CHCF Explainer

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What Is Assisted Living?

Opportunities to Advance Community-Based Care for Medi-Cal Enrollees

More than 1 out of 10 California nursing facility residents have low care needs and could potentially be well served in more residential, supportive settings like assisted living communities.[1] While assisted living has primarily operated as a private-pay residential model, eligible Medi-Cal enrollees can gain access to assisted living through some specialized pathways, which have the opportunity to grow under CalAIM (California Advancing and Innovating Medi-Cal).

This explainer aims to help Medi-Cal managed care plans (MCPs) and other stakeholders learn more about assisted living and its role for Medi-Cal enrollees, including through CalAIM. CalAIM prioritizes effective, efficient, and person-centered care models, such as coordinating care and support services to help people remain in home and community-based settings. For older adults and people with disabilities, assisted living can serve as an integral part of the housing and care continuum, and MCPs can drive a variety of system and care improvements by leveraging its use.

Supporting Medi-Cal managed care plan (MCP) goals. Expanding access to assisted living through CalAIM Community Supports enables MCPs to provide more options for person-centered care and support for older adults and people with disabilities who have low incomes by appropriately transitioning or diverting some members from nursing facilities to a lower level of care. This approach promotes cost-effective delivery of care and services and creates the potential for improved member experiences and health outcomes.

Alleviating health care system bottlenecks. Assisted living has the potential to help alleviate patient discharge bottlenecks in hospitals and skilled nursing facilities, where finding appropriate placements for Medi-Cal enrollees who no longer require acute clinical services or rehabilitation can be challenging. Through Community Supports and Enhanced Care Management, MCPs can support preparation for and provision of transitional or long-term wrap-around services in residential care settings as an alternative to members remaining in hospital or skilled nursing settings.

Enhancing quality of life for Medi-Cal enrollees. Assisted living could play a significant role in improving health and quality of life outcomes by addressing gaps in non-medical care and services that are often unavailable to older adults and people with disabilities who have low incomes. Through the development of personalized care plans and 24/7 staff oversight, assisted living communities offer care and services in residential settings in an effort to minimize crisis-based interventions and improve care coordination with health care teams. Assisted living promotes the ability to age in more home-like settings and helps to improve continuity of care and support, including end-of-life care, as people's needs change over time.

The Basics

In California, assisted living provides a wide array of supportive services for older adults and people with disabilities within a licensed residential framework.

The two most common licensure categories are residential care facilities for the elderly (RCFEs) and adult residential facilities (ARFs), which adhere to the laws and regulations enforced by the California Department of Social Services (CDSS).[2] RCFEs serve residents age 60 or older, while ARFs serve residents age 18 to 59. With 24/7 staffing, these settings deliver personal care — and at times, clinical services — to support adults in primarily non-medical residential environments and foster independence by addressing housing and functional needs, including Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). (See Text Box.)

Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs)

ADLs

- Bathing
- Dressing/Grooming
- Eating
- Toileting/Incontinence Care
- Transferring/Mobility
- Wayfinding

IADLs

- Medication Management
- Housekeeping
- Laundry
- Transportation
- Meal Preparation (including for special diets)
- Scheduling/Care Coordination

In addition to these needs-based services, residents often benefit from a supportive environment that includes daily routines, social engagement programs, nutritional support, physical fitness, and fall-mitigation programs. Under their approved plans of operation, some RCFEs and ARFs can also offer more specialized services, such as dementia care programs within a secured environment, nursing services and oversight, mental health programs, end-of-life care in collaboration with Medicare-certified hospice agencies, and health care services for people with chronic health conditions.

RCFEs vs. ARFs

CDSS envisioned regulations for RCFEs and ARFs that would recognize and accommodate a broad spectrum of care services that reflects the diverse needs and preferences of adults in need of residential assisted living services throughout California and acknowledges the need for flexibility depending on the scope of services provided.

