded from the table as they did not rank within the top three most common reasons.

The most noteworthy finding represented in the table above relates to the third most common reason for discharge among Medicaid HCBS-FE Waiver residents, not enough funds. This is concerning because low-income older adults who could utilize the HCBS-FE Waiver may be at higher risk for inappropriate nursing facility placement due to financial limitations, some of which may be related to room and board costs. Similarities to study years 1999 and 2000 exist in the category of ‘care needs are too great’ which was reported in both of these years as the most common reason for discharge as in 2004.

Discharge Destinations

In 2004, we asked AL/RHC administrators to rank the three most common discharge destinations by payor source (private pay vs. Medicaid) for the previous calendar year. The same scoring procedure was applied to obtain the mean for discharge destinations as was used for reasons for discharge discussed previously. The table below indicates the most common discharge destinations based on payor status.
Table 12. Most Common Discharge Destinations by Payor Status

<table>
<thead>
<tr>
<th>Discharge destinations in rank order</th>
<th>Private pay (Mean Score)</th>
<th>HCBS-FE Waiver (Mean Score)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing facility</td>
<td>1 (2.39)</td>
<td>1 (2.52)</td>
</tr>
<tr>
<td>Hospital</td>
<td>2 (1.94)</td>
<td>2 (1.91)</td>
</tr>
<tr>
<td>Died in setting</td>
<td>3 (1.88)</td>
<td>3 (1.82)</td>
</tr>
<tr>
<td>Independent living/back home</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Another AL</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Another RHC</td>
<td>*</td>
<td>*</td>
</tr>
</tbody>
</table>

* Figures were excluded from the table as they did not rank within the top three most common reasons.

Common discharge destinations for both private pay and Medicaid HCBS-FE Waiver residents show little variation by payor status, and show the same rank order as obtained from the 1999 survey results. Nursing facility placement ranked as the most common destination in both payor categories, although the mean score was slightly higher in the Medicaid HCBS-FE Waiver group. The second most common discharge destination for both private pay and HCBS-FE residents was to a hospital. Lastly, death in the AL/RHC setting was the third most common discharge destination.
A new area of exploration in the 2004 study focused on the presence and role of social workers in AL/RHCs in Kansas. Of the 168 administrators who responded to the survey, 60% (n = 100) indicated they have a social worker on staff (n = 44), or have access to a social worker who is not on staff (n = 56). The remaining 40% of facilities (n = 68) indicated they do not have a social worker, nor do they have access to a social worker. Findings from our 2000 study showed that approximately one-third of the responding ALs and 40% of RHCs had either full or part time social work or social services staff either as a consultant or on their payroll (Dobbs-Kepper, Chapin, Rachlin & Waltner, 2000).

Map 5 above illustrates the presence of a social worker within the facilities that responded to our survey. It is noteworthy that numerous counties in western Kansas do not have a social worker on staff, nor have access to a social worker, according to survey respondents. This raises a question about how low-income residents are served relative to identified survey...
findings on the role and function of social workers, i.e. resident advocate, serving as a liaison between the facility and the family. Furthermore, it calls attention to the issue of whether or not social workers are involved in assisting with Medicaid HCBS-FE referrals/applications, or simply accessing HCBS-FE services.

Figure 1 below represents the split between facilities that have a social worker on staff, access to a social worker, and no access to a social worker/no social worker on staff.

**Figure 1. AL/RHC Access to Social Worker**

We also inquired as to the roles and functions the social worker served in the facility, and whether or not these roles or functions were considered primary. The categories are not mutually exclusive. The table below represents the 60% of administrators who reported having a social worker on staff, or having access to a social worker who was not on their staff, recalling that 40% reported they did not have a social worker or have access to a social worker.
Table 13. Social Work Roles and Functions in AL/RHC Facilities (n =100)

<table>
<thead>
<tr>
<th>Role/Function of Social Worker</th>
<th>Percent of Administrators Who Reported Social Worker Performed This Role/Function</th>
<th>Percent of Administrators Who Reported This as Primary Role/Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assisted with Medicaid applications and other resources/benefits</td>
<td>45%</td>
<td>3%</td>
</tr>
<tr>
<td>Resident advocate</td>
<td>64%</td>
<td>23%</td>
</tr>
<tr>
<td>Mental health counselor</td>
<td>30%</td>
<td>13%</td>
</tr>
<tr>
<td>Liaison between facility and family</td>
<td>60%</td>
<td>6%</td>
</tr>
<tr>
<td>Crisis intervention</td>
<td>52%</td>
<td>4%</td>
</tr>
<tr>
<td>Assists with admissions</td>
<td>39%</td>
<td>7%</td>
</tr>
<tr>
<td>Administrative duties/marketing</td>
<td>27%</td>
<td>13%</td>
</tr>
<tr>
<td>Assessment/discharge planning</td>
<td>45%</td>
<td>1%</td>
</tr>
<tr>
<td>No primary function stated</td>
<td></td>
<td>30%</td>
</tr>
</tbody>
</table>

Overall, these findings show that the most commonly reported role and function of the social worker was that of resident advocate (64%). The second highest reported function was serving as a liaison between the resident/family and the facility (60%), and the third highest reported was that of crisis intervention (52%).