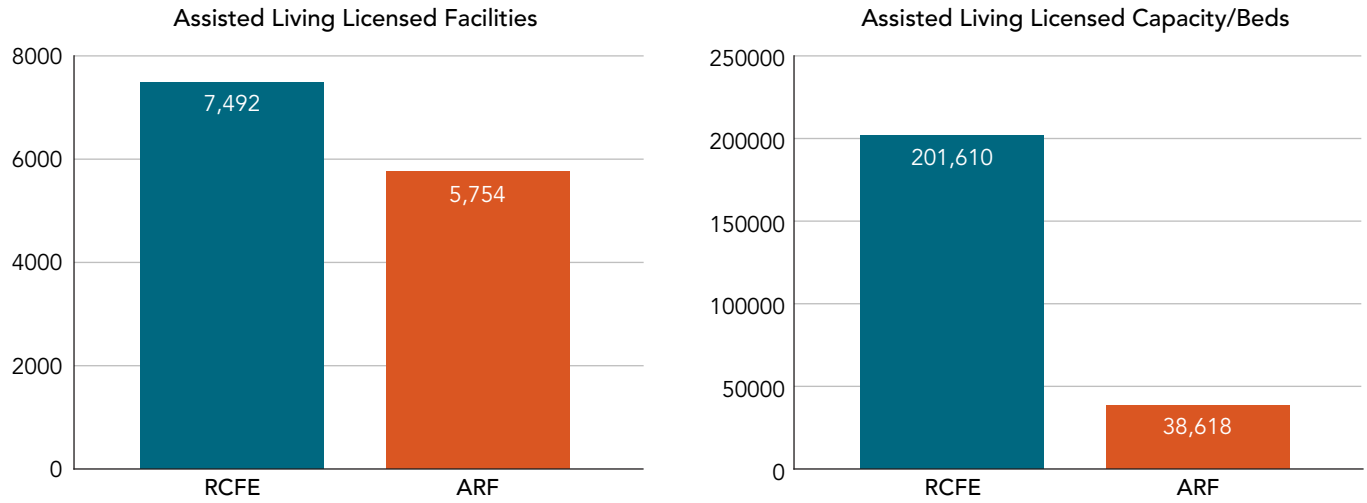
As a result, despite having a shared regulatory framework, California's RCFEs and ARFs differ in resident profile, size, program offerings, price, and care services.

Based on 2023 CDSS data, the state has 7,492 licensed RCFEs, including 110 continuing care cetirement communities (CCRCs), with a total of 201,610 licensed beds.[3] While just under 20% of California's RCFEs are licensed for 16 or more residents, those facilities serve over 80% of residents because of their larger licensed capacities.

The majority of RCFEs are smaller communities licensed for up to 15 residents. Those serve less than 20% of the state's RCFE population.

The same data show the state has 5,754 licensed ARFs with a total of 38,618 beds and an average of just under seven beds per licensed community.[4] That means the majority of ARF services are delivered in smaller settings. However, increased focus on the expanding and unmet housing and care needs of dependent adults ages 18 to 59 has led some assisted living operators to acquire ARFs with larger licensed capacities.

Figure 1. Number of Assisted Living Facilities and Beds in California, by Type, 2023



Source: "Adult and Senior Care Program Total Number of Licensed Facilities and Capacity by Facility Type" (PDF), California Department of Social Services Community Care Licensing Division, accessed June 18, 2024.

Note: *ARF* is adult residential facility; *RCFE* is residential care facility for the elderly.

Assisted Living Nomenclature

As assisted living owners and operators collaborate with Medi-Cal managed care plans to serve older adults and people with disabilities who have low incomes, differences in nomenclature can lead to confusion and unclear expectations. While the physical buildings are licensed as residential care facilities for the elderly (RCFEs) or adult residential facilities (ARFs), terms such as senior living, assisted living community, memory care, adult residential, and board and care may be used in contracts or marketing materials, causing potential misunderstandings of the scope of care and services. Clarity in terminology is helpful when developing new and effective levels of collaboration and understanding between stakeholders.

Assisted living community. Often refers to RCFEs, usually larger in size, which provide care and services as well as any specialized programs outlined in their marketing materials such as nursing oversight, diabetes care, or memory care.
Other terms: senior living community

Memory care. Refers to RCFE-licensed buildings that provide dedicated programs to meet the needs of people with dementia diagnoses. The programs can be stand-alone or part of an existing assisted living community. Memory care communities typically have additional physical plant safety amenities such as delayed egress, locked or secured perimeters, or alarms on exterior doors. In addition, they have specialized activity programs and staff training.
Other terms: Alzheimer's care centers, memory support, dementia care

Licensed board and care. Typically refers to smaller residential homes providing RCFE or ARF services.
Other terms: residential care, care home, 6-beds (based on licensed capacity)