Thirty-percent of administrators who responded to this question reported that social workers did not have one primary function. Rather, they reported that the social worker performed several different functions, with no one function as primary. The second most commonly reported primary role/function of the social worker was that of resident advocate with 23% of administrators seeing this as the primary role/function. This was also the most
commonly reported role/function of the social worker. The third most common primary function was represented equally between administrative/marketing functions and mental health counselor.

These findings indicate that less than half (45%) of social workers perform the function of assisting with Medicaid applications and other resources and benefits, with only 3% performing this as a primary role/function. AL/RHC residents’ access to Medicaid HCBS-FE Waiver services may be impacted by facility social workers infrequent involvement in this process which needs to be further explored.

**AL/RHC Administrator Focus Group**

As a part of our 2004 study, we conducted a focus group consisting of five administrators from AL/RHCs representing both rural and urban areas, private pay and HCBS-FE Waiver utilization, and various combinations of facility types. We asked in-depth, open-ended questions concerning their utilization of the Medicaid HCBS-FE Waiver (see Appendix C for Focus Group questions). We have listed the questions asked, a summary of how the questions were answered, and quotes from the administrators.

**What are some positive aspects of and benefits to accepting the Waiver?**

We asked focus group participants to name some of the positive aspects of being involved with the Medicaid HCBS-FE Waiver. First, they reported that utilization of the Medicaid Waiver allows low-income older adults to age in place. They further reported that because living in an assisted living facility allows older adults to live in an environment that is conducive to aging in place, for low-income older adults, the Waiver serves as a means to achieve this goal, even when resident assets run out or they have to spend down. Without the Medicaid Waiver option, they indicated that low-income older adults may not be able to remain in an assisted living community. One focus group participant reflected on the benefit the HCBS-FE Waiver offers to low-income older adults who wish to remain in community settings:

*It’s the most appropriate environment. A very appropriate environment is to continue living in their communities.*

Next, focus group participants suggested that the Medicaid Waiver helps low-income older adults with the cost of residing in assisted living. They discussed that due to the increasing
cost of assisted living, the task of paying for this type of care is more difficult, and how, for low-
income older adults, this may result in a premature move to a nursing facility. Thus, the Waiver
becomes an important tool to off-set specific costs associated with residing in an assisted living,
another positive finding.

It’s actually so important for them because when the families do come in
and they ask them, what if mom’s assets run out? What are you going to
do? Throw her out on the street? I mean, that’s really kind of what they
want to know is, are you going to try to work with them to get some kind
of subsidy in there to help the people stay there?

Finally, as suggested by focus group participants, the Medicaid Waiver can be beneficial
for the facility itself in the sense that it helps to fill beds and raise the occupancy rate, if the
Medicaid Waiver is accepted at a specific facility. Participants discussed how in the 1990s the
assisted living boom resulted in the tendency to over-saturate the market with facilities; as a
result, accepting the Medicaid Waiver might be a way to raise a low occupancy rate if a facility
has empty beds.

Well, what’s happening, and I think some of the reasons you see more
people taking it, is because the market is over built. These places are
sitting all over. Actually there’s a buyer’s market right now. These
assisted living facilities, especially in Johnson County, they’re lucky if
they have 70% occupancy, a lot of them. It’s that bad. They’ve over-built
the market, and they’re being forced to take Medicaid because they’d have
even more empty rooms if they didn’t.

What are some ways KDOA has helped to facilitate the use of the Medicaid HCBS-FE
Waiver in ALs and RHCs?

We asked focus group participants about the various ways in which the Kansas
Department on Aging has aided assisted living facilities in utilizing the Medicaid HCBS-FE
Waiver. Group members explained that KDOA provides workshops and seminars, set-up and
assistance with billing systems, and makes their staff accessible to answer questions that an
assisted living administrator may have.

They have made – in workshops and things - they do make people
available. And there’s always people that you can call and ask questions.
They are very good about answering questions.
I think the KDOA staff in general – I mean, they are available. They’re friendly, and they’re accessible by e-mail or phone.

And they are very good, in all honestly, are good about - as far as doing the billing. Somebody, (it’s free), they come out to help you. Who does that? EDS. They’re good about sending someone out to set up a new office manager, director, so you can learn how to bill. And they really are good about that.

Focus group participants expressed positive regard for the relationships they held with, and assistance they received from KDOA.

What are some reasons why facilities would choose not to utilize the Medicaid HCBS-FE Waiver?

When asked for some reasons why facilities would choose not to utilize the Medicaid Waiver, participants provided what they saw as potential roadblocks to participation. These include a lack of financial incentive to participate - including the potential to cause a financial loss to the facility if they do participate. Excessive paperwork and documentation were specifically noted as described by participants:

One of the reasons they don’t participate in it is because of just - I don’t want to. We just decided with everything going on, we don’t want to mess with the paperwork side of it, just the bureaucracy of it. It’s just not that attractive to us.

It’s not tempting. It is not tempting. You know, not even. Like we kind of talked about earlier, even if I have some empty beds, I would rather wait it out than fill out a weekly form like that for - I mean chase down staff like that. Seriously, I really would.

There is a facility sitting with eight empty beds. They have nine Medicaid and they will not take, no matter what, any more HCBS because we’re losing our rear ends on this deal.