Continuing care retirement communities (CCRCs). A subtype of RCFEs that offers various care levels, including independent living, assisted living, arrangements for memory care, and skilled nursing. Most CCRCs are larger (100 to over 500 units) and require an entrance fee. In California, communities with continuing care contracts must possess a certificate of authority and an RCFE license.
Other terms: life plan communities, life care, entrance fee or buy-in communities

Adult residential facilities. Cater to adults age 18 to 59 and provide housing; personalized supportive services; and support for mental health challenges, substance use, or chronic health conditions.
Other terms: board and care, residential care

Assisted Living Resident Characteristics and Services

The fundamental philosophy of assisted living services is to offer older adults and people with disabilities housing (ranging from shared rooms to full apartments), non-medical care, care coordination, and 24/7 staff supervision.

National data show that residents in California RCFEs have multiple chronic conditions.[5] The most prevalent identified chronic conditions are:

- High blood pressure: 42%
- Dementia: 40%
- Heart disease: 26%
- Depression: 18%
- Diabetes: 13%

In addition to providing 24/7 staffing, general observation, supervision, and medication management, assisted living operators focus on identifying functional and clinical needs in order to develop appropriate interventions and service plans. One source noted the following proportions of California RCFE residents needing assistance with the ADLs listed below:[6]

- Bathing: 64%
- Dressing: 55%
- Toileting: 52%
- Transferring: 39%
- Mobility/walking: 50%
- Eating: 25%

Although health outcomes data are limited, assisted living operators opine that the ability to monitor and react to early warning signs of declining health can improve health care outcomes and quality of life.[7] They also say that the acuity level in assisted living is increasing as the general population ages and the desire for residents to age in place grows. As a result, many operators are expanding technology systems and staffing to meet the demands for residential options and data reporting, and to further support complex chronic health conditions.

> *"Assisted living shows improved outcomes in reducing hospital readmission [and] medication errors, and mitigating falls. Just as important, we see improvement in other quality-of-life indicators based on interventions that reduce loneliness and isolation, communicate early detections of declining health, and offer programs that improve diet and exercise. The challenge is, not all stakeholders fully understand the value of these types of interventions."*
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> — Dave Coluzzi, President, Carlton Senior Living

Pathways for Medi-Cal Enrollees to Access Assisted Living

The vast majority of residents in assisted living pay privately for the costs of room and board and supportive services. Currently, only about 2% of California RCFE residents rely on Medi-Cal to pay a portion of their monthly fees.[8] But the size and needs of California's older adult population suggest that if expanded payment models for assisted living were available, more older adults and people with disabilities who have low incomes could avoid or transition out of nursing facility care and be more appropriately served in this setting.

The two primary mechanisms for Medi-Cal enrollees to access assisted living today are the Assisted Living Waiver (ALW) and Nursing Facility Transition/Diversion to Assisted Living Facilities, one of CalAIM's optional Community Supports.

Assisted Living Waiver

The ALW is a federal 1915(c) Medicaid Home and Community-Based Services waiver that has been in place in California since 2009 to offer an alternative to long-term nursing facility placement for eligible people age 21 or older who have resided in a nursing facility for at least 60 days. The ALW program is currently available in 15 of 58 California counties and has 14,544 total waiver slots, representing the maximum number of participants that can be in the program at any point in time. To apply, applicants must work with local Care Coordination Agencies, organizations approved by DHCS to administer the waiver program.[9]

The waiver's terms are applied in five-year increments following approval from the federal Centers for Medicare & Medicaid Services (CMS), which has approved the current waiver through February 28, 2029.[10] As of June 2024, ALW enrollment was 14,166, with 3,049 people on the waitlist.[11] With that in mind, California's Department of Health Care Services (DHCS) is seeking CMS approval to increase ALW capacity for waiver years two to five (2025-2029).[12]

Under the ALW, Medi-Cal covers state-approved amounts for five tiers of assisted living services provided in an RCFE, ALF, or public housing setting, while residents are responsible for paying for their room and board. In most cases, RCFE and ARF communities participating in the ALW have agreed to accept a significantly reduced room and board rate for ALW participants, who typically use their Supplemental Security Income/State Supplementary Payment (SSI/SSP) to pay those expenses.[13]

Community Supports: Nursing Facility Transition/Diversion to Assisted Living Facilities

Nursing Facility Transition/Diversion to Assisted Living Facilities is one of 14 Community Supports approved for optional use by MCPs as substitute services to covered Medicaid State Plan services. A foundational goal of Community Supports is to provide access to care in the least restrictive environment, allowing for choice while providing appropriate, cost-effective health care services. This particular Community Support is designed to facilitate appropriate transitions to licensed assisted living settings either as an alternative to skilled nursing care or when skilled nursing services are no longer required for the member.