Some focus group participants also noted they were apprehensive about the likelihood of increasing their risk of having a state survey if they participated in the Medicaid HCBS-FE Waiver program.
What recommendations and strategies would you give to combat barriers to Medicaid HCBS-FE Waiver utilization?

When asked for specific recommendations and strategies to combat barriers some assisted living administrators noted that they face in utilizing the Medicaid HCBS-FE Waiver, participants provided a list of some possible approaches. These include suggesting to the state a tax credit be offered to facilities to offset the losses facilities may encounter as a result of accepting the Medicaid Waiver, receiving funding assistance for room and board from the state, and appealing to the state to look at the Waiver program as an economic issue that would benefit the community in which the Waiver is utilized. For example, some participants noted that AL/RHC facilities employ members of the community, as well as serve the sizable older adult population within the state of Kansas. Some long-term goals suggested by focus group participants included raising reimbursement rates, and taking a look at ways to make documentation more manageable.

One participant expressed this view about costs of care:

*I mean, enhancing the board and care side of it. The state could help the facilities and the residents pay for the board cost, the room and board cost.*

Other focus group participants suggested that documentation for the Medicaid HCBS-FE Waiver program could be made easier:

*The barrier, I think, is just the weekly recording of every little thing- it’s a total barrier for a licensed facility to have to do. That was the argument about the care system. We’re already licensed. We’ll document that we’ve provided “X” units of service during the week, but not on a 15 minute basis. If it goes over or way under, we can - maybe there’s a way we can record ‘that’ versus ‘this’.*

What factors may explain why over one-third of facilities limit the number of Waiver residents they accept?

When asked for potential reasons why an assisted living administrator may limit the number of residents they will accept on the Waiver, the economic impact of accepting these residents is again at the forefront of explanations. Other reasons administrators reported that they limit the number of residents they will accept on the Waiver also include bureaucratic
issues, such as what administrators see as an overwhelming amount of paperwork and more state supervision.

One focus group participant compared Medicaid Waiver documentation and paperwork imposed on AL/RHCs to that required in a nursing home:

> And you start saying, well, you've got this additional paperwork, they don't want to - they (staff) start thinking okay, nursing home! This is (like) Medicare - all this nutty paperwork. And really, that's a lot of the nurses, they don't want to mess with all the silly paperwork.

Another participant referred to financial reasons why facilities limited the number of Medicaid Waiver residents they could accept:

> Profit. Bottom line. It always comes down to that.

An additional reason for limiting numbers of Medicaid Waiver residents suggested by some administrators was due to what they viewed as a social stigma aspect of the Waiver Program. They stated some other residents might object to being in a facility that accepted Medicaid.

**In your opinion, how are some facilities able to accommodate Waiver residents?**

When asked how certain assisted living facilities were able to accommodate larger amounts of Waiver residents, several explanations were offered. The type and ownership of the facility was offered as one possibility, with those owned by religious affiliations or the ‘local’ government able to accommodate larger amounts of Waiver residents. The size and location of the facility were also suggested as possibilities, with smaller facilities, older facilities, and rural facilities being suggested as possible “types” of facilities which could accommodate larger amounts of Waiver residents. When asked if administrators were able to accommodate more Medicaid Waiver residents than they had referrals for, only one administrator reported they could accomplish this task. The remaining administrators spoke of having to “cap” their acceptance of Medicaid Waiver residents, resulting in a waiting list for those particular clients.

> Older facilities that are cheaper for them at least to buy into and keep up. So some of those companies, they target the low end market. That’s what they do. That’s why some of the facilities succeed because that is their market.
Well, one more factor though, some of these are owned by local church groups or local government. So they’re doing it as a benevolent deal anyway because they’re sponsored by the county or the city or a non-profit. So they’re committed to serving their residents and their community. And they’ll take that because they want them to. So the foundation of the non-profit supports it and we have a number of those that operate that way.

How would someone in your facility happen to be on the Medicaid HCBS-FE Waiver?

The intent of this question was to find out what referral sources were most commonly associated with the utilization of the HCBS-FE Waiver. We also wanted to know about the specific referral sources of private pay residents. Focus group participants indicated that referral sources for both groups included SRS, hospitals, and ‘word of mouth.’

Who in your facility helps residents with the HCBS-FE Waiver process?

The focus group members were asked how residents were able to get on the Medicaid Waiver, how the process occurred, and how residents were able to explore other services for which they may be eligible. Several scenarios were presented by group participants, including utilizing staff members (primarily the administrators themselves), whether or not a social worker was involved in the process, and involvement of the Area Agency on Aging (AAA).

You have a AAA case manager involved because in most cases really, in many, there’s not an active social worker or social worker claims person, and that case manager can then help that resident or family be aware maybe of resources that they never would have, even that assisted living may not completely be aware of.

They do have a case manager following them, which I think would be helpful for those people who might be able to connect to those services they never knew they could have.

It’s kind of one of those things when, I mean the state has social workers, SRS, AAA has social workers. It’s just great to send them the financial part and not having to have one on staff.

Focus group participants indicated that they highly value the role of the AAA case managers and the assistance they offered. In addition, group members were asked about who assisted residents with advanced directives within their particular facilities. All administrators
reported that they – the administrators - helped residents complete advanced directives (versus a social worker).

Are there other ways—aside from the Waiver—that you assist older low-income older adults in your facility?

Focus group administrators were asked if they offer (or had heard of others offering) any other assistance (in lieu of the Medicaid Waiver) to low-income older adult residents in their facilities. While none of the administrators personally offered assistance to low-income residents, they did express knowledge of other facilities that had benevolent trusts, or performed price adjustments for their low-income residents. Some reported that family members often stepped in to work out a financial plan for the resident. One focus group participant spoke about alternative ways of assisting:

*The administrator prior to me has done that (offered extra assistance) and I’m seeing that as I’m looking at people. And that’s okay, because you’re going to get more if you can lengthen out their stay and keep them off of Medicaid. You’re going to get a little more money than you would from the HCBS services. I mean it’s going to be a little bit, but at least it’s more. But yeah, some people do do that.*

Is there anything important we have missed that could help increase use of the Medicaid HCBS-FE Waiver?

When asked what might be some reasons why 8% of all administrators who responded to the survey did not know about the Medicaid Waiver, some participants suggested that those 8% may be smaller facilities that might be privately owned, for example, or that perhaps they had not received adequate training about the HCBS-FE Waiver in the operator course.

Administrators also spoke about what they saw as an “over-abundance of information” a prospective operator must learn in a short amount of time as a concern about the assisted living system in Kansas.

*It’s too much information, you know, and then they can’t figure out later when they’re doing surveys why they’re running into problems. I mean it’s just too many rules and regulations for somebody to learn. And this area is not covered as a part of the state required – or the operator training on assisted living.*
In summary, focus group participants expressed strong positive regard for the assistance they received from KDOA related to technical assistance and problem-solving and appreciated the accessibility and availability of KDOA staff. In addition, assistance offered to AL/RHC administrators by AAA case managers was also viewed as extremely helpful. The main concern administrators expressed regarding utilization of the Medicaid Waiver was what they viewed as low reimbursement rates and excessive documentation requirements. As a whole, participants felt that ongoing dialogue was the key to continuation of successful relationships with KDOA and serving Medical Assistance Waiver recipients. Finally, AL/RHC administrators expressed appreciation for the opportunity that Waiver funding presents for low-income Kansans who might otherwise be faced with institutional care.

**Study Implications for Kansas**

Based on findings from this study of AL/RHCs in Kansas and comparisons to the 1999 and 2000 study findings, this section explores implications for the state when considering the role that assisted living plays in long-term care in Kansas.

*Availability*

The supply of assisted living has increased dramatically since the initial study was conducted by the Office of Aging and Long-Term Care in 1999. Presently, an estimated 6,200 Kansas individuals reside in assisted living/residential health care facilities (University of Kansas, Adult Care Home Semi-Annual Report, 2005). In addition, since Medicaid HCBS-FE Waiver services became available in assisted living and residential health care facilities in 1997, this long-term care funding source has become more available to low-income seniors. More than 70% of survey respondents in 2004 accepted both private pay and Medicaid residents. In addition, approximately 16.2% of the resident population of those facilities who responded to our survey were recipients of Medicaid HCBS-FE Waiver services at the time of the survey, which is higher than the national average of 11% (AARP, 2004). While increases from 1999 to 2004 are minimal (from 15% to 16.2%), this may suggest the beginning of a trend in which more low-income older adults may be served in Kansas AL/RHCs through the Medicaid HCBS-FE Waiver.

An additional implication of the 2004 study findings for the state relates to self-imposed facility limits on the number of Medicaid HCBS-FE Waiver residents a facility would accept. Of
those who accepted Medicaid residents and who responded to our survey, 38% reported limits to the number of residents on the Waiver they would accept. Furthermore, these facilities also reported waiting lists for Medicaid HCBS-FE Waiver residents of a mean of 3.68 residents. Not only are some facilities limiting the number of Waiver residents they will accept, but waiting lists pose additional threats to individuals who are low-income. When combined with the average length of stay of 2.8 years (as gathered from this study), a major concern remains as to how long Medicaid residents may have to wait to gain access to an AL/RHC, and/or if they are unnecessarily or inappropriately transferred to higher levels of care (e.g. nursing facilities).

For facilities who would not accept any Waiver residents, the most commonly cited reason was that reimbursement rates were too low. The second most common reason was that there was too much paperwork and red-tape. Lastly, 8% of administrators reported that they did not even know about the Waiver program. Based on information gathered from focus group participants, these are critical concerns for facility administrators in terms of their ability to continue to provide quality care for low-income residents.

Affordability

Affordability continues as an important factor to consider when discussing long-term care options for older adults. Much like 1999 data revealed, there continues to be a great need for affordable assisted living models, especially for low-income older adults who do not always have the option of choosing assisted living (Mollica, 2001). An important implication of the 2004 study findings is the increasing role the state is playing in assisting low-income Medicaid eligible residents in AL/RHCs in Kansas. Study findings show that since the inception of the 1915(c) Waiver in 1997, the number of residents served in Kansas on the Medicaid HCBS-FE Waiver in AL/RHCs quadrupled from 140 residents in 1997 to 536 residents in 1999, and increased another 49% between 1999 and 2004 to 796 Medicaid residents. While the overall number of low-income residents living in AL/RHCs in 2004 due to assistance provided by the Medicaid HCBS-FE Waiver (16.2%) has increased since the inception of the Waiver, the overall percentage of residents in AL/RHCs served by the Waiver has not changed dramatically from 1999-2000. This raises the question of whether some low-income older adults in AL/RHCs are able to access Waiver services in a timely manner. Barriers to Waiver utilization such as low reimbursement

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5 This number is based on the 70% of facilities who responded to our survey. The actual number of Medicaid residents in AL/RHCs may be higher.
rates, excessive paper work, and facility imposed limits on the number of Medicaid HCBS-FE residents they could or would accept may be inhibiting access, resulting in premature or unnecessary institutionalization in an NF.