As in the ALW program, the Nursing Facility Transition/Diversion to Assisted Living Facilities Community Support pays assisted living operators a negotiated rate for services through Medi-Cal, while the resident must pay for room and board. One difference is that in this case, it is MCPs, rather than the state, facilitating those payments.

Unlike the ALW, this Community Support can be offered statewide if MCPs elect to do so, and as of July 1, 2024 at least one MCP in 38 of California's 58 counties has elected to provide it.[14] As well, while the ALW program requires pre-approval and certification for each participating RCFE and ARF, for this Community Support MCPs can contract with any RCFE or ARF and negotiate reimbursement rates based on location and level of care needs. MCPs can also pair this Community Support with Enhanced Care Management services to provide additional comprehensive case management to eligible members.

Based on the DHCS Community Supports Policy Guide, members must meet the specific criteria outlined below to be eligible for this service.[15]

For Nursing Facility Transition, members must:

- Have resided 60 or more days in a nursing facility.
- Be willing to live in an assisted living setting as an alternative to a nursing facility.
- Be able to reside safely in an assisted living setting with appropriate and cost-effective supports.

For Nursing Facility Diversion, members must:

- Be interested in remaining in the community.
- Be willing and able to reside safely in an assisted living setting with appropriate and cost-effective supports and services.
- Be currently receiving medically necessary nursing facility level of care (LOC) or meet the minimum criteria to receive nursing facility LOC services.
- Choose to remain in the community to receive medically necessary nursing facility LOC services in an assisted living setting in lieu of going into a nursing facility.

To date, use of this Community Support has been low. The most recent data published by DHCS show that from January through December 2023, just 552 people received the Nursing Facility Transition/Diversion to Assisted Living Facilities Community Support across the state.[16]

Other Pathways

Other mechanisms for older adults and people with disabilities who have low incomes to access assisted living include, on a limited basis, letters of agreement or contracts with Program of All-Inclusive Care for the Elderly (PACE) providers, California Department of Developmental Services Regional Centers, Veterans Affairs, and hospital systems.

Conclusion

While Medi-Cal's role in assisted living has been limited to date, CalAIM's Community Supports provide an opportunity to expand the use of assisted living among Medi-Cal's older adults and people with disabilities. This expansion has the potential to help reduce nursing facility use while enabling more Medi-Cal enrollees to receive the support they need in home-like settings.

MCPs will play an essential role in promoting the use of assisted living for their members. Their collaboration with assisted living operators is not just beneficial, but crucial, for creating a more comprehensive care continuum. By expanding access to assisted living through Community Supports, MCPs can improve quality of life for their members, help alleviate discharge bottlenecks, and provide more cost-effective care solutions.

As California continues to innovate and improve its Medi-Cal program, the integration of assisted living services into the broader health care system will be vital. Ongoing commitment to these collaborative efforts can help contribute to a more equitable and effective health care system for all Californians.

Case Study: Leveraging Community Supports for Transition from Skilled Nursing to Assisted Living

Background

"Joe" is a 77-year-old male Medi-Cal enrollee with a complex medical history characterized by multiple complex chronic diseases (including kidney disease, dementia, vascular disease, hypertension, and unspecified psychosis) who requires ongoing medical oversight, support with activities of daily living, and psycho-social support.

Prior to moving to a licensed assisted living community, Joe resided in a skilled nursing facility for over 1000 days. During this time, he required medical oversight and custodial care for his chronic conditions. His inability to navigate the health care system and his lack of family or social support meant that he relied heavily on the health care system for all areas of his life.