Furthermore, the cost of AL/RHC placement in 2004 has increased dramatically since 2000. For example, the average minimum monthly fee for a private pay resident has increased by 33% since 2000, and the average of the range of fees for room and board for a Medicaid HCBS-FE Waiver resident has increased by 125% from 2000 to 2004. Percentage-wise, Medicaid rates have increased more than private pay rates. This has implications for older adults who are seeking long-term care, as affordability is an issue the state continually faces. This, coupled with the perceived low Medicaid rate, creates a significant challenge in keeping administrators participating in the Medicaid Waiver program and keeping the program fiscally-sound in the state of Kansas.

Supply and Demand

The number of AL/RHC beds has increased from 6,076 in 1999 to 9,180 in 2004 with average occupancy rates of 67.3%, comparable to 70% occupancy rates in 1999 in facilities that answered our survey (University of Kansas, 2005, 1999). When looking at bed availability, it is clear that older adults in the western half of the state have less access to ALs and RHCs than older adults in other parts of the state (see Appendix D for map of AL/RHC beds per 1,000 population age 65 and older). Furthermore, while AL/RHC beds in facilities located in metropolitan areas showed an increase of 71% between 1999 and 2004, beds in facilities located in rural areas showed a lower percent increase at 42% during the same time period. As the supply expands and competition increases for shares of the assisted living market, facilities appear to have become more willing to contract with Medicaid in order to maintain acceptable occupancy levels. For example, since our original study in 1999, 56 additional facilities have begun accepting Medicaid HCBS-FE Waiver residents. Of those 56 facilities, 32 began accepting HCBS-FE Waiver residents within the last three years. An implication is that we could be witnessing a positive trend of more facilities serving low-income older adults in Kansas. In addition, as previously discussed in this report, stigma associated with having Medicaid Waiver residents, and what administrators report as excessive paperwork may continue to affect facilities’ willingness to accept Medicaid Waiver residents.
While this trend has positive implications for Kansas, a cautionary note is in order. Due to what some perceive as market saturation in the assisted living industry, and less than ideal occupancy rates, some facilities report “having to” accept Waiver residents in order to keep revenue streams flowing. If, as suggested by facility administrators, reimbursement rates are too low, and facilities accept Medicaid residents only to keep revenue coming in, the ability of increasing numbers of low-income older adults to access AL/RHCs may be compromised over the long term.

Aging in Place

States are increasingly looking to assisted living as an important component of the long-term care system. The implications of some key findings in this report (i.e., increased average length of stay, common reasons for discharge, and discharge destinations) suggest that, overall, Kansas assisted living facilities are functioning as an intermediate step in the long-term care continuum. For instance, the average length of stay in an AL/RHC facility in the state of Kansas in 1999 was 1.5 years, which compared unfavorably to the then national average of 2.6 years (Dobbs et al., 1999). However, since that time, the average length of stay in Kansas has increased by 46.4% to 2.8 years in 2004, which compares favorably to the national average of 2.5-3.0 years (Hawes et al., 2000). This increase may have an effect on long-term occupancy rates. Some of the reasons which may account for the increased length of stay include: the longer tenure of assisted living facilities, thereby providing residents with an increased opportunity for aging in place; and the provision of a wider array of services, thereby more appropriately meeting residents’ care needs (e.g., expansion of the scope of services).

While the current study findings indicate that Kansas AL/RHC residents are staying longer (as evidenced by increased lengths of stay), it also shows that, when residents do leave AL/RHC facilities, they leave for reasons related to higher skill level of care (i.e., nursing home or hospital). These findings are in line with the philosophy of care of assisted living which aims to promote the highest level of functioning in the least-restrictive environment. Within an industry that has needed to identify itself and its limitations in a period of rapid growth and change, there is evidence that AL/RHCs are continuing to pursue their mission of promoting individual autonomy, dignity, and independence, and appear to recognize the limitations in their ability to care for individuals with higher levels of care needs. This conclusion is supported by
the consistency of research findings from 1999 to 2004 related to reasons for discharge and discharge destinations.

**Conclusion**

When making decisions concerning how to best provide care to aging adults in Kansas, it is important that the state have up-to-date information on the role of assisted living and residential health care facilities in the continuum of long-term care. As AL/RHC facilities become increasingly popular in Kansas, issues concerning how to pay for long-term care costs will continue to be important, especially in light of the rapidly growing aging population. By collecting follow-up information concerning utilization of the Medicaid HCBS-FE Waiver over the past 5 years, we hope to assist state policymakers in focusing attention on the critical role AL/RHC facilities play in the state’s long-term care system.

In order to accomplish this task, we have explored best practices that could benefit the state of Kansas, its long-term care system, and recipients of long-term care services in ALs and RHCs. These best practices also offer the opportunity to enhance availability and accessibility of AL/RHCs for low income older adults. For example, some states are exploring the idea of expanded federal and/or state funding for room and board in assisted living facilities in order to assist low-income older adults in their attempt to age in place, thereby limiting the numbers of early-entrances to nursing facilities (Hawes et al., 2005). Other states have adopted a framework in which the room cost of a low-income assisted living facility is reduced, and personal care services are funded through Medicaid (Robert Wood Johnson, 2005), also a way to enhance accessibility. In addition to increased affordability, some researchers recommend increased recruiting and retaining of social workers who are knowledgeable in the area of lower-income older adults and long-term care, because a lack of trained social workers in long-term care facilities impacts the type of social support service - including the Medicaid Waiver - that are made available to lower-income older adults (Malench, 2004). An increased social worker presence may also have the potential to provide screening of private pay AL/RHC residents in a timely fashion for future Medicaid Waiver eligibility, thereby contributing to the older adults’ ability to age in place.

While these best practices reflect observations from a national perspective, they also are germane to challenges facing low-income older adults and the AL/RHC industry in the state of Kansas. In our 2004 study, AL/RHC administrators in Kansas also highlighted several best
practices to address these challenges. One best practice they noted was the technical assistance and support from the state of Kansas offered to AL/RHC providers, which administrators indicated was extremely helpful and which they suggested was a mechanism by which they could continue to successfully serve Medicaid Waiver clients. They noted the importance of ongoing communication and dialogue between the state and AL/RHC providers. Administrators felt that maintaining a focus on the ultimate goal of helping low-income older adults to successfully age in place was essential. Providers expressed that having an opportunity to voice their opinions and to maintain a collaborative partnership with the state was a key ingredient in helping Waiver residents have access to AL/RHCs and aging in place. Despite what they saw as limitations, administrators indicated that utilization of the HCBS-FE Waivers for their residents was beneficial overall. They expressed a willingness to work within the constraints of the system (i.e., increased requirements for monitoring clients, low reimbursement rates) in a collaborative fashion with the state. The state and facility administrators have the opportunity to continue to explore ways in which administrators and the state can sustain meaningful dialogue to address these critical concerns. Additionally, utilization of social workers in AL/RHCs who have expertise in long-term care issues could make a positive difference in access to the Medicaid HCBS-FE Waiver for AL/RHC residents, particularly related to identifying in advance those residents who may qualify for Medicaid HCBS-FE Waiver services. More information for AL/RHC administrators in operator trainings may also be a way to address some of these issues.

Lastly, based on the increased number of AL/RHC facilities and beds and fluctuating occupancy rates, it is possible that the number of AL/RHCs in Kansas who accept Medicaid HCBS-FE Waiver services will continue to increase. As a result, the number of AL/RHC residents on Medicaid would likely continue to increase. The state should continue to pursue avenues as suggested above which pave the way for enhanced AL/RHC provider involvement in the Medicaid HCBS-FE Waiver Program. Pursuing these avenues may ultimately result in a cost savings to the state and potentially delay costly nursing home placement for low-income older adults.
References


Appendix A: Facility Data Log and Map of Survey Response Status

<table>
<thead>
<tr>
<th>Action and Outcome</th>
<th>Percentage of Facility Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 2004: Mailed first wave of survey to Administrators with a 6 week deadline to fill out and return</td>
<td>37% (n = 90) responded to first wave of survey</td>
</tr>
<tr>
<td>January 2005: Mailed second wave of survey to Administrators with a 4 week deadline to fill out and return</td>
<td>19% (n = 45) responded to second wave of survey</td>
</tr>
<tr>
<td>February 2005: Mailed third wave of survey to Administrators with a 4 week deadline to fill out and return</td>
<td>14% (n = 33) responded to third wave of survey</td>
</tr>
<tr>
<td><strong>Total Response Rate:</strong></td>
<td><strong>70% (N= 168)</strong></td>
</tr>
</tbody>
</table>

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Assisted Living and Residential Health Care Facilities in Kansas by Survey Response Status' (N=237)

Legend

Survey Respondents' (N=168) • Non-respondent (N=69)

* Survey Respondents are those facilities who responded to the Assisted Living/Residential Health Care Facility Administrator Survey conducted March 21, 2005.
Appendix B:  AL/RHC Administrator Survey

University of Kansas
School of Social Welfare
Office of Aging and Long Term Care
Assisted Living/Residential Health Care Facility/
Homes Plus Administrator Survey
2/21/05

Please complete and return by March 11, 2005

1. What type of facility do you operate? (Check all that apply)
   1. AL
   2. RHC
   3. NF
   4. Homes Plus

2. Please indicate the number of beds for which your facility is licensed:
   1. # of AL beds
   2. # of RHC beds
   3. # of NF beds
   4. # of Homes Plus beds

3. What is the number of residents residing today in your facility?
   1. # of AL residents
   2. # of RHC residents
   3. # of NF residents
   4. # of Homes Plus residents

4. In what year did your facility begin offering the following types of beds:
   1. AL beds (Year)
   2. RHC beds (Year)
   3. NF beds (Year)
   4. Homes Plus beds (Year)

5. What is the ownership status of your facility?
   1. Individually owned
   2. Part of a chain
   3. Homes Plus
   4. Other (Please specify)
6. Does your facility have a designated social worker(s) on staff or have access to a social worker to provide services to residents in your facility?