Care Management and Transition

Recognizing the opportunity for a more appropriate long-term care solution, Joe's Medi-Cal managed care plan (MCP) and Enhanced Care Management (ECM) care navigators took active roles in coordinating his transition from skilled nursing to an assisted living community. To do so, they identified the services necessary to support a successful transition to a nonmedical residential care option, including:

- **Assessment of assisted living needs.** The teams evaluated Joe's functional status and personal care requirements and developed a coordinated service plan to support his needs and preferences.
- **Selection of assisted living facility.** They identified a licensed residential care facility for the elderly (RCFE) that could provide the necessary care and support.
- **Coordination of health care services.** They arranged for continued health care oversight for Joe, including primary care, intermittent physical therapy, monitoring by a home health agency, and clinical therapy.

Highlights of the Transition to Assisted Living

Care coordination. The interdisciplinary services approach — including medication management, personal care, supervision, primary care, physical therapy, and case management — allowed the assisted living team to integrate its interventions as part of Joe's comprehensive health care plan designed by the MCP and ECM teams.

Medical emergencies. In Joe's first year in the assisted living community, he had just two 9-1-1 calls made on his behalf: one for an unwitnessed fall and one for abdominal pain. He was discharged from the emergency department back to the assisted living community on both occasions, indicating that his medical emergencies were managed effectively and did not require hospitalization. Both of these incidents occurred in the first four months of Joe's assisted living residency.

Therapy and monitoring. Joe continues to receive intermittent physical therapy to help mitigate falls. His primary care physician monitors his health conditions, including through house visits to the RCFE, and has ordered home health nursing services for non-emergency acute issues. Joe receives intermittent clinical therapy to manage symptoms caused by his unspecified psychosis.

Social engagement. Adjusting to his new environment, Joe now enjoys the company of his roommate, dines in the communal dining room, and participates in group activities. This social engagement is vital for his mental well-being and helps him build a sense of community.

Outcomes

Joe's transition from skilled nursing to assisted living has had several positive outcomes, including:

- **Improved quality of life.** The assisted living community provides a more home-like environment compared to the skilled nursing facility. This change, combined with social interactions and group activities, has enhanced Joe's overall well-being.
- **Care coordination.** The care coordination among Joe's various providers and specialists helps to ensure more timely and appropriate interventions.
- **Cost-effectiveness.** Given the high cost of skilled nursing facilities, the ability to fully meet Joe's care needs in the lower-acuity, lower-cost assisted living setting is likely more cost-effective for the MCP. *(A more comprehensive review of clinical and ancillary services and an understanding of potentially avoided costs [e.g., emergency department visits, hospitalizations] would provide a complete picture of the transition's impacts on total cost of care.)*

Conclusion

This case highlights the importance of coordinated care management in transitioning older adult patients with complex medical needs to appropriate living environments. The collaborative efforts of care managers, health care providers, and assisted living operators can result in improved quality of life and effective management of chronic conditions. This case study also underscores the value of person-centered care and the need for increased collaboration in supporting populations with complex needs.

About the Author

Paula Hertel, MSW, is founder of Senior Living Consult, which specializes in strategic, operational, and marketing services for senior living organizations. Additionally, she advises ancillary service providers, helping to identify and address emerging needs and opportunities, including credentialing for CalAIM Community Support services. Hertel also serves as a board member and education co-chair for the California Assisted Living Association.

About the Foundation

The California Health Care Foundation (CHCF) is an independent, nonprofit philanthropy that works to improve the health care system so that all Californians have the care they need. We focus especially on making sure the system works for Californians with low incomes and for communities who have traditionally faced the greatest barriers to care. We partner with leaders across the health care safety net to ensure they have the data and resources to make care more just and to drive improvement in a complex system.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

Endnotes

1. "2023 California LTSS Choices Scorecard Report," AARP, accessed June 18, 2024.
2. "Residential Regulations," California Department of Social Services (DSS), accessed June 18, 2024.
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5. ***California by the Numbers: Facts and Figures for the Profession*** (PDF), National Center for Assisted Living (NCAL), accessed March 6, 2024.
6. *California by the Numbers*, NCAL.
7. California assisted living operators, personal communication with author, February-March 2024.
8. *California by the Numbers*, NCAL.
9. "Application for a §1915(c) Home and Community-Based Services Waiver" (PDF), California Department of Health Care Services (DHCS), March 1, 2024.
10. "Assisted Living Waiver," DHCS, accessed June 6, 2024; ***The Assisted Living Waiver (ALW) Program*** (PDF), DHCS, effective January 1, 2023.
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