1. Yes, we have a social worker on staff
2. Yes, we have access to social worker who is not on our staff
3. No, we do not have a social worker on staff nor do we have access to a social worker (Please go to Question 7)

6a. On average, how many hours per week does your social worker work?

1. Hours per week, consistently
2. Hours per week, varies from week to week

6b. What roles or functions does the social worker serve in your facility? (Check all that apply)

1. Mental health counselor
2. Resident advocate
3. Performs marketing functions
4. Performs admission functions
5. Assists with applications for Medicaid and other resources and benefits
6. Performs discharge planning
7. Serves as liaison between facility, resident and family
8. Crisis intervention
9. Other (please specify)

6c. From the information provided in Question 6b, please indicate the primary function of your social worker:

1. 
2. 

6d. Which of the following categories best describes your designated social worker(s):
(If your facility has more than one social worker, please check all that apply)

1. Bachelor’s degree in social work
2. Master’s degree in social work
3. Bachelor’s degree in field other than social work
4. Master’s degree in degree in field other than social work
5. Don’t know
6. Other

7. Home and community-based services for the frail elderly (HCBS/FE Waivers) may be provided to residents of AL/RHCs/Homes Plus who are Medicaid eligible. Is this new information for you?

1. YES
2. NO

8. What type of financial arrangements does your facility accept?

1. Private pay only
2. Medicaid HCBS/FE only
3. Private pay and Medicaid HCBS/FE Waiver
4. Other (please specify)
9. If your facility *does not* accept HCBS/FE Medicaid Waiver residents, please indicate potential reasons for this: (Check all that apply)

(If you accept HCBS/Medicaid Waiver residents, please go to Question 10)

1. I don’t know about the program
2. Too much paperwork/red tape
3. Lack of adequate staffing to support this
4. Low reimbursement rates
5. Other (please specify)

10. If your facility **accepts** Medicaid HCBS/FE Waiver residents, please respond to the following questions: (If you do not accept Medicaid, please go to Question 11)

10a. How many residents are currently receiving HCBS/FE Medicaid Waiver services in your facility?

1. # in AL  
2. # in RHC  
3. # in Homes Plus

10b. Of those receiving HCBS/FE Medicaid Waiver services, how many receive Supplemental Security Income?

1. # of residents

10c. Of those receiving HCBS/FE Medicaid Waiver services, how many residents were admitted as private pay to your facility?

1. # of HCBS/FE Medicaid Waiver residents admitted as private pay

10d. Since what year has your facility accepted residents who receive Medicaid HCBS/FE Waiver services?

1. (Year)

10e. Does your facility serve as a provider of HCBS Medicaid Frail Elderly Waiver services for your residents?

1. Yes, we provide the HCBS/FE Medicaid Wavier services
2. No, another agency provides HCBS/FE Medicaid Waiver services to our residents

11. Does your facility have a waiting list for **Private Pay** residents?

1. YES  
2. NO  
3. Does not apply

12. Does your facility have a waiting list for **HCBS/FE Medicaid Waiver** residents?

1. YES  
2. NO  
3. Does not apply
13. How many **Private Pay** individuals are currently on your facility’s waiting list?

1. # of individuals on AL waiting list  
2. # of individuals on RHC waiting list

14. How many **HCBS/FE Medicaid Waiver** individuals are currently on your facility’s waiting list?

1. # of individuals on AL waiting list
2. # of individuals on RHC waiting list
3. Does not apply

15. Is there a limit to the number of residents you can have at any given time that are recipients of the HCBS/FE Medicaid Waiver Program? (If you do not accept HCBS/FE Medicaid Waiver recipients, please go to Question 16).

1. No, there is no limit  
2. Yes, there is a limit

16. Is there an entrance fee to enter your AL/RHC facility?

1. YES (Please go to question 16a)  
2. NO (Please go to question 17)

16a. Are there different entrance fees for those receiving HCBS/FE Medicaid Waiver services and those not?

1. YES  
2. NO

16b. What is the minimum entrance fee for:

1. $ **HCBS/FE Medicaid Waiver** individuals
2. $ **Private Pay** individuals

17. What is the range of fees charged for **room and board only** for a one bedroom unit for Medicaid-HCBS Frail Elderly Waiver residents?

1. $________________________

18. What is the minimum monthly fee for a one-bedroom unit for private pay residents?

1. $____________________
19. Do you calculate the average length of time residents reside in your AL/RHC/Homes Plus facility? (Check one)

Yes→ What is the average length of time residents stay in:

1. AL  
2. RHC  

No→ What is your best estimate of the average length of time residents stay in your AL/RHC facility?

1. AL  
2. RHC  

20. Using the numbers 1, 2 and 3, please rank the three most common reasons Private Pay residents have left your facility in the last six months. (Use “1” to indicate the most common reason, “2” for the second most common, and “3” for the third most common reason).

1. Care needs are too great  
2. Behavior problems  
3. Functioning improved  
4. Not enough funds  
5. Spouse died/moved  
6. Resident died  

Other: ____________________________________________

21. Using the numbers 1, 2 and 3, please rank the three most common reasons HCBS/FE Medicaid Waiver residents have left your facility in the last six months: (Use “1” to indicate the most common reason, “2” for the second most common, and “3” for the third most common reason).

1. Care needs are too great  
2. Behavior problems  
3. Functioning improved  
4. Not enough funds  
5. Spouse died/moved  
6. Resident died  

Other: ____________________________________________

22. Using the numbers 1, 2 and 3, please rank the three most common discharge destinations of your Private Pay residents in the last six months. (Use “1” to indicate the most common reason, “2” for the second most common, and “3” for the third most common reason).

1. Resident died  
2. Hospital  
3. Nursing Home  
4. Independent living/moved in with family  
5. Another AL facility  
6. Another RHC facility  
7. Moved to an RHC from AL  

Other (please specify):  
_____________________________________________________________
23. Using the numbers 1, 2 and 3, please rank the three (3) most common discharge destinations of your HCBS/FE Medicaid Waiver residents in the last six months. (Use “1” to indicate the most common reason, “2” for the second most common, and “3” for the third most common reason). If you do not serve HCBS/FE Medicaid Waiver residents, please go to Question 24.

1. Resident died
2. Hospital
3. Nursing Home
4. Independent living/moved in with family
5. Another AL facility
6. Another RHC facility
7. Moved to an RHC from AL

Other (please specify):
_____________________________________________________________

24. Please use the space below to provide any additional comments or information you may wish to share.

•
•
•
•

Thank you for taking the time to complete this survey.

Please return it in the enclosed, self-addressed stamped enveloped to:

Doreen Higgins, MSSW, CISW
Project Coordinator
The University of Kansas
1545 Lilac Lane Room 306, Twente Hall
Lawrence, KS  66045

Phone: 785-864-3830, Fax: 785-864-3677.
Appendix C: AL/RHC Focus Group Questions

University of Kansas
School of Social Welfare
Office of Aging and Long-Term Care

AL/RHC HCBS/FE Medicaid Waiver Focus Group Questions

April 22, 2005

1. According to our recent survey results, 70% of facilities use the Waiver. What are some positive aspects of and benefits to accepting the waiver? (5 minutes)

2. What are some ways KDOA has helped to facilitate the use of the HCBS/FE Waiver in ALs and RHCs? (10 minutes)

   Probe: We’re not asking this as agents of KDOA, but your thoughts are helpful here. What could KDOA do to further enhance participation in the Waiver program?

3. Survey results indicate that 30% of all responding facilities do not accept the HCBS/FE Medicaid Waiver. What are some reasons why these facilities would choose not to utilize the Medicaid Waiver? (7 minutes)

   Probe: What specific barriers exist in your facility to low-income older adults’ utilization of the Medicaid HCBS/FE waiver? (Prompt: low reimbursement rates, excessive paperwork)

4. What recommendations and strategies would you give to combat barriers to HCBS/FE Medicaid Waiver utilization? (10 minutes)

5. According to the survey results, 38% of facilities limit the number of HCBS Waiver residents they can accept into their facility. What factors may explain why over 1/3rd of facilities limit the number of Waiver residents they accept? (5 minutes)

5a. Does your facility have more Medicaid referrals than the facility can accommodate?

6. In contrast, the survey data indicates that some facilities are able to accommodate up to 60% Medicaid Waiver residents. In your opinion, how are some facilities able to accommodate Waiver residents? (3-4 minutes)

6a. Do any of your facilities have more than 50% Medicaid residents? How is your facility able to accommodate these residents?
7. **How would someone in your facility happen to be on the HCBS Waiver?** (6 minutes)

   **Probe:** If your facility accepts Waiver residents, what do you think happens more frequently: People enter the facility Waiver eligible, or they enter the facility as private pay customers and then spend down to the Waiver?

   **Probe:** Of those who come in Medicaid eligible, who were the most common referral sources? (Prompt, e.g., AAA case managers, family members, etc.)

8. **Who in your facility helps residents with the HCBS/FE Waiver process?** (6 minutes)

   8a. What, if any, is the involvement of a social worker in the HCBS/FE waiver process?

   8b. Survey results indicate that 40% of facilities do not have a social worker on staff or do not have access to a social worker. How do you think this affects access to the HCBS/Waivers for residents in facilities that do not have a social worker?

   8c. According to our survey results, social workers do a variety of things. Does your social worker help residents with advanced directives? How so?

9. **Are there other ways—aside from the Waiver—that you assist older low-income older adults in your facility?** Please give examples. (3 minutes) (Prompt: financially)

10. **Is there anything important we have missed that could help increase use of the HCBS/FE Medicaid Waiver?** (3 minutes)
Appendix D: Map of AL/RHC Beds per 1,000 People Age 65 and Over in Kansas Counties in 2004 (N=237)

*There are 237 AL/RHC facilities in Kansas.

Source: AL/RHC data from the State of Kansas, Directory of Kansas Assisted Living Facilities (2005); 2004 population estimates for the population age 65 and over by county from the U.S. Census Bureau.

Kansas Average: 25.04 AL/RHC Beds per 1,000 People Age 65 and Over

Legend
- less than state average
- more than state average
- No Facilities or No AL/RHC Beds